New Mexico Medicaid Program
MITA Assessment
'As-Is' & 'To-Be' State

Delivered to
New Mexico Human Services Department

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Version 3.0 - Final

New Mexico MITA Assessment	'As-Is' & 'To-Be'
March 19, 2009	VERSION 3.0

Revision History

Date	Description of Revision	Author
02/18/09	'As-Is' Initial Draft – Version 1.0	L. Doyle, K. Weinberger
03/12/09	Revisions to 'As-Is' Per State Comments & Addition of 'To-Be' Assessment – Version 2.0	L. Doyle, K. Weinberger
03/19/09	Final Revisions to 'To-Be' Per State – Version 3.0 Final	K. Weinberger

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1 Introduction

The Medicaid Information Technology Architecture (MITA) is an initiative of the Center for Medicaid and State Operations (CMSO) within the Centers for Medicare and Medicaid Services (CMS). It is intended to foster integrated business and IT transformation and solutions to improve the administration of Medicaid programs while enabling each State to continue to support unique local needs. MITA is to be used as a blueprint for models, guidelines, and principles as States work towards implementing technological solutions over the long term.

Beginning April 1, 2007, States were instructed by CMS to conduct assessments of their Medicaid enterprise against the MITA Framework 2.0. This process is termed as the MITA State Self Assessment (S-SA). An S-SA is necessary for a State to determine their current levels of MITA maturity, define their needs for future enhancements, and to request federal funding for Medicaid Management and Information Systems (MMIS) changes and upgrades.

Since the MITA Framework 2.0 was published, revisions have been made to the business process descriptions. These business process revisions are denoted as Framework 2.01. The Framework is a 'work in progress' and does not have all business processes or maturity levels fully defined. Due to the lack of precision and specificity within the framework, any assessment based upon it is subjective. This assessment was conducted based on the overall knowledge of MITA as it exists today. Where determination of one level over another was unclear, the lower level was assigned.

Framework 2.0 is available at:
http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp.
The revisions to the Business Process descriptions (2.01) are available at:
http://hl7projects.hl7.nscee.edu/docman/?group_id=40.

2 Scope of Assessment

The State-Self Assessment as defined by CMS is used by the State to review strategic goals and objectives, measure current business processes and capabilities, and ultimately to develop target capabilities that allow the State to transform its program toward consistency with MITA principles. The 'As-Is' is simply the current state and the 'To-Be' reflects the target.

This assessment document was prepared in two phases; first the current or 'As-Is' state followed by the future or 'To-Be' state. An assessment was conducted on the current New Mexico MMIS based on interviews of State and Fiscal Agent (FA) Subject Matter Experts (SME) regarding capabilities for each of the business processes. This was completed at the request of the State to show a representation of the 'As-Is' state of the program. Maturity levels were assigned solely based upon the information collected from the SMEs. Subsequently, a meeting was held with the State in which the goals and objectives of the State were discussed. This discussion resulted in the 'To-Be' state. This document reflects both the 'As-Is' and the 'To-Be' states.

This assessment encompasses the 72 business processes that are listed in the MITA Framework 2.01 to the extent that they are defined and applicable maturity levels have been delineated. In areas that lack specificity and clear maturity level definition the assignment was based on a general understanding of the MITA maturity levels.

3 Methodology

The MITA 'As-Is' Assessment was conducted using the following methodology:

1. Reviewed the MITA Framework
2. Determined interview questions for each business process based on the Business Capability Maturity Levels in the Framework
3. Conducted interviews with State and FA SMEs which covered all the Business Processes outlined in Framework 2.01
4. Reviewed notes from interviews and determined the current MITA 'As-Is' Level of Maturity based on the Business Capability Maturity Levels as defined in Framework 2.0 (the Maturity Levels have not been updated in a more recent version)

The MITA 'To-Be' Assessment was conducted using the following steps:

5. Discussed New Mexico Medicaid Goals and Objectives with State leadership
6. Determined the future 'To-Be' maturity levels based on the State's Goals and Objectives

Subject Matter Experts

The following State and ACS SMEs were interviewed as a part of the 'As-Is' portion of this assessment. SMEs noted by an asterisk also participated in the Goals and Objectives meeting.

State

Michael Aragon	Mark Pitcock*	Kathy Slater-Huff
Anna Bransford	Kim Price*	Mari Spaulding-Bynon
Roy Burt	Chris Pruett*	Robert Stevens*
Sandra Chavez	Jason Sanchez	Julie Weinberg*
Larry Heyeck	Rebecca Schwarz	Rita Wood
Laura Johns	Liz Shaw*	
Elise Macy	Mary Schruben	

ACS Fiscal Agent

Crystal Archbold	Michael Lawson	Jim Potts
Ross Becker*	Christine Marshall*	John Sherry
Luis Diaz	Sal Montano	Tom Vinson

4 MITA Business Architecture

The MITA Business Architecture is organized by eight (8) business areas listed in the table below. Each area consists of several major processes which are further delineated into 72 business processes. The description of each business process is provided in Section 6. Part of the assessment is to 'map' the MITA business processes to the State's business processes. This mapping is provided in Table 4.

Table 1: MITA Business Architecture

Business Area (8)	Major Business Process	Business Process (72)
Member Management	Eligibility Determination	Determine Eligibility
	Enrollment	Enroll Member
		Disenroll Member
	Member Information Management	Manage Member Information
		Inquire Member Eligibility
	Prospective and Current Member Support	Perform Population and Member Outreach
		Manage Applicant and Member Communication
		Manage Member Grievance and Appeal
Provider Management	Provider Enrollment	Enroll Provider
	Provider Information Management	Manage Provider Information
		Inquire Provider Information
	Provider Support	Manage Provider Communication
		Manage Provider Grievance and Appeal
		Perform Provider Outreach
Contractor Management	Administrative and Health Services Contracting	Produce Administrative or Health Services RFP
		Manage Administrative or Health Services Contract
		Award Administrative or Health Services Contract
		Close-out Administrative or Health Services Contract
	Contractor Information Management	Manage Contractor Information
		Inquire Contractor Information
	Contractor Support	Perform Contractor Outreach
		Manage Contractor Communication
		Support Contractor Grievance and Appeal
Operations Management	Service Authorization	Authorize Treatment Plan
		Authorize Referral
		Authorize Service
	Payment Management – Claims/Encounter Adjudication	Edit/Audit Claim-Encounter
		Price Claim - Value Encounter
		Apply Attachment

Business Area (8)	Major Business Process	Business Process (72)
		Apply Mass Adjustment
	Payment Management – Payment and Reporting	Prepare Remittance Advice-Encounter Report
		Prepare COB
		Prepare Home and Community Based Services Payment
		Prepare EOB
		Prepare Provider EFT-Check
		Prepare Premium EFT-Check
	Payment Management – Capitation and Premium Preparation	Prepare Health Insurance Premium Payment
		Prepare Medicare Premium Payments
		Prepare Capitation Premium Payment
	Payment Information Management	Manage Payment Information
		Inquire Payment Status
	Member Payment Management	Calculate Spend-Down Amount
		Prepare Member Premium Invoice
	Cost Recoveries	Manage Recoupment
		Manage Estate Recovery
		Manage TPL Recovery
		Manage Drug Rebate
		Manage Cost Settlement
Program Management	Benefit Administration	Designate Approved Service Drug Formulary
		Manage Rate Setting
		Develop and Maintain Benefit Package
	Program Administration	Develop and Maintain Program Policy
		Maintain State Plan
		Develop Agency Goals and Objectives
	Budget	Manage FFP for Services
		Manage FFP for MMIS
		Formulate Budget
		Manage State Funds
	Accounting	Manage 1099s
		Perform Accounting Functions
	Program Quality Management	Develop and Manage Performance Measures and Reporting
	Program Information	Manage Program Information
		Maintain Benefits and Reference Information
Care Management	Manage Medicaid Population Health	Manage Medicaid Population Health
	Establish Case	Establish Case
	Manage Case	Manage Case

Business Area (8)	Major Business Process	Business Process (72)
Program Integrity Management	Identify Candidate Case	Identify Candidate Case
	Manage Case	Manage Case
Business Relationship Management	Establish Business Relationship	Establish Business Relationship
	Manage Business Relationship	Manage Business Relationship
	Manage Business Relationship Communication	Manage Business Relationship Communication
	Terminate Business Relationship	Terminate Business Relationship

5 MITA Maturity Model

The MITA Maturity Model is an adaptation of industry maturity models used to illustrate how the MMIS can mature over time. There are five (5) levels of maturity in the model which describe different levels of maturity that progressively improve over a 10+ year timeframe. Each maturity level has defined business capabilities that describe the abilities of the MMIS and the maturity of the business processes. It is important to understand that maturity levels three through five are not possible today since MITA standard interfaces and federated architectures have not been defined or developed.

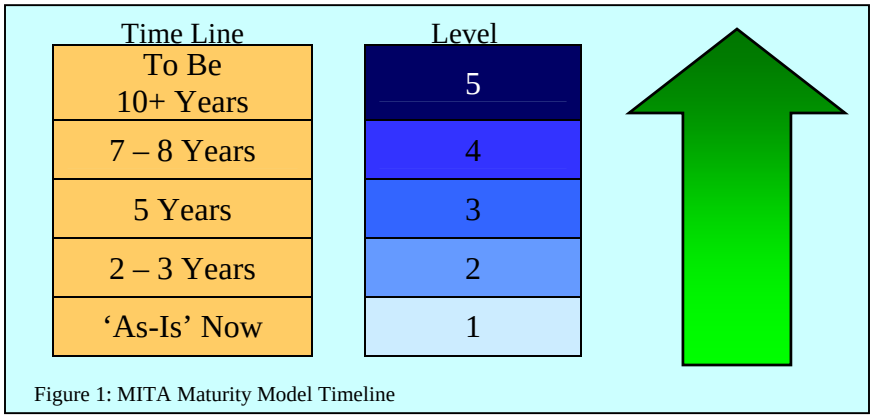

Figure 1: MITA Maturity Model Timeline

Business Capability Maturity Levels

The table below from the MITA Framework 2.0 shows the general descriptions of each level of maturity based on business capabilities. These general descriptions provide a high-level model for each level. The MITA Framework 2.0 Appendix D documents specific maturity levels for each business process based on business capabilities. The business processes that have not had maturity levels defined have been assessed based on the general understanding of the MITA maturity levels.

Table 2: MITA General Description of Maturity Levels

General Definition of Levels of MITA Maturity				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Agency focuses on meeting compliance thresholds for State and Federal regulations, primarily targeting accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.	Agency focuses on cost management and improving quality of and access to care within structures designed to manage costs (e.g., managed care, catastrophic care management, and disease management). Focus on managing costs leads to program innovations.	Agency focuses on adopting national standards, collaborating with other agencies in developing reusable business processes, and promoting one-stop-shop solutions for providers and consumers. Agency encourages intrastate data exchange.	Agency benefits from widespread and secure access to clinical data and focuses on improvement of healthcare outcomes, empowering beneficiaries and provider stakeholders, measuring objectives quantitatively, and ensuring overall program improvement.	Agency focuses on fine tuning and optimizing program management, planning and evaluation since it has benefited from national (and international) interoperability and previously noted improvements that maximize automation of routine operations.

6 MITA Maturity Levels – 'As-Is'

The table below provides the results of the 'As-Is' assessment, as well as the State's current high-level description of each business process. These 'As-Is' levels were determined by reviewing the Framework and interviewing State and Fiscal Agent staff. The center column represents the MITA business process description, verbatim from the MITA Framework 2.01. While the MITA business process description may be somewhat detailed, many of the maturity levels for each business process are not well defined in the framework. The description of the State's current process reflects the information collected from the SMEs. These descriptions are not intended to be complete accounts of the current process but rather address the high-level capabilities that enable the assignment of a maturity level based on the maturity level definitions available in the framework. For business processes that lack specificity and/or clear maturity level definition in the Framework, the assignment was based on a general understanding of the maturity levels that do exist. When a business process met some but not all of the maturity capabilities in a given level, the lower level of maturity was assigned.

KEY		
Column	**Description**	**Information**
1	Business Process	Name of the business process as outlined in MITA Framework 2.01
2	MITA Business Process Description	Short business process description from MITA Framework 2.01
3	'As-Is' Level and State's Current Process Description	MITA maturity level for the current New Mexico MMIS & short description of current process as defined by SMEs

Table 3: MITA Maturity 'As-Is'

Business Process	MITA Business Process Description	As-Is Level and State's Current Process Description
Member Management		
Determine Eligibility	The Determine Eligibility business process receives eligibility application data set from the receive inbound transaction process; checks for status (e.g., new, resubmission, duplicate); establishes type of eligible (e.g., children and parents, disabled, elderly, or other); screens for required fields; edits required fields; verifies applicant information with external entities; assigns an ID; establishes eligibility categories and hierarchy; associates with benefit packages, and produces notifications.	**Level 1** In each county there is at least one income support division office. Case workers accept and review all applications on paper and set up interviews. The applicant is interviewed and the case worker provides a preliminary assessment of whether the applicant appears to meet eligibility requirements.

Business Process	MITA Business Process Description	As-Is Level and State's Current Process Description
	NOTE: A majority of States accept the designation of eligibility from other agencies (SSI, TANF, SCHIP, and other), in which case this business process will not be used by the Medicaid agency for those individuals. In these situations, Medicaid receives and stores the member information sent from other sources in the Member data store. This may require conversion of the data. However, this process will be used by the other States which require the TANF, disabled, elderly applicant to apply for Medicaid, and where the Medicaid agency determines eligibility for State-only programs.	Information is put into the ISD2 System. The system will review the applicant's situation to determine what Medicaid benefit is the best fit of 40 categories (e.g., SSI or AFDC [TANF]). ISD2 determines eligibility and generates a paper notice to be mailed to the applicant.
Enroll Member	The Enroll Member business process receives eligibility data from the Determine Eligibility process, determines additional qualifications for enrollment in programs for which the member may be eligible (e.g., managed care, HIPP, waiver), loads the enrollment outcome data into the Member and Contractor data stores, and produces notifications to the member and the contractor. Either the Agency or enrollment brokers may perform some or all of the steps in this process. NOTE: There is a separate business process for disenroll member.	**Level 1** The ISD2 system sends a batch interface to the MMIS with eligibility information. The MMIS processes this information and generates ID cards as necessary. There is a waiting list for some Waiver programs. When slots become available members are notified and then have eligibility determined for potential enrollment into the waiver program. Members who are required to be enrolled in managed care are able to choose their managed care provider via paper, via phone call, or automated voice response. Members who do not choose by a given deadline are automatically enrolled. A proprietary format is used to notify the managed care organization of the enrollment. The HIPAA compliant 834 standard is not currently used.
Disenroll Member	The Disenroll Member business process is responsible for managing the termination of a member's enrollment in a program, including: • Processing of eligibility terminations and requests for disenrollment • Submitted by the member, a program provider, or contractor • Disenrollment based on member's death; failure to meet enrollment criteria, such as a change in health or financial status, or change of residency outside of service area • As requested by another Business Area, e.g., Prepare Member Premium Invoice process for continued failure to pay premiums or Program Integrity	**Level 2** ISD caseworkers receive information and based on that information may terminate eligibility in IDS2. ISD2 generates closure letters. Clients must periodically recertify that they are eligible. Clients who fail to do so, or who no longer meet eligibility requirements, are terminated. The updated eligibility information is then sent to the MMIS. Termination codes are sent to MCOs on the

Business Process	MITA Business Process Description	As-Is Level and State's Current Process Description
	Invoice process for continued failure to pay premiums or Program Integrity business area for fraud and abuse • Mass Disenrollment due to changes in status, or termination of, program provider or contractor • Validation that the termination meets State rules • Requesting that the Manage Member Information process reference new and changed disenrollment information • Prompting the Manage Member Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including: o The Prepare Capitation Premium Payment and Prepare Member Premium Payment business processes for changes in Member Information and stored data for payment preparation o The appropriate communications and outreach and education processes, such as the Manage Applicant and Member Communication, Perform Population and Member Outreach, and Manage Member Grievance and Appeal business process for follow up with the affected parties, including informing parties of their procedural rights (Note: This may precede *or* follow termination procedure(s)) Enrollment brokers may perform some of the steps in this process.	monthly roster. Managed care disenrollment letters are generated by the MMIS for members enrolled in managed care that lose eligibility.
Manage Member Information	The Manage Member Information business process is responsible for managing all operational aspects of the Member data store, which is the source of comprehensive information about applicants and members, and their interactions with the State Medicaid. The Member data store is the Medicaid enterprise "source of truth" for member demographic, financial, socio-economic, and health status information. A member's data store record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a member may receive a customized set of services. In addition, the Member data store stores records about and tracks the	**Level 1** Most updates are received electronically. Date stamps are applied to updates for audit trails. Notifications to interested users are not immediate and are completed via a batch cycle.

Business Process	MITA Business Process Description	As-Is Level and State's Current Process Description
	processing of eligibility applications and determinations, program enrollment and disenrollment; the member's covered services, and all communications, e.g., outreach and EOBs and interactions related to any grievance/appeal. The Member data store may store records or pointers to records for services requested and services provided; care management; utilization and program integrity reviews; and member payment and spend-down information. Business processes that generate applicant or member information send requests to the Member data store to add, delete, or change this information in data store records. The Member data store validates data upload requests, applies instructions, and tracks activity. The Member data store provides access to member records, e.g., for Medicare Crossover claims processing and responses to queries, e.g., for eligibility verification, and "publish and subscribe" services for business processes that track member eligibility, e.g., Manage Case and Perform Applicant and Member Outreach.	
Inquire Member Eligibility	The Inquire Member Eligibility business process receives requests for eligibility verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process, which generates the outbound Eligibility Verification Response Transaction. This transaction will, at minimum, indicate whether the member is eligible for some health benefit plan coverage under Medicaid, in accordance with HIPAA. This transaction may include more detailed information about the Medicaid programs, specific benefits and services, and the provider(s) from which the member may receive covered services. NOTE: This process does not include Member requests for eligibility verification. Member initiated requests are handled by the Manage Applicant and Member Communication process.	**Level 1** Member eligibility information is available via telephone, AVRS, the web, and switch vendors using proprietary formats. The HIPAA compliant 270/271 standards are not currently used.
Perform Population and Member	The Perform Population and Member Outreach business process originates internally within the Agency for purposes such as:	**Level 2** Marketing plans are developed for specific

Business Process	MITA Business Process Description	As-Is Level and State's Current Process Description
Outreach	– Notifying prospective applicants and current members about new benefit packages and population health initiatives – New initiatives from Program Administration – Receiving indicators on underserved populations from the Monitor Performance and Business Activity process (Program Management) It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the State Children's Health Insurance Program (SCHIP). Outreach information is developed for targeted populations that have been identified by analyzing member data. Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction and the Manage Business Relationship Communication processes. All outreach communications and information package production and distribution is tracked and materials archived according to State archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process. NOTE: The Perform Population and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues. Inquiries from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bi-directional communication.	populations with targeted demographics. Materials are functionally, linguistically, culturally, and competency appropriate. While outreach materials are largely prepared manually, the State website, newspaper, TV and radio advertising are used. Face-to-face meetings are also used for outreach. Programs are able to share analysis of current and prospective member demographics, socio-economic status, functional and health needs to some extent.
Manage Applicant and Member Communication	The Manage Applicant and Member Communication business process receives requests for information, appointments, and assistance from prospective and current members' communications such as inquiries related to eligibility, redetermination, benefits, providers; health plans and programs, and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and produced for distribution via Send Outbound Transaction process. NOTE: Inquiries from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bi-directional communication. Also included are scheduled	**Level 1** The State's web site contains some general information that is accessible to members. Member communications are primarily conducted via paper and phone. Members call the solution center with questions. Mail inquiries are also received from members and are distributed to the eligibility unit. Research for these communications is completed manually. Responses to frequently asked questions from members are not standardized, nor are they automated for access from voice response system.

Business Process	MITA Business Process Description	As-Is Level and State's Current Process Description
	directional communication. Also included are scheduled communications such as Member ID cards, redetermination notifications, or formal program notifications such as the dispositions of grievances and appeals. The Perform Applicant and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues.	Research and response to member inquiries are not immediate.
Manage Member Grievance and Appeal	The Manage Member Grievance and Appeal business process handles applicant or member (or their advocate's) appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Applicant and Member Communication process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the applicant or member and stored in the applicant or member information file. The applicant or member is formally notified of the decision via the Send Outbound Transaction Process. This process supports the Program Quality Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. In some states, if the applicant or member does not agree with the Agency's disposition, a second appeal can be filed requesting a review of the disposition. If the health status or medical need of the applicant or member is urgent, the appeal may be expedited. NOTE: States may define "grievance" and "appeal" differently, perhaps because of State laws. States must enforce the Balance Budget Act requirements for grievance and appeals processes in their MCO contracts at 42 CFR Part 438.400. They may adopt these for non-MCO programs.	**Level 1** The Fair Hearings Bureau coordinates and processes grievances and appeals. Depending on the nature of the complaint, different bureaus complete the research. This process is manual and paper based, regardless of the Bureau that is addressing the complaint. Internal tracking is done via an Access database.

Provider Management		
Enroll Provider	The Enroll Provider business process is responsible for managing providers' enrollment including: 1. Receipt of enrollment application data set from the Manage Provider Communication process. 2. Processing of applications, including status tracking (e.g., new, resubmission, duplicate) and validating application meets Federal and State submission rules, e.g., syntax/semantic conformance. 3. Validation that the enrollment meets Federal and State rules by a. Performing primary source verification of provider credentials and sanction status with external entities, including: b. Education and training/Board certification c. License to practice d. DEA/CDS Certificates e. Medicare/Medicaid sanctions f. Disciplinary/sanctions against licensure which may include external States g. Malpractice claims history h. NPDB (National Provider Data Bank) and HIPDB (Health Integrity Protection Data Base) disciplinary actions/sanctions i. Verifying or applying for NPI enumeration with the NPPES j. Verifying SSN or EIN and other business information k. Performing policy requirements for atypical providers such for a nonemergency provider might include validation of transportation insurance, valid driver's license 4. Determination of contracting parameters, e.g., provider taxonomy, type, category of service for which the provider can bill. 5. Establishment of payment rates and funding sources, taking into consideration service area, incentives or discounts. 6. Negotiation of contracts. 7. Supporting receipt and verification of program contractor's provider enrollment roster information, e.g., from MCO and HCBS organizations. 8. Requesting that the Manage Provider Information process load initial and changed enrollment information, including providers contracted with program contractors into the Provider data store. 9. Prompting the Manage Provider Information process to provide timely and accurate notification, or to make enrollment data required for operations	**Level 1** All provider enrollment applications are received on paper and scanned to COLD storage. The applications are manually processed. The provider enrollment applications are date stamped and reviewed for completeness. Most requirements such as insurance information, specialty certification, and DEA certification are verified against paper copies that are required to be included with the application. The verification of licensure is conducted via the web for licenses issued by boards that provide web access. The sanction report is checked to ensure that the applicant has not been sanctioned. Once all items are reviewed the application is forwarded to State for review. ACS then activates the provider based on the State's direction. Automated letters are generated out of the MMIS 90 days prior to licensure expiration that are mailed to the provider. The enroll provider process is largely conducted via paper and manual processes.

	available to all parties and affiliated business processes, including: a. The capitation and premium payment area b. The prepare provider EFT/check process c. The appropriate communications; outreach and education processes for follow-up with the affected parties, including informing parties of their procedural rights. 10. Performing scheduled user-requested: a. Credentialing reverification. b. Sanction monitoring. c. Payment rate negotiations d. Performance evaluation. External contractors such as quality assurance and credentialing verification services may perform some of these steps.	
Manage Provider Information	The Manage Provider Information business process is responsible for managing all operational aspects of the Provider data store, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the State Medicaid. The Provider data store is the Medicaid enterprise "source of truth" for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The data store includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services. In addition, the Provider data store stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and all communications with or about the provider, including provider verification requests and responses; and interactions related to any grievance/appeal. The Provider data store may store records or pointers to records for services requested and services provided; performance, utilization, and program integrity reviews; and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member data store to add, delete, or change this information in data store records. The Provider data store validates data upload requests, applies instructions, and tracks activity. The Provider data store provides access to provider records to applications and users via batch record transfers, responses to queries, and "publish and subscribe" services.	**Level 1** Updates are received from providers and the State on paper. Changes are applied to the provider file manually with an automated date stamp and audit trail. All changes are checked for quality. The NPI is stored in the provider file and is translated to local provider identifiers for claims processing.
Inquire Provider Information	The Inquire Provider Information business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set	**Level 1** Requests for provider enrollment information are not automated via AVRS or the web. Inquiries from

	for the Send Outbound Transaction process.	providers to check the status of their enrollment applications are received via telephone. These calls are sent via the queue based on the selection the provider makes from the phone menu. Research and responses for this process are conducted manually.
Manage Provider Communication	The Manage Provider Communication business process receives requests for information, provider publications, and assistance from prospective and current providers' communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via Send Outbound Transaction process. Note: Inquiries from prospective and current providers are handled by the Manage Provider Communication process by providing assistance and responses to individual entities, i.e., bi-directional communication. Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The Perform Provider Outreach process targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues.	**Level 1** Providers call or send written inquiries. Some written inquiries come in via email; however, there is no formal process for email communications with providers. Each inquiry is logged with the date and general information about the inquiry. All inquiries receive a response. Providers whose licensure is due to expire are notified via a system generated letter. Program information is available on the web; however there is no look up capability to identify enrolled providers or to verify if a specific service is covered.
Manage Provider Grievance and Appeal	The Manage Provider Grievance and Appeal business process handles provider* appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process. This process supports the Program Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.	**Level 1** The provider files a grievance/appeal or request for a fair hearing on paper. The Fair Hearings Bureau notifies the appropriate bureau and forwards the grievance or appeal to the appropriate bureau where it is manually reviewed. A summary of evidence is prepared. Information may be obtained from a contractor depending upon the nature of the grievance or appeal. Hearings are held before the administrative law judge. The judge makes a recommendation to the Director's office. The decision may be reviewed by a Bureau Chief who can agree or disagree with the decision. The Director can agree or disagree with the judge's decision. The Director's office has final word. A letter describing the final decision is sent to the provider. This is a very manual process that

	NOTE: States may define "grievance" and "appeal" differently, depending on State laws. States may involve multiple agencies in the Provider Grievance and Appeal process. *This process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when an application for enrollment is denied.	involves significant manual research.
Perform Provider Outreach	The Perform Provider Outreach business process originates internally within the Medicaid Enterprise in response to multiple activities, e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical break-throughs, changes in the Medicaid program policies and procedures. Prospective Provider outreach information, also referred to as Provider Recruiting information, may be developed for targeted providers that have been identified by analyzing program data (for example, not enough dentists to serve a population, new immigrants need language-compatible providers) Enrolled Provider outreach information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives. Outreach communications and information packages are distributed accordingly through various media. All outreach communications and information package production and distribution are tracked and materials archived according to State archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.	**Level 1** Detailed information about new policies and changes in policy is made available to advocates, providers and other interested parties using various media including the provider Remittance Advice Newsletter process, the State website, and through special mailings by the State. The State drafts policy changes and mails information to providers and also posts information on the State website. The use of the portal/State website by providers is not monitored to ensure that all are actively engaged in downloading information. Managed care programs conduct their own outreach to recruit providers.
Contractor Management		
Produce Administrative or Health Services RFP	The Produce Administrative or Health Services RFP business process gathers requirements, develops a Request for Proposals (RFP), requests and receives approvals for the RFP, and solicits responses.	**Level 1** At the beginning of this process an Executive Sponsor and Procurement Manager are identified. The Procurement Manager organizes committees and arranges meetings to get input across State agencies and from internal staff. An APD is prepared and submitted to CMS. This process is coordinated with the HSD Office of General Counsel. IT projects are also coordinated with the ITD and then with the NM Department of Information Technology. The RFP is developed.

		Existing requirements are reviewed. The RFP is approved by CMS and published. A question and answer period is conducted. The Procurement Library is developed. Responses are received and reviewed. This is largely a paper based process with manual verification and updates; however the Procurement Library is on the web and proposals are received electronically as well as on hard copy.
Manage Administrative or Health Services Contract	The Manage Administrative or Health Services Contract business process receives the contract award data set, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the contract throughout its duration.	**Level 1** This business process is primarily manual. Manual and automated reports are supplied by the Fiscal Agent or MCO. The data is standardized.
Award Administrative or Health Services Contract	The Award an Administrative or Health Services Contract business process utilizes requirements, advanced planning documents, requests for information, request for proposal and sole source documents. This process is used to request and receive proposals, verifies proposal content against RFP or sole source requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, and notifies parties. In some States, this business process may be used to make a recommendation of award instead of the award itself.	**Level 1** An evaluation committee is assembled. The evaluation committee and other SMEs review and score the proposal. Scores are then calculated. Clarifications may be requested on different proposals/costs. Orals may be held. A recommendation is made by the evaluation committee to the HSD Secretary or executive sponsor. Contract negotiations are held. The Award is given. Protests are handled if they arise. This is a manual process that is primarily conducted on paper.
Close-out Administrative or Health Services Contract	The Close-out Administrative or Health Care Services Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.	**Level 1** The contract outlines the turnover requirements. The State oversees and tracks the transfer of information. Almost all of the inputs and outputs for this process are electronic. Verifications are a mix of manual and automated steps.
Manage Contractor Information	The Manage Contractor Information business process receives a request for addition, deletion, or change to the Contractor data store; validates the request, applies the instruction, and tracks the activity.	**Level 1** Once a health services contract is negotiated the contractor is set up in Omnicaid and a plan file is

		developed. This includes all criteria about client qualifications for this plan. Rates are also included. Requests are standardized but not automated. Information is stored in Omnicaid and is available on-demand. Administrative contractors are set up in the State's accounting system, SHARE.
Inquire Contractor Information	The Inquire Contractor Information business process receives requests for contract verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the send outbound transaction process.	**Level 1** Inquiries for information on administrative contractors are conducted via telephone and in writing. A monthly automated plan file is posted to a secure web portal for the MCO to retrieve. Questions are conducted via telephone. Although some of the steps for this process are manual, the monthly reports to the MCOs are automated.
Perform Contractor Outreach	The Perform Contractor Outreach business process originates initially within the Agency in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures. For prospective contractors, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs. For currently enrolled contractors, information may relate to public health alerts, public service announcements, and other objectives. Contractor outreach communications are distributed through various mediums via Send Outbound Transaction. All contractor outreach communications are produced, distributed, tracked, and archived by the agency according to State archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.	**Level 1** For MCO communications, this process is largely done via formal letters, e-mails, meetings, phone calls and the State website. No newspaper, TV or radio outreach is conducted. Programs do not share analysis/performance measures based on increase standardization of administrative data.
Manage Contractor Communication	The Manage Contractor Communication business process receives requests for information, appointments, and assistance from contractors such as inquiries related to changes in Medicaid program policies and procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed, and produced for distribution. NOTE: Inquiries from prospective and current contractors are handled by the	**Level 1** Monthly meetings are held with the MCOs; one meeting focuses on program issues and the other on system issues. Performance measures, incentives and/or pay for performance communications occur through meetings, phone calls, email and formal correspondence, including

	Manage Contractor Communication process by providing assistance and responses to individual entities, i.e., bi-directional communication. The Perform Contractor Outreach process targets both prospective and current contractor populations for distribution of information regarding programs, policies, and other issues. Other examples of communications include: - Pay for performance communications – performance measures could effect capitation payments or other reimbursements. - Incentives to improve encounter data quality and submission rates	Letters of Direction. Questions from MCOs are usually presented at meetings, on phone calls, by formal correspondence or via email. Regular meetings are held with the State's administrative contractors, including multiple weekly meetings with the MMIS fiscal agent on specific topics.
Support Contractor Grievance and Appeal	The Support Contractor Grievance and Appeal business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Contractor Communications process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented, and relevant documents are distributed to the contractor information file. The contractor is formally notified of the decision via the Send Outbound Transaction process. This process supports the Program Management business area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. NOTE: States may define "grievance" and "appeal" differently, perhaps because of State laws. *This process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor can file a grievance or appeal, for example, when an application is denied.	**Level 1** A Fee for Service or Managed Care Organization member or their contracted provider can contact the State and file a grievance or appeal if they haven't file the grievance or appeal with the MCO. This is done either in writing or via a phone call. The documents are not electronically captured via optical character recognition, nor are they scanned as images. Paper copies are maintained. The issue is entered into an Access database. Reports are derived from this database and improvements are made as needed. The New Mexico Medicaid website posts all the Medicaid program benefits so the member and/or contractor can discern whether services are covered. The new Long Term Care managed care program through the Department of Aging and Long Term Services will have access to the current Access database.
Operations Management		
Edit / Audit Claim - Encounter	The Edit Claim/Encounter business process receives an original or an adjustment claim/encounter data set from the Receive Inbound Transaction process and • Determines its submission status • Validates edits, service coverage, TPL, coding	**Level 1** The State has recently mandated electronic billing with several exceptions. The MMIS processes Waiver claims in addition to Medicaid claims. Claims are put through editing logic. Some edits

	• Populates the data set with pricing information Sends validated data sets to Audit Claim/Encounter process and data sets that fail audit to the Prepare Remittance Advice/Encounter Report process All claim/encounter types must go through most of the steps within the Edit Claim/Encounter process with some variance of business rules and data. See Constraints. NOTE: This business process is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, and Prepare Remittance Advice/Encounter processes. NOTE: The Edit Claim/Encounter process does not apply to: • Point of Sale, which requires that Edit, Audit, and other processes be integrated, or • Direct Data Entry, On-line adjudication, or Web-enabled submissions that require field-by-field accept/reject and pre-populate fields with valid data. The Audit Claim-Encounter business process receives a validated original or adjustment claim/encounter data set from the Edit Claim-Encounter process and checks payment history for duplicate processed claims/encounters and life time or other limits. Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity. Suspends data sets that fail audits for internal review, corrections, or additional information Sends successfully audited data sets to the Price Claim-Value Encounter process All claim/encounter types must go through most of the steps within the Audit Claim-Encounter process with some variance of business rules and data. See Constraints. NOTE: This process is part of a suite that includes: Edit Claim-Encounter, Audit Claim-Encounter, Price Claim-Value Encounter, Apply Attachment, and Prepare Remittance Advice/Encounter processes. In Edit Claim-Encounter, a single transaction is edited for valid identifiers and codes, dates, and other information required for the transaction. Audit Claim-Encounter is the next step in which a claim-encounter with valid content is further edited against historical data. Edit and Audit could be combined into a single process, e.g., point-of-	are dispositioned to auto deny or auto pay. Many edits are dispositioned to suspend. The editing logic is automated; however there is a significant amount of manual review required for edits that are dispositioned to suspend. There is an effort underway to identify and revise edits that are disposition to suspend to enable them to be automated, thus reducing the amount of manual intervention required for processing claims. The HIPAA 837 transactions and standards are used for claims and encounters but are not yet in place for voids or adjustments. There is no automated transaction generated to request more information on a specific claim while the claim is in suspense.

	sale transaction processing.	
Price Claim - Value Encounter	NOTE: Framework 2.0 describes three separate processes to edit the content of individual claims and encounters, further adjudicate these services against rules and history, and finally price or evaluate the service. These three processes may be combined into a single process. This is an implementation decision. Whether combined or separate, the requirements of Pricing a claim or Evaluating an Encounter are described below. The Price Claim-Value Encounter business process begins with receipt of claim/encounter adjudicated data. Pricing algorithms are applied. Examples include calculating managed care and Primary Care Case Management [PCCM] premiums, calculating and applying member contributions, DRG and/or APC pricing, provider advances, liens and recoupment. This process is also responsible for ensuring that all adjudication events are documented in the Payment History Information data store by passing the appropriate data set to the Manage Payment Information process. All claim types must go through most of the process steps but with different logic associated with the different claim types. NOTE: An adjustment to a claim is on an exception use case to this process that follows the same process path except it requires a link to the previously-submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the payment history data store.	**Level 2** Most claims are automatically priced. Some manual pricing is done (mostly DME) based on instruction from the State. Provider rates are on file for institutions and are priced automatically. The Medicaid agency supports payment of waiver programs and a-typical providers and has coordinated with waiver programs for adjudication and pricing. MS-DRG pricing is used to price inpatient hospital claims from in-state and bordering providers.
Apply Attachment	This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) or has been sent by the provider (unsolicited).The solicited attachment data sets can be in response to requests for more information from the following processes for example: Audit Claim/Encounter, Authorize Service, Authorize Treatment Plan, and Manage Estate Recovery. The attachment data set is then linked to the associated applicable transaction [claim, prior authorization, treatment plan, etc.] and is either attached to the associated transaction or pended for a predetermined time period set by State-specific business rules, after which it is purged. Next, the successfully associated attachment data set is validated using application level edits, determining whether the data set provides the additional information necessary to adjudicate/approve the transaction. If yes, the attachment data	**Level 1** Claims that require attachments must be submitted on paper. Attachments cannot be accepted electronically. Medicare cross-over claims may be submitted electronically only by the COBA contractor, with the Medicare information included in the transaction. Such claims may not be submitted electronically by providers at this time.

	set is moved with the transaction to the approval process. If no, it is moved to a denial process or triggers an appropriate request for additional information, unless precluded by standard transaction rules.	
Apply Mass Adjustment	The Apply Mass Adjustment business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with Healthcare Common Procedure Coding System (HCPCS), Current Procedural Technology (CPT), Revenue Codes, or program modifications/ conversions that affect payment or reporting. This mass adjustment business process includes identifying the claims by claim/bill type or HCPCS, CPT, Revenue Code(s), or member ID that were paid incorrectly during a specified date range, applying a predetermined set or sets of parameters that will reverse the paid claims and repay correctly. NOTE: This should not be confused with the claim adjustment adjudication process. A mass adjustment may involve many previous payments based on a specific date or date range affecting single or multiple providers, members, or other payees. Likewise, Mass Adjustment historically refers to large scale changes in payments as opposed to disenrolling a group of members from an MCO.	**Level 1** A mass adjustment steering committee made up of ACS managers and key State staff reviews all mass adjustment requests. ACS Business Analysts develop the information for the selection of the claims to be adjusted by manually determining selection criteria. The steering committee approves the criteria for the claim selection as well as how edits are to be resolved. Adjustments are then applied to the applicable claims via automated means.
Prepare Remittance Advice - Encounter Report	The Prepare Remittance Advice-Encounter Report business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers to reconcile their accounts receivable. This process begins with receipt of data resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data, which is sent to the Send Outbound Transaction technical process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment Information to update the Payment Information data store. NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.	**Level 1** Remittance Advices (RAs) are generated via the MMIS system. They are saved to COLD and automatically uploaded to the web portal. Since RAs are available on the web NM Medicaid no longer mails paper RAs to providers. The X12 835 HIPAA transaction is in the process of being implemented for NM Medicaid.
Prepare COB	The Prepare COB business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries. The Prepare COB business process begins with the completion of the Price Claim/Value Encounter process. Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria such as error codes and associated disposition, service codes, program codes, third party liability information available from both the	**Level 1** Other insurance information is stored on client's TPL file in the MMIS. The MMIS checks for claims that should have been covered by Other Insurance. On a weekly basis, paper claims are generated and mailed to Other Insurance carriers. A TPL billing record is automatically created. When a payment is received from the Other Insurance and is entered

	original claim and/or eligibility files. This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, formatting of claims data into the outbound EDI data set, validating that the outbound EDI transaction is in the correct format and forwarding to the Send Outbound Transaction.	on the TPL record, an adjustment is systematically created and the payment is recorded on the billing record.
Prepare HCBS Payment	Many home and community based services are not part of the traditional Medicaid benefit package. Services tend to be client specific and often are arranged through a plan of care. Services for Home & Community Based waivers are often rendered by a-typical providers and may or may not be authorized or adjudicated in the same manner as other health care providers. The Prepare Home and Community-Based Services Payment business process describes the preparation of the payment report data set. These will be sent on paper or electronically to providers and used to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History process for loading into the Payment History data store. The reimbursement amount is sent to the Manage Provider Information process for loading into the Provider data store for purposes of accounting and taxes. NOTE: This process does not include sending the home & community based provider payment data set transaction.	**Level 2** The NM Medicaid agency works with HCBS programs to share Medicaid processes. All HCBS use Medicaid Business Processes for payment. HCBS providers agree to use Medicaid standards for claims adjudication and payment.
Prepare EOB	The Prepare EOB business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the explanation of benefits (EOBs), and processing returned EOBs to determine if the services claimed by a provider were received by the client. The EOBs or letters must be provided to the clients within 45 days of payment of claims. This process includes identifying sample data using random sampling methodology, retrieving the sample data set, preparing the Explanation of Benefits (EOBs) and/or notification letters, formatting the data into the required data set, which is sent to the Send Outbound Transaction for generation. The resulting data set is also sent to Manage Applicant and Member Communication. NOTE: This process does not include the handling of returned data nor does it	**Level 1** On a monthly basis the NM MMIS selects every 250th client and generates a Recipient EOMB with the claims processed that month. Some services are excluded from the EOMB. The EOMBs are mailed out. When they are received back they are reviewed to determine whether the clients show a discrepancy. Recipient EOMBs with discrepancies are forwarded to the State. Counts are maintained of EOMBs that are received back from recipients.

	include sending the EOB Sample Data Set.	
Prepare Provider EFT - Check	The Prepare Provider EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including: • Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, HCBS provider claims, and MCO encounters based on inputs such as the priced claim, including any TPL, crossover or member payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and taxes, performance incentives, recoupments, garnishments, and liens per data in the Provider data store, Agency Accounting and Budget Area rules, including the Manage 1099 process • Payroll processing, e.g., for HCBS providers, includes withholding payments for payroll, federal and State taxes, as well as union dues • Dispersement of payment from appropriate funding sources per State and Agency Accounting and Budget Area rules • Associating the EFT with an X12 835 electronic remittance advice transaction is required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the remittance advice within the banking system may not be HIPAA covered entities.] • Routing the payment per the Provider data store payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction • Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history • Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate, e.g., Pharmacy POS	**Level 1** Currently, paper checks are mailed to providers for FFS payments. The State is in the process of implementing EFT for providers for Fee For Service claims. The State is in the process of implementing the HIPAA compliant 835 standard.
Prepare Premium Capitation EFT - Check	The Prepare Premium Capitation EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including	**Level 1** Omnicaid produces a warrant for each MCO during one regular payment cycle each month. The

	• Calculation of
	  o HIPP premium based on members' premium payment data in the Contractor data store
	  o Medicare premium based on dual eligible members' Medicare premium payment data in the Member data store
	  o PCCM management fee based on PCCM contract data re: different reimbursement arrangements in the Contractor data store
	  o MCO premium payments based on MCO contract data re: different reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package in the Contractor data store
	  o Stop-loss claims payments for MCOs in the Contractor data store
	  o HIFA waiver small employer refunds (i.e. Parents of kids on SCHIP).
	• Application of automated or user defined adjustments based on contract, e.g., adjustments or performance incentives
	• Dispersement of premium, PCCM fee, or stop loss payment from appropriate funding sources per Agency Accounting and Budget Area rules
	• Associate the MCO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the Premium Payment within the banking system may not be HIPAA covered entities]
	• Routing the payment per the Contractor data store payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction
	• Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid premium, fees, and stop loss claims transaction accounting details, tying all transactions back to a specific contractual payment obligation and its history.
		warrant is delivered to ASD, which arranges for an EFT payment to be generated in the amount of the warrant. The 820 transaction is not used and the EFT transaction requires manual intervention.

Prepare Health	Medicaid agencies are required to pay the private health insurance premiums	**N/A**

Insurance Premium Payments	for members who have private health insurance benefits if the insurance is determined to be cost effective. In these circumstances, a premium is prepared and sent to the member's private health insurance company rather than enrolling them into a Medicaid managed health care plan. The Prepare Health Insurance Premium Payments business process begins with an application for Medicaid where the applicant indicates they have third party health coverage or by receiving eligibility information via referrals from Home and Community Services Offices, schools, community services organizations, or phone calls directly from members; checking for internal eligibility status as well as eligibility with other payers, editing required fields, producing a report, and notifying members via Manage Applicant and Member Communication. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. The formatted premium payment data set is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Maintain Member Information for updating. NOTE: This process does not include sending the health insurance premium payment data set.	
Prepare Medicare Premium Payment	State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process State Medicaid agencies, the Social Security Administration (SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance. The Prepare Medicare Premium Payments business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member data store, generating buy-in files for CMS for verification, formatting the premium payment data into the required output data set, which is sent to the Send Outbound Transaction. The resulting data set is also sent to Manage Payment History and Manage Member Information for loading. NOTE: This process does not include sending the Medicare premium payments EDI transaction.	**Level 1** The Application Support Bureau within ITD receives two monthly VSAM (flat file) Data Bases that contain Medicare premium information - one from Medicare Part A and one from Medicare Part B via connect direct. ITD reviews and shares data with the Income Support Division and MMIS. On the 17th of each month ITD gathers data from ISD2 system via electronic feed, Medical Assistance Division manually, and SDX SSI disability via electronic feed. ISD creates and edits records via manual edit process, updates the 2 VSAM files originally received from CMS and sends back a file to CMS on 25th of each month along with payment. This process includes some electronic feeds and manual steps. The State has requested a waiver from the Federal government to not implement the new buy-in process until the ISD2 eligibility system

		has been replaced.
Prepare Capitation Premium Payment	The Prepare Capitation Premium Payment business process includes premiums for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the Member data store, retrieving the rate data associated with the plan from the Provider or Contractor data store, formatting the payment data into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading NOTE: This process does not include sending the capitation payment data set.	**Level 1** For managed care organizations the State treasury office generates an EFT into the managed care organization's account. This is in the process of being automated along with provider EFTs. The HIPAA compliant 820 standard for Premium Payments is not currently being used. A proprietary format is used in place of the 820.
Manage Payment Info	The Manage Payment Information business process is responsible for managing all the operational aspects of the Payment Information data store, which is the source of comprehensive information about payments made to and by the state Medicaid enterprise for healthcare services. The Payment Information data store exchanges data with Operations Management business processes that generate payment information at various points in their workflows. These processes send requests to the Payment Information data store to add, delete, or change data in payment records. The Payment Information data store validates data upload requests, applies instructions, and tracks activity. In addition to Operations Management business processes, the Payment Information data store provides access to payment records to other Business Area applications and users, such as the Program, Member, Contractor, and Provider Management business areas, via record transfers, response to queries, and "publish and subscribe" services.	**Level 1** Data sources are primarily an electronic interchange for claims but not for other insurance payments as a result of TPL billing. The payment history updates are scheduled around the legacy systems' production cycles.
Inquire Payment Status	The Inquire Payment Status business process begins with receiving a 276 Claim Status Inquiry transaction or a request for information received through other means such as paper, phone, fax or AVR request for the current status of a specified claim(s), calling the payment history data store and/or data store, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response or other mechanism for responding via the medium used to communicate the inquiry, and sending claim status response data set via the Send Outbound Transaction process.	**Level 1** This process is currently conducted by providers contacting the provider call center or via the web. AVRS also provides check amount information but not specific claim status. The HIPAA compliant 276/277 transaction is not currently being used.

Calculate Spend-Down Amount	A person that is not eligible for medical coverage when they have income above the benefit package or program standards may become eligible for coverage through a process called "spend-down" (see Determine Eligibility). The Calculate Spend-Down Amount business process describes the process by which spend-down amounts are tracked and a client's responsibility is met through the submission of medical claims. The spend down amount is automatically accounted for during the claims processing process resulting in a change of eligibility status once spend-down has been met which allows for Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels, but may also occur in other situations. The Calculate Spend-Down Amount business process begins with the receipt of member eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the member is assigned to a benefit package or program that requires a predetermined amount the member must be financially responsible for prior to Medicaid payment for any medical services. NOTE: The 'Calculate Spend-down Amount' today is primarily a manual process in the Eligibility Determination, Member Payment Management and Maintain Payment History threads. At Level 3 these processes have almost eliminated any use of manual intervention.	**N/A**
Prepare Member Premium Invoice	States may implement client/member cost-sharing through the collection of premiums for medical coverage provided under the Medicaid/SCHIP umbrella. The premium amounts may be based on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment. The Prepare Member Premium Invoice business process begins with a timetable (usually monthly) for scheduled invoicing. The process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium invoices which will be sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Maintain Member Information process for updating. NOTE: This process does not include sending the member premium invoice EDI transaction.	**Level 1** State Coverage Insurance (SCI) is a program for uninsured adults who don't qualify for other categories of Medicaid. Individuals apply for the program through either an employer group or as an individual without employer sponsorship. If required, the premium must be paid before enrollment begins. Employers find out about the program through various resources such as: insurance broker, the Managed Care Organizations or the INM Group Enrollment Center. The Group Enrollment Center facilitates all employer group applications and serves as the liaison with ISD during the application process. Once eligibility is approved, the group completes the enrollment process with the SCI MCO. Non- employer

		sponsored individuals submit eligibility applications directly to the ISD office and once approved enroll directly and pay the applicable premium to the MCO. For the Premium Assistance for Maternity Program (non Medicaid eligibles without maternity health benefits), a one-time premium amount based on the client's trimester is collected by the State before eligibility is given. The client is informed of potential eligibility and the appropriate premium amount, which is then sent to a State lockbox by the client. Upon verification of receipt of premium, client eligibility is manually entered into Omnicaid. Premium Assistance for Children Program (non Medicaid eligibles without current health insurance), The State assists parents to purchase commercial health insurance plans that have been approved by the State. The State processes eligibility for the program via application review. Once approved, the client arranges to pay a monthly portion of the premium with the health plan while the State is billed for the remainder via a monthly reverse roster process.
Manage Recoupment	The Manage Recoupment business process describes the process of managing provider recoupment. Provider recoupment are initiated by the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where monies are owed to the agency due to fraud/abuse. The business thread begins with discovering the overpayment, retrieving claims payment data via the Manage Claims History, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results via the Manage Provider Communication, applying recoupments in the system via the Perform Accounting Functions, and monitoring payment history until the repayment is satisfied.	**Level 1** Normally the State identifies claims to be reprocessed and directs ACS to conduct recoupments. If ACS identifies overpayments, they identify claims and send this information to the State for approval to reprocess. This is called the Mass Adjustment Process. The agency is increasing use of electronic interchange and automated processes for managing recoupments. They are in the process of implementing the HIPAA mandated X12 835 transaction.

	Recoupments can be collected via check sent by the provider or credited against future payments for services.	
Manage Estate Recovery	Estate recovery is a process whereby States are required to recover certain Medicaid benefits correctly paid on behalf of an individual. This is done by the filing of liens against a deceased member's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, ICF/MR, or other medical institution. The Manage Estate Recovery business process begins by receiving estate recovery data from multiple sources (e.g., date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), generating correspondence data set (e.g., demand of notice to probate court via Send Outbound Transaction process, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the Manage Applicant and Member Communication process, opening formal estate recovery case based on estate ownership and value of property, determining value of estate lien, files petition for lien, files estate claim of lien, conducts case follow-up, sending data set to Perform Accounting Functions, releasing the estate lien when recovery is completed, updating Member data store, and sending to Manage Payment History for loading. NOTE: This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.	**Level 1** This process is currently conducted via telephone with no current automation for this process. New Mexico is a No-Lien State. NM Medicaid does not take a lien on property to recover Medicaid funds.
Manage TPL Recovery	The Manage TPL Recoveries business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, attorneys, Program Integrity/Fraud & Abuse, Medicaid Fraud Control Unit, providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from Manage Payment History, creating post-payment recovery files, sending notification data to other payer or provider from the Manage Provider Communication process, receiving payment from provider or third party payer, sending receivable data to Perform Accounting Function, and updating payment history Manage Payment History. NOTE: States are generally required to cost avoid claims unless they have a waiver approved by CMS which allows them to use the pay and chase	**Level 1** Other insurance information is put on a client's file in the MMIS. The MMIS checks for claims that should have been covered by Other Insurance. On a weekly basis, paper claims are generated and mailed to Other Insurance carriers. A TPL billing record is automatically created. When a payment is received from the Other Insurance an adjustment is automatically created and the payment is recorded on the billing record. Information regarding third-party resources is manually validated. TPL recovery

	method.	is primarily accomplished via Medicaid Subrogation.
Manage Drug Rebate	The Manage Drug Rebate business process describes the process of managing drug rebate that will be collected from manufacturers. The process begins with receiving quarterly drug rebate data from CMS and includes comparing it to quarterly payment history data, identifying drug data matches based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the drug manufacturer via the Send Outbound Transaction Process sending to Perform Accounting Functions.	**Level 2** DRAMS is used by the State to manage drug rebates. A CMS tape is loaded into DRAMS. History claims are loaded into DRAMS on a weekly basis. Drugs provided via Indian Health Services providers are not rebated. At the end of the quarter after the CMS tape is loaded, calculations are made and invoices are created. Invoices are mailed. Summary level information is put on a tape and sent to CMS.
Manage Cost Settlement	The Manage Cost Settlement business process begins with requesting annual claims summary data from Manage Payment History. The process includes reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates. In some States, cost settlements may be made through the application of Mass Adjustments.	**Level 1** Cost Settlement is done on outpatient services only. Providers (hospitals and home health agencies) submit a report annually. This process is a combination of paper and CDs being submitted from the providers. NM Medicaid contracts with an audit agent to perform desk or field audits. Costs are reviewed and reports from providers are compared with reports from the data warehouse. A notice of program reimbursement is sent to the providers and can result in the provider owing money or a payment being generated to the provider.

Authorize Treatment Plan	The Authorize Treatment Plan business process encompasses both a pre-approved and post-approved treatment plan. The Authorize Treatment Plan is primarily used in care management settings where the care management team assesses the client's needs, decides on a course of treatment, and completes the Treatment Plan. A Treatment Plan prior-authorizes the named providers or provider types and services or category of services. Individual providers can be pre-approved for the service or category of services and do not have to submit their own service request. A treatment plan typically covers many services and spans a length of time. (In contrast, an individual service request, primarily associated with fee-for-service payment, is more limited and focuses on a specific visit, services, or products, such as a single specialist office visit referral, approval for a specific test or particular piece of Durable Medical Equipment [DME]). The pre-approved treatment plan generally begins with the receipt of an authorize treatment plan request from the care management team, is evaluated based on urgency, State priority requirements, and type of service/taxonomy (speech, physical therapy, home health, behavioral, social). It includes validating key data, and ensuring that requested plan of treatment is appropriate and medically or behaviorally necessary. After reviewing, the request is approved, modified, pended, or denied and the appropriate response data set is forwarded to the Care Management team and the Manage Provider Communication process. A post-approved treatment plan is an audit function that reviews pended or paid claims to ensure the services were appropriate and in accordance with the treatment plan. NOTE: MITA contains three different "Authorize Service" business processes: • Authorize Service – the standard process of prior authorization of fee-for-service service • Authorize Treatment Plan – the approval of a treatment plan prepared by a care management team in a care management setting	**Level 1** Each MCO has a Utilization Review department that processes the treatment plan authorizations for MCO members. BCBS processes treatment plan authorizations for NM Medicaid Fee For Service members. The MCOs have web access for submission of treatment plan authorizations, BCBS does not. All BCBS authorizations are submitted on paper to BCBS by the provider. The authorizations are manually reviewed. BCBS sends an electronic interface to the MMIS with the authorization information. BCBS also has direct access to the authorization files within the MMIS. The HIPAA compliant 278 transaction standard is not used. The X12 277 is not used to notify the provider when additional information is needed.

	• Authorize Referral – specifically the approval of a referral to another provider, requested by a primary care physician	
Authorize Referral	The Authorize Referral business process is used when referrals between providers must be approved for payment, based on State policy. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. This business process is primarily associated with Primary Care Case Management programs where additional approval controls are deemed necessary by the State. Most States do not require this additional layer of control. NOTE: MITA contains three different "Authorize Service" business processes: 1. Authorize Service – the standard process of prior authorization of fee-for-service service 2. Authorize Treatment Plan – the approval of a treatment plan prepared by a care management team in a care management setting 3. Authorize Referral – specifically the approval of a referral to another provider, requested by a primary care physician The Authorize Referral business process may encompass both a pre-approved and post-approved referral request, especially in the case where immediate services are required. This business process may include, but is not limited to, referrals for specific types and numbers of visits, procedures, surgeries, tests, drugs, durable medical equipment, therapies, and institutional days of stay. Requests are evaluated based on urgency and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state, validating key data, and ensuring that the referral is appropriate and medically necessary. ability to perform activities of daily living. A post-approved referral request is an editing/auditing function that requires review of information after the referral has been made. A review may consist	**Level 1** NM Medicaid FFS does not utilize the authorization referral process, however the MCOs do. MCOs don't require authorization for referrals in network. Out of network referrals are required. The HIPAA compliant 278 standard is not used. The X12 277 is not used when additional information is needed.

	of: verifying documentation to ensure that the referral was appropriate, and medically and or functionally necessary; validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the Edit Claims/Encounter or Audit Claims/Encounter processes.	
Authorize Service	The Authorize Service business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment. It is primarily used in a fee-for-service setting. Pre-approval of a service request is a care management function and begins when a care manager receives a referral request data set from an EDI, Paper/Fax, phone, or 278 Health Care Services Review Inbound Transaction Process. Requests are evaluated based on State rules for prioritization such as urgency and type of service/taxonomy (durable medical equipment, speech, and physical therapy, dental, out-of-state), validating key data, and ensuring that requested service is appropriate and medically necessary. After review, a service request is approved, modified, denied or pended for additional information. The appropriate response data set for the outbound 278 Response Transaction, 277 Request for additional information or paper/fax notifications/correspondence is sent to the provider using the Send Outbound Transaction through Manage Provider Communication. A post-approved service request is an editing/auditing function that requires review of information after the service has been delivered. A review may consist of verifying documentation to ensure that the services were appropriate and medically necessary; validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the Edit Claims/Encounter or Audit Claims/Encounter processes. NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs , and Off-label use of drugs, Social Service, Experimental Treatments, Out-of-State Services, and Emergencies	**Level 1** NM Medicaid contracts with BCBS for the authorization service process for fee-for-service members. All BCBS authorizations are submitted to BCBS on paper by the provider. The authorizations are manually reviewed. BCBS sends an electronic interface to the MMIS with the authorization information. BCBS also has direct access to the authorization files within the MMIS. The HIPAA compliant 278 standard is not used. The X12 277 is not used to notify the provider when additional information is needed.
Program Management		
Designate Approved Service and Drug Formulary	The Designate Approved Services and Drug Formulary business process begins with a review of new and/or modified service codes (such as HCPCS and ICD-9) or national drug codes (NDC) for possible inclusion in various	**Level 2** As new drugs come on the market there is a high level review to determine whether they will be

	Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package. Service, supply, and drug codes are reviewed by an internal or external team(s) of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and or State plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes. NOTE: This does not include implementation of Approved Services and Drug Formulary	covered or non-covered (based on generic and therapeutic class indicators). The agency has started coordinating across siloed systems (e.g., Waiver, Family planning, and Children's Medical Services). Drug information is received from First Databank's proprietary format. Decisions are not primarily based on clinical data or health care outcomes. As new services are developed procedures are reviewed to determine whether they will be covered or non-covered. HCPCS information is received electronically.
Manage Rate Setting	The Established Rate Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program.	**Level 1** MMIS FFS pricing logic determines the claim or line item allowed charge using a number of pricing methods. These methods include ambulatory surgical center (ASC) group, anesthesia base units, special rate tables, fee schedule pricing for procedure or revenue codes, per diem, percent of charge, DRG Grouper, Relative Value Scale (RVS) pricing for procedures, and usual and customary charge. Input for these rates comes from a variety of sources and methods, some of which are electronic, but the overall process is highly manual and requires human judgment and intervention. On an annual basis the State renegotiates managed care rates via cohorts. The data warehouse is used to pull information on certain populations to determine Medicaid costs. Deltas (of 10% or more) due to program changes (e.g. new services) on the based dollars are reviewed. Medical expenses are reviewed and categorized. Electronic reports are reviewed manually.

Develop and Maintain Benefit Package	The Develop & Maintain Benefit Package business process begins with receipt of coverage requirements and recommendations through new or revised Federal statutes and/or regulations, State law, organizational policies, requests from external parties such as quality review organizations, changes resulting from court decisions, or medical procedures or processes. Benefit package requirements and approved recommendations are reviewed for impacts to State plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including, but not limited to: • Determination of scope of coverage • Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc. • Identification of impacted members and trading partners such as Medicaid managed care plans or clearinghouses.	**Level 2** Procedure updates are made systematically to the extent possible. Some information must be manually reviewed and supplied. These fields are systematically updated. Occasionally the process is totally manual for specific changes in policies. In self directed waivers, the programs are structured to permit more flexibility around selection of services and providers within a benefit package.
Develop and Maintain Program Policy	The Develop and Maintain Program Policy Business Process responds to requests or needs for change in the enterprise's programs, benefits, or business rules, based on factors such as: federal or State statutes and regulations; governing board or commission directives; Quality Improvement Organization's findings; federal or State audits; enterprise decisions; and consumer pressure.	**Level 1** This process is manual and paper based. The process uses manual verification and manual updates. There is no electronic receipt of information for this process.
Maintain State Plan	The Maintain State Plan business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.	**Level 1** When benefits or policies change they are manually researched to see if a State plan amendment is needed. If it is, the State plan is amended and sent to CMS. There is no electronic receipt of information for this process. However, CMS is rolling out an electronic State Plan Amendment system that all states will soon be required to utilize.
Develop Agency Goals and Objectives	The Develop Agency Goals and Objectives business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary. Changes to goals and objectives could be warranted for example, under a new administration; or in response to changes in demographics, public opinion or medical industry trends; or in response to regional or national disasters.	**Level 1** There is some electronic receipt of information for this process and a few steps for this process are automated.

Manage FFP for Services	The Manage FFP for Services business process applies rules for assigning the correct Federal Medical Assistance Percentages (FMAP) rate to service expenditures and recoveries documented by the Medicaid enterprise. FFP for expenditures for medical services under the Medicaid enterprise is dependent on the nature of the service and the eligibility of the beneficiary. The FMAP rate applies to Medicaid expenditures for services covered under the State Plan with the exception of things such as: • Family planning services for which FFP is 90% • Services provided through Indian Health Service facilities for which FFP is 100% • Services provided to members eligible under the optional Breast and Cervical Cancer program for which FFP is based on SCHIP Enhanced FMAP rate • Medicare Part B premiums for Qualified Individuals for which FFP is 100% unless the allotment is exceeded and then the FFP is 0% • Transportation provided per the requirements of 42 CFR431.53 for which FFP is 50% • FFP for expenditures for medical services under the SCHIP program is based on the Enhanced Federal Medical Assistance Percentages" (enhanced FMAP). Recoveries of expenditures are assigned the same FFP rate as the FFP rate in effect at the time of the expenditure.	**Level 1** The MMIS stores FFP rates for the full range of services by federal fiscal year. The FFP rates are used to determine FMAP for claims payment. Backend reports are reviewed to ensure that expected results are achieved. Some receipt and review of information is automated.
Manage FFP for MMIS	The Federal government allows funding for the design, development, maintenance, and operation of a federally certified MMIS. The Manage Federal Financial Participation for MMIS business process oversees reporting and monitoring of Advance Planning Documents and other program documents necessary to secure and maintain federal financial participation.	**Level 1** MAD, ITD, and ASD collaborate on the development and tracking of Advanced Planning Documents. Invoices are prepared manually. Each item is assigned a specific FFP based on CMS regulations and approvals.
Formulate Budget	The Formulate Budget business process examines the current budget, revenue stream and trends, and expenditures, assesses external factors affecting the program, assesses agency initiatives and plans, models different budget scenarios, and periodically produces a new budget.	**Level 1** This process includes analysis of data and the review of standards to make projections based on enrollment and trends. This process is paper based with limited electronic receipt of information.

Manage State Funds	The Manage State Funds business process oversees Medicaid State funds and ensures accuracy in the allocation of funds and the reporting of funding sources. Funding for Medicaid services may come from a variety of sources, and often State funds are spread across State agency administrations such as Mental Health, Aging, Substance Abuse, physical health, and across State counties and local jurisdictions. The Manage State Funds monitors State funds through ongoing tracking and reporting of expenditures and corrects any improperly charged expenditure of funds. It also deals with projected and actual over and under allocations of funds.	**Level 1** NM Medicaid receives an allotment from the General fund and other funds which are electronically transferred. This process is paper based and manually reviewed on a statistical basis.
Manage 1099s	The Manage 1099s business process describes the process by which 1099s are handled, including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single Social Security Number or Federal Tax ID Number. The Manage 1099s process receives payment and/or recoupment data from the Price Claim/Value Encounter Process or from the Perform Accounting Functions process. The Manage 1099s process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies via the Send Outbound Transaction process. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.	**Level 2** Every year the State is required to send 1099 MISC forms to all providers. These forms contain all of the information needed by providers for tax purposes. The MMIS pays claims and generates 1099s for Medicaid, General Assistance (ISD), Children's Medical Services (DOH), LTC (ALTSD), and foster care (CYFD) services. There are two main files produced as part of 1099s: 1099 Forms that are sent to each provider, and the IRS 1099 file that contains the information for each provider. The 1099 Forms are sent to ACS for printing. The IRS1099 file is transmitted electronically to the IRS using the IRS FIRE (Filing Returns electronically) system.
Perform Accounting Functions	Currently States use a variety of solutions including outsourcing to another Department or use of a COTS package. Activities included in this process can be as follows: • Periodic reconciliations between MMIS and the system(s) that performs accounting functions • Assign account coding to transactions processed in MMIS • Process accounts payable invoices created in the MMIS. • Process accounts payable invoices created in Accounting System (gross adjustments or other service payments not processed through MMIS, and administrative payables) • Load accounts payable data (warrant number, date, etc.) to MMIS	**Level 1** Cash receipts are taken in by ACS but are not deposited. They are sent to the State for deposit. Drug rebate is initiated by ACS but is tracked by the State. Paper documents are received and input into the MMIS system. Reports are generated electronically. The State uses a variety of solutions including a COTS product. Periodic reconciliations between MMIS and the accounting system are conducted. Information such as warrant number and date of warrant are sent by the COTS product to the MMIS. The process is largely paper based

	• Manage canceled/voided/stale dated warrants • Perform payroll activities • Process accounts receivable (estate recovery, co-pay, drug rebate, recoupment, TPL recovery, and Member premiums) • Manage cash receipting process • Manage payment offset process to collect receivables • Develops and maintain cost allocation plans • Manages draws on letters of credit • Manages disbursement of federal administrative cost reimbursements to other entities • Respond to inquiries concerning accounting activities	to the MMIS. The process is largely paper based and includes manual processes. Some processes are automated.
Develop and Manage Performance Measures and Reporting	The Develop and Manage Performance Measures and Reporting process involves the design, implementation, and maintenance of mechanisms and measures to be used to monitor the business activities and performance of the Medicaid enterprise's processes and programs. This includes the steps involved in defining the criteria by which activities and programs will be measured and developing the reports and other mechanisms that will be used by the Monitor Performance and Business Activity process to track activity and effectiveness at all levels of monitoring. Examples of performance measures and associated reports may be things such as: Goal: To assure that prompt and accurate payments are made to providers. Measurement: Pay or deny 95% of all clean claims within 30 days of receipt. Mechanism: Weekly report on claims processing timelines. Goal: Accurately and efficiently draw and report funds in accordance with the federal Cash Management Improvement Act (CMIA) and general cash management principles and timeframes to maximize non-general fund recovery. Measurement: Draw 98% of funds with the minimum time allowed under CMIA. Mechanism: Monthly report on funds drawn. Goal: Improve healthcare outcomes for Medicaid members. Measurement: Reduce emergency room visits by ten percent by assigning a primary care case manager. Mechanism: Monthly report comparing emergency room usage by member for the period prior to and after PCCM assignment.	**Level 1** This process includes generation of daily, weekly and monthly reports. Some are manually generated, updated and verified.

Manage Program Information	The Manage Program Information business process is responsible for managing all the operational aspects of the Program Information data store, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The Program Information data store receives requests to add, delete, or change data in program records. The data store validates data upload requests, applies instructions, and tracks activity. The Program Information data store provides access to payment records to other Business Area applications and users, especially those in Program Management and Program Integrity Management, through communication vehicles such as batch record transfers, responses to queries, and "publish and subscribe" services.	**Level 2** The majority of the steps for the business process are automated. The Decision Support System is a 'read only' data warehouse. Data is input from Omnicaid DB2 on various schedules based on the subsystem. Users can query the DSS.
Maintain Benefit - Reference Information	The Maintain Benefits/Reference Information process is triggered by any addition or adjustment that is referenced or used during the Edit Claim/Encounter, Audit Claim/Encounter, or Price Claim/Encounter. It can also be triggered by the addition of a new program, or the change to an existing program due to the passage of new State or Federal legislation, or budgetary changes. The process includes revising code information including HCPCS, CPT, NDC, and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the Manage Prospective & Current Member Communication, updating/adding provider information from the Manage Provider Information, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the receive inbound transaction.	**Level 1** While the bulk of the annual HCPCS updates are input into the MMIS automatically, there is intensive manual effort involved in this process. Individual changes are sent by the State on paper and are manually updated on the file.
Care Management		
Manage Medicaid Population Health	This business process designs and implements strategy to improve general population health by targeting individuals by cultural or diagnostic or other demographic indicators. The inputs to this process are census, vital statistics, immigration, and other data sources. This business process outputs materials for: • Campaigns to enroll new members in existing program • New program areas, services, etc. • Updated Benefits/Reference , Member , Provider Communications with Impacted Members, Providers, and Contractors (e.g., program strategies	**Level 1** The MCOs conduct much of this via the distribution of information on the web, TV. Fairs, in member handbooks and newsletters, and in provider manuals and newsletters. This process is not automated.

	and materials, etc	

Establish Case	The Care Management, Establish Case business process uses criteria and rules to identify target members for specific programs, assign a care manager, assess client's needs, select program, establish treatment plan, identify and confirm providers, and prepare information for communication.
	
	A case may be established for one individual, a family or a target population such as:
	• Medicaid Waiver program case management
	• Home and Community-Based Services
	• Other
	  o Disease management
	  o Catastrophic cases
	  o Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
	  o Population management
	
	Each type of case is driven by State-specific criteria and rules, different relationships, and different data.
		Level 1
		There is no formal care management for Fee-For-Service members. Consumers who meet both medical and financial eligibility are eligible for HCBW services. A person's category of eligibility will dictate which waiver he/she is eligible for. In the CoLTS waiver, a person chooses the MCO of their choice. Once chosen, the MCO assigns a Service Coordinator, who is then responsible for assessing the consumer's needs, developing a service plan, identifying providers, and coordinating both physical/medical and home- and community-based needs. In the other waivers (i.e., DD, MF, AIDs), a person chooses a case management agency from a list of providers. The case manager from the chosen case management agency then assists with the development and implementation of the service plan. For Salud! managed care, the MCOs utilize both state required and internal criteria to pull client data, stratify the data and perform care coordination outreach contact. Some of the information for this business process is received electronically by the MCOs from the State.

Manage Case	The Care Management Manage Case business process uses State-specific criteria and rules to ensure appropriate and cost-effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as: • Medicaid Waiver program case management • Home and Community-Based Services • Other agency programs • Disease management • Catastrophic cases • Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	**Level 1** Most of this business process is conducted via telephone. For the MCOs, Verification and updates are entered into their member's file on their systems.

	These are individuals whose cases and treatment plans have been established in the Establish Case business process. It includes activities to confirm delivery of services and compliance with the plan. Also includes activities such as: • Service planning and coordination • Brokering of services (finding providers, establishing limits or maximums, etc.) • Facilitating/Advocating for the member • Monitoring and reassessment of services for need and cost effectiveness. This includes assessing the member's placement and the services being received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs.	
Program Integrity Management		
Identify Candidate Case	The Identify Candidate Case business process uses criteria and rules to identify target groups (e.g., providers, contractors, trading partners or members) and establishes patterns or parameters of acceptable/ unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Candidate cases may be identified by: • Provider utilization review • Provider compliance review • Contractor utilization review [includes MCOs] • Contractor compliance review • Member utilization review • Investigation of potential fraud review • Drug utilization review • Quality review • Performance review • Erroneous payment • Contract review • Audit Review	**Level 2** Health Spotlight and the Fraud and Abuse Detection System (FADS) are the tools for this process to detect fraud and conduct utilization review. This is done on an adhoc basis. Some filters have been developed. There are some standardized queries but not automated alerts.

	• Other Each type of case is driven by different State criteria and rules, different relationships, and different data.	
Manage Case	The Program Integrity, Manage Case business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or member from the Medicaid program; or the case may be terminated or suspended. Individual State policy determines what evidence is needed to support different types of cases: • Provider utilization review • Provider compliance review • Contractor utilization review [includes MCOs] • Contractor compliance review • Beneficiary utilization review • Investigation of potential fraud review • Drug utilization review • Quality review • Performance review • Contract review • Erroneous payment review Each type of case is driven by different criteria and rules, different relationships, and different data. Each type of case calls for different types of external investigation.	**Level 1** NM State Medicaid staff manages cases for FFS and tracks them on an Excel spreadsheet. The MCOs are responsible for program integrity for managed care services. MCOs investigate and report the outcomes to the State. The Medicaid State staff reports to the Medicaid Fraud Control Unit (MFCU). This process is paper based with manual verification and updates.
Business Relationship Management		
Establish Business Relationship	The Establish Business Relationship business process encompasses activities undertaken by the State Medicaid enterprise to enter into business partner relationships with other stakeholders for the purpose of exchanging data. These include Memoranda of Understanding (MOU) with other agencies; electronic data interchange agreements with providers, managed care organizations, and others; and CMS, other Federal agencies, and Regional	**Level 1** NM Medicaid maintains business relationships with FFS providers, MCOs, contractors, and multiple State and federal agencies for the purpose of exchanging information electronically. Data exchanges include claims, encounters, client

	Health Information Organizations (RHIO).	eligibility records, buy-in data, managed care enrollments, prior authorizations, and vital records data. Mechanisms for establishing these relationships vary with the entity, and include Trading Partner Agreements, Joint Powers Agreements, Memorandums of Understanding, and other contract vehicles. These agreements are generally paper-based although authorization for data exchanges may be incorporated into automated systems. For example, a Trading Partner Management System maintains data on entities that are authorized to submit claims electronically to the Transaction Interface Exchange (TIE) HIPAA translator.
Manage Business Relationship	The Manage Business Relationship business process maintains the agreement between the State Medicaid enterprise and the other party. This includes routine changes to required information such as authorized signers, addresses, terms of agreement, and data exchange standards.	**Level 1** This process is manual with telephone, paper, and e-mail communications.
Manage Business Relationship Communication	The Manage Business Relationship Communication business process produces routine and ad hoc communications between the business partners.	**Level 1** This process is manual with telephone, paper, and e-mail communications.
Terminate Business Relationship	The Terminate Business Relationship business process cancels the agreement between the State Medicaid agency and the business or trading partner.	**Level 1** This is a manual process.

7 Maturity Level Summary – 'As-Is' and 'To-Be' Assessment

The following table is the information that CMS requires when submitting an Advanced Planning Document (APD). This table depicts the 'As-Is' which are the levels of the current New Mexico MMIS and the 'To-Be' which are the future levels based on the State's goals and objectives.

Table 4: Maturity Level Summary

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
Member Management					
Member Management	Client Services Bureau	Determine Eligibility	Eligibility Determination	1	2
Member Management	Client Services Bureau	Enroll Member	Enroll in Managed Care	1	2
Member Management	Client Services Bureau	Disenroll Member	Eligibility Termination	2	2
Member Management	Client Services Bureau	Manage Member Information	Recipient File Maintenance	1	1
Member Management	Client Services Bureau	Inquire Member Eligibility	Eligibility Inquiry	1	2
Member Management	Client Services Bureau	Perform Population and Member Outreach	Marketing and Outreach	2	2
Member Management	Client Services Bureau	Manage Applicant and Member Communication	Solution Center	1	2
Member Management	Contract Administration Bureau and Quality Assurance Bureau	Manage Member Grievance and Appeal	Grievance, Appeals and Fair Hearing	1	2

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
Provider Management					
Provider Management	Provider Enrollment (FA)	Enroll Provider	Provider Enrollment	1	2
Provider Management	Provider Enrollment (FA)	Manage Provider Information	Provider File Updates	1	2
Provider Management	Provider Enrollment (FA)	Inquire Provider Information	Provider Enrollment Status Inquiry	1	2
Provider Management	Provider Enrollment (FA)	Manage Provider Communication	Provider Relations/Enrollment/Eligibility Call Center	1	2
Provider Management	Benefits Services Bureau	Manage Provider Grievance and Appeal	Fair Hearings Process	1	2
Provider Management	Provider Relations (FA)	Perform Provider Outreach	Provider Outreach	1	1
Contractor Management					
Contractor Management	Directors Office and Benefits Services Bureau	Produce Administrative or Health Services RFP	Procurement	1	1
Contractor Management	Program Information Systems Bureau	Manage Administrative or Health Services Contract	Manage Administrative or Health Services Contract	1	1
Contractor Management	Benefits Services Bureau	Award Administrative or Health Services Contract	Contract Award	1	1
Contractor Management	Benefits Services Bureau	Close-out Health Administrative or Health Services Contract	Turnover	1	1
Contractor Management	Program Information Systems Bureau	Manage Contractor Information	Managed Care Plan File	1	1
Contractor Management	Program Information Systems Bureau	Inquire Contractor Information	Contractor Inquiry	1	1
Contractor Management	Contract Administration Bureau	Perform Contractor Outreach	MCO and Provider Communications	1	1

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
Contractor Management	Contract Administration Bureau	Manage Contractor Communication	MCO Communications	1	1
Contractor Management	Contract Administration Bureau	Support Contractor Grievance and Appeal	Complaints and Tracking /Trending System	1	1
Operations Management					
Operations Management	Claims Department (FA)	Edit/Audit Claim-Encounter	Adjudication/Claim Resolution	1	2
Operations Management	Claims Department (FA)	Price Claim - Value Encounter	Pricing	2	2
Operations Management	Claims Department (FA)	Apply Attachment	Attachments	1	1
Operations Management	Business Analysts (FA)	Apply Mass Adjustment	Mass Adjustment	1	1
Operations Management	Claims Subsystem (FA)	Prepare Remittance Advice - Encounter Report	Remittance Advice	1	2
Operations Management	Claims Subsystem (FA)	Prepare COB	Third Party Liability	1	2
Operations Management	Claims Subsystem (FA)	Prepare HCBS Payment	Prepare HCBS Payment	2	2
Operations Management	Claims Subsystem (FA)	Prepare EOB	REOMB	1	1
Operations Management	Claims Subsystem (FA)	Prepare Provider EFT - Check	Prepare Provider EFT/Check	1	2
Operations Management	Claims Subsystem (FA)	Prepare Premium EFT - Check	Prepare MCO Check	1	2
Operations Management	N/A	Prepare Health Insurance Premium Payments	N/A	N/A	N/A
Operations Management	Information Technology Division	Prepare Medicare Premium Payment	Prepare Medicare Buy-in Payment	1	2

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
Operations Management	Business Support (FA)	Prepare Capitation Premium Payment	Capitation Generation	1	2
Operations Management	Finance (FA)	Manage Payment Information	Accounting and Financial	1	1
Operations Management	Provider Call Center (FA)	Inquire Payment Status	Claim Status Inquiry	1	2
Operations Management	N/A	Calculate Spend-Down Amount	N/A	N/A	N/A
Operations Management	Insure New Mexico	Prepare Member Premium Invoice	Premium Billing	1	1
Operations Management	Business Support (FA)	Manage Recoupment	Mass Adjustment Process	1	2
Operations Management	Client Services Bureau	Manage Estate Recovery	Estate Recovery	1	1
Operations Management	TPL (FA)	Manage TPL Recovery	TPL	1	2
Operations Management	Pharmacy Benefits Management (FA)	Manage Drug Rebate	Drug Rebate	2	2
Operations Management	Program Administration Bureau	Manage Cost Settlement	Cost Settlement	1	1
Operations Management	Quality Assurance Bureau	Authorize Treatment Plan	Utilization Review	1	1
Operations Management	Contract Administration Bureau	Authorize Referral	Authorize Referral	1	1
Operations Management	Benefits Services Bureau	Authorize Service	Prior Authorization and Post Payment Review	1	1

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
Program Management					
Program Management	Pharmacy Benefits Management (FA)	Designate Approved Service and Drug Formulary	Designate Approved Services/Drug Formulary	2	2
Program Management	Directors Office	Manage Rate Setting	Rate Setting	1	1
Program Management	Benefits Services Bureau	Develop and Maintain Benefit Package	File Updates	2	2
Program Management	Benefits Services Bureau	Develop and Maintain Program Policy	Program Benefit Changes	1	1
Program Management	Benefits Services Bureau	Maintain State Plan	State Plan Amendment	1	1
Program Management	Directors Office	Develop Agency Goals and Objectives	Develop Agency Goals and Initiatives	1	1
Program Management	Directors Office	Manage FFP for Services	Manage FFP for Services	1	1
Program Management	Directors Office	Manage FFP for MMIS	Manage FFP for MMIS	1	1
Program Management	Program Administration Bureau	Formulate Budget	Develop Projection Model	1	1
Program Management	Program Administration Bureau	Manage State Funds	Cash Management	1	1
Program Management	Finance (FA)	Manage 1099s	Annual 1099 Process	2	2
Program Management	Finance (FA)	Perform Accounting Functions	Accounting and Financial Subsystem	1	1
Program Management	Continuous Quality Improvement (FA)	Develop and Manage Performance Measures and Reporting	Monitor Service Level Agreement (SLAs)	1	1

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
Program Management	Decision Support (FA)	Manage Program Information	Decision Support System	2	2
Program Management	Business Support (FA)	Maintain Benefit - Reference Information	Reference File Updates	1	1
Care Management					
Care Management	Long Term Services and Support Bureau	Manage Medicaid Population Health	Client Services	1	1
Care Management	Long Term Services and Support Bureau	Establish Case	Case Tracking	1	1
Care Management	Long Term Services and Support Bureau	Manage Case	Manage Case	1	1
Program Integrity Management					
Program Integrity Management	Quality Assurance Bureau	Identify Candidate Case	Health Spotlight and EFADS	2	2
Program Integrity Management	Quality Assurance Bureau	Manage Case	Manage Case	1	1
Business Relationship Management					
Business Relationship Management	Information Technology Division	Establish Business Relationship	Memorandum of Understanding (MOU) Execution	1	1
Business Relationship Management	Information Technology Division	Manage Business Relationship	Manage Business Relationships	1	1
Business Relationship Management	Information Technology Division	Manage Business Relationship Communication	Manage Business Relationship Communications	1	1

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
Business Relationship Management	Information Technology Division	Terminate Business Relationship	Terminate Business Relationships	1	1

8 Maturity Level Counts and Percentages

The following table shows the counts of occurrences for each maturity level and associated percentages broken down by business area. No business processes are rated at MITA maturity levels 3, 4, or 5. There are two business processes that are not applicable to the New Mexico Medicaid Program. Therefore, the numbers in the chart reflect the 70 business processes that apply to the NM Medicaid Program.

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Table 5: Maturity Level Counts and Percentages

	As-Is				To-Be			
Business Area (Number of Processes)	**# at Level 1**	**% at Level 1**	**# at Level 2**	**% at Level 2**	**# at Level 1**	**% at Level 1**	**# at Level 2**	**% at Level 2**
Member Management (8)	6	75%	2	25%	1	13%	7	87%
Provider Management (6)	6	100%	0	0%	1	17%	5	83%
Contractor Management (9)	9	100%	0	0%	9	100%	0	0%
Operations Management (23)	20	87%	3	13%	10	43%	13	57%
Program Management (15)	11	73%	4	27%	11	73%	4	27%
Care Management (3)	3	100%	0	0%	3	100%	0	0%
Program Integrity Management (2)	1	50%	1	50%	1	50%	1	50%
Business Relationship Management (4)	4	100%	0	0%	4	100%	0	0%
Totals (70)	**60**	**86%**	**10**	**14%**	**40**	**57%**	**30**	**43%**

This table shows that currently 86% the NM Medicaid Program's business processes are rated at MITA maturity level 1 and 14% are rated at MITA maturity Level 2. If the initiatives outlined in Section 10: 'To-Be Maturity' were implemented the program would move 29% of the business processes from level 1 to level 2, resulting in 43% of all business processes being at level 2. The increases in maturity levels would apply to the member management, provider management, and operations management business areas and would move 20 business processes to level 2.

9 High-Level Requirements for Enhanced Maturity

The following table provides high-level requirements for moving toward the next level of maturity for each business process and was used as a tool for the selection of the business processes that align with the State's goals and objectives for future enhancement. Refer to Table 4 for the 'As-Is' and 'To-Be' summary and to Section 10 for a detailed outline of the 'To-Be' levels.

**Level 3 cannot be reached until the MITA standards are developed. The development of the MITA standards is being conducted on a national level. The State should ensure that they are represented in the development of these standards as eventually they will have a need to utilize them.*

Table 6: Requirements for Enhanced Maturity Opportunities

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
		Member Management
Determine Eligibility	1	While some processes are automated such as SSI verification, to reach a full level 2 the following apply: o Automate the application process so members can apply via the web o Improve the data conversion process between ISD2 and MMIS to prevent loss of data o Incorporate the application for Waiver Services into the eligibility application o Increase the automation of verification of application information
Enroll Member	1	While several items in level 2 are already met, such as verification is automated and rule driven, to reach a full level 2 the following items apply: o Utilize the HIPAA compliant 834 standard o Implement web capability for members to make selections on-line
Disenroll Member	2	To reach level 3*, the following apply: o Utilize MITA standard interfaces o Automate information received from Managed Care Organizations

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
Manage Member Information	1	Almost all of the capabilities in level 2 are met. To reach level two the following item applies: o Updates to Member Information are sent real-time to authorized parties, versus in batch mode
Inquire Member Eligibility	1	To reach level 2, the following apply: o Utilize HIPAA Compliant 270/271 standards o Integrate member information across programs/agencies
Perform Population and Member Outreach	2	To reach level 3*, the following apply: o Utilize MITA Standard Interfaces o Agencies support deployment of internet access points, such as kiosks and low cost telecommunication devices such as cell phones for distribution to mobile communities, to alleviate communications barriers o Outreach is primarily electronic, with paper used only secondarily o Access to standardized electronic clinical data via registries, electronic prescribing, claims and service review attachments and electronic health records o Use of GIS and socio-economic indicators support targeting populations for outreach o Member registries use standardized contact data, including NPS address standards, to alleviate postal delivery failures
Manage Applicant and Member Communication	1	To reach level 2, the following apply: o Provide members access via the web and AVRS for standard inquiries o Provide members access to submit non standard inquiries via the web o Develop standard responses to standard inquiries
Manage Member Grievance and Appeal	1	To reach level 2, the following apply: o Implement the submission and response to grievances and appeals via the web o Automate processes where possible

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
		Provider Management
Enroll Provider	1	To reach level 2, the following apply: o Enable submission of provider applications via the web o Use on line editing for data elements entered via the web o Implement automated processes to validate specific data elements such as licensure information
Manage Provider Information	1	To reach level 2, the following apply: o Enable submission of changes to specific provider data elements via the web o Implement the ability to collect linguistic information from providers
Inquire Provider Information	1	To reach level 2, the following apply: o Enable provider enrollment status inquiries via the web, AVRS and EDI
Manage Provider Communication	1	To reach level 2, the following apply: o Enable provider location via the web o Provide provider communications in languages other than English o Implement a formal process for e-mail communications with providers
Manage Provider Grievance and Appeal	1	To reach level 2, the following apply: o Scan grievance and appeal documents and make available to appropriate individuals
Perform Provider Outreach	1	To reach level 2, the following apply: Develop standards to identify enrollment of providers based on specialty, location, cultural and linguistic needs
		Contractor Management
Produce Administrative or Health Services RFP	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of the maturity levels. To reach level 2, the following applies: o Automate and use electronic means to the extent feasible

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
Manage Administrative or Health Services Contract	1	To reach level 2, the following applies: o Automate and use electronic means to the extent feasible
Award an Administrative or Health Services Contract	1	To reach level 2, the following applies: o Automate and use electronic means to the extent feasible
Close-out Administrative or Health Services Contract	1	To reach level 2, the following applies: o Automate and use electronic means to the extent feasible
Manage Contractor Information	1	To reach level 2, the following applies: Automate and use electronic means to the extent feasible
Inquire Contractor Information	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Perform Contractor Outreach	1	To reach level 2, the following applies: o Automate and use electronic means to the extent feasible.
Manage Contractor Communication	1	To reach level 2, the following applies: o Automate and use electronic means to the extent feasible.
Support Contractor Grievance and Appeal	1	To reach level 2, the following applies: o Capture documents electronically by scanning or Optical Character Recognition (OCR)

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
		Operations Management
Edit/Audit Claims-Encounter Process	1	To reach level 2, the following applies o Implement electronic submission of adjustment and void of claims and encounters via the HIPAA compliant 837 standard
Price Claim - Value Encounter	2	To reach level 3*, the following apply: o Develop pricing for services currently manually priced o Utilize MITA Standard Interfaces
Apply Attachment	1	To reach level 2, the following applies: o Capture documents electronically via Optical Character Recognition (OCR)
Apply Mass Adjustment	1	To reach level 2, the following applies: o Automate the selection of claims to be adjusted
Prepare Remittance Advice-Encounter Report	1	To reach level 2, the following applies: o Implement the use of the HIPAA compliant 835 standard
Prepare COB	1	To reach level 2, the following apply: o Implement electronic billing to other insurance carriers o Automate the application of payments received from other insurance carriers
Prepare Home and Community Based Services Payment	2	To reach level 3*, the following applies: o Utilize MITA Standard Interfaces
Prepare EOB	1	To reach level 2, the following apply: o Enhance the sampling process to target selected populations o Automatically tabulate member responses

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
Prepare Provider EFT - Check	1	To reach level 2, the following apply: o Implement EFT o Implement the use of the HIPAA compliant 835 standard
Prepare Premium EFT - Check	1	To reach level 2, the following apply: o Implement EFT o Implement the use of the HIPAA compliant 820 standard
Prepare Health Insurance Premium Payment	N/A	N/A
Prepare Medicare Premium Payment	1	To reach level 2, the following applies: o Implement the new Medicare Buy-in Premium process required by the Federal Government
Prepare Capitation Premium Payment	1	To reach level 2, the following apply: o Automate the EFT process for Managed Care Organizations o Implement the use of the HIPAA compliant 820 standard
Manage Payment Information	1	To reach level 2, the following applies: o Automate the application of TPL payments
Inquire Payment Status	1	To reach level 2, the following apply: o Implement the use of the HIPAA compliant 276/277 standard o Develop claim status capability via AVRS
Calculate Spend-Down Amount	N/A	N/A
Prepare Member Premium Invoice	1	To reach level 2, the following apply: o Automate the invoice process

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
Manage Recoupment	1	To reach level 2, the following applies: o Implement the use of the HIPAA compliant 835 standard
Manage Estate Recovery	1	To reach level 2, the following apply: o Increase standardization of data o Automate process to the extent feasible
Manage TPL Recovery	1	To reach level 2, the following apply: o Implement electronic billing to other insurance carriers o Automate the application of payments received from other insurance carriers
Manage Drug Rebate	2	To reach level 3*, the following apply: o Utilize MITA Standard Interfaces
Manage Cost Settlement	1	To reach level 2, the following apply: o Develop electronic interfaces with the providers o Automate the review of data to the extent feasible
Authorize Treatment Plan	1	To reach level 2, the following apply: o Implement the use of the HIPAA compliant 278 standard o Automate processing of authorization requests to the extent feasible o Implement web submission capability for fee for service authorization treatment plan requests o Implement the use of the 277 to notify the provider when additional information is needed o Implement the use of the 275 electronic attachment transaction
Authorize Referral	1	To reach level 2, the following apply: o Implement the use of the HIPAA compliant 278 standard o Automate processing of authorization requests to the extent feasible o Implement web submission capability for MCO referral requests o Implement the use of the 277 to notify the provider when additional information is needed

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
Authorize Service	1	To reach level 2, the following apply: o Implement the use of the HIPAA compliant 278 standard o Automate processing of authorization requests to the extent feasible o Implement web submission capability for fee for service authorization treatment plan requests o Implement the use of the 277 to notify the provider when additional information is needed o Implement the use of the 275 electronic attachment transaction
		Program Management
Designate Approved Service and Drug Formulary	2	To reach level 3*, the following apply: o Utilize MITA Standard Interfaces o Decisions should be based primarily on clinical data and health care outcomes
Manage Rate Setting	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Develop and Maintain Benefit Package	2	To reach level 3*, the following apply: o Utilize MITA Standard Interfaces. o Increase flexibility within the non Waiver benefit packages to enable more choices of services and providers o Utilize clinical data to design benefit packages

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
Develop and Maintain Program Policy	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Maintain State Plan	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Develop Agency Goals and Objectives	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Manage FFP for Services	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
Manage FFP for MMIS	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Formulate Budget	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Manage State Funds	1	To reach level 2, the following applies: o Move paper processes to electronic interchange
Manage 1099s	2	To reach level 3, the following applies: o Utilize MITA Standard Interfaces o Automate process to the extent feasible
Perform Accounting Functions	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
Develop and Manage Performance Measures and Reporting	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Manage Program Information	2	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 3*, the following apply: o Utilize MITA Standard Interfaces o Automate process to the extent feasible
Maintain Benefits-Reference Information	1	To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
		Care Management
Manage Medicaid Population Health	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase automation of the process. o Increase electronic receipt of information

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
Establish Case	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Manage Case	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
		Program Integrity Management
Identify Candidate Case	2	To reach level 3*, the following apply: o Utilize MITA Standard Interfaces o Implement automated alerts
Manage Case	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process

Business Process	Maturity Level	High-Level Requirements for Enhanced Maturity (Next Level)
		Business Relationship Management
Establish Business Relationship	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Manage Business Relationship	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Manage Business Relationship Communication	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process
Terminate Business Relationship	1	The maturity levels within the Business Capability matrix have not been defined for this business process. The 'As-Is' maturity level for this business process is based on the general understanding of maturity levels. To reach level 2, the following apply: o Increase electronic receipt of information o Increase automation of the process

10 'To-Be' Maturity Based on State Goals and Objectives

On February 18, 2009 a meeting was held with the New Mexico State Medicaid executive leadership, ACS leadership and the ACS MITA Assessment team to discuss the State's goals and objectives for the future. In this meeting ACS provided an overview of the New Mexico Medicaid MITA As-Is assessment and the basis for outlining key goals and objectives to establish 'To-Be' maturity levels. These 'To-Be' levels provide a 'roadmap' for the program's future.

The identified strategic goals for the program's future address the key challenges facing the New Mexico Medicaid program, balancing the need to improve program efficiencies and increased access to information while making the program financially sustainable for future generations. Through our discussions with the State, three strategic goals emerged for New Mexico Medicaid's future:

1. Compliance with HIPAA Mandated Transactions
2. Implementation of Client and Provider Web Services
3. Enhanced Cost Containment

Compliance with HIPAA Mandated Standard Transactions
This goal encompasses eight MITA business processes that could move from maturity level 1 to maturity level 2. In order for some business processes to move to level 2, other enhancements are also needed. The following table shows the HIPAA transactions that are required for compliance, the business processes that would be impacted by the implementation of the HIPAA standards, and the additional enhancements that are needed to reach the next maturity level. The State is already in the process of implementing Electronic Funds Transfer (EFT) for providers and is streamlining the process for managed care organizations which is additional functionality needed to reach level 2 in several areas. The State is also in the process of implementing the X12N 4010A1 X091 Remittance Advice (835) transaction which is a key enhancement for level two in three business processes.

In the event that it is not feasible from a time/funding aspect for the State to implement the 4010A1 versions much before January 2012, the State may consider moving directly into the implementation of the 5010 version of all mandated transactions for use starting on January 1, 2012. The X12N 4010A1 X094 Authorization and Referral Request and Response (278) transaction is not included in this table below, even though technically required under the current HIPAA mandate. This transaction has not been widely adopted in the industry due to significant insufficiencies. The Authorization and Referral Request and Response (278) transaction is also mandated under HIPAA and would be required to achieve compliance and maturity level 2 for the authorization related business processes.

Table 7: 'To-Be' Levels with HIPAA Compliance

HIPAA Standard Transaction	MITA Business Processes Impacted	'To-Be' MITA Maturity Level
X12N 4010A1 X091 Remittance Advice (835)	Prepare Remittance Advice	2
	Manage Recoupment	2 (if sending 837s to other payers is also implemented)
	Prepare Provider EFT - Check	2 (if EFT also implemented and is associated with the 835)
X12N 4010A1 X096, X097, and X098 Claims (837) Adjustment, and Void functionality	Edit/Audit Claim - Encounter	2 (if implemented with the 277U request for additional information when more information is needed to process the claim)
X12N 4010A1 X092 Eligibility Inquiry and Response (270/271)	Inquire Member Eligibility	2
X12N 4010A1 X093 Claim Status Inquiry and Response (276/277)	Inquire Payment Status	2 (if coupled with claim status inquiry and response via AVR)
X12N 4010A1 X061 Premium Payment (820)	Prepare Capitation Premium Payment	2 (if EFT also implemented)
	Prepare Premium EFT – Check	2 (If EFT also Implemented)
X12N 4010A1 X095 Enrollment (834)	Enroll Member	2 (if coupled with Web MCO Selection)
New Medicare Buy-In Process*	Prepare Medicare Premium Payment	2

*While this is not a HIPAA mandated standard transaction, the Medicare Program has implemented a new process for Medicare Buy-in Premium Payments. Implementing this new process will result in an increase from level 1 to level 2 MITA maturity in the Prepare Medicare Premium Payment business process.

Implementation of Client and Provider Web Services

With the implementation of web functionality for both members and providers, a significant number of business processes could increase from maturity level 1 to maturity level 2. The table below lists the new web functionality, the MITA business processes impacted, and the MITA maturity level that could be achieved along with any additional enhancements needed to reach that level.

Table 8: 'To-Be' Levels with Web Functionality

Web Functionality	MITA Business Processes Impacted	'To-Be' MITA Maturity Level
Member Application	Determine Eligibility	2 (if implemented with an increase of automated validation of data. improving data conversion process between ISD2 and MMIS, and incorporating the application for Waiver services into the application process)
Member MCO Selection	Enroll Member	2 (if coupled with HIPAA Standard 834 for enrollment transactions)
Member & Provider Grievance/Appeal Submission	Manage Member Grievance and Appeal	2
	Manage Provider Grievance and Appeal	2
Standard Member Inquiry Submission and Response	Manage Applicant and Member Communication	2
Provider Enrollment	Enroll Provider	2 (if implemented with collection of data on the languages spoken by the provider and an increase of automated validation of data including on-line editing at time of entry and automated verification of information such as credentials, sanctions, certificates, etc.)
Provider Data Updates (Address, etc.)	Manage Provider Information	2
Provider Enrollment Status Inquiry and Response	Inquire Provider Information	2
Enrolled Provider Look-Up Capability	Manage Provider Communication	2

Member Application

The Member Application web functionality is already in the early stages with the initiative lead by the Human Services Department to replace the current State's Integrated Service Delivery

system (ISD2) and the Your Eligibility System – New Mexico (YES-NM). The new customer portal will provide eligibility screening and electronic application submission for programs administered by the Human Services Department, Children, Youth and Families Department and the Department of Health. With the implementation of these two new systems it will be important to ensure that efficiencies are gained by automating much of the data validation.

Member MCO Selection

Although a member currently may select an MCO via paper or Automated Voice Response, this capability on the web will provide even more accessibility to members. The HIPAA mandated Enrollment transaction standard (834) must also be implemented to reach level 2 maturity for the Enroll Member business process.

Member & Provider Grievance and Appeal Submission

Enabling the submission of member and provider grievances and appeals via the web will provide increased accessibility. Inherent to the nature of such a transaction is that the data would be captured electronically thus providing the ability for a basic level of editing at time of entry to ensure that complete information was provided for the request. It would also enable information to be electronically transferred to the appropriate entity for research and would enable the automated tracking of these requests.

Standard Member Inquiry and Response

Providing the ability for members to submit standard types of inquiries via the web, such as eligibility verification, will increase access to information for members. Additional types of standard inquiries received from members could also be included. Over time, this would result in a reduction in telephone calls.

Provider Enrollment & Provider Data Updates

Implementing the functionality for providers to submit enrollment requests and changes to enrollment data via the web will have significant benefits. With the electronic capture of data, on-line editing can be accomplished at the time of entry thus ensuring the receipt of complete information necessary for processing. This will greatly reduce the need to return paper forms to the provider for additional information resulting in streamlining of the process. It will also enable the automated verification of some information against other data sources, such as sanction lists and licensing boards to the extent the sources are available electronically. Turn around time will be improved, manual efforts will be reduced, and provider satisfaction will increase.

Enrolled Provider Look-Up Capability

Implementing this capability will provide better access to care for members. It would also give providers the ability to identify other Medicaid enrolled providers for referrals.

Enhanced Cost Containment

There are many avenues the State can take to increase cost containment. At a cursory review it may appear that many of these solutions would not result in an increase in MITA maturity levels; however, one must acknowledge the relative infancy of the MITA maturity model. Currently, the MITA maturity model is quite vague in some areas and absent information in other areas. Even though it may not appear to move the State to the next level given the current state of the MITA maturity model, it is certainly beneficial from a fiscal standpoint to implement cost containment measures. Although the maturity model does not stress this within the business process maturity descriptions, the general definition of maturity level two in Framework 2.0 reads:

> *'Agency focuses on cost management and improved quality and access to care within structures designed to manage costs. Focusing on managing costs leads to program innovations.'*

The table below lists cost containment methods that will result in an increase in maturity level for several business processes and strengthen the State's fiscal responsibility.

Table 9: 'To-Be' Levels with Cost Containment Functions/Processes

New Function/Process	MITA Business Processes Impacted	'To-Be' MITA Maturity Level
Search Engine for Other Insurance Coverage for New Medicaid Applicants	Determine Eligibility	2 (if implemented with Member Application via the Web; an increase of automated validation of data, improving the data conversion process between ISD2 and MMIS, and incorporating the application for Waiver services into the application process)
National Correct Coding Initiative (NCCI)	Edit/Audit Claim - Encounter	While this does not directly result in a maturity level increase in a specific business process, it does strengthen the Edit/Audit Claim/Encounter process and is beneficial for budget management.
Fee Schedule Review	Manage Rate Setting	The maturity levels for this business process are not defined. Conducting this review is expected to result in more accurate rates and would strengthen this business process and be beneficial for budget management.
	Price Claim - Value Encounter	The maturity levels for this business process are written at a very high level. Conducting this review is expected to result in more accurate rates which would strengthen this business process and be beneficial for budget management.

New Function/Process	MITA Business Processes Impacted	'To-Be' MITA Maturity Level
Reimbursement Model Changes	Manage Rate Setting	The maturity levels for this business process are not defined. A change in reimbursement models is expected to result in the reduction of incentives to increase costs which would strengthen this business process and be beneficial for budget management.
	Price Claim - Value Encounter	The maturity levels for this business process are written at a very high level. A change in reimbursement models is expected to result in the reduction of incentives to increase costs which would strengthen this business process and be beneficial for budget management.
Identification of Medicare Eligibility	Manage TPL Recovery	While this does not directly result in a maturity level increase in a specific business process, it does strengthen the Manage TPL Recovery and Prepare COB processes and is beneficial for budget management.
	Prepare COB	
Electronic billing to other insurance companies for pay and chase	Prepare COB	2
Automate the application of payments from other insurance companies via the 835	Manage TPL Recovery	2

Search Engine for Other Insurance Coverage for New Medicaid Applicants

Identifying other insurance coverage before a person is determined to be eligible for Medicaid is much more cost effective than identifying other coverage after Medicaid has already paid claims. This solution would entail the use of an Internet-based search engine portal that would allow State case workers to check for other insurance coverage information, from payers that have real-time processing, as the application information is being entered into the ISD2 eligibility system. This would reduce the reliance on the applicant to provide the information and would greatly increase the ability to reduce unnecessary expenditures by cost avoidance from the very first day of eligibility as well as avoiding the added costs of the Third Party Liability recovery process.

National Correct Coding Initiative

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payments. Medicare is using this strategy to reduce inappropriate payments with respect to codes that are mutually exclusive and should not both be paid when submitted for a single encounter. This initiative involves thousands of HCPCS/CPT codes for which edits can be developed or COTS products can be implemented, therefore reducing unnecessary expenditures.

Fee Schedule Review

A focused review of the fee schedule and related limitations for the top 200 codes (most dollars paid) often reveals problems that can be solved resulting in significant savings. This type of review can identify a variety of opportunities for improvement ranging from a simple change to a limitation flag to the development of a new policy that would result in more control over unnecessary costs.

Reimbursement Model Changes

Replacing cost reimbursement models with case mix-adjusted, bundled, and prospective payment models can help in reducing the incentive of cost based reimbursement. Reimbursement models such as the Ambulatory Payment Classification (APC) model provide incentives for hospitals to provide economical and efficient outpatient services rather than an incentive to increase costs. There are a variety of other reimbursement models available for differing types of services that could be considered.

Identification of Medicare Eligibility

There are a number of cases where a Medicaid member over the age of 64 or a Medicaid member of any age that is receiving maintenance dialysis may qualify for Medicare but is not enrolled. Additionally, Medicaid members may be on file without the presence of their Medicare coverage. Analysis of potential Medicare coverage can result in significant savings.

Electronic Billing for Pay and Chase & Automated Application of Payments

The implementation of electronic billing to other insurance companies will greatly streamline the process and very likely result in a higher recovery rate. Coupling this with automating the payment received from the other insurance companies and using the 835 to post the payment will reduce manual effort. With the new HIPAA mandates, Medicaid Pharmacy Claim Subrogation will be mandated to use the electronic NCPDP standard that was developed for this specific use. This requirement goes into effect on January 1, 2012 with an extra year for small health plans. The new 5010 version of the claims transactions enables the use of a 'pay-to-plan' specifically designed for Medicaid Subrogation. While HIPAA does not mandate the use of the 5010 standard for Medicaid Subrogation (of non-pharmacy claims) it is anticipated that trading partners will be more willing to utilize these transactions for this purpose.