
Part I - BUSINESS ARCHITECTURE

Chapter 3 – MATURITY MODEL



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Introduction

This chapter introduces the maturity model used for the Medicaid IT Architecture (MITA) and explains both its role in the MITA Framework and its use by the MITA team, Centers for Medicare & Medicaid Services (CMS), States, and vendors.

The topics covered in this chapter include:

- ❖ Maturity Model Explained
- ❖ MITA Maturity Model Explained
- ❖ MMM levels of Maturity Defined
- ❖ Using the MMM in the MITA Framework

Purpose

The purpose of the MITA Maturity Model (MMM) is to serve as a reference model for grounding the definitions of business capabilities as described in Part I, Chapter 5, Business Capability Matrix, information capabilities as described in Part II, Chapter 6, Information Capability Matrix, and technical capabilities as described in Part III, Chapter 7, Technical Capability Matrix. The MMM establishes boundaries and measures used to determine whether a business capability has a clear and concise definition.

Scope

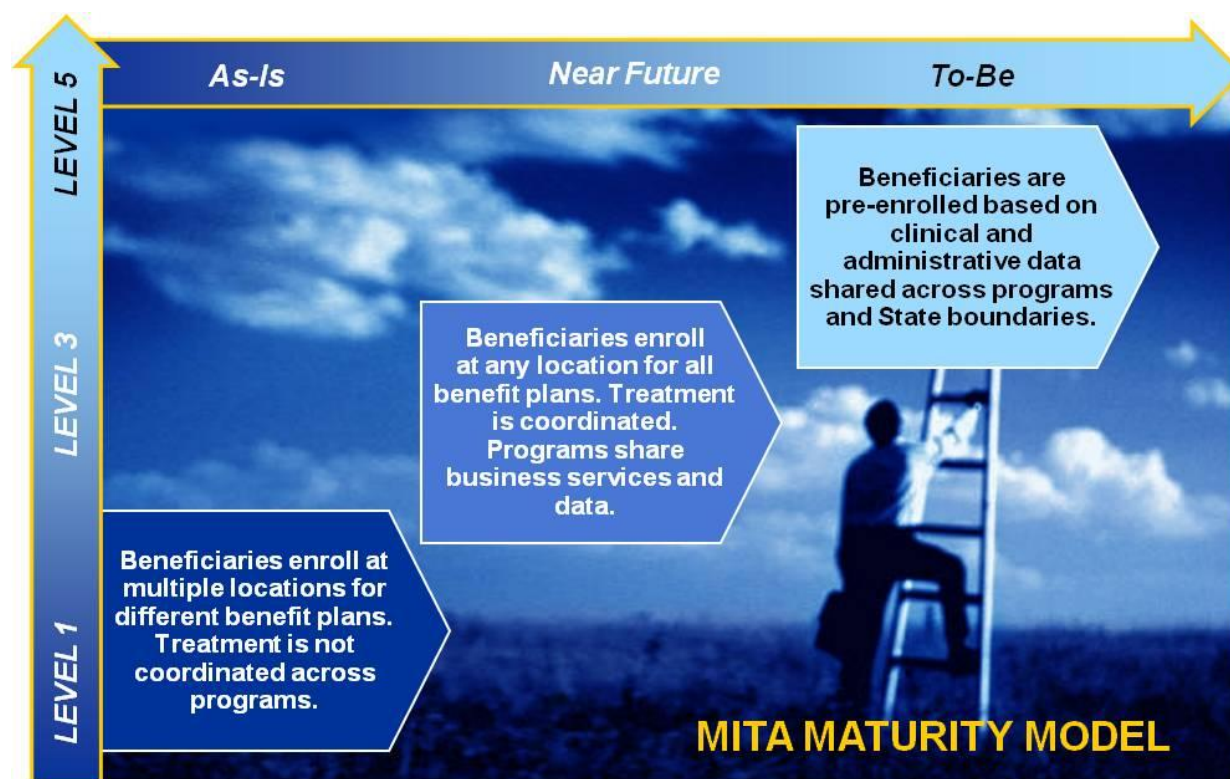
The MMM applies to the State Medicaid Enterprise, the domain that centers on the Medicaid environment, including leveraged systems and interconnections among Medicaid stakeholders, providers, beneficiaries, insurance affordability programs (e.g., Children's Health Insurance Program (CHIP), tax credits, Basic Health Program), Health Insurance Exchange (HIX), Health Information Exchange (HIE), other state and local agencies, other payers, CMS, and other federal agencies. The MITA context defines Medicaid Enterprise as:

- ❖ The domain where federal matching funds apply.
- ❖ The interfaces and bridges among Medicaid stakeholders, including providers, beneficiaries, other state and local agencies, other payers, CMS, and other federal agencies.
- ❖ The sphere of influence touching and touched by MITA (e.g., national and federal initiatives such as the Nationwide Health Information Network (NwHIN)). (See Front Matter, Chapter 6, Overview of the MITA Initiative, for a discussion of the Medicaid Enterprise.)

The previous version of the MITA Framework did not include MITA maturity Level 4 and 5 definitions. The MITA team provides definitions for these maturity levels at a high-level taking into account the recent factors concerning Medicaid Enterprise modernization (e.g., American Recovery and Reinvestment Act (ARRA) of 2009, Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, and Affordable Care Act of 2010). As the MITA Framework continues to evolve, CMS expects to refine Levels 4 and 5.

Maturity Model Explained

A maturity model measures the improvement and transformation of a business or a business function across the two dimensions - time and level of process sophistication. **Figure 3-1** provides an example of the time and level of sophistication dimensions by depicting progressive improvements in the beneficiary enrollment process. The time dimension marks progress from the present to a future time. The level of maturity dimension shows how the business looks at present and what its capabilities likely will be as it matures.



BA-3-1

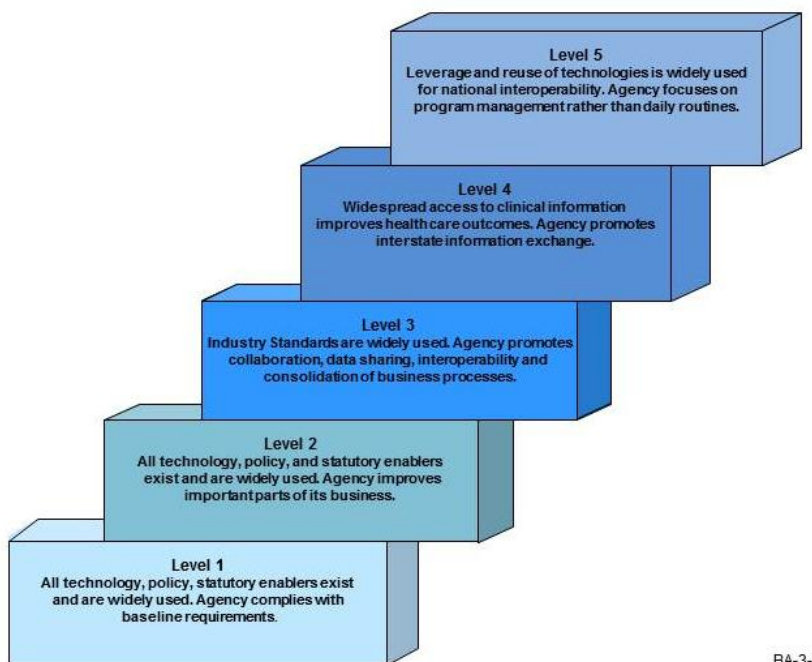
Figure 3-1. Example Maturity of Beneficiary Enrollment over Time

The maturity models that architects and designers use for planning business and technical transformations in contemporary industries to establish goals for achieving and measuring progress typically focus on a single enterprise (e.g., a single state Medicaid Program). The MITA Framework, by contrast, accommodates the State Medicaid Enterprise in all States, territories and the District of Columbia (hereinafter referred to as States), which have distinct commonalities and differences.

MITA Maturity Model Explained

The MITA Framework requires a maturity model to define boundaries and provide guidelines for the transformation of the State Medicaid Enterprise from its As-Is operations level of maturity to progressively higher levels of capability. The MITA team has applied industry best practices to create the MMM, drawing upon the Concept of Operations (COO) (Part I, Chapter 2, Concept of Operations) for the definition of the To-Be environment for the State Medicaid Enterprise. The MMM provides the boundaries to define capabilities for each of the three (3) MITA architectures: Business Architecture (BA), Information Architecture (IA) and Technical Architecture (TA).

Figure 3-2 depicts the MMM providing the guidelines for five (5) levels of maturity.



BA-3-2

Figure 3-2. Five Levels of Maturity

The MMM uses five (5) levels of maturity in its timeline for the following reasons:

- ❖ The State Medicaid Enterprise is a complex system with many moving parts. The MITA Framework needs a maturity model that reflects the breadth and depth of the State Medicaid Enterprise business processes.

- ❖ A timeline establishes a reasonable course of measurable progression. Ten (10) levels create too many checkpoints, and two (2) levels leave too large a gap in capabilities to determine progression. Five (5) intervals, or levels, establish identifiable targets for progress that States can understand, plan for, implement, and measure.
- ❖ Technology is now available to enable Level 1 through 3 maturities. New development of standards and technologies are bringing the capabilities of Level 4 and 5 closer to achievement.

The assumptions for the maturity timeline include dependencies on technology advances, state and federal policies, and enactment of legislation that supports the improvement of state Medicaid Programs. ARRA of 2009 and the Affordable Care Act of 2010 are examples.

MMM Levels of Maturity Defined

This section defines the MMM five (5) levels for the MITA Framework. Level 1 of the MMM include capabilities to demonstrate adherence to federal and state legislative mandates. Level 2 improves over Level 1 with the introduction of quality improvements and data access with the implementation of technology standards. Level 3 has high use of industry standards for data exchange, and the SMA is collaborating with intrastate agencies to improve health care coordination. Level 4 introduces the intrastate and interstate exchange of clinical information. Seamless coordination, real-time processing, and the integration of state and federal agencies are the defining capabilities for Level 5.

Table 3-1 describes the Medicaid Enterprise as it moves from one maturity level to another.

Table 3-1. State Medicaid Enterprise Levels of Maturity

Levels of Maturity				
Level 1	Level 2	Level 3	Level 4	Level 5
The SMA focuses on meeting compliance thresholds for state and federal regulations, aiming primarily at accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.	The SMA focuses on cost management and improving the quality of and access to care within structures designed to manage costs (e.g., managed care, catastrophic care management, and disease management).	The SMA focuses on coordinating and collaborating with other agencies to adopt national standards and develop and share reusable processes to improve the cost effectiveness of health care service delivery. The SMA promotes intrastate information exchange and business services.	The SMA, now with widespread and secure access to clinical information, can improve health care outcomes, empower members and provider stakeholders, measure objectives quantitatively, and focus on program improvement. The SMA promotes interstate information exchange and business services.	The SMA focuses on fine-tuning and optimizing program management, planning, and evaluation, with national (and international) interoperability improvements that maximize automation of routine operations.

The general definition of the five (5) levels of maturity establishes boundaries for each level. For example, a business process is only a Level 4 if it uses clinical data to improve health outcomes and operational efficiencies. The MMM shows a pathway of continuous business improvement toward a realistic future state. Each higher level of maturity incorporates the best practices of the level below and, more importantly, introduces new higher level capabilities.

Business Qualities for MMM

To further explain the differences between the levels of maturity, the MMM includes a set of six (6) measurable business qualities to help distinguish performance at one level from another level for each business process. These qualities are as follows:

1. **Timeliness of Process** – Time lapse between the SMA's initiation of a business process and attaining the desired result (e.g., length of time to enroll a provider, enroll a member, pay for a service, respond to an inquiry, make a change, or report on outcomes).
2. **Data Access and Accuracy** – Ease of access to data that the business process requires and the timeliness and accuracy of data used by the business process.
3. **Effort to Perform, Efficiency** – Level of effort necessary to perform the business process given current resources.
4. **Cost Effectiveness** – Ratio of the amount of effort and cost to outcome.
5. **Accuracy of Process Results** – Demonstrable benefits from using the business process.
6. **Utility or Value to Stakeholders** – Impact of the business process on individual members, providers, and Medicaid staff.

Qualities defined for each level differentiate clearly between the levels and show a realistic progression toward improvement for each business process.

Table 3-2 illustrates the quality of timeliness of the business process.

To develop the MMM, the MITA team took a general description of the levels and definition of the qualities and applied them first to the Medicaid Enterprise's and the MITA's mission, goals, and objectives, and then to the business processes referenced in the Business Process Model (BPM). The MMM defines information and technical capabilities across five (5) levels of maturity as well. The next section gives examples of the impact of the MMM on mission, goals, and objectives.

Table 3-2. The MMM and the Timeliness of the Business Process

MITA Maturity Model Detailed Business Qualities					
General Description	Level 1	Level 2	Level 3	Level 4	Level 5
Timeliness of process	Business processes meet threshold, mandated requirements for timeliness, i.e., the results achieved within the time specified by law or regulation.	Enhancement of business process timeliness with the use of Web portal; Electronic Data Interchange (EDI). Prioritized business processes that result in cost savings. Timeliness exceeds legal requirements.	Timeliness improves via collaboration, data sharing, and use of intrastate information exchange hubs.	Clinical data is available in real time. Processes using clinical data provide immediate action, response, and results. State or regional stakeholders are interoperable, optimizing timeliness.	Enhancement of timeliness of business process through connectivity with other States and federal agencies. Most business processes execute at the point of service. Results are as close to immediate as we can envision at this time.

Information Capabilities for MMM

The MMM for the IA includes a set of four (4) qualities to help distinguish performance at one level from performance at another level for each of the MITA business model business areas. See Part II, Chapter 6, Information Capability Matrix, for detailed descriptions. The information capabilities are as follows:

- ❖ **Data Management Strategy** – Provides a structure that facilitates the development of information/data, effectively shared across a State Medicaid Enterprise to improve mission performance.
- ❖ **Conceptual Data Model** – Represents the overall conceptual structure of the data, providing a visual representation of the high-level data needed to run an enterprise or business activity.
- ❖ **Logical Data Model** – Identifies all of the logical data elements that are in motion in the system or shared within the Medicaid Enterprise.
- ❖ **Data Standards** – Identifies the applicable standard for each MITA data element.

Technical Capabilities for MMM

The MMM for the TA includes a set of three (3) technical services areas with specific technical service classification qualities to help distinguish performance levels for each of the MITA business model business areas. See Part III, Chapter 7, Technical Capability Matrix, for detailed descriptions. The technical capabilities are as follows:

- ❖ **Access and Delivery** – Encompasses design drivers and enablers such as web browser connectivity, language support, Customer Relationship Management (CRM), and forms and reporting services.
 - Client Support
 - Business Intelligence
 - Forms and Reporting
 - Performance Measurement
 - Security and Privacy
- ❖ **Intermediary and Interface** – Contains drivers and enablers, such as process orchestration, work flow and relationship management functionality.
 - Business Process Management
 - Relationship Management
 - Data Connectivity
 - Service-Oriented Architecture
 - System Extensibility
- ❖ **Integration and Utility** – Includes design drivers and enablers such as solution stacks, database access layer services, scalability, application versioning and verification type utility services.
 - Configuration Management
 - Data Access and Management
 - Decision Management
 - Logging

- Utility

Seven Standards and Conditions Capabilities for MMM

The Seven Standards and Conditions Maturity Model serves as a reference model to define boundaries for establishing business capabilities. See SS-A Companion Guide, Appendix A, Seven Standards and Conditions Details for more detailed descriptions. The Seven Standards and Conditions Capability Matrix (SCM) defines the business qualities for the five (5) levels of maturity for each:

- ❖ **Modularity Standard** – Uses a modular, flexible approach to systems development, including the use of open interfaces and exposed Application Programming Interfaces (API); the separation of standardized business rule definitions from core programming; and the availability of standardized business rule definitions in both human and machine-readable formats. The States commit to formal system development methodology and open, reusable system architecture.
- ❖ **MITA Condition** – States align to and advance increasingly in MITA maturity for business, architecture, and data.
- ❖ **Industry Standards Condition** – Ensures alignment with, and incorporation of, industry standards: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with Federal Civil Rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act.
- ❖ **Leverage Condition** – State solutions should promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States.
- ❖ **Business Results Condition** – Systems should support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public.
- ❖ **Reporting Condition** – Solutions should produce transaction data, reports, and performance information that contributes to program evaluation, continuous improvement in business operations, transparency and accountability.
- ❖ **Interoperability Condition** – Systems must ensure seamless coordination and integration with the Exchanges (whether run by the state or federal government), and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.

Maturity Levels Applied to Medicaid Mission and Goals

Part I, Chapter 2, Concept of Operations, presents the Medicaid mission and goals, a statement in business terms of the long-range vision of the Medicaid Program. The BA describes the Medicaid mission and goals for each level of maturity in Part I, Appendix B, Maturity Model Details.

Table 3-3 provides an example of these descriptions using the Medicaid goal to improve health care outcomes for Medicaid members. These descriptions illustrate improvements identified for each higher level. Visioning sessions conducted with a number of state agencies and recent national initiatives such as the Nationwide Health Information Network (NwHIN) have shaped Medicaid mission and goals.

Table 3-3. The MMM and the Improvement of Health Outcomes

MITA Maturity Model Vision Layer – Medicaid Mission and Goals					
Component	Level 1	Level 2	Level 3	Level 4	Level 5
Improve health care outcomes for Medicaid Member	The SMA focuses on compliance with regulatory requirements for enrollment of providers and members, and payment of claims within a specified timeframe to encourage the participation of providers and thereby promote access to care.	Improved health care outcomes are a by-product of new, creative programs primarily focused on managing costs, e.g., managed care and waiver programs.	There is widespread adoption and use of national standards for administrative data, and sharing of business services that provides a better base for comparing outcomes. Coordination and collaboration across intrastate health care programs contributes to improved outcomes.	All stakeholders have access to clinical data that produces a major leap forward in analysis of health care outcomes. In addition, the SMA empowers members and providers to make decisions affecting outcomes.	National interoperability among state and federal agencies in the most comprehensive way we can envision at this time. Agencies now have access to necessary data to compare outcomes across a broad spectrum of other agencies and States.

Levels of maturity do not suggest good or bad values, though MITA encourages States to achieve higher levels for some or all business processes.

Maturity Levels Applied to MITA Goals and Objectives

The MITA goals and objectives support the Medicaid mission and goals. The Medicaid mission draws on a variety of sources, including policy making, strategic planning, and legislation. MITA is one of the key supports for achieving the Medicaid mission. MITA has its own stated objectives and goals that align with the Medicaid mission and with federal initiatives such as the Federal Health Architecture (FHA) and the NwHIN. The MITA Framework has built Medicaid and MITA goals and objectives into it. Each level of maturity describes the realization of these goals at each level of maturity. This is the capstone of the MMM.

Table 3-4 shows how progressive levels of maturity improve the ability of the SMA to meet the MITA goal to “promote an environment which supports flexibility and adaptability and rapid response to changes in programs and technologies.”

Table 3-4. The MMM and the SMA Adaptations to Changes

MMM Vision Layer – MITA Mission and Goals					
MITA Goals	Level 1	Level 2	Level 3	Level 4	Level 5
Promote an environment which supports flexibility and adaptability and rapid response to changes in programs and technologies	Agencies meet mandatory changes, but lack technical flexibility. Program changes are costly and time consuming to implement.	Agencies introduce elements of flexibility in program design and selection of technology driven by requirements to manage costs and implement new programs.	Agencies improve on flexibility and adaptability through implementation of shared and extensible business services, adoption of nationally accepted standards, and increased collaboration among intrastate agencies, with use of intrastate agencies information exchange.	Integration of clinical data calls for increased flexibility and adaptability. Immediate access to the clinical information speeds of response time in critical business processes.	Agencies have full interoperability within the intrastate, interstate and federal agencies. Agencies can collaborate on response to changes and share solutions.

Table 3-5 illustrates another MITA goal to “provide data that is timely, accurate, usable, and easily accessible in order to support analysis and decision making for health care management and program administration.”

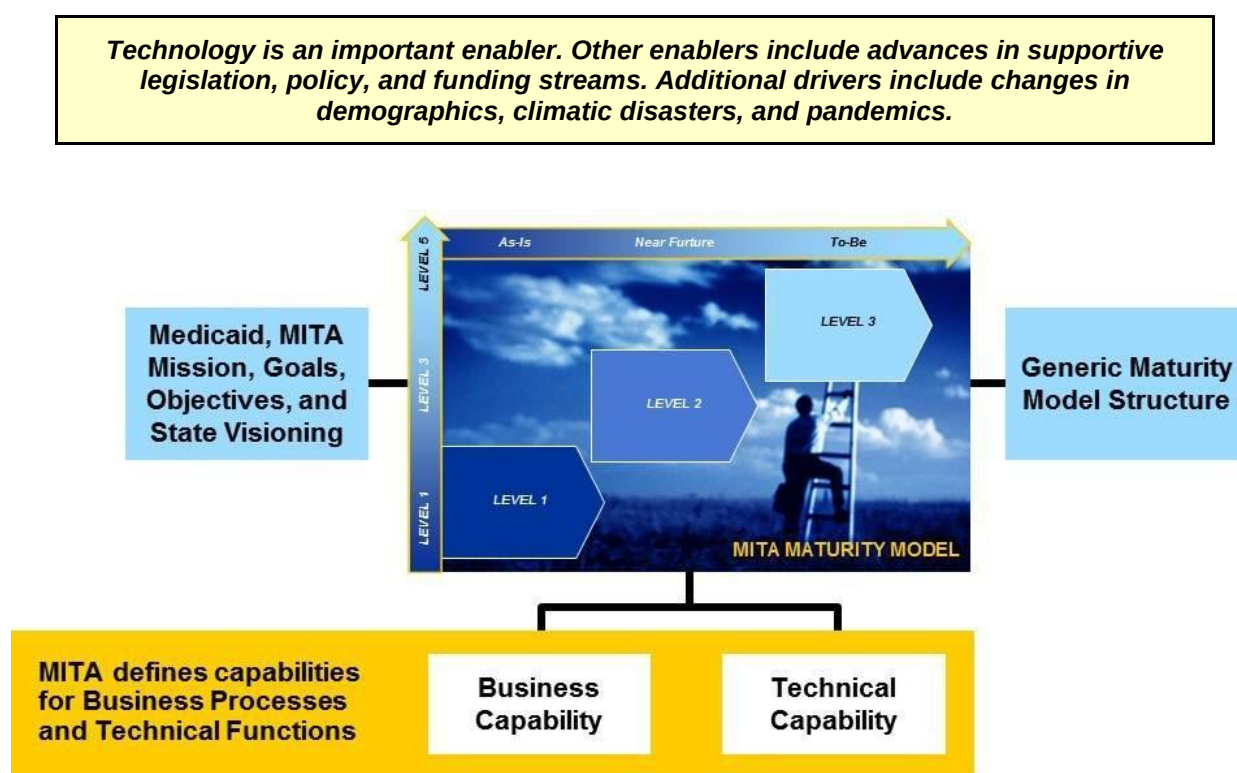
Table 3-5. The MMM and the SMA Ability to Provide Data

MMM Vision Layer – MITA Mission and Goals					
<i>MITA Goals</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>	<i>Level 5</i>
Provide data that is timely, accurate, usable, and easily accessible in order to support analysis and decision making for health care management and program administration	The source of data is primarily the claim. Data is accessible via a request/response process that meets the current goals, but management experiences delays and inconsistencies in acquisition of data. Data is non-standard, and the SMA primarily uses it to manage operations.	Claim data and managed care encounter data are available. Decision support tools provide faster, better analysis, and improve decision-making. HIPAA mandates some data exchange standards for limited external stakeholders, but few agencies use the standard data in their internal processes.	The SMA uses MITA Framework, industry standards, and other nationally recognized standards, such as the Council of Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating Rules for intrastate exchange of information. Intrastate information exchanges improve efficiency of access. This results in improvements in accessibility and accuracy of data used in program administration.	The SMA uses MITA Framework, industry standards, and other nationally recognized standards for interstate exchange of information. Access to standardized clinical data through regional health information exchange using the Enterprise Master Patient Index (EMPI) greatly enhances the decision-making process. With clinical evidence, decisions can be consistent and decisive.	Access to Master data management exchange on a national scale optimizes the decision-making capabilities of state, regional and federal agencies.

Using the MMM in the MITA Framework

The MMM shows how the Medicaid Enterprise evolves over time. It applies the general definition of a maturity model to the complexities of the Medicaid Program as manifested in and across the States.

The MMM applies to the three parts of MITA – the BA, IA, and TA. **Figure 3-3** shows the relationship of the MMM to the MITA transformation path. The Framework associates business capabilities with levels of maturity. TA defines technical capabilities, as enablers of the business capabilities, with corresponding levels.



BA-3-4

Figure 3-3. The MMM: A Direction for the MITA Transformation Path

This chapter presents the MMM and shows how to use it specifically in building business capabilities.

The BA describes the progress of business capabilities for each business process. Business capabilities conform to the definition of levels in the MMM. For example, a Level 3 business

capability adheres to the general description of MMM Level 3 and exhibits the same Level 3 qualities.

The MMM is the keystone for the MITA business, information, and technical capabilities.

Putting It All Together

Figure 3-4 shows the traceability of the State Medicaid transformation from the beginning of the vision in the COO (Part I, Chapter 2, Concept of Operations) to the creation of business capabilities (Part I, Chapter 5, Business Capability Matrix). The MMM concept describes the levels of maturity along the way. The levels of maturity apply to each business process to determine its unique levels of capability. Within the context of the BA, States can use the business capabilities to perform a State Self-Assessment (SS-A) and plan their moves to higher levels of capability. The migration path also includes information and technical transformations as discussed in Parts II and III of the MITA Framework.

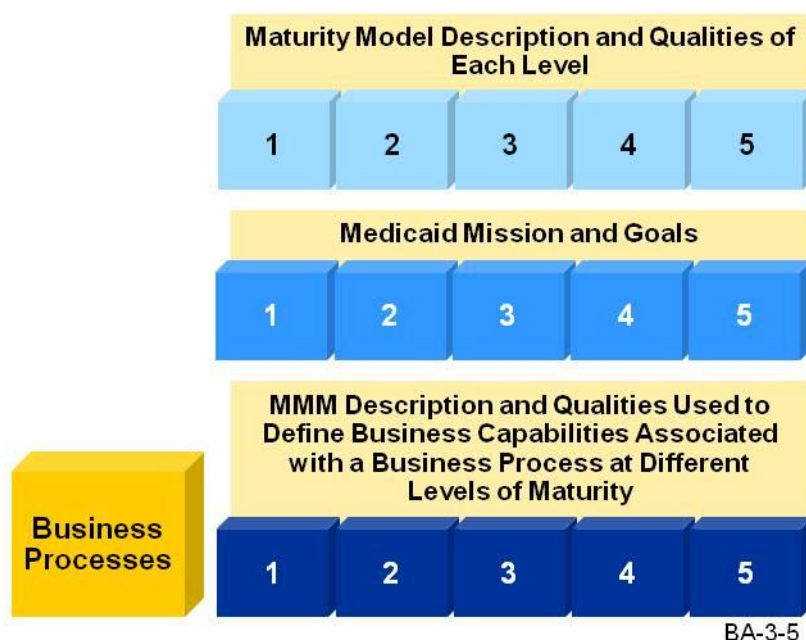


Figure 3-4. The MMM: Translating Medicaid Vision into Business Capabilities

The Traceability Model shown above illustrates the following:

- ❖ The MMM provides a framework that consists of a timeline and five (5) levels of maturity to achieve as the business matures.
- ❖ The MMM describes the Medicaid Enterprise in general at the five (5) levels of maturity. The description includes a list of qualities to clarify the intent of each level.

- ❖ The MMM applies the levels of maturity to the Medicaid and MITA mission statements and sample goals.
- ❖ The MMM serves as a guide for defining business capability statements for each business process at Levels 1 through 5. Business capabilities at each level trace to the corresponding MMM maturity level. Business capability statements mirror the MMM general description and detailed qualities. States should use the Business Capability Matrix (BCM) (a table of business capabilities for each business process at each level where they apply) to perform a MITA SS-A.
- ❖ CMS anticipates that over time, States collaborate with the MITA team to refine their business capabilities. The MITA repository retains these products for reuse by other States.

USE OF THE MITA MATURITY MODEL

The MMM is a reference model used to define business capabilities associated with all MITA business processes, and the information and technical capabilities for each MITA business area. The following summarizes the principal uses of the MMM:

- ❖ The MMM provides the framework for a common definition of each level, model qualities for further detail, and a baseline for levels of maturity.
- ❖ The MMM is traceable from the mission and goals of Medicaid and MITA to the definition of business, information, and technical capabilities.
- ❖ The MMM provides consistency (e.g., by giving all Level 3 business capabilities a common look and feel).
- ❖ The MMM serves as a basis for CMS to measure state agencies' performance.
- ❖ The MMM serves as a basis for States and vendors to clarify their understanding of business, information, and technical capabilities.

States are to use the business capabilities in their MITA SS-A with the MMM serving as a reference model, where necessary, to explain the level of maturity. CMS encourages States to participate in refining the capabilities.

Below, a single MITA business process (i.e., Determine Provider Eligibility) illustrates the use of the MMM in defining distinct business capabilities associated with up to five (5) levels of maturity. The example illustrates both the definition of the level of maturity and the qualities defined for each level.

Table 3-6 shows the application of the MMM to a specific business process, Determine Provider Eligibility. The first row repeats the general description of the maturity level. The second row contains the specific translation of the maturity level to the business capability of Determine Provider Eligibility.

Table 3-6. The MMM and the Determine Provider Eligibility Business Process

The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicant, renewing member, new provider or revalidation of an existing provider. The Business Objectives for this Business Area are to provide a “one-stop shop” for enrollment and eligibility determination based on standardized business rules definitions.					
Determine Provider Eligibility	Level 1	Level 2	Level 3	Level 4	Level 5
Maturity Model General Description	The SMA focuses on meeting compliance thresholds for state and federal regulations, aiming primarily at accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.	The SMA focuses on cost management and improving the quality of and access to care within structures designed to manage costs (e.g., managed care, catastrophic care management, and disease management).	The SMA focuses on coordinating and collaborating with other agencies to adopt national standards, and to develop and share reusable processes to improve the cost effectiveness of health care service delivery. The SMA promotes intrastate information exchange and business services.	The SMA, with widespread and secure access to clinical information, improves health care outcomes, empowers member and provider stakeholders, measures objectives quantitatively, and focuses on program improvement. The SMA promotes interstate information exchange and business services.	The SMA focuses on fine-tuning and optimizing program management, planning, and evaluation with national (and international) interoperability improvements that maximize automation of routine operations.
Determine Provider Eligibility business	The SMA provider enrollment staff	The SMA provider enrollment staff	The SMA provider enrollment staff	The SMA provider enrollment staff	The SMA provider enrollment staff has

The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicant, renewing member, new provider or revalidation of an existing provider. The Business Objectives for this Business Area are to provide a “one-stop shop” for enrollment and eligibility determination based on standardized business rules definitions.					
Determine Provider Eligibility	Level 1	Level 2	Level 3	Level 4	Level 5
process receives application data, verifies data, validates credentials, validates National Provider Identifier (NPI), and captures demographics.	meets state and federal requirements for processing applications. Staff receives and processes paper enrollment applications, manually applies the SMA business rules, and validates credentials.	receives automated applications and applies some standardized business rules automatically, which creates and helps maintain a provider network that complies with state and federal law and policy. The SMA meets members' clinical, cultural, and linguistic needs faster and more accurately. The SMA supports the needs of managed care and waiver programs, and improves quality of care overall.	collaborates with other agencies to receive standardized, electronic enrollment applications. The SMA applies automatic standardized business rules definitions, and accesses federated registries. The SMA performs all available verifications (e.g., credentialing) electronically. This creates and helps maintain a robust, coordinated provider network that meets quality and effectiveness objectives, supports integrated monitoring of provider performance, and allows members to interact directly with providers.	refines the verification and validation process via automated access to providers' clinical records to create and maintain a robust, coordinated, clinically sound provider network that exceeds Level 3 goals of quality, cultural appropriateness, accurate credentialing, and adequacy in meeting the needs of the population.	automated the enrollment process to the fullest extent possible and can access all provider registries nationally via data sharing and interoperability agreements, which optimizes the provider network and meets members' needs and choices. Staff handles exceptions and essentially performs a professional oversight and consumer satisfaction function.

The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicant, renewing member, new provider or revalidation of an existing provider. The Business Objectives for this Business Area are to provide a “one-stop shop” for enrollment and eligibility determination based on standardized business rules definitions.					
Determine Provider Eligibility	Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Descriptions					
Does enrollment process meet state and federal regulations or policies?	Meets state and federal requirements for accurate and timely processing of applications.	The SMA exceeds state and federal requirements for the accurate and timely processing of applications.	The SMA exceeds state and federal requirements for accurate and timely processing of provider enrollment applications including one-stop collaboration across the Medicaid Enterprise including dual eligibility with Medicare and CHIP, as well as enhanced background check and screening by level of risk with federal agencies.	The SMA exceeds state and federal requirements for accurate and timely processing of provider enrollment applications. The SMA collaborates with federal agencies for regional validation of background information and screening by level of risk in near-real time enrollment based on taxonomy.	The SMA exceeds state and federal requirements for processing provider enrollment applications timely and accurately. The SMA uses federated registries that identify providers across the country who qualify to serve special populations or who the Office of Inspector General (OIG) or CMS has disqualified based on criminal activity.
Is the process primarily manual or automated?	The process consists primarily of manual activity to receive and process paper enrollments submitted via mail.	The SMA uses a mix of manual and automated processes to process paper and web-based applications.	The SMA automates the enrollment application process to the fullest extent possible within the intrastate. The SMA receives a majority of Provider applications online.	The SMA automates the enrollment application process to the fullest extent possible within the region.	The SMA automates the enrollment application process to the fullest extent possible within the nation.

The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicant, renewing member, new provider or revalidation of an existing provider. The Business Objectives for this Business Area are to provide a “one-stop shop” for enrollment and eligibility determination based on standardized business rules definitions.					
<i>Determine Provider Eligibility</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>	<i>Level 5</i>
			Audit trail of determination results is produced 100% of the time.		
Does the State Medicaid Agency use standards in the process?	The SMA focuses on meeting compliance thresholds for state and federal regulations using state-specific standards.	The SMA applies a mix of HIPAA and state-specific standards.	The SMA adopts CMS standard enrollment application interfaces and other nationally recognized standards for intrastate exchange of information.	The SMA adopts CMS standard enrollment application interfaces and other nationally recognized standards for regional exchange of information.	The SMA adopts CMS standard enrollment application interfaces and other nationally recognized standards for national exchange of information.
Does the State Medicaid Agency use required screening requirements?	The SMA uses state-specific screening requirements.	The SMA uses a mix of federal screening and state-specific requirements.	The SMA adopts all federal screening requirements for low, medium and high risk providers within the intrastate.	The SMA adopts all federal screening requirements for low, medium and high risk providers within the region.	The SMA adopts all federal screening requirements for low, medium and high risk providers across the nation.
What provider identifier does the SMA use?	The SMA uses local identifier assigned by the state.	The SMA cross-references NPI to state identification	The NPI is the ID of record for all health care providers. The SMA enumerates atypical providers differently. The SMA retains legacy	The SMA widely uses the NPI for providers for whom the regulations require within the region. The SMA uses	The SMA widely uses the NPI for providers for whom the regulations require nationally. The SMA uses Atypical provider IDs

The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicant, renewing member, new provider or revalidation of an existing provider. The Business Objectives for this Business Area are to provide a “one-stop shop” for enrollment and eligibility determination based on standardized business rules definitions.					
Determine Provider Eligibility	Level 1	Level 2	Level 3	Level 4	Level 5
			identifiers for some business purposes, but newly enrolled providers will not require them.	Atypical provider IDs for non-NPI regulated providers within the region.	for non-NPI regulated providers across the nation.
How does the State Medicaid Agency verify credentials (e.g., college degree, license, certification, NPI, Employer Identification Number (EIN), and Social Security Number (SSN))?	The SMA manually validates information. Staff contacts external and internal document verification sources via telephone, facsimile, mail. Decisions on information verifications take three (3) to seven (7) business days. Validation is manual and subjective.	Medicaid agency has many automated application information validations (SSN, address, birth certificate, etc.). Validation is consistent and rules-based.	The SMA adopts CMS enrollment application standard interfaces and national standards within the intrastate that use standardized business rules definitions for consistent validation.	The SMA adopts CMS enrollment application standard interfaces and national standards within the interstate region that use regional standardized business rules definitions for consistent validation.	The SMA adopts CMS enrollment application standard interfaces and national standards within the nation that use national standardized business rules definitions for consistent validation.
Is there a process for revalidation of credentials?	State re-enrolls providers as needed, and revalidates credentials manually at that time.	Medicaid agency re-enrolls providers periodically, and revalidates credentials via a mix of manual and automated processes	The SMA automatically revalidates credentials within the intrastate and staff receive alerts when adverse results occur (e.g.,	The SMA automatically revalidates credentials across the interstate region and staff receives alerts when adverse	The SMA automatically revalidates credentials across the nation and staff receives alerts when adverse results

The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicant, renewing member, new provider or revalidation of an existing provider. The Business Objectives for this Business Area are to provide a “one-stop shop” for enrollment and eligibility determination based on standardized business rules definitions.					
Determine Provider Eligibility	Level 1	Level 2	Level 3	Level 4	Level 5
		(consistent with enrollment process).	the SMA terminates provider license; OIG or CMS has added provider to a criminal investigation list).	results occur.	occur.
How does the State Medicaid Agency collaborate with other agencies or entities in performing the process?	Very little collaboration occurs with other agencies to standardize information exchange or business tasks. Staff verifies information manually using telephone, facsimile and mail.	The SMA collaborates with other agencies and entities to adopt HIPAA standards and EDI transactions for information verification with credentialing organization and identification sources.	The SMA collaborates with other intrastate agencies and entities to adopt national standards to develop and share reusable enrollment application business services for information verification.	The SMA collaborates with other regional agencies and entities to adopt national standards and develop and share reusable enrollment application processes for information verification.	The SMA collaborates with national agencies and entities for national (and international) interoperability improvements that maximize automation of routine enrollment application operations.

Table 3-7 expands the definition of maturity levels to include qualities applicable to the Determine Provider Eligibility business process at different levels of maturity.

Table 3-7. The Business Qualities for Determine Provider Eligibility

Determine Provider Eligibility					
Capability Question	Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Quality: Timeliness of Process					
How timely is the end-to-end process?	Process meets threshold or mandated requirements for timeliness (e.g., the process achieves results within the time specified by law, regulation, or regulation). Average end-to-end process time to complete is in 30-60 business days.	Process timeliness improves through use of automation. Average end-to-end process time to complete is in 15-30 business days.	Timeliness improves via state and federal collaboration, use of enrollment application information sharing, standards, and regional information exchange hubs. Turnaround time on application decision for 85% or higher of applications is no more than 24 hours. Exceptions may be those requiring extensive credentialing or site visits. The SMA distributes eligibility determination notice of appeal rights	Enrollment application information and verification is available in near real time. The SMA has regional interoperability. Turnaround time on application decision for 95% or higher of enrollments is no more than four (4) hours.	Enrollment application information is available in real time. Enrollment application processes improve further through connectivity with other States and with federal agencies. Most processes execute at the point of service. Results are almost immediate.

Determine Provider Eligibility					
Capability Question	Level 1	Level 2	Level 3	Level 4	Level 5
			within 15 minutes or less 100% of the time.		
Business Capability Quality: Data Access and Accuracy					
How accurate is the information used in the process?	Use of direct data entry for information collection is manually intensive and susceptible to inconsistent or incorrect information. Stakeholders are unable to rely on information for decision making.	HIPAA standard transactions improve accuracy of information, but the decision-making process may be erroneous or misleading. Accuracy is higher than at Level 1.	Automation of enrollment application and verification information collection increases the reliability of SMA internal information. External sources of enrollment application and verification information use industry standards for information submission and verification. Automated decisions based on standardized business rules definitions. Accuracy rating is at 99% or higher.	Automation of enrollment application and verification information collection increases the reliability of regional the SMA internal and external sources of information. The SMA uses national standards for information submission and verification by regional agencies. Automation of decision making uses regional standardized business rules definitions. Accuracy rating is at 99% or higher.	The SMA uses national standards for national enrollment application and verification information submission and verification. Automated decision making uses national standardized business rules definitions. Accuracy rating is at 99% or higher.

Determine Provider Eligibility					
Capability Question	Level 1	Level 2	Level 3	Level 4	Level 5
How accessible is the information used in the process?	The SMA stores information in disparate systems including paper storage and obtains information manually.	The SMA stores information in disparate systems, but automation and HIPAA standards increase accessibility over Level 1.	The SMA obtains enrollment application and verification information easily and exchanges with intrastate agencies and entities based on MITA Framework and nationally recognized standards. System produces enrollment reports showing status of entire Medicaid population in graphical format for management use. Accessibility is greater than Level 2.	The SMA obtains enrollment application and verification information easily and exchanges with regional agencies and entities. Accessibility is greater than Level 3.	The SMA obtains enrollment application and verification information easily and exchanges with national agencies and entities. Accessibility is greater than Level 4.
Business Capability Quality: Cost-Effectiveness					
What is the cost of the process compared to the benefits of its results?	High relative cost due to low number of automated, standardized tasks.	Automation improves process and allows focus on exception resolution, increasing cost effectiveness ratio over Level 1.	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards further increasing cost effectiveness ratio over Level 2.	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for regional exchange increasing cost	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for national (and international)

Determine Provider Eligibility					
Capability Question	Level 1	Level 2	Level 3	Level 4	Level 5
				effectiveness ratio over Level 3.	exchange increasing cost effectiveness ratio over level 4.
Business Capability Quality: Effort to Perform; Efficiency					
How efficient is the process?	Process is labor intensive. State wastes effort or expense to accomplish tasks. Process meets minimum state process guidelines and SMA performance standards. Efficiency is low.	Automation and state standards increase productivity. Efficiency is higher than Level 1.	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for intrastate agencies and entities information exchange improving efficiency to 100%.	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for regional agencies and entities information exchange improving efficiency to 100%.	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for national agencies and entities information exchange improving efficiency to 100%.
Business Capability Quality: Accuracy of Process Results					
How accurate are the results of the process?	Manual processes results in greater opportunity for human error. Accuracy is low.	Automation and standardized business rules definitions reduce error and improve accuracy above Level 1.	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for intrastate agencies and entities information exchange improving accuracy to 90% or	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for regional agencies and entities information exchange improving accuracy to 98% or	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for national agencies and entities information exchange improving accuracy to 98% or

Determine Provider Eligibility					
Capability Question	Level 1	Level 2	Level 3	Level 4	Level 5
			higher.	higher.	higher.
Business Capability Quality: Utility or Value to Stakeholders					
How satisfied are the stakeholders?	Stakeholders lack confidence in information negatively affecting stakeholder satisfaction with the process.	Automation and standardization provide clear and useful information. Stakeholder satisfaction is greater than Level 1.	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for intrastate agencies and entities information exchange improving stakeholder satisfaction to 90% or higher. The SMA uses survey or questionnaire for information collection.	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for regional agencies and entities information exchange improving stakeholder satisfaction to 95% or higher.	The SMA adopts MITA Framework, standard interfaces, and other nationally recognized standards for national agencies and entities information exchange improving stakeholder satisfaction to 98% or higher.

In summary, the MMM defines boundaries for each level of maturity across the MITA BA, IA, and TA. This provides a consistent definition for each level. Capabilities defined for each business process point back to the MMM. The next two chapters (Part I, Chapter 4, Business Process Model, and Part I, Chapter 5, Business Capability Matrix) explain how these pieces fit together.

See Part I, Appendix B, Maturity Model Details, for information on the MMM applied to the BA.