MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA) 3.0 STATE SELF-ASSESSMENT

MITA REPORTS

MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA) 3.0 STATE SELF-ASSESSMENT

BUSINESS ARCHITECTURE

Version	Date	Author	Change Description
1.0	12/23/2016	Greg Haskamp	Original document created – submitted as draft
Final	5/5/2017	Greg Haskamp	Incorporates feedback

TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF AUTHORITIES

MITA Business Architecture

The Centers for Medicare and Medicaid Services (CMS) defines the Medicaid Information Technology Architecture (MITA) as both a framework and an initiative. The MITA 3.0 model consists of four interrelated components which include:

- Business Architecture (BA)
- Information Architecture (IA)
- Technical Architecture (TA)
- Seven Conditions and Standards (7C&S)

The identified business needs and capabilities from the BA define data strategies used in the IA and subsequently, the business and technical services which are employed for the TA. All three architectures are used to determine the degree of conformance to the 7C&S. CMS further uses all three architectures to promote business driven enterprises and consistency among all state Medicaid programs, as shown in the figure below.

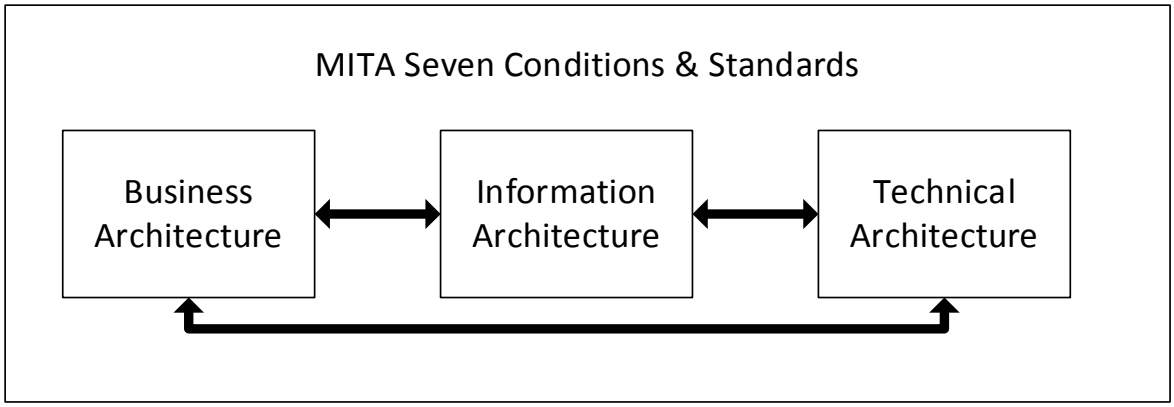


Figure 1: MITA Framework Relationship Diagram

The BA represents the starting point of the MITA framework, describing the business needs and goals of the Department of Social Services (DSS), Connecticut's State Medicaid Agency (SMA). As a conceptual framework, the BA for the DSS MITA 3.0 State Self-Assessment (SS-A) is constructed using CMS defined models, matrices, and templates.

The CMS defined MITA Business Process Model (BPM) is comprised of 80 distinct business processes, which are organized more broadly into categories and further grouped into business areas as shown in the figure below.

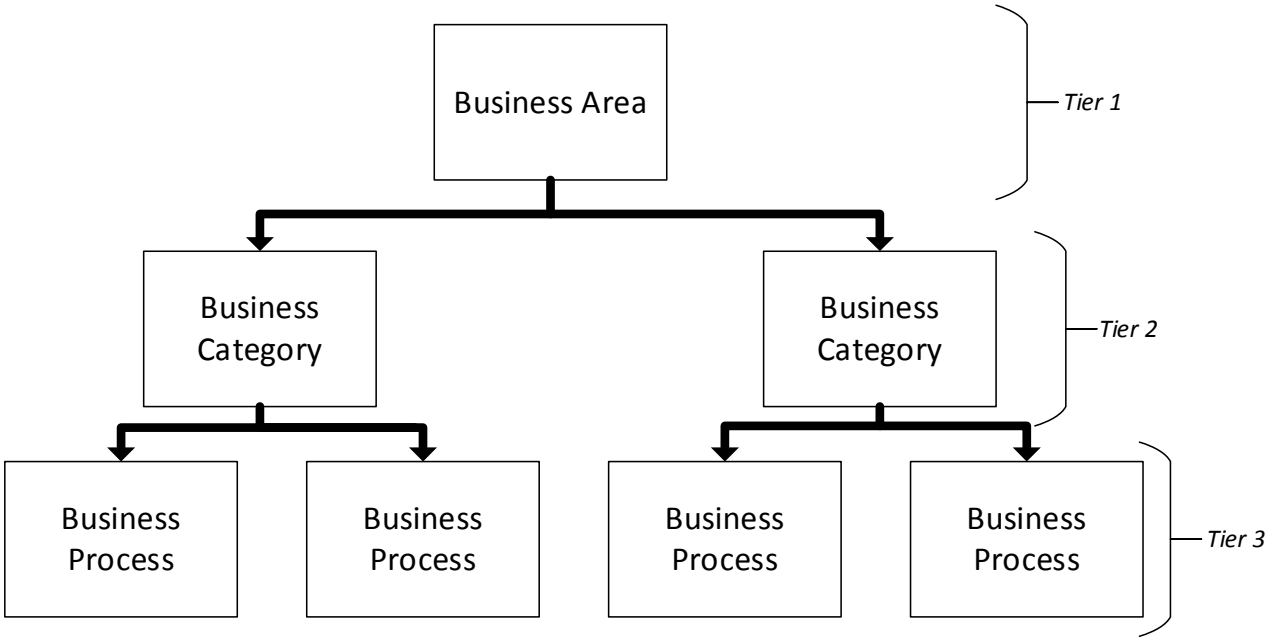


Figure 2: MITA Business Process Model Hierarchy

The MITA BPM is broadly defined by ten business areas. The table below illustrates the total number of MITA business processes across each business area, in comparison to the DSS identified processes. DSS utilizes the same ten areas identified from MITA 3.0 definitions. Individual processes were analyzed for differences, and those have been recorded using the CMS defined MITA Business Process Templates (BPTs) as supporting documentation.

MITA Business Area	MITA 3.0 Processes	Connecticut Processes
Business Relationship Management	4	4
Care Management	9	9
Contractor Management	9	9
Eligibility & Enrollment Management	8	8
Financial Management	19	18
Member Management	4	4
Operations Management	9	8
Performance Management	5	5
Plan Management	8	8
Provider Management	5	5
Total	**80**	**78**

Table 1: Business Area Comparison

The current MITA 3.0 framework released by CMS does not yet include processes for Member Management. For the purpose of this assessment, the applicable processes from the MITA 2.0 framework are being used.

Business Architecture Overview

CMS requires States to align to and advance increasingly in MITA maturity for the BA. CMS expects States to use the BA components to plan for improvements in the State Medicaid Program, both in the delivery of services to providers and beneficiaries, and in its internal operations and exchanges of information with other external stakeholders.

The BA defines Connecticut's "As-Is" operations and develops targeted "To-Be" capabilities or environments within the DSS enterprise, using CMS defined processes, capabilities, and standards. The outline below is utilized throughout the BA portion of the SS-A:

I. Connecticut Business Area Overview
   - A. Connecticut Area Profile

II. Connecticut Business Process
   - A. MITA Process Description
   - B. Connecticut Organizational Owners
   - C. Connecticut Data & Systems
   - D. As-Is Process Summary
   - E. To-Be Process Summary
   - F. Capability Matrix Summary

The document below provides an overview of MITA 3.0 areas, business categories, and processes, as well as a summary profile of BA capabilities for DSS as it relates to the Medicaid enterprise.

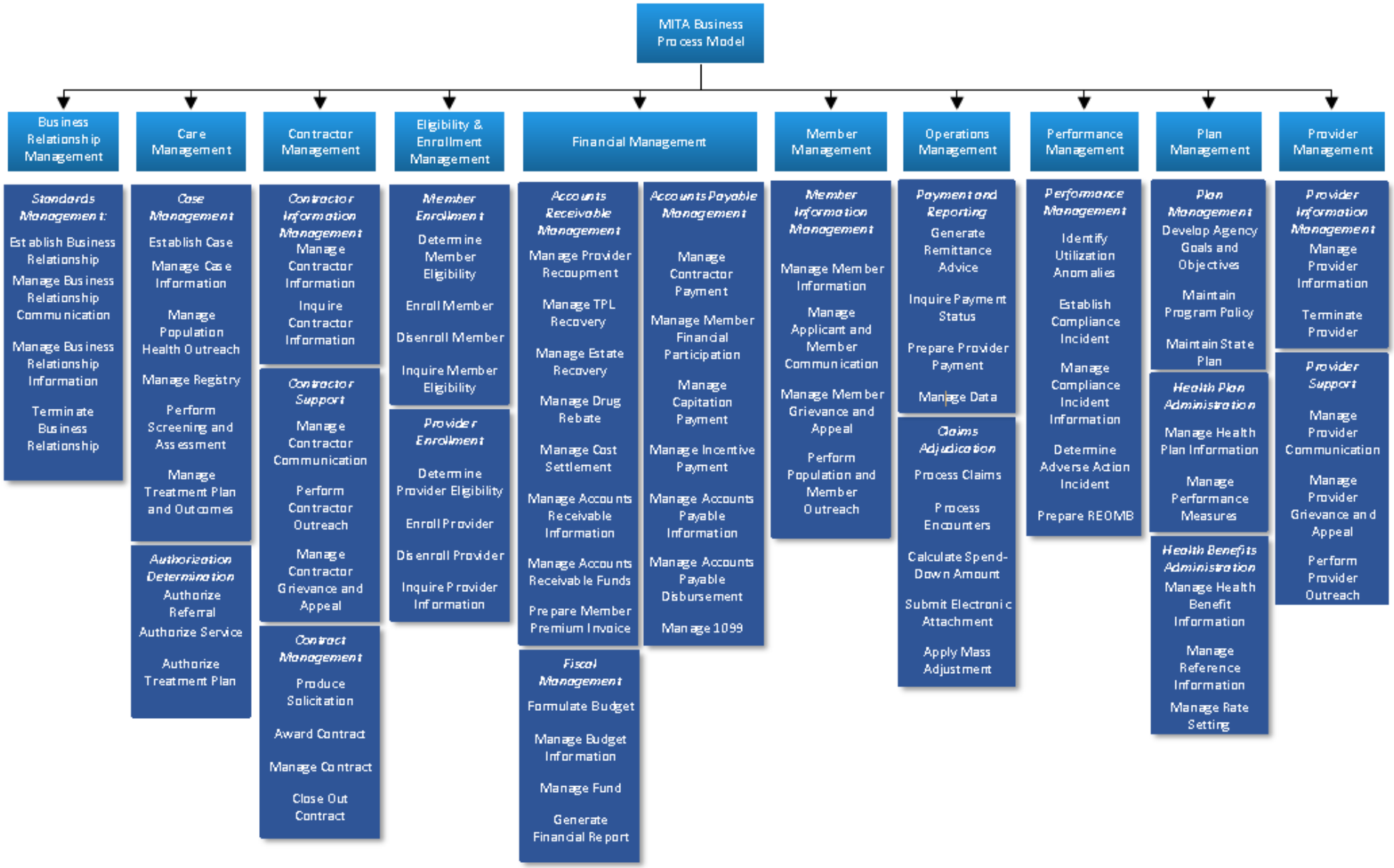


Figure 3: MITA Business Process Model

Connecticut Medicaid Business Architecture Profile MITA 3.0					
Business Relationship Management	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
BR01 Establish Business Relationship	As-Is	To-Be			
BR02 Manage Business Relationship Communication	As-Is	To-Be			
BR03 Manage Business Relationship Information	As-Is	To-Be			
BR04 Terminate Business Relationship	As-Is	To-Be			
Care Management					
CM01 Establish Case		As-Is	To-Be		
CM02 Manage Case Information		As-Is	To-Be		
CM03 Manage Population Health Outreach		As-Is	To-Be		
CM04 Manage Registry	As-Is	To-Be			
CM05 Perform Screening and Assessment		As-Is	To-Be		
CM06 Manage Treatment Plan and Outcomes		As-Is	To-Be		
CM07 Authorize Referral	As-Is	To-Be			
CM08 Authorize Service		As-Is	To-Be		
CM09 Authorize Treatment Plan		As-Is	To-Be		
Contractor Management					
CO01 Manage Contractor Information	As-Is	To-Be			
CO04 Inquire Contractor Information	As-Is		To-Be		
CO02 Manage Contractor Communication	As-Is		To-Be		
CO03 Perform Contractor Outreach	As-Is		To-Be		
CO09 Manage Contractor Grievance and Appeal		As-Is	To-Be		
CO05 Produce Solicitation		As-Is	To-Be		
CO06 Award Contract		As-Is	To-Be		
CO07 Manage Contract	As-Is	To-Be			
CO08 Close Out Contract	As-Is	To-Be			
Eligibility and Enrollment Management					
EE01 Determine Member Eligibility		As-Is	To-Be		
EE02 Enroll Member		As-Is	To-Be		
EE03 Dis-enroll Member		As-Is	To-Be		
EE04 Inquire Member Eligibility		As-Is	To-Be		
EE05 Determine Provider Eligibility		As-Is	To-Be		
EE06 Enroll Provider		As-Is	To-Be		
EE07 Dis-enroll Provider		As-Is	To-Be		
EE08 Inquire Provider Information		As-Is	To-Be		
Financial Management					
FM01 Manage Provider Recoupment		As-Is/To-Be			
FM02 Manage TPL Recovery		As-Is	To-Be		
FM03 Manage Estate Recovery		As-Is	To-Be		
FM04 Manage Drug Rebate		As-Is	To-Be		
FM05 Manage Cost Settlement		As-Is	To-Be		
FM06 Manage Accounts Receivable Information	As-Is		To-Be		
FM07 Manage Accounts Receivable Funds	As-Is		To-Be		
FM08 Prepare Member Premium Invoice		As-Is	To-Be		
FM09 Manage Contractor Payment	As-Is	To-Be			
FM10 Manage Member Financial Participation		As-Is	To-Be		
FM11 Manage Capitation Payment (not performed in CT)					
FM12 Manage Incentive Payment		As-Is	To-Be		

FM13 Manage Accounts Payable Information		As-Is	To-Be		
FM14 Manage Accounts Payable Disbursement	As-Is	To-Be			
FM15 Manage 1099		As-Is	To-Be		
FM16 Formulate Budget	As-Is	To-Be			
FM17 Manage Budget Information	As-Is	To-Be			
FM18 Manage Fund	As-Is	To-Be			
FM19 Generate Financial Report	As-Is	To-Be			
Member Management					
ME01 Manage Member Information		As-Is	To-Be		
ME02 Manage Applicant and Member Communication		As-Is	To-Be		
ME08 Manage Member Grievance and Appeal		As-Is	To-Be		
ME03 Perform Population and Member Outreach		As-Is	To-Be		
Operations Management					
OM14 Generate Remittance Advice		As-Is	To-Be		
OM18 Inquire Payment Status		As-Is	To-Be		
OM27 Prepare Provider Payment		As-Is	To-Be		
OM28 Manage Data	As-Is		To-Be		
OM07 Process Claim		As-Is	To-Be		
OM29 Process Encounter (not performed in CT)					
OM20 Calculate Spend Down Amount	As-Is	To-Be			
OM04 Submit Electronic Attachment	As-Is	To-Be			
OM05 Apply Mass Adjustment		As-Is	To-Be		
Performance Management					
PE01 Identify Utilization Anomalies	As-Is	To-Be			
PE02 Establish Compliance Incident	As-Is	To-Be			
PE03 Manage Compliance Incident Information	As-Is	To-Be			
PE04 Determine Adverse Action Incident	As-Is	To-Be			
PE05 Prepare REOMB	As-Is/To-Be				
Plan Management					
PL01 Develop Agency Goals and Objectives	As-Is	To-Be			
PL02 Maintain Program Policy	As-Is	To-Be			
PL03 Maintain State Plan		As-Is	To-Be		
PL04 Manage Health Plan Information	As-Is	To-Be			
PL05 Manage Performance Measures	As-Is	To-Be			
PL06 Manage Health Benefit Information		As-Is	To-Be		
PL07 Manage Reference Information		As-Is	To-Be		
PL08 Manage Rate Setting	As-Is	To-Be			
Provider Management					
PM01 Manage Provider Information		As-Is	To-Be		
PM08 Terminate Provider		As-Is	To-Be		
PM02 Manage Provider Communication		As-Is	To-Be		
PM07 Manage Provider Grievance and Appeal		As-Is	To-Be		
PM03 Perform Provider Outreach		As-Is	To-Be		

Table 2: Connecticut Business Architecture Capabilities Profile Summary

I. Business Relationship Management

The Business Relationship Management (BR) business area is a collection of business processes that facilitate the coordination of standards of interoperability. This business area defines the exchange of information and Trading Partner Agreements (TPA) between the State Medicaid Agency (SMA) and its partners, including collaboration among intrastate agencies, interstate agencies, and federal agencies. These agreements contain functionality for interoperability, establishment of inter-agency Service Level Agreements (SLA), identification of the types of information exchanged, and security and privacy requirements. The Business Relationship Management business area has a common focus (e.g., data exchange standards and SLA) and is responsible for the business relationship data store.

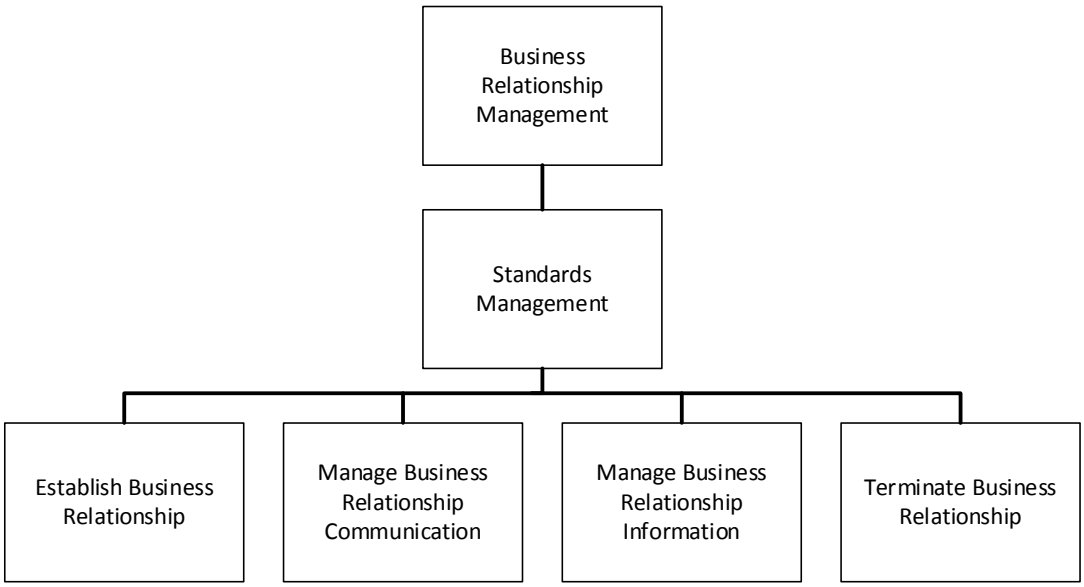


Figure 4: Business Relationship Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
BR01 Establish Business Relationship	1	2
BR02 Manage Business Relationship Communication	1	2
BR03 Manage Business Relationship Information	1	2
BR04 Terminate Business Relationship	1	2
Area Assessment	**1**	**2**

Table 3: Business Relationship Management Area Profile

Connecticut Organizational Owners

The DSS Contract Administration and Procurement Division provides oversight and support to formal contract and procurement processes. DXC Technology (DXC), formerly Hewlett Packard Enterprises (HPE), as fiscal agent for DSS, supports Electronic Data Interchange (EDI) transactions with providers.

As-Is Business Area Summary

The Contract Administration and Procurement Division maintains formal responsibility for contract and procurement processing. Informally, establishing data and exchange standards via contract terms and conditions are also included within Division responsibilities. Service Level Agreements and data standards within DSS are ad hoc. Provider interactions are more standardized. DXC (fiscal agent) maintains the Trading Partner Agreements within the EDI subsystem of the MMIS system, interChange. In order for a Trading Partner to submit electronically (whether through PES or any other HIPAA compliant electronic transactions) the trading partner must have a Trading Partner Agreement in place and have successfully tested the transactions they signed up for.

To-Be Business Area Summary

DSS should formalize the process of incorporating data standards for the procurement and contract processes. Enforcement mechanisms will become increasingly critical for a modular approach to enterprise system architecture. Formal establishment and maintenance of DSS data standards and Service Oriented Architecture (SOA) are further addressed by the Data Management Strategy and Technical Management Strategy within the Information and Technical Architectures of the MITA State Self-Assessment.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Establish Business Relationship	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	1	2
What is the cost of the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 4: Capabilities Summary Matrix - Establish Business Relationship

Manage Business Relationship Communication	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Is communication linguistically, culturally, and competency appropriate?	2	3
Does State Medicaid Agency use standards in the process?	2	3
Does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost of the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 5: Capabilities Summary Matrix - Manage Business Relationship Communication

Manage Business Relationship Information	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
Does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	2
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost of the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 6: Capabilities Summary Matrix - Manage Business Relationship Information

Terminate Business Relationship	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 7: Capabilities Summary Matrix - Terminate Business Relationship

II.Care Management

The Care Management business area illustrates the increasing shift away from the Fee-For-Service (FFS) model of care. Care Management collects information about the needs of the individual member, plan of treatment, targeted outcomes, and the individual's health status. It also contains business processes that have a common purpose (e.g., identify members with special needs, assess needs, develop treatment plan, monitor and manage the plan, and report outcomes). This business area includes processes that support individual care management and population management. Population management targets groups of individuals with similar characteristics to promote health education and awareness. The Electronic Health Record (EHR), Electronic Medical Record (EMR), and Personal Health Record (PHR) can be primary sources of individual health information from the Health Information Exchange (HIE).

Care Management includes Disease Management, Catastrophic Case Management, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Population Management, Patient Self-Directed Care Management, national health registries, and Waiver Program Case Management. The Care Management business area is responsible for case management, authorizations, referrals, treatment plans, and data stores. Care Management also contains business processes for authorization determination including authorizing referrals, as well as service and treatment plans.

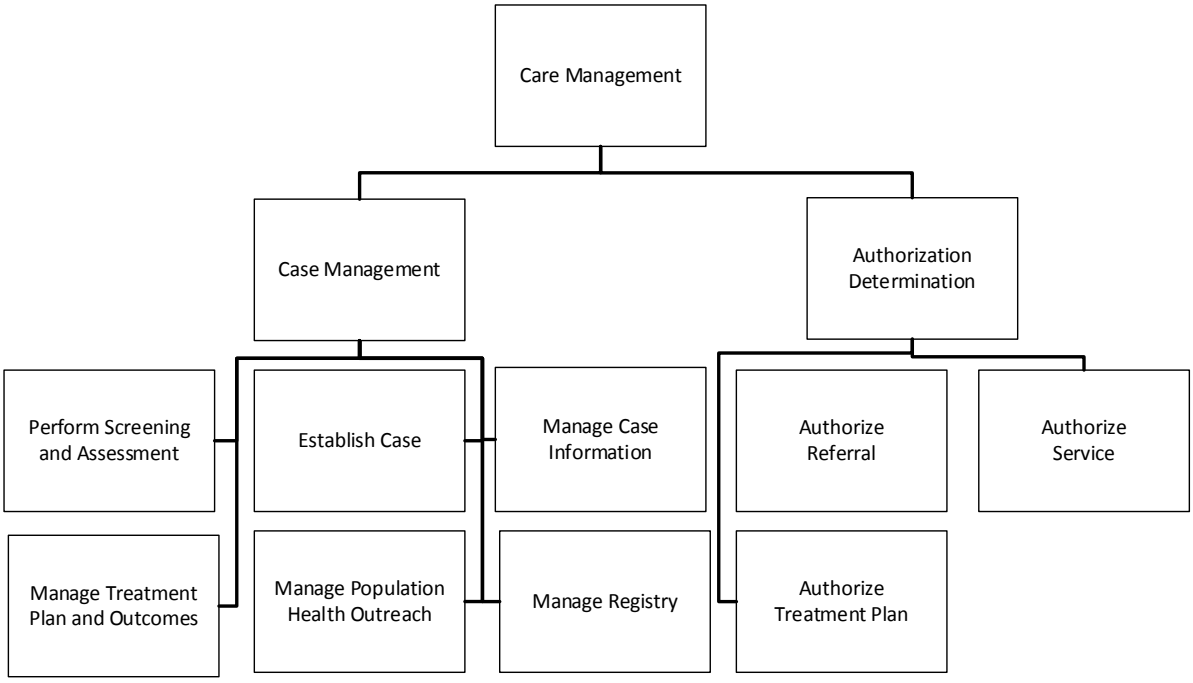


Figure 5: Care Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
CM01 Establish Case	2	3
CM02 Manage Case Information	2	3
CM03 Manage Population Health Outreach	2	3
CM04 Manage Registry	1	2
CM05 Perform Screening and Assessment	2	3
CM06 Manage Treatment Plan and Outcomes	2	3
CM07 Authorize Referral	1	2
CM08 Authorize Service	2	3
CM09 Authorize Treatment Plan	2	3
Area Assessment	**1**	**2**

Table 8: Care Management Business Area Profile

Connecticut Organizational Owners

Within the Department of Social Services, Care Management activities are disseminated across multiple organizational units, and external partners.

The Division of Health Services consists of five units:

- **Integrated Care Unit-** Manages the ASOs and coordinates/integrates all Medicaid services, ensuring that members' needs are met, that health outcomes are improved, and that this is done in a cost-efficient manner.
- **Community Options Unit-** Stewards the work of the Governor's long term services and supports (LTSS) rebalancing agenda, which aims through system transformation to enable choice and self-direction for people who use LTSS. The Community Options Unit includes the Strategy and Operations Teams. The Operations Team includes Community Engagement, Eligibility, and Autism Services Groups. General responsibilities of the Strategy Group include grant administration and operation (currently MFP and TEFT), the strategic rebalancing plan (design and implementation), and design and implementation of person-centered systems. General responsibilities of the Operations Group include waiver administration and operation, financial eligibility processing, and nursing home level of care determinations.
- **Medical Operations Unit-** Medical Operations serves as the Division's functional arm, and is the means through which all medical programs are operationalized, paid, and reported within the Medicaid Management Information System (MMIS). Medical Operations works with and supports DSS units, sister Agencies, and the ASOs to implement and modify existing programs and services, ensure that claims are processed in compliance with federal rules, and ensure that program expenditures are reported correctly so that federal match can be claimed.
- **Medical Policy Unit and Clinical Review Team-** The Medical Policy Unit creates, monitors, and updates the Department's Medical Policies and interprets new federal

and state statutes and policy initiatives. The Clinical Review Team, with the Medical Director, provides clinical oversight of the Department's medical programs. The Clinical Review Team provides expert clinical perspective in policy making, coverage determinations, and liaison work with the ASOs, supporting both the prevention agenda of the Division and its emphasis on use of data to guide decision-making.

- **Reimbursement and Certificate of Need (CON) Unit-** Responsible for establishing federally approvable reimbursement methodologies in order to maintain a well-balanced medical provider network while maximizing federal revenue. Specific duties include establishing and implementing reimbursement methodologies for medical and residential services covered under the Medicaid and State Supplement/AABD programs.

External entities with responsibility for Care Management activities include:

- Connecticut Department of Public Health (DPH)
- Administrative Service Organizations (ASOs)
  - Medical Services- Community Health Network of Connecticut (CHN)
  - Behavioral Health Services- Beacon Health Options
  - Dental Services- BeneCare Dental Benefits
  - Pharmacy Services- DSS Pharmacy Team & DXC Technology (DXC)
  - Non-emergency Medical Transportation (NeMT) - LogistiCare
- Waiver administering agencies (non DSS)
  - Department of Development Services (DDS)
  - Department of Mental Health and Addiction Services (DMHAS)
  - Department of Administrative Services (DAS) (claim support)
- Waiver entities and partners
  - DXC (care plan portal)
  - Allied Community Resources
- DXC (fiscal agent)- claims processing
- Access Health CT (HIX Marketplace)

As-Is Business Area Summary

Processes within the Care Management Business Area in Connecticut utilize a mix of manual and automated steps with business being accomplished through departmentalized data store systems. ASOs, Waiver programs, and contractors maintain their own systems. Systems contain data stores for care plans, case management, and assessment data without the capability of cross system communication. For waivers administered by DSS, waiver information (i.e. care plan, case management activities, and assessment data) is stored in the Waiver Data Base. DSS utilizes sister agencies and contracts with Access Agencies across the state to assist with waiver management and provide care plans. These Agencies include the Department of Development Services, Department of Mental Health and Addiction Services, Department of Rehabilitation Services and The Department of Aging, each utilizing their own unique system for care plans and case management. There is little coordination between waivers and ASOs for care coordination. Each division within the ASOs and Waivers have unique criteria for the qualifying member, creating a cumbersome process of identifying need and duplication of services. Limited clinical

information is available through HIE. Data integrity and data standards management are issues due to decentralized operations. Authorization of treatment/service plans is processed differently across Connecticut SMA Programs. In-house systems are utilized for case management and tracking; functionality is limited and not accessible to partner agencies or entities.

To-Be Business Area Summary

The Care Management Business Area would benefit from improved data governance activities throughout SMA, and a unified care management system for use by ASOs. Improved data sources, standardization defined data elements across SMA Programs, analytic tools, and dynamic reports would allow for greater automation and accuracy within the business processes across DSS. A unified case management system with referral tracking, and automated workflows would benefit all business processes within the area. An Integrated Care Management Platform following HIPAA compliance and standardized secure messaging system with real time data sharing among the programs will enhance member care and efficiency with communication between the various entities within SMA. As care management for waivers extends beyond the agency, shared data could be accessed with data standards and bi-directional data sharing capabilities using an enterprise service bus. System improvements would aid in case/service processing, as well as provide greater MITA maturity. MITA maturity scores are constrained for a number of processes due to a lack of planned system enhancements.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Establish Case	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 9: Capabilities Summary Matrix - Establish Case

Manage Case Information	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 10: Capabilities Summary Matrix - Manage Case Information

Manage Population Health Outreach	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 11: Capabilities Summary Matrix – Manage Population Health Outreach

Manage Registry	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	1	2
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	1	2
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	1	2
Business Process Assessment	**1**	**2**

Table 12: Capabilities Summary Matrix – Manage Registry

Perform Screening and Assessment Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 13: Capabilities Summary Matrix - Perform Screening and Assessment

Manage Treatment Plans and Outcomes Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 14: Capabilities Summary Matrix - Manage Treatment Plans and Outcomes

Authorize Referral Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	1	2
How easy is it to change the business rules of Authorize Referral?	1	2
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 15: Capabilities Summary Matrix - Authorize Referral

Authorize Service Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	3	3
Does State Medicaid Agency use standards in the process?	2	3
How easy is it to change the business rules of Authorize Services?	3	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 16: Capabilities Summary Matrix - Authorize Service

Authorize Treatment Plan Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How easy is it to change the business rules of Authorize Treatment Plan?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 17: Capabilities Summary Matrix - Authorize Treatment Plan

III. Contractor Management

The Contractor Management business area accommodates Administrative Service Organization contracts and a variety of outsourced contracts. The Contractor Management business area has a common focus on Medicaid contractors (e.g., managed care, at-risk mental health or dental care, Primary Care Physician (PCP)), is responsible for contractor data store, and uses business processes that have a common purpose (e.g., Fiscal Agent, enrollment broker, Fraud Enforcement Agency, and third-party recovery).

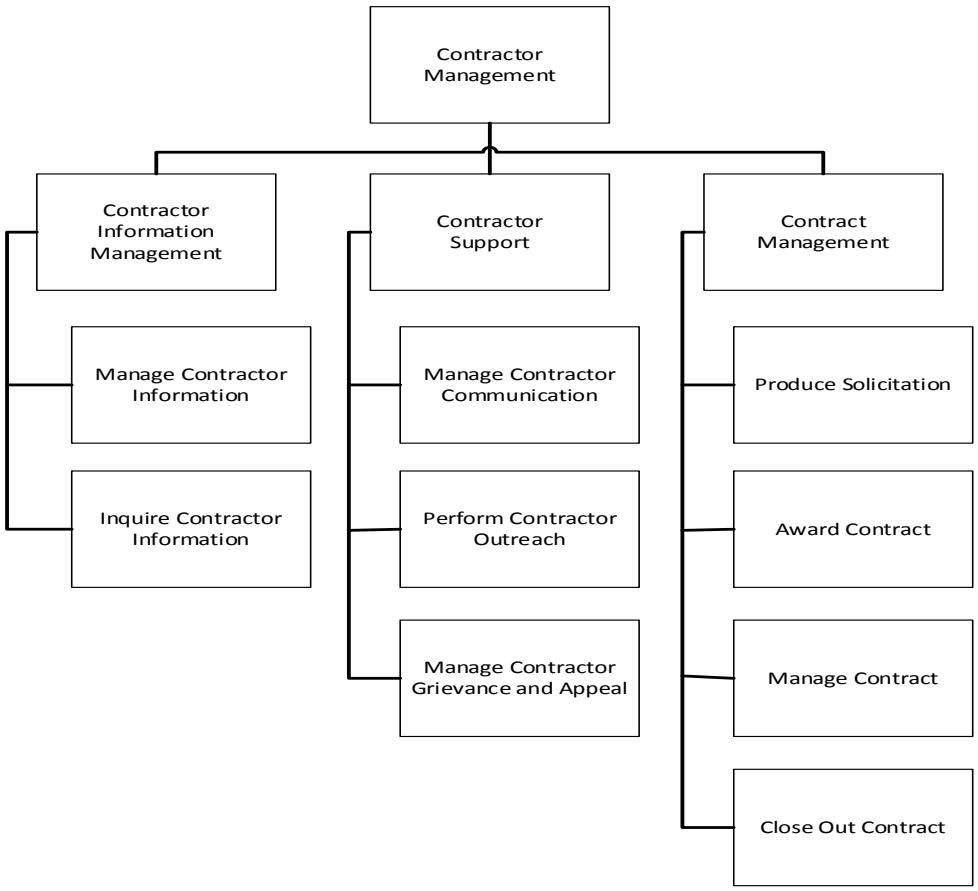


Figure 6: Contractor Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
CO01 Manage Contractor Information	1	2
CO04 Inquire Contractor Information	1	3
CO02 Manage Contractor Communication	1	3
CO03 Perform Contractor Outreach	1	3
CO09 Manage Contractor Grievance and Appeal	2	3
CO05 Produce Solicitation	2	3
CO06 Award Contract	2	3
CO07 Manage Contract	1	2
CO08 Close Out Contract	1	2
Area Assessment	**1**	**2**

Table 18: Contractor Management Area Profile

Connecticut Organizational Owners

Primary responsibility for Contractor Support and Contract Management is with DSS Program Staff to monitor existing services to ensure that client services are being provided effectively and in accordance with contracts. The DSS Contract Administration and Procurement Division provides oversight and support to formal contract and procurement processes.

The Connecticut Medicaid program contracts with four Administrative Service Organizations (ASOs) for member benefits, rather than the Managed Care Organization (MCO) model. DHS staff ensures network adequacy, development and modification of fee schedules, provider enrollment, claims adjudication, and payment, in addition to functions related to coordination of care (Person Centered Medical Homes (PCMH) and Intensive Care Management (ICM)) and continuous quality improvement.

The Division of Health Services- Integrated Care Unit- Manages the four ASOs and coordinates/integrates all Medicaid services, ensuring that members' needs are met, that health outcomes are improved, and that this is done in a cost-efficient manner.

Within the MITA framework, DXC Technology (DXC) is involved with Contractor Information Management processes as fiscal agent for DSS.

As-Is Business Area Summary

Oversight activities for contract management are decentralized within DSS by program area. Oversight of procurement and formal contract management processes are performed by the DSS Contract Administration and Procurement Division. DXC, as fiscal agent, maintains oversight of provider related contracts. DSS contracts are housed within the Procurement and Contracts System (PACS). The PACS system stores contract details and supporting documentation. DSS actively maintains approximately 500 contracts on an annual basis. System upgrades are

currently in process to include procurement activities (currently in test in PACS) and fiscal reporting. Contract information is initially recorded via a paper information sheet (CARIS) which is manually entered in the PACS system by the Division staff. Once a contract is awarded, it is posted on the DSS website.

To-Be Business Area Summary

System capabilities, staffing levels, and decentralized management are affecting MITA maturity for the Business Area. Increases in automation and staffing will be required to improve timeliness and other aspects of MITA based capabilities. Improvements to invoice tracking, submission, and support would help improve accuracy in both Contractor Management and Financial Management Business Area processes. Service Level Agreements exist for larger contracts.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Manage Contractor Information	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
How is the information regarding the Contractor information validated?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	1	2
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 19: Capabilities Summary Matrix - Manage Contractor Information

Inquire Contractor Information	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	1	3
What information does the inquiry and response convey?	1	3
How formalized is the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**3**

Table 20: Capabilities Summary Matrix - Inquire Contractor Information

Manage Contractor Communication Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Is communication linguistically, culturally, and competency appropriate?	1	3
Does State Medicaid Agency use standards in the process?	1	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
How satisfied are the stakeholders with the process?	2	3
Business Process Assessment	**1**	**3**

Table 21: Capabilities Summary Matrix - Manage Contractor Communication

Perform Contractor Outreach Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Is communication linguistically, culturally, and competency appropriate?	1	3
Does State Medicaid Agency use standards in the process?	1	3
How formalized is the process?	1	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	1	2
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
How satisfied are the stakeholders with the process?	2	3
Business Process Assessment	**1**	**3**

Table 22: Capabilities Summary Matrix - Perform Contractor Outreach

Manage Contractor Grievance and Appeal	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
How central is the grievance and appeals process?	2	3
Do contractors know how to access the grievance and appeals process?	2	3
How does the State Medicaid Agency manage the process?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
How satisfied are the stakeholders with the process?	2	3
Business Process Assessment	**2**	**3**

Table 23: Capabilities Summary Matrix - Manage Contractor Grievance and Appeal

Produce Solicitation	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
How integrated or central is the process?	2	3
Is the process primarily manual or automatic?	2	3
What is the primary mechanism for publication of the solicitation and communication with potential respondents?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 24: Capabilities Summary Matrix - Produce Solicitation

Award Contract Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
What is the primary mechanism for receipt of proposals and communication with respondents?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency verify proposal information?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 25: Capabilities Summary Matrix - Award Contract

Manage Contract Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
How integrated or central is the process?	2	3
Is the process primarily manual or automatic?	2	3
What is the primary mechanism for exchange of contract information?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	1	2
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 266: Capabilities Summary Matrix - Manage Contract

Close Out Contract Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
How integrated or central is the process?	2	3
Is the process primarily manual or automatic?	2	3
What is the primary mechanism for exchange of contract information?	1	2
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 27: Capabilities Summary Matrix - Close Out Contract

IV. Eligibility and Enrollment Management

The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicants, re-determination of existing members, enrolling new providers, and re-validation of existing providers. The Provider Enrollment business category and related business processes focus on patient safety and fraud prevention through functions such as determining screening level (i.e., limited, moderate, or high) for provider verifications. These processes share a common set of provider-related data for determination of eligibility, enrollment, and inquiry to provide services. The Eligibility and Enrollment Management business area is responsible for the eligibility and enrollment information of the member data store as well as the provider data store.

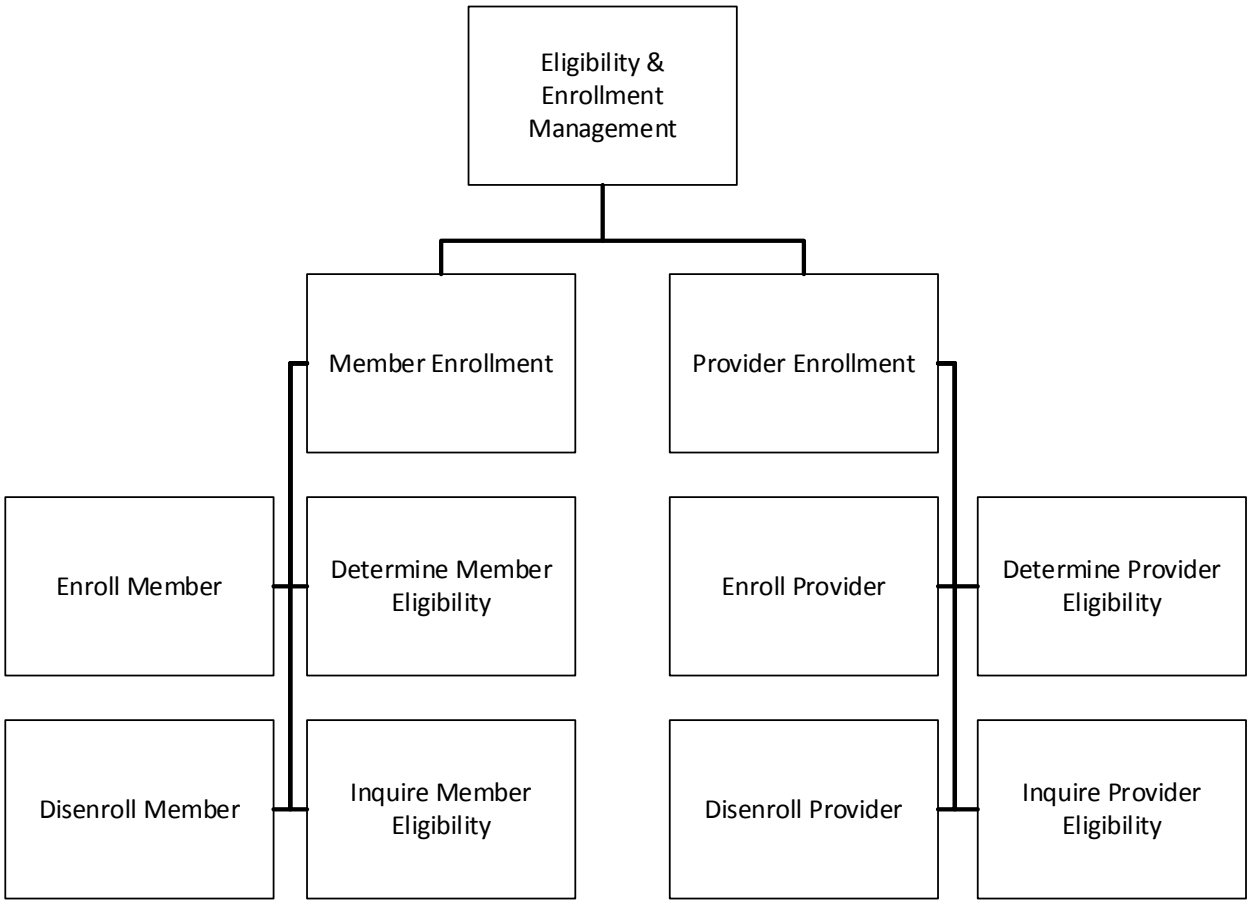


Figure 7: Eligibility & Enrollment Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
EE01 Determine Member Eligibility	2	3
EE02 Enroll Member	2	3
EE03 Disenroll Member	2	3
EE04 Inquire Member Eligibility	2	3
EE05 Determine Provider Eligibility	2	3
EE06 Enroll Provider	2	3
EE07 Disenroll Provider	2	3
EE08 Inquire Provider Information	2	3
Area Assessment	**2**	**3**

Table 28: Eligibility & Enrollment Area Profile

Connecticut Organizational Owners

Within DSS, the Division of Eligibility Policy and Economic Security (DEPES) and Division of Health Services (DHS) Medical Operations Unit Provider Relations Team oversee Eligibility and Enrollment Management processes for members and providers respectively. The Community Option Unit and Operation Team within DHS also support waiver program enrollment activities. DXC Technology (DXC), as fiscal agent for DSS, also supports provider enrollment. Husky B (CHIP) enrollment is supported by Xerox (Conduent.)

As-Is Business Area Summary

Member Eligibility and Enrollment business processes in Connecticut are in transition from a legacy multi-system environment towards an automated streamlined single system, ImpaCT. The ImpaCT system operates independently of the state based marketplace eligibility system, Access Health. Connecticut has self-identified ImpaCT enhancements necessary to support program rules and regulations which are currently undergoing implementation. Eligibility and enrollment processes associated with the Aged, Blind, and Disabled (ABD) population and long term care still involve manual aspects and are less technically mature. Eligibility for waiver programs requires both financial and functional determinations; ImpaCT will complete all financial determinations when it is introduced statewide, and functional assessments are completed using multiple systems and processes. Data governance and management are identified issues, results from functional assessments are not directly interfaced to ImpaCT across the board, and there are instances when the results must be manually entered. Until the transition to ImpaCT is completed, the use of multiple systems is creating duplicate enrollment for Administrative Service Organizations (ASOs). It is anticipated that full implementation of ImpaCT will resolve this issue. Currently, all ASOs and DXC receive enrollment files and maintain separate rosters, so reconciliation between multiple entities is time consuming and resource intensive.

Provider Eligibility and Enrollment Management processes in Connecticut have been automated and are performed by DXC with the oversight of the DHS Medical Operations Unit - Provider Relations Team. The business process of Determine Provider Eligibility and Enroll Provider begins

with the submission of a web-based application via the provider web portal. Re-enrollment applications are prepopulated with provider information currently contained in the MMIS, and initial enrollment applications are not pre-populated. The process of reviewing applications is shared between DXC and the DSS Division of Quality Assurance (QA). HPE completes initial reviews against business owner defined criteria, and then shares the information electronically with DSS QA for final review and approval. Currently, the application is not connected with any outside data sources. Verification of credentials is often manual, interoperability with outside entities is limited, and very little sharing of information occurs between states.

To-Be Business Area Summary

Data governance and exchange are key issues for both member and provider Eligibility and Enrollment Management processes. For member enrollment, a single rules engine for eligibility determination shared by ImpaCT and the state based marketplace, Access Health, would greatly improve efficiencies in this business area. A shared rules engine would be less costly to maintain and would more effectively support the agency's goals for consumer experience and outcomes. An emphasis on streamlining and automating eligibility for the ABD population is needed. To improve processes and capture all needed data from a waiver functional assessment, a single tool or data sharing process is needed. A shared enrollment roster would aid in maintaining consistency across the ASOs.

Connecticut has identified increased automation as a primary goal moving forward in all provider enrollment processes. Allowing for interoperability between DSS, DXC, and the ASOs' various systems will increase efficiency in enrollment and credential verification. Since multiple parties are involved in the provider enrollment processes, a focus on increased alignment of the review process for provider types and specialties between DSS and DXC will help to increase efficiency. The introduction of a Single Sign-On capability will allow for easier access to the multiple systems utilized during these activities. Data collected throughout the enrollment process has great value to many downstream processes; the refinement of the data governance associated with the enrollment data will add value not only to the provider enrollment processes, but to the downstream processes as well.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Determine Member Eligibility	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	3	4
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	3	4
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	3	4
How accessible is the information in the process?	2	3
What is the ratio for the cost of eligibility determination compared to the value of the results?	2	3
How efficient is the process?	3	4
How accurate are the results of the process?	3	4
How satisfied are the stakeholders?	3	4
Business Process Assessment	**2**	**3**

Table 299: Capabilities Summary Matrix - Determine Member Eligibility

Enroll Member	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	3	4
How timely is this end-to-end process?	3	4
How accurate is the information in the process?	3	4
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	3	4
How accurate are the results of the process?	3	4
How satisfied are the stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 30: Capabilities Summary Matrix - Enroll Member

Disenroll Member Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	3	4
How accurate are the results of the process?	2	3
How satisfied are the stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 301: Capabilities Summary Matrix - Disenroll Member

Inquire Member Eligibility Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	4	5
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	3	4
How satisfied are the stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 312: Capabilities Summary Matrix - Inquire Member Eligibility

Determine Provider Eligibility Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Does enrollment process meet state and federal regulations or policies?	2	3
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
Does the State Medicaid Agency use required screening requirements?	3	3
What provider identifier is used?	2	3
How does the State Medicaid Agency verify credentials (e.g., college degree, license, certification, NPI, Employer Identification Number (EIN), Social Security Number (SSN))?	2	3
Is there a process for revalidation of credentials?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 323: Capabilities Summary Matrix - Determine Provider Eligibility

Enroll Provider Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Does enrollment process meet state and federal regulations or policies?	2	3
Is the process primarily manual or automatic?	2	3
How does the applicant complete and submit the application?	3	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 334: Capabilities Summary Matrix - Enroll Provider

Disenroll Provider Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 345: Capabilities Summary Matrix - Disenroll Provider

Inquire Provider Information Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 356: Capabilities Summary Matrix - Inquire Provider Information

V. Financial Management

The Financial Management business area is a collection of business processes to support the payment of providers, ASOs, other agencies, insurers, and Medicare premiums; and supports the receipt of payments from other insurers, providers, and member premiums and financial participation. These processes share a common set of payment and receivables-related data. The Financial Management business area is responsible for the financial data store.

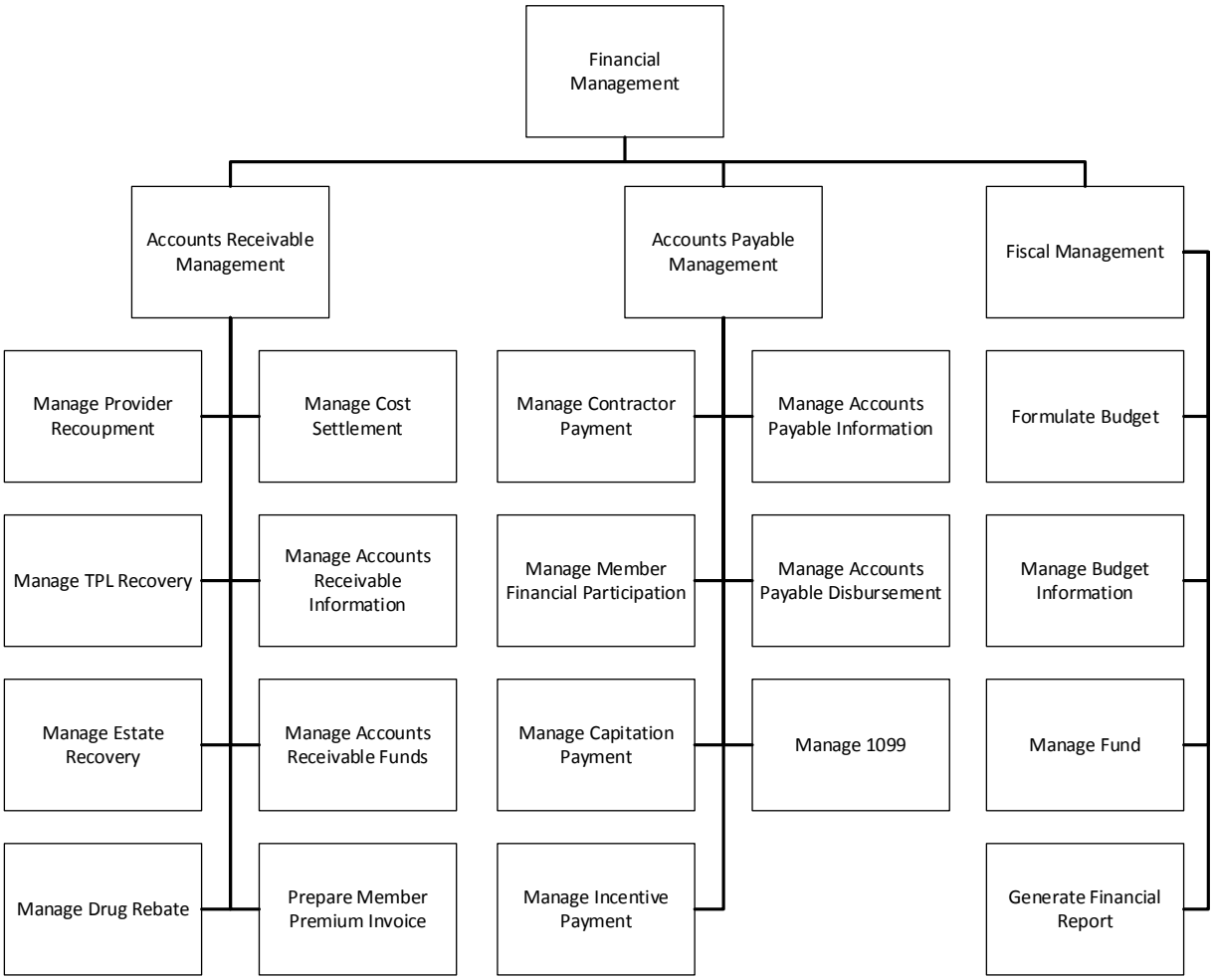


Figure 8: Financial Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
FM01 Manage Provider Recoupment	2	2
FM02 Manage TPL Recovery	2	3
FM03 Manage Estate Recovery	2	3
FM04 Manage Drug Rebate	2	3
FM05 Manage Cost Settlement	2	3
FM06 Manage Accounts Receivable Information	1	3
FM07 Manage Accounts Receivable Funds	1	3
FM08 Prepare Member Premium Invoice	2	3
FM09 Manage Contractor Payment	1	2
FM10 Manage Member Financial Participation	2	3
FM11 Manage Capitation Payment	N/A	N/A
FM12 Manage Incentive Payment	2	3
FM13 Manage Accounts Payable Information	2	3
FM14 Manage Accounts Payable Disbursement	1	2
FM15 Manage 1099	2	3
FM16 Formulate Budget	1	2
FM17 Manage Budget Information	1	2
FM18 Manage Fund	1	2
FM19 Generate Financial Report	1	2
Area Assessment	**1**	**2**

Table 367: Financial Management Area Profile

Connecticut Organizational Owners

Within DSS, the Division of Fiscal Services (DFS) maintains primary responsibility for financial management, accounting, budget, fiscal reporting, and support services. DFS includes the Budget Unit, Core Financial Accounting, and Revenue Accounting.

DXC Technology (DXC), as fiscal agent for DSS, also supports Financial Management processes which are claims based. The Division of Health Services (DHS) Medical Operations Unit, Reimbursement & Certificate of Need Unit, and Integrated Care Unit (Pharmacy Team- for Drug Rebate) provide additional support for claims based processing and oversight.

Recoupments, recoveries, and settlements are performed by DFS in coordination with DHS, and the DSS Division of Quality Assurance Investigations and Recoveries Unit. Member Premium Invoicing and Member Financial Participation processes are supported by DSS Division of Eligibility Policy and Economic Security.

External to DSS, the Office of the Comptroller, Office of Policy and Management, and Department of Administrative Services (DAS) provide additional programmatic support and financial services from a statewide level.

As-Is Business Area Summary

Processes within the Financial Management Business Area in Connecticut utilize a mix of manual and automated steps. Use of an Enterprise Service Bus is not widely applied, and system data is siloed; reconciliation between systems relies on the use of manual or legacy reporting mechanisms. Multiple systems store programmatic information throughout DSS, business partners, and ancillary agencies. Data integrity and management are operational issues throughout the Business Process.

A number of processes, while automated, are constrained because the MITA Framework has not been fully adopted. Challenges exist for the determination of federal participation based on claims-driven data, and several processes are constrained by the ability to accept electronic payments which are limited by legacy system capabilities.

Provider-based processes which are housed within the MMIS tend to be more automated. Budgetary and reporting functions are performed utilizing manually intensive steps using multiple system-generated reports. The ability to create and manage custom reports would strengthen Financial Management processes which rely on provider-based data.

To-Be Business Area Summary

Financial Management business processes require automation and system functionality which is more closely integrated with operational systems. Master Data Management and custom report generation capabilities are critical for DSS to develop for the Financial Management Area to advance in MITA maturity. The ability to accept electronic payments and to record negative adjustments at the claims level would eliminate the need for manual calculations and processing.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Manage Provider Recoupment Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	2
What is the mode of communication?	2	3
How does the State Medicaid Agency requests recoupment of monies in TPL situations requested?	2	2
How integrated is the process?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**2**

Table 378: Capabilities Summary Matrix - Manage Provider Recoupment

Manage TPL Recovery Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
How does the State Medicaid Agency validate TPL information?	2	3
How integrated is the process?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency conduct coordination of benefits (COB)?	3	4
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 389: Capabilities Summary Matrix - Manage TPL Recovery

Manage Estate Recovery Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
What is the media of communication with stakeholders involved in the recovery?	2	3
How integrated is the process?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process? Note: Due to the variables involved in estate recovery process (i.e., wills, lawsuits, claims and other procedural steps inherent in the probate process), it is difficult to estimate the end-to-end timeline.	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 40: Capabilities Summary Matrix - Manage Estate Recovery

Manage Drug Rebate Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
How integrated is the process?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	3	4
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 41: Capabilities Summary Matrix - Manage Drug Rebate

Manage Cost Settlement Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
How integrated is the process?	2	3
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 392: Capabilities Summary Matrix - Manage Cost Settlement

Manage Accounts Receivable Information Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
How integrated is the process?	1	3
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**3**

Table 403: Capabilities Summary Matrix - Manage Accounts Receivable Information

Manage Accounts Receivable Funds Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**3**

Table 414: Capabilities Summary Matrix - Manage Accounts Receivable Funds

Prepare Member Premium Invoice Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 425: Capabilities Summary Matrix –Prepare Member Premium Invoice

Manage Contractor Payment Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	1	2
How accessible is the information in the process?	1	2
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	1	2
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 436: Capabilities Summary Matrix - Manage Contractor Payment

Manage Member Financial Participation Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 447: Capabilities Summary Matrix - Manage Member Financial Participation

Manage Incentive Payment Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 458: Capabilities Summary Matrix - Manage Incentive Payment

Manage Account Payable Information Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
How integrated is the process?	2	3
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
What is the source of the information?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 469: Capabilities Summary Matrix - Manage Account Payable Information

Manage Account Payable Disbursement	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
What format does SMA use for payments?	2	3
Is the process primarily manual or automatic?	3	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 50: Capabilities Summary Matrix - Manage Account Payable Disbursement

Manage 1099	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 51: Capabilities Summary Matrix - Manage 1099

Formulate Budget Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	1	2
Does the State Medicaid Agency use standards in the process?	1	2
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 52: Capabilities Summary Matrix - Formulate Budget

Manage Budget Information Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 473: Capabilities Summary Matrix - Manage Budget Information

Manage Fund Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	1	2
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	1	3
Business Process Assessment	**1**	**2**

Table 484: Capabilities Summary Matrix - Manage Fund

Generate Financial Report Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 495: Capabilities Summary Matrix- Generate Financial Report

VI. Member Management

Note: Due to the regulation rule-making efforts underway at CMS, the MITA Framework 3.0 does not include the Member Management business processes or business capability matrices. However, in order to provide a complete assessment, the MITA 2.01 definitions were used and any updates since that time were noted below.

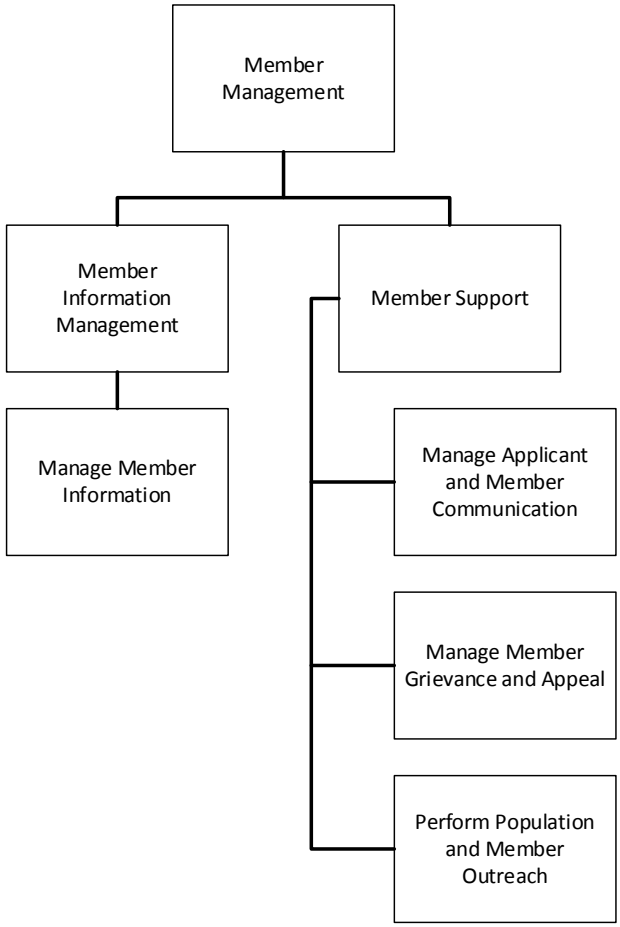


Figure 9: Member Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
ME01 Manage Member Information	2	3
ME02 Manage Applicant and Member Communication	2	3
ME08 Manage Member Grievance and Appeal	2	3
ME03 Perform Population and Member Outreach	2	3
Area Assessment	**2**	**3**

Table 506: Member Management Area Profile

Connecticut Organizational Owners

Member Management activities are distributed throughout DSS and among external partners. Within DSS, Eligibility Policy and Program Support and the Division of Health Services share primary responsibility for the processes within the MITA Business Area. External partners, which includes both sister agencies and vendors comprise:

- Department of Developmental Services (DDS)
- Department of Mental Health and Addiction Services (DMHAS)
- Department of Rehabilitation Services (DORS)
- Department on Aging
- Administrative Service Organizations (ASOs)
  - Medical Services- Community Health Network of Connecticut (CHN)
  - Behavioral Health Services- Beacon Health Options
  - Dental Services- BeneCare Dental Benefits
  - Pharmacy Services- DSS Pharmacy Team & DXC Technology (DXC)
  - Non-emergency Medical Transportation (NeMT)- LogistiCare
- DXC (fiscal agent)

As-Is Business Area Summary

Connecticut stores member data across a multitude of systems both within and outside the agency. Eligibility information is currently in transition to Connecticut's new ImpaCT system. Flagging or pointers are used in some instances but not all, to indicate records exist in other areas or systems. Business processes exist that generate auto updates of member information based on changes in the eligibility and enrollment system. In some occurrences, information is being manually loaded. Across the waiver programs there are many unique and separate systems used for case management and care plans, as well as incident reports and other relevant information. Data extracted from those systems often requires manual intervention and is limited. Member communication and outreach is performed primarily at the ASO level and via call centers, but with four ASOs and multiple call centers, there is not a single repository to reflect what communications have occurred at the member level. Waiver program outreach is performed by UCONN. Grievance and appeal information is transitioning to ImpaCT; upon the completion of that transition, they anticipate greater automation.

To-Be Business Area Summary

Improvements in managing Member information can be achieved through increased data governance. Data governance and a Service Oriented Architecture (SOA) are critical to support a modular MMIS system that is required by CMS and will make data more available and relevant. Improvements to the decision support system for Master Data Management are also needed to utilize the data now available for population outreach and health disparities activities. A single call center system with enhancements such as call back, would aid in ensuring uniformity and improve the member experience. In addition, improvements to the member portal to increase usability and data available would allow the portal to be used for outreach and health education by the ASOs.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Manage Member Information	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 517: Capabilities Summary Matrix- Manage Member Information

Manage Applicant and Member Communication	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 528 Capabilities Summary Matrix- Manage Applicant and Member Communication

Manage Member Grievance and Appeal Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 539: Capabilities Summary Matrix- Manage Member Grievance and Appeal

Perform Population and Member Outreach Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 60: Capabilities Summary Matrix- Perform Population and Member Outreach

VII. Operations Management

The Operations Management business area is a collection of business processes that manage claims and prepare premium payments. This business area uses a specific set of claims-related data and includes processing (i.e., editing, auditing, and pricing) a variety of forms for professional, dental, institutional, and drug claims, as well as sending payment information to the provider. All claim processing activity incorporates compatible methodologies of the National Correct Coding Initiative (NCCI). The Operations Management business area is responsible for the claims data store.

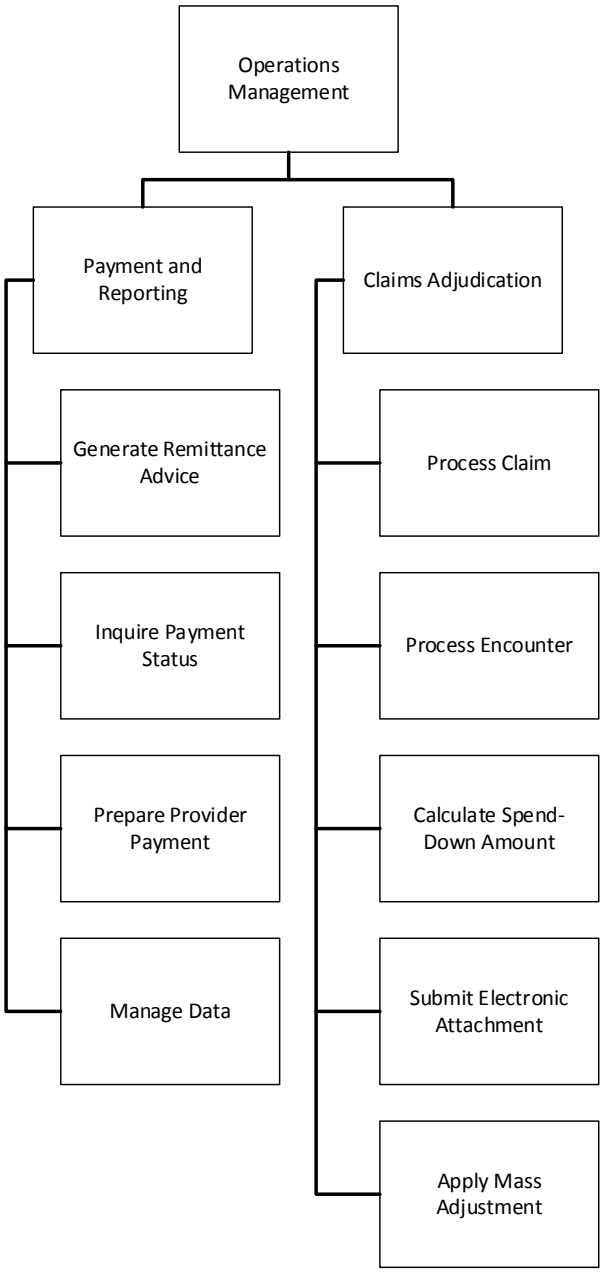


Figure 10: Operations Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
OM14 Generate Remittance Advice	2	3
OM18 Inquire Payment Status	2	3
OM27 Prepare Provider Payment	2	3
OM28 Manage Data	1	3
OM07 Process Claims	2	3
OM29 Process Encounters	N/A	N/A
OM20 Calculate Spend-Down Amount	1	2
OM04 Submit Electronic Attachment	1	2
OM05 Apply Mass Adjustment	2	3
Area Assessment	**1**	**2**

Table 6541: Operations Management Area Profile

Connecticut Organizational Owners

Within DSS, the Division of Health Services (DHS) Medical Operations Unit, Reimbursement & Certificate of Need Unit and Medical Policy Unit (for special edits or audits) maintain primary responsibility for the processes within the Operations Management Business Area. DXC Technology (DXC), as fiscal agent for DSS, also supports all Operations Management processes.

As-Is Business Area Summary

Processes within the Operations Management Business Area in Connecticut utilize a mix of manual and automated steps. All processes in the Operations Management process area are served by DXC staff and the Medicaid Management Information System (MMIS) in some capacity. All processes or portions of processes are performed or depend on DXC and the MMIS, and thus tend to score higher in technical maturity due to documented business processes, reporting, performance management, and automated system processing.

Some processes, such as Calculate Spend-Down Amount, which is supported by Xerox, must pass information to DXC and the MMIS to indicate when applicants have met spend-down thresholds. Calculate Spend-Down Amount and Submit Electronic Attachment are still manually intensive processes.

A number of processes, while automated, are constrained because the MITA Framework has not been fully adopted. Claims Processing is highly automated with electronic submission being mandatory with a few exceptions. The exceptions to mandatory electronic submission are: out of state providers, claim submission for review and override of an edit, and a small portion of providers (3) who do not have computers. Due to the change in DSS from a Managed Care Organization (MCO) model to an Administrative Service Organization (ASO) model, the Process Encounter process is not applicable to the Connecticut State Medicaid Agency. Some intrastate collaboration is taking place with other agencies supporting the Generate Remittance Advice

process. There are opportunities to increase collaboration with other intrastate entities in back-office processes to increase efficiencies.

Standardization is varied across the Business Area. The Process Claims and Apply Mass Adjustment show the use of industry and national standards, while Calculate Spend-Down Amount and Manage Data are ad hoc processes.

To-Be Business Area Summary

Areas of opportunity for Operations Management include the ability to receive electronic attachments and increased automation of mass adjustments. Increasing levels for detailed claims criteria are being requested, and automation is needed to mitigate human error during data entry. Additional identification for processing cross-over claims at both the header level and detail level is needed. Spend-Down payments are expected to improve with full implementation of the ImpaCT eligibility system.

Within the MMIS, improvements to data governance and identification of enterprise data standards are needed to support the Decision Support System. There is a high demand across all MITA Business Areas for users' ability to easily consume and understand data. A number of processes within the Operations Management area can mature with the adoption of the MITA Framework.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Generate Remittance Advice	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	3	4
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	3	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 62: Capabilities Summary Matrix - Generate Remittance Advice

Inquire Payment Status	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How integrated is the process?	3	4
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 63: Capabilities Summary Matrix - Inquire Payment Status

Prepare Provider Payment Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	3	4
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	3	4
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 554: Capabilities Summary Matrix - Prepare Provider Payment

Manage Data Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost of the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	1	3
Business Process Assessment	**1**	**3**

Table 565: Capabilities Summary Matrix - Manage Data

Process Claim Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How integrated is the process?	3	4
How easy is it to change edit business rules and criteria?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	3	4
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 576: Capabilities Summary Matrix - Process Claim

Calculate Spend Down Amount Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
What methodology is used for managing spend-down calculations?	2	3
How does the member present proof that it has incurred and/or paid health care bills?	1	2
How does the State Medicaid Agency track payments for health care bills?	3	3
How does the agency determine that the member has met the spend- down target	2	3
How does the State Medicaid Agency transmit that the member has met spend-down requirements to the claims payment processes and the provider community?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 587: Capabilities Summary Matrix – Calculate Spend-Down Amount

Submit Electronic Attachment Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	1	2
How is clinical information requested and received when this information is required to process a transaction (claim, service authorization request, treatment plan) or for other processes?	1	2
Does State Medicaid Agency use standards in the process?	1	2
Does the clinical information accompany the transaction?	1	2
Are validation activities manual or automatic?	1	2
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	2	2
How accurate is the information in the process?	1	2
How accessible is the information in the process?	2	2
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	1	2
Does the business process satisfy stakeholders?	1	2
Business Process Assessment	**1**	**2**

Table 598: Capabilities Summary Matrix - Submit Electronic Attachment

Apply Mass Adjustment Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	3	3
How does the State Medicaid Agency identify claims affected by a mass adjustment?	2	3
How does the State Medicaid Agency apply adjustment to the claims?	2	3
Does State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 609: Capabilities Summary Matrix - Apply Mass Adjustment

VIII. Performance Management

The Performance Management business area is a collection of business processes involved in the assessment of program compliance (e.g., auditing and tracking medical necessity and appropriateness of care, quality of care, patient safety, fraud and abuse, erroneous payments, and administrative anomalies). This business area uses information regarding an individual provider or member (e.g., demographics, information about the case itself such as case manager ID, dates, actions, and status, and information about parties associated with the case), and uses this information to perform functions related to utilization and performance. The Performance Management business area is responsible for the business activity and compliance data stores.

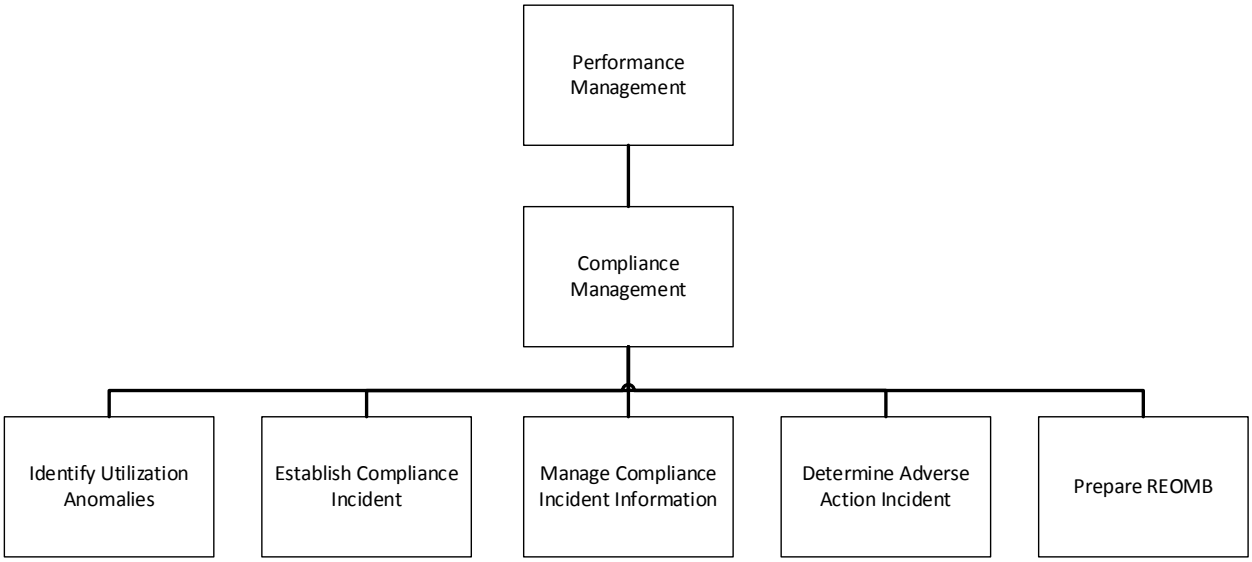


Figure 11: Performance Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
PE01 Identify Utilization Anomalies	1	2
PE02 Establish Compliance Incident	1	2
PE03 Manage Compliance Incident Information	1	2
PE04 Determine Adverse Action Incident	1	2
PE05 Prepare REOMB	1	1
Area Assessment	**1**	**1**

Table 70: Performance Management Area Profile

Connecticut Organizational Owners

Within DSS the Office of Quality Assurance provides assurance for programmatic and fiscal integrity. The Office is comprised of five divisions:

- Audit- which performs federally mandated audits of medical and health care providers; departmental operational reviews; analytical reviews of billing, administrative, and programmatic functions; investigatory support for the Special Investigations Division; and general audit support activities for DSS
- Investigations and Recoveries Division- which is comprised of two units. The Client Investigations Unit investigates alleged client fraud, waste or abuse. The Resources and Recoveries Unit ensures that DSS is the payer of last resort for client care.
- Special Investigations- which is comprised of two units. The Provider Investigations Unit which coordinates investigations of alleged fraud. The Provider Enrollment Unit is responsible for review and approval of enrollment and re-enrollment activities.
- Quality Control Division- is responsible for federally-mandated reviews of child care, Medicaid, and SNAP programs.
- Third Party Liability Division- is responsible for compliance with TPL requirements and provides oversight in recovery of client health care costs.

Additional entities involved in augmenting oversight activities include:

- Surveillance Utilization Review (SUR) services performed by DXC
- Member Utilization and Drug Utilization Reviews (DUR and retro-DUR) performed by the Division of Health Services- Integrated Care Unit, Clinical Review Team; DXC and Administrative Service Organizations (ASOs)
- Quality reviews (CAPHS and HEDIS) Division of Health Services- Integrated Care Unit, Clinical Review Team; and ASOs
- Payment reviews-
    - DXC for provider claims
    - 21st Century (fraud detection)
    - HMS (Medicaid Recovery Audit Contractor (RAC); TPL)
    - Center for Medicare Advocacy (Medicare Coverage)
- Audit Services provided by Myers and Stauffer (long term-care; credit balance for nursing facilities; cost reporting)

As-Is Business Area Summary

Processes within the Performance Management Business Area in Connecticut utilize a mix of manual and automated steps. The Office of Quality Assurance consumes system reports from a variety of vendor maintained systems. Data integrity and data standards management are issues due to decentralized oversight. Sampling and analytics are performed using manual processing. In-house systems are utilized for case management and tracking, functionality is limited and not accessible to partner agencies or entities. The REOMB process is performed by DXC as the fiscal agent, and these are sent out monthly as a regularly scheduled production job.

To-Be Business Area Summary

The Office of Quality Assurance would benefit from improved data governance activities throughout DSS. Improved data sources, defined data elements, analytic tools, and dynamic reports would allow for greater automation and accuracy within the business processes. A unified case management system with referral tracking, and automated workflows would benefit all business processes within the area. A document management system or automated work-paper solution would aid in case processing, as well as provide greater MITA maturity. MITA maturity scores are constrained for a number of processes due to a lack of planned system enhancements.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Identify Utilization Anomalies	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
How integrated is the process?	2	2
Is the process primarily manual or automatic?	2	2
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	2
How accessible is the information in the process?	2	2
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	2	2
How accurate are the results of the process?	2	2
Does the business process satisfy stakeholders?	2	2
Business Process Assessment	**1**	**2**

Table 71: Capabilities Summary Matrix - Identify Utilization Anomalies

Establish Compliance Incident	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
How integrated or central is the process?	2	3
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	1	2
Business Process Assessment	**1**	**2**

Table 72: Capabilities Summary Matrix - Establish Compliance Incident

Manage Compliance Incident Information	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
How integrated or central is the process?	1	2
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	1	2
Business Process Assessment	**1**	**2**

Table 73: Capabilities Summary Matrix - Manage Compliance Incident Information

Determine Adverse Action Incident	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
How integrated or central is the process?	2	3
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 7614: Capabilities Summary Matrix - Determine Adverse Action Incident

Prepare REOMB Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
If sampling is used, what sampling algorithm is used?	1	1
Is communication linguistically, culturally, and competency appropriate?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	2
Does the business process satisfy stakeholders?	1	2
Business Process Assessment	**1**	**1**

Table 625: Capabilities Summary Matrix - Prepare REOMB

IX. Plan Management

The Plan Management business area includes the strategic planning, policymaking, monitoring, and oversight business processes of DSS. This business area is responsible for the primary data stores (e.g., Medicaid State Plan, health plans, and health benefits) as well as performance measures, reference information, and rate setting data stores. The business processes include a wide range of planning, analysis, and decision-making activities. These activities include service needs and goals, health care outcome targets, quality assessment, performance and outcome analysis, and information management.

As the Medicaid Enterprise matures, Plan Management benefits from immediate access to information, addition of clinical records, use of nationally recognized standards, and interoperability with other programs. The Medicaid Program is moving from a focus on daily operations (e.g., number of claims paid) to a strategic focus on how to meet the needs of the population within a prescribed budget.

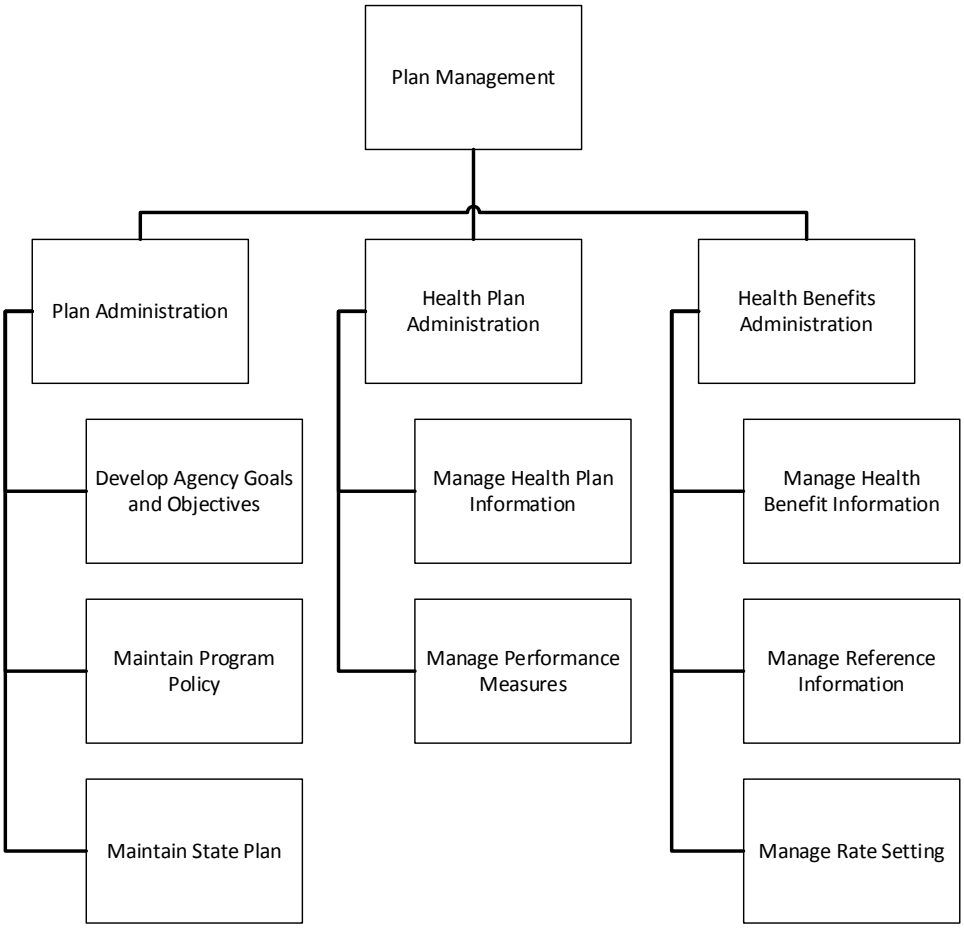


Figure 12: Plan Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
PL01 Develop Agency Goals and Objectives	1	2
PL02 Maintain Program Policy	1	2
PL03 Maintain State Plan	2	3
PL04 Manage Health Plan Information	1	2
PL05 Manage Performance Measures	1	2
PL06 Manage Health Benefit Information	2	3
PL07 Manage Reference Information	2	3
PL08 Manage Rate Setting	1	2
Area Assessment	**1**	**2**

Table 636: Plan Management Area Profile

Connecticut Organizational Owners

In Connecticut, the Division of Health Services (DHS), within the Department of Social Services (DSS), administers policy and day-to-day operations for the Connecticut Medicaid program, Children's Health Insurance Program (CHIP), Connecticut AIDS Drug Assistance Program (CADAP), Money Follows the Person (MFP) and other federal grants, and the Governor-led Connecticut long-term services and supports (LTSS) Rebalancing Plan.

DHS is comprised of five units:

- **Integrated Care Unit-** Manages the four ASOs and coordinates/integrates all Medicaid services, ensuring that members' needs are met, that health outcomes are improved, and that this is done in a cost-efficient manner.
- **Community Options Unit-** Stewards the work of the Governor's long term services and supports (LTSS) rebalancing agenda, which aims through system transformation to enable choice and self-direction for people who use LTSS. The Community Options Unit includes the Strategy and Operations Teams. The Operations Team includes Community Engagement, Eligibility, and Autism Services Groups. General responsibilities of the Strategy Group include grant administration and operation (currently MFP and TEFT), the strategic rebalancing plan (design and implementation), and design and implementation of person-centered systems. General responsibilities of the Operations Group include waiver administration and operation, financial eligibility processing, and nursing home level of care determinations.
- **Medical Operations Unit-** Medical Operations serves as the Division's functional arm, and is the means through which all medical programs are operationalized, paid, and reported within the Medicaid Management Information System (MMIS). Medical Operations works with and supports DSS units, sister Agencies, and the ASOs to implement and modify existing programs and services, ensure that claims are processed in compliance with federal rules, and ensure that program expenditures are reported correctly so that federal match can be claimed.

- **Medical Policy Unit and Clinical Review Team-** The Medical Policy Unit creates, monitors, and updates the Department's Medical Policies and interprets new federal and state statutes and policy initiatives. The Clinical Review Team, with the Medical Director, provides clinical oversight of the Department's medical programs. The Clinical Review Team provides expert clinical perspective in policy making, coverage determinations, and liaison work with the ASOs, supporting both the prevention agenda of the Division and its emphasis on use of data to guide decision-making.
- **Reimbursement and Certificate of Need (CON) Unit-** Responsible for establishing federally approvable reimbursement methodologies in order to maintain a well-balanced medical provider network while maximizing federal revenue. Specific duties include establishing and implementing reimbursement methodologies for medical and residential services covered under the Medicaid and State Supplement/AABD programs.

The Connecticut Medicaid program contracts with four Administrative Service Organizations (ASOs) for member benefits rather than the Managed Care Organization (MCO) model. DHS staff ensures network adequacy, development and modification of fee schedules, provider enrollment, claims adjudication, and payment, in addition to functions related to coordination of care (Person Centered Medical Homes (PCMH) and Intensive Care Management (ICM)) and continuous quality improvement.

As-Is Business Area Summary

Plan Management processes are overseen by the Office of the Commissioner, DHS, and executive management within DSS. DSS goals and objectives are set by the Office of the Commissioner according to strategic directives. Within DHS, Medicaid goals and objectives are reviewed on an annual basis. In the past, Balanced Scorecard methodologies have been employed to measure performance against goals and objectives. Development of goals and objectives, and tracking of program performance, is limited by existing resources. There is no formal performance management program internal to DSS. A document management system, performance tracking system, and additional research capabilities would facilitate higher levels of MITA maturity within the business process.

To-Be Business Area Summary

Within the MITA framework, processes which fall within Plan Administration and Health Plan Administration are manually intensive with limited supporting technical resources. Processes which fall within the category of Health Benefits Administration are generally more automated, although they are still comprised of both manual and automated steps. The MITA framework has not been fully adopted in Connecticut; efforts to streamline, automate, and align to MITA functional areas will facilitate advancement toward CMS objectives. In the future, automated workflows and an enterprise level document management system would help advance MITA maturity within the Business Area. Lean initiatives are underway within DSS; this program can augment Plan Management activities but resources are required for an enterprise level tracking and reporting system. Improvements in data management activities and improvements within the Decision Support System would help to increase the accuracy and timeliness of program reporting.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Develop Agency Goals and Objectives	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	1	2
How adaptable is the process to change?	1	2
Are goals and objectives traceable throughout the org?	1	2
Does the State Medicaid Agency use standards in the process?	1	2
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	1	2
How accessible is the information in the process?	1	2
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	1	2
Business Process Assessment	**1**	**2**

Table 647: Capabilities Summary Matrix - Develop Agency Goals and Objectives

Maintain Program Policy	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
How adaptable is the process to change?	2	3
Are policies traceable throughout the organization?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 658: Capabilities Summary Matrix - Maintain Program Policy

Maintain State Plan Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	1	2
How adaptable is the process to change?	2	3
Is Medicaid State Plan traceable throughout the organization?	1	2
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	1	2
What is the cost to perform the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	1	3
Business Process Assessment	**1**	**2**

Table 669: Capabilities Summary Matrix - Maintain State Plan

Manage Health Plan Information Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	1	2
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	1	2
How accessible is the information in the process?	1	2
What is the cost of the process compared to the benefits of the results?	1	2
How efficient is the process?	1	2
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 80: Capabilities Summary Matrix - Manage Health Plan Information

Manage Performance Measures Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
Does the State Medicaid Agency use Plan of Action with Milestones (POAM)?	2	3
How does the State Medicaid Agency publish performance measures?	1	2
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	1	2
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	1	2
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 81: Capabilities Summary Matrix - Manage Performance Measures

Manage Health Benefit Information Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How flexible are the contents of the health benefit package?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 82: Capabilities Summary Matrix - Manage Health Benefit Information

Manage Reference Information	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 83: Capabilities Summary Matrix - Manage Reference Information

Manage Rate Settings	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	1	2
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**1**	**2**

Table 84: Capabilities Summary Matrix - Manage Rate Settings

X. Provider Management

The Provider Management business area is a collection of business processes involved in communications between the State Medicaid Agency (SMA) and the prospective or enrolled provider and actions that DSS takes on behalf of the provider. Business processes focus on terminating providers, communications with providers, dealing with provider grievance and appeal issues, and performing outreach services to providers. The Provider Management business area is responsible for the provider data store.

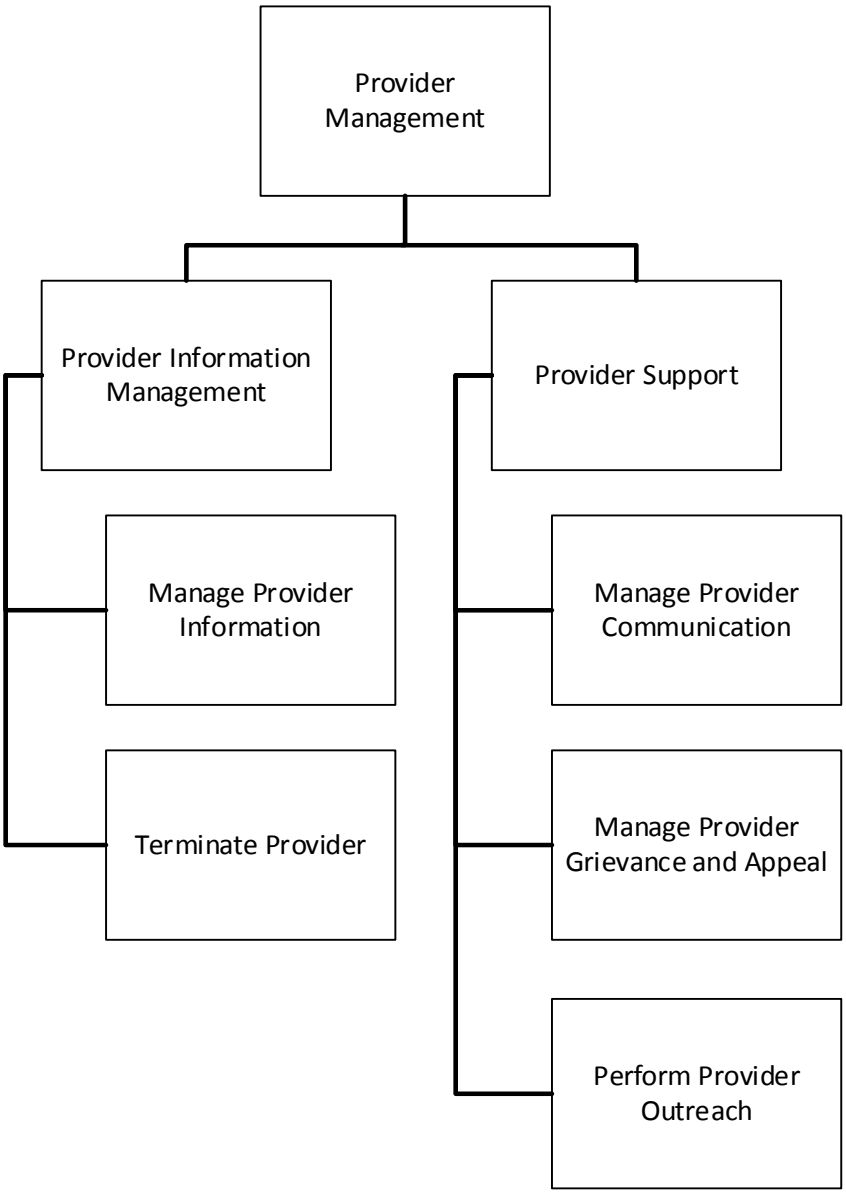


Figure 13: Provider Management Business Area

Summary MITA Business Process Scores	AS-IS Assessment	TO-BE Assessment
PM01 Manage Provider Information	2	3
PM08 Terminate Provider	2	3
PM02 Manage Provider Communication	2	3
PM07 Manage Provider Grievance and Appeal	2	3
PM03 Perform Provider Outreach	2	3
Area Assessment	**2**	**3**

Table 85: Provider Management Area Profile

Connecticut Organizational Owners

Within the Department of Social Services, Medical Care Administration- Medical Operations, the Provider Relations Team is responsible for directing and coordinating all areas of the Fee-for-Service provider enrollment process. Provider Relations also has oversight responsibility for claim processing issues, the publication and updating of the provider specific fee schedules, provider billing manuals and provider bulletins.

Additional entities involved in augmenting oversight activities include:

- DXC Technology (DXC) Provider Relations Team, Provider Enrollment Department, and Provider Assistance Center.

As-Is Business Area Summary

The Provider Management business processes in Connecticut utilize a mix of automated and manual steps. Portions of the Provider Enrollment process have been automated by utilizing a web portal to allow for the initiation of the enrollment process. Information is auto populated when a provider is re-enrolling, with the goal of decreasing potential data errors. All additional information required during the enrollment process must be submitted via paper. There is currently no integration of the provider application with other data sources for initial enrollment.

The process for communicating or conducting outreach to the provider community may be handled by different entities including the DSS Provider Team, DXC, or the Administrative Service Organizations (ASOs), and the process varies based upon the nature of the inquiry. There is a Contract Tracking Management System in place, the CTMS, for inquiries or requests received at the DXC Provider Assistance Center. CTMS allows for inquiries or requests to be automatically passed to the appropriate parties for response or resolution, but this system is not utilized for the tracking of inquiries initiated by entities other than DXC.

To-Be Business Area Summary

Connecticut would benefit from continued shift toward greater automation of the business processes in the Provider Management business area. Continued enhancement of the Web Portals, to include self-service options for tasks such as password reset and the ability to upload and attach supporting documentation related to the enrollment applications, would serve to create greater efficiency. Connection of the provider application to other provider data sources,

such as CAQH, will further enhance the automation of the enrollment process by allowing for the pre-population of applications beyond re-enrollment and decreasing potential data errors.

The creation of a Provider Registry (PR) is currently in process. This PR will serve as a data repository for DSS, DXC, and the ASOs. Data received from the MMIS and ASOs will be enhanced by the inclusion of licensure data and data pulled from the NPPES NPI registry. The PR will facilitate the creation of a "best record" that may be utilized by all stakeholders. The PR will allow for the ownership of local provider records by each contributing entity. The contributing entity will have update capabilities for those local records. The ability to update provider data directly will yield easier management of provider information.

The implementation of a Customer Relationship Management (CRM) tool will give DSS greater standardization in the process of managing provider communication and outreach by permitting all parties to access, notate, and track inquiries from providers and to assist in detailing the relationships that exist between providers, groups, and facilities. The addition of the CTMS to Business Objects will give easier access to CTMS information, and also will improve efficiency in the process of managing provider communication.

Business Capability Matrices

A Business Capabilities Matrix is defined for each business process in the MITA Framework. For each process, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Manage Provider Information	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
How does the State Medicaid Agency validate application information?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 676: Capabilities Summary Matrix - Manage Provider Information

Terminate Provider	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 687: Capabilities Summary Matrix - Terminate Provider

Manage Provider Communication	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
Is communication linguistically, culturally, and competency appropriate?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 698: Capabilities Summary Matrix - Manage Provider Communication

Manage Provider Grievance and Appeal	AS-IS Assessment	TO-BE Assessment
Capability Question	Level	Level
Is the process primarily manual or automatic?	2	3
How central is the grievance and appeals process?	2	3
Do providers know how to access the grievance and appeals process?	3	4
How does the State Medicaid Agency manage the process?	3	4
Does the State Medicaid Agency use standards in the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
Does the business process satisfy stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 709: Capabilities Summary Matrix - Manage Provider Grievance and Appeal

Perform Provider Outreach Capability Question	AS-IS Assessment Level	TO-BE Assessment Level
Is the process primarily manual or automatic?	2	3
Is communication linguistically, culturally, and competency appropriate?	2	3
Does the State Medicaid Agency use standards in the process?	2	3
How formalized is the process?	2	3
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	2	3
How timely is this end-to-end process?	2	3
How accurate is the information in the process?	2	3
How accessible is the information in the process?	2	3
What is the cost to perform the process compared to the benefits of the results?	2	3
How efficient is the process?	2	3
How accurate are the results of the process?	2	3
How satisfied are the stakeholders?	2	3
Business Process Assessment	**2**	**3**

Table 90: Capabilities Summary Matrix - Perform Provider Outreach

Connecticut Department of Social Services

Making a Difference

MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA) 3.0 STATE SELF-ASSESSMENT

INFORMATION ARCHITECTURE

Version	Date	Author	Change Description
1.0	2/24/2017	Greg Haskamp	Original document created – submitted as draft
Final	5/5/2017	Greg Haskamp	Incorporates feedback

TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF AUTHORITIES

I. MITA Business Architecture

The Centers for Medicare and Medicaid Services (CMS) defines the Medicaid Information Technology Architecture (MITA) as both a framework and an initiative. The MITA 3.0 model consists of four interrelated components which include:

- Business Architecture (BA)
- Information Architecture (IA)
- Technical Architecture (TA)
- Seven Conditions and Standards (7C&S)

The identified business needs and capabilities from the BA define data strategies used in the IA and subsequently, the business and technical services which are employed for the TA. All three architectures are used to determine the degree of conformance to the 7C&S. CMS further uses all three architectures to promote business driven enterprises and consistency among all state Medicaid programs, as shown in the figure below.

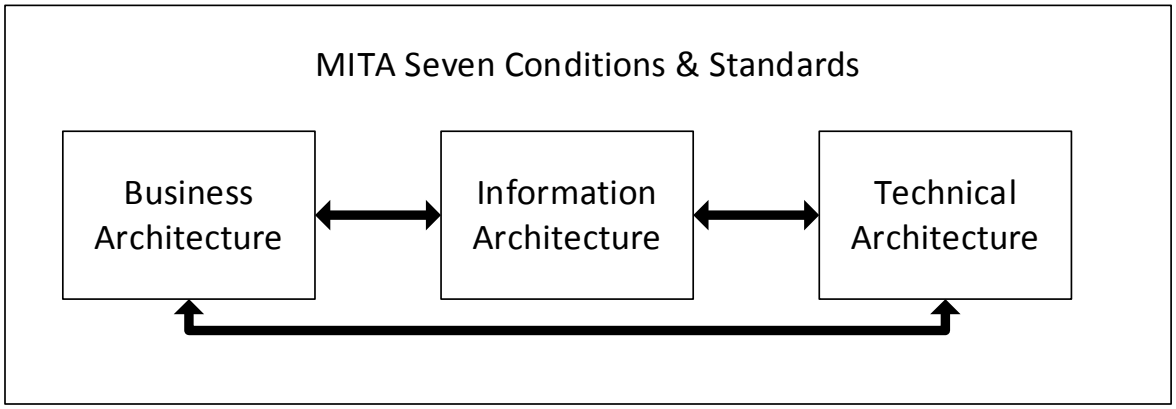


Figure 14: MITA Framework Relationship Diagram

The BA represents the starting point of the MITA framework, describing the business needs and goals of the Department of Social Services (DSS), Connecticut's State Medicaid Agency (SMA). As a conceptual framework, the BA for the DSS MITA 3.0 State Self-Assessment (SS-A) is constructed using CMS defined models, matrices, and templates.

The CMS defined MITA Business Process Model (BPM) is comprised of 80 distinct business processes, which are organized more broadly into categories and further grouped into business areas as shown in the figure below.

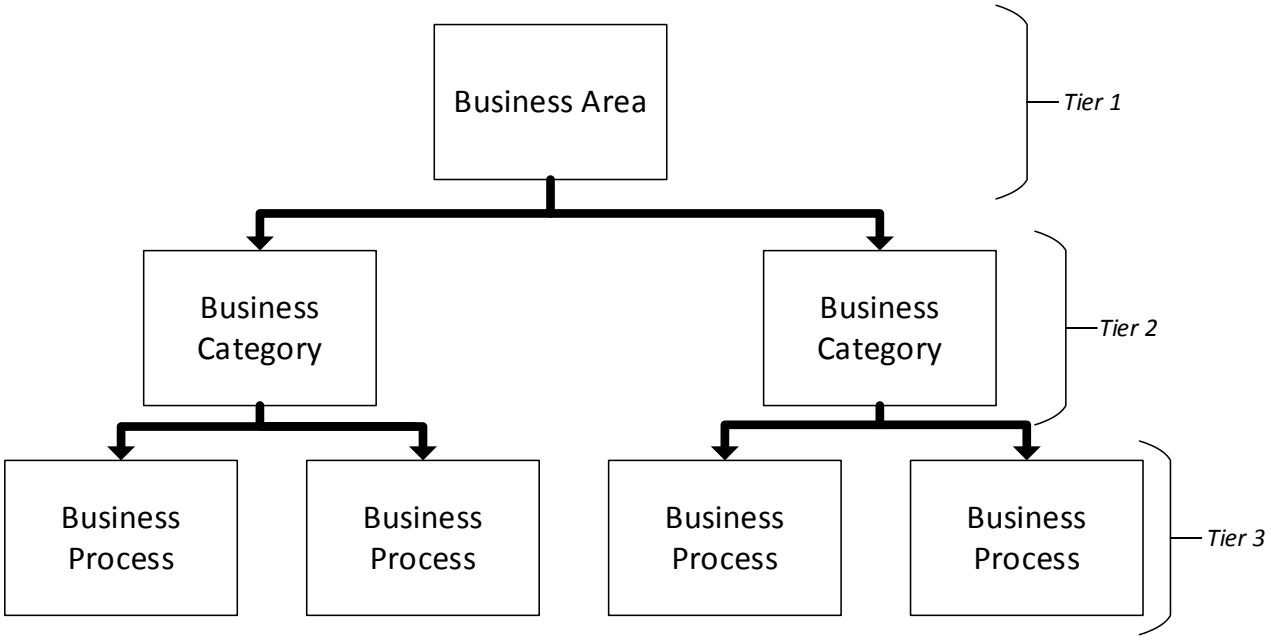


Figure 15: MITA Business Process Model Hierarchy

The MITA BPM is broadly defined by ten business areas. The table below illustrates the total number of MITA business processes across each business area, in comparison to the DSS identified processes. DSS utilizes the same ten areas identified from MITA 3.0 definitions. Individual processes were analyzed for differences, and those have been recorded using the CMS defined MITA Business Process Templates (BPTs) as supporting documentation.

MITA Business Area	MITA 3.0 Processes	Connecticut Processes
Business Relationship Management	4	4
Care Management	9	9
Contractor Management	9	9
Eligibility & Enrollment Management	8	8
Financial Management	19	18
Member Management	4	4
Operations Management	9	8
Performance Management	5	5
Plan Management	8	8
Provider Management	5	5
Total	**80**	**78**

Table 71: Business Area Comparison

The current MITA 3.0 framework released by CMS does not yet include processes for Member Management. For the purpose of this assessment, the applicable processes from the MITA 2.0 framework are being used.

II. Information Architecture Overview

CMS requires States to align to and advance increasingly in MITA maturity for the IA. CMS expects States to use the BA components to plan for improvements in the State Medicaid Program, both in the delivery of services to providers and beneficiaries, and in its internal operations and exchanges of information with other external stakeholders.

The MITA IA is a consolidation of principles, models, and guidelines that form a template for States to use to develop their own enterprise IA. The Connecticut Medicaid Information Architecture Profile presents the current "As-Is" operational baseline ratings and the targeted "To-Be" capability goals for each of the business areas identified in the Connecticut Business Architecture Profile. Meetings were held with Connecticut Medicaid business and technical staff to assess each business area utilizing the CMS defined Information Capability Matrix (ICM). As a result of these sessions, a profile was created to represent the results of the assessment as presented in the sections that follow.

MITA 3.0 Business Area	Level 1	Level 2	Level 3	Level 4	Level 5
Business Relationship Management		As-Is	To-Be		
Care Management	As-Is		To-Be		
Contractor Management		As-Is	To-Be		
Eligibility & Enrollment	As-Is		To-Be		
Financial Management	As-Is	To-Be			
Member Management	As-Is		To-Be		
Operations Management	As-Is	To-Be			
Performance Management	As-Is	To-Be			
Plan Management	As-Is		To-Be		
Provider Management	As-Is		To-Be		

Table 2: Connecticut Medicaid Information Architecture Profile

CMS defines the primary objectives of an IA as follows:

- Align information requirements with Medicaid Enterprise vision and direction
- Improve system effectiveness
- Facilitate growth and innovation
- Lower overall life cycle costs
- Enable interoperability and data sharing

The IA maps enterprise data to the BA business processes. The IA contains five (5) interrelated components:

- Data Management Strategy (DMS): Provides a structure that facilitates the development of information to effectively share across State Medicaid Enterprise boundaries to improve mission performance. The DMS addresses the fundamental areas necessary to enable information-sharing opportunities and to position the State Medicaid Agency (SMA) to operate in an environment of global information.

- Conceptual Data Model (CDM): Represents the overall conceptual structure of the data, independent of any software or data storage structure, and provides a visual representation of the high-level data needed to run an enterprise or business activity.
- Logical Data Model (LDM): Shows data subject areas broken down into the data classes and attributes needed for one drilled-down business process, as well as the relationships between the classes. The LDM identifies all of the logical data elements that are in motion in the system or shared within the Medicaid Enterprise.
- Data Standards (DS): Provides a discussion of the use of data standards. The MITA IA coordinates the identification and use of common data standards for the administration and operation of the Medicaid Enterprise.
- Information Capability Matrix (ICM): Defines the information capabilities identified in the business process that enable technical capabilities. The ICM includes four (4) components: Data Management Strategy, Conceptual Data Model, Logical Data Model, and Data Standards.

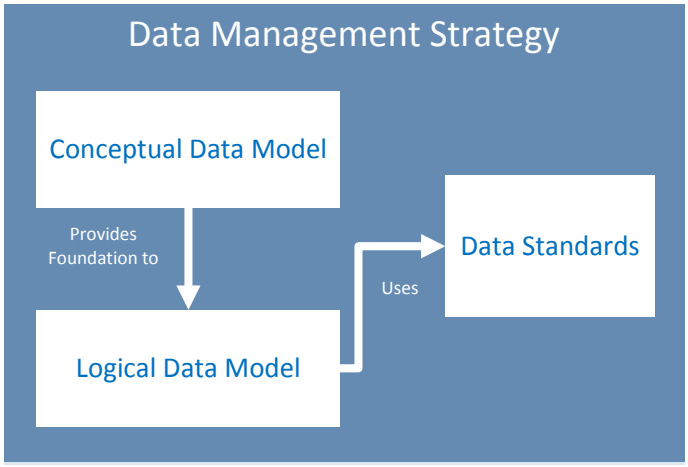


Figure 3: Data Management Strategy

The IA defines the DSS "As-Is" operations and develops targeted "To-Be" capabilities or environments within the enterprise, using CMS defined processes, capabilities, and standards. The outline below is utilized throughout the IA portion of the SS-A:

III. Connecticut Business Area Overview
- A. IA Capability Matrix Summary
- B. As-Is Process Summary
- C. To-Be Process Summary

III. Business Relationship Management

The Business Relationship Management (BR) business area is a collection of business processes that facilitate the coordination of standards of interoperability. This business area defines the exchange of information and Trading Partner Agreements (TPA) between the State Medicaid Agency (SMA) and its partners, including collaboration among intrastate agencies, interstate agencies, and federal agencies. These agreements contain functionality for interoperability, establishment of inter-agency Service Level Agreements (SLA), identification of the types of information exchanged, and security and privacy requirements. The Business Relationship Management business area has a common focus (e.g., data exchange standards and SLA) and is responsible for the business relationship data store.

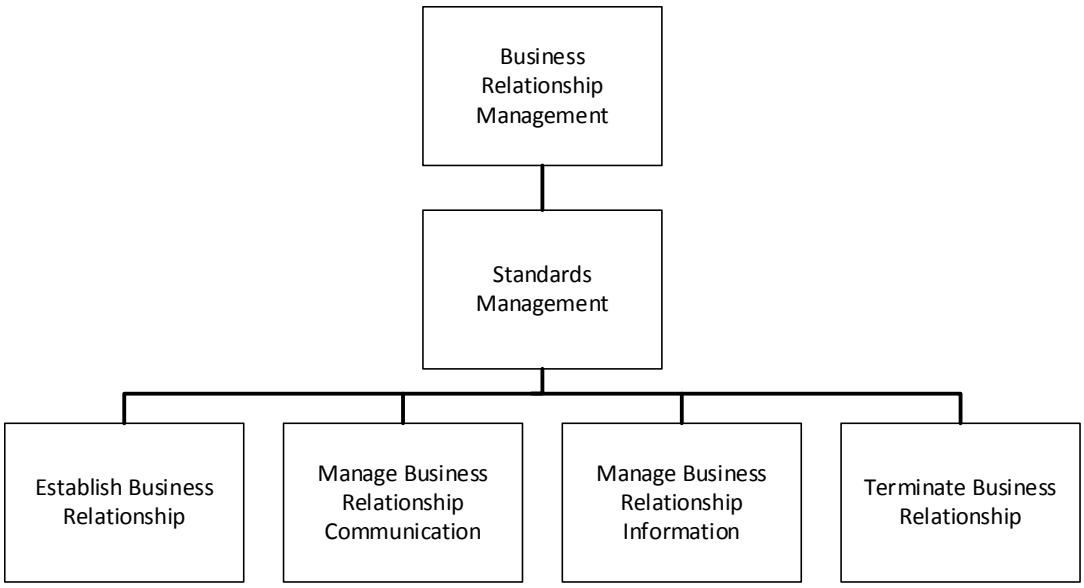


Figure 16: Business Relationship Management Business Area

Information Capability Matrix

An Information Capabilities Matrix is defined for each of the Business Areas in the MITA Framework. For each Area, state Subject Matter Experts were asked to evaluate current maturity levels using a 1-5 scale in terms of current and projected (5-10 years) capabilities as defined by CMS.

Business Relationship Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?		As-Is	To-Be		
Does the business area have a common data architecture?		As-Is	To-Be		
Does the business area use Enterprise Data Modeling?		As-Is	To-Be		
Does the business area utilize data sharing architectures?		As-Is	To-Be		
Does the business area have a Conceptual Data Model?		As-Is	To-Be		
Does the business area have a Logical Data Model?		As-Is	To-Be		
Does the business area use structure and vocabulary data standards to support current and emerging health data standards?		As-Is	To-Be		

Table 3: Business Relationship Management ICM

As-Is Business Area Summary

Processes within the current Business Area combine a mix of manual and automatic steps to gather, communicate, record, and distribute contract, procurement, and Service Level Agreement (SLA) information. Service Level Agreements and data standards within DSS are ad hoc. Provider interactions are more standardized. DXC Technology (DXC), formerly Hewlett Packard Enterprises (HPE), the fiscal agent, maintains the Trading Partner Agreement within the EDI subsystem of the MMIS system, interChange. The Procurement and Contracts System (PACS) is the primary system utilized for establishing contracts and data sharing agreements within DSS.

To-Be Business Area Summary

DSS has identified a MITA maturity level of 3 for a future state goal. In order to facilitate that advancement, DSS will need to expand both system functionality and oversight of data management and data sharing agreements. DSS will need to formally implement enterprise data governance, enterprise modeling, and formal data sharing architectures which are currently ad hoc and system/program specific. Conceptual Data Models (CDMs) and Logical Data Models (LDMs) are system specific and locally stored.

IV. Care Management

The Care Management business area illustrates the increasing shift away from the Fee-For-Service (FFS) model of care. Care Management collects information about the needs of the individual member, plan of treatment, targeted outcomes, and the individual's health status. It also contains business processes that have a common purpose (e.g., identify members with special needs, assess needs, develop treatment plan, monitor and manage the plan, and report outcomes). This business area includes processes that support individual care management and population management. Population management targets groups of individuals with similar characteristics to promote health education and awareness. The Electronic Health Record (EHR), Electronic Medical Record (EMR), and Personal Health Record (PHR) can be primary sources of individual health information from the Health Information Exchange (HIE).

Care Management includes Disease Management, Catastrophic Case Management, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Population Management, Patient Self-Directed Care Management, national health registries, and Waiver Program Case Management. The Care Management business area is responsible for case management, authorizations, referrals, treatment plans, and data stores. Care Management also contains business processes for authorization determination including authorizing referrals, as well as service and treatment plans.

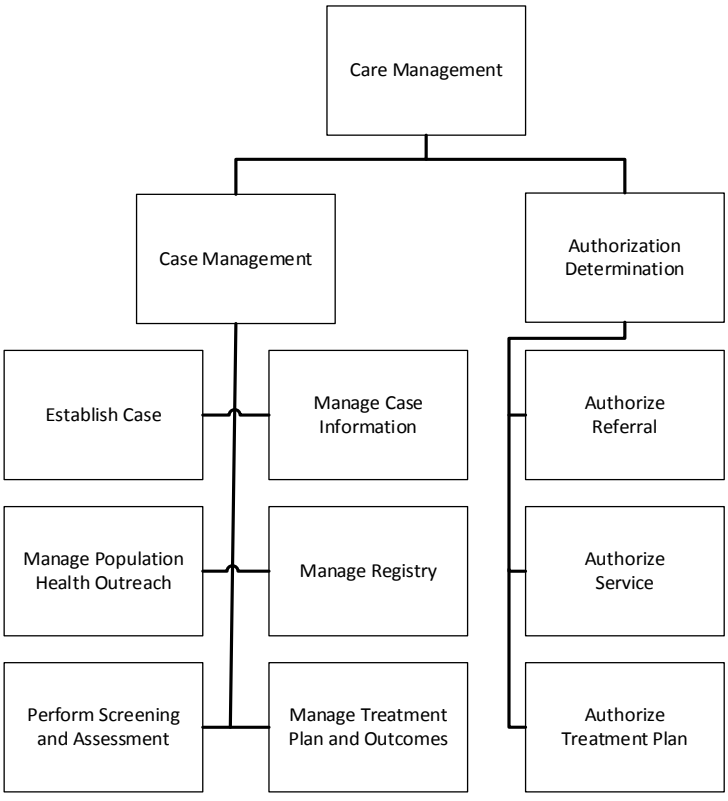


Figure 17: Care Management Business Area

Information Capability Matrix

Care Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?		As-Is	To-Be		
Does the business area have a common data architecture?		As-Is	To-Be		
Does the business area use Enterprise Data Modeling?	As-Is		To-Be		
Does the business area utilize data sharing architectures?		As-Is	To-Be		
Does the business area have a Conceptual Data Model?	As-Is		To-Be		
Does the business area have a Logical Data Model?	As-Is		To-Be		
Does the business area use structure and vocabulary data standards to support currentand emerging health data standards?		As-Is	To-Be		

Table 4: Care Management ICM

As-Is Business Area Summary

DSS is actively undergoing a transition in their approach to Care Management. Administrative Service Organizations (ASOs) provide coordinated care for the majority of beneficiaries. DSS is implementing changes in their Waiver Programs to achieve greater rebalancing, expanding Person-Centered Medical Homes (PCMH) with a new PCMH+ program, and implementing a Community First Choice (CFC) State Plan option. Care Management activities are often captured in each ASO's unique system and data stores; waivers and CFC are utilizing various contracted entities (including sister agencies and DSS staff for Care Management.) As DSS strives to achieve rebalancing of long-term services and supports, they are developing an infrastructure for their waiver programs to support uniform assessments and streamlined processes. They have been utilizing the University of Connecticut to consolidate waiver information for data analytics. Data governance is promoted via contracts and internal policies; however, retrieving data from the various entities and systems is hindered by the current approach.

To-Be Business Area Summary

In the future, the Care Management Business Area would benefit from a uniform Care Management module and a Data Mart subset within an Enterprise Data Warehouse. Promotion of bidirectional data flows, in open formats, and establishing data governance activities will facilitate higher levels of MITA maturity. DSS has articulated the need for increased availability of data analytics and business intelligence tools. An integrated care management platform would allow for HIPAA compliance and provide a standardized secure messaging system with real time data sharing, referral and prior authorization tracking, including automatic generation of notices.

The platform would make plans of care accessible, and include alerts to determine if services approved in the care plan are provided. Use of automated workflows to incorporate screenings and assessments would promote greater alignment with MITA.

V. Contractor Management

The Contractor Management business area accommodates Administrative Service Organization (ASO) contracts and a variety of outsourced contracts. The Contractor Management business area has a common focus on Medicaid contractors (e.g., managed care, at-risk mental health or dental care, Primary Care Physician (PCP)), is responsible for contractor data store, and uses business processes that have a common purpose (e.g., Fiscal Agent, enrollment broker, Fraud Enforcement Agency, and third-party recovery).

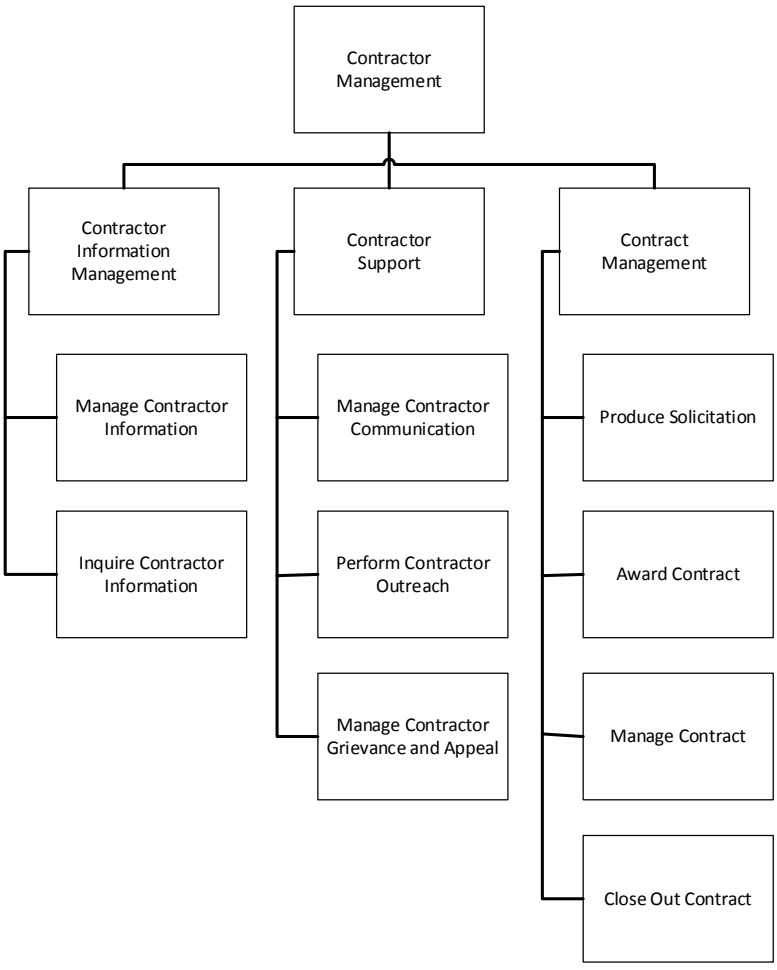


Figure 18: Contractor Management Business Area

Information Capability Matrix

Contractor Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?		As-Is	To-Be		
Does the business area have a common data architecture?		As-Is	To-Be		
Does the business area use Enterprise Data Modeling?		As-Is	To-Be		
Does the business area utilize data sharing architectures?		As-Is	To-Be		
Does the business area have a Conceptual Data Model?		As-Is	To-Be		
Does the business area have a Logical Data Model?		As-Is	To-Be		
Does the business area use structure and vocabulary data standards to support current and emerging health data standards?		As-Is	To-Be		

Table 5: Contractor Management ICM

As-Is Business Area Summary

DSS contracts are housed within the recently developed Procurement and Contracts System (PACS). The PACS system stores contract details and supporting documentation, and there has been a thoughtful approach to the conceptual data and logical data modeling. DSS Contract Administration and Procurement staff have the capability to query PACS for reporting. There are enhancements underway to incorporate contract management tracking information and fiscal information from CORE and other systems, so PACS will be more robust. There are still manual processes and interfaces which prevent PACS from being an enterprise system.

To-Be Business Area Summary

Both the Business Relationship Management and Contractor Management Business Areas disproportionately affect all other Business Areas within the MITA Information Architecture framework. These respective Business Areas are critical for establishing common data standards, architecture, data sharing relationships, and Service Oriented Architecture (SOA) for the state Medicaid enterprise with vendors and external entities. DSS requires both process and system improvements to reach higher levels of MITA maturity.

VI. Eligibility and Enrollment Management

The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicants, re-determination of existing members, enrolling new providers, and re-validation of existing providers. The Provider Enrollment business category and related business processes focus on patient safety and fraud prevention through functions such as determining screening level (i.e., limited, moderate, or high) for provider verifications. These processes share a common set of provider-related data for determination of eligibility, enrollment, and inquiry to provide services. The Eligibility and Enrollment Management business area is responsible for the eligibility and enrollment information of the member data store as well as the provider data store.

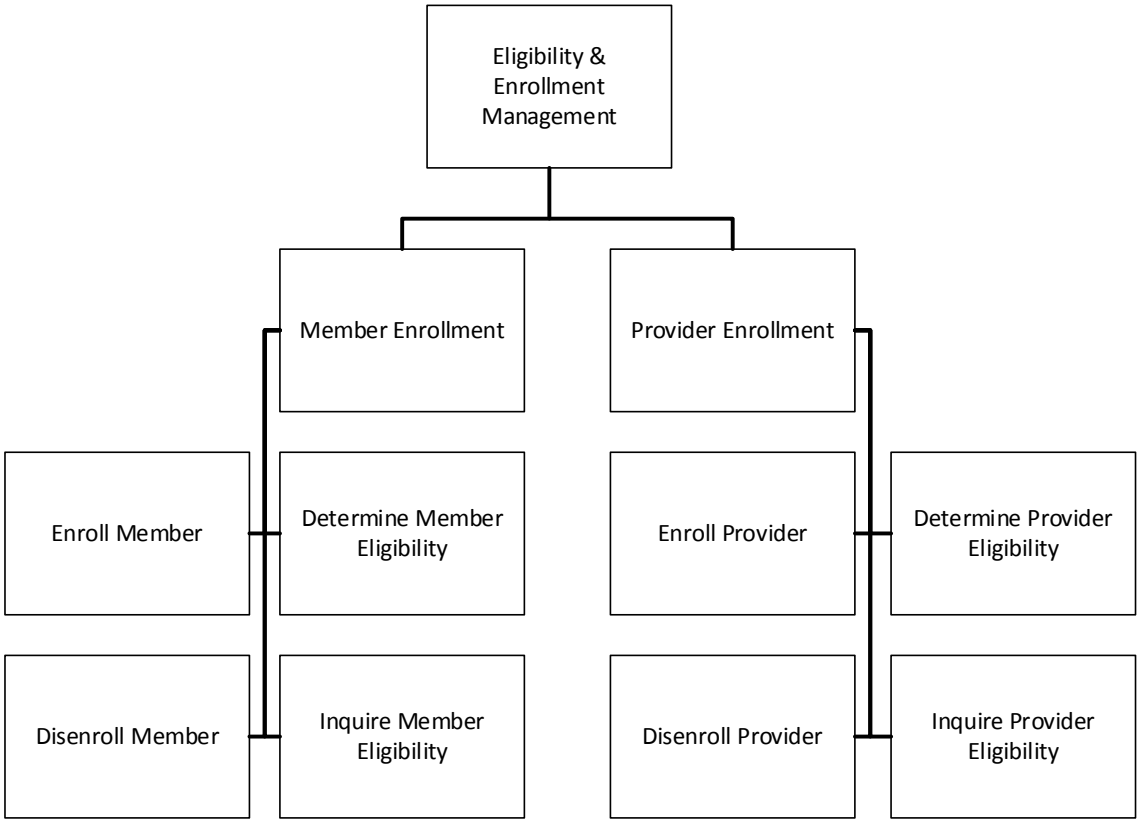


Figure 19: Eligibility & Enrollment Management Business Area

Information Capability Matrix

Eligibility and Enrollment Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?		As-Is	To-Be		
Does the business area have a common data architecture?	As-Is		To-Be		
Does the business area use Enterprise Data Modeling?	As-Is		To-Be		
Does the business area utilize data sharing architectures?		As-Is	To-Be		
Does the business area have a Conceptual Data Model?	As-Is		To-Be		
Does the business area have a Logical Data Model?	As-Is		To-Be		
Does the business area use structure and vocabulary data standards to support current and emerging health data standards?	As-Is		To-Be		

Table 6: Eligibility and Enrollment Management ICM

As-Is Business Area Summary

Member Eligibility and Enrollment business processes in Connecticut are in transition from a legacy multi-system environment towards an automated streamlined single system, ImpaCT. Data governance and architecture are currently ad hoc and unique within each eligibility system. The implementation of ImpaCT is promoting a common data sharing architecture within the enterprise. Data modeling and standards remain constrained by legacy systems. Provider Eligibility and Enrollment is managed within the MMIS system, interChange, through a Provider Web Portal with its own data governance and architecture.

To-Be Business Area Summary

Increased utilization and integration with the ImpaCT system will facilitate higher levels of MITA maturity. Enterprise level efforts for data governance and development of information-exchange formats will also facilitate higher maturity levels. Implementation of internal structure and vocabulary data standards will facilitate performance monitoring, management reporting, and analysis for provider services. In order to maximize user convenience, increase security, and reduce the effort of managing large user pools, DSS would benefit from a secure identity access and management solution. This would provide self-service features such as account request and password reset, as well as standards based single sign-on to applications according to user roles or permissions. Future applications should be built to be compatible with federated security standards.

VII. Financial Management

The Financial Management business area is a collection of business processes to support the payment of providers, ASOs, other agencies, insurers, and Medicare premiums; and supports the receipt of payments from other insurers, providers, and member premiums and financial participation. These processes share a common set of payment and receivables-related data. The Financial Management business area is responsible for the financial data store.

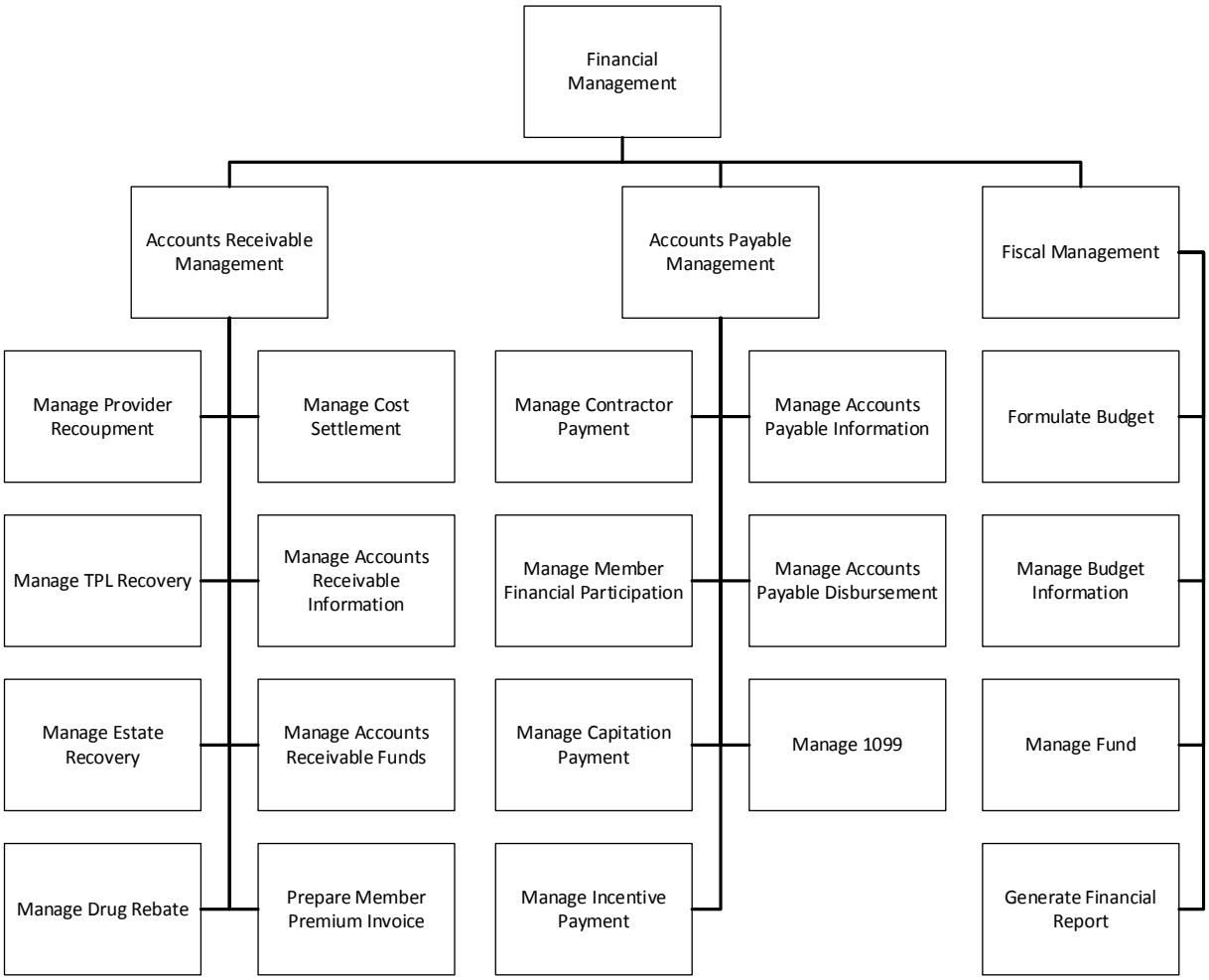


Figure 20: Financial Management Business Area

Information Capability Matrix

Financial Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?		As-Is	To-Be		
Does the business area have a common data architecture?		As-Is	To-Be		
Does the business area use Enterprise Data Modeling?	As-Is	To-Be			
Does the business area utilize data sharing architectures?		As-Is	To-Be		
Does the business area have a Conceptual Data Model?	As-Is		To-Be		
Does the business area have a Logical Data Model?	As-Is		To-Be		
Does the business area use structure and vocabulary data standards to support current and emerging health data standards?		As-Is	To-Be		

Table 7: Financial Management ICM

As-Is Business Area Summary

Processes within the Financial Management Business Area in Connecticut utilize a mix of manual and automated steps. Use of an Enterprise Service Bus is not widely applied, and system data is siloed; reconciliation between systems relies on the use of manual or legacy reporting mechanisms. Multiple systems store programmatic information throughout DSS, business partners, and ancillary agencies. All systems provide assurance for Generally Accepted Accounting Principles (GAAP). In some areas, state specific data standards are in place, but enterprise data modeling, a unified data dictionary, and reporting data inventories are not.

To-Be Business Area Summary

Building a financial Data Mart within the future Enterprise Data Warehouse will provide robust reporting capabilities and facilitate higher levels of MITA maturity. Additionally, process improvement steps, such as allowing more payments to be sent via direct deposit, will increase operational efficiency. The DSS staff recognized needs for a COTS predictive modeling software for forecasting specific to Medicaid operations, a document management system, and tools for dashboard reporting on programs and budgets.

VIII. Member Management

Note: Due to the regulation rule-making efforts underway at CMS, the MITA Framework 3.0 does not include the Member Management business processes or business capability matrices. However, in order to provide a complete assessment, the MITA 2.01 definitions were used and any updates since that time were noted below.

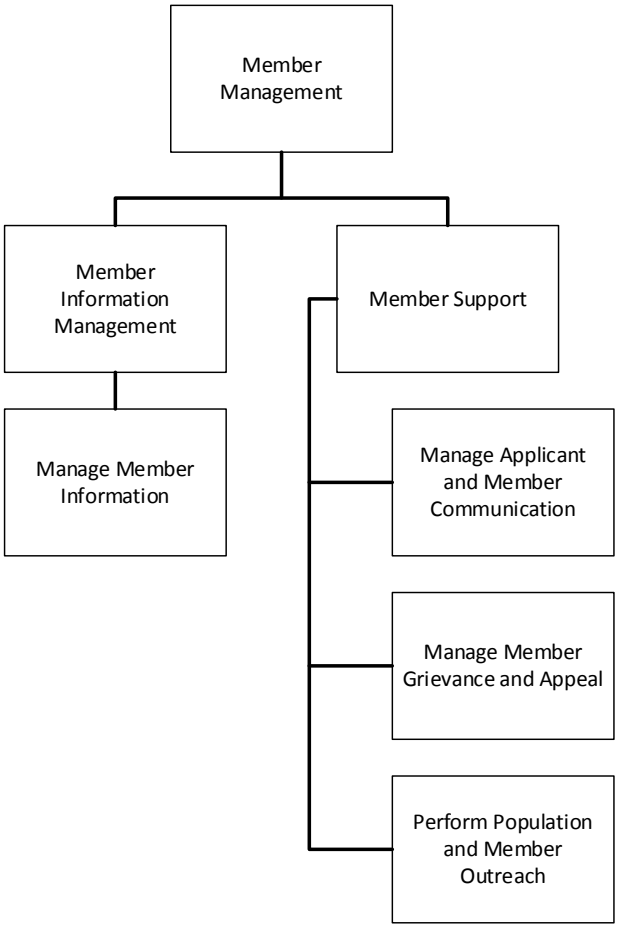


Figure 21: Member Management Business Area

Information Capability Matrix

Member Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?		As-Is	To-Be		
Does the business area have a common data architecture?	As-Is		To-Be		
Does the business area use Enterprise Data Modeling?	As-Is		To-Be		
Does the business area utilize data sharing architectures?		As-Is	To-Be		
Does the business area have a Conceptual Data Model?	As-Is		To-Be		
Does the business area have a Logical Data Model?	As-Is		To-Be		
Does the business area use structure and vocabulary data standards to support current and emerging health data standards?	As-Is		To-Be		

Table 8: Member Management ICM

As-Is Business Area Summary

Member information in Connecticut is stored across multiple partners and by programmatic involvement. Administrative Service Organizations (ASOs), DXC as fiscal agent with the MMIS, waiver programs and administering agencies, and eligibility systems which include both ImpaCT and legacy systems are all involved with maintenance, creation, and distribution of Medicaid member information. There is no formal program of data governance to implement controls and reduce redundancy among systems. Data models, relationships, and attributes are system specific. There is no metadata repository for member information. Data standards, definitions, semantics, and harmonization strategies are system and program specific. Conceptual and Logical Data Models do not exist at an enterprise level.

To-Be Business Area Summary

Improvements in managing Member information can be achieved through increased data governance. Data governance and a Service Oriented Architecture (SOA) are critical to support a modular MMIS system that is required by CMS and will make data more available and relevant. DSS has begun the implementation of Medicaid internal policy and procedures to promote enterprise modeling. DSS will require formal adoption of MITA, as well as a Data Management Strategy and Technical Management Strategy to advance toward the desired level 3 maturity.

IX. Operations Management

The Operations Management business area is a collection of business processes that manage claims and prepare premium payments. This business area uses a specific set of claims-related data and includes processing (i.e., editing, auditing, and pricing) a variety of forms for professional, dental, institutional, and drug claims, as well as sending payment information to the provider. All claim processing activity incorporates compatible methodologies of the National Correct Coding Initiative (NCCI). The Operations Management business area is responsible for the claims data store.

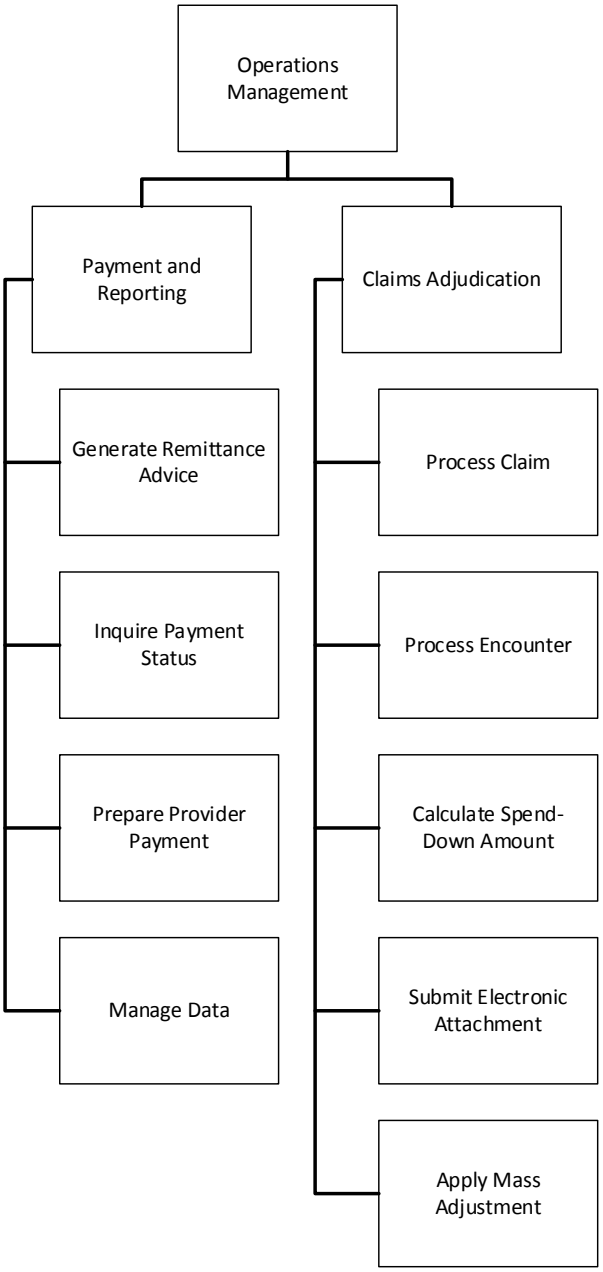


Figure 22: Operations Management Business Area

Information Capability Matrix

Operations Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?		As-Is	To-Be		
Does the business area have a common data architecture?	As-Is	To-Be			
Does the business area use Enterprise Data Modeling?	As-Is	To-Be			
Does the business area utilize data sharing architectures?		As-Is	To-Be		
Does the business area have a Conceptual Data Model?	As-Is		To-Be		
Does the business area have a Logical Data Model?	As-Is		To-Be		
Does the business area use structure and vocabulary data standards to support current and emerging health data standards?	As-Is		To-Be		

Table 9: Operations Management ICM

As-Is Business Area Summary

The Operations Management business area primarily relies upon the MMIS for executing business processes. The MMIS functions at a high level of maturity and automation using both HIPAA and national industry standards. As-Is capabilities are constrained by the lack of enterprise level data governance, CDM and LDM documentation, and standards implementation.

To-Be Business Area Summary

Adoption of the MITA framework, enterprise data governance, CDM and LDM documentation, and development of an enterprise level metadata repository and reporting system will facilitate higher levels of MITA maturity.

X. Performance Management

The Performance Management business area is a collection of business processes involved in the assessment of program compliance (e.g., auditing and tracking medical necessity and appropriateness of care, quality of care, patient safety, fraud and abuse, erroneous payments, and administrative anomalies). This business area uses information regarding an individual provider or member (e.g., demographics, information about the case itself such as case manager ID, dates, actions, and status, and information about parties associated with the case), and uses this information to perform functions related to utilization and performance. The Performance Management business area is responsible for the business activity and compliance data stores.

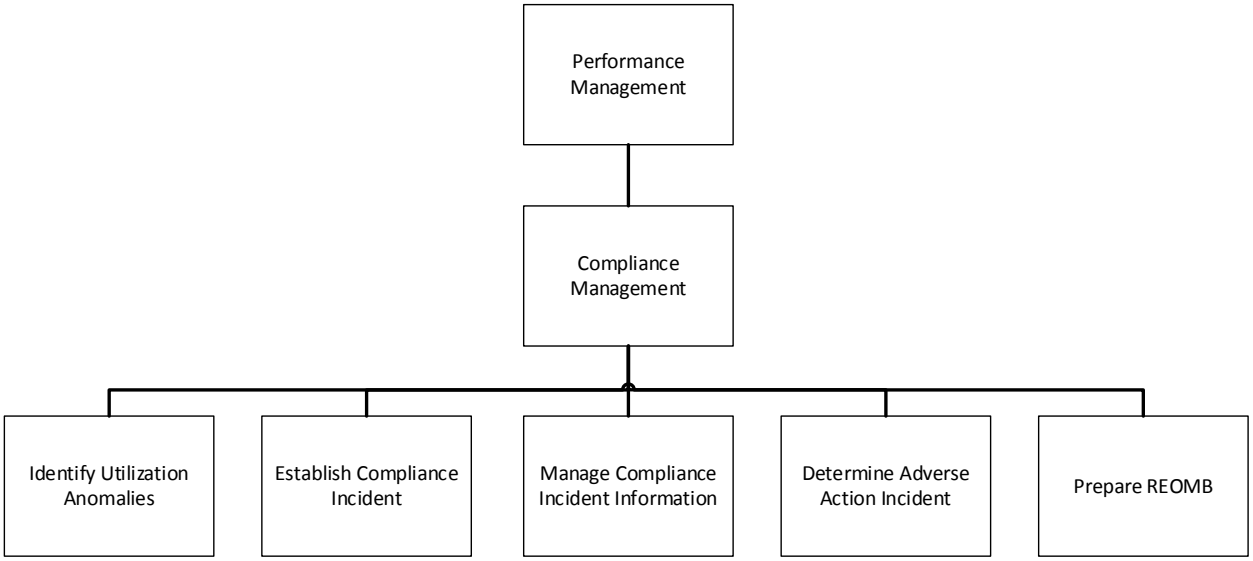


Figure 23: Performance Management Business Area

Information Capability Matrix

Performance Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?	As-Is		To-Be		
Does the business area have a common data architecture?	As-Is		To-Be		
Does the business area use Enterprise Data Modeling?	As-Is	To-Be			
Does the business area utilize data sharing architectures?	As-Is		To-Be		
Does the business area have a Conceptual Data Model?	As-Is		To-Be		
Does the business area have a Logical Data Model?	As-Is		To-Be		
Does the business area use structure and vocabulary data standards to support current and emerging health data standards?	As-Is		To-Be		

Table 10: Performance Management ICM

As-Is Business Area Summary

The Performance Management Business Area is performed across multiple systems within DSS. Data exchange formats are not standardized which impacts the efficacy of the overall Business Area although system specific standards are in place. Data integrity and data standards management are issues due to decentralized oversight. Sampling and analytics are performed using manual processing. In-house systems are utilized for case management and tracking; functionality is limited and not accessible to partner agencies or entities. Formal implementation of data standards, data stewards, and enterprise level governance are not in place. There is no extant inventory of data used to support Performance Management processes within the Business Area.

To-Be Business Area Summary

Formalized data exchange formats will facilitate data sharing agreements with external entities which include law enforcement and other regulatory agencies. Adoption of the MITA framework, enterprise data governance, data modeling, and development of an enterprise level metadata repository and reporting system will facilitate higher levels of MITA maturity.

XI. Plan Management

The Plan Management business area includes the strategic planning, policymaking, monitoring, and oversight business processes of DSS. This business area is responsible for the primary data stores (e.g., Medicaid State Plan, health plans, and health benefits) as well as performance measures, reference information, and rate setting data stores. The business processes include a wide range of planning, analysis, and decision-making activities. These activities include service needs and goals, health care outcome targets, quality assessment, performance and outcome analysis, and information management.

As the Medicaid Enterprise matures, Plan Management benefits from immediate access to information, addition of clinical records, use of nationally recognized standards, and interoperability with other programs. The Medicaid Program is moving from a focus on daily operations (e.g., number of claims paid) to a strategic focus on how to meet the needs of the population within a prescribed budget.

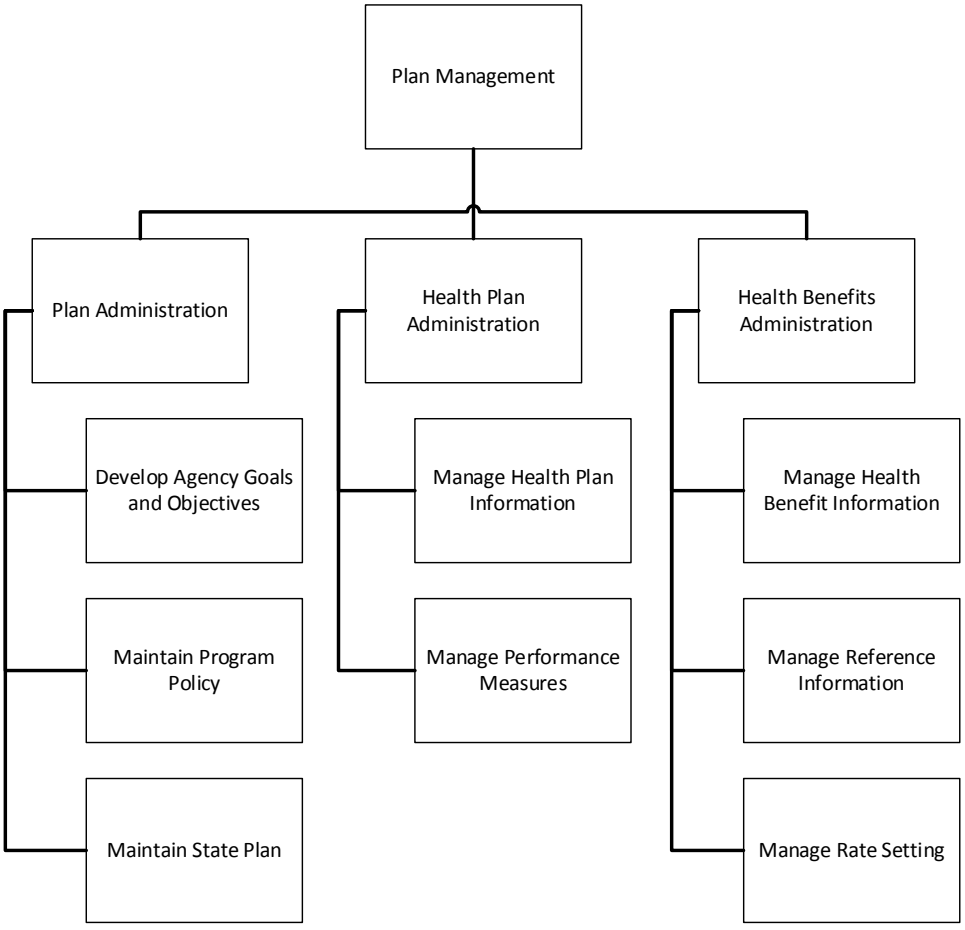


Figure 24: Plan Management Business Area

Information Capability Matrix

Plan Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?	As-Is		To-Be		
Does the business area have a common data architecture?	As-Is		To-Be		
Does the business area use Enterprise Data Modeling?	As-Is		To-Be		
Does the business area utilize data sharing architectures?		As-Is	To-Be		
Does the business area have a Conceptual Data Model?	As-Is		To-Be		
Does the business area have a Logical Data Model?	As-Is		To-Be		
Does the business area use structure and vocabulary data standards to support current and emerging health data standards?	As-Is		To-Be		

Table 11: Plan Management ICM

As-Is Business Area Summary

Plan Management processes are overseen by the Office of the Commissioner, DHS, and executive management within DSS. DSS goals and objectives are set by the Office of the Commissioner according to strategic directives. Within DHS, Medicaid goals and objectives are reviewed on an annual basis. There is no formal performance management program internal to DSS. A document management system, performance tracking system, and additional research capabilities would facilitate higher levels of MITA maturity within the business process.

To-Be Business Area Summary

Within the MITA framework, processes which fall within Plan Administration and Health Plan Administration are manually intensive with limited supporting technical resources. Higher levels of MITA maturity will be achieved through the implementation of data governance, development of enterprise level data architecture standards, formal data modeling, and technologies which promote data sharing through orchestration using SOA.

XII. Provider Management

The Provider Management business area is a collection of business processes involved in communications between the State Medicaid Agency (SMA) and the prospective or enrolled provider, and actions that DSS takes on behalf of the provider. Business processes focus on terminating providers, communications with providers, dealing with provider grievance and appeal issues, and performing outreach services to providers. The Provider Management business area is responsible for the provider data store.

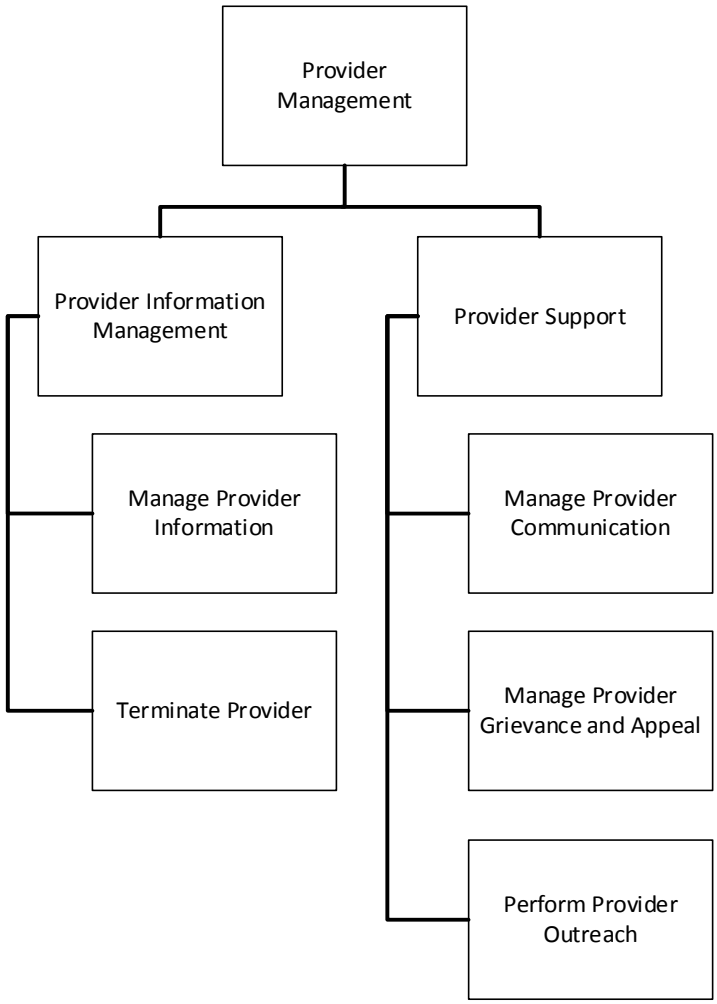


Figure 25: Provider Management Business Area

Information Capability Matrix

Provider Management	Level 1	Level 2	Level 3	Level 4	Level 5
Does the business area have governance of data management?		As-Is	To-Be		
Does the business area have a common data architecture?		As-Is	To-Be		
Does the business area use Enterprise Data Modeling?	As-Is		To-Be		
Does the business area utilize data sharing architectures?		As-Is	To-Be		
Does the business area have a Conceptual Data Model?	As-Is		To-Be		
Does the business area have a Logical Data Model?	As-Is		To-Be		
Does the business area use structure and vocabulary data standards to support current and emerging health data standards?	As-Is		To-Be		

Table 12: Provider Management ICM

As-Is Business Area Summary

The primary systems involved include the MMIS provider subsystem and the provider portal which is used to initiate the provider enrollment process. HIPAA and required standards are in place. The process for communicating or conducting outreach to the provider community may be handled by different entities including the DSS Provider Relations, DXC, or the Administrative Service Organizations (ASOs), and the process varies based upon the nature of the inquiry.

To-Be Business Area Summary

Connection of the provider application to other provider data sources, such as CAQH, will further enhance the automation of the enrollment process by allowing for the pre-population of applications beyond re-enrollment and decreasing potential data errors. The creation of a Provider Registry (PR) is currently in process. This PR will serve as a data repository for DSS, DXC, and the ASOs. Data received from the MMIS and ASOs will be enhanced by the inclusion of licensure data and data pulled from the NPPES NPI registry. The PR will facilitate the creation of a "best record" that may be utilized by all stakeholders. The PR will allow for the ownership of local provider records by each contributing entity. The contributing entity will have update capabilities for those local records. The ability to update provider data directly will yield easier management of provider information. The implementation of a Customer Relationship Management (CRM) tool would also give DSS greater standardization in the process of managing provider communication and outreach by permitting all parties to access, notate, and track

inquiries from providers and to assist in detailing the relationships that exist between providers, groups, and facilities.

XIII. Enterprise Level Information Architecture Assessment

Throughout the Information Architecture assessment, several key improvements were identified at the enterprise level which would facilitate higher levels of MITA maturity.

- **Data Management Strategy (DMS):** To facilitate implementation of a SOA, which is characterized by a modular MMIS, DSS should implement a DMS consistent with MITA. The DMS should include goals for consistent enterprise data standards; articulate a clear vision for enterprise architecture; emphasize service-based and cloud-first technologies; document data types, locations and access points; create data stewards; implement formal conceptual and logical data models; create a formal data governance process; and emphasize the creation and use of an enterprise metadata repository. The DMS should be used as part of Request for Proposals (RFP) evaluation criteria.

- **Data Governance:** As articulated by MITA, Data Governance defines the governance processes for making enterprise-wide decisions regarding information holdings. It provides the capability to determine ownership and data standard adoption processes, to address data integrity, to define processes for business-process development, and to establish a mechanism for arbitrating differences. The benefits are that it decreases data duplication, improves cost effectiveness of data sharing throughout the enterprise, and increases data quality. DSS should implement at an enterprise level Data Governance, which establishes Data Stewards and Owners, and sets Data Policy.

- **Data Architecture:** Using the Data Governance process and DMS, DSS should provide specific guidelines at an enterprise level regarding data documentation, data sharing development and use, applicable to both structured and unstructured data, and management of metadata of all types. These guidelines should be used to ensure that DSS defines data entities and attributes, data models, and relationships to convey the overall meaning and use of Medicaid data and information.

- **Enterprise Modeling:** Enterprise Modeling should be applied to business processes, data relationships, and technical assets. Data and technical modeling should formalize at the enterprise level the use of a:

    - Conceptual Data Model (CDM): Representing the overall conceptual structure of the data, independent of any software or data storage structure, and provide a visual representation of the high-level data needed to run an enterprise or business activity; and

    - Logical Data Model (LDM): Showing data subject areas broken down into the data classes and attributes, as well as the relationships between the classes. The LDM

identifies all of the logical data elements that are in motion in the system or shared within the Medicaid Enterprise.

- **Master Data Management & Metadata Repository:** A centralized metadata repository would allow all stakeholders to have access to review and reuse models and metadata. This facilitates data accessibility and sharing. Use of a common Enterprise Service Bus (ESB) and rules engine, in combination with formal data governance activities, would ensure that all systems (whether vendor or state owned) would produce reliable, accessible data. The metadata repository also reinforces data governance activities, because as systems are interfaced, any disparities or changing definitions become discoverable.

MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA) 3.0 STATE SELF-ASSESSMENT

TECHNICAL ARCHITECTURE

Version	Date	Author	Change Description
1.0	2/24/2017	Greg Haskamp	Original document created – submitted as draft
Final	5/5/2017	Greg Haskamp	Incorporates feedback

TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF AUTHORITIES

I. The MITA Framework

The Centers for Medicare and Medicaid Services (CMS) defines the Medicaid Information Technology Architecture (MITA) as both a framework and an initiative. The MITA 3.0 model consists of four interrelated components which include:

- Business Architecture (BA)
- Information Architecture (IA)
- Technical Architecture (TA)
- Seven Conditions and Standards (7C&S)

The identified business needs and capabilities from the BA define data strategies used in the IA and subsequently, the business and technical services which are employed for the TA. All three architectures are used to determine the degree of conformance to the 7C&S. CMS further uses all three architectures to promote business driven enterprises and consistency among all state Medicaid programs, as shown in the figure below.

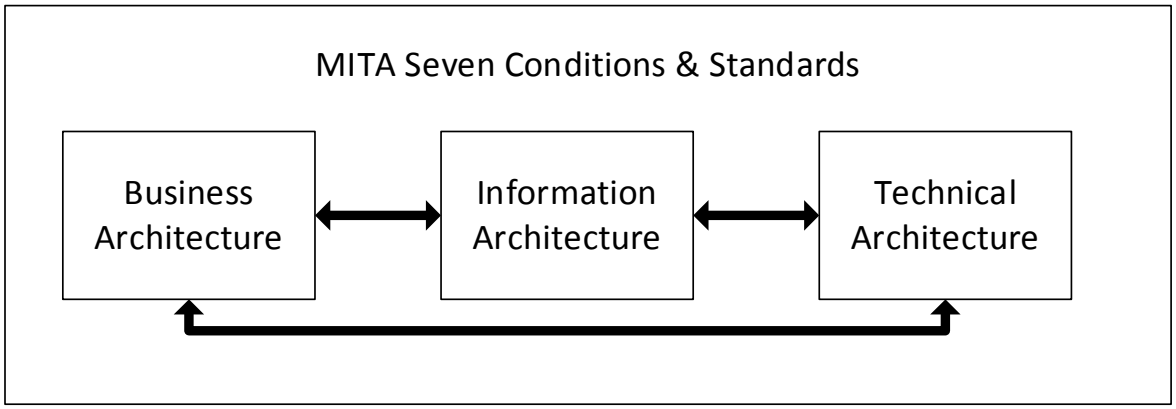


Figure 26: MITA Framework Relationship Diagram

The BA represents the starting point of the MITA framework, describing the business needs and goals of the Department of Social Services (DSS), Connecticut's State Medicaid Agency (SMA). As a conceptual framework, the BA for the DSS MITA 3.0 State Self-Assessment (SS-A) is constructed using CMS defined models, matrices, and templates.

The CMS defined MITA Business Process Model (BPM) is comprised of 80 distinct business processes, which are organized more broadly into categories and further grouped into business areas as shown in the figure below.

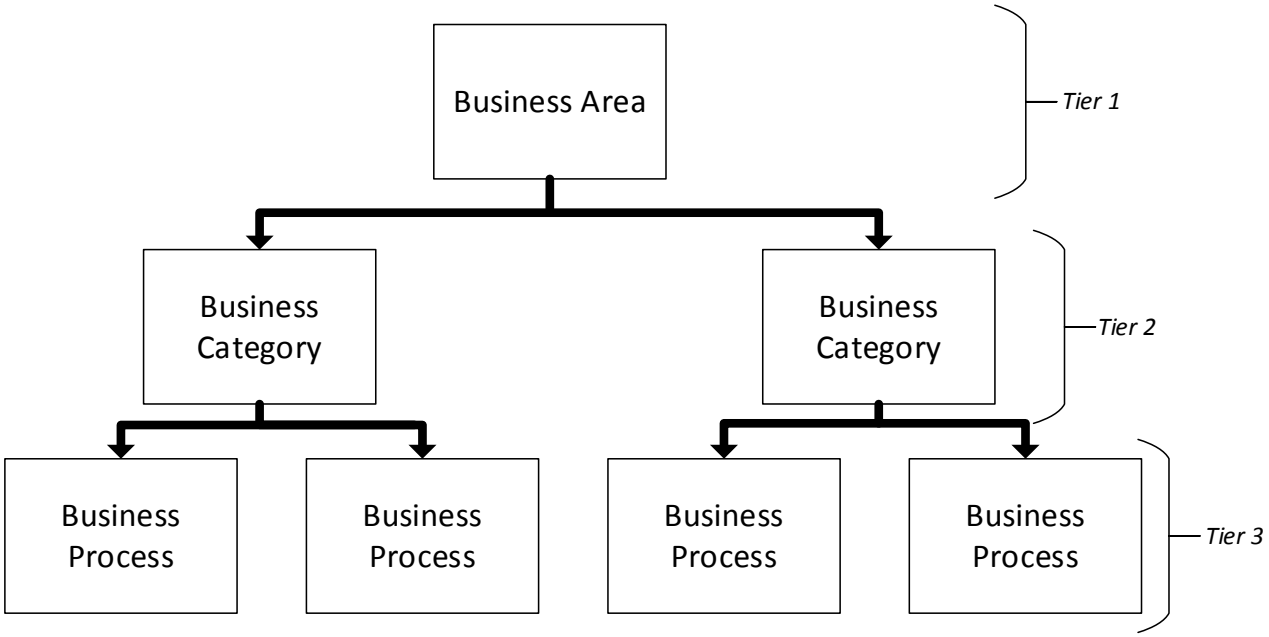


Figure 27: MITA Business Process Model Hierarchy

The MITA BPM is broadly defined by ten business areas. The table below illustrates the total number of MITA business processes across each business area, in comparison to the DSS identified processes. DSS utilizes the same ten areas identified from MITA 3.0 definitions. Individual processes were analyzed for differences, and those have been recorded using the CMS defined MITA Business Process Templates (BPTs) as supporting documentation.

MITA Business Area	MITA 3.0 Processes	Connecticut Processes
Business Relationship Management	4	4
Care Management	9	9
Contractor Management	9	9
Eligibility & Enrollment Management	8	8
Financial Management	19	18
Member Management	4	4
Operations Management	9	8
Performance Management	5	5
Plan Management	8	8
Provider Management	5	5
Total	**80**	**78**

Table 72: MITA Business Area Comparison

The current MITA 3.0 framework released by CMS does not yet include processes for Member Management. For the purpose of this assessment, the applicable processes from the MITA 2.0 framework are being used.

II. Technical Architecture Overview

CMS requires States to align and advance increasingly in MITA maturity for the Technical Architecture (TA). The TA framework describes the technical and application design aspects of the Medicaid Enterprise by leveraging industry standards and best practices. At a conceptual level, the TA can be broken down into the following components:

- Conceptual - Provides the business owners' view of the solution as a high-level rough framework identifying the most important components and business entities
- Logical - Provides the system designers'/architects' view of the solution as a comprehensive picture identifying major components and relationships; this level does not specify vendor solutions or details that will impact flexibility regarding the application creation process
- Physical - Provides the builders'/software developers' view of the solution detailing implementation of the solution

The MITA TA is a consolidation of principles, models, and guidelines that form a template for Connecticut to use to develop their own enterprise TA. The Connecticut Medicaid Technical Architecture Profile presents the current "As-Is" operational baseline ratings and the targeted "To-Be" capability goals for each of the business areas identified in the Connecticut Business Architecture Profile. Meetings were held with Connecticut Medicaid business and technical staff to assess each business area utilizing the CMS defined Technical Capability Matrix (TCM). As a result of these sessions, a profile was created to represent the results of the assessment as presented in the sections that follow.

MITA 3.0 Business Area	Level 1	Level 2	Level 3	Level 4	Level 5
Business Relationship Management	As-Is	To-Be			
Care Management	As-Is		To-Be		
Contractor Management	As-Is	To-Be			
Eligibility & Enrollment	As-Is		To-Be		
Financial Management	As-Is	To-Be			
Member Management	As-Is		To-Be		
Operations Management	As-Is	To-Be			
Performance Management	As-Is	To-Be			
Plan Management	As-Is		To-Be		
Provider Management	As-Is	To-Be			

Table 2: MITA 3.0 Technical Architecture Assessment by Business Area

The primary objectives of the TA, as defined by CMS, are to promote collaboration between states, CMS, and vendors by:

- Creating and maintaining enterprise models
- Creating infrastructure for information exchange
- Identifying common requirements (i.e., business and technical services)
- Developing implementation patterns
- Identifying and developing selected reusable components
- Establishing defined, common agreed-upon interfaces

The TA defines the DSS "As-Is" operations and develops targeted "To-Be" capabilities or environments within the enterprise, using CMS defined processes, capabilities, and standards. The outline below is utilized throughout the TA portion of the SS-A:

IV. Connecticut Business Area Overview
   a) TA Capability Matrix Summary
   b) As-Is Process Summary
   c) To-Be Process Summary

III. Components of the Technical Architecture

The MITA framework is most often referenced to provide specific solutions, describe processes, and achieve a certain level of commonality. The TA components are an integrated architecture that provides standardization, data sharing, and interoperability to the BA business processes. The TA contains six (6) interrelated components:

- **Technical Management Strategy (TMS)**: Provides the background and process for expanding Medicaid systems to incorporate modern-day technologies into the Medicaid Enterprise; the involvement of sound software design architecture practices and advances in technology such as Cloud Computing will provide the foundation for enhanced capabilities
- **Business Services**: Implements capability for a business process without regard to technical details; reusable business services are leveraged for multiple processes, a basic tenet of Cloud Computing and Service Oriented Architecture (SOA)
    - One goal of the TA is to specify the optimal set of compatible business services to recombine in various ways to support the SMA mission, bringing greater adaptability to Medicaid business processes
- **Technical Services**: Consists of a detailed set of technical functions and software services that collectively define the MITA technology infrastructure within a given Technical Service Classification (TSC) and corresponding Technical Service Application (TSA)
- **Application Architecture**: Provides the information necessary to develop enterprise applications using business and technical services
- **Technical Standards**: Consists of -
    - Technical Reference Model (TRM) - a list of technical services, either aggregated or broken down into levels that specify the standards
    - Standards Profile including current, future, and emerging industry standards
- **Technical Capability Matrix (TCM)**: Defines a set of high-level technical functions to enable business capabilities which meet MITA goals and objectives while supporting the success of Medicaid mission and goals
    - TCM supplements the Business Capability Matrix (BCM), and the Information Capability Matrix (ICM) in defining a benchmark for States to transform themselves in accordance with MITA principles

IV. Technical Service Areas (TSAs)

The MITA Framework includes two categories of services: business services and technical services. The TA derives the technical services from the business service requirements described in the MITA framework by the Business Architecture.

Technical services define what services a State Medicaid Enterprise should design for required generic support functions. The goal of the MITA Framework is to specify services that enable interoperable Medicaid services. An orchestration process weaves individual services and messages with other business and technical services. MITA technical services are component-driven, technical outlines that leverage a common, standardized vocabulary to allow intrastate and interstate agencies, federal partners, and health care stakeholders to leverage collaboration.

A technical service is a piece of software that executes a generic IT capability. It has a defined interface for its invocation, performs a defined function that corresponds to the capability, and returns defined results. The MITA Technical Services Framework consists of three (3) TSAs:

- **Access and Delivery** – Encompasses design drivers and enablers such as web browser connectivity, language support, Customer Relationship Management (CRM), and forms and reports services. The access and delivery functions have a direct impact on the state staff, the public, providers, and all other stakeholders. The span of coverage of the services offered will tend to change over time as the demands and technology needs of the end-user evolve.
- **Intermediary and Interface** – Contains drivers and enablers, such as process orchestration, workflow, and relationship management functionality. The Enterprise Service Bus (ESB) offerings handle the intermediary services (sometimes referred to as middleware). The interface services tie to connectivity offerings of the nearby Medicaid Enterprise entities and other external organizations that require a connection.
- **Integration and Utility** – Includes design drivers and enablers such as solution stacks, database access layer services, scalability, application versioning, and verification type utility services. These core service components will likely be a combination of the unique services and a set of reusable services across the Medicaid Enterprise.

Meetings were held with DSS business and technical staff and vendors to assess each business area utilizing the CMS defined Technical Capability Matrix (TCM). As a result of these sessions, a profile was created to represent the results of the assessment as presented in the sections that follow.

A. Technical Service Area: Access & Delivery

Access and Delivery encompasses design drivers and enablers such as web browser connectivity, language support, Customer Relationship Management (CRM), and forms and reports services. The access and delivery functions have a direct impact on the state staff, the public, providers, and all other stakeholders. The scope of services offered will tend to change over time as the demands and technology needs of the end-users evolve.

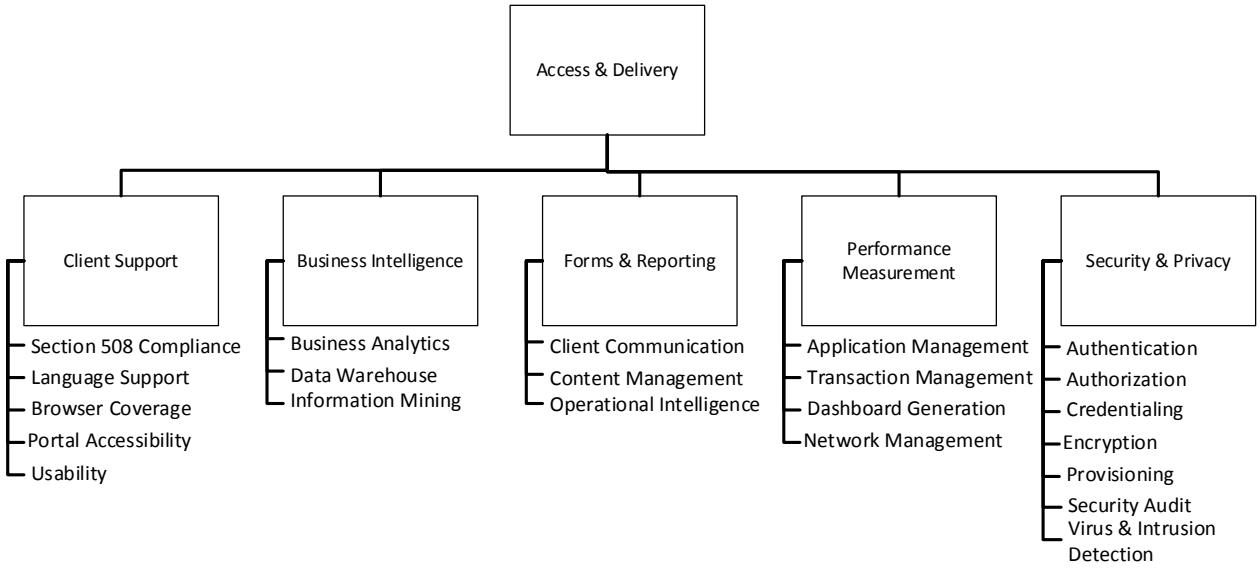


Figure 3: MITA Technical Service Area: Access & Delivery

	Client Support		Business Intelligence		Forms and Reporting		Performance Measurement		Security and Privacy	
	As-Is	To-Be	As-Is	To-Be	As-Is	To-Be	As-Is	To-Be	As-Is	To-Be
Business Relationship Management	2	3	3	4	3	4	2	3	2	3
Care Management	2	3	2	3	2	3	2	3	2	3
Contractor Management	2	3	3	4	3	4	2	3	2	3
Eligibility & Enrollment	2	3	2	4	1	3	2	3	2	3
Financial Management	1	2	2	3	2	3	1	3	1	3
Member Management	2	3	2	4	1	3	2	3	2	3
Operations Management	2	3	2	3	3	4	2	3	2	3

Performance Management	2	3	1	3	1	3	1	2	2	3
Plan Management	1	3	3	4	1	3	1	3	1	3
Provider Management	2	4	3	4	2	3	1	3	2	3
Overall	**1**	**2**	**1**	**3**	**1**	**3**	**1**	**2**	**1**	**3**

Table 3: MITA Access & Delivery Profile

Client Support As-Is Summary

As defined by MITA, "clients" include Medicaid members, providers and workers. DSS currently provides both member and provider portals; worker portals are system specific. Both member and provider portals provide basic functionality utilizing a programmatic focus for organization. Workers currently navigate multiple systems with varying navigational schemas, and divergent user interfaces. Not all systems utilized by DSS are web-enabled.

Client Support To-Be Summary

DSS has identified a MITA maturity level of 3 for a future state goal in most Business Areas. In order to facilitate that advancement, DSS will need to consolidate client support activities across programs. Member and Provider portals will require consolidation across the enterprise; consolidation of intake processes and systems will increase adherence to the MITA Seven Conditions and Standards (7C&S). For workers, Single-Sign-On capabilities, and a common rules engine implemented across all systems in the Medicaid enterprise will promote greater efficacy and efficiency in program administration. All client portals need improvements in accessibility, self-service functions, and workflow management. The goal is to provide users with a consistent user interface driven by a layer of reusable component technologies. The use of a Systems Integrator, as defined by CMS, will assist DSS with the transition to higher levels of client support through promotion of an SOA.

Business Intelligence As-Is Summary

DSS currently utilizes a data warehouse for data analysis and reporting, however it does not contain all enterprise Medicaid service data. Many analysis and reporting functions must be carried out system-by-system and rely on manual processes for reconciliation. Financial, Performance, and Plan Management are areas within the MITA framework which are disproportionately impacted by current Business Intelligence capabilities.

Business Intelligence To-Be Summary

DSS has prioritized the development of consistent enterprise level data for business services. DSS has expressed the goal to describe both a formal Data Management Strategy and Technical Management Strategy as defined by MITA for system acquisition and MITA implementation. Use of a Metadata repository, as well as an ESB and enterprise rules engine will reduce or eliminate many of the data related issues which have been cited by all MITA Business Area Leads.

Forms & Reporting As-Is Summary

Client communication for members and providers is accomplished through respective portals. Worker communication, content management, and operational intelligence are impaired without the use of an enterprise level document management solution. All MITA Business Areas currently require some level of manual intervention.

Forms & Reporting To-Be Summary
The implementation of an enterprise level document management solution and enterprise level solution for automated workflows will advance the majority of business services within DSS. Automated workflows with defined business roles will reduce duplication, increase responsiveness, and provide higher levels of services for all clients.

Performance Measurement As-Is Summary
Currently there is no formal Performance Management program with DSS. Service Level Agreements (SLAs) are implemented on an ad hoc basis for use with trading partners (including providers). There is currently no system for tracking vendor compliance to SLAs. Business Relationship Management activities are not supported by a formally defined Data Management Strategy (DMS) or Technical Management Strategy (TMS), which is disproportionately impacting the Medicaid enterprise.

Performance Measurement To-Be Summary
To achieve higher levels of maturity, DSS will need to systematize Business Relationship Management activities, and articulate formal DMS and TMS documents for inclusion as part of the RFP process. Application management, transaction management, and network management need to be defined for all vendors using a formal SLA. Vendors and partners should have required reporting via a Performance Management program.

Security & Privacy As-Is Summary
System assets with DSS are secure and private. DSS is compliant with the Health Insurance Portability and Accountability Act (HIPAA) and utilizes direct secure messaging for external entities.

Security & Privacy To-Be Summary
DSS will continue to ensure a secure IT infrastructure. Compliance with federal standards and protocols will remain a key priority for the Medicaid enterprise. In the distributed computing environment required by MITA, the availability of role-based security and single-sign-on capabilities will be of significant and increased importance for internal functions. The use of a Metadata repository will also increase the need for formal data governance, role-based security, and publish-subscribe messaging patterns for secure exchange of information.

B. Technical Service Area: Intermediary & Interface

Intermediary and Interface contains drivers and enablers, such as process orchestration, workflow, and relationship management functionality. The Enterprise Service Bus (ESB) offerings handle the intermediary services (sometimes referred to as middleware). The interface services tie to connectivity offerings of the nearby Medicaid Enterprise entities and other external organizations that require a connection.

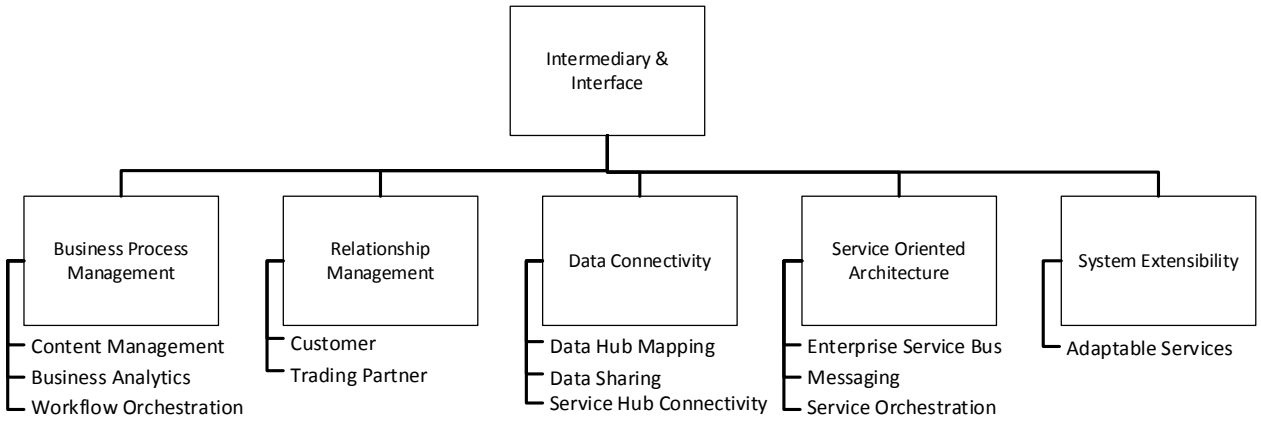


Figure 4: MITA Technical Service Area: Intermediary & Interface

	Business Process Management		Relationship Management		Data Connectivity		Service Oriented Architecture		System Extensibility	
	As-Is	To-Be	As-Is	To-Be	As-Is	To-Be	As-Is	To-Be	As-Is	To-Be
Business Relationship Management	1	3	2	3	2	3	1	3	2	3
Care Management	1	3	2	3	2	3	2	3	2	3
Contractor Management	1	3	2	3	2	3	1	3	2	3
Eligibility & Enrollment	1	3	2	3	2	3	2	3	2	3
Financial Management	1	3	2	3	2	3	1	3	2	3
Member Management	1	3	2	3	2	3	2	3	2	3
Operations Management	2	3	2	3	2	3	2	3	2	3
Performance Management	2	3	1	3	1	3	1	3	1	3

Plan Management	1	3	1	3	1	3	1	3	1	3
Provider Management	1	3	2	3	2	3	1	3	2	3
Overall	**1**	**3**	**1**	**3**	**1**	**3**	**1**	**3**	**1**	**3**

Table 4: MITA Intermediary & Interface Profile

Business Process Management As-Is Summary
DSS does not currently employ a formal process for workflow orchestration based on the MITA framework for business, data, or technical architecture. Business processes utilize limited modeling, and utilize varying degrees of manual and automatic processing.

Business Process Management To-Be Summary
The adoption of MITA and formal business modeling will allow DSS to conform to national standards. Content management, business analytics, and workflow orchestration will become easier as DSS advances in MITA maturity by utilizing the MITA Roadmap and increasingly aligns with business, data, and technical standards.

Relationship Management As-Is Summary
Business Relationship Agreements and data standards within DSS are ad hoc. Provider interactions are more standardized. DXC Technology (DXC), formerly Hewlett Packard Enterprises (HPE), the fiscal agent, maintains the Trading Partner Agreements within the EDI subsystem of the MMIS, interChange. The Procurement and Contracts System (PACS) is the primary system utilized for establishing contracts and data sharing agreements within DSS. DSS does not have business analytic tools to support performance management.

Relationship Management To-Be Summary
To achieve the targeted MITA maturity of a level 3, an enterprise business relationship system would be beneficial in Connecticut. DSS will need to track and support the development of an enterprise level services registry to support modular systems acquisition and implementation of industry standards.

Data Connectivity As-Is Summary
Data exchange in DSS primarily relies upon the use of the Data Warehouse, MMIS, and systems which reside within each of the Administrative Service Organizations (ASOs). DSS does not currently have a centralized metadata repository for electronic exchange with intrastate or interstate entities. Business process owners are familiar with data types which reside in their respective systems, however access is system specific. Data exchange is a mix of point-to-point interface, or user created exchange of reports.

Data Connectivity To-Be Summary
DSS has identified a MITA maturity level of 3 for a future state goal. In order to facilitate that advancement, DSS acknowledges the needs to expand both system functionality and oversight of data management and data sharing agreements. The creation and use of an enterprise wide metadata repository and a Master Data Management approach would facilitate the future state goal.

Service Oriented Architecture As-Is Summary
Connecticut does not currently utilize an SOA for technical architecture, nor a MITA recommended approach to ESB, rules engine, and system management. There is no formal centralized System Development Life Cycle (SDLC) methodology in place. Reliable messaging does occur from those Business

Areas which are supported by the MMIS or ImpaCT systems. There is an active "As-Is" effort to promote a modular SOA for system acquisition and replacement.

Service Oriented Architecture To-Be Summary

To reach higher MITA maturity levels, DSS should drive adoption of an enterprise level stack of technical assets which are utilized by all Business Areas. DSS should adopt an enterprise ESB and rules engine to which all systems are connected. DSS will need to formalize both a DMS and TMS, leveraging MITA, in order to implement an SOA. Additional recommendations for business, information, and technical transformation of the enterprise which support SOA are present in the Concept of Operations and Roadmap.

System Extensibility As-Is Summary

System extensibility throughout DSS is low; web based services are limited. Information exchange with the Nationwide Health Information Network (NwHIN) and the Health Insurance Exchange (HIX) is limited. Workers would benefit from systems which promote seamless integration with state, interstate, and federal entities.

System Extensibility To-Be Summary

DSS has identified the need to transition to a SOA which promotes adaptable services from a common technology stack. Emphasis should be placed on Commercial Off the Shelf (COTS) and Cloud based solutions per the MITA framework. The development of a Master Data Management initiative, modular SOA, and a Care Management module would facilitate extensibility in MITA Business Areas and promote higher levels of client service.

C. Technical Service Area: Integration & Utility

Integration and Utility includes design drivers and enablers such as solution stacks, database access layer services, scalability, application versioning, and verification type utility services. These core service components will likely be a combination of the unique services and a set of reusable services across the Medicaid Enterprise.

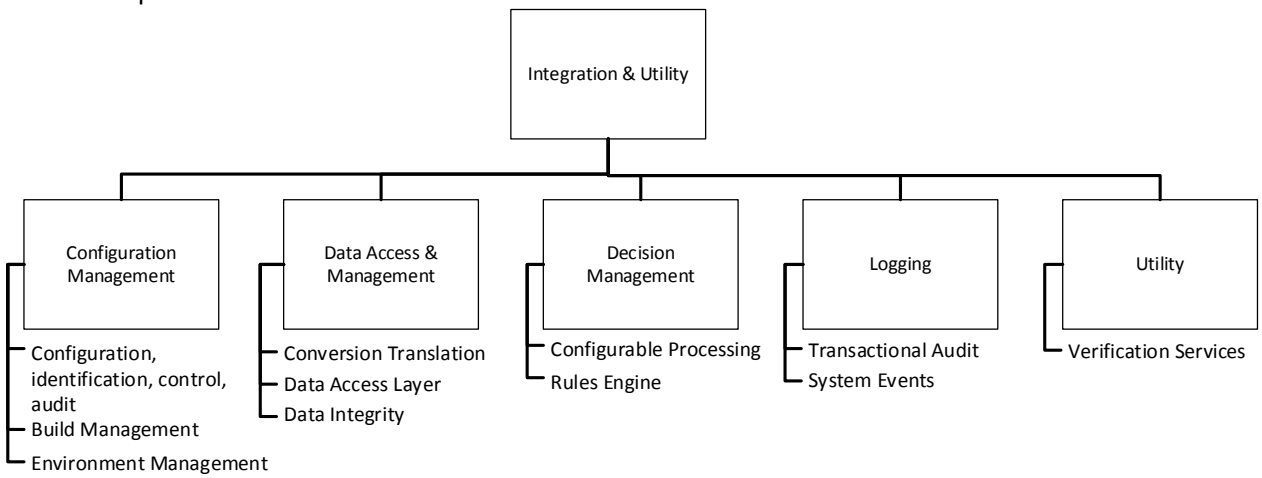


Figure 5: MITA Technical Service Area: Integration & Utility

	Configuration Management		Data Access & Management		Decision Management		Logging		Utility	
	As-Is	To-Be	As-Is	To-Be	As-Is	To-Be	As-Is	To-Be	As-Is	To-Be
Business Relationship Management	1	2	1	2	1	2	2	3	2	3
Care Management	1	3	1	3	2	3	2	3	1	3
Contractor Management	1	2	1	2	1	2	2	3	2	3
Eligibility & Enrollment	1	3	1	3	1	3	2	3	2	3
Financial Management	1	3	1	3	2	3	2	3	2	3
Member Management	1	3	1	3	1	3	2	3	2	3
Operations Management	1	2	1	2	1	2	2	3	1	2
Performance Management	1	3	1	3	1	3	1	3	1	3
Plan Management	1	3	1	3	1	3	1	3	1	3
Provider Management	1	2	1	2	1	2	2	3	2	3
Overall	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**3**	**1**	**2**

Table 5: MITA Integration & Utility Profile

Configuration Management As-Is Summary
DSS does not currently utilize SDLC throughout the enterprise for build, process, or environmental management. Interfaces are characterized as point-to-point exchanges which are technology dependent upon the respective systems. There is no formal configuration management methodology in place.

Configuration Management To-Be Summary
Implementation of a formal DMS and TMS which emphasize SOA will help to reach higher levels of MITA maturity. Both the DMS and TMS should define the use of technology-neutral interfaces and implement metadata definitions. Implementation of Master Data Management, a common ESB, and rules engine will facilitate higher levels of maturity throughout the enterprise.

Data Access & Management As-Is Summary
Information exchange is characterized by point-to-point interfaces throughout the enterprise. Formal use of data models is limited by system. Information resides in multiple siloed systems. The emphasis for data exchange is built around state and federal programmatic compliance.

Data Access & Management To-Be Summary
DSS desires to formally implement an enterprise data schema with a tight coupling approach, built to industry standards within the MITA framework. To facilitate higher levels of MITA maturity, a Master Data Management initiative should be implemented. Use of a unified metadata repository and enterprise archiving solution (for meeting data retention policies and federal compliance guidelines) will allow for the use of Cloud based solutions called for in the MITA framework.

Decision Management As-Is Summary
Decision management is currently characterized by system specific business rules which are not uniformly documented throughout the enterprise. There is limited ability to develop configurable processing between systems. There is no common rules engine which is utilized and orchestrated through an ESB.

Decision Management To-Be Summary
Adoption of a common rules engine for use throughout the Medicaid enterprise will allow DSS to advance in MITA maturity. The rules engine will need to automate testing scenarios and enable analysts and developers to trace execution paths for implementation verification. DSS acknowledges the need to promote an open system for ease of integration with any computing environment. The rules engine should accept inputs from multiple databases, XML documents, Java objects, .NET/COM objects, and COBOL copybooks and integrate with various environments.

Logging As-Is Summary
Logging of user activity and system events is common throughout the Medicaid enterprise. Logs include approvals/denials but are system specific. Role-based security is the norm throughout DSS.

Logging To-Be Summary

Use of MITA and role-based user rights which are centrally managed will facilitate higher levels of MITA maturity. Use of single-sign-on and enterprise level system auditing tools would allow for greater compliance to national and industry standards. Logging standards, requirements, and retention measures should be specified by the TMS.

Utility As-Is Summary

Worker portals have limited web service utility throughout the enterprise. SOA is not in place, although DSS is moving toward a distributed system environment. Formal SDLC is not in place; use of self-service applications is limited.

Utility To-Be Summary

DSS will advance maturity with improvements to client verification services, a Master Data Management environment which can facilitate a publish-subscribe model, and business process orchestration. Implementation of a formal DMS and TMS will further advance MITA maturity levels across the enterprise. DSS should further promote the use of a simple architected software services environment, which offers database integration and reliable messaging.

V. Enterprise Level Technical Architecture Assessment

Throughout the TA assessment, DSS identified and acknowledged that several key improvements are required at the enterprise level to facilitate higher levels of MITA maturity. DSS's goal is to establish solid data management processes, techniques, and products needed by the Medicaid Enterprise to achieve optimal technical performance. Due to the close linkages between MITA architectures, the following TA efforts rely and build upon enterprise level efforts identified throughout the assessment (e.g. development of Enterprise Data Modeling and Enterprise Data Governance related to Information Architecture) and must be considered as a cohesive whole that is defined by the MITA Roadmap.

- **Technical Management Strategy -** As DSS evolves and begins aligning their technology with the MITA Framework, they will shift from traditional siloed methodologies to an enterprise approach that includes related systems within the State of Connecticut. This shift will result in the engagement of interoperability concepts to replace outdated distribution methods with master data management, data sharing, Service Oriented Architecture, and Cloud Computing concepts and practices. Increased attention must be given to building out the Medicaid enterprise environment through sound strategic design. It is of critical importance that this transformation is being driven by the business goals of the enterprise.

  Given the sheer number of moving parts within a Medicaid program, an enterprise level strategy combined with a transformation plan are imperative for moving forward in a structured manner. Technical Services Management includes the identification, development, and management of business functions for reuse and sharing, as well as the technical architecture to support it.

- **Enterprise Service Oriented Architecture -** In the future, DSS has identified the need to promote an enterprise wide SOA and a formal System Development Life Cycle (SDLC) process. The SOA will be enabled through the enterprise efforts identified during the Information Architecture assessment. DSS will maintain a master systems listing including all interfaces, standards, and methods of data exchange. SOA will be further enabled through the development of enterprise standards and data dictionaries.

- **Enterprise Service Bus, Rules Engine, and Single Sign-On –** In order to facilitate data exchange, the efficiency and efficacy of services, and higher levels of MITA maturity, DSS will pursue the use of an enterprise level rules engine with shareable rules definitions. Also, DSS recognizes the need for a secure and streamlined user experience via a Single Sign-On (SSO) solution.

- **Unified Document Management System and Automated Workflows -** DSS currently utilizes a number of Document Management Systems and localized storage. Automated workflows and a unified Document Management System would improve the MITA maturity for a number of processes.

- **Enterprise Business Modeling Tools -** DSS does not currently possess Business Modeling Tools. Such tools are a necessary prerequisite for much of the technical work required to promote SOA and improvements to DSS operational efficacy. As part of the modeling efforts, DSS will leverage

the MITA 3.0 assessment as well as Lean process improvement techniques to ensure that both business and technical processing are efficient and cost effective.

- **Modularized Technical Architecture and Consolidated Portals -** As part of SOA efforts, DSS seeks to distribute the current environment, creating more flexibility within the Technical Architecture. DSS also identifies the need to promote unified experiences for members and providers. In order to create higher levels of efficiency, DSS will evaluate and implement modularized architectures and consolidated portals where it will generate the greatest process improvements and cost avoidance. This architectural framework must be able to incorporate and integrate many different technologies and promote the adoption of RESTful and SOAP based web services. DSS should implement enterprise based auditing tools and develop a mechanism for monitoring enterprise business activity using event driven dashboards.

MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)
3.0 STATE SELF-ASSESSMENT

SEVEN CONDITIONS AND STANDARDS

Version	Date	Author	Change Description
1.0	3/17/2017	Greg Haskamp	Original document created – submitted as draft
Final	5/5/2017	Greg Haskamp	Incorporates feedback

TABLE OF CONTENTS

TABLE OF AUTHORITIES

III. Seven Conditions and Standards Overview

In April 2011, CMS released the Seven Conditions and Standards[1] to ensure approval of enhanced Federal Financial Participation (FFP) funding. This funding will apply only when Medicaid infrastructure and information systems projects meet statutory and regulatory requirements to support efficient and effective operations pursuant to 42 CFR Part 433 for the Medicaid Program. As part of the MITA 3.0 State Self-Assessment (SS-A), each standard or condition is evaluated for maturity based on the Seven Conditions and Standards Capability Matrix.

The MITA Medicaid Enterprise includes all three (3) of the MITA architectures (i.e., Business, Information, and Technical) and supports the Seven Conditions and Standards described below:

- **Modularity Standard:** Requires the use of a modular, flexible approach to systems development, including the use of open interfaces and exposed Application Programming Interfaces (API), the separation of business rules from core programming, and the availability of business rules in both human and machine-readable formats. The commitment to formal system development methodology and open, reusable system architecture is extremely important.

- **MITA Condition:** States align to and advance increasingly in MITA maturity for business processes, technical architecture, and data exchange.

- **Industry Standards Condition:** States must ensure alignment with, and incorporation of, industry standards: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with federal civil rights laws; standards adopted by the Secretary of the U.S. Department of Health & Human Services (HHS) under section 1104 of the Affordable Care Act of 2010; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act.

- **Leverage Condition:** State solutions should promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States.

- **Business Results Condition:** Systems should support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public.

- **Reporting Condition:** Solutions should produce transaction data, reports, and performance information that contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.

[1] The "Seven Conditions and Standards," is used interchangeably by CMS as the "Seven Standards and Conditions."

- **Interoperability Condition:** Systems must ensure seamless coordination and integration with the Health Insurance Exchange (whether run by the state or federal government), and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.

VI. Seven Conditions & Standards Summary Capability Matrix

The Seven Conditions and Standards Capability Matrix identifies the required conditions and standards for a specific level of maturity. Each condition or standard is measured using the capability matrix and applying the MITA Maturity Model (MMM) representing 1-5 levels of maturity. The Seven Conditions and Standards Capability Matrix is the primary tool for defining the "As-Is" operations and the "To-Be" environment.

In conducting the State Self-Assessment, Connecticut's State Medicaid Agency (SMA), the Department of Social Services (DSS), applied this model to each Business Area, and produced the following matrix as a collective product. The scores are therefore consistent across each MITA Business Area (i.e., there is no difference in scoring between Business Areas).

Business Architecture

MITA 3.0 Standard/Condition	Level 1	Level 2	Level 3	Level 4	Level 5
Modularity Standard	As-Is		To-Be		
MITA Condition		As-Is	To-Be		
Industry Standards Condition		As-Is	To-Be		
Leverage Condition	As-Is		To-Be		
Business Results Condition		As-Is	To-Be		
Reporting Condition		As-Is	To-Be		
Interoperability Condition		As-Is	To-Be		

Table 1: MITA 3.0 Business Architecture Assessment by Standard/Condition

Information Architecture

MITA 3.0 Standard/Condition	Level 1	Level 2	Level 3	Level 4	Level 5
Modularity Standard	As-Is		To-Be		
MITA Condition		As-Is	To-Be		
Industry Standards Condition		As-Is	To-Be		
Leverage Condition	As-Is		To-Be		
Business Results Condition		As-Is	To-Be		
Reporting Condition		As-Is	To-Be		
Interoperability Condition		As-Is	To-Be		

Table 2: MITA 3.0 Information Architecture Assessment by Standard/Condition

Technical Architecture

MITA 3.0 Standard/Condition	Level 1	Level 2	Level 3	Level 4	Level 5

Modularity Standard	As-Is		To-Be		
MITA Condition		As-Is	To-Be		
Industry Standards Condition		As-Is	To-Be		
Leverage Condition	As-Is		To-Be		
Business Results Condition		As-Is	To-Be		
Reporting Condition		As-Is	To-Be		
Interoperability Condition		As-Is	To-Be		

Table 3: MITA 3.0 Technical Architecture Assessment by Standard/Condition

VII. Modularity Standard

The Modularity Standard requires the use of a modular, flexible approach to systems development, including the use of open interfaces and exposed API; the separation of standardized business rule definitions from core programming; and the availability of standardized business rule definitions in both human and machine-readable formats. The States commit to formal system development methodology and open, reusable system architecture. Activities include the following:

- Use of Systems Development Life Cycle Methodology (SDLC)
- Identification and description of open interfaces
- Use of standardized business rule definitions engines
- Submission of standardized business rule definitions to an HHS-designated repository

The table below presents the MITA Maturity Model applied to the Seven Conditions and Standards as a summary for all MITA Business Areas. "As-Is" capabilities are depicted with light blue shading, whereas "To-Be" capabilities are depicted with darker blue shading. The timeframe for "To-Be" capabilities is defined as 5-10 years in the future.

Seven Conditions & Standards (All Business Areas)					
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Modularity Standard					
Business Architecture	The SMA does not use a Business Process Management (BPM) methodology nor does it have any defined business rules.	The SMA adopts BPM methodology to identify primary business operations and business processes and has some standardized business rules definitions.	The SMA uses BPM methodology to transform intrastate business operations into manageable business processes for re-usability and maintainability and has interstate standardized business rules definitions.	The SMA uses BPM methodology to transform interstate business operations into manageable business processes for re-usability and maintainability. The SMA uses regionally standardized business rules definitions and submits them	The SMA uses BPM methodology to transform national business operations into manageable business processes for re-usability and maintainability. The SMA submits standardized business rules definitions to an HHS-

				to a regional repository.	designated repository.
Information Architecture	The SMA does not use an SDLC, reusable interfaces, and has no inventory or interface details documented.	The SMA adopts data standards, and documents some interfaces. The SMA has an interface inventory.	The SMA uses intrastate standardized business rule definitions separate from core programming. The SMA adopts SDLC methodology. The SMA documents and inventories open interfaces within intrastate agencies and stakeholders.	The SMA uses regionally standardized business rule definitions separate from core programming in both human and machine-readable formats. The SMA uses documented and inventoried open interfaces across state and regional agencies and stakeholders.	The SMA uses nationally standardized business rule definitions submitted to the HHS design repository. The SMA uses documented and inventoried open interfaces across state, regional, and national agencies and stakeholders.
Technical Architecture	The SMA does not use an SDLC, reusable interfaces, and has no inventory or interface details documented.	The SMA adopts data standards, and documents some interfaces. The SMA has an interface inventory.	The SMA uses intrastate standardized business rule definitions separate from core programming. The SMA adopts SDLC methodology. The SMA documents and inventories open interfaces within	The SMA develops and maintains an exposed API to any regional data services hub available. The SMA develops Cloud Computing functions. The SMA uses interstate standardized business rules definitions via	The SMA interfaces with other federal or interstate state agencies' cloud services and repositories. The SMA uses national standardized business rules definitions via business rules engine.

			intrastate agencies and stakeholders.	business rules engine.	

Table 4: Modularity Standard for all MITA Business Areas

Modularity Standard As-Is

The Connecticut Department of Social Services (DSS) does not utilize a formal process for BPM or SDLC methodologies across the entire agency. Recent program development - for example, the new ImpaCT eligibility system - demonstrates adherence to these processes, but overall, business functions remain siloed by program. An Enterprise Service Bus (ESB) is being used by the Eligibility & Enrollment (E&E) solution but lacking enterprise wide use of standards or integration. Business rules definitions are not uniformly employed throughout the enterprise.

Modularity Standard To-Be

DSS should develop both a MITA defined Data Management Strategy (DMS) and Technical Management Strategy (TMS) as a first step to facilitate implementation of modular technology. DMS can provide the mechanism for DSS to better understand their data and how it fits in the total realm of healthcare information. It can also facilitate the development of data sets that can be shared effectively across the enterprise. Interfaces across state agencies should be recorded, with the use of SDLC more conventionally, and business processes should be more formally documented. DSS should continue their adoption and use of common industry standards. Use of a common ESB and Rules Engine will promote higher levels of MITA maturity for Modularity

within a Service Oriented Architecture (SOA). A modular approach to system acquisition will be in accordance with MITA and CMS standards.

VIII. MITA Condition

The MITA Condition requires states to align and incrementally advance in MITA maturity for business, architecture, and data. States demonstrate this by completing a MITA Roadmap and performing MITA Self-Assessments. States also develop a Concept of Operations (COO) and Business Process Models (BPM).

The table below presents the MITA Maturity Model applied to the Seven Conditions and Standards as a summary for all MITA Business Areas. "As-Is" capabilities are depicted with light blue shading, whereas "To-Be" capabilities are depicted with darker blue shading. The timeframe for "To-Be" capabilities is defined as 5-10 years in the future.

Seven Conditions & Standards (All Business Areas)					
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
MITA Condition					
Business Architecture	The SMA does not align to or advance increasingly in MITA maturity for Business Architecture (BA).	The SMA begins to use MITA SS-A for evaluation of its As-Is and identification of its To-Be capabilities for BA.	The SMA updates or completes its SS-A for BA and the Seven Standards and Conditions BA portion.	The SMA develops its MITA Roadmap for BA.	The SMA updates the MITA Roadmap for BA annually. The SMA develops a COO and BPM using Business Process Model and Notation (BPMN) to advance alignment with the MMM.
Information Architecture	The SMA does not align to or advance increasingly in MITA maturity for	The SMA begins to use MITA SS-A for evaluation of its As-Is and identification of its To-Be	The SMA updates or completes its SS-A for BA and the Seven Standards and	The SMA develops its MITA Roadmap for IA.	The SMA updates the MITA Roadmap for IA annually. The SMA develops a

	Information Architecture (IA).	capabilities for IA.	Conditions IA portion.		COO, Conceptual Data Model (CDM), and Logical Data Model (LDM) using Unified Modeling Language (UML).
Technical Architecture	The SMA does not align to or advance increasingly in MITA maturity for Technical Architecture (TA).	The SMA begins to use MITA SS-A for evaluation of its As-Is and identification of its To-Be capabilities for TA.	The SMA updates or completes its SS-A for BA and the Seven Standards and Conditions TA portion.	The SMA develops its MITA Roadmap for TA.	The SMA updates the MITA Roadmap for TA annually. The SMA develops a COO and Technical Process Models using BPMN and UML.

Table 5: MITA Condition for all Business Areas

MITA Condition As-Is

DSS completed MITA State Self-Assessments in 2012 and 2017. DSS evaluated current processes, data practices, and systems using the Business, Information, and Technical Architectures defined by the MITA framework. DSS further evaluated all MITA Business Areas using the Seven Conditions and Standards from CMS. DSS developed a Concept of Operations and Roadmap as defined by CMS. With full engagement of all business leads in the SS-A this year, there is strong awareness of the agency's potential for success through implementation of the MITA framework.

MITA Condition To-Be

DSS is expected to continue conducting MITA State Self-Assessments, with a goal of performing annual updates to the MITA roadmap. DSS should also continue to develop a COO and BPM representing their healthcare business processes and organizing them into various categories of common interest or focus. This COO can be used to describe current business operations and to envision a future transformation that meets the needs of all stakeholders. DSS should make strides toward aligning existing business processes to MITA definitions. A MITA defined DMS and TMS should be adopted. DSS can continue to make progress toward a service oriented architecture using modular system acquisition.

IX. Industry Standards Condition

The Industry Standards Condition ensures alignment with, and incorporation of: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with Federal Civil Rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act. Activities include the following:

- Identification of industry standards
- Incorporation of industry standards in requirements, development, and testing phases

The table below presents the MITA Maturity Model applied to the Seven Conditions and Standards as a summary for all MITA Business Areas. "As-Is" capabilities are depicted with light blue shading, whereas "To-Be" capabilities are depicted with darker blue shading. The timeframe for "To-Be" capabilities is defined as 5-10 years in the future.

Seven Conditions & Standards (All Business Areas)					
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Industry Standards Condition					
Business Architecture	The SMA focuses on meeting compliance thresholds for state and federal regulations using state-specific business analysis standards.	The SMA applies a mixture of federal and state specific standards for business analysis. The SMA incorporates industry standards in requirements and testing phases of projects.	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for business analysis within intrastate agencies. The SMA incorporates industry standards in business modeling techniques	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for business analysis of health care and clinical information across state and interstate agencies.	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for national business analysis.

			(e.g., UML and BPMN).		
Information Architecture	The SMA focuses on meeting compliance thresholds for state and federal regulations using state-specific data standards.	The SMA applies a mixture of HIPAA and state-specific data standards.	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for intrastate exchange of information within the intrastate agencies and stakeholders. The SMA incorporates industry standards such as Section 508(c) compliance for all interfaces in requirements, development, and testing phases. The SMA incorporates industry standards in data modeling techniques (e.g., UML).	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for interstate exchange of health care and clinical information across state and regional agencies and stakeholders. The SMA complies with Affordable Care Act Section 1104 Administrative Simplification, and Section 1561 Health IT Enrollment Standards and Protocols.	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for national exchange of health care information.

Technical Architecture	The SMA focuses on meeting compliance thresholds for state and federal regulations using state-specific business analysis standards.	The SMA applies a mixture of federal and state specific standards for business analysis. The SMA incorporates industry standards in requirements and testing phases of projects.	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for business analysis within intrastate agencies. The SMA incorporates industry standards in business modeling techniques (e.g., UML and BPMN).	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for business analysis of health care and clinical information across state and interstate agencies.	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for national business analysis.

Table 6: Industry Standards Condition for all MITA Business Areas

Industry Standards Condition As-Is

DSS applies a mix of both state and national/federal standards including HIPAA in the Medicaid systems. Formal business modeling is not applied at an enterprise level, but does exist within some applications. MITA has not been fully implemented; however, national/federal standards are pursued where feasible.

Industry Standards Condition To-Be

DSS should adopt a MITA DMS and TMS which will incorporate national level best practices. DSS should continue their adoption of data and technical industry standards, data sharing, and secure data. DSS can utilize the MITA Framework, industry standards, and other nationally recognized standards for business analysis of health care and clinical information. DSS should continue to pursue data management activities which promote intrastate sharing using national/federal standards.

X. Leverage Condition

State solutions should promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states. Activities include the following:

- Multi-state efforts
- Availability for reuse
- Identification of open source, cloud-based, and commercial products
- Customization
- Transition and retirement plans

The table below presents the MITA Maturity Model applied to the Seven Conditions and Standards as a summary for all MITA Business Areas. "As-Is" capabilities are depicted with light blue shading, whereas "To-Be" capabilities are depicted with darker blue shading. The timeframe for "To-Be" capabilities is defined as 5-10 years in the future.

Seven Conditions & Standards (All Business Areas)					
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Leverage Condition					
Business Architecture	Very little collaboration occurs with other agencies to leverage or reuse business processes. The SMA has no system transition or retirement plans.	The SMA identifies existing agency solutions for its business processes and identifies duplicative business processes.	The SMA works collaboratively with intrastate agencies and entities to promote and leverage the reuse of Medicaid business processes within the state.	The SMA shares its reusable business process components with other States.	The SMA shares its reusable business process components with other stakeholders, state, and federal agencies nationally.
Information Architecture	Very little collaboration occurs with other agencies and entities to leverage or reuse	The SMA identifies and demonstrates consideration of existing agency data management and	The SMA collaborates and identifies existing intrastate data management and standardizatio	The SMA collaborates with other interstate agencies and entities and identifies data	The SMA collaborates with other state, regional, and national agencies and entities

	data standards or information. The SMA has no system transition or retirement plans.	standardization solutions. The SMA identifies existing duplicative information components within the agency.	n of data solutions. The SMA identifies existing intrastate duplicative system and technical components.	management and data standards. The SMA identifies existing interstate duplicative information capabilities. The SMA identifies a system retirement plan.	and identifies national data management and data standards. The SMA identifies existing state, regional, or national duplicative information. The SMA adopts nationally standardized system transition and retirement plans.
Technical Architecture	Very little collaboration occurs with other agencies and entities to leverage or reuse messages and technical solutions. The SMA has not adopted an SOA from public, commercial modules, or cloud	The SMA collaborates within its agency to identify message, technical components, and technology solutions with high applicability for reuse. The SMA identifies existing duplicative system components within the agency. The	The SMA collaborates and identifies existing intrastate message, technical components, and technology solutions, before embarking on ground-up custom development. The SMA identifies existing duplicative	The SMA collaborates with other interstate agencies and entities and identifies message, technical components, and technology solutions. The SMA pursues a cloud-first strategy for systems development. The SMA	The SMA collaborates with other state, regional, and national agencies and entities and identifies national message standards, technical components, and technology solutions. The SMA

	technologies. The SMA has no system transition or retirement plans.	SMA has adopted SOA. The SMA identifies the type of system plan, and development, enhancement, and implementation.	system components within the state. The SMA minimizes ground-up or customized solutions. The SMA implements its system transition plan that includes cost-allocation information across the intrastate.	identifies existing regional agency duplicative system components.	identifies existing national duplicative systems, technical components, and technology. The SMA adopts nationally standardized system transition and retirement plans.

Table 7: Leverage Condition for all MITA Business Areas

Leverage Condition As-Is

DSS has not had the opportunity to formally adopt a DMS or TMS, so it is impractical to leverage technologies, even among the SMA divisions. Service Oriented Architecture is in the initial stages of implementation. Sharing of technologies between state agencies is limited, and reuse is inhibited by the lack of an enterprise-wide SOA, an enterprise ESB and a common rules engine.

Leverage Condition To-Be

DSS should continue making progress toward SOA by formalizing a MITA DMS and TMS. To promote modularity/re-use, DSS can establish SOA governance, an SOA registry/repository, and a rules engine repository housing human readable rules from across the enterprise. Centralized data governance and SDLC will allow for greater progress in leveraging interagency systems. In the future, DSS should seek to align to the MITA framework and other industry standards which facilitate reuse of technologies for better efficiency and cost benefits.

XI. Business Results Condition

Systems should support accurate and timely processing of claims (including eligibility claims) and adjudications, and facilitate effective communications with providers, beneficiaries, and the public. Activities include the following:

- Degree of automation
- Customer Service
- Performance standards and testing

The table below presents the MITA Maturity Model applied to the Seven Conditions and Standards as a summary for all MITA Business Areas. "As-Is" capabilities are depicted with light blue shading, whereas "To-Be" capabilities are depicted with darker blue shading. The timeframe for "To-Be" capabilities is defined as 5-10 years in the future.

Seven Conditions & Standards (All Business Areas)					
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Results Condition					
Business Architecture	The SMA business processes are predominantly manual. The SMA does not communicate effectively with the beneficiaries or providers. Account access is manual. The SMA does not have SLA or KPI for business operations.	The SMA supports accurate and timely processing of health care and eligibility claims via automated business processes and account access management. The SMA communicates more effectively with the providers, beneficiaries, and the public.	Highly automated business processes support accurate and timely processing of health care and eligibility claims. The SMA documents customer service using web and account self-management functionality. The SMA accommodates customer preferences for communications by email, text,	The SMA automates processing of health care and eligibility claims to the fullest extent possible. The SMA monitors and adjusts business processes for optimum performance using state-, regional-, and CMS-defined KPI and shares performance measures with other	The SMA monitors and adjusts business processes for optimum performance using nationally defined KPI and shares performance measures across the nation. The SMA evaluates operational business processes against established national SLA and KPI. The

			mobile devices, or phones. The SMA identifies state SLA and KPI for automated business processes.	state and regional agencies and stakeholders. The SMA shares its processes for identifying errors with other state and regional agencies and stakeholders.	SMA creates and executes a POAM for SLA and KPI resolution.
Information Architecture	The SMA does not have SLA or KPI for data standards.	The SMA establishes SLA and some KPI for collection and monitoring of data standards.	The SMA uses information and data standards for automating messages in the highly automated processing of health care and eligibility claims. The SMA identifies information performance standards within state.	The SMA uses information and data standards for automated messages in the highly automated processing of healthcare and eligibility claims across the interstate. The SMA increases the use of state-, regional-, and any CMS-defined information performance standards.	The SMA uses national information and data standards for automated messages in the highly automated processing of healthcare and eligibility claims across the nation. The SMA adopts national performanc e standards. The SMA creates and executes a POAM for

					SLA and KPI resolution.
Technical Architecture	The SMA does not have SLA or KPI for system performance.	The SMA establishes SLA and some KPI for collection and monitoring of system performance.	The SMA uses automated services and messages in the highly automated processing of health care and eligibility claims. The SMA adopts system performance standards within state.	The SMA uses automated services and messages in the highly automated processing of health care and eligibility claims across the interstate. The SMA adopts interstate system performance standards.	The SMA uses nationally defined automated services and messages in the highly automated processing of health care and eligibility claims across the nation. The SMA adopts national system performanc e standards. The SMA creates and executes a POAM for SLA and KPI resolution.

Table 8: Business Results Condition for all MITA Business Areas

Business Results Condition As-Is

DSS incorporates some degree of automation for most MITA defined processes. The existing MMIS is not architected according to SOA. Service Level Agreements (SLAs) exist for major systems and outsourced services; however, there is not a formal Key Performance Indicator (KPI) program within DSS at an enterprise level. Web portals exist for both members and providers. Automated messages and services could be improved to support processing. Enterprise level system performance standards have not been developed, so there is not any routine management review to monitor that DSS achieves the business results that are contracted for and expected.

Business Results Condition To-Be

DSS has a prevailing need for an enterprise level Master Data Management initiative and technical stack, which would support standards development and the sharing of information between siloed systems and intrastate agencies. Additionally, the adoption of an enterprise level document management solution with the implementation of automated workflows will increase the MITA maturity level for the majority of business processes. The areas of Business Relationship Management and Contractor Management would be strengthened through the use and adoption of a MITA DMS and TMS. DSS recognizes the need for a more formal performance management program with the adoption of KPIs. Portal options and the ability for greater levels of self-service are desired for both members and providers, as well as DSS workers.

XII. Reporting Condition

Solutions should produce transaction data, reports, and performance information that contribute to program evaluation, continuous improvement in business operations, transparency, and accountability. Activities include the following:

- Produce accurate data
- Interfaces with designated federal repositories or hubs
- Automatic generation of reports
- Audit trails

The table below presents the MITA Maturity Model applied to the Seven Conditions and Standards as a summary for all MITA Business Areas. "As-Is" capabilities are depicted with light blue shading, whereas "To-Be" capabilities are depicted with darker blue shading. The timeframe for "To-Be" capabilities is defined as 5-10 years in the future.

Seven Conditions & Standards (All Business Areas)					
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Reporting Condition					
Business Architecture	The SMA does not conduct program evaluations, or continuous improvement in business operations.	The SMA begins to produce reports to conduct program evaluations and continuous improvement in business operations. The SMA has some processes for identifying and correcting adjudication errors.	The SMA solutions produce transaction data, reports, and performance information that contribute to program evaluation, continuous improvement in business operations, and transparency and accountability. The SMA provides eligibility decision logic	The SMA conducts program evaluations and continuous improvement in business operations and provides it to other agencies and stakeholders within the region.	The SMA conducts program evaluations and continuous improvement in business operations and provides it to state, regional, and national agencies and stakeholders.

			to the public. The SMA produces decision audit trails.		
Information Architecture	The SMA has very little transaction data, reports, or performance information available for program management.	The SMA produces HIPAA-compliant transaction data, some reports, and some performance information. The SMA has some information for identifying and correcting adjudication errors.	The SMA has intrastate transaction data and reports with performance information available for program management. The SMA provides eligibility data to the public for intrastate agencies. The SMA produces audit trails for information within the system and shares it within the state.	The SMA has transaction data and reports with performance information available for program management and provides it to other agencies and stakeholders within the region. The SMA provides eligibility data to the public for interstate agencies and stakeholders. The SMA produces audit trails for information within the system and shares it with state and regional agencies and stakeholders.	The SMA has transaction data and reports with performance information available for program management and provides it to state, regional, and national agencies and stakeholders. The SMA provides eligibility data to the public across state, regional, and national agencies and stakeholders. The SMA produces audit trails for information within the system and shares it with state, regional, and national

					agencies and stakeholders.

Technical Architecture	The SMA produces very little message data, services, or performance information.	The SMA generates services to produce reports through open messages within the agency.	The SMA uses services that automatically generate reports through open interface messages, to designated intrastate agencies and entities, repositories or data hubs, with appropriate audit trails.	The SMA uses services that automatically generate reports through open interface messages to designated interstate agencies and entities, repositories or data hubs, with appropriate audit trails.	The SMA uses automatic services to generate reports through open interface messages to designated federal repositories or data hubs, with appropriate audit trails.

Table 9: Reporting Condition for all MITA Business Areas

Reporting Condition As-Is

DSS has had little opportunity to utilize reporting as a tool to improve operations. Report generation is accomplished through predefined (canned) reports or limited customization within systems. Reports which must be compiled from multiple systems have limited automation and are primarily accomplished using manual intervention with spreadsheets and databases. Audit trails exist within system assets.

Reporting Condition To-Be

To increase maturity for the MITA Reporting Condition, DSS should seek to implement a Master Data Management technical stack and an initiative to increase sharing of data between systems and intrastate entities. DSS will benefit from an ESB, rules engine, enterprise data hub, and metadata repository to be implemented at an enterprise level. DSS expects to implement an Enterprise Data Warehouse (EDW) with data feeds from a variety of legacy systems. Electronic Medical Records (EMR) generate Quality of Care Reporting which can be loaded into this repository to assist the providers who are required to produce population reports. Furthermore, this repository can be the interchange mechanism with CMS. Over time, best-in-breed solutions in the form of functionality packages could be added to the EDW with the goal of retiring the MMIS backend reporting subsystem. Adoption of a DMS and TMS will facilitate business modeling and data management activities. Formal efforts should encourage technical, data, and business process modeling management activities in support of SOA.

XIII. Interoperability Condition

Systems must ensure seamless coordination and integration with the Exchanges (whether run by the state or federal government), and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services. Activities include:

- Interactions with the Health Insurance Exchange, or Health Information Exchanges
- Interactions with other entities

The table below presents the MITA Maturity Model applied to the Seven Conditions and Standards as a summary for all MITA Business Areas. "As-Is" capabilities are depicted with light blue shading, whereas "To-Be" capabilities are depicted with darker blue shading. The timeframe for "To-Be" capabilities is defined as 5-10 years in the future.

Seven Conditions & Standards (All Business Areas)					
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Interoperability Condition					
Business Architecture	There is no coordination with the Exchange, or Health Information Exchanges (HIE), or any other agencies to allow interoperability with other agencies.	The SMA identifies areas where it interacts with the Exchange, or Health Information Exchanges (HIE), or any other agencies to allow interoperability.	The SMA implements seamless coordination and integration with the Exchange, and allows interoperability with exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services	The SMA implements seamless coordination and integration with the Exchange, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services across interstate agencies.	The SMA implements seamless interoperability with all state, regional, and federal agency exchange services and hubs.

			within the intrastate agencies. The SMA works with community service organizations in assisting health care coverage applicants with the completion and electronic submission of forms.		
Information Architecture	The SMA uses state-specific data standards and is not coordinating with the Exchange, Health Information Exchanges (HIE), or any other agencies to allow interoperability with other agencies.	The SMA identifies information and data standards for interaction with the Exchange, or Health Information Exchanges (HIE), or any other agencies to allow interoperability. The SMA begins to convert to national data standards, such as HIPAA transactions, International Classification of Diseases 10th Edition	The SMA adopts MITA Framework, industry standards, and other nationally recognized standards and information for interaction with the Exchange, or state Health Information Exchanges (HIE), or any other state agencies to allow intrastate agency interoperability.	The SMA adopts MITA Framework, industry standards, and other nationally recognized standards and information with the Exchange, or regional Health Information Exchanges (HIE), or any other regional agencies to allow interstate agency interoperability.	The SMA adopts MITA Framework, industry standards, and other nationally recognized standards and information for interaction with the Exchange, or state, regional, and national Health Information Exchanges (HIE), or any other state, regional, or national agencies to allow national

		(ICD-10), and Healthcare Common Procedure Coding System (HCPCS).			interoperability.
Technical Architecture	The SMA uses state-specific messages and technology standards and is not coordinating with the Exchange, Health Information Exchanges (HIE), or any other agencies to allow interoperability with other agencies.	The SMA identifies messages and technology standards for interaction with the Exchange, or Health Information Exchanges (HIE), or any other agencies to allow interoperability.	The SMA adopts MITA Framework, industry standards, and other nationally recognized messaging and technology standards for interaction with the Exchange, or state Health Information Exchanges (HIE), or any other state agencies to allow intrastate agency interoperability.	The SMA adopts MITA Framework, industry standards, and other nationally recognized messaging and technology standards with the Exchange, or regional Health Information Exchanges (HIE), or any other regional agencies to allow interstate agency interoperability.	The SMA adopts MITA Framework, industry standards, and other nationally recognized messaging and technology standards for interaction with the Exchange, or state, regional, and national Health Information Exchanges (HIE), or any other state, regional, or national agencies to allow national interoperability.

Table 10: Interoperability Condition for all MITA Business Areas

Interoperability Condition As-Is

Major system assets in Connecticut are interfaced to the state Health Insurance Exchange (AccessCT). Although DSS can interact with Electronic Health Records, Connecticut does not

currently have an operational Health Information Exchange. DSS does adopt ICD-10 and HCPCS standards for clinical reporting.

Interoperability Condition To-Be

DSS recognizes the need for increased interoperability between system assets. Adoption of strategies for Data Management and Technical Management, and use of an enterprise level rules engine and service bus can facilitate higher levels of MITA maturity in the future. The interoperability will be based on national/international standards that are harmonized by HITSAC, an organization responsible for keeping up with standard setting organizations as well as federal initiatives. Additional Health Information Technology planning efforts are described in the DSS Concept of Operations.

MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)
3.0 STATE SELF-ASSESSMENT

CONCEPT OF OPERATIONS

Contents

1. Introduction – Connecticut MITA Initiative

MITA is both a national initiative and framework from the Centers for Medicare and Medicaid Services (CMS). The CMS MITA initiative is intended to foster integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program and support improved systems development and health care management for the Medicaid enterprise.

The CMS MITA Framework outlines the three Architectures to be assessed through a state self-assessment process. CMS provides the MITA Framework 3.0 via their website (CMS MITA Framework) which currently provides the following guiding information:

Front Matter

- Description of Initiative and Framework, Quick Reference Guide, Acronyms and Terms

Part I Business Architecture

- Concept of Operations, Maturity Model, Business Process Model, Business Process Templates, Business Capability Matrices

Part II Information Architecture

- Data Management Strategy (DMS), Conceptual Data Model (CDM), Logical Data Model (LDM), Data Standards, Information Capability Matrix

Part III Technical Architecture

- Technical Management Strategy, Business Services, Technical Services, Application Architecture, Technology Standards, Technical Capability Matrix

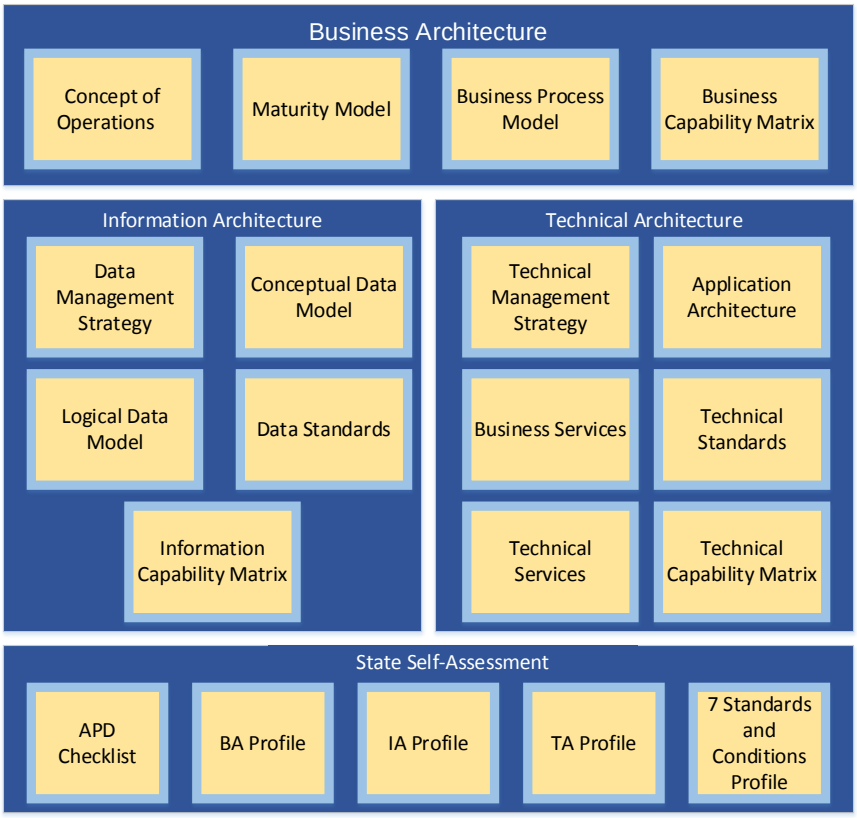


Figure 28 MITA v3.0 Framework

Companion Guide

- SS-A Process, Advance Planning Document (APD) Process, Scorecards Profiles

Appendix A – Seven Standards and Conditions

- Seven Standards and Conditions Capability Matrix

MITA has a number of goals, including development of seamless and integrated systems that communicate effectively through interoperability and common standards. The MITA Assessment takes into account:

- The Business Architecture: What is done, by whom, how, when and why
- The Data Architecture: Information used by the Agency to do business
- The Application Architecture: Computer applications/software that process the data according to defined business rules (system inventory)
- The Technology Architecture: Computer/communications technology/hardware that supports the above three layers

The Connecticut Medicaid Information Technology Architecture (MITA) 3.0 State Self-Assessment (SS-A) was undertaken to assess the Connecticut Medicaid Enterprise (CME) in accordance with the CMS MITA 3.0 guidance to assist the state in determining the best course of action for transforming Connecticut Medicaid to a MITA aligned enterprise.

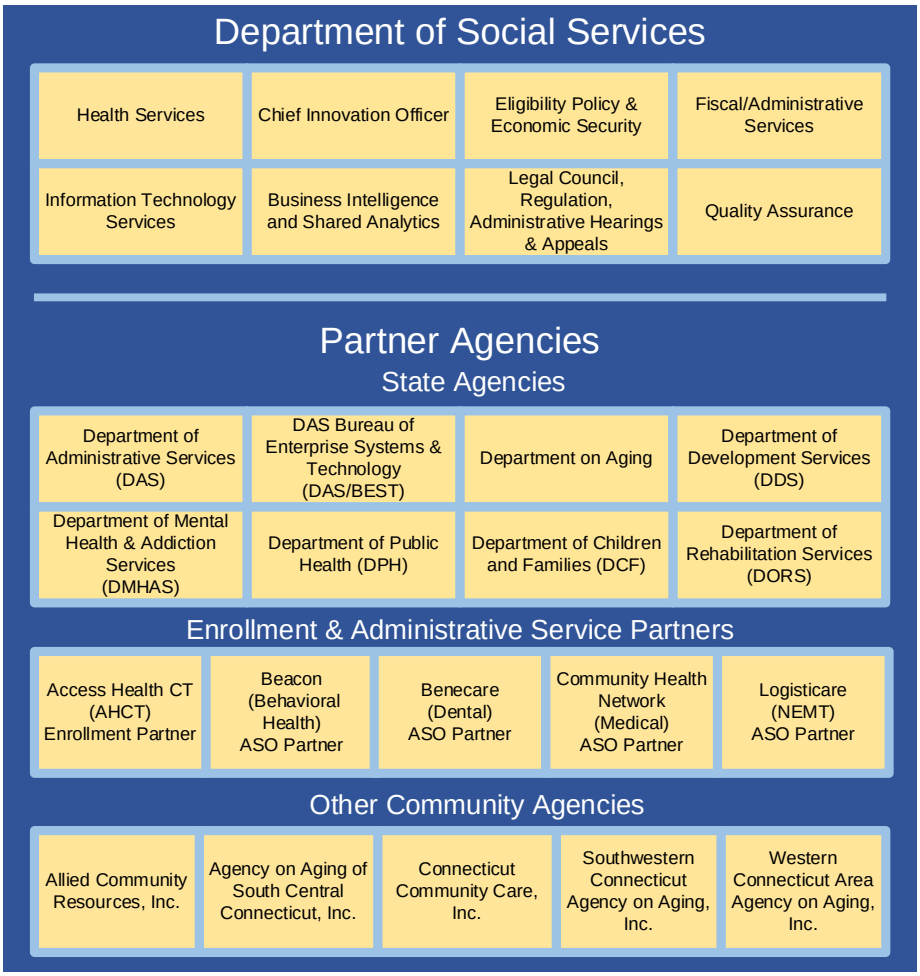


Figure 29 Connecticut Department of Social Services and Partner Agencies

The Connecticut Department of Social Services (DSS) is the single state agency for the administration of Connecticut Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP are collectively described as the HUSKY Health Program. The DSS Division of Health Services administers the medical services policy and day-to-day operations for the Connecticut Medicaid and CHIP program. The eligibility and field staff handle policy and support the day to day eligibility determination processes.

HUSKY Health programs offer health care coverage to eligible children, parents, relative caregivers, elders, individuals with disabilities, adults without dependent children, and pregnant women. As the administering agency, the DSS partners with Access Health CT (AHCT), Connecticut's health insurance marketplace, in HUSKY Health enrollment.

DSS also partners with its contracted administrative services organizations (ASO) and enrolled providers to coordinate medical, dental, pharmacy, behavioral health, and other benefits. HUSKY Health is self-insured, and the ASO contracts that help manage services and supports are currently as follows: CHN-CT (medical), Beacon (behavioral health), BeneCare (dental) and LogistiCare (transportation).

DSS considers its Partner Agencies an integral part of the Medicaid Enterprise for the MITA SS-A efforts. DSS works in partnership with various stakeholders across the health care delivery system to ensure that eligible people in Connecticut receive the support and services necessary to promote self-sufficiency, improved well-being, and positive health outcomes. DSS works to ensure that the delivery of these services is consistent with federal and state policies. The Connecticut Husky Program coverage groups include:

Coverage Group	Description

Husky A	Connecticut children and their parents/relative caregivers, as well as pregnant women, all based on income
HUSKY B (Children's Health Insurance Program or CHIP)	Uninsured children under age 19 in higher-income households
Husky C	Individuals age 65 and older, individuals who are blind, individuals who have disabilities
Husky D	Childless individuals age 19-64 who do not otherwise qualify for Medicaid
Medicare Savings Programs	Medicare Savings pays Medicare Part B premiums for low income Medicare Beneficiaries, there are multiple categories under this program, household income determines the category, and the lowest income category covers co-pays and deductibles on Medicare-covered services.
Medicaid for Employees with Disabilities	Provides Medical assistance to employed individuals with disabilities, earning below $75,000 per year.
HUSKY (Medicaid) Coverage for Breast and Cervical Cancer	The Connecticut Breast and Cervical Cancer Early Detection Program is a comprehensive screening program for medically underserved women, offered through the Connecticut Department of Public Health, or their contracted health care providers. Income based for under or uninsured.
Healthy Start	Eligible pregnant women can receive case management and assistance with obtaining Medicaid/HUSKY coverage for themselves and their children.
Connecticut AIDS Drug Assistance Program (CADAP)	Pharmaceutical assistance program that pays for medications approved by the U.S. Food and Drug Administration (FDA) to treat HIC and HIV disease related conditions. CADAP clients may also qualify for assistance with health insurance premium payment through the Connecticut Insurance Premium Assistance (CIPA) program.
Connecticut Insurance Premium Assistance (CIPA) Program	The CIPA Program is a health insurance assistance program funded through the CADAP for individuals living with HIV/AIDS who are CADAP eligible (400% FPL). CIPA will help pay health insurance premiums for eligible individuals who have coverage through a CIPA-approved health insurance policy. CIPA is collaboration between DPH and DSS.
CHOICES	Connecticut's program for Health insurance assistance, Outreach, Information and referral, Counseling, Eligibility Screening. Provides information to persons age 60 and older and persons with disabilities, and is a cooperative program of the Department of

	Social Services, the Area Agencies on Aging, and the Center for Medicare Advocacy. Administered by Department on Aging.
Long-Term Services and Supports- Connecticut Home Care for Elders (CHCPE)	Eligible applicants must be 65 years of age or older, be at risk of nursing home placement and meet the program's financial eligibility criteria. CHCPE helps clients continue living at home instead of going to a nursing home.
Long-Term Services and Supports- Community Options (Medicaid Waivers)	Includes Personal Care Assistance, Acquired Brain Injury, Katie Beckett, Department of Developmental Services, Department of Mental Health and Addiction Services.
Money Follows the Person	State offered assessment, case management and transition services to assist people in institutionalized settings based on their individual needs
Alzheimer's Respite Care Program	Offers relief to stressed caregivers by providing information, support, the development of an appropriate plan of care, and services for the individual with Alzheimer's disease or related dementias. Administered by the Department on Aging
Refugee Medical Assistance	Time limited coverage for needy individuals, families and children designated as refugees.
ConnTrans	Connecticut Organ Transplant Program help residents pay for medical and ancillary expenses associated with an organ transplant
Durable Medical Equipment	Under the Medicaid program, Durable Medical Equipment is medical equipment that can be used continually for medical and health care purposes.

Table 73 Connecticut Medicaid Coverage Groups

A. 1.1 Document Purpose – CT MITA Concept of Operations

The purpose of this document is prescribed by the CMS ***MITA Framework 3.0, Part I Chapter 2 Concept of Operations.*** The Connecticut MITA Concept of Operations (COO) represents the Vision for the future transformation to a MITA 3.0 aligned and modernized Connecticut Medicaid Enterprise. The MITA 3.0 SS-A COO document describes the vision for transformation of the Connecticut Medicaid operations and supporting technology platforms. The COO transformation vision supports development of Medicaid system services on technology platforms that allow for modularity, seamless integration, and secure data exchange with partner entities, and removes silos that impede the optimal Medicaid business operations and paves the way for implementation of new mechanisms to achieve improved health outcomes.

CMS chose the MITA COO model as the best approach for communicating future capabilities and identifying transition plans for States as they leverage modular technical solutions to improve their business operations. Figure 3 below represents an outline of the CMS MITA Framework approach utilizing the COO as a key aspect of the Framework.

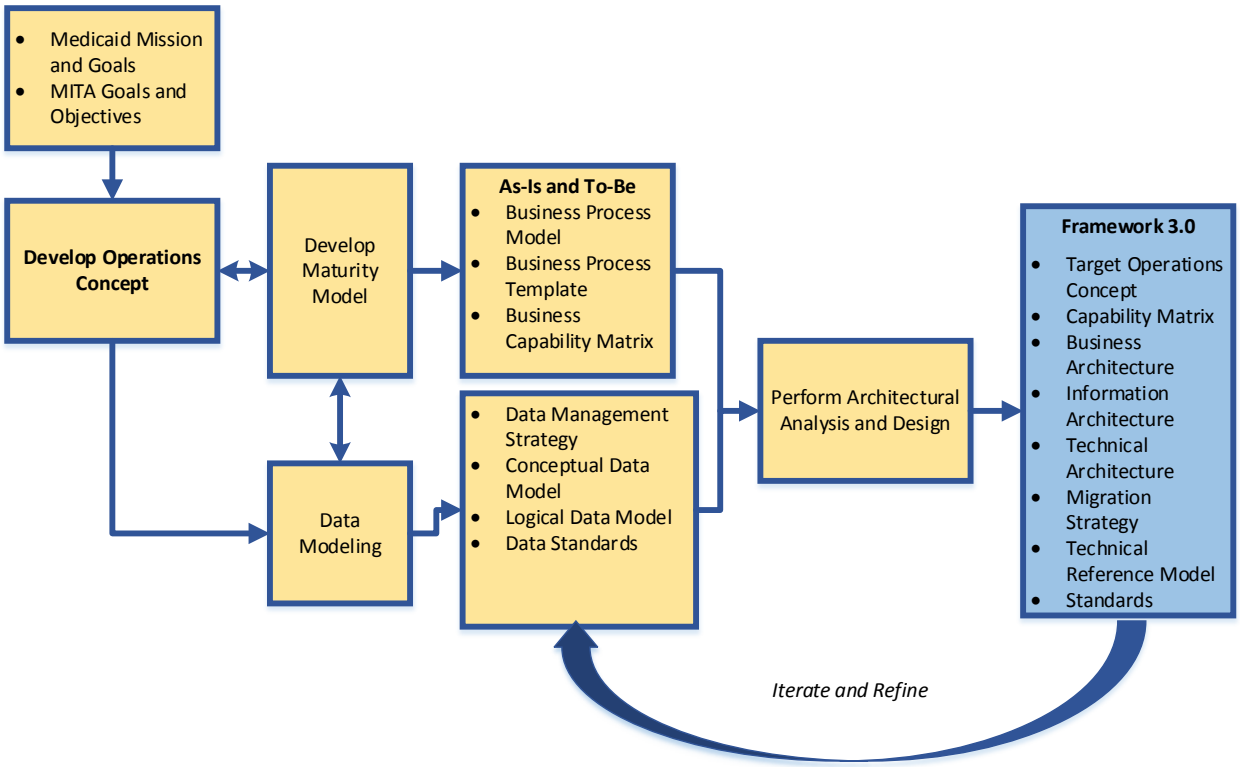


Figure 30 MITA Framework Development Approach

The COO is part of a series of documents that will outline the Medicaid transformation strategy for modernizing the Medicaid Program to improve health outcomes and controlling costs while focusing on quality. This COO frames Connecticut's vision for future improvements to the Medicaid Enterprise and will serve as a key artifact, working in conjunction with the gap analysis, Roadmap, and procurement strategy documents to guide the transformation and outline the transformation pathway.

The COO structure as part of the MITA process provides key information including:

- Description of the Connecticut Medicaid Enterprise
- Description of the As-Is (current) operations in terms of business, architecture, and data
- Description of the drivers and enablers that propel and support transformation
- Description of the To-Be environment in terms of business, architecture, and data
- Description of operational scenarios with sequence of events and activities carried out by stakeholders and the State Medicaid Enterprise
- Description of the impacts on each stakeholder
- Description of a summary of the improvements to the State Medicaid Enterprise and stakeholders. Describes the desired impact of:
    - Improvements to Stakeholder Interactions

- Improvements to Content and Quality of Data Exchange
- Improvements to Business Capabilities
- Improvements targeting better citizen health outcomes

The CT MITA COO is a stakeholder-oriented document that describes system characteristics for a proposed system from the stakeholders' viewpoints. The COO will communicate the overall quantitative and qualitative system characteristics to the stakeholders, buyers, developers, and other organizational elements (e.g., procurement). It includes the Medicaid Enterprise organization mission and organizational objectives, influences on the Medicaid enterprise as well as diagrams depicting the new modular and integrated systems point of view.

B. 1.2 Seven Conditions and Standards

The CMS MITA 3.0 Framework and SS-A is a critical activity that is required to receive federal funding participation (FFP) for the business transformation and the design, development, and implementation (DDI) of new modular supporting systems.

States submit their updated MITA assessment with a correlating Implementation Advance Planning Document (IAPD) to request CMS approval for the transformation plan. In order for states to receive enhanced funding for Medicaid transformations, CMS outlines specific conditions and standards that must be met.

> "States should develop a Concept of Operations (COO) and business workflows for the different business functions of the state to advance the alignment of the state's capability maturity with the MITA Maturity Model (MMM). The COO and business workflows should align to those provided by the Centers for Medicare & Medicaid Services (CMS) in support of Medicaid and Exchange business operations and requirements. States should work to streamline and standardize these operational approaches and business workflows to minimize customization demands on technology solutions and optimize business outcomes."

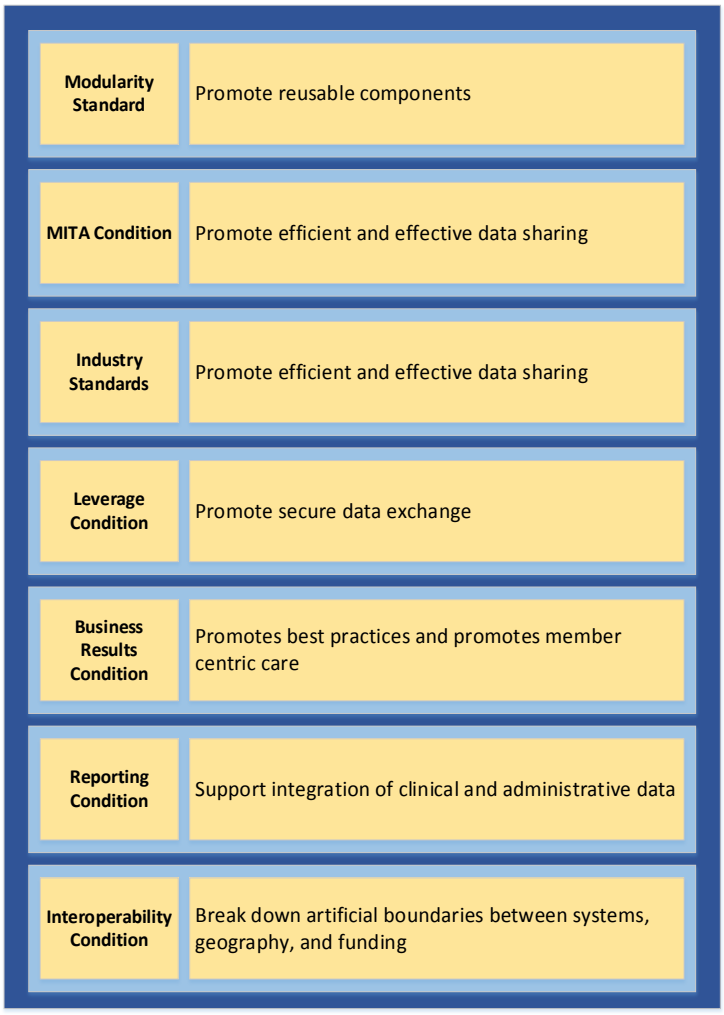


Figure 31 MITA Seven Conditions and Standards

On behalf of DSS, HealthTech Solutions (HTS) developed the MITA 3.0 SS-A and COO documents according to the CMS ***Enhanced Funding Requirements: Seven Conditions and Standards Medicaid IT Supplement (MITS-11-01-v1.0)***.

The transformation and Roadmap will be planned to fully meet the ***Seven Conditions and Standards***. In conducting the SS-A, Connecticut applied the standard/condition to each MITA Architecture Area.

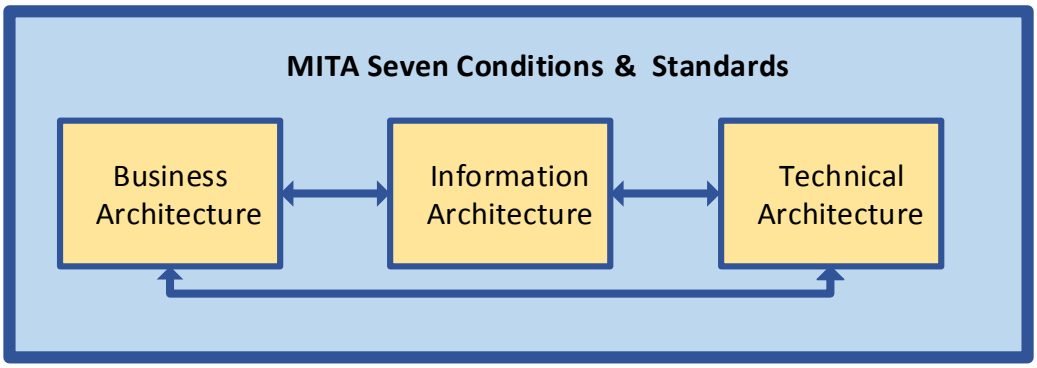


Figure 32 MITA Interrelated Architectures

The following matrix reflects the collective results/product of the Connecticut Seven ***Conditions and Standards*** assessment.

Seven *Conditions and Standards*: **Business, Information, and Technical Architectures**

MITA 3.0 Standard/Condition	Level 1	Level 2	Level 3	Level 4	Level 5
Modularity Standard	As-Is		To-Be		
MITA Condition		As-Is	To-Be		
Industry Standards Condition		As-Is	To-Be		
Leverage Condition	As-Is		To-Be		
Business Results Condition		As-Is	To-Be		
Reporting Condition		As-Is	To-Be		
Interoperability Condition		As-Is	To-Be		

Table 74 MITA v3.0 Assessment by Condition/Standard for all Architectures and Business Areas

The To-Be levels will be targeted in the Medicaid Enterprise Transformation and the MMIS re-procurement strategy.

2. Mission and Goals for the Medicaid Enterprise

Both the MITA framework and the MITA initiative are traceable within the Medicaid mission and goals defined by the CMS:

Medicaid Mission: To provide quality health care to members by providing access to the right services for the right people at the right time for the right cost.

Medicaid Goals: To improve health care outcomes for Medicaid members. To ensure efficient, effective, and economical management of the Medicaid Program.

2.1 MITA Mission and Goals

CMS further defines MITA as a primary enabler of the Medicaid mission, which contains its own mission and goals:

MITA Mission: To establish a national framework of enabling technologies and processes that support improved program administration for the Medicaid Enterprise and for stakeholders dedicated to improving health care outcomes and administrative procedures for Medicaid members.

MITA Goals:

- Develop seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards
- Promote an environment that supports flexibility, adaptability, and rapid response to changes in programs and technology
- Promote an enterprise view that supports enabling technologies aligned with Medicaid business processes and technologies
- Provide data that is timely, accurate, usable, and easily accessible in order to support analysis and decision making for health care management and program administration
- Provide performance measurement for accountability and planning
- Coordinate with public health and other partners, and integrate health outcomes within the Medicaid community

CMS requires states to align with the MITA mission and goals, and to increasingly advance in MITA maturity.

2.2 Connecticut Department of Social Services Mission, Vision, and Goals

DSS delivers and funds a wide range of Medicaid and other programs and services as Connecticut's multi-faceted health and human services agency. DSS serves about 1 million residents of all ages in all 169 Connecticut cities and towns, and supports the basic needs of children, families, older adults, and others, including persons with disabilities. Services are delivered through 12 field offices, central administration, and with both online and phone access options. With service partners, DSS:

- Provides federal/state food and economic aid, health care coverage, independent living and home care, social work, child support, home-heating aid, protective services for older adults, and more vital service areas

- Supports the health of over 750,000 residents through HUSKY Health (Medicaid & Children's Health Insurance Program), including medical, dental, behavioral health, prescription medications, long-term services and supports
- Helps over 400,000 residents afford food and supports Connecticut's economy with federally-funded Supplemental Nutritional Assistance Program (SNAP)
- Has 1,665 dedicated staff led by Commissioner Roderick L. Bremby

The DSS executive leadership team is currently engaged in a strategic planning process which has produced a mission, vision, cross-cutting principles, goals, and objectives for the agency. Over the next several months, these concepts will be cascaded to the entire organization so that objectives can be developed in each division to support the overall goals of DSS with a focus on the immediate concerns of each workgroup in the agency.

DSS Mission: We, along with our partners, provide person-centered programs and services to enhance the well-being of individuals, families, and communities.

DSS Vision: Guided by our shared belief in human potential, we envision a Connecticut where all have the opportunity to be healthy, secure, and thriving.

DSS Cross-Cutting Principles: In everything we do, DSS strives to:

- Use best practices to make decisions
- Increase use of evidence-based decision-making
- Reduce health disparities in communities across the state
- Share, reuse, and leverage existing systems, tools, and mechanisms

DSS Goals and Subtending Objectives:

1. Improve access to health and human services to enable our customers to gain independence, enhance health, and achieve well-being
    - Increase access to Medicaid and/or other Human Services for eligible Connecticut residents not currently using the programs
    - Implement a universal person centered assessment of customers, by DSS staff and our partners, to improve outcomes
    - Increase knowledge of available resources, by DSS and our partners, to enhance referral to and coordination of services
    - Improve the distribution of existing social and health services to reduce health disparities and better meet the current and future needs of individuals and communities

2. Drive decision-making, collaboration, and service-coordination through enhanced use of data to improve services
    - Increase knowledge and use of data by state staff and our partners
    - Increase integrity and standardization of data, and manage data use and release through a data governance process

- Identify and address confidentiality barriers to improve sharing of information among identified programs and with our partners
- Institute a common dashboard to track and monitor key performance indicators within all programs, e.g., access, quality, timeliness, quantity, utilization, value, and impact
- Implement uniform approach and methods for service coordination among programs and partners

3. Instill public trust by continuously improving the way we administer programs, manage our resources, and operate our infrastructure
    - Increase transparency about DSS's effectiveness as measured by organization-wide key performance indicators
    - Improve awareness, perceptions, knowledge, and understanding among stakeholders about DSS's effectiveness and efficiency
    - Continuously improve and monitor progress toward achieving strategic goals and objectives
    - Increase staff competencies to meet the needs of the 21st century health and human services world

While these statements are designed to represent the entire department, elements of the MITA framework and initiative are clearly evident in these goals. The Leadership Team's Strategic Planning efforts are closely engaged with the MITA State Self-Assessment Project Team in order to ensure alignment of the Medicaid Enterprise goals with the larger DSS Enterprise goals. Touchpoints have been scheduled throughout both projects' timelines with the intent to refine and validate that both efforts are mindful of the impact to stakeholders and to business operations as we seek optimal initiatives to advance Medicaid services.

2.3 Division of Health Services Mission and Vision

Medicaid services in Connecticut are organizationally supported by multiple units within DSS. These include:

- Health Services
- Eligibility Policy & Program Support, as well as the ImpaCT Project Team
- Field Operations (12 offices)
- Quality Assurance
- Fiscal/Administrative Services, including Contract Administration and Procurement
- Legal Counsel, Regulations, and Administrative Hearings
- Information Technology, along with the Chief Innovation Officer
- Business Intelligence & Shared Analytics
- Human Resources
- Other Executive Support Functions (e.g., Public Affairs, Government Relations, Facilities Operations)

Most of these divisions support multiple programs and functions in addition to Medicaid; hence, there is not one organizational unit to define a discrete Medicaid Mission and Vision for Connecticut, but there are good examples of Medicaid leadership displayed within the Divisions' strategies and objectives. For example, within

DSS, the Division of Health Services (DHS) works with and for more than 750,000 people who are served by the following programs:

- HUSKY Health
  - Connecticut Medicaid Program
  - Children's Health Insurance Plan (CHIP)
- Connecticut AIDS Drug Assistance Program (CADAP)
- Money Follows the Person grant
- Connecticut long-term services and supports (LTSS) rebalancing plan

DHS has articulated their mission and vision within the Medicaid Enterprise:

DHS Mission: DHS works in partnership with stakeholders across the health care delivery system to ensure that eligible people in Connecticut receive the support and services they need to promote self-sufficiency, improved well-being, and positive health outcomes. We ensure that the delivery of these services is consistent with federal and state policies.

DHS Vision: The well-prepared and professional staff of the DSS DHS manage an effective health care delivery system for eligible people in Connecticut that promotes:

- Well-being with minimal illness and effectively managed health conditions
- Maximal independence
- Full integration and participation in their communities

3. Stakeholders

An important step in any major initiative is to identify the people, groups, or organizations, both internal and external, that could impact the project or be impacted by the project. The MITA Team understands the importance of communication, along with employee and stakeholder engagement, to build awareness of potential changes and benefits, as well as to gain and maintain stakeholder buy-in. Stakeholders of the Connecticut Medicaid Enterprise include beneficiaries (members), providers, community/state/federal agencies, information exchanges, legislators/regulators/general public, as well as employees of DSS and other departments in Connecticut state government. The following sections will describe in more detail DSS and its partner agencies, organizations, and contract companies which support the Medicaid mission.

3.1 Connecticut Medicaid Agency Organizational Units

The Department of Social Services was established on July 1, 1993, through a merger of the Departments of Income Maintenance, Human Resources, and Aging. DSS is designated as the state agency for the administration of the Medicaid program, pursuant to Title XIX of the Social Security Act. A brief description of the organizational units follows the functional organization chart below. In Figure 6 below, the diagram depicts the DSS divisions most involved in the MITA SS-A business process interviews and scoring.

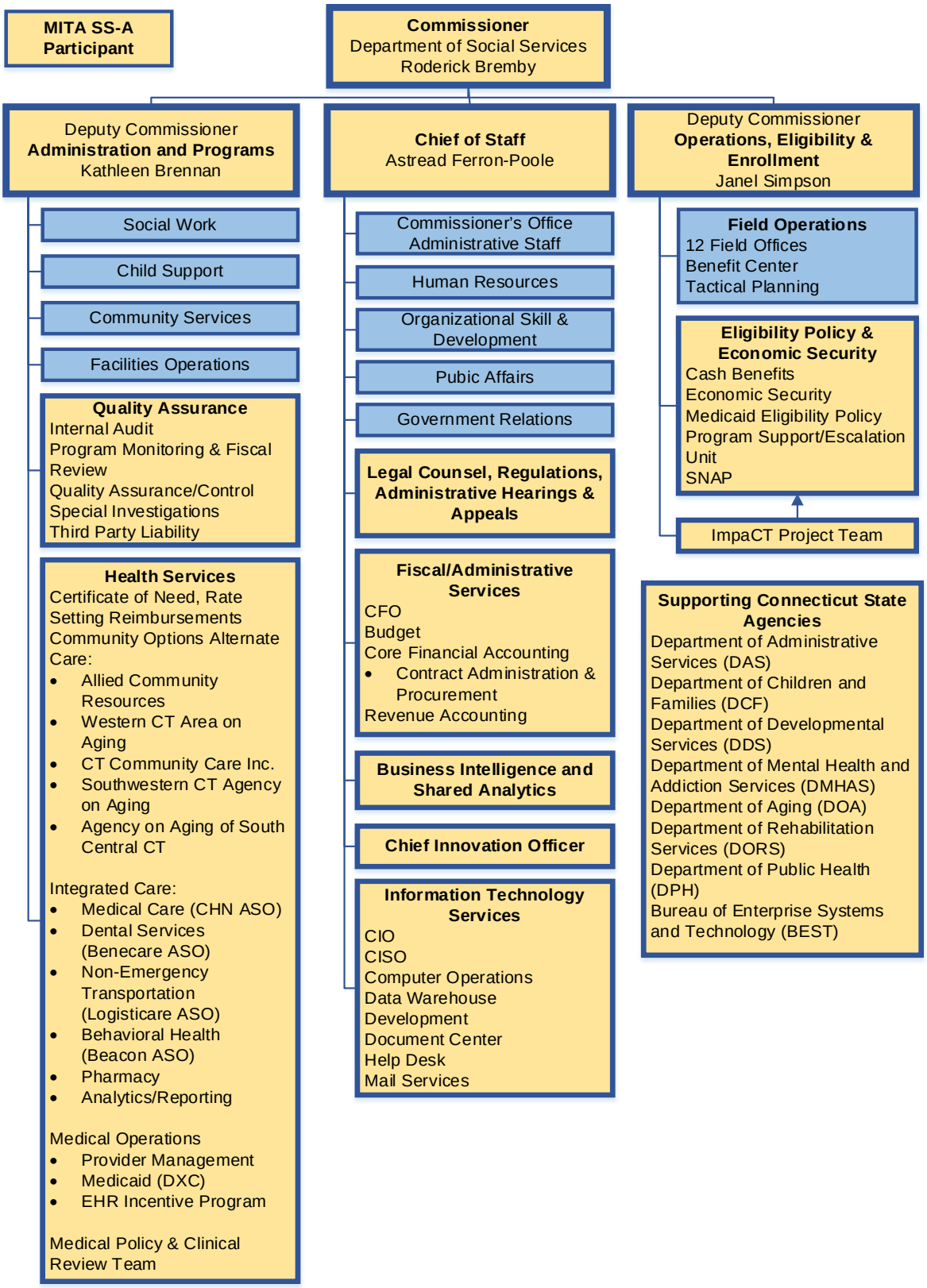


Figure 33 Connecticut Department of Social Services Organizational Units

- **Business Intelligence and Shared Analytics –** Responsible for quality metrics and interoperability which facilitates business analytics and informed decision-making
- **Chief Innovation Officer –** Provides support to the state Integrated Eligibility Project Management Office (IEPMO) to ensure coordination of resources to implement several shared service initiatives
- **Child Support –** As lead agency for Title IV-D child support enforcement activity, works with the Judicial Branch and the Office of the Attorney General to establish and enforce paternity, financial, and medical orders to assist families in reaching independence
- **Commissioner -** Articulates and administers DSS's mission, vision, and goals
- **Community Services –** Administers the Community Services Block Grant (CSBG) and other program funds to leverage state, local, and private resources to deliver programs and services for low-income families and individuals to help the state's vulnerable population reduce barriers and work toward self-sufficiency
- **Eligibility Policy & Economic Security** – Fulfills both line and staff duties in the central office and field with the following: Supplemental Nutrition Assistance Program services and Quality Control reviews, the Escalation Unit customer troubleshooting/issue resolution operations, Pre-Release Entitlement eligibility services, Medicaid eligibility Policy Administration, as well as the ImpaCT Project Team to continue implementation of the new advanced eligibility management system to all state locations
- **Facilities Operations –** Monitors and addresses building-related maintenance and operational matters, including security needs, health and safety, environmental issues, and emergency requirements to all DSS offices (central administration and 12 field offices)
- **Field Operations –** Offers the option of contacting the DSS in person to apply for services, screen for eligibility, and receive other service assistance during weekday business hours
- **Fiscal/Administrative Services** – Supports DSS with financial oversight and operational functions through three key service groups: Budget, Federal Reporting and Accounting Services, and Fund Management and Reporting. Contract Administration and Procurement functions are in the Accounting Services group
- **Health Services** - Administers policy and day-to-day operations for Medicaid programs. There are five units, including Community Options, Integrated Care, Medical Operations, Medical Policy and Clinical Review Team, and the Rate Setting, Reimbursement, and Certificate of Need (CON) Unit
- **Government Relations** - Coordinates and responds to constituent requests and inquiries and is responsible for working with both state and federal legislative bodies
- **Human Resources** - Provides internal technical guidance and support functions for all DSS employees regarding personnel related issues
- **Information Technology Services** - Comprised of Technical Services, Support Services, the Data Warehouse, and the Document Center/Mailroom. These sections provide extensive technical, business, and operational support to both the program and administrative areas of the agency
- **Legal Counsel, Regulations, Administrative Hearings & Appeals** - Acts as in-house counsel to the agency, including interpretation of requirements, review of proposed policies and procedures, coordinating, conducting, and representing DSS in legal proceedings and overseeing the agency's regulation promulgation process

- **Organizational Skill & Development** - Provides the department, its staff, and partners with training and organizational development services that enhance staff skills and support the DSS mission
- **Public Affairs** - Coordinates communications and outreach activities on behalf of DSS
- **Quality Assurance (QA)** - Responsible for ensuring the fiscal and programmatic integrity of DSS programs as well as the integrity of administrative functions of the Department. QA has five separate divisions with unique program integrity functions: Audit, Investigations and Recoveries, Special Investigations, Quality Control, and Third Party Liability
- **Social Work –** Assists elderly, indigent, disabled, pregnant teens, domestic violence victims, and families with counseling, case management, advocacy, information and referral, housing and homelessness assistance, and consultation through Family and Individual Social Work Services by Field and Central Office staff

3.2 Connecticut Medicaid Designated Authorities of DSS

The current state government Medicaid organizational structure is supported by designated authorities of DSS, as well as contracted entities which provide system support for various programs.

- **Administrative Services Organizations**

  In contrast to managed care arrangements, under which companies receive capitated payments for serving beneficiaries, Connecticut Medicaid is structured as a self-insured, managed fee-for-service model, through which the program contracts with four statewide Administrative Services Organizations (ASO), respectively, for medical, behavioral, and dental health, and for non-emergency medical transportation services.

  - Medical Coverage - Community Health Network of CT
  - Behavioral Health Coverage – Beacon
  - Dental Coverage – BeneCare
  - Pharmacy Coverage is handled within DHS and DXC technology
  - Non-Emergency Medical Transportation - LogistiCare

  A percentage of each ASO's administrative payments is withheld by the Department pending completion of each fiscal year. To earn back these withholdings, each ASO must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction outcomes. An important feature of the ASO arrangement is that three of the ASOs provide Intensive Care Management (ICM), an intervention developed specifically to meet the diverse needs of our most socially and medically vulnerable members.

  ASO arrangements have substantially improved beneficiary outcomes and experience through centralization and streamlining of the means of receiving support. The ASOs act as hubs for member support, location of providers, ICM, grievances, and appeals. ASO arrangements have also improved engagement with providers, who now have a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid. Providers can bill daily and check the status of the claim

right away. This allows providers the opportunity to correct any billing errors before the financial cycle runs. Approximately every two weeks (twice per month), the financial cycle runs which generates payment to the provider for 'clean claims/details' through a single fiscal intermediary – Hewlett Packard Enterprises (HPE) (now known as DXC Technology). This promotes participation and retention of providers, as well as enabling monitoring of the adequacy of the networks needed to support a growing population of beneficiaries.

- **Contracted Services**

  Connecticut holds contracts with entities which have service level agreements to provide functions and system support to DSS.

Contractor	Service(s)
Hewlett Packard Enterprise (HPE) (now known as DXC Technology)	Fiscal Agent (MMIS), Pharmacy Benefits Management, Provider Portal, Pharmacy, Provider and Client Call Centers, Provider Enrollment, Cost avoidance
Ascend	Homecare for Elders, Preadmission Screening and Resident Review (PASRR)
Conduent/Xerox	CHIP, Premium Billings
Myers & Stauffer	Rate promulgation
Health Management Systems (HMS)	Identify TPL, Pay and chase, Medicaid Recovery Audit Contractor (RAC)
Pulselight	Fraud and Abuse detection

Table 75 DSS Contracted Services

- **Medicaid Waiver Services**

Connecticut is continuing to streamline and improve access to its Medicaid waiver coverage which exempts states from certain federal Medicaid rules and covers home and community-based long-term services and supports using Medicaid funds. Existing waivers enable services to older adults, individuals with physical

disabilities, individuals with behavioral health conditions, children with complex medical profiles, individuals with intellectual disabilities, children with autism spectrum disorder, and individuals with acquired brain injury.

- **Community Agencies**
  DSS has contracted with community care management professionals to offer resources, administer programs, and provide support for Connecticut citizens, families, and caregivers under multiple waiver plans and related services.

    - Allied Community Resources, Inc.
        - Fiscal agent, provider credentialing, and provider directory for non-medical providers
    - Contract care management agencies (geographic)
        - Western Connecticut Area Agency on Aging, Inc.
        - Connecticut Community Care, Inc.
        - Southwestern Connecticut Agency on Aging
        - Agency on Aging of South Central Connecticut, Inc.

3.3 Other CT Agencies Supporting Medicaid

Many Connecticut state government agencies partner with DSS to perform functions that support the Medicaid enterprise as well as other social services populations.

Support for claims management is provided by:

- Department of Administrative Services (DAS)

Systems support for Medicaid services, including waivers, is provided by Connecticut's centralized IT:

- Department of Administrative Services' Bureau of Enterprise Systems & Technology (DAS/BEST)

Support for population health outreach, disease detection and registries, health threat monitoring, immunization, etc. is provided by:

- Department of Public Health (DPH)

The DSS Community Options Unit (formerly the Alternate Care Unit and the Money Follows the Person Unit) administers the demonstration project Money Follows the Person (MFP), the state plan option Community First Choice (CFC), and multiple waiver programs and related services in support of Connecticut citizens of all ages and/or with disabilities. DSS manages these waiver programs:

- CT Home Care Program for Elders
- Personal Care Attendant
- Acquired Brain Injury I and II
- Katie Beckett

In addition, there are several waiver programs operated by other state agencies, with administrative oversight by the DSS Community Options Unit.

- Department of Development Services (DDS) Medicaid Waiver programs:
    - Comprehensive Waiver
    - Individual and Family Supports Waiver
    - Employment and Day Supports Waiver
    - Early Childhood Autism Waiver (recently transitioned to DSS)
    - Autism Waiver (recently transitioned to DSS)

- Department of Mental Health & Addiction Services (DMHAS) Waiver Program
    - Mental Health Waiver

Connecticut State agencies have begun planning shared services that benefit multiple agencies and comply with the Seven Conditions and Standards for MITA maturity. For example, chief executives from the Office of Policy & Management, DSS, DAS/BEST, Department of Children and Families, Department of Rehabilitation Services, and AHCT are pursuing the extension of integrated eligibility technology supports and services across the entire platform of human service agencies in Connecticut.

4. Information and Data Exchange

Connecticut Health and Human Services (CT HHS) agencies, including DSS, are presently organized around programs and large operational systems based upon program specific needs, not enterprise wide solutions to support business capability advancement. Similarly, technology/IT solutions have historically aligned with organizational structure, and local codes and state specific standards continue to be used across the enterprise as opposed to the use of national standards.

For DSS to advance in MITA maturity, the agency should embrace a MITA compliant Enterprise Service Bus (ESB), use of Service Oriented Architecture (SOA), adherence to the ***Health Insurance Portability and Accountability Act (HIPAA)*** and MITA standard transactions, and adoption of Systems Development Lifecycle Methodology (SDLC) for the Healthcare Enterprise. The ESB should become the sole mechanism for on-demand and real-time information and data exchange between all systems across the enterprise. In accordance with MITA, it is recommended that CT HHS adopt an enterprise strategy around the concept of cloud computing. Cloud computing promotes the practice of distributing software applications over high-speed Internet connections from remote data centers so that members, providers, staff, and other users can utilize the apps on any device with online access. All of CT HHS will benefit from adopting centralized or federated data technology for hardware storage and other services that help navigate the increasing amount of information flowing in from stakeholder interactions with the Connecticut Medicaid Enterprise.

CT HHS agencies have already embarked on a modernization journey with the implementation of their modular and SOA compliant system, AHCT, and the ongoing phased implementation of their state-of-the-art Eligibility & Enrollment system, ImpaCT. However, the data schemas and data sharing architectures are unique to most systems, and data exchange is still done in an ad hoc and point-to-point fashion. This means that information

and exchanged data is generally redundant, may be inaccurate due to timing of exchange, and relies on a combination of manual, ad hoc, semi-automated, and automated processes. For example, most systems rely on daily, weekly, or monthly file exchanges to obtain necessary data. Few systems operate in silos, i.e., without directly exchanging data from required systems. Certain systems rely on data being entered via a web user interface (UI), printed onto paper, and then keyed into yet another system.

By deploying a Data Governance Organization, the Agency can attain higher MITA maturity. This organization would be responsible for instituting the processes and standards for Data Governance, Data Architecture, Data Modeling, and Metadata repositories across the enterprise. It may establish standards for the creation and maintenance of both electronic and hardcopy forms, as well as designate standard forms to use in relation to specific processes. This has the potential to simplify and streamline interactions between the enterprise and external stakeholders (staff, members, providers, and vendors).

One of the major frustrations expressed by DSS staff relates to their inability or difficulty to acquire the necessary information to carry out their responsibilities. DSS staff must access multiple systems to acquire the information needed to perform a process. These extra steps are costly in terms of time and effort involved.

A unified interface for all Medicaid users would advance the agency's MITA maturity. A unified user interface can display consolidated real-time data from multiple systems while appearing as a single system to the user. This means that, based on their role, workers will be able to access all information they need to perform their jobs from a central location. DSS Staff's ability to obtain data to increase their efficiency and to make informed decisions will be magnified by making use of metadata repositories, collections of data tables (views) that can be reused and modified to further integrate systems and information. Complete, well-defined, and accessible metadata enables DSS business analysts to access and understand the data with minimum reliance on IT support. A data dictionary is also part of the metadata repository, and it is maintained in a data warehouse. The dictionary contains listings of data warehouse tables and data elements, source-to-target mappings, and data transformation rules for creating data categories and summaries, and cataloging archived information. Metadata naming standards can be applied to schemas, databases, table spaces, tables, rows, columns, and indices in a data warehouse to specifically address reporting and analytic requirements. When metadata definitions are complete, accurate, and written in narrative form, it helps the user to easily understand, despite a lack of technical knowledge. The domain values help users to understand the applicable valid values for each data element. In short, CT HHS staff will have access to information that is timely, accurate, usable, and accessible to support decision making for health care management and program administration.

DSS is making great progress toward unifying and simplifying members' interactions and access to data within the agency's systems. However, members continue to be unclear where to apply and what services are available to them. Members are occasionally required to use multiple systems, thus having to re-enter the same data multiple times and resulting in duplicate member data and verifications.

To continue the implementation of the DSS "no wrong door" policy, the agency should transition to a unified user interface. Members will be able to access service information via this "no wrong door" consumer portal,

directly enter intake information, and self-administer initial assessments. Members may select services from a multi-agency menu, and their data is then routed to a care manager.

Providers can enroll in Medicaid and obtain access to relevant Medicaid data via a provider portal. Data exchanges with providers are mostly automated; however, providers must use multiple systems to obtain data that is necessary to efficiently coordinate and provide care for their members.

Additionally, if the agency transitions to a unified user interface, it will attain MITA 3.0 compliance and improve the providers' experience. In addition to existing provider-centric functionality, this user interface will allow providers to access relevant clinical data and electronic health records, subscribe to receive admission, diagnosis, and treatment (ADT) alerts, complete meaningful use attestation, subscribe for direct messaging, and subscribe for referrals.

5. Transformation Drivers and Enablers

CMS describes the need for State Medicaid Agencies to consider Drivers and Enablers in CMS MITA Framework 3.0, Part I Chapter 2 – Concept of Operations and CMS MITA Framework 3.0, Part I Appendix A – Concept of Operations Details.

This section provides a summary for the transformation drivers that require the Medicaid program to change and enablers that support the transformation. Both Federal and State technical, legislative, operational and policy drivers and enablers facilitate the transformation of the Medicaid Enterprise and support the vision of the future. Drivers are the incentive for change based on statements of need. Drivers may include things such as HHS directives, legislation, new requirements, and needed improvements in performance, meeting stakeholder expectations, or funding matters requiring action. Enablers facilitate the transformation and may include things such as funding opportunities, technology advancements, legislation, HHS initiatives, or strategic plans and goals.

C. 5.1 Federal Drivers and Enablers

The following outlines the federal initiatives (Drivers and Enablers) that are considered as part of the planning and guidance for the Connecticut MITA COO.

Federal initiatives impacting the Connecticut Medicaid Enterprise and considered for the COO			
Initiative/Law	**Brief Description**	**Purpose**	**Connecticut Consideration**
HIPAA	Health Insurance Portability and Accountability Act (HIPAA) Security and Privacy	Provides rights and protections for participants and beneficiaries in group health plans	Connecticut's transformation and modular procurements will strictly adhere to HIPAA requirements.
ARRA	American Recovery and Reinvestment Act of 2009 (ARRA)	To create new jobs and save existing ones, spur economic activity, invest in long-term	Connecticut's transformation and modular procurements will be conducted in a transparent

		growth, and foster unprecedented levels of accountability and transparency in government spending	manner and will set the stage for future growth by creating a system that is flexible and easily modified to suit the needs of the ever- changing healthcare landscape.
ACA	Affordable Care Act of 2010 (ACA)	Established several programs designed to improve the balance between institutional long term care and community care including the Community First Choice Option, a state plan option to provide long term supports and services in the community, and the State Balancing Incentive Program to aid states in streamlining their programs to increase the proportion of non-institutionally-based long-term care services. In addition, the ACA extended the Money Follows the Person Rebalancing Demonstration program	The modular nature of Connecticut's To-Be vision will serve to increase the interoperability of the State Medicaid Enterprise with other state agencies and entities, healthcare exchanges, and various community agencies helping to support the goals of ACA through ease of communication and information exchange.
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)	To continue coverage for the millions of children who rely on CHIP today and provide the resources for states to reach millions of additional uninsured children. New legislation is needed to continue CHIP funds beyond 9/30/2017	The transformation of the Connecticut Medicaid Enterprise to a more MITA aligned and modular enterprise will allow for greater efficiency and flexibility making it possible for the system to accommodate additional growth and expansion of the program as required. Connecticut will be mindful of potential program growth throughout the procurement process to ensure that any systems selected can and will accommodate future expansion.

HITECH	Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH)	Part of the ARRA that promotes the adoption and meaningful use of health information technology and widens the scope of privacy and security protections	Privacy and security protections will be an integral part of the planning and considerations as Connecticut moves toward implementing new modular procurements. The modular nature of the To-Be vision will serve to promote meaningful use by increasing the ease of electronic information exchange.
MITA 3.0	Medicaid Information Technology Architecture, version 3	Fosters integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program. Development of seamless and integrated systems that communicate effectively through interoperability and common standards	The To-Be vision of the Connecticut Medicaid Enterprise is based on the recommendations and findings that resulted from the MITA 3.0 SS-A. The direction moving forward will be to become a more MITA aligned enterprise.
T-MSIS	Transformed Medicaid Statistical Information System (TMSIS) data	Section 4735 of the Balanced Budget Act of 1997 statutory requirement for states to submit claims data, enrollee encounter data, and supporting information. Section 6504 of the Affordable Care Act requirement for states to include data elements the Secretary determines necessary for program integrity, program oversight, and administration	The modular nature of the future envisioned MMIS will allow for easy access to all claims, encounter, oversight, program integrity, administrative, or any other information deemed necessary for reporting purposes. Connecticut will be mindful of reporting requirements when evaluating potential modular procurements.
ICD-10	International Classification of Diseases (ICD-10)	The 10th revision of the International Statistical Classification of Diseases and	Any procurement made as a result of the Connecticut Medicaid Enterprise will be

		Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). Contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases	able to accommodate ICD-10 codes.
Medicaid Waiver programs	Increasing use of Medicaid Waiver programs	Propel State Medicaid Agencies (SMAs) to collaborate on benefit design, processing and standardization of data. Allow for Health Accounts and Healthy behavior incentives, and encourage states to use waivers to focus on quality and outcomes in the most cost-effective manner.	The high degree of flexibility made possible by the modular nature of the To-Be vision of the Connecticut Medicaid Enterprise will better accommodate Medicaid Waiver Programs and position Connecticut for future expansion. The needs of the Medicaid Waiver Programs will be considered during the procurement process.
CMS XLC, ILC	CMS Exchange Life Cycle and Governance and CMS Integrated Life Cycle (ILC)	CMS's governance approach ensures the effective use and oversight of the MITA and the Exchange Reference Architecture, and encompasses well-established processes from the published CMS Integrated Life Cycle (ILC) and the Exchange Life Cycle (a tailoring of the CMS ILC for use by states), as well as the collaborative ALM environment	CT will utilize CMS templates and guidance for the acquisition, development, and implementation of the Medicaid Enterprise procurements.
SMDs	State Medicaid Directors Letters, Informational Bulletins, and FAQs	SMD# 16-004, SMD # 16-009, SMD # 13-004, Fact Sheet: Mechanized Claims Processing and	State Medicaid Director Letters that provide guidance and clarification on current information and/or statutory changes pertaining to Medicaid

		Information Retrieval Systems (90/10) Final Rule (CMS 2392-F)	and CHIP policy and financing will be utilized along with CMCS Informational Bulletins designed to highlight recently released policy guidance and regulations and also to share important operational and technical information related to Medicaid and CHIP. Frequently Asked Questions provide additional information and/or statutory guidance not found in State Medicaid Director Letters, State Health Official Letters, or CMCS Informational Bulletins.
FEA	Federal Enterprise Architecture (FEA)	Establishes frameworks for the architecture of the future	Connecticut will consider the FEA frameworks when establishing the architecture associated with the MMIS Re-procurement Project.
ONC	Office of the National Coordinator for Health Information Technology (ONC)	Establishes frameworks for the architecture of the future	Connecticut will consider the ONC frameworks when establishing the architecture associated with the MMIS Re-procurement Project.
PCAST	President's Council of Advisors on Science and Technology (PCAST)	An advisory group of the nation's leading scientists and engineers who directly advise the President and the Executive Office of the President	
MACPAC	Medicaid and CHIP Payment and Access Commission	Independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability, authorizing	Connecticut will be mindful and analyze any guidance put forth by MACPAC throughout the MMIS Re-procurement Project.

		statute, 42 U.S.C. 1396, outlines a number of areas for analysis	
SIM	The State Innovation Models (SIM) Program	Provides federal grants to states, under cooperative agreements, to design and test innovative, state-based multi-payer health care delivery and payment systems; to test whether new models with potential to improve care and lower costs in Medicare, Medicaid, and CHIP will produce better results when implemented in the context of a state-sponsored plan that involves multiple payers, broader state innovation, and larger health system transformation to improve population health	Connecticut will review and utilize any lessons learned and brought forth by the SIM Program throughout the MMIS Re-procurement Project.
Pandemic Threats	Pandemic threats (e.g., bird flu, bioterrorism, and natural disasters)	Demands new methods to capture and access critical clinical data in a timely manner	The high level of interoperability made possible by the modular nature of the To Be Vision of the Connecticut Medicaid Enterprise assists in providing the ability to access healthcare data electronically in a timely manner and utilize it for areas such as syndromic surveillance to thwart public health threats.

Demographic shifts	Demographic shifts (e.g., aging populations, new immigrants)	Continues to bring new pressures on the health care delivery system	The transformation of the Connecticut Medicaid Enterprise to a more MITA aligned and modular enterprise will allow for greater efficiency and flexibility making it possible for the system to accommodate additional growth, changes in the healthcare landscape, and expansion of the program as required.
Federal Funding	Revenue limitations for public agencies	Increases the need to find administrative efficiencies, shift money to pay for benefits, and get better results for the money spent	For the Transformation efforts, Connecticut will focus on ways to reduce operational costs and redundancies, reducing the level of health care expenditures per capita and the level of Medicaid costs, while continuing the current services and improving quality and health outcomes.

Table 76 Federal MITA Drivers and Enablers

D. 5.2 Connecticut Medicaid Agency Drivers and Enablers

There have been significant changes in business requirements, federal requirements, and the technology landscape since the implementation of Connecticut's existing MMIS system in 2008. Over the past few years, several legislative initiatives and CMS directives have changed how the Medicaid Enterprise should operate. Those initiatives are summarized in the table below:

Connecticut initiatives/areas impacting the CT Medicaid Enterprise and considered for the COO			
Initiative/Law	**Brief Description**	**Purpose**	**Connecticut Consideration**
MMIS Re-procurement	The contract extension for the current MMIS ends September 2019 creating a contractual driver for the MMIS Re-procurement Project.	There have been significant changes in business requirements, federal requirements and technology landscape since the implementation of Connecticut's existing MMIS system in 2008. The current MMIS lacks the	Connecticut is utilizing the MITA 3.0 SSA as the framework for MMIS Re-procurement process and will be developing the BA, IA, TA assessments, Concept of Operations, Gap Analysis, Procurement Strategy, Roadmap, IAPD,

		modular flexibility needed to stay current with the rapidly changing healthcare landscape.	and RFPs with CMS approval and enhanced 90 % funding. 10% match funding will be requested from the CT capital fund process.
CT Medicaid State Plan	A Medicaid and CHIP state plan is an agreement between the state and the Federal government describing how that state administers its Medicaid and CHIP programs.	Medicaid and CHIP state plans give assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that are underway in the state.	Connecticut will analyze the transformation changes and if necessary, request any permissible program changes, or update the Medicaid or CHIP state plan with new information via SPAs.
MAPOC	Medical Assistance Program Oversight Council	CGS 17b-28 is a Connecticut law that charges this council with monitoring and advising DSS on various aspects of the Medicaid program. MAPOC includes legislators, consumers, advocates, health care providers, ASO representatives, and state agency personnel. It generally meets monthly and also has subcommittees that meet separately.	This council will be engaged during the Medicaid Enterprise transformation and transition planning, procurement planning, and implementation planning.
CT ASO Model	CT transitioned to Medical Administrative Services Organizations (ASO) structured as a self-insured, managed, fee-for-	The HUSKY Health model is self-insured and uses an administrative services organization (ASO) platform to promote efficient, cost-effective and	Focus on the supports for ASOs to: • implement comprehensive Care Management to enable individuals in

	service program Model in 2012	consumer/provider responsive Medicaid medical, behavioral health, dental, and non-emergency medical transportation (NEMT) services. The Department of Social Services (DSS) contracts with ASOs to coordinate care, provide customer service, and credential providers.	development of health goals and improved outcomes, • utilize predictive modeling tools and data to inform and to target beneficiaries in greatest need of assistance, improvements in health outcomes, and improve beneficiary experience, as well as help to control the rate of increase in Medicaid spending, • implement Contract Management to improve outcome based contracts for the Medicaid Enterprise.
Medicaid Expansion	Expansion of Medicaid eligibility (HUSKY D) under the ACA	Connecticut elected Expansion of Medicaid eligibility (HUSKY D) under the ACA.	One in five CT citizens is served by HUSKY Health. Federal funding at 100% for the Expansion population ended in CY 2016, the match dropped to 95% in CY 2017, and will phase down to 90% by CY 2020
CT Medicaid Waiver programs	List all waivers here • Home Care Program for Elders • Katie Beckett • Personal Care Attendant • Acquired Brain Injury • Comprehensive	There is increasing use of Medicaid waivers, and collaboration on benefit design and processing to standardize data is required. This also includes a Universal Assessment	During transformation, Connecticut will place a focus on Care Management that will encompass a robust and integrated Waiver Management solution to support these type of initiatives as they continue to

	• Individual and Family Supports • Employment and Day Supports • Early Childhood Autism • Autism	and a No Wrong Door approach.	expand. CT will streamline the approach to Universal Assessments and No Wrong Door.
Eligibility Determination Modernization	Roll out of the CT Integrated Eligibility System -ImpaCT	ImpaCT is Connecticut's integrated eligibility and eligibility case management system which allows the sunset of the old legacy mainframe eligibility systems.	During the MITA transformation process and Roadmap, CT will take advantage of the systems and services built as part of the ImpaCT rollout that can be reused as required by the CMS 7 Standards & Conditions.
Shared Services	As part of the ACA, Connecticut took the opportunity to develop several foundational components as building blocks that can be used in the Medicaid Enterprise Transformation and the MMIS re-procurement with modular components.	Building on Tiers 1, 2, 3 architecture and infrastructure, Tier 4 Shared Services will be extended and refined to utilize for the MITA/ Medicaid Enterprise Certification Toolkit (MECT) aligned Enterprise.	Shared Services will be utilized as building blocks for the implementation of the new Medicaid Enterprise systems that are MITA 3.0 aligned.
PCMH	Person Centered Medical Homes	Connecticut's Person Centered Medical Home (PCMH) initiative now serves over one-third of Medicaid members with extended hours, care coordination, and Electronic Health Records (EHRs).	During transformation, Connecticut will place a focus on modernizing Care Management.

BIP	CT Balancing Incentive Program	Long term services and supports include services that provide Medicaid recipients with assistance with daily living activities. LTSS include, but are not limited to, nursing services, personal care services, transportation, and supported employment, as well as assistance provided by a family caregiver.	During the MITA transformation, Connecticut will place a focus on Care Management that will encompass a robust and integrated Waiver Management solution as these type initiatives continue to be expanded. CT will streamline the approach to Universal Assessments and No Wrong Door.
PCMH+	Person Centered Medical Home plus	A key goal for the Connecticut PCMH+is clinical and community integration for Medicaid members, other than those served by long-term services and supports. Care coordination is funded by Medicaid supplemental payments to FQHCs and is supported by primary care-based care team.	While PCMH will remain the foundation of Medicaid care delivery transformation, and Intensive Care Management (ICM) will continue to be a resource to high need, high cost beneficiaries, PCMH+will incorporate new requirements related to integration of primary care and behavioral health care, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits. These requirements will be considered in the Medicaid Enterprise transformation and Care Management functions.

PHR	Personal Health Record	Medicaid Personal Health Record (PHR): The Department is planning to leverage existing PHR efforts in the state to provide Medicaid beneficiaries with the option to access a Personal Health Record. A PHR enables beneficiaries to view their healthcare information, including records from multiple providers, using a single log in ID and password.	DSS is the recipient of a four-year grant from CMS, Testing Experience and Functional Assessment Tools (TEFT), which will provide PHRs to Medicaid beneficiaries. This four-year initiative is comprised of four components, of which two are related to Health IT (1) testing the use of PHRs among the community-based long-term services and supports (LTSS) and (2) aiding the development and testing of the eLTSS content and transport standard. The Medicaid Enterprise transformation and MMIS Re-procurement effort will take into account the PHR.
State Funding Shortfall	Revenue limitations for public agencies	The shortfall increases the need to find administrative efficiencies, shift money to pay for benefits, and get better results for the money spent.	For the Transformation efforts, Connecticut will focus on ways to reduce operational costs and redundancies, reducing the level of health care expenditures per capita and the level of Medicaid costs while continuing the current services and improving quality and health outcomes.

Table 77 Connecticut MITA Drivers and Enablers

The following tables categorize and outline the Transformation Drivers and Enablers that will help pave the way to a modernized and MITA aligned Connecticut Medicaid Enterprise.

Connecticut Medicaid Enterprise Transformation Driver Overview					
ID	**Category**	**Type**	**Source**	**Name**	**Description**
001	Driver	Operational	State	MMIS Re-procurement	The contract extension for the current MMIS ends September 2019 creating a contractual driver for the MMIS Replacement Project.

					There have been significant changes in business requirements, federal requirements, and technology landscape since the implementation of Connecticut's existing MMIS system in 2008. The current MMIS lacks the modular flexibility needed to stay current with the rapidly changing healthcare landscape.
002	Driver	Legislative	Federal	New Federal Rule - 42 CFR part 433 and 95	The CMS Final Rule for Mechanized Claims Processing and Information Retrieval Systems published in the Federal Register in December 2015 with an effective date of January 1, 2016, transforms the certification of MMIS systems to a modular approach. The changes include: • Broadens the definition of "mechanized claims processing and information retrieval systems" to include Eligibility and Enrollment (E&E) • Supports an enterprise approach where individual processes, modules, sub-systems, and systems are interoperable and work together seamlessly to support a unified enterprise. • Promotes modular development as the most efficient and cost effective long-term solution for states' business needs. Modular certification will be applied to MMIS systems as new modules are introduced and as existing modules are replaced.
003	Driver	Operational	State	Shared Services Initiative	As part of the ACA, Connecticut took advantage of and utilized the opportunity to develop several foundational components as building blocks that can be utilized in the

					Medicaid Enterprise Transformation and the MMIS re-procurement.
004	Driver	Operational and Legislative	State	Improved Health Outcomes and self-sufficiency for CT Citizens	The need for a Person-Centric Delivery System will require Organizational Change to re-organize DSS according to the HHS MITA/National Human Services Interoperability Architecture (NHSIA)/Substance Abuse and Mental Health Services (SAMHSA) frameworks as well as utilization of advanced technology.

Table 78 Connecticut Transformational Drivers and Enablers

A more detailed summary of each of the Drivers and Enablers identified in the Connecticut Medicaid Transformation Drivers Summary table above is outlined in the Connecticut Medicaid Enterprise Transformation Driver Detailed Summary table below. The Transformation Driver Detailed Summary table is aligned with the Transformation Drivers summary table by ID number.

ID # 001 Connecticut Medicaid Enterprise Transformation Driver Detailed Summary		
Type	**Name**	**As-Is Situation**
Driver	MMIS Re-procurement	The contract extension for the current MMIS ends September 2019 creating a contractual driver for the MMIS Re-procurement Project.
Enabler or Mitigation Plan:	Conduct MITA SS-A to obtain the approved Roadmap for a new Connecticut Medicaid Enterprise. Connecticut will meet the 7 Standards and Conditions to receive Enhanced 90/10 funding for the acquisition (RFPs) and implementation of the new Medicaid Enterprise.	
	As-Is	**To-Be**
Business Impact	There have been significant changes in business requirements, federal requirements, and technology landscape since the implementation of Connecticut's existing MMIS system in 2008.	New improved Medicaid Enterprise operations and organization that is MITA aligned. Provides the Medicaid program with access to industry standard advanced technology and services and solutions to conduct business operations.
Operational Impact	The current MMIS is expensive to maintain and upgrade, and lacks the flexibility needed to stay current with the rapidly changing healthcare landscape.	A Medicaid Enterprise that consists of modular, interoperable, and standards based systems as well as establishment of Enterprise Governance. Connecticut will meet the 7 Standards and Conditions and receive Enhanced 90/10 funding for the acquisition and implementation of the new Medicaid Enterprise. These systems and solutions will be implemented with

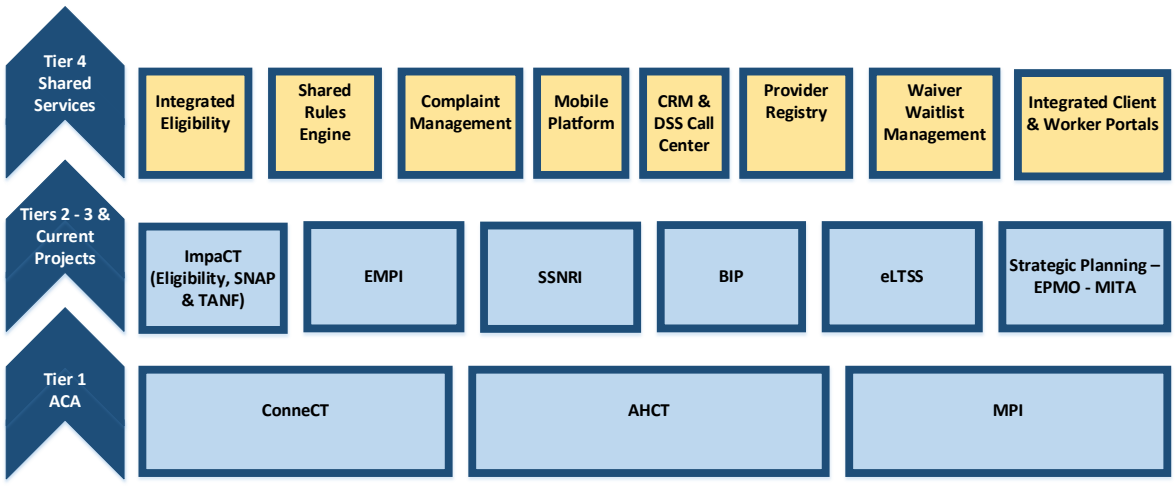
		the independent services of a Systems Integrator.
Technical Impact	The current Medicaid systems are not modular and do not take advantage of technology advancements.	Development of Data Management and Technical Management Strategies will be completed as part of this project, and an IV&V will oversee and monitor the implementation of the new Medicaid Enterprise. An Enterprise Service Bus and Rules Engine will be brought to full operation for the Medicaid Enterprise (SAMHSA) and will be a shared service for the DSS agencies.

Table 79 MMIS Re-procurement

ID # 002 Connecticut Medicaid Enterprise Transformation Driver Detailed Summary			
Type	**Name**	**As-Is Situation**	
Driver	New Federal Rule - 42 CFR part 433 and 95	CMS Final Rule for Mechanized Claims Processing and Information Retrieval Systems published in the Federal Register in December 2015, with an effective date of January 1, 2016, transforms the certification of MMIS systems to a modular approach rather than the prior way of a single MMIS system. There have been significant changes in business requirements, federal requirements, and technology landscape since the implementation of Connecticut's existing MMIS system in 2008.	
Enabler or Mitigation Plan:	Conduct MITA SS-A to obtain the approved Roadmap for a new Connecticut Medicaid Enterprise. Connecticut will meet the 7 Standards and Conditions to receive Enhanced 90/10 funding for the acquisition and implementation of the new Medicaid Enterprise.		
	As-Is		**To-Be**
Business Impact	Current Systems design impedes easy data sharing and real time data exchange. Connecticut Medicaid is not currently aligned with MITA. In order to improve efficiency and effectiveness, as well as to align with State and Federal directives and strategies, the State needs to reorganize to a MITA aligned enterprise and replace its legacy MMIS.		A Transformed Medicaid Enterprise that supports an enterprise approach where individual processes, modules, sub-systems, and systems are interoperable and work together seamlessly to support a unified enterprise. A Reorganization of the organizational structure to reflect a process oriented approach and organization that is aligned with MITA/NHSIA. The process oriented approach would be comprised of the following processes: • Member/Client Management • Eligibility & Enrollment • Provider Management • Care/Service Management • Performance/Utilization Management • Contractor Management • Financial Management • Operations Management

		• Plan/Program Management • Business Relationship Management • Data & Information Exchange • Information Services
Operational Impact	The current system is comprised of silos and service fragmentation which results in manual entry, multiple log-ins, and lack of automation.	Using MITA/NHSIA as a basis for automated workflows will make meaningful Lean Process Improvements. The To-Be Vision promotes modular development as the most efficient and cost effective long-term solution. Modular certification will be applied to MMIS systems as new modules are introduced and as existing modules are replaced.
Technical Impact	Current siloed systems have point-to-point custom interfaces and redundant capabilities that can create system configuration problems, impeding interoperability and access services.	Operationalizing interoperable modular components and access services will eliminate redundant interchange handling and connections via standardized interfaces with less risk, maintenance, cost, and implementation time.

Table 80 Federal Rule Change

ID # 003 Connecticut Medicaid Enterprise Transformation Driver Detailed Summary		
Type	**Name**	**As-Is Situation**
Driver	Shared Services Initiative	As part of the ACA, Connecticut utilized the opportunity to develop several foundational components as building blocks that can be utilized in the Medicaid Enterprise Transformation and the MMIS re-procurement.
Enabler or Mitigation Plan:	ACA related projects and Shared Services Initiative will be utilized as building blocks for the implementation of the new Medicaid Enterprise systems that will be MITA 3.0 aligned. Building on Tiers 1, 2 & 3 architecture and infrastructure and Tier 4 Shared Services, the existing components will be enhanced where necessary and will be extended and refined to utilize for the Medicaid MITA/MECT aligned Enterprise. The following represents those building blocks:  	
	As-Is	**To-Be**
Business Impact	The Integrated Eligibility system is currently being implemented across the state and workers are being trained on use of the new systems. Core system components are in various stages of implementation. DSS is addressing a Shared Services Assessment report that affects operations.	Implementation of core components that can be reused and enhanced for the Medicaid Enterprise will be utilized. This is in the spirit of the 7 Standards and Conditions.

Operational Impact	Shared Services Assessment was completed by conducting an analysis of the current state of business enterprise viewpoints, service viewpoints, business and technology capabilities, and the IT operating model capabilities. A number of challenges and key findings were identified. The following are key findings: • Clients are unclear where to apply and what services are available • Resource constraints, duplication of client data (including verifications), and the need for staff to use multiple systems • Inconsistent messaging with federal partners • Duplication of client-facing processes for staff • Separate contracts with vendors across programs providing overlapping services. Duplication of contracts across programs to perform same/similar functions • Different/unclear service level agreements (SLAs) to monitor vendors • Project governance in its initial stages of maturity • IT solution delivery occurs independently across programs • IT operating model is managed across programs independently with limited coordination • Overlapping software components that can be optimized • Limited sharing of infrastructure and processes for IT operations	Further enhancements to the shared service components planned to be reused as part of the MMIS Re-procurement project, and the assessment findings will be addressed.
Technical Impact	Incremental technical components are in various stages of implementation.	The MMIS Re-procurement project will bring the data and technical architecture to a new level of maturity on an incremental basis. Standards - such as Service Oriented Architecture (SOA), Cloud Computing, and Data

		standards will enable the State to achieve their future vision.

Table 81 Shared Services Initiative

ID # 004 Connecticut Medicaid Enterprise Transformation Driver Detailed Summary			
Type	**Name**	**As-Is Situation**	
Driver	Improved Health Outcomes and self-sufficiency for CT Citizens	While CT Medicaid has made strides in health outcome improvements there remains a need for further advancement to a Person-Centric delivery and care system. This will require Organizational Change to re-organize DSS according to the HHS (MITA/NHSIA/SAMHSA) frameworks as well as to utilize advanced technology. The Affordable Care Act (ACA), enacted on March 23, 2010, expanded the Medicaid program significantly as part of a broader plan to cover millions of uninsured Americans. Specifically, the ACA expanded Medicaid eligibility to nearly all non-elderly adults with income at or below 138% of the federal poverty level (FPL). The law required states to simplify and modernize their enrollment processes, and to create a coordinated eligibility and enrollment system for Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace, to facilitate enrollment and promote continuity of coverage. The law also provided new options and incentives to help states rebalance their Medicaid long-term care programs in favor of community-based services and supports rather than institutional care.	
Enabler or Mitigation Plan:	Conduct MITA SS-A to obtain the approved Roadmap for a new Connecticut Medicaid Enterprise. Connecticut will meet the 7 Standards and Conditions to receive Enhanced 90/10 funding for the acquisition and implementation of the new Medicaid Enterprise. The implementation of a new Medicaid Enterprise with a focus on modularity will increase interoperability and allow for the implementation and greater utilization of tools to better manage care and increase coordination among partner agencies to allow a higher degree of synergy which will benefit Medicaid beneficiaries.		
	As-Is	**To-Be**	
Business Impact	Currently, the existing organizational structure is an impairment to business operations. Activities are often siloed and technology is a barrier to process. There is a high degree of manual entry, multiple log-ins, and limited automation under the current systems. There are limited self-service options available to Medicaid recipients which limits self-sufficiency for CT Citizens. The amount	The To-Be Vision for the Connecticut Medicaid Enterprise includes the procurement of MMIS modules that will help to alleviate the current issues surrounding the siloed nature of activities and will provide technology that fosters efficient business processes. Proposed activities include: • Care and Case Management Modernization including Waiver Management	

	of manual processes limits care and case management which can in turn impact health outcomes.	• Business Intelligence Enhancements and improved Decision Support System • Provider Management Modernization • Program Integrity Modernization • Contract/Vendor Performance Management Modernization • Document Management and Automated Workflow Modernization • ESB and SOA Implementation • Coordination with public health and other partners to integrate health outcomes within the Medicaid community as a priority
Operational Impact	The current MMIS was implemented in 2008, and there have been numerous changes in the overall landscape of healthcare since that time. The current MMIS lacks the modular flexibility needed to stay current with the rapidly changing healthcare landscape.	The MECT will be utilized to operationalize and deploy modular and agile development. The implementation will focus on certification criteria aligned with MITA and reflect the latest regulations and guidance. A cornerstone of the new Toolkit is the updated Medicaid Enterprise Certification Life Cycle (MECL). CMS is leveraging lessons learned from the MECT pilots and is fully implementing it nationally. This approach: •Introduces certification milestone reviews throughout the MMIS life cycle so the state receives early feedback about issues that may impede certification •Is aligned to MITA and the latest standards and conditions •Is flexible to fit various state approaches and system development life cycles (agile, waterfall, using commercial-off-the-shelf software, or a hybrid) •Expands upon and better defines the role of the IV&V contractor as an unbiased evaluator of the state's progress toward certification •Contains templates and tools to assist in the certification process

Technical Impact	The As-Is environment is lacking an enterprise level focus which has led to siloed solutions and technology that does not always serve as an effective tool to support business processes. There is a need for Data Management and Technical Management strategies at the enterprise level. This would include both Data Governance and Technical Governance.	Creation of an Enterprise Architecture Group. This group will establish and verify the general technical requirements that all new systems must meet. The group will establish and maintain an overall systems landscape that meets MITA compliance and is flexible, reliable, scalable, and consistent. During implementation, the group would be called upon to perform gate reviews at certain points in the project lifecycle to ensure that standards are adhered to. This group will participate as a lead resource for the Data Management and Technical Management Strategies, Plans and ongoing operations. Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision making for health care management and program administration.

Table 82 Improved Health Outcomes

E. 5.3 Technical Drivers and Enablers

CMS identifies five specific technical concepts that drive and enable change to a Medicaid enterprise as described in the CMS MITA Framework 3.0. The following sub-sections and tables outline the five technology concepts that present drivers for change.

- Enterprise Architecture (EA) – Governance practice, systems of record, performance standards, and MetaData
- Service-Oriented Architecture (SOA).
- Cloud Computing as a design principle
- Common interoperability and access services
- Customer Relationship Management (CRM) Applications

1. 5.3.1 Enterprise Architecture Drivers

Enterprise Architecture (EA) is a thorough description of an enterprise, how it conducts business, and the information systems that support the business currently and in the future.

The state agencies are encouraged to adopt the concepts of an EA that encompasses all systems and entities within their state enterprise. The EA should include the definition of a target technical platform that supports the current and future operations and provides for rapid response to changes in business needs or technical components.

Enterprise Architecture		
Type	**Name**	**Description**
Driver	Enterprise Architecture	EA consists of models, diagrams, tables, and narrative which together translate the complexities of the agency into simplified yet meaningful representations of how the agency operates (and intends to operate). Such operations are described in logical terms (e.g., business processes, rules, information needs and flows, users, locations) and technical terms (e.g., hardware, software, data, communications, and security standards and protocols). EA provides these perspectives both for the enterprise's current or "as is" environment and for its target or "to be" environment, as well as a sequencing plan that charts the journey between the two.
Enabler or Mitigation Plan:	Centralized IT with an Enterprise Architecture group or focus should be established within DSS. Utilize MITA Framework - The three architectural components provide the states with the business methods, analytical techniques and conceptual tools to understand and document the structure and dynamics of the enterprise. The EA Group will utilize the MITA State Self-Assessment (SS-A) for the evaluation of the Business Architecture (BA), Information Architecture (IA) and Technical Architecture (TA), as well as the CMS Seven Conditions and Standards.	
	As-Is	**To-Be**
Business Impact	MMIS systems address core functions unique to Medicaid operations, primarily claims adjudication and related processes. Related and support functions are provided via non-MMIS systems requiring point-to-point data connections. Current technology is siloed and requires multiple, manual processes.	The MITA Framework is utilized to analyze the current systems and develop a roadmap for incremental changes to the operations, business processes and supporting systems. DSS will have an established Enterprise Architecture and governance structure for information and technical architectures across the Enterprise.

Operational Impact	Enterprise Architecture Governance is not established across the enterprise; systems of record documentation is not maintained in a single place and may not be updated timely; performance standards are not consistent across the enterprise; no Master Data Management plan currently exists.	Enterprise Governance and Enterprise Architecture practice will be operational; well documented systems of record will exist. Mature performance standards and a robust Master Data Management strategy and plan will be established and operationalized including MetaData. Evidence of the goals include: • Increased use of common data architectures • Increased use of shared technical components • Procurement and implementation of modular components • Reduced reliance on data replication • Increased use of real-time capabilities • Increased use of shared business processes • Reduced custom development
Technical Impact	Inconsistent architecture and potentially redundant system functionality is built across the enterprise. Legacy systems evolve over time based on individual modifications from legislative mandates and policy changes resulting in multiple systems, databases, and disparate data. Support functions are provided via non-MMIS systems requiring multiple, manual processes.	Modular system implementations will be supported through the use of standardized system interface layers. Data will be shared across the enterprise with minimal duplication and synchronization will occur in an automated fashion. Emerging technology and standards, such as Service Oriented Architecture and Cloud Computing standards, will contribute or enable the State to achieve their future vision.

Table 83 Enterprise Architecture

2. 5.3.2 Service-Oriented Architecture (SOA)

A service-oriented architecture (SOA) is an application architecture within which business functions, data interchange and other technical functions can be invoked using standard documented interfaces.

Service Oriented Architecture		
Type	**Name**	**Description**
Driver	Service-Oriented Architecture	SOA is a design concept that allows systems to invoke business functions as services with standard, message-driven interfaces. Systems can invoke services or reuse them in a platform-independent manner. An ESB is a component of a service-oriented architecture that promotes the agile, flexible interaction between different applications within an enterprise. The ESB acts as a universal translation program for non-homogenous applications to communicate effectively even if they are written with different messaging protocols. An ESB or ESB-type environment exposes universal and open Application Programming Interfaces (APIs).
Enabler or Mitigation Plan:	Connecticut will work toward fully implementing the ESB to provide: Message Services and Management - reliable delivery of messages between services and built-in recovery Data Management - converts all messages between services to a common format, and in turn, converts messages from the common format to the application-specific format within a service. The MITA message format for interoperability is based on XML standards. Information sharing and event-notification standards are also defined for allowing information to be aggregated and integrated Service Coordination - orchestrates the execution of an end-to-end business process through all needed services on the ESB. Services can adapt to changes in environments and are supported by a standards-based set of service-management capabilities	
	As-Is	**To-Be**
Business Impact	Current Systems design impedes easy data sharing and real time data exchange.	Systems will have capability via the ESB to easily and timely share data internally and externally and have ability to access data from multiple sources in real time.
Operational Impact	Data exchanges are coordinated manually by working with IT staff of other systems to negotiate formats, record layouts, data dictionaries, volumes, and scheduling.	ESB and Standards will allow for automated functions and real time data exchange between systems. Development of exposed API to any data services hub will be available for the reporting of data, verifications, and exchange of data.

Technical Impact	Data exchange requires point-to-point custom interfaces with redundant work and event processing to handle each interchange.	Standardized interfaces will connect applications and facilitate data exchange from any system or vendor whose products conform to the standards with less cost and implementation time. ESB Utility services eliminate redundant interchange handling. Service interfaces documented in an Interface Control Document (ICD). The ICD contains details of hardware, operating systems, software, memory, service packs, product keys, and versions.

Table 84 Service Oriented Architecture

3. 5.3.3 Cloud Computing

CMS requires that States should pursue a service-based and cloud-first strategy for system development. States should identify and discuss how they will identify, evaluate, and incorporate commercially or publicly available off-the-shelf or open source solutions, and discuss considerations and plans for cloud computing.

Cloud Computing		
Type	**Name**	**Description**
Driver	Cloud Computing	Cloud computing is the on-demand delivery of compute power, database storage, applications, and other IT resources through a cloud services platform via the Internet with pay-as-you-go pricing.
Enabler or Mitigation Plan:	The MMIS Re-procurement and MITA SS-A will provide a method and catalyst to evaluate cloud based services for the next gen Medicaid Enterprise.	
	As - Is	**To-Be**
Business Impact	Current architecture impedes data sharing, performance and outcome measures and program innovation.	Improved data sharing, performance improvements and business model changes will be more agile and less costly.
Operational Impact	The State Medicaid Enterprise relies on a model with the applications, databases, and other services housed in the state's data center or the vendor's data center through a sign-on to a mainframe or local network resource. This model is expensive and is not flexible. The current design often impedes data sharing,	Cloud Computing design will be evaluated to maximize the ability to share data internally and externally, reduce costs, and increase flexibility. With cloud computing, on-demand delivery of compute power, database storage, applications, and other IT resources will improve operations.

	performance and outcome measures, and program innovation.	
Technical Impact	The State Medicaid Enterprise relies on a model with the applications, databases, and other services housed in the state's data center or the vendor's data center through a sign-on to a mainframe or local network resource. This model is expensive and is not flexible. The current design often impedes data sharing, performance and outcome measures, and program innovation.	Cloud Computing design will be evaluated to maximize the ability to share data internally and externally, reduce costs, and increase flexibility. Technical changes and addition of advanced technical capabilities will be more easily achieved through cloud services.

Table 85 Cloud Computing

4. 5.3.4 Common Interoperability and Access Services

An interoperable development and operations approach forces component modularity and standards adoption and allows for adaptability in changing program drivers or technical evolution.

Interoperability and Access Services		
Type	**Name**	**Description**
Driver	Interoperability and Access Services	Interoperability and access services deals with the ability for two or more systems to exchange information and the ability to use the information that has been exchanged via technical infrastructure and stable communications.
Enabler or Mitigation Plan:	The MMIS Re-procurement will focus on a Modular approach with interoperability and access services core components. Fully implementing the SOA and ESB as well as a focus on the following data exchange initiatives for the Medicaid MMIS Re-procurement: – Policy alignment & good governance – Legal pathways (privacy) – Security – Transport interoperability – Message/content interoperability (ripe for MMIS) – Semantic interoperability (ripe for MMIS and E&E) – Process interoperability	
	As – Is	**To-Be**
Business Impact	Systems are siloed and are not interoperable. People and organizations traditionally involved in health care delivery rely on manual processes and systems that are not interoperable.	Individuals involved in clinical care delivery will have access to longitudinal electronic health information from various system sources and can contribute to that information and direct it to any appropriate electronic location. Access to interoperable systems is critical for exchange of health information used in clinical care to positively impact health outcomes.
Operational Impact	Lack of interoperability impedes achievement of the exchange of electronic health information and the use of electronic health information in decision making.	Interoperability will provide the underpinning infrastructure that is fundamental to enabling a learning health system. In addition, interoperability avoids vendor/solution lock.
Technical Impact	Current systems have point-to-point custom interfaces and redundant capabilities that can create system	Operationalizing interoperability and access services will eliminate redundant interchange handling and connects via standardized interfaces with less risk,

	configuration problems, impeding interoperability and access services.	maintenance, cost, and implementation time.

Table 86 Interoperability and Access Services

5. 5.3.5 Customer Relationship Management (CRM) Applications

CMS discusses in the MITA Framework 3.0, Part I, Chapter 2 Concept of Operations, CRM as a strategy that uses technology to organize, automate, and synchronize business processes that interact with clients. As it relates in the MITA Framework, this concept focuses on:

- Member and provider access to their own demographic, claim history, and financial information
- Member and provider access to clinical information
- Individual access to health insurance alternatives
- Business operations monitoring by management

Customer Relationship Management (CRM) Applications		
Type	**Name**	**Description**
Driver	Customer Relationship Management (CRM) Applications	CRM software is used to manage a business-customer relationship. CRM is a category of software that covers a broad set of applications designed to help businesses manage many business processes, customer services, client data, and client interaction.
Enabler or Mitigation Plan:	The MMIS Re-procurement will focus on a modular approach including Customer Relationship Management. The Customer and Provider Self-Service Web Portal offers a single point of entry for members, providers, state staff, business partners, and other agencies. Information collection is online. Automated decision making is facilitated with business rules engines for real-time information and determinations. The worker portal is utilized to distribute work tasks across business units. Information is centralized across business units and state agencies. Content is distributed based on the role the user has within the system. Information dashboards are available for current monitoring of business activities and program performance measures by managers and executives. Centralized Customer Management offers a unified method to organize, automate, and synchronize customer service and technical support. This can be utilized for population outreach and information distribution using mobile technology (e.g., text messaging, smartphones, etc.).	

	As - Is	To-Be
Business Impact	Members and Providers have more than one venue for assistance and communications with the Medicaid Enterprise.	Members and Providers will receive appropriate assistance, communications, notices, appointment, via single online, text or telephone methods.
Operational Impact	Members and Providers have more than one venue for assistance and communications with the Medicaid Enterprise.	Members and Providers will receive access to role-based, self-service web portals that contain data including demographics, financial, claim history, and health information.
Technical Impact	Multiple platforms to support. Current technology requires some redundant and manual processes for CRM.	A CRM focuses on eliminating redundant interchanges and maximizes real-time customer-centric interfaces.

Table 87 Customer Relationship Management Applications

6. As-Is Technical Operations

The following systems model was developed to depict the current state in DSS (also found in Appendix B). There are many disparate boxes with point-to-point connections. The MMIS faces several challenges:

- Medicaid Workers, Members, and Providers must navigate through multiple systems to perform tasks on various platforms, such that information cannot be shared easily and functionality cannot be reused
- Systems have tightly coupled programs, databases, and subsystems, and they are interconnected through individual, point-to-point interfaces
- To accommodate any changes required, for example, due to plan management, policy updates, or legislative mandate, major modifications are necessary, but difficult and costly to achieve
- Furthermore, staff resources to perform upgrades are increasingly difficult to find. Fewer people are familiar with the systems based on older technologies and how they integrate with other systems in the enterprise

The existing technical framework allows for point-to-point exchange of information, which inhibits the use and exchange of information at an enterprise level. For instance, the ASOs are contracted services which operate independently of DSS. Each ASO performs the functions required by their agreement with DSS; however, there is a wealth of information in that space which could improve decision making in other areas if data could be standardized, exchanged, and made accessible for more users. The changes would positively impact care managers trying to understand all aspects of a beneficiary's case; quality assurance managers checking to make certain that contract services are delivering according to SLAs and providing value for Connecticut; and members and their families who face multiple websites and phone numbers to select from when reaching out for help.
As the HHS environment has programmatically changed over time, both DSS and its systems have grown and adapted to those diverse conditions. As a result, programmatic areas have become technology dependent on a limited number of systems without recognition or ability to transition to common enterprise services. For example, DSS employees cite problems with document management – filing, attaching to applications and case

files, approval workflow, and other functions in the document life cycle. One of the major problems in the current environment is the lack of centralized Data Governance, and formal SDLC planning. To advance in MITA maturity and support the transition to an SOA, DSS will need formal Data Management and Technical Management Strategies. In the current environment, the large number of existing connections coupled with new technical services, are creating a growing problem with potential points of failure and increased risk of poor decision making when relying on non-standardized data. It becomes increasingly difficult to troubleshoot problems in the environment and ensure the quality of exchange, and the aging workforce supporting the platforms offers limited documentation to train new employees about the intricacies of the equipment. Furthermore, it is difficult for DSS to manage all the technology to its best advantage since Data and Technical Management Strategies are not in place to guide the growth of the enterprise.

DSS is beginning to implement some newer technology, such as ImpaCT, which is a good foundation for building the future Medicaid enterprise, and it will benefit all stakeholders to move away from the obsolete and expensive technology remaining in the enterprise.

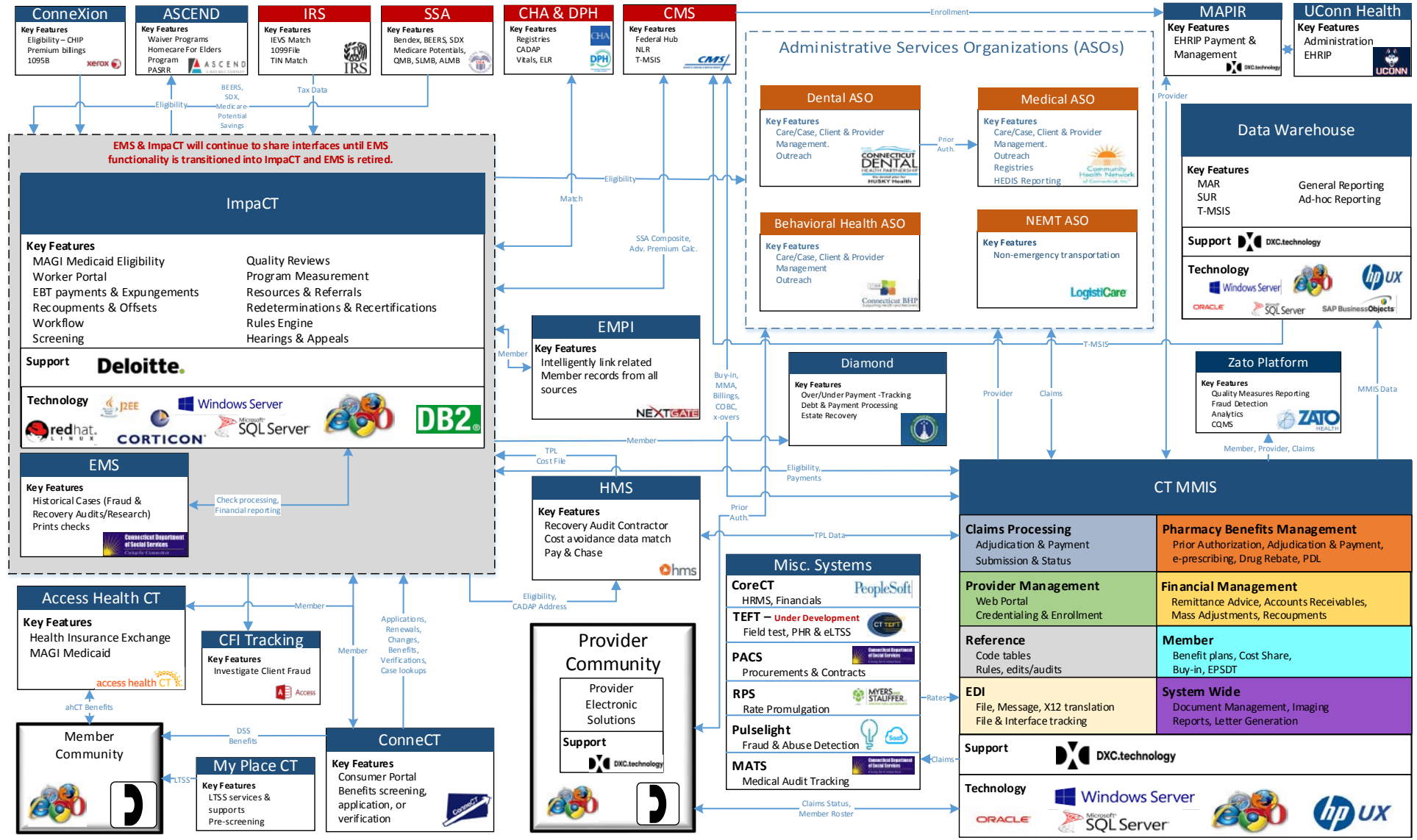


Figure 34 As-Is Concept of Operations Diagram

7. To-Be Technical Operations

In the future environment, the MMIS will be replaced by a MITA-aligned, MECL- and MECT-compliant, Next Generation Medicaid Enterprise Management Systems, as shown in the To-Be Systems Conceptual Model below (also found in Appendix C). The future state is characterized by a service oriented architecture that will conform to national standards, increase automation, and facilitate interoperability for better outcomes. The following paragraphs describe the crosswalk from the As-Is model to the To-Be environment.

From CT MMIS…

MMIS performs the core automated functions for processing claims and handling other business functions, including management of baseline member, provider, pharmacy, financial, and reference data. Additional functionality residing in this environment includes the Decision Support System (DSS), Enterprise Data Interface, Third-Party Liability (TPL), and other system-wide applications such as document management, report imaging, and letter generation.

…To SOA, ESB, and Rules Engine

The key to success for Next Generation MEMS in the Medicaid enterprise is the implementation of service oriented architecture. Shown at the heart of the future model, SOA is the architectural framework that allows the integration of multiple technologies using an Enterprise Service Bus (ESB) with a common Business Rules Engine. In the To-Be diagram, system-wide applications are shown for Identity & Access Management, Document Management, External Data Interchange, and the Business Process Model & Workflow Engine. It is important to note that all systems/services in the future Medicaid environment must be SOA compliant and interface directly to Connecticut's ESB.

Common Web Platform and ESB Connectivity

The ESB serves as a hub to manage messages and standardize data flowing between the various services. The "hub and spoke" design is scalable, where the point-to-point architecture was unwieldy and difficult to change. The use of a common web portal for workers, members, and providers becomes the key source for information within the To-Be environment. Data governance and technical management become formalized and utilize modeling techniques developed in Connecticut's strategy. Exchange between Medicaid federal and state agencies is brokered through the centralized data hub employing standardized methods of exchange. The diagram shows connections to Medicaid modules (for example, Contract Management, Care Management, and Claims Processing), to entities that support Medicaid processes (like ImpaCT, Access Health CT, CoreCT), to other Medicaid service entities (such as ASOs, state agencies), and to resources (e.g., registries, data warehouse, and federal partners). All connections will be SOA compliant and meet Connecticut's data and technical standards.

Services

As discussed in the MITA framework, services can perform either business or technical functions. Services such as Process Claim and Enroll Provider perform business processes. Services such as Single Sign-On and Document Workflow perform high level technical services that are shared by many business processes. Services can be simple or may be complex multi-step services that are interconnected and orchestrated by the ESB. The ESB lets services interoperate and can invoke services as a chain of simple services that perform a more complex process from end-to-end. An example of this is the workflow required to author, approve, publish, edit, and archive a document. The service layer is designed to handle normal conditions, as well as respond to failures and adapt to changes. As part of data and technical management, a log of enterprise system interfaces will be developed and maintained.

The former MMIS core functions are distributed to discrete elements in the SOA. These include Care (Member) Management, Provider and Contract Management, Financial Management, Claims Processing, Program Integrity (QA), Reference Data Management, Third Party Liability, and Pharmacy Management.

With each of these elements, DSS will establish cleanly cut service contracts with clearly defined functionality in a manner that is transparent to the underlying technology platforms providing the functionality. Hence, there can be multiple agencies and vendors with SLAs and KPIs to guide the operations within the SOA environment which were once handled by the MMIS.

Single System Eligibility

ImpaCT, Connecticut's new eligibility system for Medicaid, performs in a modern, modular architecture that has the capability and scalability to support additional programs. The statewide transition to ImpaCT is underway, and once that is accomplished, eligibility functions can be extended to other services, as envisioned by Connecticut's leadership for shared services to benefit multiple agencies. In the To-Be environment, ImpaCT can serve as a generalized eligibility framework handling multiple eligibility use cases in compliance with the Seven Conditions and Standards for MITA maturity. The future state of Connecticut's Medicaid enterprise promotes the modular, interoperable systems design sought by CMS. It has the effect of producing a consistently aligned environment over time that significantly lowers the bar for meeting the inevitable new challenges in the Medicaid program.

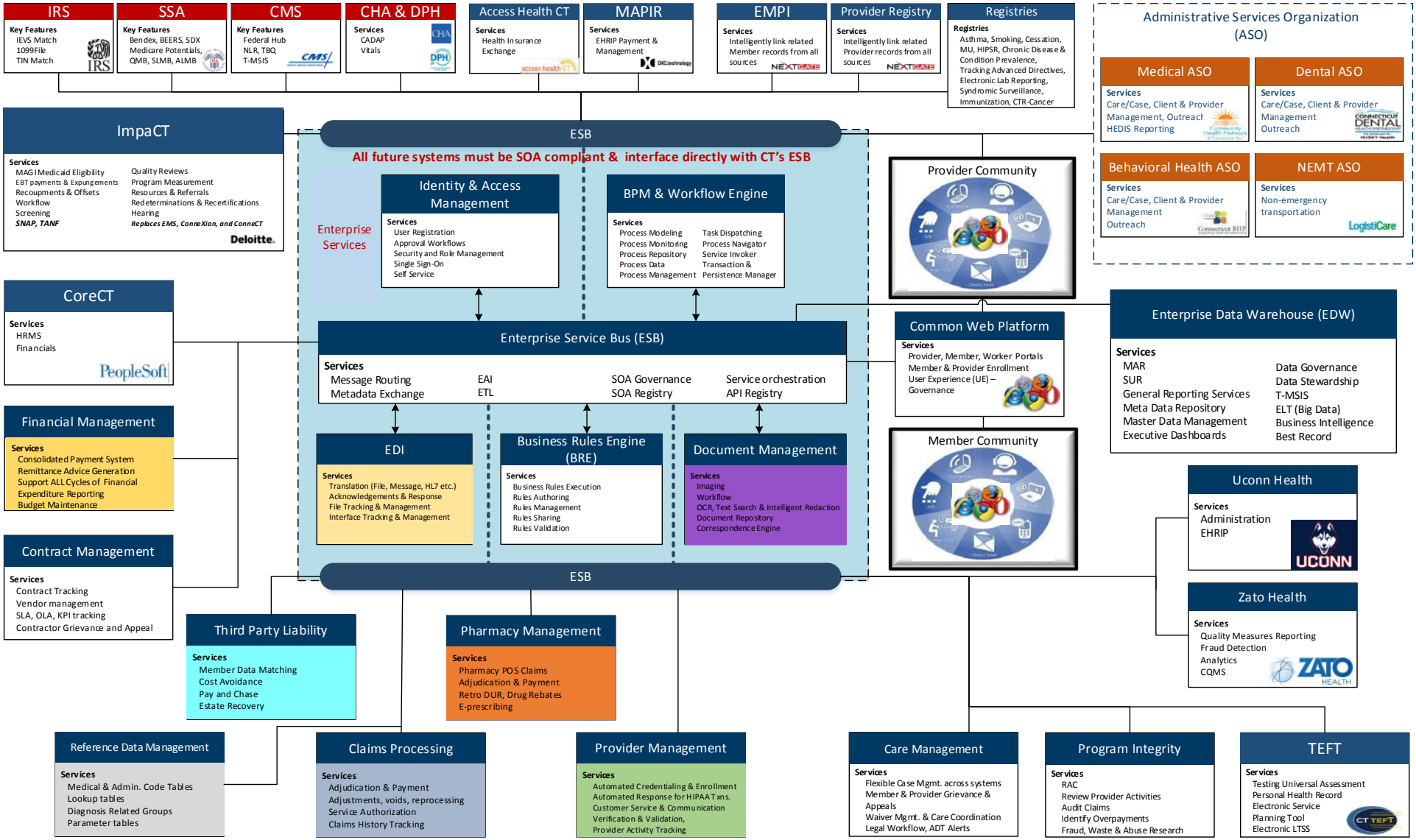


Figure 35 To-Be Concept of Operations Diagram

8. As-Is and To-Be Business Process Transformation Narratives

MITA describes State Medicaid Agency operations within a framework of 10 MITA Business Areas, which include:

- Business Relationship Management
- Care Management
- Contractor Management
- Eligibility and Enrollment Management
- Financial Management
- Member Management
- Operations Management
- Performance Management
- Plan Management
- Provider Management

As part of future state development, DSS will continue toward alignment with the MITA framework. The transition to focus operations in these business process areas will enhance Connecticut's ability to coordinate with other states on levels ranging from simple exchange of policies and processes to potential process sharing with other states.

8.1 Business Relationship

As-Is

In the absence of a MITA aligned SMA, business area staff who identify the need for a service or an IT solution are responsible for identifying TPA criteria, and SLA, KPI and milestones for the contract. In addition, many agreements with sister agencies have no MOU, and a consistent request for improvements included lack of adequate data sharing across agencies. Many of the issues within this Business Area track back to Contracts and Procurement and the limitations of the system in use for that area. To promote the future vision of SOA based Medicaid Enterprise the use of enterprise data standards and TPA criteria are critical to success. Similarly, within business processes, the enterprise use of SLA and KPI milestones ensure member centric care and efficient operations.

To-Be

The Contract and Procurement IT solution will allow centralized tracking of all contract TPAs, SLAs, KPIs and Milestones. The SLA component of IT solutions will be centralized in an IT area to ensure each newly signed contract has adequate language to meet the advancing technologies of the SMA. All staff involved in contract development ensure SLA and KPIs are included to contracts. The SMA utilizes the MOU when utilizing sister agencies to meet the requirement of the program, the MOU ensure the changing needs of the SMA are meet. Automated work flow is introduced and utilized with a centralized call tracking system to aid in the communications with business partners.

8.2 Care Management

As-Is

Connecticut care management business process activities extend across multiple entities utilizing different systems and processes which results in limited coordination, difficult oversight and inadequate opportunity for meaningful analysis. Care management extends across Connecticut's eleven different waivers, administered by three different Departments, State Plan programs (including Community First Choices (CFC), and four ASOs. Activities are siloed as data is not easily accessible across programs and agencies. Waiver programs are constrained in their ability to share data by the utilization of various assessment tools and care management systems with little to no automated exchanges of information. Oversite and analysis of Waivers is obstructed

by the utilization of multiple systems for storing and tracking care plans. When data is shared, it is often limited and or accomplished by manual entry or uploading in a format that is difficult to process, such as PDF files.
The current structure has resulted in difficulties in sharing information across ASOs and Waivers.
Agencies responsible for creating care plans and acting as care managers for waiver members do not have the benefit of real time clinical data.

To-Be

Enterprise Master Patient Index and Shared Services across eligibility and enrollment will aid in real time accurate association of members with state plan programs, grant programs and waivers. Shared Services will allow waiver applicants a true "No Wrong Door" experience, pre-assessment data can be uploaded and pre-populate both the functional assessment and the financial application. The SOA repository includes ESB and Master Data Management analytic capabilities to support data collection from all entities and systems involved in care management activities and enable bi-directional data sharing of meaningful data to support better outcomes. The Care Management Module will support a dash board view of all waivers, enrollment numbers, utilization and budget neutrality. DSS staff can use the care plan component to support waiver case management, and track utilization of services. Sister agencies and ASO's can either use or connect with the modules Case Management system. A single log in feature which includes "user roll" provides the user with appropriate access. The SOA repository will facilitate accessing data through EHR/PHR and HIE's. Information can be utilized to develop care plans and allow care managers to receive real time alerts of hospital admits, discharge and transfers.

8.3 Contractor Management

As-Is

Existing DSS contracts are currently housed within the Procurement and Contracts System (PACS). Contract information is initially recorded on a paper form, known as CARIS, and then manually entered into the PACS by the staff of Contract Administration and Procurement. Agency staff do not have access to initiate their own contract renewal, development, or amendment within the PACS system and frequently make their request untimely.

To Be

Implementation of automated workflow and a more integrated and automated contact and procurement system will improve the functionality of contract management. A workflow tool will reduce the time needed to accomplish business activities in contract management as it will automate the communication between agency staff and contract staff. The upgraded system will allow agency staff to use the system to initiate new contract request or contract amendments. When a request is initiated, work flow management can be used to send task alerts to appropriate agency staff. These tasks delivered to agency staff can include reference documents, information request and due dates. The enhanced contract procurement system will interact with other state systems, such as the State Financial system and the document management system. It can include a dashboard that gives an overview of activities that can include budget information, such as current spending against projection, tracking and management of invoices, and tracking of existing contracts renewal dates. The system can work in conjunction with automated workflow management to send task to agency staff as their contracts near renewal dates.
Utilization of a single DSS call center platform enterprise wide will allow each area to view summaries of all prior calls received from the current caller. Technology allows staff to receive screen "pop-up" summaries of prior calls. Knowing who the caller has spoken with, their prior questions and provided answer brings value to the

current exchange. In addition, this knowledge can be leveraged to elevate the knowledge of all, inaccurate information is easier to identified and can be used to initiate training.

8.4 Eligibility and Enrollment

Member As-Is

The use of multiple eligibility systems with separate rules engines and the lack of a modular Enterprise Master Person Index is resulting in duplicative effort for staffs, duplicate enrollment, and potential miss alignment of processes and rules. The current view of a consumer needing long term services and support in the community remains disjointed despite the advances accomplished in recent years as a result of changes introduced by the Affordable Care Act and the Balancing Incentive Program. The implementation of a "No Wrong Door" has been hindered by the lack of connectivity between the various systems and components. A recent KPMG report indicated that consumers are unclear where to apply and what services are available. These issues are compounded when the consumer is seeking waiver services as this benefit requires both a functional assessment and financial eligibility determination, these two components of a single eligibility determination are currently disconnected, resulting in manual entries and processing of some data elements. Efforts to streamline and automate eligibility determinations for non-MAGI populations appears to be in its early stage. Coordination of benefit between Medicaid and Exchange offered insurance is limited.

Member To-Be

A single rules engine from any entry point utilizing an Enterprise Master Person Index ensures a no wrong door experience for consumers, and operates more efficiently. The single rules engine promotes greater coordination of benefits across Medicaid and the Exchange. For example, when the system processes information that results in termination of Medicaid, it will present the citizen with any tax credit benefits they may be entitled and support shopping. No Wrong Door functionality is further supported by utilization of an Enterprise Service Bus, making data elements from a pre-screening (Level 1) assessment completed through My Place CT (or other web site) available for auto population of both the full assessment (level 2) and financial eligibility components (the Medicaid application). Consumers would have a single sign-on to access all areas of their eligibility determination, as well as services authorized, utilized and personal health record.

8.5 Financial Management

As-Is

Activities in Financial Management dealing with recoupments and recoveries are labor intensive due to lack of historic data within the MMIS and Data Warehouse. Other areas of financial management are hindered by a lack of automation, for example recoupment letters and reporting, issues with electronic payment, and a need for data governance and higher function data warehouse.

To-Be

Financial Management activities will become more automated when supported by a SOA that includes data governance and a high performing claims and adjudication module and data warehouse. Work flows will be improved with the addition of a work flow management system. Manual intervention to calculate federal shares of recoveries should be eliminated based on greater access to historical data via these improved systems. Automated recoupment letters and improved reporting capabilities will be supported by these systems. The enhanced contract and procurement system will also support several areas of financial management including the management of contractor payments.

8.6 Member Management

As-Is

Member Management data is currently siloed and inaccessible to many partners. Waiver information is manually keyed into the eligibility systems, care plans are housed in various systems. Member enrollment in community first choice is not part of the member file but stored separately. Currently care plans from sister agencies are shared manually in PDF format and the image is manually loaded to a DSS database. Member communication is handled by various entities including the four ASO, and multiple call centers tracked across multiple call tracking systems. Outreach and communications is not centrally coordinated or tracked. Members seeking information have multiple portals they must access.

To-Be

Adaption of data governance across the SMA will aid in identifying areas where data is lacking. Moving to a SOA with an enterprise service bus and Care Management Module will allow data sharing between the ASO, sister agencies and DSS. This data will allow a more complete view of member information and a centralized repository for tracking and analysis. Utilizing one enterprise wide call center platform will allow member communication to be centrally stored. Having a single sign on for all member information access will simplify and streamline members' access to information and communications.

8.7 Operations Management

As-Is

The existing solutions do not have the functionality for accepting and processing electronic attachments. All attachments must be submitted by paper, either fax or mail, with a few provided via web portal. Once received DXC Technology scans into the MMIS. The SMA is making advances in compliance with CAQH CORE. DSS currently uses a vendor to aid in the processing of Spend-down, as a corrective action to decrease processing time. The process is manual with no automation to obtain known expenses such as Medicare premiums. DSS has indicated that HCBS providers and services are adjudicated in the same manner as other health care providers. However, non-medical services vendors, such as Boarding Homes, are stored and processed outside the MMIS (currently through the EMS system).

The current Manage Data Business Process is handled primarily within the MMIS and E & E systems. Data for reporting is pulled from both as well as the Data Warehouse. Efforts to launch data governance are beginning, but not fully developed, and useful data from outside sources is difficult to obtain until data governance is in place.

To-Be

The SMA is operating with SOA, utilizing a single Enterprise Service Bus (ESB). All data flows into the single repository. Data is presented in a meaningful way. The SMA has implemented data governance and increased the availability of data by established information hubs for the various lines of business across the enterprise with dashboards present relevant data. For example, waiver management dashboard may be displaying enrollment numbers, dollars spent on specific areas of interest (i.e. non-medical, management and pharmacy), budget neutrality, waiting lists, presented cumulative and or by waiver. Policy staff have the data necessary to analyze the impact of proposed policy changes, and evaluate past health care activities. The Agency has ready access to the number of spend-down recipients, the time line between application and approval, and can evaluate the impact of any changes in the approach. Electronic submission of documents is supported, the system screens and captures electronic images, validates the image is legible and meets quality standards. For images not claims related the document management and work flow system ensures the images are routed appropriately to reduce delays. For claims submissions with electronic attachments the system includes an

attachment indicator field to be used by the submitter to identify claims for which attachments are being submitted separately, it date-stamps, assigns unique control numbers, and batches hardcopy attachments as well as any adjustments and other documents to the related claim. The Claims and Adjudication module will be able to access historical eligibility in real-time further enhancing the accuracy of mass adjustments

8.8 Performance Management

As-Is

Identifying Utilization Anomalies is a function currently carried out by several systems and entities. The lack of enterprise data governance creates obstacles due to inability extract clean and accurate data. HPE currently performs Surveillance Utilization Reviews. Drug Utilization Reviews (DUR) are performed by Health Information Designs (HID), who is contracted out by DXC. Medicaid Recovery Audit Contractor (RAC) services are performed by HMS, and additional payment reviews are completed by 21st Century and the Center for Medicare Advocacy. Myers and Stauffer provide Audit Services for Nursing Facilities. The siloed structure is a barrier to data exchange and big picture identification of problem areas. REOMB for detecting payment problems is performed monthly. Identifying and tracking adverse action incidents requires different types of investigation. Provider compliance and utilization is highly manual work and requires manual interaction with several applications pulling static reports and creating excel worksheets and pivot tables.

To-Be

Program Integrity Module performs analysis of rendering, ordering, and billing practices and generates reports of aberrant utilization and or billing patterns, in addition to identifying member utilization outliers. A master data management system with analytics produces more defined and usable reports. These systems support the algorithm for random automated REOMB, to aid in the detection of billing issues. Single platform call center flags member calls regarding billing issues, enabling the identification of potential billing error patterns. Greater interoperability between the enterprise and outside vendor systems combined with the introduction of automated workflows support staff in the appropriate steps necessary upon receipt of vendor supplied data. These changes reduce the manual task and promote the goals of performance management by use of data and automation.

8.9 Plan Management

As-Is

Plan Management, includes maintaining program policy, including the State Plan, administering the health plan (rates and reference), monitoring business activities and tracking the performance of the SMA against set goals and objectives. The ability to measure internal performance based on unique goals of the SMA is often hindered by the lack of readily available data. The current process DSS has been utilizing for dissemination of policy bulletins and policy transmittals to Medicaid providers (via MMIS eMessaging) is manually intensive. Many changes are time sensitive, and the approach does not support a method to track or monitor the progress. Errors in identification of appropriate review staff can lead to miss information and recalls of distributed bulletins or transmittals.

To-Be

Plan Management activities will be supported by a SOA repository which supports integration, interoperability and data supported analysis. Allowing seamless integration of clinical and administrative information received from multiple entities, including but not limited to HIE, EHR, Public Health and Sister Agencies. The availability of this data will support decision making, aid in the design of the health plan, and establish pathways for evaluation of internal and external performance.

Implementation of workflow automation will significantly impact the day to day operations of Plan Management. A workflow tool can reduce the time needed to accomplish business activities while improving accuracy. When tied to document management, workflow tools allow users to route content to a recipient in the best way for them to use it. Replacing the Orange folder with workflow automation means selecting reviewers from a pre-set reviewer menu or profile. Flagging, or tagging the document based on time-lines (due dates) or priority. The document electronically moves around the necessary reviewers, obtaining and tracking their comments or electronic signature of approval. The creator can track the item in real time as it moves through the process. Reviewers receive automated notification for prompt action. Reviewers can delegate task to others, to avoid delays (out of the office, etc.). Rework is greatly reduced, as delays are avoidable, master edits can be made by the owner if needed, and started again at any stage. Workflow automation will assist in all areas of Plan Management.

8.10 Provider Management

As-Is

Provider Management has many manual activities; paper information faxed or mailed in must be manually uploaded and associated with the provider. Providers looking to enroll can access information via the web, but are unable to upload supporting documents and must physically mail information. The current system does not have the ability to cross-reference with other state or federal agencies.

Currently providers have multiple portals to work with, ASOs have their own provider portals the SMA has a two-step portal, where providers must enter a password to view detailed information. The password re-set requires the provider to call in and speak to a representative.

To-Be

A new Provider Management Module will include provider enrollment activities, evaluation of the quality of the provider network and store data to support multiple provider specific reimbursements rates, with begin and end dates, such as medical homes and volume purchase contracts etc. Provider enrollment activities will allow electronic submission of enrollment paperwork, interactions with other state systems necessary to validate application, electronic notification to the provider seeking enrollment of their current status (pending, approval or rejection). In addition, the system will send alerts to providers with contracts nearing termination. The system can evaluate provider networks and performance measure to ensure a correct mix of providers within the state. The module will support communication to and from provider and track responses.

The new Provider Module combined with a work flow management system will automate many of the current manual process completed in Provider Management. A single sign on will allow providers to access information from multiple sources from a single web portal.

9. Transformation Outcomes

Increasing maturity within the MITA Maturity Model will impact both As-Is and To-Be needs of stakeholders because the transformation of Medicaid business processes and supporting technology will be achieved incrementally over the next five to ten years. Stakeholders include:

- Beneficiaries
- Providers
- Information exchanges
- Community/state/federal agencies
- Legislators/regulators/general public
- DSS Employees

The MITA Roadmap is designed to positively impact the members, providers, communities, and public representatives. The To-Be Environment will improve outcomes with automated processes facilitating self-service functions and better access to data to inform decision making - both through electronic health records for individuals and through analytics for health populations. Ideally, stakeholders' roles will change; for example, providers and community organizations will have smoother operations, faster and better, so they can focus on member care instead of paperwork; and taxpayers will get a better value for each dollar spent to serve vulnerable populations.

The following table captures highlights of the As-Is and To-Be Outcomes.

Connecticut As-Is and To-Be		
MITA Area	**As-Is**	**To-Be**
Business Relationship	• TPAs are ad hoc and system specific without central management • SLA and MOU's are under-utilized and often not formalized • KPI are often missing from contracts	• Document management system and automated work flows will be utilized • SOA to support the sharing of information • Data governance will create standards for future contracts • Systems support for tracking existing business relationships, SLA and KPI will be in place • Centralization of IT SLA
Care Management	• Siloed clinical data • Limited data exchange • No real time clinical data • Potential duplication of services • Multiple call centers and web portals for member's	• EMPI will reflect enrollment in Waivers or programs to avoid duplication of services • Greater data collection supported by Master Data Management • Real time ADT alerts for care managers • Development of a Care Management Module and SOA repository will support access to data for waiver dashboards, analysis and oversight. • Central log on will make access to information easier for members
Contractor Management	• No coordination with State Financial System • Paper processes • Limited system support • Agency Staff unfamiliar with process • Lack of centralized call tracking results in answer shopping	• Contract and Procurement system with enhanced functionality • Automated work flows • Agency staff can use enhanced system to self-initiate request • System dash board will allow contract and procurement overview • Centralized call center/tracking platform

Member Eligibility	• Eligibility components, including systems, portals, and tools lack connectivity • Two rules engines • Multiple call centers • Manual process for non-MAGI eligibility groups. • Coordination of benefits between Medicaid/CHIP and Tax Credit plans limited • No connection between the financial and functional eligibility components of LTSS • No Modular Enterprise Master Person Index	• Single rules engine accessed by both Exchange and Medicaid • Function (pre-screening and full assessment) and Financial eligibility components will be linked to ensure appropriate information is pre-populated and shared • Single call center platform • Improved coordination of benefits between Medicaid and Exchange
Financial Management	• Lack of automation • Labor intensive manual processes for application of recoveries • Lack of data governance makes available data of limited usefulness when planning for future expenditures	• Enterprise data governance combined with a high performing data ware house provide FM staff needed data to streamline work efforts • The ability to produce standard reports and data analysis
Member Management	• Member clinical data inaccessible to many • Care plans across waivers are not centrally stored • ASO's have not secure method of sharing information with each other • Outreach and communication with members is not centrally tracked	• Enterprise data governance ensures all member details are captured • Utilization of the Care Management Module will allow data sharing between the ASO, Sister agencies and DSS • Centralized repository for member data will support analysis and oversight • Single sign on for members will make information more accessible • Centralized call center improves member communication

Operation Management	• No electronic attachments • Lack of data governance makes data sharing difficult across systems • Multiple ESB in use • Payment information for non-medical and medical stored in separate systems	• Electronic Attachments supported, with system quality validation and routing • Data governance • Single ESB supports greater access to data • Data Hubs support dashboards for subject areas
Performance Management	• Siloed data • Manual processes, excel worksheets and pivot tables • Lack of automation	• Automated work flows • Data governance model increase the available data • Automation in the program integrity module aid in the identification of problem areas • Automated generation of REOMB based on a monthly pre-set algorithm
Plan Management	• Internal performance measurement is labor intensive due to lack of data • Paper based process lead to rework • Orange Folder utilization	• Efficiencies will be achieved through automated work flows • Establishment of an enterprise data governance model will increase the usability of available data • Internal and external performance measurements will be supported by a SOA repository with advanced DATA warehouse and easy-to-use analysis tools
Provider Management	• Paper processes • Lack of necessary data • Limited automation	• Provider enrollment system supported by the provider management module • Automated responses and alerts • Greater details captured and stored to support payment reform options • Single sign on web portal to access enterprise wide information

Table 88 Connecticut As-Is and To-Be Transformation Outcomes

10. Summary of Improvements

Medicaid transformation improvements for each key group of stakeholders are critical to the operations and success of Connecticut Medicaid programs and the stakeholders will be able to appreciate and validate how the transformed Medicaid Enterprise affects and improves their operations.

This Medicaid Enterprise transformation effort will build upon prior efforts and initiatives to further advance positive Connecticut health outcomes. As an example, many of the changes required to meet 2010 ACA requirements brought with it opportunities for Connecticut to take advantage of increased capabilities that can be built upon as outlined in the 7C&S for re-use in achieving a higher MITA maturity level and ultimately a full transformation of the Medicaid Enterprise. The following depicts and summarizes the trajectory of the Connecticut Medicaid Enterprise over the last several years and how that effort is paving the way for the current Medicaid transformation and MITA maturity efforts.

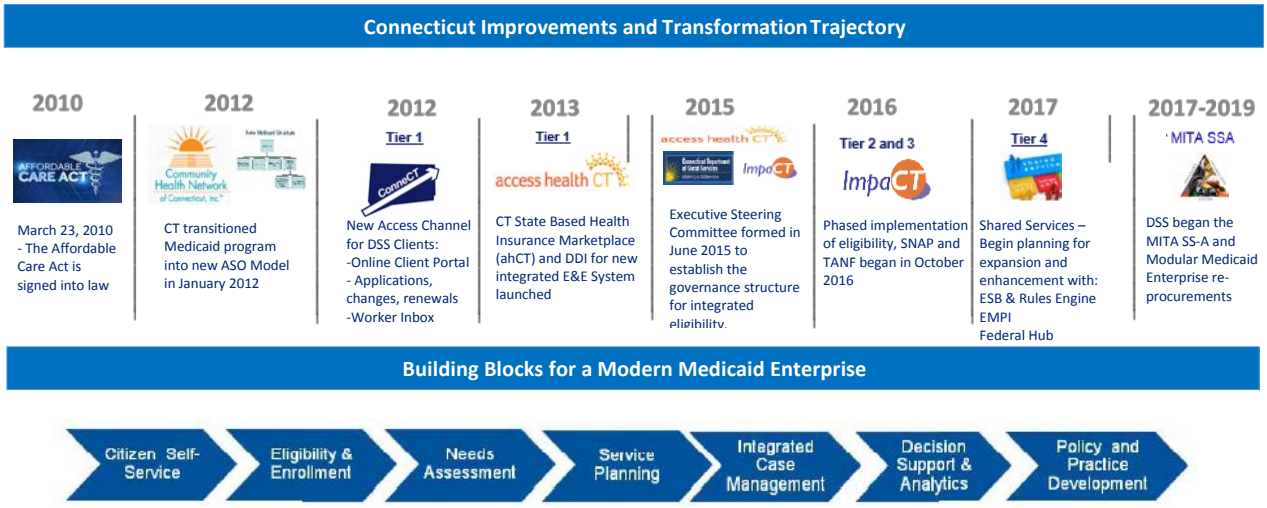


Figure 36 Connecticut Improvements and Transformation Trajectory

Connecticut is strategically building upon the ACA related projects and Shared Services Initiative to utilize as building blocks for the Medicaid re-procurement and transformation. Building on Tiers 1, 2, & 3 architecture and infrastructure and Tier 4 Shared Services, the existing components will be enhanced where necessary and will be extended and refined to utilize for the Medicaid MITA/MECT aligned Enterprise. The following further describes the tiered building blocks that will be leveraged in the transformation of the Connecticut Medicaid Enterprise.

- **Tier I** –ACA MAGI Medicaid and CHIP eligibility determination rules as required by the Affordable Care Act (ACA). Tier I was successfully deployed in production at Access Health CT (AHCT) as a part of the Health Insurance Exchange project. Tier 1 included the implementation of ConneCT which provided new channels for DSS clients to get information and new technology tools for DSS workers such as:
    - Pre-Screening
    - Client Accounts (Integration w/ the legacy eligibility system (EMS))
    - Online Applications (Cash, SNAP, Non-MAGI, LTSS Programs)

- Online Change Reporting
- Online Renewals
- Telephony (IVR and Benefit Center)
- Worker Functionality (Inbox, Document Management and 1348 Generation)

It also included the implementation of AccessHealthCT (AHCT) for the new population of clients who purchase/receive medical insurance through the Exchange as a new quasi-government agency. The functionality included:

- Eligibility determination and enrollment into QHP (+ APTC), MAGI Medicaid, CHIP programs
- Initial Enrollment/Change Reporting/Renewals on Customer/Worker Portals
- Worker Portal Functionality (Appeals Processing, Workflow and Work Item Management, Document Management)
- Interfaces with external systems (EDI, Bulk Services, FDSH, MPI, CHIP, DOL, 1095, ConneCT)
- Batch Processing (Notices, 90 day Reminders/Termination, Automated Renewals)
- Reporting
- EMPI - The initial roll out of the EMPI that will provide a comprehensive and customizable solution for client demographic record management and matching across AHCT and DSS providing a consolidated view of client demographics across the systems. The goal is for the solution to function as a master record.

- **Tiers II and III** were combined into one phase based on the different sets of functionalities and business processes.
  - **Tier II** – consists of integrating the remaining DSS medical eligibility rules (ABD Medical, Medically Needy, Long Term Care, etc.) as well as the case management capabilities.
  - **Tier III** – consists of the eligibility and case management for the programs including TANF (called Temporary Family Assistance or TFA in Connecticut), SNAP, Summer EBT, State Administered General Assistance (SAGA), State Supplement to ABDs, and Refugee Assistance. Tiers II & III are currently being implemented at DSS under the ImpaCT project in a phased roll-out. These tiers included:
    - End-to-End Integrated Eligibility Determination / Case Management
    - Modern Web Interface for Improved Worker Usability
    - Integration w/ Current COTS Products for Security, Document Generation, Document Management and Rules Engine
    - Enhanced Integration w/ ConneCT and ahCT
    - EMPI to provide a comprehensive and customizable solution for client demographic record management and matching across AHCT and DSS

Other current projects such as the Balancing Incentive Program, Social Security Number Removal Initiative (SSNRI), eLTSS TEFT grant and initiation of an EMPO office are projects that are of importance to the Medicaid enterprise.

- **Tier IV –Shared Services -** includes the enhancement of shared service components (and expansion of Integrated Eligibility System (IES) functionalities and other shared services for non-DSS Health and Human Services agencies under the Integrated Eligibility Platform. Tier 4 includes critical components such as:

    - **Integrated Eligibility Expansion –** Complete the necessary work to expand the ImpaCT Integrated Eligibility System to other HHS programs
    - **Integrated Enterprise Rules Engine** - The long-term goal is to implement a shared rules engine that can include all HHS programs. The priority for work to be performed by December 31, 2018 is to build a shared rules engine for DSS and ahCT via the DSS Enterprise Service Bus (ESB).
    - **Integrated Verification Services** – Development of a common framework for services and handle common cross-cutting concerns such as logging, usage accounting, and monitoring for a shared data service hub such as FDSH services, address validation and standardization at the enterprise level.
    - **Enhanced EMPI -** Complete the necessary work to expand the EMPI to other HHS programs.
    - **Shared Notice Engine** - shared across in-scope Connecticut agencies that provides a centralized noticing service and adopting Service Oriented Architecture (SOA) principles.
    - **Integrated Client Portal**: This project consolidates the existing online applications and screening portals implemented within the State (e.g., AHCT client portal, ConneCT, ConneXion, etc.). The client portal will harmonize the application intake process.
    - **Integrated Worker Portal** - Implement a shared worker portal to consolidate the software applications required to manage client data, eligibility and benefits, noticing, and case maintenance.
    - **Integrated Mobile Platform**: Expand the ahCT mobile capabilities for other HHS services, including Medicaid, to provide a “no wrong door” approach focused self-service consumer tools including easily checking their status in each program they are enrolled in.
    - **Integrated Call Center and Connecticut HHS-wide Customer Relationship Management Solution –** Enhance and consolidate existing eligibility support services. Acquire new technology to emphasize person-centric services.
    - **Enhancements to Provider and Waiver Waitlist Management** - Enhancements and integration of new modular functionality to build on the existing ImpaCT platform for Provider Management and Waitlist Management. These enhancements will be building blocks for the CT Child Care Program as well as future Medicaid work.
    - **Enhance Complaint Management Operations** - Consolidate the complaint management system between ahCT and DSS, through the implementation of an end-to-end complaint management solution. This will help improve the timely

response to complaints, ensure each agency knows how the complaint was resolved, and provide data for improvements to efficiency and responsiveness.

- **EPMO** - Deploy effective Enterprise Program Management Office Support for coordination and project success.

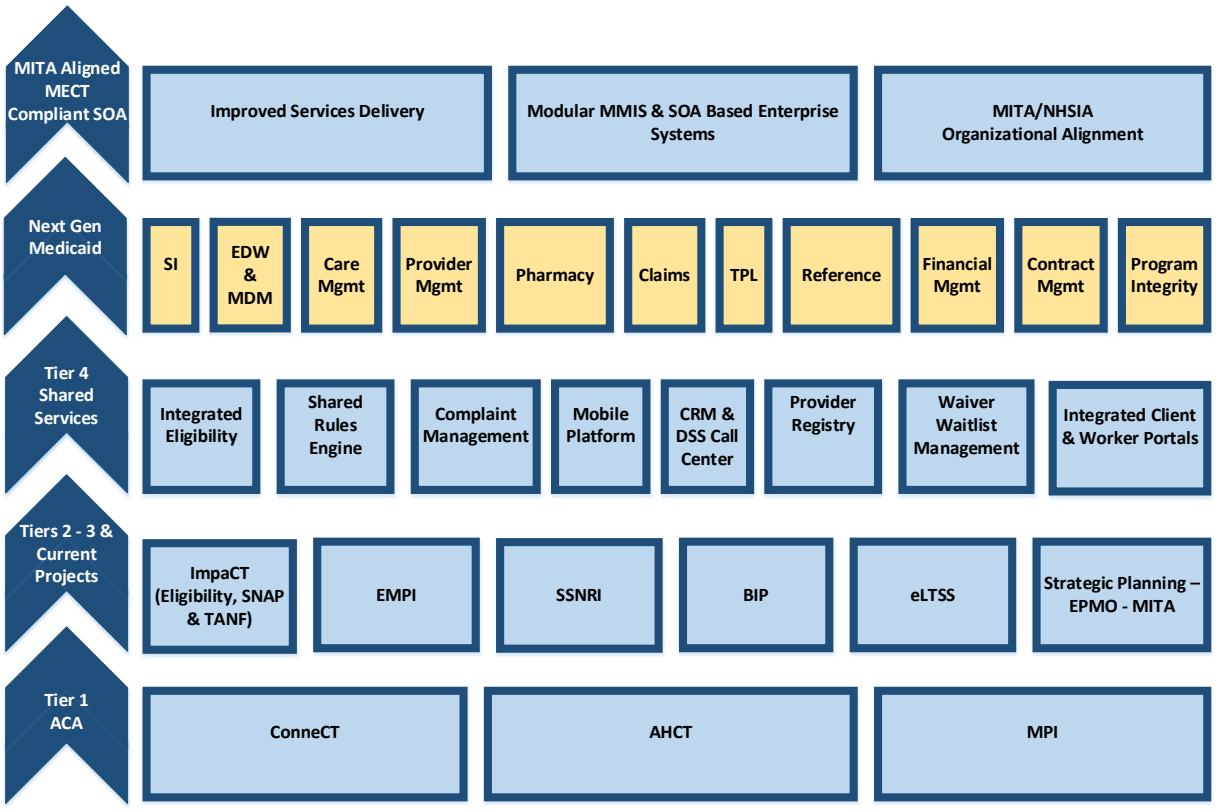


Figure 37 Tier Level Overview

The MITA and Medicaid MMIS Re-procurement process will leverage and enhance the infrastructure and advanced technology components achieved over the last few years as provided via the ACA. The end result of all these efforts and building blocks will ultimately yield a new Medicaid Enterprise and Service delivery model via a Modular and Integrated Medicaid Enterprise System (MME) that implements best-of-industry solutions from multiple vendors, integrate solutions at the data layer and employ a robust governance structure. The organization will also be re-aligned to the most efficient and effective organization structure to deliver those services in a fashion that improves health outcomes for the individuals serves. The MECL and MECT frameworks will be utilized as well as the NHSIA framework for growth beyond Medicaid. The MECL and MECT process are being used to frame MITA Roadmap Recommendations and introduce stage/phase gate methodologies for the MMIS replacement. The Medicaid Enterprise Certification Toolkit was developed to assist states as they plan, develop, test, and implement their Medicaid Management Information Systems (MMIS) and an updated Medicaid Enterprise Certification Lifecycle (MECL) provides templates and tools to assist in the certification process and introduces certification milestone reviews throughout the MMIS life cycle so the state

receives early feedback about issues that may impede certification. The findings of the MITA SS-A have brought forth a focus on the following key areas for transformation enablers and key initiative/efforts.

- **Organizational Change Management** – Connecticut will undergo organizational change to align to the MITA driven organizational capacity and improved processes, competencies, tools and technology. Internal processes and organization structure will be reviewed to deliver products and services better, faster, and cheaper.

- **Systems Integrator (SI)** – SI will be a critical player in achieving improvements with a modular approach to MMIS. SI will be responsible to:
    - Gather requirements and assist with RFP development and implementation of the various modular components - assure avoidance of lock-in to a single vendor or an otherwise closed set of solutions.
    - Ensure the integrity and interoperability of the Medicaid IT architecture and cohesiveness of the various modules incorporated into the Medicaid enterprise
    - Foster "best of breed" solutions for Medicaid business requirements
    - Successful integration of the chosen solutions and infrastructure into a seamless functional and interoperable system.
    - SI cannot bid on functional modules, but could provide parts of technical infrastructure such as the enterprise service bus, master data management, etc.
    - Integrated Platform – hardware/software/ implementation Plan
    - Integration management services

- **EDW -** A critical component will be to acquire a new Business Intelligence System (BIS) that can meet the specific modernized Connecticut Medicaid Enterprise needs such as:
    - Promote new models and modernization of care delivery
    - Efficiently promote a higher quality of care and improve health outcomes
    - Manage costs and cost saving provisions
    - Provide for data verification programs and quality assurance initiatives
    - Profile data across multiple dimensions to discover outliers in order to detect fraud, waste or abuse

  The EDW will include:
    - Decision Support System (DSS)
    - Surveillance Utilization Review Subsystem (SURS)
    - Transformed Medicaid Statistical Information System (T-MSIS)
    - Management Administration Reporting System (MARS)

- **Care Management**

The procurement of a robust and comprehensive care and case management module to bring the current siloed care management practices to standard, consistent care planning across the

Connecticut Medicaid Enterprise is a critical component. The module will include improvements to behavioral health integration, chronic care management and LTSS services. The care management module will allow for outreach to geographic and ethnic health disparities, focus on waiver management and include major improvements to transitional care management.

- **Pharmacy**

The new Connecticut Medicaid Enterprise will procure a state of the art Pharmacy Benefit Administrator that will manage the pharmacy benefit in a manner that focuses on the role medication therapy plays within the larger context of patient care and is user friendly for prescribing providers and Medicaid members with evidence based methods to assist in establishing policies, clinical criteria, claims edits and drug coverage rules. The new PBM will provide business operations services that include improved:

  - Claims adjudication and benefit plan support
  - Prior authorization
  - Preliminary payment editing and post payment analytics
  - Retrospective drug use review
  - Maximum allowable cost (MAC) list administration
  - Benefit plan consulting
  - Trend analysis and reporting
  - Rebate operations
  - Pricing and prior authorization for medical benefit drugs

- **Claims**

  Connecticut utilizes an ASO model in which the ASO utilizes functionality of the core MMIS systems to provide member services, utilization management, intensive care management, quality management and predictive modeling based on Medicaid data. The new claims processing system will support this model as well as provide for additional tools and functionality.

  The system will screen, and capture electronic images, and accept electronic claims attachments. This will reduce manual processing and reduce the number of adjustments. In addition, quality measures will increase from reduction of manual processes and reduction of rework and claims adjustments within the new system. The module will be positioned for growth and flexibility as Medicaid expands and implements new business models and service approaches. In the re-procurement of the new Connecticut Medicaid Enterprise components, a focus on modularized components as the most efficient and cost effective long-term solution will be required and will support an enterprise approach. The modular approach will support future changes and new programs/needs in the Medicaid program by providing better access to quality data and reduced time and cost to implement change.

- **Reference Management**

  The new MMIS will be procured as a modular approach consistent with CMS guidelines and DSS business needs. The solution will have a robust Reference Management module with a user interface and table driven administrative update capability for ease of

program and policy adjustments as well as on-line query capability and reference table audit trails of all changes.

- **TPL**

  The new Connecticut Medicaid Third Party Liability (TPL) solution will deliver state of the art administration of TPL services and will become an integral component in the modular approach. The solution will ensure data is properly exchanged and maintained and provide business operations that will ensure Medicaid is the payer of last resort. This will be a key component in cost containment goals.

  Business operations will include at a minimum:

  - Identification of and recovery from third-party resources and estates
  - TPL outreach
  - Interface with other systems and subsystems
  - Maintains original source of TPL information
  - Automation of TPL functions
  - Claims analysis for potential TPL triggers and activities
  - Insurance policy file maintenance
  - Private insurance industry analysis
  - Reports for TPL recoveries, funds and activities

- **Provider**

  The new provider management module will improve and consolidate the existing provider management functionality and activates into a robust solution which can be expanded as the needs of Connecticut change. The system will automate provider credentialing and enrollment activities for both medical and non-medical service providers. It will accept electronic images and attachments to improve the enrollment of providers. It will support provider outreach and provider communication and maintain an audit trail of changes. The solution will allow multiple address capabilities for providers and maintain multiple provider specific reimbursement rates supporting the ability for volume purchase contract or other cost-containment initiatives with begin and end effective dates. In addition, the solution will maintain up to date geographic data on each provider allowing for analysis of the Medicaid provider network by specialty across the state. The solution functions include:

  - Supports communications to and from providers and tracks/monitors responses
  - Supports provider appeals or request for review
  - Tracks provider review schedules
  - Verifies provider eligibility in support of claims processing
  - Cross references license and sanction information with other state or federal agencies
  - Generates notices of providers of expiring Medicaid agreements

- **Financial and Contractor Management** - A financial management module will support all cycles, and HHS programs, with financial expenditure reporting. Further it will provide a mechanism for a wide range of activities, from budget maintenance within DSS to Medicaid

remittance advice generation. A contract management module will allow for greater levels of vendor management through SLA, OLA and KPI tracking. Both modules directly and significantly impact operational aspects of DSS and the pursuit of higher levels of MITA maturity.

- **Program Integrity**

  The new Program Integrity module will improve the detection, identification, and review of suspected fraud, waste, and abuse in the Medicaid Program including innovative ways to detect fraud through expansion of data analysis techniques and the use of automated capabilities with information technology.

  The solution and services will include:

  - Design and implementation of a solution with best practices in fraud detection and reports required by CMS and Connecticut Medicaid. Tools and reports will be available to state agency staff.
  - Implementation of intuitive tools for the state agency to use parameterized reports and easy creation of ad-hoc reports.
  - Development and support of new methods of detecting and preventing fraud, waste, and abuse;
  - Implementation of automated monitoring and auto-generated alerts and workflow management to reduce administrative overhead
  - Establishment of a robust PI case management system to improve the administration of program integrity business functions
  - Provide Subject Matter Experts (SME) in Medicaid fraud, waste, and abuse to improve and provide ongoing, up-to-date support to the current review activities of Medicaid Providers and Participants

11. Appendix A - Connecticut MITA v3.0 Gap Analysis

Business Relationship Management			
MITA Business Area Definition:	The Business Relationship Management (BR) business area is a collection of business processes that facilitates the coordination of standards of interoperability. This business area defines the exchange of information and Trading Partner Agreements (TPA) between the State Medicaid Agency (SMA) and its partners, including collaboration among intrastate agencies, interstate agencies, and federal agencies. These agreements contain functionality for interoperability, establishment of inter-agency Service Level Agreements (SLA), identification of the types of information exchanged, and security and privacy requirements. The Business Relationship Management business area has a common focus (e.g., data exchange standards and SLA) and is responsible for the business relationship data store.		
MITA Business Processes:	BR01 BR02 BR03 BR04	Establish Business Relationship Manage Business Relationship Communication Manage Business Relationship Information Terminate Business Relationship	
	As-Is	**To-Be**	**Gap Mitigation**
Business Architecture Summary:	1	2	• Implement Organizational Change Management (OCM) to formalize, centralize and automate the processes • Implement a metrics based performance management program
Information Architecture Summary:	2	3	• Formalize Data Governance across the DSS enterprise • Develop an enterprise Level Conceptual Data Model (CDM) and Logical Data Model (LDM) • Implement an enterprise Level Data Management Strategy (DMS)
Technical Architecture Summary:	1	2	• Acquire and automate processes with a Contractor Management Module, with appropriate Service Oriented Architecture linkages • Acquire and utilize enterprise modeling tools (ex. BPEL, UML) • Implement an enterprise Level Technical Management Strategy (TMS)
7 Conditions & Standards Summary:	1	3	• Require formal process models based upon MITA/NHSIA (and other relevant federal frameworks) utilizing Business Process Modeling Notation (BPMN) • Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the Department of Social Services (DSS) enterprise

			• Maintain a formal inventory of interfaces, interface details, and trading partners for all systems across the DSS enterprise. • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements. • Align business processes to the MITA framework

Care Management			
MITA Business Area Definition:	The Care Management business area illustrates the increasing shift away from the Fee-For-Service (FFS) model of care. Care Management collects information about the needs of the individual member, plan of treatment, targeted outcomes, and the individual's health status. It also contains business processes that have a common purpose (e.g., identify members with special needs, assess needs, develop treatment plan, monitor and manage the plan, and report outcomes). This business area includes processes that support individual care management and population management. Population management targets groups of individuals with similar characteristics to promote health education and awareness. The Electronic Health Record (EHR), Electronic Medical Record (EMR), and Personal Health Record (PHR) can be primary sources of individual health information from the Health Information Exchange (HIE). Care Management includes Disease Management, Catastrophic Case Management, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Population Management, Patient Self-Directed Care Management, national health registries, and Waiver Program Case Management. The Care Management business area is responsible for case management, authorizations, referrals, treatment plans, and data stores. Care Management also contains business processes for authorization determination including authorizing referrals, as well as service and treatment plans.		
MITA Business Processes:	CM01 CM02 CM03 CM04 CM05 CM06 CM07 CM08 CM09	Establish Case Manage Case Information Manage Population Health Outreach Manage Registry Perform Screening and Assessment Manage Treatment Plan and Outcomes Authorize Referral Authorize Service Authorize Treatment Plan	
	As-Is	**To-Be**	**Gap Mitigation**
Business Architecture Summary:	1	2	• Implement OCM to formalize, centralize and automate processes • Develop and maintain MITA/NHSIA process models using BPMN • Automate and centralize processes and service authorizations.

Information Architecture Summary:	1	3	• Maintain a formal inventory of interfaces, interface details, and trading partners for all DSS Care Management partners • Formalize Data Governance (includes CDM, LDM, DMS) • Link Administrative Service Organizations (ASOs) and DSS systems utilizing SOA principles and technologies (e.g. ESB, rules engine)
Technical Architecture Summary:	1	3	• Acquire and automate processes with a Care Management Module, include functionality for case management, referral tracking, automated workflows and secure messaging
7 Conditions & Standards Summary:	1	3	• Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the DSS enterprise • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements. • Align business processes to the MITA framework

Contractor Management			
MITA Business Area Definition:	In Connecticut, the Contractor Management business area accommodates Administrative Service Organization (ASO) contracts and a variety of outsourced contracts. The Contractor Management business area has a common focus on Medicaid contractors (e.g., managed care, at-risk mental health or dental care, Primary Care Physician (PCP)), is responsible for contractor data store, and uses business processes that have a common purpose (e.g., Fiscal Agent, enrollment broker, Fraud Enforcement Agency, and third-party recovery).		
MITA Business Processes:	CO01 CO02 CO03 CO04 CO05 CO06 CO07 CO08 CO09	Manage Contractor Information Manage Contractor Communication Perform Contractor Outreach Inquire Contractor Information Produce Solicitation Award Contract Manage Contract Close Out Contract Manage Contractor Grievance and Appeal	
	As-Is	**To-Be**	**Gap Mitigation**
Business Architecture Summary:	1	2	• Implement OCM to formalize, centralize and automate processes • Develop and maintain MITA/NHSIA process models using BPMN

			• Implement automated workflows and a document management system with automated alert capabilities • Implement a metrics based performance management program
Information Architecture Summary:	2	3	• Maintain a formal inventory of interfaces, interface details, and trading partners for all DSS partners • Formalize Data Governance (includes CDM, LDM, DMS) • Maintain a services registry from available systems and vendors
Technical Architecture Summary:	1	2	• Acquire and automate processes with a Contractor Management Module, include functionality for invoice management, performance tracking, automated workflows and messaging
7 Conditions & Standards Summary:	1	3	• Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the DSS enterprise • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements. • Align business processes to the MITA framework

Eligibility & Enrollment Management			
MITA Business Area Definition:	The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicants, re-determination of existing members, enrolling new providers, and re-validation of existing providers. The Provider Enrollment business category and related business processes focus on patient safety and fraud prevention through functions such as determining screening level (i.e., limited, moderate, or high) for provider verifications. These processes share a common set of provider-related data for determination of eligibility, enrollment, and inquiry to provide services. The Eligibility and Enrollment Management business area is responsible for the eligibility and enrollment information of the member data store as well as the provider data store.		
MITA Business Processes:	EE01 EE02 EE03 EE04 EE05 EE06 EE07 EE08	Determine Member Eligibility Enroll Member Disenroll Member Inquire Member Eligibility Determine Provider Eligibility Enroll Provider Disenroll Provider Inquire Provider Information	
	As-Is	**To-Be**	**Gap Mitigation**
Business Architecture Summary:	2	3	• Implement OCM to formalize, centralize and automate processes • Develop and maintain MITA/NHSIA process models using BPMN • Consolidate member eligibility and enrollment processes through the Shared Services DSS strategic vision
Information Architecture Summary:	1	3	• Formalize Data Governance (includes CDM, LDM, DMS) • Maintain a services registry from available systems and vendors • Utilize a Systems Integrator (SI) to link all relevant systems to SOA based technologies utilizing an ESB and common rules engine
Technical Architecture Summary:	1	3	• Acquire and implement an enterprise level Data Warehouse to receive, exchange and report on all DSS systems data and services data from trading partners • Implement the Shared Services DSS strategic vision, and continue the active implementation of the ImpaCT system for member eligibility

			• Acquire and implement a Provider Management Module as part of SOA adoption and phased MMIS replacement
7 Conditions & Standards Summary:	1	3	• Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the DSS enterprise • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements. • Align business processes to the MITA framework

Financial Management			
MITA Business Area Definition:	The Financial Management business area is a collection of business processes to support the payment of providers, ASOs, other agencies, insurers, and Medicare premiums; and supports the receipt of payments from other insurers, providers, and member premiums and financial participation. These processes share a common set of payment and receivables-related data. The Financial Management business area is responsible for the financial data store.		
MITA Business Processes:	FM01	Manage Provider Recoupment	
	FM02	Manage TPL Recovery	
	FM03	Manage Estate Recovery	
	FM04	Manage Drug Rebate	
	FM05	Manage Cost Settlement	
	FM06	Manage Accounts Receivable Information	
	FM07	Manage Accounts Receivable Funds	
	FM08	Prepare Member Premium Invoice	
	FM09	Manage Contractor Payment	
	FM10	Manage Member Financial Participation	
	FM11	Manage Capitation Payment (Note: Process not performed in CT)	
	FM12	Manage Incentive Payment	
	FM13	Manage Accounts Payable Information	
	FM14	Manage Accounts Payable Disbursement	
	FM15	Manage 1099	
	FM16	Formulate Budget	
	FM17	Manage Budget Information	
	FM18	Manage Fund	
	FM19	Generate Financial Report	
	As-Is	**To-Be**	**Gap Mitigation**
Business Architecture Summary:	1	2	• Implement OCM to formalize, centralize and automate processes • Develop and maintain MITA/NHSIA process models using BPMN • Develop and utilize an enterprise Data Warehouse, MITA based SOA, and MMIS modules articulated in the Roadmap to improve reporting and financial analysis
Information Architecture Summary:	1	2	• Formalize Data Governance (includes CDM, LDM, DMS) • Acquire and implement an enterprise level Data Warehouse to receive, exchange and report on all DSS systems data and services data from trading partners

Technical Architecture Summary:	1	2	• Acquire and implement an enterprise level Data Warehouse • Acquire and implement MMIS replacement modules consistent with the MECT Checklist and Connecticut Roadmap- including but not limited to: Financial, Contract, Reference Data, Third Party Liability, Claims Processing, and Pharmacy Management
7 Conditions & Standards Summary:	1	3	• Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the DSS enterprise • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements.
Member Management			
MITA Business Area Definition:	Note: Due to the regulation rule-making efforts underway at CMS, the MITA Framework 3.0 does not include the Member Management business processes or business capability matrices. However, in order to provide a complete assessment, the MITA 2.01 definitions were used. Member Management activities are distributed throughout DSS and among external partners. Within DSS, Eligibility Policy and Program Support and the Division of Health Services share primary responsibility for the processes within the MITA Business Area.		
MITA Business Processes:	ME01 ME02 ME03 ME08	Manage Member Information Manage Applicant and Member Communication Perform Population and Member Outreach Manage Member Grievance and Appeal	
	As-Is	**To-Be**	**Gap Mitigation**
Business Architecture Summary:	2	3	• Implement OCM to formalize, centralize and automate processes • Develop and maintain MITA/NHSIA process models using BPMN • Consolidate member eligibility and enrollment processes through the Shared Services DSS strategic vision • Consolidate and centrally manage the member portal
Information Architecture Summary:	1	3	• Formalize Data Governance (includes CDM, LDM, DMS) • Utilize a Systems Integrator (SI) to link all relevant systems to SOA based technologies utilizing an ESB and common rules engine • Acquire and implement an enterprise level Data Warehouse to receive, exchange and report on all DSS systems data and services data from trading partners

Technical Architecture Summary:	1	3	• Implement the Shared Services DSS strategic vision, and continue the active implementation of the ImpaCT system for member eligibility • Ensure integration and adoption of an Enterprise Master Person Index (EMPI) for member management and service coordination • Acquire and automate processes with a Care Management Module, include functionality for case management, referral tracking, automated workflows and secure messaging
7 Conditions & Standards Summary:	1	3	• Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the DSS enterprise • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements. • Align business processes to the MITA framework

Operations Management			
MITA Business Area Definition:	The Operations Management business area is a collection of business processes that manage claims and prepare premium payments. This business area uses a specific set of claims-related data and includes processing (i.e., editing, auditing, and pricing) a variety of forms for professional, dental, institutional, and drug claims, as well as sending payment information to the provider. All claim processing activity incorporates compatible methodologies of the National Correct Coding Initiative (NCCI). The Operations Management business area is responsible for the claims data store.		
MITA Business Processes:	OM04 OM05 OM07 OM14 OM18 OM20 OM27 OM28 OM29	Submit Electronic Attachment Apply Mass Adjustment Process Claim Generate Remittance Advice Inquire Payment Status Calculate Spend Down Amount Prepare Provider Payment Manage Data Process Encounter (Note: Process not performed in CT)	
	As-Is	**To-Be**	**Gap Mitigation**
Business Architecture Summary:	1	2	• Implement OCM to formalize, centralize and automate processes • Develop and maintain MITA/NHSIA process models using BPMN
Information Architecture Summary:	1	2	• Formalize Data Governance (includes CDM, LDM, DMS) • Utilize a Systems Integrator (SI) to link all relevant systems to SOA based technologies utilizing an ESB and common rules engine
Technical Architecture Summary:	1	2	• Acquire and implement an enterprise level Data Warehouse • Acquire and implement MMIS replacement modules consistent with the MECT Checklist and Connecticut Roadmap • Implement the ability to accept electronic attachments • Pursue automation for all claim types
7 Conditions & Standards Summary:	1	3	• Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the DSS enterprise • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements. • Align business processes to the MITA framework

Performance Management			
MITA Business Area Definition:	The Performance Management business area is a collection of business processes involved in the assessment of program compliance (e.g., auditing and tracking medical necessity and appropriateness of care, quality of care, patient safety, fraud and abuse, erroneous payments, and administrative anomalies). This business area uses information regarding an individual provider or member (e.g., demographics, information about the case itself such as case manager ID, dates, actions, and status, and information about parties associated with the case), and uses this information to perform functions related to utilization and performance. The Performance Management business area is responsible for the business activity and compliance data stores.		
MITA Business Processes:	PE01 PE02 PE03 PE04 PE05	Identify Utilization Anomalies Establish Compliance Incident Manage Compliance Incident Information Determine Adverse Action Incident Prepare REOMB	
	As-Is	**To-Be**	**Gap Mitigation**
Business Architecture Summary:	1	2	• Implement OCM to formalize, centralize and automate processes • Develop and maintain MITA/NHSIA process models using BPMN • Develop and utilize an enterprise Data Warehouse, MITA based SOA, and MMIS modules articulated in the Roadmap to improve reporting and financial analysis
Information Architecture Summary:	1	2	• Formalize Data Governance (includes CDM, LDM, DMS) • Utilize a Systems Integrator (SI) to link all relevant systems to SOA based technologies utilizing an ESB and common rules engine • Acquire and implement an enterprise level Data Warehouse to receive, exchange and report on all DSS systems data and services data from trading partners
Technical Architecture Summary:	1	2	• Acquire and implement an enterprise level Data Warehouse • Acquire and implement MMIS replacement modules consistent with the MECT Checklist and Connecticut Roadmap • Acquire a Performance Management Module as part of the MMIS

			• Acquire and implement unified document management with automated workflows
7 Conditions & Standards Summary:	1	3	• Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the DSS enterprise • Maintain a formal inventory of interfaces, interface details, and trading partners for all systems across the DSS enterprise. • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements. • Align business processes to the MITA framework

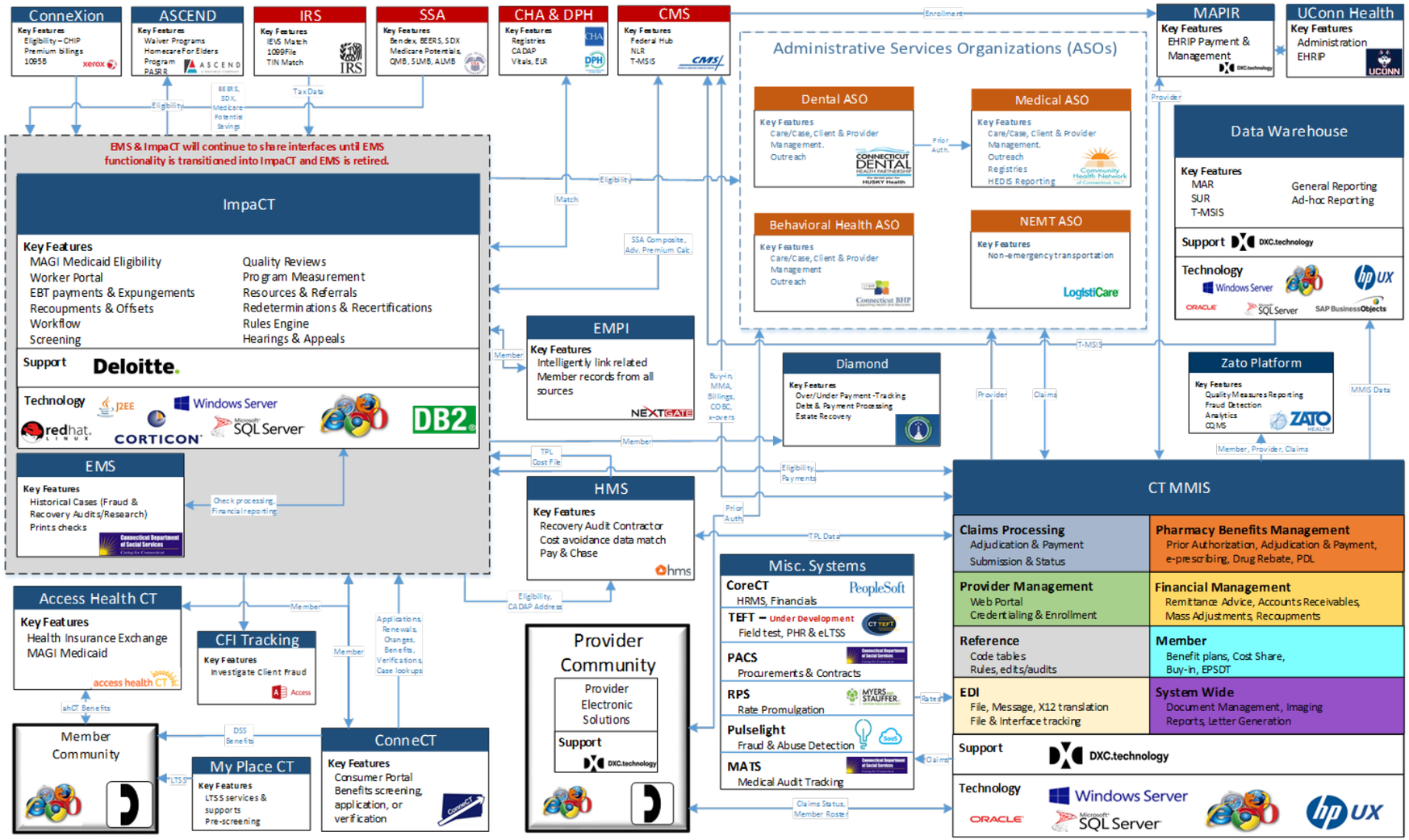
Plan Management			
MITA Business Area Definition:	The Plan Management business area includes the strategic planning, policymaking, monitoring, and oversight business processes of DSS. This business area is responsible for the primary data stores (e.g., Medicaid State Plan, health plans, and health benefits) as well as performance measures, reference information, and rate setting data stores. The business processes include a wide range of planning, analysis, and decision-making activities. These activities include service needs and goals, health care outcome targets, quality assessment, performance and outcome analysis, and information management. As the Medicaid enterprise matures, Plan Management benefits from immediate access to information, addition of clinical records, use of nationally recognized standards, and interoperability with other programs. The Medicaid Program is moving from a focus on daily operations (e.g., number of claims paid) to a strategic focus on how to meet the needs of the population within a prescribed budget.		
MITA Business Processes:	PL01 PL02 PL03 PL04 PL05 PL06 PL07 PL08	Develop Agency Goals and Objectives Maintain Program Policy Maintain State Plan Manage Health Plan Information Manage Performance Measures Manage Health Benefit Information Manage Reference Information Manage Rate Setting	
	As-Is	**To-Be**	**Gap Mitigation**

Business Architecture Summary:	1	2	• Implement Organizational Change Management (OCM) to formalize, centralize and automate the processes • Implement a metrics based performance management program • Develop and maintain MITA/NHSIA process models using BPMN
Information Architecture Summary:	1	3	• Formalize Data Governance (includes CDM, LDM, DMS) • Utilize a Systems Integrator (SI) to link all relevant systems to SOA based technologies utilizing an ESB and common rules engine • Implement an enterprise level Data Warehouse to exchange and report on all DSS systems and services data from trading partners
Technical Architecture Summary:	1	3	• Acquire and implement an enterprise level Data Warehouse • Acquire and implement MMIS replacement modules consistent with the MECT Checklist and Connecticut Roadmap • Acquire and implement unified document management with automated workflows
7 Conditions & Standards Summary:	1	3	• Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the DSS enterprise • Maintain a formal inventory of interfaces, interface details, and trading partners for all systems across the DSS enterprise. • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements. • Align business processes to the MITA framework

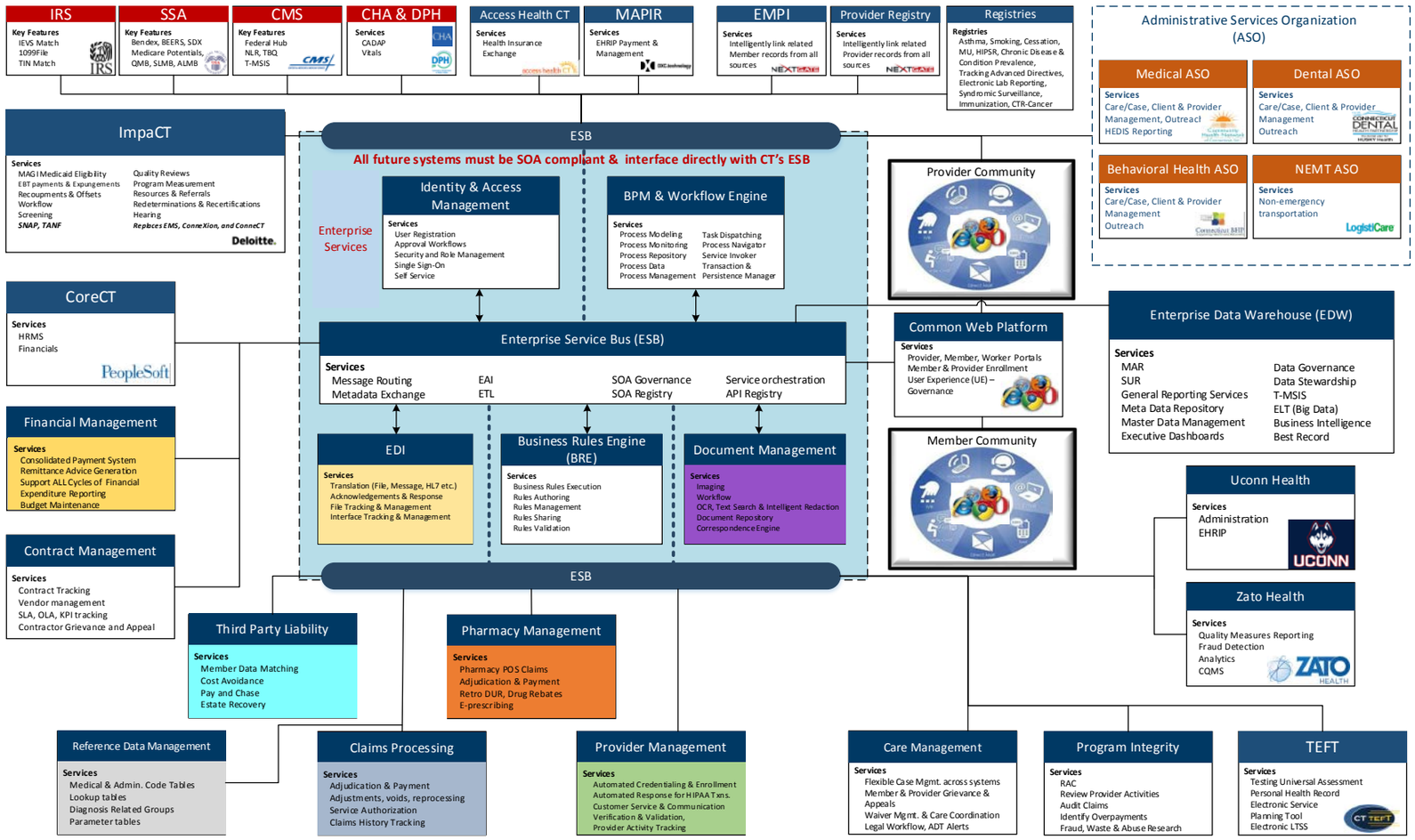
Provider Management		
MITA Business Area Definition:	The Provider Management business area is a collection of business processes involved in communications between the State Medicaid Agency (SMA) and the prospective or enrolled provider and actions that DSS takes on behalf of the provider. Business processes focus on terminating providers, communications with providers, dealing with provider grievance and appeal issues, and performing outreach services to providers. The Provider Management business area is responsible for the provider data store.	
MITA Business Processes:	PM01	Manage Provider Information
	PM02	Manage Provider Communication
	PM03	Perform Provider Outreach
	PM07	Manage Provider Grievance and Appeal

	PM08	Terminate Provider	
	As-Is	**To-Be**	**Gap Mitigation**
Business Architecture Summary:	2	3	• Implement OCM to formalize, centralize and automate processes • Develop and maintain MITA/NHSIA process models using BPMN • Enhance web portal to include self-service options for tasks and the ability to upload and attach supporting documentation
Information Architecture Summary:	1	3	• Formalize Data Governance (includes CDM, LDM, DMS) • Utilize a Systems Integrator (SI) to link all relevant systems to SOA based technologies utilizing an ESB and common rules engine • Acquire and implement an enterprise level Data Warehouse to receive, exchange and report on all DSS systems data and services data from trading partners
Technical Architecture Summary:	1	2	• Ensure integration and adoption of the Provider Registry to augment Provider management and service coordination • Acquire and automate processes with a Provider Management Module which includes automated workflows and secure messaging
7 Conditions & Standards Summary:	1	3	• Adopt and implement a formal Systems Development Lifecycle Methodology (SDLC) across the DSS enterprise • Formally adopt and incorporate the MITA framework for the DSS enterprise in the DMS, TMS, and future procurements. • Align business processes to the MITA framework

Appendix B


ConneXion
Key Features
Eligibility – CHIP
Premium billings
10958
xerox
ASCEND
Key Features
Waiver Programs
Homecare For Elders
Program
PASRR
IRS
Key Features
IEVS Match
1099File
TIN Match
SSA
Key Features
Bendex, BEERS, SDX
Medicare Potentials,
QMB, SLMB, ALMB
CHA & DPH
Key Features
Registries
CADAP
Vitals, EIR
CMS
Key Features
Federal Hub
NLR
T-MSIS
Enrollment
MAPIR
Key Features
EHRIP Payment & Management
UConn Health
Key Features
Administration
EHRIP
Eligibility
BEERS, SDX, Medicare Potential Savings
Tax Data
Provider
Administrative Services Organizations (ASOs)
Dental ASO
Key Features
Care/Case, Client & Provider Management.
Outreach
Prior Auth.
Medical ASO
Key Features
Care/Case, Client & Provider Management.
Outreach
Registries
HEDIS Reporting
Behavioral Health ASO
Key Features
Care/Case, Client & Provider Management
Outreach
NEMT ASO
Key Features
Non-emergency transportation
LogistiCare
Data Warehouse
Key Features
MAR
SUR
T-MSIS
General Reporting
Ad-hoc Reporting
Support
DXC.technology
Technology
Windows Server
SQL Server
ORACLE
SAP BusinessObjects
EMS & ImpaCT will continue to share interfaces until EMS functionality is transitioned into ImpaCT and EMS is retired.
ImpaCT
Key Features
MAGI Medicaid Eligibility
Worker Portal
EBT payments & Expungements
Recoupments & Offsets
Workflow
Screening
Quality Reviews
Program Measurement
Resources & Referrals
Redeterminations & Recertifications
Rules Engine
Hearings & Appeals
Support
Deloitte.
Technology
J2EE
Windows Server
redhat.
CORTICON
SQL Server
DB2
Eligibility
Match
SSA Composite, Adv. Premium Calc.
EMPI
Key Features
Intelligently link related Member records from all sources
NEXTGATE
Member
Buy-in, MMA, Billings, COBC, x-overs
Diamond
Key Features
Over/Under Payment -Tracking
Debt & Payment Processing
Estate Recovery
T-MSIS
Zato Platform
Key Features
Quality Measures Reporting
Fraud Detection
Analytics
CQMS
ZATO
MMIS Data
Member, Provider, Claims
Provider
Claims
EMS
Key Features
Historical Cases (Fraud & Recovery Audits/Research)
Prints checks
Check processing, Financial reporting
TPL
Cost File
Member
Eligibility, Payments
HMS
Key Features
Recovery Audit Contractor
Cost avoidance data match
Pay & Chase
hms
Prior Auth.
TPL Data
CT MMIS
Claims Processing
Adjudication & Payment
Submission & Status
Pharmacy Benefits Management
Prior Authorization, Adjudication & Payment, e-prescribing, Drug Rebate, PDL
Provider Management
Web Portal
Credentialing & Enrollment
Financial Management
Remittance Advice, Accounts Receivables, Mass Adjustments, Recoupments
Reference
Code tables
Rules, edits/audits
Member
Benefit plans, Cost Share, Buy-in, EPSDT
EDI
File, Message, X12 translation
File & Interface tracking
System Wide
Document Management, Imaging
Reports, Letter Generation
Support
DXC.technology
Technology
Windows Server
SQL Server
ORACLE
Misc. Systems
CoreCT
HRMS, Financials
PeopleSoft
TEFT – Under Development
Field test, PHR & eLTSS
PACS
Procurements & Contracts
RPS
Rate Promulgation
Pulselight
Fraud & Abuse Detection
MATS
Medical Audit Tracking
Rates
Claims
Access Health CT
Key Features
Health Insurance Exchange
MAGI Medicaid
access health CT
Member
CFI Tracking
Key Features
Investigate Client Fraud
Access
Applications, Renewals, Changes, Benefits, Verifications, Case lookups
Eligibility, CADAP Address
Provider Community
Provider Electronic Solutions
Support
DXC.technology
Claims Status, Member Roster
ahCT Benefits
Member Community
DSS Benefits
My Place CT
Key Features
LTSS services & supports
Pre-screening
LTSS
ConneCT
Key Features
Consumer Portal
Benefits screening, application, or verification

Appendix C


IRS
Key Features
IEVS Match
1099File
TIN Match
SSA
Key Features
Bendex, BEERS, SDX
Medicare Potentials,
QMB, SLMB, ALMB
CMS
Key Features
Federal Hub
NLR, TBQ
T-MSIS
CHA & DPH
Services
CADAP
Vitals
Access Health CT
Services
Health Insurance Exchange
MAPIR
Services
EHRIP Payment & Management
EMPI
Services
Intelligently link related Member records from all sources
Provider Registry
Services
Intelligently link related Provider records from all sources
Registries
Registries
Asthma, Smoking, Cessation, MU, HIPSR, Chronic Disease & Condition Prevalence, Tracking Advanced Directives, Electronic Lab Reporting, Syndromic Surveillance, Immunization, CTR-Cancer
Administrative Services Organization (ASO)
Medical ASO
Services
Care/Case, Client & Provider Management, Outreach
HEDIS Reporting
Dental ASO
Services
Care/Case, Client & Provider Management
Outreach
Behavioral Health ASO
Services
Care/Case, Client & Provider Management
Outreach
NEMT ASO
Services
Non-emergency transportation
LogistiCare
ImpaCT
Services
MAGI Medicaid Eligibility
EBT payments & Expungements
Recoupments & Offsets
Workflow
Screening
SNAP, TANF
Quality Reviews
Program Measurement
Resources & Referrals
Redeterminations & Recertifications
Hearing
Replaces EMS, ConneXion, and ConneCT
Deloitte.
ESB
All future systems must be SOA compliant & interface directly with CT's ESB
Enterprise Services
Identity & Access Management
Services
User Registration
Approval Workflows
Security and Role Management
Single Sign-On
Self Service
BPM & Workflow Engine
Services
Process Modeling
Process Monitoring
Process Repository
Process Data
Process Management
Task Dispatching
Process Navigator
Service Invoker
Transaction & Persistence Manager
Provider Community
CoreCT
Services
HRMS
Financials
PeopleSoft
Enterprise Service Bus (ESB)
Services
Message Routing
Metadata Exchange
EAI
ETL
SOA Governance
SOA Registry
Service orchestration
API Registry
Common Web Platform
Services
Provider, Member, Worker Portals
Member & Provider Enrollment
User Experience (UE) – Governance
Enterprise Data Warehouse (EDW)
Services
MAR
SUR
General Reporting Services
Meta Data Repository
Master Data Management
Executive Dashboards
Data Governance
Data Stewardship
T-MSIS
ELT (Big Data)
Business Intelligence
Best Record
Financial Management
Services
Consolidated Payment System
Remittance Advice Generation
Support ALL Cycles of Financial
Expenditure Reporting
Budget Maintenance
EDI
Services
Translation (File, Message, HL7 etc.)
Acknowledgements & Response
File Tracking & Management
Interface Tracking & Management
Business Rules Engine (BRE)
Services
Business Rules Execution
Rules Authoring
Rules Management
Rules Sharing
Rules Validation
Document Management
Services
Imaging
Workflow
OCR, Text Search & Intelligent Redaction
Document Repository
Correspondence Engine
Member Community
Uconn Health
Services
Administration
EHRIP
UCONN
Contract Management
Services
Contract Tracking
Vendor management
SLA, OLA, KPI tracking
Contractor Grievance and Appeal
ESB
Zato Health
Services
Quality Measures Reporting
Fraud Detection
Analytics
CQMS
ZATO HEALTH
Third Party Liability
Services
Member Data Matching
Cost Avoidance
Pay and Chase
Estate Recovery
Pharmacy Management
Services
Pharmacy POS Claims
Adjudication & Payment
Retro DUR, Drug Rebates
E-prescribing
Reference Data Management
Services
Medical & Admin. Code Tables
Lookup tables
Diagnosis Related Groups
Parameter tables
Claims Processing
Services
Adjudication & Payment
Adjustments, voids, reprocessing
Service Authorization
Claims History Tracking
Provider Management
Services
Automated Credentialing & Enrollment
Automated Response for HIPAA Txns.
Customer Service & Communication
Verification & Validation,
Provider Activity Tracking
Care Management
Services
Flexible Case Mgmt. across systems
Member & Provider Grievance & Appeals
Waiver Mgmt. & Care Coordination
Legal Workflow, ADT Alerts
Program Integrity
Services
RAC
Review Provider Activities
Audit Claims
Identify Overpayments
Fraud, Waste & Abuse Research
TEFT
Services
Testing Universal Assessment
Personal Health Record
Electronic Service
Planning Tool
Electronic LTSS
CT TEFT

Connecticut Department of Social Services

Making a Difference

MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)

3.0 STATE SELF-ASSESSMENT

Roadmap

Contents

6. Introduction – Connecticut MITA Initiative

The Connecticut Medicaid Information Technology Architecture (MITA) 3.0 State Self-Assessment (SS-A) was undertaken to assess the Connecticut Medicaid Enterprise (CME) in accordance with CMS guidance to help the state determine the best course of action for transforming Connecticut Medicaid to a MITA aligned enterprise. The Department of Social Services (DSS) is Connecticut's State Medicaid Agency.

The transformation and this Roadmap are planned to fully meet the Seven Conditions and Standards. In conducting the SS-A, Connecticut applied the standard/condition to each MITA Architecture Area.

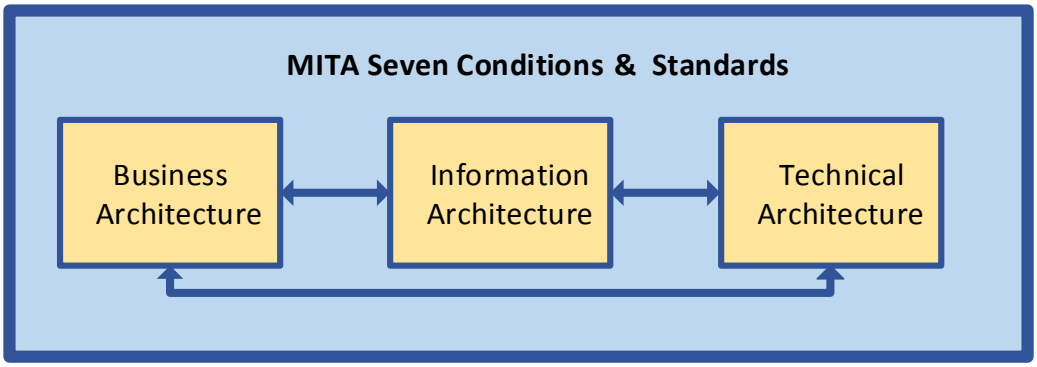


Figure 38 MITA Framework

To receive enhanced Federal Financial Participation (FFP), States submitting partial system updates will need to submit and have an approved MITA Roadmap for achieving full compliance with the Seven Standards and Conditions. CMS will track progress against an approved roadmap when determining if system updates meet the Seven Standards and Conditions for the enhanced match. Connecticut followed CMS guidance by using these Goals and Objectives in the development of their Roadmap:

- Customers should experience a high level of service, support, and ease of use, similar to that experienced by customers of leading service and retail companies and organizations doing business in the United States. States should aim to provide the same customer experience to all individuals seeking coverage, regardless of source or amount of financial assistance for which they may qualify or whether they enter the process through the Exchange, Medicaid, or Children's Health Insurance Program (CHIP). States should aim to replicate this customer experience with other stakeholders and business partners, including plans, employers, and Navigators.
- States should make it easy for individuals to explore information on their health coverage options, and should quickly and accurately enroll individuals into coverage. For most people, this routing and enrollment in the Exchange, Medicaid, or CHIP will happen in real time. Some people may experience discrepancies between the information they provide and the information obtained through authoritative sources, which affects their eligibility. For those individuals, federal law requires a timely and responsive resolution process. Other individuals may seek a specific determination by Medicaid (because of disability, for example) that may require more information and processing time.
- Most individuals are evaluated for eligibility in the Exchange, tax credits, Medicaid, and CHIP using a coordinated set of rules. As a result, we expect the use of a common or shared eligibility system or service to adjudicate placement for most individuals. Integration of systems, programs, and administration will limit duplication of costs, processes, data, and effort on the part of either the state or the beneficiary. Such integration will support

Exchanges as they execute responsibilities for Medicaid and CHIP eligibility determinations under federal law and Medicaid and CHIP agencies that interact with Exchange-eligible individuals.

- States should not assume they will have to operate a "shadow eligibility system" for the purpose of claiming appropriate match for Medicaid individuals based on whether they were eligible under state rules in effect prior to 2014 or are "newly eligible." Federal rulemaking will propose other methods for managing appropriate accounting between the federal and state governments.
- A federal data services hub will support certain functions and responsibilities of the Exchange, Medicaid, and CHIP.
- IT systems should be able to generate data in support of performance management, public transparency, policy analysis, program integrity, and program evaluation.

The DSS executive leadership team is engaged in a strategic planning process which has produced a mission, vision, cross-cutting principles, goals, and objectives for the agency. It articulates the following:

Consistent with federal and state policies, DSS works in partnership with various stakeholders across the health care delivery system to ensure that eligible people in Connecticut receive the support and services necessary to promote self-sufficiency, improved well-being, and positive health outcomes.

11. Roadmap Activities

The Medicaid Enterprise transformation effort will build upon prior efforts and initiatives to further advance positive Connecticut health outcomes. As an example, many of the changes required to meet 2010 Affordable Care Act (ACA) requirements brought with them opportunities for Connecticut to take advantage of increased capabilities that can be built upon as outlined in the 7C&S for re-use in achieving a higher MITA maturity level and ultimately a full transformation of the Medicaid Enterprise. The following depicts and summarizes the trajectory of the Connecticut Medicaid Enterprise over the last several years and how that effort is paving the way for the current Medicaid transformation and MITA maturity efforts.

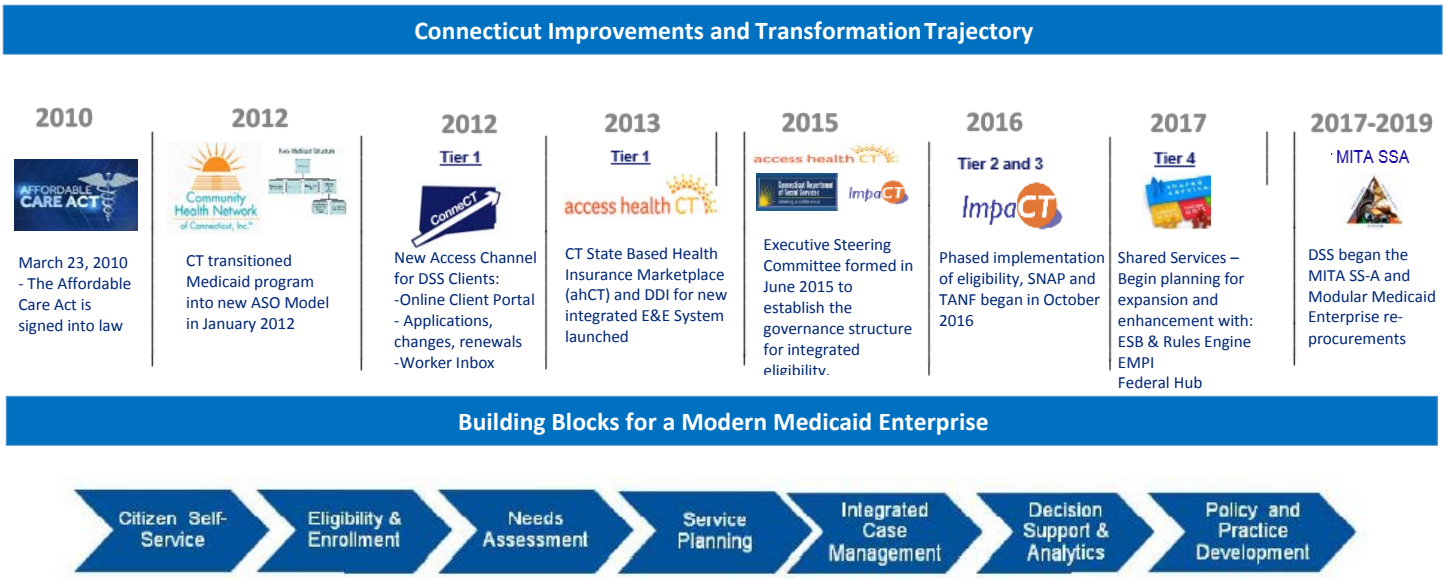


Figure 39 Connecticut Improvements and Transformation Trajectory

Connecticut is strategically building upon the ACA related projects and Shared Services Initiative as the foundation for the Medicaid re-procurement and transformation. As described in the MITA Concept of Operations, Building on Tiers 1, 2, and 3 architecture and infrastructure, and Tier 4 Shared Services, the existing components will be enhanced where necessary and will be extended and refined to utilize for the Medicaid MITA/MECT aligned Enterprise.

Project plans will be formalized as part of the MMIS Concept of Operations and submitted during the Medicaid Enterprise Certification Lifecycle (MECL). An IAPD will be prepared to seek CMS approval to proceed with the project. In accordance with MECL, Connecticut has elected to pursue the MMIS oriented approach to MMIS replacement, with customizations

including the creation of an Enterprise Data Warehouse, as well as Financial and Contract Management as defined by MITA. The following roles and modules are called for as part of the Roadmap and To-Be MITA Concept of Operations:

- Independent Verification and Validation
- Systems Integrator
- Organizational Change Management
- Reference Management Module
- Enterprise Data Warehouse
- Care Management Module
- Provider Management Module
- Claims Management Module
- Pharmacy Management Module
- Third Party Liability
- Program Integrity Module
- Financial and Contract Management Module

In addition to the procurement of new technology for the Next Gen Medicaid Enterprise Management System, the Roadmap recommends a restructuring of DSS's organization to support national frameworks including MITA, the National Human Services Interoperability Architecture (NHSIA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) framework, according to process-oriented models. An Organizational Change Management initiative is expected to commence quickly, as shown in the Roadmap Timeline, to bolster leadership efforts to integrate the technology and processes with DSS culture.

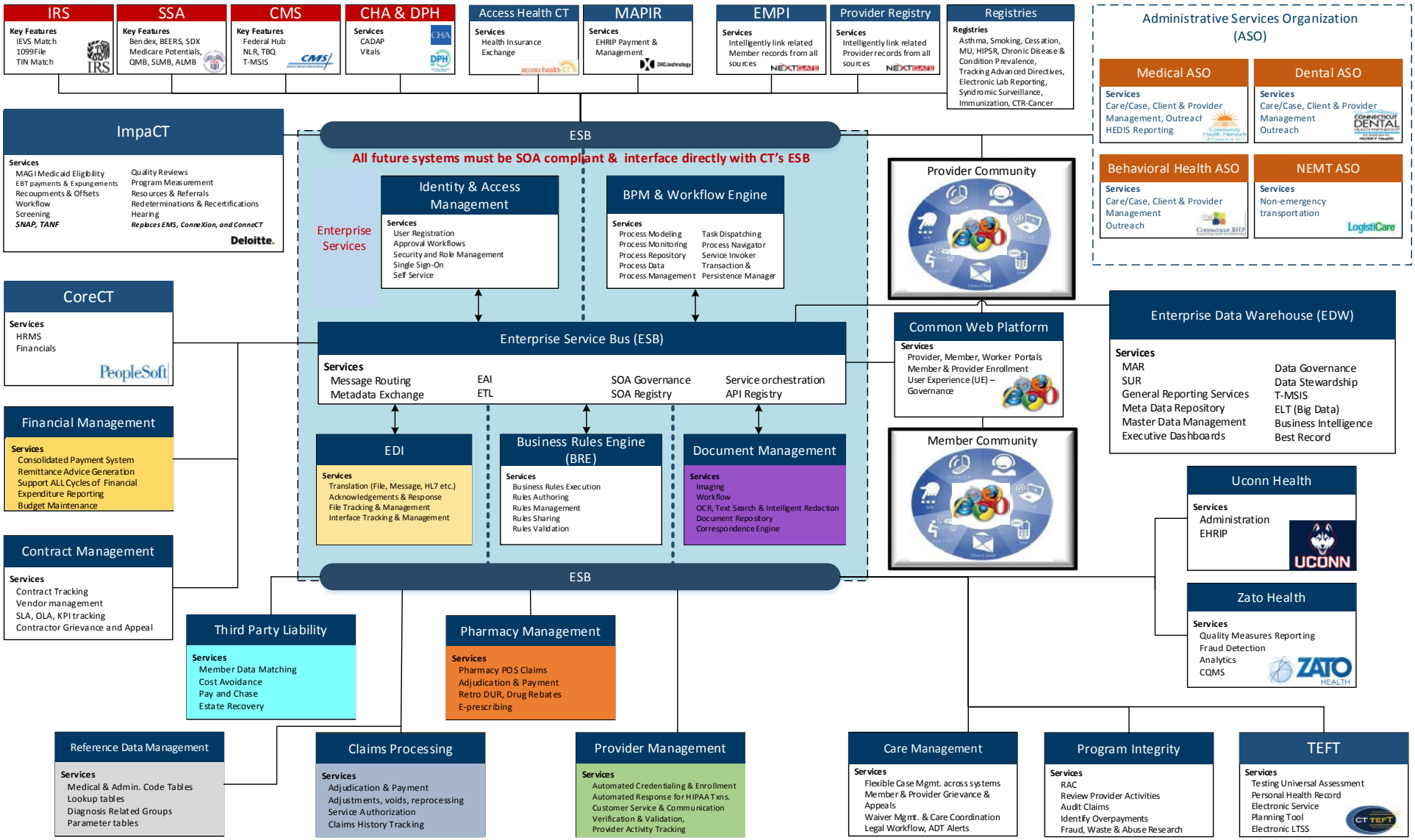


Figure 40 To-Be Concept of Operations Diagram

12. Roadmap Timeline

The timeline below presents a summary level view of procurement activities which support both a modular MMIS and Service Oriented Architecture:

Revised: 9/13/2017

Final Draft MITA Timeline

No.	Procurement/Activity	2017								2018												2019												2020												2021											
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	IV&V																																																						
	IAPD																																																						
	DMS, TMS, MMIS ConOps																																																						
2	Organizational Change Management																																																						
3	Systems Integrator																																																						
4	Reference Management Module																																																						
5	Enterprise Data Warehouse																																																						
6	Care Management																																																						
7	Provider Management																																																						
8	Claims Management																																																						
9	Pharmacy Management																																																						
10	Third Party Liability																																																						
11	Program Integrity																																																						
12	Financial & Contract Management																																																						

Stakeholder Engagement
Requirements Development
DSS/DAS RFP Drafting
Procurement Execution
CMS Approval
Planning/DDI
Certification Period
Ongoing Activity
Indicates Preliminary Plan- Systems Integrator will help facilitate- and assist with requirements/activities

4. Roadmap Procurements

Independent Verification and Validation	
Description:	The Independent Verification and Validation (IV&V) contractor represents state and Centers for Medicare and Medicaid Services (CMS) interests throughout each project and provides an independent and unbiased perspective on the progress of system development and the integrity and functionality of the MMIS modules. The scope of IV&V responsibilities is detailed in the MECT and includes evaluation of project management and performance, project development and testing processes, and technical reviews of the modules. The IV&V contractor must also verify that adequate regression testing has been performed to confirm that the replaced or enhanced module does not adversely impact the functionality and operation of the MMIS, E&E systems, or other related components of the state's Medicaid Enterprise.
MITA Business Area(s):	All
Estimated Cost:	*TBD*
Estimated Timeframe:	June 2018 - September 2021
Key Functions:	• Required and defined by 45 CFR 95.626 • Reviews and makes recommendations on the management of projects, both by state and vendor(s), and technical aspects of the projects • Incorporates criteria and standard language defined in the Medicaid Enterprise Certification Toolkit (MECT) • Monitors project and technical progress against the state's baseline plans and against requirements contained within the MECT Checklists

Organizational Change Management	
Description:	The Organizational Change Management (OCM) contractor will guide DSS to create a foundation for member-centric care by creating process oriented structures. Governance will be implemented to support data and the technical environment for use with modular services and Service Oriented Architecture. DSS leadership will engage stakeholders and follow a communication plan to effect a successful transition project. Business processes and expected outcomes will be defined according to national frameworks, and technology will support the needs of stakeholders.
MITA Business Area(s):	All
Estimated Cost:	*TBD*
Estimated Timeframe:	September 2018 – September 2021
Key Functions:	• Data gathering for existing processes, roles, and responsibilities, including documentation and development of Business Process Modeling Notation (BPMN) workflows for current business processes • Skills and gap analyses • Process alignment to MITA/NHSIA/SAMHSA frameworks • Training • Defining roles, strategic objectives, and key performance indicators

Systems Integrator	
Description:	The role of the Systems Integrator (SI) is critical to modular system design, development, and implementation as defined by CMS through State Medicaid Director letter 16-010 and the Medicaid Enterprise Certification Toolkit. The SI coordinates the merger of technical solutions, modules, and testing schedules, to achieve both state and CMS project goals.
MITA Business Area(s):	All
Estimated Cost:	*TBD*
Estimated Timeframe:	October 2018 – September 2021
Key Functions:	• Enterprise Service Bus (ESB) • Business Rules Engine (BRE) • Electronic Data Interchange (EDI) • Identity and Access Management • Business Process Modeling Tools • Workflow Engine • Document Management
Additional Requirements:	• Develops and maintains Enterprise Level Conceptual and Logical Data Models • Documents enterprise interfaces • Develops and maintains service registries • Ensures that all modules work together seamlessly and work securely with external systems • Ensures that overall security and privacy remain intact when various modules and components are integrated • Negotiates solutions to disagreements that may arise between development contractors who are developing or testing different MMIS components • Manages risks that may arise when schedule or technical slippage in one module(s) affects other modules • Cooperates with a state PMO and the IV&V contractor to give an accurate, honest reporting of the project status • Documents and develops Business Process Modeling Notation (BPMN) and Business Process Execution Language (BPEL) workflows for processes not addressed by Organizational Change Management or other modules

Reference Data Management Module		
Description:	This module handles storing and tracking of all code tables shared by other modules, including but not limited to policy, pricing, limitations, exclusions, benefit plans, etc. This module is expected to reside within the enterprise operational data store (ODS). Vendor's proposed solution will include collaboration with DSS to determine and implement governance for reference file, benefit package, and policy updates that are rules-based and easily modifiable by DSS-authorized Stakeholders for use in an automated workflow management process that also allows the capability for electronic approvals by program.	
MITA Business Area(s):	OM PL	Operations Management Plan Management
Estimated Cost:	*TBD*	
Estimated Timeframe:	October 2018 – September 2021	
Key Functions:	• Medical and Administrative Code Tables • Diagnosis Related Groups • Lookup Tables • Parameter Tables	
Additional Requirements:	• Document and develop new workflows for this module using BPMN and BPEL	

Enterprise Data Warehouse	
Description:	The EDW is comprised of the hardware and software that provides the functionality and infrastructure needed to support the data analytics, program integrity, and information management needs of the Medicaid program. This module will include the data models and structures necessary to support the data analytical needs of DSS. The EDW also incorporates business services, software tools, and program integration necessary to support user access to DSS-required data analytics. Functionality will include predictive modeling, business intelligence, dashboards, and reporting.
MITA Business Area(s):	All
Estimated Cost:	*TBD*
Estimated Timeframe:	February 2020 – September 2021
Key Functions:	• Decision Support System (DSS) • Management and Administrative Reporting (MAR) • Surveillance and Utilization Reporting (SUR) • Programmatic and Federal Reporting • Transformed Medicaid Statistical Information System (TMSIS) • Business Intelligence ▪ Self Service Reporting ▪ Predictive and Statistical Analysis ▪ Dashboards ▪ Geospatial Analysis • Historical Data Migration/Conversion • Metadata Repository • Extract, Transform and Load (Big Data)

Care Management Module		
Description:	The Care Management Module will enable DSS to store data related to members from various sources and utilize that data to support the agency in its efforts to improve outcomes, reduce cost, and ensure beneficiaries are receiving the right care in the right setting for the right cost. The module will pull data stored in the Master Data Repository to generate reports such as utilization reports for monitoring cost neutrality of waivers, enrollment reports, and data reportable to CMS. The module will store care plans and assessment outcomes for the various waivers administered in house or by sister agencies, and support cross waiver analysis for cost and outcome. The module can be used to support health homes, and it will provide a method of communication and data sharing across the ASOs.	
MITA Business Area(s):	CM CO EE ME FM OM PL PM	Care Management Contractor Management Eligibility and Enrollment Management Member Management Financial Management Operations Management Plan Management Provider Management
Estimated Cost:	*TBD*	
Estimated Timeframe:	February 2020 – September 2021	
Key Functions:	• Case Management • Grievance and Appeals • Care Coordination • ADT Alerts	
Additional Requirements:	• Document and develop new workflows for this module using BPMN and BPEL	

Provider Management Module		
Description:	The Provider Management Module will automate provider credentialing and enrollment activities for both medical and non-medical service providers. It will support provider outreach and provider communication and maintain an audit trail of changes. The solution will allow multiple address capabilities for providers and maintain multiple provider specific reimbursement rates supporting the ability for volume purchase contracts or other cost-containment initiatives with begin and end effective dates. In addition, the solution will maintain up to date geographic data on each provider, allowing for analysis of the Medicaid provider network by specialty across the state.	
MITA Business Area(s):	PM EE PL	Provider Management Eligibility and Enrollment Management Plan Management
Estimated Cost:	*TBD*	
Estimated Timeframe:	March 2020 – September 2021	
Key Functions:	• Credentialing and Enrollment • Verification and Validation • Provider Activity Tracking • Network Adequacy • Automated Response for HIPAA Transactions	
Additional Requirements:	• Document and develop new workflows for this module using BPMN and BPEL	

Claims Management Module		
Description:	The Claims Management Module will process specific types of claims such as waivers, atypical, crossovers, reversals, and adjustments according to DSS-administered program policies. The solution will capture and adjudicate all submitted claims (paper and electronic) to ensure timely, accurate, and appropriate payment of services based on DSS-approved guidelines and procedures, screened against other files such as: member, provider, reference, history, and edits/audits.	
MITA Business Area(s):	OM CM FM PL PM	Operations Management Care Management Financial Management Plan Management Provider Management
Estimated Cost:	*TBD*	
Estimated Timeframe:	March 2020 – September 2021	
Key Functions:	• Claims adjudication and payment • Adjustments, voids and reprocessing • Service Authorization • Claims history tracking	
Additional Requirements:	• Document and develop new workflows for this module using BPMN and BPEL	

Pharmacy Management Module		
Description:	The Pharmacy Management Module will provide a flexible, integrated, and clinical evidence-based approach to manage drug utilization. The solution will include Pharmacy Claims and Rebate Administration, Preferred Drug List (PDL), Drug Utilization Review (DUR), and Prior Authorization (PA). The solution is expected to provide the services and any functionality necessary to provide drug reimbursement pricing support, as well as cost and rate scenario support for decision making.	
MITA Business Area(s):	CM CO ME FM OM PE PL PM	Care Management Contractor Management Member Management Financial Management Operations Management Performance Management Plan Management Provider Management
Estimated Cost:	*TBD*	
Estimated Timeframe:	March 2020 – September 2021	
Key Functions:	• Drug Utilization • Pharmacy Claims and Rebate Administration • Maintenance of Preferred Drug List • Prior Authorizations	
Additional Requirements:	• Document and develop new workflows for this module using BPMN and BPEL	

Third Party Liability		
Description:	The Third Party Liability module will receive, validate, and make the TPL information available throughout the enterprise in an accurate and timely manner. The solution will help DSS minimize upfront expenditures by maximizing cost avoidance, performing post pay recovery functions, and supporting health insurance premium purchase programs.	
MITA Business Area(s):	EE ME FM OM	Eligibility and Enrollment Management Member Management Financial Management Operations Management
Estimated Cost:	*TBD*	
Estimated Timeframe:	March 2020 – September 2021	
Key Functions:	• Member Data Matching • Cost Avoidance • Pay and Chase • Estate Recovery	
Additional Requirements:	• Document and develop new workflows for this module using BPMN and BPEL	

Program Integrity Management Module		
Description:	This module will provide the functionality to support identification and reduction of fraud, waste, and abuse. The module is to be the primary collection point of program integrity information and will support the communication and sharing of program integrity data/utilization review data across the Connecticut Medicaid Enterprise.	
MITA Business Area(s):	PE CM FM OM	Performance Management Care Management Financial Management Operations Management
Estimated Cost:	*TBD*	
Estimated Timeframe:	June 2020 – September 2021	
Key Functions:	• Case Management • Analytics	
Additional Requirements:	• Document and develop new workflows for this module using BPMN and BPEL	

Financial and Contract Management Module		
Description:	The Financial Management module will support all cycles and HHS programs with financial expenditure reporting. Further, it will provide a mechanism for a wide range of activities, from budget maintenance within DSS to Medicaid remittance advice generation. A Contract Management module will allow for greater levels of vendor management through SLA, OLA, and KPI tracking. The module directly and significantly impacts operational aspects of DSS and the pursuit of higher levels of MITA maturity.	
MITA Business Area(s):	CO FM OM	Contractor Management Financial Management Operations Management
Estimated Cost:	*TBD*	
Estimated Timeframe:	June 2020 – September 2021	
Key Functions:	• Financial Reporting • Federal and Program Reporting • Budget Maintenance • Contract Tracking • Vendor Management • TPA Tracking • SLA, OLA, and KPI Tracking • Contractor Grievance and Appeals	
Additional Requirements:	• Document and develop new workflows for this module using BPMN and BPEL	

5. Next Steps

As Connecticut embarks on the transformational project to implement the MITA Roadmap, DSS will prepare an Advance Planning Document and supporting documentation per MECT and CMS guidance to seek formal approval to proceed with the project. DSS has fully articulated the goals and outcomes desired to achieve increased MITA maturity, and described the actions which will be taken to implement "To-Be" improvements and concepts identified in this report. The adoption and implementation of MITA based organizational, technical, and process oriented changes will allow DSS to increase in MITA maturity over the course of the next five- and ten-year periods. Project descriptions, timelines, and cost estimates included in the Roadmap represent preliminary estimates. As these projects are fully defined and scoped, these estimates will change to support Advance Planning Document submission.