MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)

3.0 STATE SELF-ASSESSMENT

MITA Validation 2019
Summary Report v1.0

Table of Contents

1. MITA Assessment Background

The Connecticut Medicaid Information Technology Architecture (MITA) 3.0 State Self-Assessment (SS-A) was undertaken in 2016-2017 to assess the Connecticut Medicaid Enterprise (CME) in accordance with guidance from the Centers for Medicare and Medicaid Services (CMS) 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), Connecticut's State Medicaid Agency, was granted federal funding for an Advance Planning Document (APD), a planning effort to include the MITA assessment as well as agency-wide support in the form of an Enterprise Program Management Office (EPMO) and a Strategic Planning engagement. The EPMO conducted the SS-A for DSS by considering the Seven Conditions and Standards across each MITA Architecture Area – Business Architecture, Information Architecture, and Technical Architecture. CMS uses all three architectures to promote business driven enterprises and consistency among all state Medicaid programs, as shown in the figure below. The Business Architecture is constructed using CMS defined models, matrices, and templates, and it represents the starting point of the MITA framework, describing the business needs and goals of DSS.

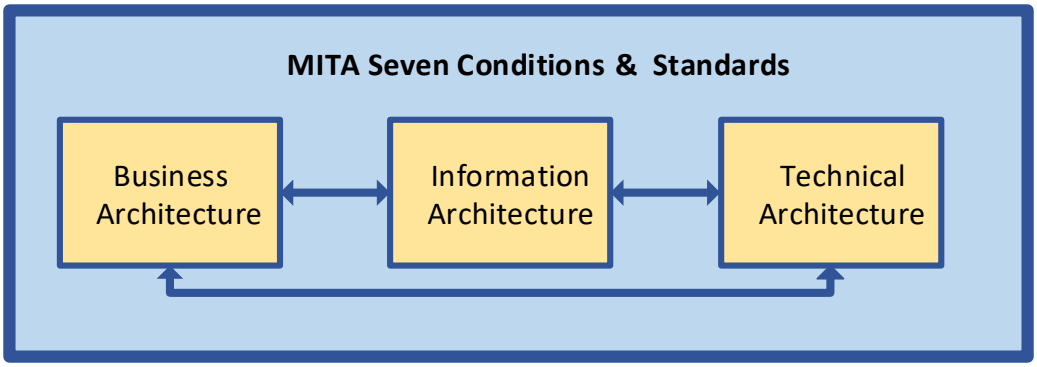

Figure 1 MITA Framework Relationship

After the assessment exercise, Connecticut DSS submitted an updated APD application to receive enhanced Federal Financial Participation (FFP) with a MITA Roadmap for achieving full compliance with the Seven Standards and Conditions as part of the MITA reports. The DSS executive leadership team engaged in a strategic planning process to articulate a mission, vision, cross-cutting principles, goals, and objectives for the agency. DSS also followed CMS guidance by aligning the mission/vision/goals from DSS' strategic initiatives with goals and objectives for the future Medicaid system envisioned in the Roadmap, which came to be named the Connecticut Medicaid Enterprise Technology System (CT METS.) CT METS' goals support and advance:

- DSS Vision, Mission, and Values
- DSS Strategic Plan Goals and Objectives
- Healthcare Reform Objectives
- CMS Modularity Goals

In Phase 1 of the CT METS program, foundational work began in 2018, to include hiring project staff with both technical and business acumen and procuring contractors for Independent

Verification and Validation (IV&V), Organizational Change Management (OCM), and Systems Integrator (SI). This phase is expected to continue through 2021. In particular, the OCM contractor is responsible for mapping DSS business processes to streamline work and design a MITA-aligned organization to support the new technology and business processes.

2. Purpose of MITA Validation

As the CT METS Project Team worked through the steps of procuring new vendors, they identified tasks which could ensure a smooth transition if completed in advance of the foundational contractors coming on board. It was recognized that the MITA State Self-Assessment reports and MITA Roadmap will be major inputs to the OCM task for business process mapping and organizational design. It was also noted that the MITA assessment material was collected in late 2016, so its content could be outdated. It was decided to conduct a MITA Validation exercise for two purposes:

- MITA Validation sessions will be an opportunity to update business processes that have changed since 2016
- MITA Validation sessions will be an opportunity to discuss what is important to the business stakeholders so it can be included in OCM planning for CT METS

The CT METS Program Director met with the DSS Leadership Team in June 2019, to present the project team's plans to engage staff to participate in validation of the MITA-defined process information that was collected during the MITA 3.0 State Self-Assessment in 2016. It was explained that the Organizational Change Management vendor will begin work on the project within a year, and they will use the updated business process information to document, review, and recommend changes to business processes to comply with CMS standards and conditions for federal funding.

It was emphasized that the MITA Validation would not be a complete MITA State Self-Assessment Update. Since the team planned to concentrate on the business processes, we would not ask DSS staff to invest the additional time needed to address detailed changes to the Business Capability Matrices, Information Architecture, and Technical Architecture that were documented in 2016-2017.

3. MITA Validation Method

A. Prepare MITA Validation Template

During the 2016 assessment, a Business Process Template (BPT) was prepared to address each of the Medicaid business processes defined by CMS. For the MITA Validation in 2019, the CT METS project team and EPMO staff used the 2016 BPT as a starting point (excluding the Business Capability Matrix part of the BPT) to develop a MITA Validation Template which collects the dates and attendees and defines the questions that guide discussion. To capture process changes and additional input during the validation sessions, the following page was added to the template.

2019 MITA Validation Review:

Assigned SMEs:

Date Complete:

Confirm or update MITA business process documentation:

1. Significant changes that are in the planning stage or have been completed since the MITA state self-assessment in 2016-2017, including but not limited to legislative/regulatory changes (Section A.2 or E.2)

2. Key Performance Indicators (KPI) or metrics that are available to support operations and strategic plans (Section K.2)

3. Opportunities for process improvements, areas that key staff indicate are problematic, including gaps, disconnects, fragmented processes, and issues due to lack of automation (Section I.3)

4. Successes with business processes to be carried over to the new Medicaid environment, including LEAN/process improvements or automation that has been deployed

5. At the **MITA business area level**, other Medicaid processes performed by DSS that have not been addressed by the 80 MITA business processes (list or catalog processes, but do not document details)

Sections mentioned in red font above refer to the original template where answers or comments may have already been captured during the validation session.

The new template operated as a familiar document allowing DSS participants to review each business process, track changes in the original text, and/or add notes at the end of the template. As they did in the original assessment, the templates can serve as both an agenda and record of meeting notes for the MITA sessions, however an agenda and meeting notes were sent to the participants for most meetings.

B. Identify MITA Business Area Leads

The MITA Business Architecture contains 80 Medicaid business processes which are subdivided into 10 MITA Business Areas:

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

At least one lead Subject Matter Expert (SME) from DSS staff was selected for each business area, based primarily on participants in the 2016 SS-A. The role of a business area lead was explained as the following responsibilities:

1. Review templates for all processes in their assigned business area or areas
2. Consider where there might be changes in the processes since 2016
3. Identify who can best describe the changes and provide contact information for them to be invited to the appropriate MITA validation sessions
4. Consider responses to additional questions in the MITA validation template
5. Identify who can best answer the additional questions
6. Attend or be represented at MITA validation sessions with EPMO staff to review all business processes in their assigned area or areas
7. Ensure that updated templates are completed with the EPMO

After planning discussions were held with Medical Operations management, 15 business area leads were identified as candidates to participate in the effort. A MITA Validation Kickoff was held in August 2019, with 10 business area leads attending, and CT METS project team, EPMO, ITS, and OSD staff were present.

Some business leads have continued to work with the CT METS project team on the Steering Committee or in other ways since 2016, but others have not had much exposure to the CT METS planning and development. To address this gap, an overview of CT METS was presented at the kickoff, including reasons for the MITA Validation, highlights of Phase 1 foundational work and Phase 2 implementation, as well as links to websites for more information, project status, and answers to questions. All slides and handouts from the kickoff were provided in advance to those invited. The materials were covered briefly again during the initial validation session for each business area and whenever a new participant came to a validation session.

DSS is fortunate that almost everyone involved in the original 2016 assessment exercise was available to participate in MITA validation. Their familiarization with MITA reduced the necessity for detailed training and minimized the time required for business stakeholders to participate.

C. Conduct MITA Validation Sessions

After the kickoff session with business area SMEs, the EPMO person leading the MITA Validation began contacting the individual participants to discuss the MITA business area and set up meeting(s) to capture information. It was explained that sessions would be scheduled at the convenience of the DSS participants, and they could be held in person, by audio/video conference - or if preferred by the client – by email or using paper copies with no meeting. The EPMO expected to schedule multiple sessions as needed to address all the business processes because some business areas are small (4 processes in Member Management) while others are large and diverse requiring many participants (19 processes in Financial Management).

Each session was scheduled in Outlook with an agenda and all the MITA Validation Templates to be discussed. To ease the pressure on busy staff personnel, the MITA Validation lead indicated that the main points of all the documents would be covered during the meeting if the participants did not have time to review the attachments ahead of time. The team was also respectful of those who were unable to attend. Substitutes were welcome, separate meetings were held with some persons, and several sessions were rescheduled until everyone had a chance to complete their validation sessions. The original target had been to complete the sessions by October, but the date was extended to accommodate DSS schedules and requests for additional participants to review the templates.

During the engagement period, a MITA Validation report was submitted to the CT METS Program Director to explain the status of the engagement. It was an iterative report, updated weekly. The report contained a grid that was color-coded to indicate how many sessions had been scheduled, how many business processes had been discussed, and how many templates had been updated and accepted. In the style of a typical project status report, there was also a narrative statement about the work completed each week and the planned activities for the upcoming week. In addition, the MITA Validation team provided a bi-weekly update for inclusion in the Steering Committee presentation deck.

The final weekly MITA Validation report dated 12/6/2019 is shown below with all blocks marked green to indicate the sessions are complete and the templates have been edited and closed out.

MITA Validation Sessions as of 12/6/2019

MITA Validation Sessions																	
					# Business Processes Discussed												
Business Area Description					Aug '19	Sept '19				Oct '19				Nov '19			
	Total # Processes	C	S	D	8/30	9/6	9/13	9/20	9/27	10/4	10/11	10/18	10/25	11/1	11/8	11/15	11/22
Business Relationship Management	4	4											4				
Care Management (ASOs, Waivers, CFC, DPH)	9	9									3A-1W	5A	7W			1D	1C
Contractor Management	9	9											6			3	
E&E Management	8	8						2			4				2		
Financial Management	19	19						3		1	3	3	7	2			
Member Management	4	4			1			3									
Operations Management	9	9					2	1			2	3			1		
Performance Management	5	5						5									
Plan Management	8	8						4		4							
Provider Management	5	5			5												
Total	80	80															

C – Completed template; S – Scheduled; D - Process discussed T – Tentative meeting proposed A/W/C/D – Care Management processes were discussed with several groups in separate sessions

4. MITA Validation Findings

Although three years have passed since the business architecture material was collected for the original MITA assessment, the MITA Validation group was not expecting to find sweeping changes in the Medicaid environment.

Even so, the Connecticut Medicaid Enterprise made strides to increase the MITA Maturity of the current environment which can be carried over into the plans for a new Medicaid Enterprise and a new Medicaid Management Information System (MMIS.) It was also noted that many of the business area leads have an increased understanding of the benefits of continuing to advance the MITA Maturity of the Enterprise. In particular, the leads cited the capabilities of modernized systems to automate routine processes and perform business analysis and intelligence that takes advantage of data the state already owns to enhance services to citizens.

The MITA Validation Templates contain all the detailed changes and notes that were collected during the sessions. The templates are stored in zip files located on the CT METS SharePoint site. The following summary tables provide a brief description of each business area and juxtapose the baseline 2016 As-Is and To-Be Summaries with the 2019 Validation Findings.

Business Relationship Management	
Description:	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.
2016 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.
2016 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.
2019 Validation Findings	1. PACS REQ is the new automated requisition process in place since April 2019. The CIRAS form is eliminated. The OPM requisition form is uploaded, coding and funding is added, and the approval process workflow transmits the requisition to Budget with feedback to the program staff.

Care Management	
Description:	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.
2016 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 has 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.
2016 To-Be Business Area Summary	The Care Management Business Area would benefit from improved data governance activities throughout the 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 the SMA. Since 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.
2019 Validation Findings	1. Minor changes were noted in ASO processes for Care Management. Several ideas were expressed for future opportunities for improvement. 2. One waiver program was discontinued (Autism) and one waiver was added (ABI2). 3. CT AIDS Drug Assistance Program (CADAP) administration is no longer managed by DSS. The program is managed by the Department of Public Health (DPH.) 4. Community Options updated the Money Follows the Person (MFP) and Community First Choice (CFC) program information. The Universal Assessment tool has achieved success and is in the planning stage for expansion to state agencies, ASOs, and other contractors statewide. They are also expecting success with the launch of the Connecticut Housing Engagement and Support Services (CHESS) which integrates housing information with care plan information to better serve the homeless population. They also offered suggestions and examples for the to-be scenario about integration of system information to address member needs in a person-centric manner and provide actionable information to care managers, including Social Determinants of Health. 5. The Testing Experience and Functional Tools (TEFT) grant has ended. MFP was extended to 2024, although funding must be re-appropriated periodically. 6. DPH identified changes in the Manage Registry template for three areas. The Connecticut Tumor Registry information was clarified, and the Electronic Laboratory Reporting process had minor updates. A major change occurred

	in September 2018, as the Immunization Information System (IIS), called Connecticut Immunization Registry and Tracking System (CIRTS) was migrated to the CT WiZ system, enabling bi-directional electronic data exchange with electronic health records (EHRs), vaccine ordering and inventory management, and robust reporting capabilities to ensure data quality. Providers and hospitals who order vaccines from the Connecticut Vaccine Program (CVP), report immunizations administered to children ages 0 through 18, and who are mandated to report immunizations to CT WiZ per state regulations, can apply for electronic data exchange with CT WiZ.

Contractor Management	
Description:	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).
2016 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 (which had been HPE), 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 (CIRAS) which is manually entered in the PACS system by the Division staff. Once a contract is awarded, it is posted on the DSS website.
2016 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.
2019 Validation Findings	1. There is a new contract management system in PACS that tracks and houses DSS contracts, memoranda of agreement/understanding (MOA/MOU), statements of work (SOW), data share agreements, and contractor organizations. It also facilitates PACS REQ (requisition) to initiate new or renew existing contracts or amendments. The manual process with CIRAS form is no longer used. Once contracts are awarded, they are loaded in the Department of Administrative Services (DAS) Biznet portal.

Eligibility and Enrollment Management	
Description:	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.
2016 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). DXC 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.
2016 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.
2019 Validation Findings	1. The ImpaCT rules-based eligibility system statewide rollout was completed in August 2018, and the template was updated to reflect the current business processes. There is no more manual processing in the legacy system, however, ImpaCT is unable to ingest about 10% of the data transfers (eligibility determinations) from HIX. Those enrollments are processed manually in ImpaCT before going to the MMIS. 2. In CT, files transfer from ImpaCT to the MMIS and ASOs, whereas most states transfer files only from the MMIS, not the eligibility system. There is an opportunity for improvement if CT changed to align eligibility status with a single data transfer of the enrollment file between MMIS and the ASOs. One roster could be used for all ASOs. 3. CT AIDS Drug Assistance Program (CADAP) is now operated by DPH instead of DSS. 4. Conduent no longer performs the functions for CHIP.

	5. EMS and Connexion were sunsetted; all information is in ImpaCT 6. Phone applications remain a problem for HUSKY C because the DSS Benefit Center telephone system can't record the call for an electronic signature.

Financial Management	
Description:	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.
2016 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.
2016 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.
2019 Validation Findings	1. DFS staff refined the previous assessment descriptions to include use of a contract statistician to develop samples and extrapolations for audits. 2. Staff requested more analytics and functionality in reporting, for example, to split federal and state share instead of gross expenditure which must be manually calculated. 3. The premium process has been changed to an ImpaCT module, so Conduent only handles exceptions where there is not a remittance slip. The People's

	Bank lockbox processes the payments, and this has improved cash flow. This also is the new process for Manage Member Premium Invoice. 4. SMEs elaborated more fully on incentive payments and described the capitated payment process for Veyo, the new non-emergency medical transportation contractor. 5. Staff noted the high volume of manual accounts payable disbursements to hospitals, physicians, towns, municipalities, and schools. 6. There is no change to Estate Recovery or Manage Drug Rebate processes. 7. Third Party Liability Recovery has a more robust process description using the monthly federal Bendex file, and TBQ files with Medicare Beneficiary Identifier (MBI# - SSN replacement) from the eligibility system to reconcile. 8. The Rate Setting group has a new APD-funded project in the planning stage with Myers & Stauffer. 9. Additional details about the Manage Provider Recoupment process were provided.

Member Management	
Description:	***Note from CMS in 2016 SS-A: 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.***
2016 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.
2016 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.
2019 Validation Findings	1. Grievance & Appeals processes are very efficient since implementation of ImpaCT module for Hearings - there is no backlog; hearings are timely; daily reports are available automatically. 2. The HIX platform is stabilized with new functionality; there is increased use of ImpaCT; EMS is no longer used. 3. Contractor name changes were noted for HPE, now DXC; and Xerox is now Conduent; Veyo is the new vendor for NEMT instead of Logisticare.

	4. CT will be using Asset Verification System (AVS) data through automated interface by 2/2020, which will be good for passive renewals. 5. An opportunity was noted to decide the direction for CT's two eligibility systems (HIX and ImpaCT); the possibility of a direct interface has been suggested. 6. An opportunity to improve data quality was noted if CT could send files from the MMIS to the ASOs instead of sending from ImpaCT to the ASOs. 7. The shared Access Health CT (AHCT) DSS Call Center is now operated by Faneuil for the MAGI Medicaid, CHIP, and insurance affordability programs.

Operations Management	
Description:	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.
2016 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.
2016 To-Be Business	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

Area Summary	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.
2019 Validation Findings	1. Electronic Visit Verification (EVV) capability has been added to the MMIS with a subcontract between DXC and Sandata. 2. Staff confirmed that electronic attachments are still not used in Operations, as recorded in the business process OM04 – Submit Electronic Attachment. 3. It was noted that there is a new capitation payment per member per month (PMPM) for PCMH+. 4. Manage Data processes did not progress as expected since the assessment. 5. Updates were made to the processes for Calculate Spend-Down Amount now handled in ImpaCT with improved results, daily reports, and data stored in one place.

Performance Management	
Description:	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.
2016 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.
2016 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.
2019 Validation Findings	1. Legislative change in 2015 has been implemented to publish audit protocols. 2. The contractor 21CT is now named Pulselight; it is used more and has improved functionality; an automated audit selection tool is in pilot stage. 3. QA is also developing customized REOMBs through Pulselight for claims which are under investigation.

Plan Management	
Description:	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.
2016 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.
2016 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.

2019 Validation Findings	1. Staff suggested the need for a repository for approved plans which are currently received in email, managed in paper files, and saved in shared drives. 2. It was noted that the TEFT grant ended. 3. There is a dashboard in development by the Department of Health Services. 4. Beacon also provides HEDIS measures as of 2017. 5. UConn no longer provides the business intelligence function. 6. DSS is developing Tableau for visualization of analytics. 7. Minor changes were noted on some templates and confirmed with other DSS staff.

Provider Management	
Description:	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.
2016 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.
2016 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.
2019 Validation Findings	1. The Grievance & Appeals process has not been automated, but following new legislation, a Lean process was developed and documented; this should be carried forward in CT METS planning. 2. There was a change in the vendor for non-emergency transportation from Logisticare to Veyo. 3. Staff noted there have been enhancements and continued automation of fingerprinting, updating how we receive CMS data files (DEX) for credentialing, and requiring an application fee for certain provider types. Ongoing enhancements include provider types and specialties, conversion of the remaining specialties from paper applications to electronic web-based enrollment applications, verification of provider address, service location, and the automation of enrollment checks and verifications, as well as improved capability to electronically document the time and date when each enrollment check happened. 4. Enterprise Provider Registry went into production September 2017 and provides a consolidated view of provider information across subscribing systems; it also provides a few basic reporting tools for ongoing maintenance of accurate information. EPR integrates provider data DSS Medicaid Provider Enrollment, the DSS Medicaid Medical ASO, National Plan and Provider Enumeration System (NPPES), and data extracts from the Allied Health LTSS program. Also, it publishes a provider directory to support the Connecticut Home Care Program for the Elders. Phase II work is underway and includes plans for sharing the technology with sister agencies.

Although the MITA Validation engagement did not review detailed changes to the Information Architecture and Technical Architecture, notes from the updated Business Process Templates were captured by the EPMO in updated drawings from the MITA Reports including subsequent updates created since 2017.

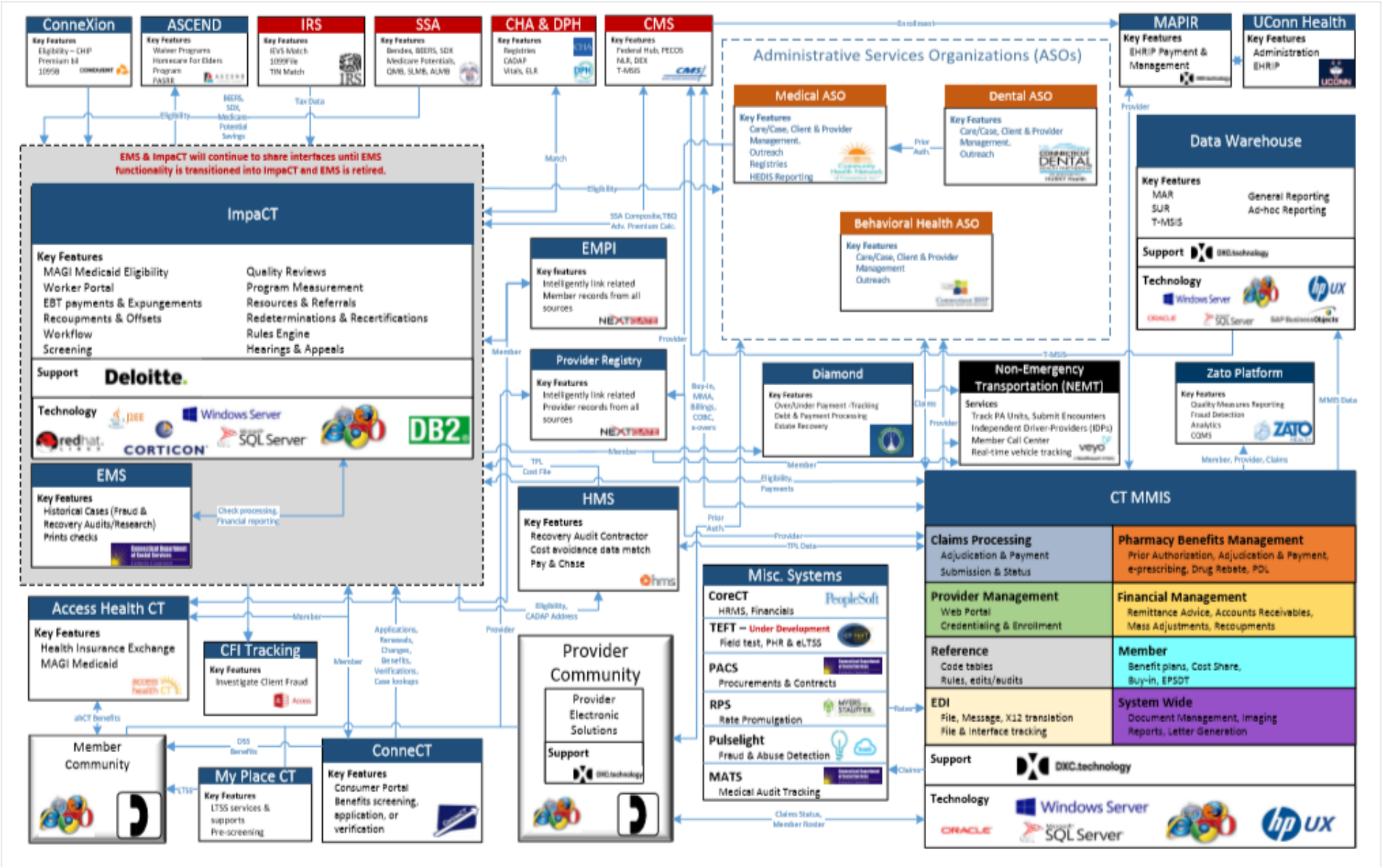

FIGURE 2 AS-IS CONCEPT OF OPERATIONS DIAGRAM

HealthTech SOLUTIONS

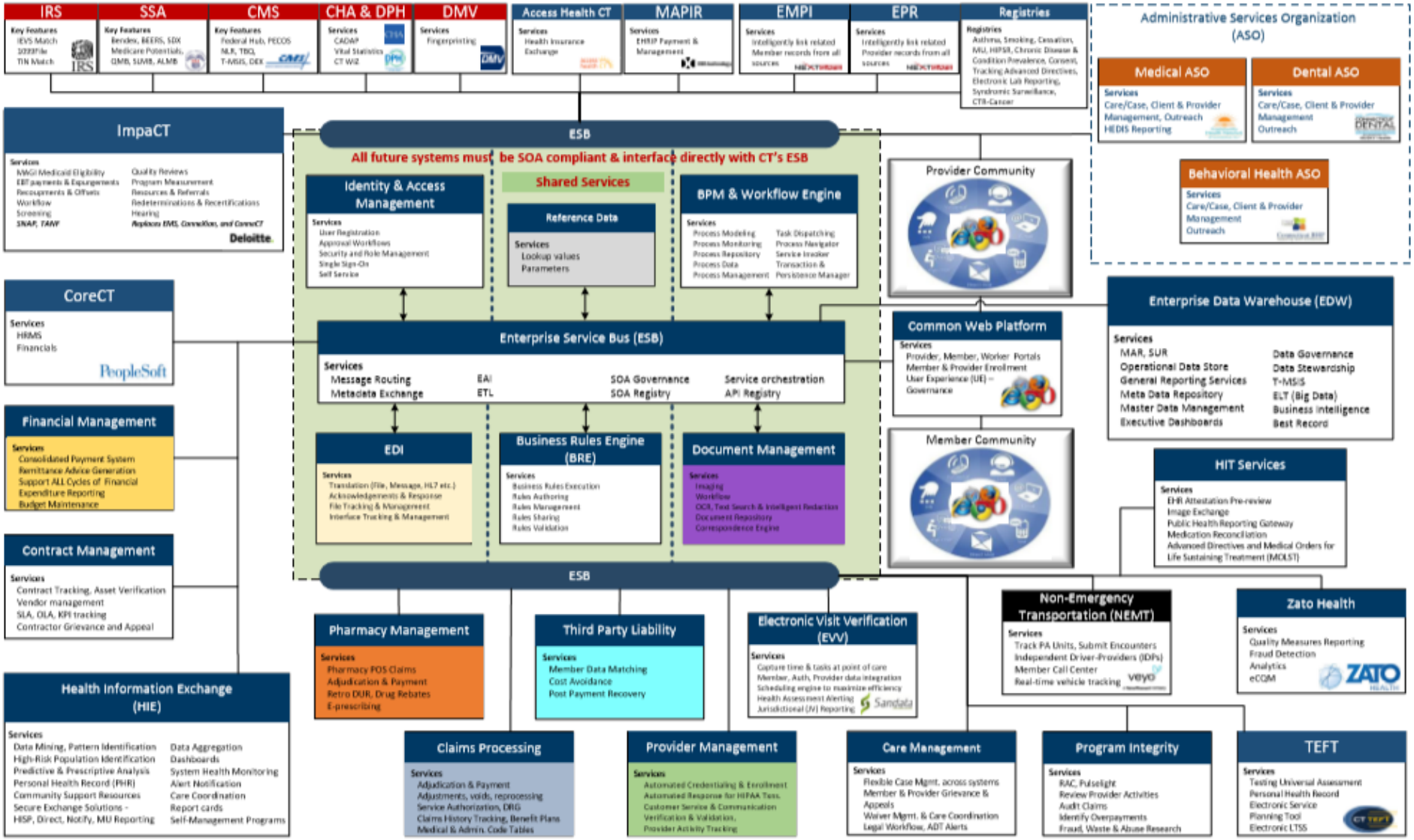

FIGURE 2 TO-BE CONCEPT OF OPERATIONS DIAGRAM

5. Next Steps

After this report has been accepted by the CT METS Program Director and Project Staff who sponsored the engagement and the DSS Med Ops staff who assisted with the effort, the information will be shared with the OCM contractor for use in the adoption and implementation of MITA based organizational, technical, and process oriented changes that will allow DSS to increase in MITA maturity over the course of the next five and ten year periods. The content of the report will also support the Systems Integrator work to define requirements for the CT METS core system and modules.

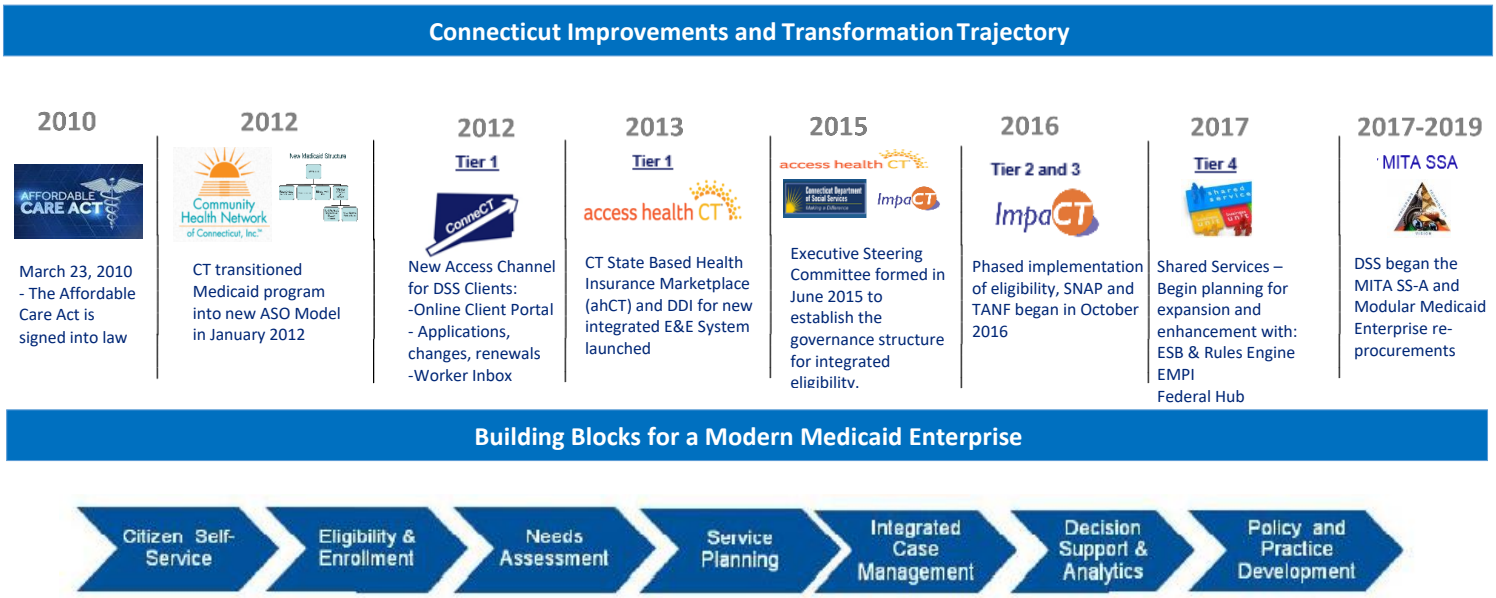

FIGURE 4 CONNECTICUT IMPROVEMENTS AND TRANSFORMATION TRAJECTORY

The Medicaid Enterprise transformation effort is building 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 enhanced, extended, and leveraged wherever possible, as expected by the Seven Conditions and Standards for re-use, in achieving a higher MITA maturity level and ultimately a full transformation of the Medicaid Enterprise. The trajectory of the Connecticut Medicaid Enterprise over the last several years has paved the way for the current Medicaid transformation and MITA maturity efforts that are evident in the MITA Validation findings and CT METS Phase 1 planning efforts.