BTC End-To-End Lifecycle & Module Functionality Views MMISR Handover

February 25, 2021

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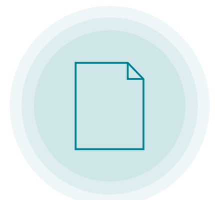
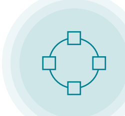
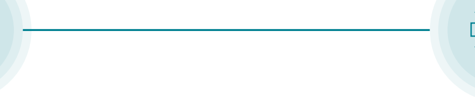
MAD's Transformation, a key enabler of HSD's Mission, encompasses systems, processes, people

Focus of Deliverable 14



This document focuses on the processes and systems components of MAD's transformation





Processes

- BTC and Journeys Redesign

Systems

- Medicaid Management Information System Replacement (MMISR)

People

- Organizational Health
- and Change
- Management

In scope for this phase of work

Business Process Catalog Refresh

E2E Lifecycle Review

IT Module Views

Contents

Deliverable Sub-task	Context	Objectives	Outputs
End-to-end journey lifecycle	Over the past ~18 months, MAD and sister agencies redesigned ~50 sub journeys to set the basis for MMISR[3]	Identify highest priority innovations from redesigned sub journeys Identify gaps and further innovation opportunities in redesigned sub journeys Review feedback themes from HSD leadership	Synthesis of all ~50 sub journeys redesigned that identifies gaps, overlaps, and improvement opportunities
Module functionality view	HSD[4] has scoped the delivery of MMISR into 7 different "modules" to be delivered by different vendors	Review module functionalities and details	Key functionalities overview for five MMISR modules[5], including mapping functionalities to redesigned journeys and MITA categories

1 Medicaid Assistance Division
2 Medicaid Information Technology Architecture
3 Medicaid Management Information System Replacement
4 Human Services Division
5 Five modules in scope are Data Services, Benefit Management Services, Financial Services, Quality Assurance, and Care / Case Management Services. Customer facing modules (Unified Portal, Consolidated Customer Service Center), not in scope of deliverable and are currently in progress for early 2021

Contents

- **End-To-End Lifecycle Views**
- Module Functionality Views

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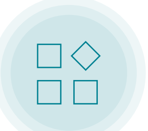
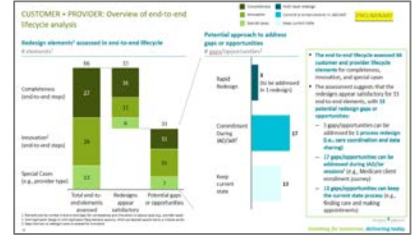
B The end-to-end lifecycle review captures feedback across three outputs

End-to-end outputs



B2

	Future state highlights	Key end-to-end lifecycle outcomes and metrics	"Pressure tested" future state
Output description	Highlights of business process innovation across the redesigned journeys	MMISR success metrics that address HSD goals	 List of redesigned journey gaps/enhancements and potential next steps to address them
Objective of HSD leadership feedback	Identify highest priority innovations from redesigned journeys and capture additional future state innovations	Identify important metrics to track MMISR success	Agree on next steps to address gaps identified during end-to-end lifecycle review

Contents

- **Customer details**
- Provider details
- MCO details
- Staff details
- External partner details

CUSTOMER: Highlights across the customer end-to-end lifecycle

End-to-end lifecycle covers 70-80% of Medicaid population[2]

Learn & apply → Utilize → Renew & resolve

Lifecycle Steps[1]

Steps 1, 2, 3, 4	Steps 5, 6 ,7, 8	Steps 9,10	Steps 11,12,13
Outreach, application, and plan selection	**Review coverage, ask questions, and find care**	**Receive care and receive care coordination**	**Find help, access record or switch status/eligibility**

Highlights

Outreach, application, and plan selection
- Customers receive communications (e.g., via email, text, social media) sharing what benefits they qualify for
- Forms auto-populate with data pulled from other enterprise systems (e.g., ASPEN)
- Customer can track the progress of their application with a progress bar across
- Portal shows information about customer health plan options including comparison grids and FAQs
- Waiting for physical enrollment package for benefit utilization is eliminated
- Chatbot helps answer customer questions

Review coverage, ask questions, and find care
- Customer can login to portal profile via face recognition or thumb print
- Portal shows all historical information, status of benefits, and what benefits the customer is eligible for

Receive care and receive care coordination
- Customer can use portal to message providers for information/scheduling
- Care coordinator (if available through MCO) can assist the customer with scheduling all services

Find help, access record or switch status/eligibility
- Customer has access to support via multiple channels
- Customer gets automatically notified of open enrollment periods, and what they might need
- Automatic notifications are sent to all relevant stakeholders when customer status changes

The end-to-end customer lifecycle covers enrollment, receiving treatment, and changing status

Customer lifecycle phases

Learn → Apply → Utilize → Renew → Resolve

	1	2	3	4	5	6	7	8	9	10	11	12
	Proactive outreach	**Apply to Medicaid**	**Learn more about plans**	**Enroll in Medicaid / MCO**	**Review coverage and ask questions**	**Find care & make appointment**	**Receive medical care from provider**	**Coordinate care and other support**	**Renew or switch Medicaid plans**	**Adverse actions and Fair Hearings**	**Access health record**	**Change in status / eligibility**
Core Sub-Journey(s)	EligibilityEnroll, MCEnroll-3 & PortalAccess-6	EligibilityEnroll & MCEnroll & PortalAccess & 3rdPartyAppl-9 (Staff)	EligibilityEnroll & MCEnroll & PortalAccess & 3rdPartyAppl-9 (Staff)	EligibilityEnroll & MCEnroll-3 & 3rdPartyAppl-9 (Staff)	EscalationInquiry-TT, CCSCuse-4, IssueMgmt-5, CorresGen-7 & PortalAccess-6	ProvUpdates-4 (Provider)	NA	BenMgmtCC-1 & LOC-2 & MemCareMgmt-9 & EPSDT-11 (Staff)	EligibilityEnroll & MCEnroll-3	EligibilityEnroll & FairHearings-10 (Staff)	PortalAccess-6	EligibilityEnroll-TT

Customers may not start at beginning of lifecycle or reach end of lifecycle

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Select KPIs will inform improvements in the customer lifecycle

KPI	Indicator metric[1]
Time to determination	Online time to determination
Customer satisfaction	Overall satisfaction with HSD experience
Productivity	# of customer service calls for questions related to eligibility or applications

KPIs can be used to assess if redesigned journey impact is captured during vendor implementation

1 Indicator metric is one that closely resembles KPI when KPIs cannot be holistically tracked

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Customer: Overview of end-to-end lifecycle analysis

Redesign elements[1] assessed in end-to-end lifecycle

elements[1]

	Total end-to-end elements assessed	Redesigns appear satisfactory	Potential gaps or opportunities
Completeness (end-to-end steps)	12	7	5
Innovation (end-to-end steps)	11	5	6
Special Cases (eligibility groups)	10	5	5
Total	33	17	16

Legend: Completeness; Innovation; Special cases; Details on next steps to follow

- The customer end-to-end lifecycle assessed:
  - 12 steps for journey redesign completeness
  - 11 steps for journey redesign innovation
  - 10 special cases (i.e., populations potentially not covered by end-to-end lifecycle)
- The assessment suggests that the redesigns appear satisfactory for 17 end-to-end elements
- The assessments identified 16 potential gaps or opportunities

1 Elements are the number of end-to-end steps (for completeness and innovation) or eligibility groups (for special cases)

"Completeness" and "innovation" definition

	Completeness	Innovation
Assessment questions	▪ **Relevant redesigned journey:** Are there redesigned journeys that mention this lifecycle step? ▪ **Clarity:** Is the redesigned journey clear in the steps taken by the stakeholder? ▪ **Exhaustiveness:** Is every required step included in the redesigned journey? ▪ **Consistency:** Is the overlap across redesigned journeys (if any) consistent across journeys?	▪ **Operating model shift:** Did we shift our operating model to partner better with customers (e.g., help MCOs pre-emptively be aware of issues)? ▪ **Process evaluation:** Did we evaluate each process step to determine which are necessary, which can be eliminated and which can be automated? ▪ **Digitization:** Did we digitalize as much of the process as possible? Did we eliminate printed documents? Did we eliminate email-driven processes? ▪ **Automation:** Did we find all areas where automation can save time and improve accuracy? Did we automate reporting and shift to a self-service model? ▪ **Data visibility and access:** Did we analyze all areas where data can be collected and used to improve the process or awareness (e.g., dashboards, KPIs, predictive analytics etc.)?
Assessment definition	Answer to all 4 questions is a "yes"	Answer to all 5 questions is "yes"
	Answer to 2 to 3 questions is a "yes"	Answer to 2 to 4 questions is a "yes"
	Answer to 0 or 1 questions is a "yes"	Answer to 0 or 1 questions is a "yes"

Customer end-to-end lifecycle redesign highlights and opportunities

- ● (green) Covered by redesigned sub-journey
- ● (yellow) Gaps in redesigned sub-journey
- ● (gray) Missing from sub-journey redesign
- (#) Gap ID

Customer lifecycle phases

Phase	#	Sub-journey	Core Sub-Journey(s)	Completeness Assessment	Innovation Assessment
Learn	1	Proactive Outreach	EligibilityEnroll, MCEnroll-3 & PortalAccess-6	Green	Green
Apply	2	Apply to Medicaid	EligibilityEnroll & MCEnroll & PortalAccess & 3rdPartyAppl-9 (Staff)	Yellow	Yellow
Apply	3	Learn more about plans	(shared with 2)	Green	Green
Apply	4	Enroll in Medicaid / MCO	EligibilityEnroll & MCEnroll-3 & 3rdPartyAppl-9 (Staff)	Green	Yellow
Utilize	5	Review coverage and ask questions	EscalationInquiry-TT, CCSCuse-4, IssueMgmt-5, CorresGen-7 & PortalAccess-6	Green	Green
Utilize	6	Find care & make appointment	ProvUpdates-4 (Provider)	Gray	Yellow
Utilize	7	Receive medical care from provider	*NA*	Gray	
Utilize	8	Coordinate care and other support	BenMgmtCC-1 & LOC-2 & MemCareMgmt-9 & EPSDT-11 (Staff)	Yellow	Yellow
Renew	9	Renew or switch Medicaid plans	EligibilityEnroll & MCEnroll-3	Green	Green
Resolve	10	Adverse actions and Fair Hearings	EligibilityEnroll & MemFraudMgmt-10 & FairHearings-10 (Staff)	Green	Yellow
Resolve	11	Access health record	PortalAccess-6	Yellow	Yellow
Resolve	12	Change in status / eligibility	EligibilityEnroll-TT	Green	Green

Detailed highlights, completeness gaps, innovation opportunities to follow

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Highlights and suggested opportunities in customer lifecycle (1/3)

	Learn	Apply		
	1	**2**	**3**	**4**
	Proactive Outreach	**Apply to Medicaid**	**Learn more about plans**	**Enroll in Medicaid / MCO**
Core Sub-Journey(s)	EligibilityEnroll, MCEnroll-3 & PortalAccess-6	EligibilityEnroll & MCEnroll & PortalAccess & 3rdPartyAppl-9 (Staff)	EligibilityEnroll & MCEnroll & PortalAccess & 3rdPartyAppl-9 (Staff)	EligibilityEnroll & MCEnroll-3 & 3rdPartyAppl-9 (Staff)
Completeness Assessment	(green)	1 (yellow)	(green)	(green)
Innovation Assessment	(green)	6 (yellow)	(green)	7 (yellow)
Highlights	▪ Proactive outreach via advertising and social media ▪ Digital outreach (email) for customers in other NM programs ▪ Partnerships with community outreach programs	▪ Information will be auto-populated data collection fields in ASPEN (using optical character recognition for previously submitted paper forms) ▪ Client is able to track the progress of their application	▪ Eligibility verifications completed on the same of inquiry ▪ Ability to see if plans cover their provider(s) and a formulary ▪ Webinars, YouTube tutorials, FAQs, comparison grids, brochures, and other written materials	▪ Applications accepted via paper, on-line, through portal, or on phone ▪ Elimination of waiting for physical enrollment package for benefit utilization ▪ Chatbot to help answer questions and take actions (e.g., notification of newborn)

Suggested Opportunities	*NA*	▪ **Completeness:** Overlap?
		  ▪ MCEnroll: Real Time Eligibility determination
		  ▪ EligibilityEnroll: Eligibility verification done “the same day as inquiry”
		▪ Real-time application acceptance
			NA	▪ MCO suggestion based on questionnaire
				▪ Comprehensive Needs Assessment online scheduling

Highlights and suggested opportunities in customer lifecycle (2/3)

Utilize

	5	6	7	8
	Review coverage and ask questions	**Find care & make appointment**	**Receive medical care from provider**	**Coordinate care and other support**
Core Sub-Journey(s)	EscalationInquiry-TT, CCSCuse-4, IssueMgmt-5, CorresGen-7 & PortalAccess-6	ProvUpdates-4 (Provider)	NA	BenMgmtCC-1 & LOC-2 & MemCareMgmt-9 & EPSDT-11 (Staff)
Completeness Assessment		2	3	4
Innovation Assessment		8		9
Highlights	▪ Login to portal profile via thumb print or face recognition ▪ Portal shows historical information, status of benefits, and what benefits client is eligible for ▪ Chatbot helps answer questions, but can direct to customer service center	▪ Provider portal allows for integration with MMIS for appointment scheduling	▪ Message provider through system	▪ Care coordinator (if available through MCO) assists customer with scheduling all services
Suggested Opportunities	NA	▪ **Completeness:** No redesign journey around finding care or appointment scheduling ▪ **Completeness:** Limited details on MCO integration journey ▪ Design care search / suggestor journey	▪ **Completeness:** No redesigned journey around receiving care ▪ Appointment reminders ▪ Gather feedback about provider ▪ Support transportation	▪ **Completeness:** No care coordination for FFS customers ▪ Data sharing / gathering across providers and services

Highlights and suggested opportunities in customer lifecycle (3/3)

	Renew	Resolve		
	9	10	11	12
	Renew or switch Medicaid plans	Adverse actions and Fair Hearings	Access health record	Change in status / eligibility
Core Sub-Journey(s)	EligibilityEnroll & MCEnroll-3	EligibilityEnroll & MemFraudMgmt-10 & FairHearings-10 (Staff)	PortalAccess-6	EligibilityEnroll-TT
Completeness Assessment	●	●	5	●
Innovation Assessment	●	10	11	●
Highlights	▪ MCOs provide transition of care information (e.g., prior authorizations, care plans, assessments) through MMIS ▪ Automating switch request validation (including administrative errors) ▪ Notification for open enrollment periods	▪ Medical history (e.g., records, claims) pulled and compiled during fair hearing process ▪ Fair hearing request completed through online chat and appeal form ▪ Fair hearing status, transcription, and decision tracked in portal	▪ Integration with MCO health portals (but integration plan needs more details)	▪ Auto-population of waiver application ▪ Physician send pre-populated disability determination document ▪ Automatically triggers notifications when status changes
Suggested Opportunities	*NA*	▪ Automated, personalized reasons for denial with common steps to resolution	▪ **Completeness:** No journey around receiving health record (only claims and care coordination notes) ▪ Produce consolidated health record ▪ Inform MCO and care coordinators of medical questions ▪ Medical information about common diagnoses	*NA*

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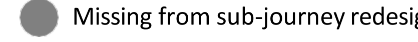
The end-to-end customer lifecycle covers most Medicaid patients, but select steps may be missing for certain categories of eligibility

Covered by redesigned sub-journey
May be gaps in redesigned sub-journey

Missing from sub-journey redesign
Gap ID

Category of eligibility	% of Customer Population[1]	Key differences with core lifecycle	Covered by Redesigned Sub-Journey	Rationale
Children, including CHIP (and not in other category)	38%	CHIP pays copays (not relevant for all population)		Covered by core lifecycle
Adult affordable care categories & Medicaid extension (non-CHIP)	32%	No differences		Covered by core lifecycle
Parents, caretakers, transitional Medicaid, and pregnant women	11%	No differences		No differences in Medicaid journey
Fee-for-Service - Full Benefits	8%	No MCO enrollment		Covered by core lifecycle and several steps in redesigned journeys
Supplemental Security Income (SSI)	7%	SSI provides cash benefits		No differences in Medicaid journey
Medicare partial fee for service[3]	6%	Medicaid pays some of Medicare premiums		No aligned journey with Medicare enrollment
Family planning (fee for service)	4%	Access only family planning clinics (incl. birth control and labs)		No explicit journey about non-Medicaid family planning customer
Home and Community Based Waivers and Developmentally Disabled	1%	Eligibility determined by Department of Health or Aging and Long-Term Services Department		No explicit journey about other department eligibility determinations
CYFD Children	0.8%	Children, Youth and Families Department makes eligibility determination		No explicit journey about other department eligibility determinations
Other[2]	<0.7%	Copays, assessing CDC criteria for cancer for cervical cancer patients	16	May not be included in redesigns

1 Overlapping customer types, so may not sum to 100%
2 Others include institutional care Medicaid (0.4%), Working Disabled Individuals (0.3%), Breast / Cervical cancer (<.01%), and refugees / aliens (<.01%)
3 Includes Qualified Medicare Beneficiaries, Specific Low-Income Medicare Beneficiaries, and Qualified Individuals 1

Source: Medicaid Eligibility enrollment report, September 2020

Contents

- Customer details
- **Provider details**
- MCO details
- Staff details
- External partner details

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PROVIDER: Highlights across the provider end-to-end lifecycle

End-to-end lifecycle captures most providers' Medicaid lifecycle[2]

	Enroll	Serve customers	Get reimbursed	Renew & resolve
Lifecycle Steps[1]	**1, 2 ,3, 4**	**5, 6, 7**	**8, 9**	**10, 11, 12, 13, 14, 15**
	Inquire, submit application, enroll, and provide updates	**Intake, scheduling, prior auth, and MCO care coordination**	**Submit claims and receive payments**	**Resolve issues and receive updates**
Highlights	▪ Application is auto-filled based on data from external resources and information submitted in a brief questionnaire ▪ There is a single application across MCOs and State of New Mexico departments[3] ▪ Application status is tracked real-time ▪ Billing instructions and Electronic Data Interface (EDI) are shared upon enrollment ▪ Profile is auto-populated from state licensing information ▪ Providers are prompted to send updates when state identifies changes ▪ Web-based (i.e., LinkedIn-style) information update is enabled ▪ Provider information update status tracking is visible and updated automatically	▪ An optional ability to integrate scheduling system with the new MMIS is enabled ▪ Prior authorization is submitted through portal for all Medicaid customers (MCO/FFS) ▪ Real-time prior authorization approval/denial is provided (unless review is automatically detected) ▪ Hospital discharge planners can enter treatment plan into the new MMIS ▪ Customers can exchange messages with the provider through portal	▪ All claims (FFS/MCO) are submitted through a single portal (e.g., electronic data interface) ▪ Pre-screening is done to identify potential claim errors/issues (e.g., missing documentation) ▪ Analytics prioritize and flag claims that need additional scrutiny before approval ▪ Weekly remittance advice is automatically distributed in multiple channels (e.g., paper, electronic)	▪ Fair hearing and appeal process can be immediately started in the portal ▪ Fair hearing process is standardized, including opportunity for informal resolution ▪ Providers receive text, mobile app, or email alerts regarding new requirements ▪ Providers receive text, mobile app, or email alerts regarding recertification needs and expiring licenses ▪ Multi-channel support and question escalation is enabled ▪ Unresolved issues from feedback will automatically create a case in the CRM and be escalated as necessary ▪ Algorithms to detect fraud, waste, and abuse are incorporated

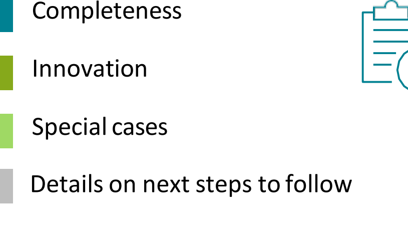
The end-to-end provider lifecycle covers enrollment, serving customers, submitting claims, renewing enrollment, and resolving issues

Provider lifecycle phases

Enroll — Serve clients — Get Reimbursed — Renew and resolve

Phase	Step	Description	Core Sub-Journey(s)
Enroll	1	Inquire about enrolling	NA
Enroll	2	Submit application	ProviderEnroll
Enroll	3	Enroll and onboard	ProviderEnroll
Enroll	4	Provide updates	ProvUpdates
Serve clients	5	Intake patients, scheduling	MedProv Pymts
Serve clients	6	Prior authori-zation	PriorAuth & MedProv-Pymts
Serve clients	7	Follow-up and MCO care coordi-nation	BengMgmtCC
Get Reimbursed	8	Submit claims	MedProv Pymts
Get Reimbursed	9	Receive payments	MedProvPymts & PymtRec-9
Renew and resolve	10	Fair hearings and denial appeals	MedProvPymts & FairHearings (Staff)
Renew and resolve	11	Renew enroll-ment	NA
Renew and resolve	12	Receive notifications/updates on changes	ProviderEnroll
Renew and resolve	13	Resolve issues and questions	IssueMgmt
Renew and resolve	14	Share feedback with Medicaid	IssueMgmt
Renew and resolve	15	Inquire and manage fraud inquiries	FraudWaste-Abuse

Provider: Overview of end-to-end lifecycle analysis



Redesign elements[1] assessed in end-to-end lifecycle

elements[1]

	Total end-to-end elements assessed	Redesigns appear satisfactory	Potential gaps or opportunities
Completeness (end-to-end steps)	15	9	6
Innovation (end-to-end steps)	15	6	9
Special Cases (e.g., provider type)	3	2	1
Total	33	17	16

- The provider end-to-end lifecycle assessed:
  - 15 steps for journey redesign completeness
  - 15 steps for journey redesign innovation
  - 3 special cases (i.e., populations potentially not covered by end-to-end lifecycle)
- The assessment suggests that the redesigns appear satisfactory for 17 end-to-end elements
- The assessments identified 16 potential gaps or opportunities

1 Elements are the number of end-to-end steps (for completeness and innovation) or special cases (e.g., provider types)

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Provider end-to-end lifecycle redesign highlights and opportunities

Gap ID

- Covered by redesigned sub-journey (green)
- Gaps in redesigned sub-journey (yellow)
- Missing from sub-journey redesign (grey)

Provider lifecycle phases

Phase	#	Step	Core Sub-Journey	Completeness Assessment	Innovation Assessment
Enroll	1	Inquire about enrolling	*NA*	1 (grey)	
Enroll	2	Submit application	Provider-Enroll-1 (steps 2–3)	Green	Green
Enroll	3	Enroll and onboard	Provider-Enroll-1 (steps 2–3)	Green	7 (yellow)
Enroll	4	Provide updates	Prov-Updates-4	Green	8 (yellow)
Serve clients	5	Intake patients, scheduling	MedProv-Pymts-2	Green	9 (yellow)
Serve clients	6	Prior authori-zation	PriorAuth-3 & MedProvPymts-2 & PharmBen-6 (MCO)	Green	Green
Serve clients	7	Follow-up and MCO care coordi-nation	BengMtmt CC-1	2 (yellow)	10 (grey)
Get Reimbursed	8	Submit claims	MedProv-Pymts-2	Green	Green
Get Reimbursed	9	Receive payments	MedProv-Pymts-2 & PymtRec-9	3 (yellow)	11 (yellow)
Renew and resolve	10	Fair hearings and denial appeals	MedProv-Pymts-2 & & AdverActions-11 FairHearings (Staff)	Green	Green
Renew and resolve	11	Renew enrollment	*NA*	4 (yellow)	12 (yellow)
Renew and resolve	12	Receive notificatio ns/updates on changes	Provider-Enroll-1	Green	13 (yellow)
Renew and resolve	13	Resolve issues and questions	IssueMgmt-5 & EscalationInq uiry-TT (Cust.)	Green	Green
Renew and resolve	14	Share feedback with Medicaid	CCSCuse-4 (Customer)	5 (yellow)	14 (yellow)
Renew and resolve	15	Inquire and manage fraud inquiries	FraudWast eAbuse-7	6 (yellow)	15 (yellow)

Gaps and opportunities

- (1) No provider out-reach journey
- (2) Application auto-filled based on known information and uploaded documents
- (7) Support with MCO contracting
- (9) Ability to accept appointment requests online
- (10) Opportunity to design interaction between MCO care coordination team / systems. Limited data collection from provider

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Highlights and suggested opportunities in provider lifecycle (1/4)

Enroll

	1	2	3	4
	Inquire about enrolling into Medicaid	**Submit application**	**Enroll and onboard**	**Provide Updates**
Redesigned journeys impacting:	NA	ProviderEnroll-1	ProviderEnroll-1	ProvUpdates-4
Completeness Assessment:	1	●	●	●
Innovation Assessment:		●	7	8
Highlights		▪ Application auto-filled based on uploaded documents ▪ Single application across MCOs and State of New Mexico departments ▪ Application status tracking	▪ Billing instructions and Electronic Data Interface (EDI) shared upon enrollment	▪ Profile auto-populated from state licensing information ▪ Providers prompted to send updates when state identifies changes ▪ Web-based (i.e., LinkedIn-style) information update ▪ Update approval status tracking
Suggested Opportunities	▪ **Gap:** Journey about provider outreach / education ▪ Create provider outreach and marketing materials ▪ Active provider social media marketing		▪ Support provider with MCO contracting and network sufficiency ▪ Online appointment scheduling for BHSD/CYFD site visit ▪ Automated verification that provider is active in MCO system	▪ Real-time status update approval

Highlights and suggested opportunities in provider lifecycle (2/4)

Gap ID

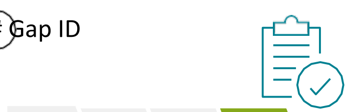
Serve clients

	5	6	7
	Intake patients and scheduling	**Prior Authorization**	**Follow-up and MCO care coordination**
Redesigned journeys impacting:	MedProvPymts-2	PriorAuth-3 & MedProvPymts-2 & PharmBen-6(MCO)	BenMgmtCC-1
Completeness Assessment:			2
Innovation Assessment:	9		10
Highlights	▪ Optional ability to integrate scheduling system with MMISR	▪ Prior authorization submitted through portal for Medicaid customers (MCO and FFS) ▪ Real-time prior auth approval/denial (MCO and FFS)	▪ Hospital discharge planners can enter treatment plan into MMIS ▪ Customer can message provider through portal
Suggested Opportunities	▪ Online scheduling or integration with MCO scheduling options ▪ Automated eligibility/referral check		▪ Design interaction between MCO care coordination team / systems ▪ Make available case information (e.g., health risk assessment) results to providers (in HIPPA-compliant way)

Highlights and suggested opportunities in provider lifecycle (3/4)

	Get Reimbursed		Renew and Resolve
	8	9	10
	Submit claims	**Receive payments**	**Fair hearings and denial appeals**
Redesigned journeys impacting:	MedProvPymts-2	MedProvPymts-2 & PymtRec-9	MedProvPymts-2 & AdverActions-11 & FairHearings-10 (Staff)
Completeness Assessment:	●	3	●
Innovation Assessment:	●	11	●
Highlights	▪ Claims (FFS and MCO) submitted through single portal ▪ Pre-screening to identify potential claim errors/issues (e.g., missing documentation) ▪ Analytics supports some real-time claims approval / denial	▪ Weekly remittance advice distributed in multiple channels (e.g., paper, electronic)	▪ Fair hearing and appeal process can be immediately started in portal ▪ Standardized fair hearing process, including opportunity for informal resolution ▪ Notices cite (and reference) rules and regulations that can easily be located
Suggested Opportunities		▪ **Gap:** Journey of FFS provider receiving payments ▪ Track payment status (not only claim approval status) ▪ Multi-channel generation of remittance advice ▪ Day-of-service payment option	

Highlights and suggested opportunities in provider lifecycle (4/4)



Renew and resolve

	11	12	13	14	15
	Renew enrollment in Medicaid	**Receive notifications/updates on change in policy**	**Resolve issues and questions**	**Share feedback with Medicaid**	**Inquire and manage fraud inquiries against providers**
Redesigned journeys impacting:	NA	ProviderEnroll-1	IssueMgmt-5 & EscalationInquiry-TT (Customer)	CCSCuse-4 (Customer)	FraudWasteAbuse-7
Completeness Assessment:	4			5	6
Innovation Assessment:	12	13		14	15
Highlights	▪ Providers receive text, mobile app, or email alerts regarding new requirements	▪ Providers receive text, mobile app, or email alerts regarding recertification needs and expiring licenses	▪ Multi-channel support and question escalation	▪ Unresolved issues from feedback will automatically create a case in the CRM and be escalated as necessary	▪ Incorporates algorithms and studies to detect fraud, waste, and abuse.
Suggested Opportunities	▪ **Completeness:** Journey on renewing enrollment or recertification ▪ Suggest key actions for recertification	▪ Personalized implications/ highlighting for policy changes		▪ **Completeness:** Capture feedback outside of CCSC interaction ▪ Proactively capture feedback during digitized processes (e.g., enrollment, submitting claims) ▪ Conduct randomized feedback surveys	▪ **Completeness:** Journey not designed around provider experience (e.g., how does provider resolve) ▪ **Completeness:** Need to incorporate Senate Bill 41 requirements

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The end-to-end provider lifecycle covers most providers, but select steps may be missing for special cases

GapID
Covered by redesigned sub-journey
Gaps in redesigned sub-journey
Missing from sub-journey redesign

NOT EXHAUSTIVE

Provider type	Population size (# people)[2]	Key differences with core lifecycle	Covered by Redesigned Sub-Journey
BHSD providers[3]	**137**	*Additional application for BHSD (separate from Medicaid payments)*	Covered (green)
Presumptive Eligibility Determiners	**745**	*Registers through Medicaid, but different credentialing needed*	Gaps (yellow) 16
MCO out-of-network providers	**~46,000**	*No key differences with primary journey. If provider encounters out-of-MCO-network client, MCO typically pays fee-for-service rate*	Covered (green)

1 Overlapping provider types, so will not sum to 100%
2 For context: New Mexico has ~39,000 enrolled providers
3 Includes only providers with "encounter" claims. Encounter includes services that provide targeted services at an approved rate. Other BHSD providers ("workbook" providers) request grant-like funding from BHSD for services (e.g., DUI campaigns/outreach)

Contents

- Customer details
- Provider details
- **MCO details**
- Staff details
- External partner details

MCO: Highlights in MCO lifecycle

End-to-end lifecycle captures all three MCOs and TPA[2]

Enroll — **Manage Customer Care** — **Report, receive payment, & resolve**

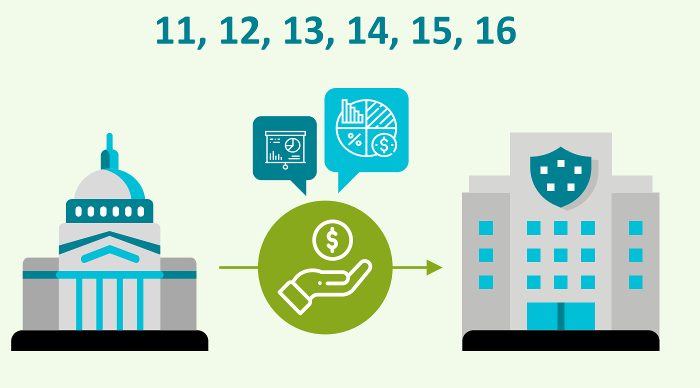
Lifecycle Steps[1]

1, 2, 3, 4

Outreach, education, risk assessment, and migrate customer between MCOs

5, 6, 7, 8, 9, 10

Provider prior authorization, edit claims, reimburse providers, and identify fraud



11, 12, 13, 14, 15, 16

View and receive capitation rates, submit data, identify fraud, and improve Medicaid contract

Highlights

Enroll

- Clients are contacted via advertising, social media, and email
- Partnerships exist with community outreach programs
- Application data is auto-populated from fields in other HSD databases (e.g., ASPEN)
- Customers complete online health risk assessment immediately upon MCO enrollment
- Customer MCO transition is simple: All care plans and authorizations will be automatically transferred from the relinquishing MCO to receiving MCO

Manage Customer Care

- Portal identifies if prior authorization is needed based on MCO rules
- Prior authorization quality is immediately completed at submission
- System pre-edits all claims (e.g., ensuring correct documentation)
- Provider receives real-time notifications of claims status through portal
- Critical incident reports are shared with applicable reporting parties (e.g., HSD, provider, MCO)

Report, receive payment, & resolve

- Capitation rate development analytics are transparent (e.g., PMPM calculation methodology)
- Routine policy, requirements, and program changes are triggered by "machine learning system", which automatically implements capitation rate adjustment
- Dashboards (with alerts) calculate, report, track, and trend capitation adjustments
- MCO quality data is immediately reviewed upon submission (e.g., rejection if incomplete, wrong data, timeliness)
- Reports are automatically generated (e.g., trends, visualizations, red flags)
- Fair hearing requests, data tracking, and resolutions are digitally available through portal
- A single algorithmic fraud/waste/abuse system supports HSD/MAD, MCOs, and Office of Attorney General (OAG) needs

1 Lifecycle step details (including relevant redesigned journeys, highlights, suggested opportunities) can be found in the following slides

2 TPA = Third Party Administrator, who is NM Medicaid's fiscal agent for FFS customers

The end-to-end MCO lifecycle covers customer onboarding, managing customer care, and receiving Medicaid payment

MCO lifecycle phases

Source, qualify, and onboard customers	Manage customer care	Report and receive Medicaid payment	Resolve Issues

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	Customer outreach and education	**Gather patient information**	**Perform risk / needs assessment**	**Remove / migrate customer**	**Contract with and onboard providers**	**Help customer find care**	**Provide prior authorization**	**Approve, change, or deny claims**	**Reimburse Providers**	**Member care management**	**View capitation rates, adjustments, and penalties**	**Collect and submit compliance, performance, and other data**	**Receive Medicaid payment**	**Respond to fair hearings**	**Identify fraud, waste, and abuse**	**Amend and improve Medicaid contract**
Core Sub-Journey(s)	MCEnroll & PortalAccess and 3rdParty Appl-9 (Staff)	MCEnroll-3 (Customer)	BenMgmtCC-1 (Customer) & RideAlong-1 & EligibilityEnroll (Customer)	MCEnroll-3 (Customer)	Provider Enroll-1 (Provider) & ValuPurchasing-5 (Staff)	NA	PriorAuth-3 (Provider) & PharmBen-6	PriorAuth-3 (Provider) & MedProv Pymts-2 (Provider) & ClaimsEncMgmt-4 (Staff)	MedProv Pymts-2 (Provider) & PharmBen-6 and Claims EncMgmt-6 (Staff)	MemCare Mgmt (Customer) & EVV & BenMgmt Srvcs-10	CapRates-2, CapRates-4, ContractCompPen-7, PerMeasures-3	Contract CompPen-7, Reporting-TT, & Perf Measures-3	NA	PriorAuth-3 (Provider) &FairHearings-10 (Staff)	FraudWasteAbuse-7 (Provider) & MemFraudMgmt (Customer)	Contract CompPen-7

MCO: Overview of end-to-end lifecycle analysis

Redesign elements[1] assessed in end-to-end lifecycle

elements[1]

Completeness
Innovation
Special cases
Details on next steps to follow

	Total end-to-end elements assessed	Redesigns appear satisfactory	Potential gaps or opportunities
Completeness (end-to-end steps)	16	11	5
Innovation (end-to-end steps)	12	10	2
Special Cases[2]	0	0	0
Total	28	21	7

- The MCO end-to-end lifecycle assessed:
  - 16 steps for journey redesign completeness
  - 12 steps for journey redesign innovation
- The assessment suggests that the redesigns appear satisfactory for 21 end-to-end elements
- The assessments identified 7 potential gaps or opportunities

1 Elements are the number of end-to-end steps (for completeness and innovation) or special cases (e.g., provider types)
2 No special cases identified for MCO journey. TPA is covered by end-to-end lifecycle steps

MCO end-to-end lifecycle redesign highlights and opportunities

MCO lifecycle phases

Phase	#	Lifecycle step	Core Sub-Journey(s)	Completeness Assessment	Innovation Assessment
Source, qualify, and onboard customers	1	Customer Outreach and Education	MCEnroll & PortalAccess and 3rdParty Appl-9 (Staff)		
	2	Gather patient information	MCEnroll-3 (Customer)		
	3	Perform risk / needs assessment	BenMgmtCC-1 (Customer) & RideAlong-1 & EligibilityEnroll (Customer)		
	4	Remove / migrate customer	MCEnroll-3 (Customer)		
Manage customer care	5	Contract with and onboard providers	PriorAuth-3 (Provider) & PharmBen-6	1	6
	6	Help customer find care	ProviderEnroll-1 (Provider) & ValuPurchasing-5 (Staff)	2	
	7	Provide prior authorization	NA		7
	8	Approve, change, or deny claims	PriorAuth-3 (Provider) & MedProv Pymts-2 (Provider) & ClaimsEnc Mgmt-4 (Staff)		
	9	Reimburse Providers	MedProv Pymts-2 (Provider) & Pharm Ben-6 and Claims EncMgmt-6 (Staff)		
	10	Customer Care Manage-ment	MemCareMgmt (Customer) & EVV & BenMgmt Srvcs-10	3	
Report and receive Medicaid payment	11	View capitation rates, adjustments, and penalties	CapRates-2, CapRates-4, ContractCompPen-7, PerMeasures-3		
	12	Collect and submit compliance, performance, and other data	Contract CompPen-7, Reporting-TT, & Perf Measures-3		
	13	Receive Medicaid payment	NA	4	
Resolve issues	14	Respond to Fair Hearings	Contract CompPen-7, Reporting-TT, & Perf Measures-3		
	15	Identify fraud, waste, and abuse	Fraud Waste Abuse-7 (Provider) and MemFraudMgmt (Customer)		
	16	Amend and improve Medicaid contract	NA	5	

Gaps and opportunities

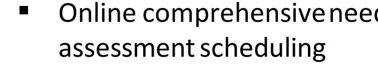
- Data is auto-populated from documents / data from HSD databases
- Health risk assessment completed upon enrollment
- Unclear how MCOs contract with provider when provider enrolls through Medicaid
- No clear MCO journey for supporting care navigation or portal integration details
- Opportunity for portal to manage referrals
- Pre-editing claims
- No clear sub-journey explaining care coordination journey.
- No payment sub-journey, only calculating payment
- Fraud detection system across agencies and MCOs
- No redesigned journey for MCO contracting

Deep dives to follow

Highlights and suggested opportunities in MCO lifecycle (page 1 of 4)

Source, qualify, and onboard customers

	1	2	3	4
	Customer Outreach and Education	**Gather patient information**	**Remove / migrate customer**	**Perform risk / needs assessment**
Redesigned journeys impacting:	MCEnroll & PortalAccess & 3rdPartyAppl-9 (Staff)	MCEnroll-3 (Customer)	BenMgmtCC-1 (Customer) & RideAlong-1 & EligibilityEnroll (Customer)	MCEnroll-3 (Customer)
Completeness Assessment:	●	●	●	●
Innovation Assessment:	●	●	●	●
Highlights	▪ Proactive outreach via advertising and social media ▪ Digital outreach (email) for customers in other NM programs ▪ Partnerships with community outreach programs	▪ Data is auto-populated from fields in other HSD databases (e.g., ASPEN)	▪ Health risk assessment completed upon enrollment	▪ All care plans, authorizations, and pertinent other medical information will be automatically transferred from the relinquishing MCO to the receiving MCO ▪ Portal-based MCO switch request processing
Suggested Opportunities			▪ Online comprehensive needs assessment scheduling	▪ Support with information transfer when switching to HIX (or non-Medicaid plan)



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Highlights and suggested opportunities in MCO lifecycle (page 2 of 4)

Manage Customer Care

	5	6	7	8
	Contract with and onboard providers	**Help customer find care**	**Provide prior authorization**	**Approve, change, or deny claims**
Redesigned journeys impacting:	ProviderEnroll-1 (Provider) & ValuPurchasing-5 (Staff)	NA	PriorAuth-3 (Provider) & PharmBen-6	PriorAuth-3 (Provider) & MedProvPymts-2 (Provider) & ClaimsEncMgmt-4 (Staff)
Completeness Assessment:	1	2		
Innovation Assessment:	6		7	
Highlights			▪ Portal identifies if prior authorization is needed based on MCO requirements Multiple quality checks at submission ▪ MCO formulary is uploaded into portal	▪ MMISR pre-editing MCO claims (e.g., ensuring correct documentation) ▪ Single portal/interface for receiving all Medicaid claims ▪ Optical Character Recognition for paper-based claims
Suggested Opportunities	▪ **Completeness**: Design how MCOs contract with providers if enrollment is through portal ▪ Support with contracting and network sufficiency	▪ **Completeness:** No clear MCO journey for supporting care navigation or portal integration details	▪ Opportunity for portal to manage and support referrals ▪ Provide more details around automated drug edit	▪ Support with information transfer when switching to HIX (or non-Medicaid plan)

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Highlights and suggested opportunities in MCO lifecycle (page 3 of 4)

	Manage Customer Care		Report and Receive Medicaid Payment	
	9	10	11	12
	Reimburse Providers	**Customer Care Management**	**View capitation rates, adjustments, and penalties**	**Collect and submit compliance, performance, and other data**
Redesigned journeys impacting:	MedProvPymts-2 (Provider) & PharmBen-6 & ClaimsEncMgmt-6 (Staff)	MemCareMgmt (Customer) & EVV & BenMgmtSrvcs-10	CapRates-2, CapRates-4, ContractCompPen-7, PerMeasures-3	ContractCompPen-7, Reporting-TT, & PerfMeasures-3
Completeness Assessment:	●	3	●	●
Innovation Assessment:	●		●	●
Highlights	▪ Provider receives real-time notifications of payments/denials through portal ▪ Provider information (including EDI information) capturing during enrollment	▪ Critical incident reports are shared with applicable reporting parties (e.g., HSD, provider, MCO) ▪ Co-creation of critical incident follow-up plan	▪ Transparent rate development analytics (e.g., PMPM calculation methodology) ▪ Routine policy, requirements, and program changes triggered by "machine learning system", which automatically implements capitation rate adjustment ▪ Dashboards (with alerts) to calculate, report, track, and trend capitation adjustments	▪ Automated data review (e.g., rejection if incomplete, wrong data, timeliness) ▪ Automated report generation (e.g., trends, visualizations, red flags) ▪ Web-based report feedback
Suggested Opportunities		▪ **Completeness:** No clear sub-journey explaining care coordination journey		

Highlights and suggested opportunities in MCO lifecycle (page 4 of 4)

	Report and receive Medicaid payment	Resolve Issues		
	13	14	15	16
	Receive Medicaid payment	**Identify fraud, waste, and abuse**	**Identify fraud, waste, and abuse**	**Amend and improve Medicaid contract**
Redesigned journeys impacting:	NA	PriorAuth-3 (Provider) & FairHearings-10 (Staff)	FraudWasteAbuse-7 (Provider) & MemFraudMgmt-10 (Customer)	NA
Completeness Assessment:	4	●	●	5
Innovation Assessment:		●	●	
Highlights		▪ MCO receives alert informing them of fair hearing request ▪ Fair hearing documentation uploaded directly into UP for viewing by judge, claimant, and fair hearings unit ▪ Fair hearing decision uploaded and tracked in portal	▪ Fraud and abuse detection system incorporates algorithms and studies to detect fraud, waste, and abuse ▪ Provider alerts for required training ▪ Single system for HSD/MAD, MCOs, and Office of Attorney General (OAG) ▪ Real-time dashboard to view all open cases	
Suggested Opportunities	▪ **Completeness:** No payment sub-journey, only calculating payment			▪ **Completeness:** No structured source of feedback from MCOs

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- Customer details
- Provider details
- MCO details
- **Staff details**
- External partner details

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STAFF: Highlights across 4 different business functions

End-to-end lifecycle covers most staff business processes[2]

Functions performed by staff[1]

Deliver services

Highlights

- Multi-channel (e.g., chat, phone, email) and cross-HSD knowledgeable support center resolves common issues
- Single platform executes and tracks all stakeholder correspondences
- Waiver waitlist (e.g., updates on waitlist eligibility, place on waitlist, placement notification) is automated and transparent
- Data analysis automatically detects fraud, third-party payment needs, overpayments

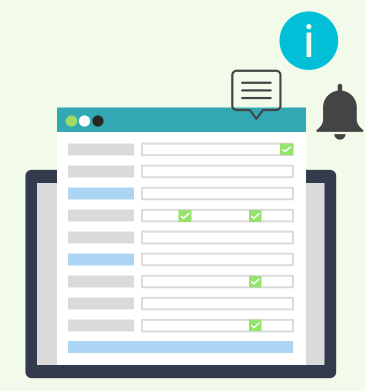
Generate reports

- Internal staff can run self-service reporting through dashboards with a view of the library of canned reports available
- Data gathered from MCOs are automatically reviewed for quality and compliance
- Dashboards automatically populate with summaries, trends, and red flags
- System supports assigning and prioritizing Ad-hoc data request
- System automatically generates recurring standard public reporting
- System tracks documents and processes for audits

Manage vendors

- System maintains approved vendor lists with auto-populated contracts, digital contracting features (e.g., signatures), and immediate contractor access capability
- Capitation rate is transparently developed by internal staff
- Capitation adjustments are applied automatically
- System automatically calculates penalties based on quality reports
- System records and tracks feedback and corrective actions plans

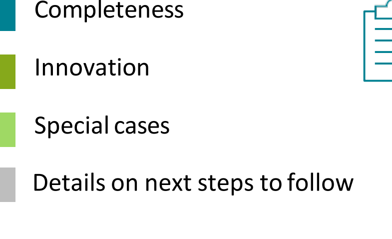
Implement policy



- Templates auto-fill (e.g., date) for policy documentation and communication
- System transcribes, consolidates, and tracks response of public comments
- System digitally tracks policy workflow (e.g., edit history, action items, approvals, notifications)
- Interested parties (e.g., MCOS, other state agencies, external parties) are automatically notified of rule changes

1 "Functions performed by staff" captures the day-to-day activities performed by staff. Functions are distinct groups of activities (not a flow)
2 All businesses processes captured during business process cataloging effort have been reviewed as a part of the end-to-end lifecycle review

Staff: Overview of end-to-end lifecycle analysis



Redesign elements[1] assessed in end-to-end lifecycle

elements[1]

	Total end-to-end elements assessed	Redesigns appear satisfactory	Potential gaps or opportunities
Completeness (end-to-end steps and groups of responsibilities)	13	8	5
Innovation (end-to-end steps)	1	1	0
Special Cases[2]	0	0	0
Total	14	9	5

- The provider end-to-end lifecycle assessed:
  - 13 steps and groups of responsibilities for journey redesign completeness
  - 1 step for journey redesign innovation
- The assessment suggests that the redesigns appear satisfactory for 9 end-to-end elements
- The assessments identified 5 potential gaps or opportunities

1 Elements are the number of end-to-end steps (for completeness and innovation) or special cases (e.g., provider types)
2 No "special cases" for staff, as most key responsibilities were covered in end-to-end lifecycle

	Application & onboarding	Training	Evaluations & compensation	Transitioning roles[1]
Completeness Assessment	Missing (grey)	Covered (green)	Missing (grey)	Missing (grey)
Innovation Assessment	Not innovative (empty)	Innovative (green)	Not innovative (empty)	Not innovative (empty)

Deliver services	Generate and review reports	Manage Vendors	Make decision and implement policies

Functional-level gap analysis completed on next page

1 Transitioning roles means leaving current role (e.g., leaving for a new role, retiring)

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Deep dive into staff responsibility grouping and coverage by redesigns sub-journeys

Legend: 🟢 Covered by redesigned sub-journey · 🟡 Gaps in redesigned sub-journey · ⚫ Missing from sub-journey redesign

Business Function Type	Responsibility Grouping[1]	Example business processes	Covered by Redesigned Sub-Journey	Relevant redesigned sub-journeys *(Or gap descriptions)*
Deliver services	**Questions & issues**	Clarify policy questions, manage fair hearings	Green	CCSCuse-4, IssueMgmt-5, FairHearings-10
	Quality assurance	Manage fraud inquiries and investigate potential quality issues or fraudulent scenarios	Green	FraudWasteAbuse-7, AdverActions-11, AuditMgmt-7,MemFraudMgmt-10,PymtRec-9,RACMgmt-8
	Member management & outreach	Support with enrollment, support with FFS customer transportation	Green	MCEnroll-3, BenMgmtCC-1, CorresGen-7, LOC-2, CorresGen-7, JUSTHealth-8, IDTurst-8
	Provider management	Support with provider information capture and updates, share policy updates	Green	PriorAuth-3, ProviderEnroll-1, ProvUpdate-4
	Administration, IT, and other	Provider external users access to reports and systems	Yellow	*NA - Limited detail behind how "superusers" are identified and how they grant access to data for external users*
Generate reports	**Data reporting**	Generate quality and operational data	Green	QualReport-3, Reporting-TT
	Financial management and report	Generate CMS reports and financial reports	Green	IntFinRpts-6, CMS64-2, CMS37-4
Manage vendors	**Contracts & program management**	Manage MCO/TPA contracts and contracts with other 3rd parties (e.g., LOC auditors). Includes program management (e.g., waivers)	Green	Reporting-TT, Contract-CompPen-7, RideAlong-1, Sml-Purchase-1, ValuPurchasing-5, PerfMeasures-3, CapRates-2, CapRates-4
Implement policies and programs	**Implement policies and programs**	Create and update MAD forms, promulgate policy across division and public	Yellow	NMAC-TT, MADForms-1 - *Missing management and workflows for federal rules*

1 Responsibility grouping based on analysis of ~450 business processes captured during business process cataloging (September 2020)

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- Provider details
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- Staff details
- **External partner details**

EXTERNAL STAKEHOLDERS: Highlights across key lifecycle phases

End-to-end lifecycle covers most key reports types and critical external stakeholders[2]

Activity groups from end-to-end lifecycle[3]

Program design and funding	Reporting (CMS)	Reporting (Other external[1])

Highlights

Program design and funding

- HSD creates "Forms Committee", which has representatives from external stakeholders to inform form changes
- System digitally tracks update approvals, including alerts, status, and electronic signatures
- System automatically flags materials that may be impacted by updates and new rules
- Public notices are digitally generated and system automatically transcribes/consolidates public comments
- Rule change automatically notify interested parties (e.g., MCOs, other state agencies, external stakeholders)
- Documents publish automatically (e.g., new forms) upon approval
- System interfaces with CMS and Payment Management System for funding approval letter (i.e., grant of approval) and authorization of federal funds

Reporting (CMS)

- Systems tracks consistent and structured internal report review processes
- Forecasted expenditures vs actual expenditures variance report is available in real-time and in line-item detail
- CMS receives automatic budget variance notifications with explanations
- Analytical tools support spending projections related to Medicaid Program changes, including state plan amendments (SPAs) and HSD policies
- Alerts for select thresholds (e.g., 10% over budget) can be set by staff members or CMS
- System generates and tracks CMS follow-up requests

Reporting (Other external[1])

- External stakeholders can review common reports or to build (and save) custom reports
- Regular reports are generated automatically and indexed within a library of reports
- Users can view reports on the system or have the ability to download the report in desired format (e.g., xlsx, pdf, csv)
- Dedicated administrators (i.e., "superusers") provide and manage external user data access
- Chatbot answers common questions and helps with simple inquiries (e.g., password reset)

1 Includes public, legislature, auditors, lawsuits
2 Key reports and critical external stakeholder as identified by External Stakeholder Subject Matter Expert group. Includes public, legislature, auditors, lawsuits, Center for Law and Poverty, and Disability Rights of New Mexico
3 Activity groups on this slide are not sequential

The end-to-end external stakeholder lifecycle is separated into legislative stakeholder and "other" stakeholder lifecycles

a Federal and state legislative stakeholder lifecycle phases

	Program design				Assess and distribute funding			Program performance monitoring	
	1	2	3	4	5	6	7	8	9
	Propose rules and updates	Collect feedback on rules	Apply rules and policy changes	Define success goals and metrics	Discuss funding needs with State Program	Accept funding requests	Distribute funds	Audit, review updates, and review reports	Follow-up questions, feedback, and corrective actions
Core Sub-Journey(s)	NMAC-TT & MADForms-1				CMS37-4			QualReport-3 & CMS64-2 & CMS37-4	QualReport-3 & CMS64-2

b Other external stakeholder lifecycles (e.g., Center for Law and Poverty, Community Programs, Public)

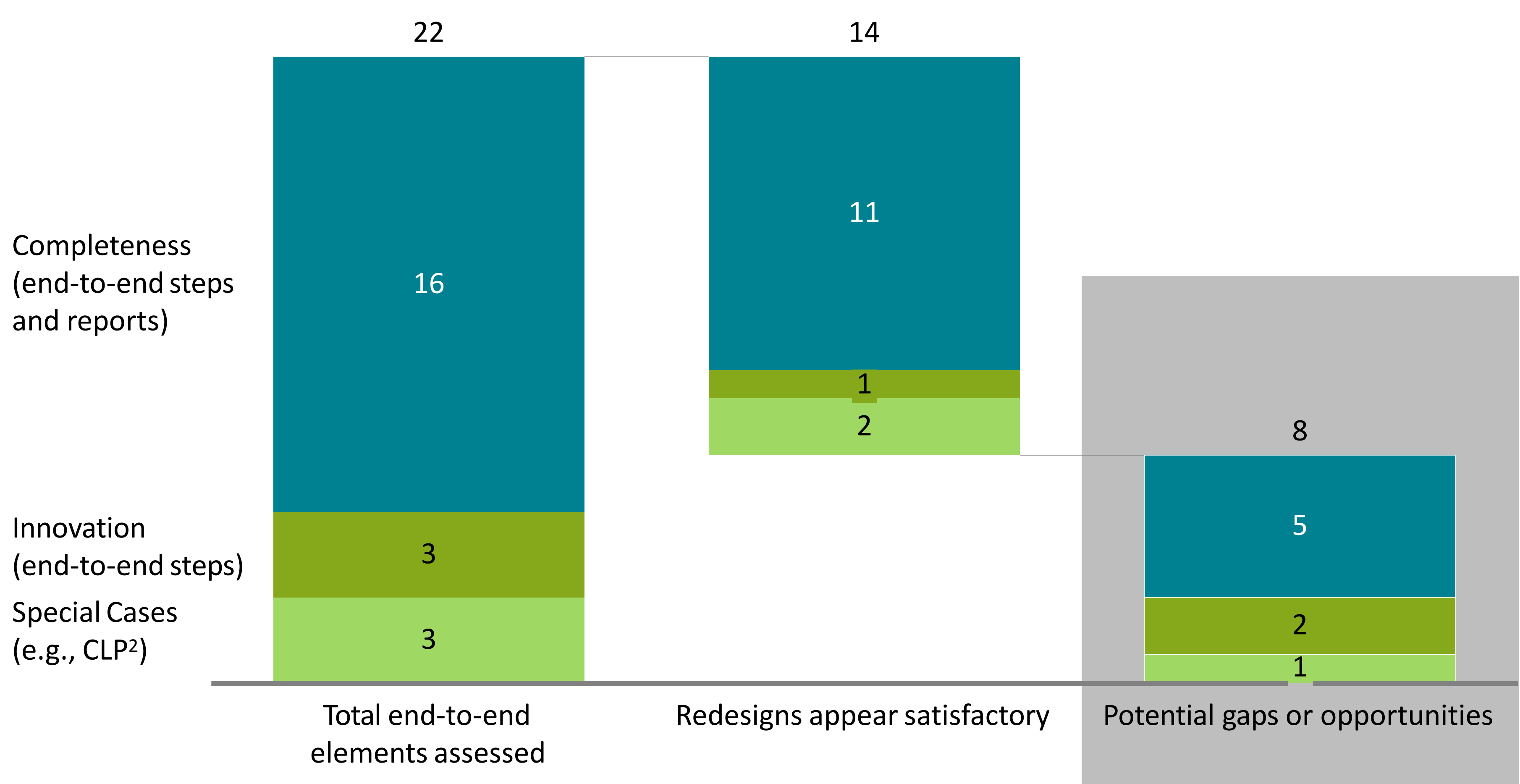
Core Sub-Journey(s): NMAC-TT & MADForms-1, LOC-2, MCEnroll-3, JUSTHealth-8, EligibilityEnroll-TT, FairHearings-10

External Stakeholders: Overview of end-to-end lifecycle analysis

Completeness
Innovation
Special cases
Details on next steps to follow

Redesign elements[1] assessed in end-to-end lifecycle

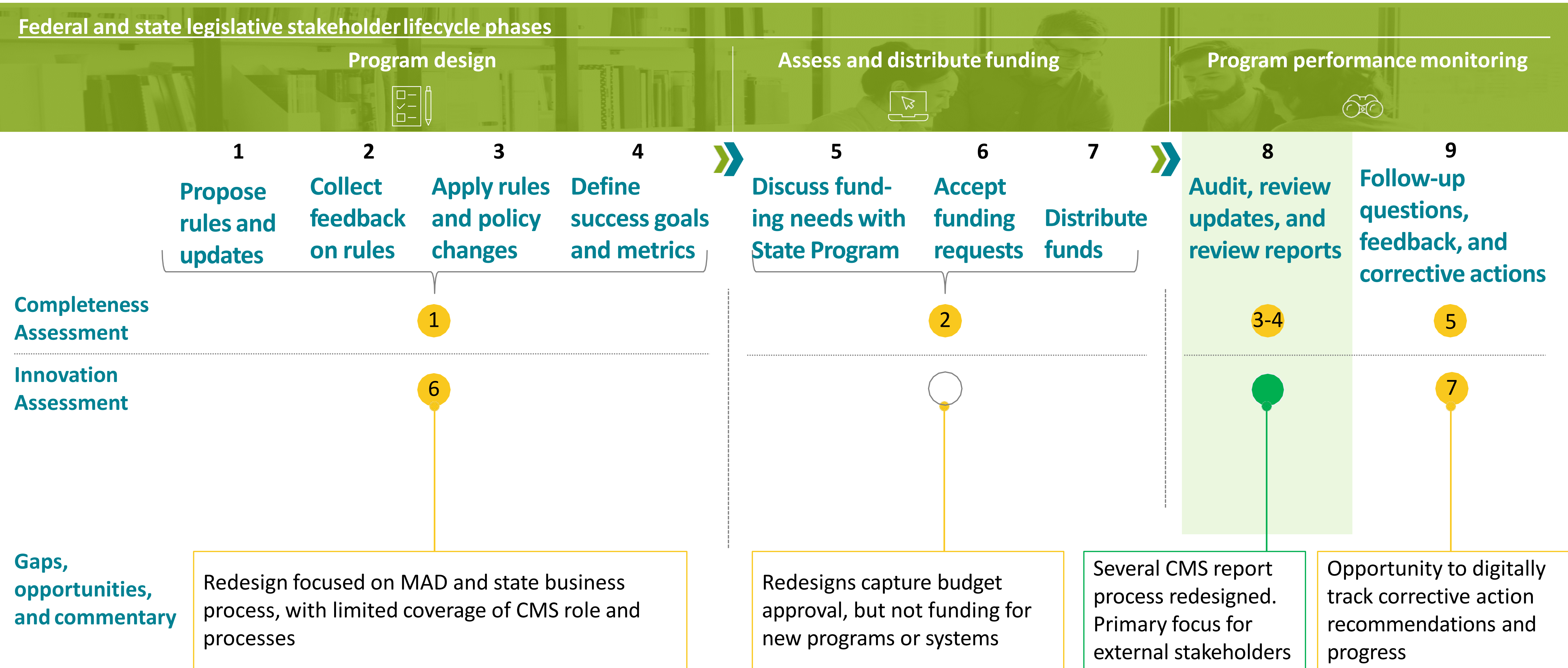
elements[1]



- The provider end-to-end lifecycle assessed:
  - 16 steps / reports for journey redesign completeness
  - 3 steps for journey redesign innovation
  - 3 special cases (i.e., populations potentially not covered by end-to-end lifecycle)
- The assessment suggests that the redesigns appear satisfactory for 14 end-to-end elements
- The assessments identified 8 potential gaps or opportunities

1 Elements are the number of end-to-end steps (for completeness and innovation) or special cases (e.g., provider types)
2 Center on Law and Poverty

Legislative lifecycle: external stakeholder end-to-end lifecycle redesign highlights and opportunities



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Key external stakeholder reports and redesign journey coverage

a

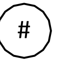
Legend: Fully covered by redesigns (green) · Partially covered by redesigns (yellow) · Not covered by redesigns (grey) · # GapID

Report type	Report	Report details	Sub journeys (or gap details, if applicable)	Coverage
Financial reports	CMS64	Medicaid expenditures (quarterly)	CMS64-2	Fully covered
	CMS37[1]	Medicaid budget (quarterly), includes admin and professional reports	CMS37-4	Fully covered
	CMS21	CHIP expenditures	CMS64-2	Fully covered
	CMS21-B	CHIP budget report	CMS37-4	Fully covered
Operational reports	ESPB[3] audit	Audit of customer level of care (LOC)	AuditMgmt-7	Fully covered
	CMS-416	Annual EPSDT report	EPSDT-11	Fully covered
	T-MSIS reporting	Operational data reporting (e.g., eligibility files, claims processing, 3rd party liability) to CMS	QualReport-3	Fully covered
	Programmatic reporting	Quarterly and annual program monitoring reports (e.g., 1115 waiver, Mi VIA, Disability)	QualReport-3 (data reporting only - no narrative)	Partially covered (3)
Quality reports	EQRO[2] report	External Quality Review Organization (plan quality audit and report)	QualReport-3	Fully covered
	Plan quality reporting	Plan quality (e.g., HEDIS)	QualReport-3	Fully covered
Other reports	Independent evaluation reporting	Medicaid provides access of data to contractors who create reports for public, CMS, and legislature (e.g., 1915c waiver)	QualReport-3	Fully covered
	Internal policy document sharing	Externally share internal policies to educate other any external partner (e.g., CMS, public)	NA - no related journey	Not covered (4)
	Other required data reports	Reporting requirements from legislative bills, lawsuits, corrective actions	QualReport-3	Fully covered

1 Budgeting process covered in journeys. Detailed data element mapping and integration to be completed during detailed design sessions
2 External Quality Review Organization
3 Exempt Services Bureau

“Other stakeholders” and redesign journey coverage

b



Fully covered by redesigns · Partially covered by redesigns · Not covered by redesigns · # Gap ID

External Stakeholder	Key activities	Relevant sub journeys	Coverage details	Coverage assessment
CLP[1] and DRNM[3]	Support clients with complex fair hearings	EligibilityEnroll-TT, FairHearings-10, MCEnroll-3, MADForms-1	Fair hearings redesigned, but not direct interactions with CLP or DRNM	Fully covered
Community Programs	Support non-medical support organizations (e.g., homelessness prevention, senior programs, food insecurity) with customer outreach	LOC-2, MCEnroll-3, JUSTHealth-8	Includes education materials, limited details on data sharing/ integration	Partially covered (8)
Public	Alerting and gather feedback from public on rule changes	NMAC-TT, QualReport-3	Includes reporting, public hearings for rule updates, web posting, etc.	Fully covered
PEDs[2]	Captured as part of Provider End-to-End Lifecycle Review			

1 Center for Law and Poverty
2 Presumptive eligibility determiners
3 Disability Rights New Mexico

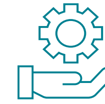
Contents

- Module Functionality Views
- End-To-End Lifecycle Views

HUMAN SERVICES DEPARTMENT

MMISR module overview

= MMISR Modules



Benefit management services

Quality assurance

Care and case management services

CCSC[1]

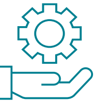
Unified portal[2]

Data services

Financial services

1 Consolidated Customer Service Center
2 Includes internal (staff-facing) and external (customer/provider/MCO-facing) portals

Module functionality view outputs



Functionality Overview

Functionality Tracking

Outputs

4A BMS Module View Outputs (key business functionality details)

HSD Module Owner: Dan Clavio

BMS Components	Key business functionality	Details	Example
Member management	4.01 Member outreach and information management	Identify potential customers and contact customers, informing customers about available options and benefits. Includes general public awareness of available programs and services. Compile member information and data from MDM	A New Mexican eligible for Medicaid (but not enrolled) is contacted in the portal while accessing SNAP benefit details
	4.02 EPSDT program management	EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) case identification, initial and ongoing EPSDT correspondence, outreach related to EPSDT populations, track EPSDT services, and report on EPSDT services	Well-child visit is missed by a customer, and BMS generates an automated letter notifying member of missed visit
Provider Management	4.03 Provider outreach	Collaborate with Provider Associations, Universities, MCOs and the State for provider outreach. Includes provider sufficiency analysis, direct contact with providers, and education	Provider unenrolled in Medicaid receives email with information about the Medicaid enrollment process
	4.04 Provider enrollment	Determine relevant information for provider enrollment and screening , and analyze provider documentation across all agencies and divisions	An unenrolled provider submits documentation and information, which can be accessed or updated in the future
	4.05 Provider data management	Share available provider data, input provider data into MDM database, and update MDM database with new provider information	A provider switches addresses and submits new address details/documentation for billing purposes
Utilization Management / Utilization Review	4.06 Services, referrals, and treatment plan automation	Check service coverage for member and track prior authorization, treatment plans and referrals.	A provider submits a prior authorization for a CT scan, which is immediately approved
	4.07 Recommendations to improve customer outcomes	Assess effectiveness of services provided, generate suggestions, and reporting on performance	An analysis suggests that a particular type of knee injury is better served by rest and physical therapy than knee surgery
Benefit Plan Management	4.08 Health benefit information, health plan information, and state plan management	Maintain business rules related to service authorization/eligibility under each plan. Includes suggestions for initiatives on how to improve program quality of care	A policy update changes medicaid coverage for transportation support
	4.09 Rate setting management (FFS)	Determine the fee-for-service (FFS) rates for covered procedural and drug codes	At the start of a new year, Medicaid updates the FFS rate for an urgent care visit
	4.10 Capitation payment rate analysis	Ensure capitation rates are actuarially sound, automatically implement routine cap rate adjustments, measure and assess MCO performance, assess rates against CMS checklist and regulatory requirements	Medicaid needs to determine the amount to pay an MCO for covered populations

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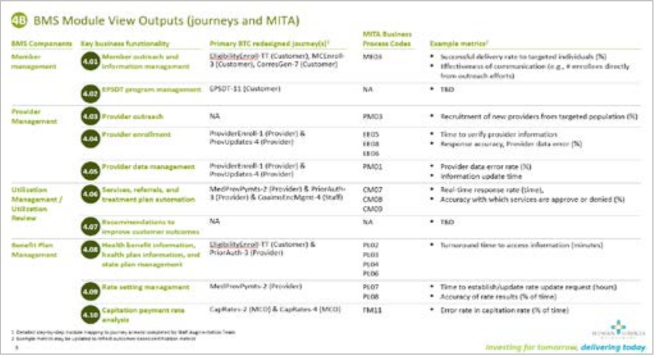

4B BMS Module View Outputs (journeys and MITA)

BMS Components	Key business functionality	Primary BTC redesigned journey(s)[1]	MITA Business Process Codes	Example metrics[2]
Member management	4.01 Member outreach and information management	EligibilityEnroll-TT (Customer), MCEnroll-3 (Customer), CorresGen-7 (Customer)	ME04	• Successful delivery rate to targeted individuals (%) • Effectiveness of communication (e.g., # enrollees directly from outreach efforts)
	4.02 EPSDT program management	EPSDT-11 (Customer)	NA	• TBD
Provider Management	4.03 Provider outreach	NA	PM03	• Recruitment of new providers from targeted population (%)
	4.04 Provider enrollment	ProviderEnroll-1 (Provider) & ProvUpdates-4 (Provider)	EE05 EE08 EE06	• Time to verify provider information • Response accuracy, Provider data error (%)
	4.05 Provider data management	ProviderEnroll-1 (Provider) & ProvUpdates-4 (Provider)	PM01	• Provider data error rate (%) • Information update time
Utilization Management / Utilization Review	4.06 Services, referrals, and treatment plan automation	MedProvPymts-2 (Provider) & PriorAuth-3 (Provider) & CoaimsEncMgmt-4 (Staff)	CM07 CM08 CM09	• Real-time response rate (time), • Accuracy with which services are approve or denied (%)
	4.07 Recommendations to improve customer outcomes	NA	NA	• TBD
Benefit Plan Management	4.08 Health benefit information, health plan information, and state plan management	EligibilityEnroll-TT (Customer) & PriorAuth-3 (Provider)	PL02 PL03 PL04 PL06	• Turnaround time to access information (minutes)
	4.09 Rate setting management	MedProvPymts-2 (Provider)	PL07 PL08	• Time to establish/update rate update request (hours) • Accuracy of rate results (% of time)
	4.10 Capitation payment rate analysis	CapRates-2 (MCO) & CapRates-4 (MCO)	FM11	• Error rate in capitation rate (% of time)

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Details

List of functionalities by module, include detailed descriptions, example of functionality usage, and module owner

Functionality alignment with BTC redesigned sub journeys, MITA business processes, and potential outcome metrics

Objective

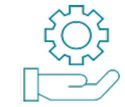
- Seek executive-level engagement in module functionality
- Agree on module "owner", who will oversee functionality implementation

- Tie functionality to redesigned journeys
- Align functionality to MITA categories

Output is completed for each module with details below

Module functionality view may be used to support vendor implementation and OCM

Module view summarizes key functionality for each module to support module implementation and OCM



Illustrative example in following pages

MMIS Modules

Stakeholders	DS	QA	C/CMS	BMS	FS	UP	CCSC	HIX	ASPEN
Customer									
Provider									
MCO									
Staff									
Ext. Partner									

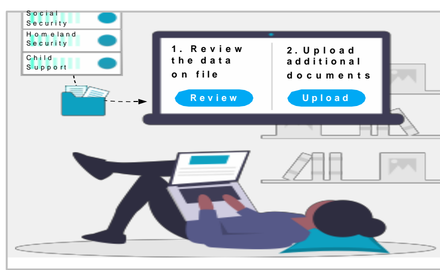
- A module view will be created to help identify business needs for each module
- Module view can be use for:
  - Supporting vendor implementation success
  - Informing functionality roadmap
  - Tracking success metrics
  - Tracking estimated costs

Snapshot of steps in the customer lifecycle and corresponding functionalities

ILLUSTRATIVE AND NOT EXHAUSTIVE

1 — 2 — 3 …

1. Proactive outreach & eligibility

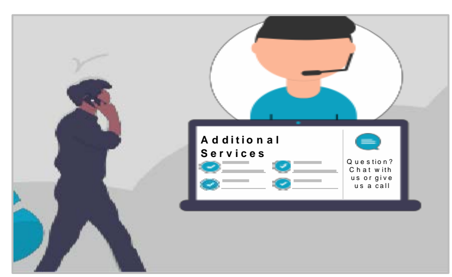


Client visit the states web page to access SNAP benefits. Upon login, she receives a message that she may qualify for Medicaid.

2. Apply

She fills out her application online. She verifies her pre-populated information. She receives status updates online through approval.

3. Enroll in MCO



There are multi-channel resources to inform her of MCO options. Upon MCO selection, she has immediate access to benefits, and her Health Risk Assessment is conducted by MCO.

Module Functionalities / Outcomes

Proactive outreach & eligibility	Apply	Enroll in MCO
Benefit Management Services: Targeted messaging to Members and potential Members on programs, services, wellness, access to Providers and care.		NOT EXHAUSTIVE: ILLUSTRATIVE EXAMPLE
Data Services: All state-collected data retrieved to inform customer qualification	**Data Services:** Pre-populated data fields filled and customer information entered in database	
	System Integration: Single sign-on allows customer to sign in to Medicaid with same username and password as SNAP	

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BMS Module View Outputs (key business functionality details)

BMS Components	Key business functionality	Details	Example
Member management	4.01 Member outreach and information management	Identify potential customers and contact customers, informing customers about available options and benefits. Includes general public awareness of available programs and services. Compile member information and data from MDM	A New Mexican eligible for Medicaid (but not enrolled) is contacted in the portal while accessing SNAP benefit details
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BMS Module View Outputs (journeys and MITA)

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Member management	4.01 Member outreach and information management	EligibilityEnroll-TT (Customer), MCEnroll-3 (Customer), CorresGen-7 (Customer)	ME03	▪ Successful delivery rate to targeted individuals (%) ▪ Effectiveness of communication (e.g., # enrollees directly from outreach efforts)
	4.02 EPSDT program management	EPSDT-11 (Customer)	NA	▪ TBD
Provider Management	4.03 Provider outreach	NA	PM03	▪ Recruitment of new providers from targeted population (%)
	4.04 Provider enrollment	ProviderEnroll-1 (Provider) & ProvUpdates-4 (Provider)	EE05 EE08 EE06	▪ Time to verify provider information ▪ Response accuracy, Provider data error (%)
	4.05 Provider data management	ProviderEnroll-1 (Provider) & ProvUpdates-4 (Provider)	PM01	▪ Provider data error rate (%) ▪ Information update time
Utilization Management / Utilization Review	4.06 Services, referrals, and treatment plan automation	MedProvPymts-2 (Provider) & PriorAuth-3 (Provider) & CoaimsEncMgmt-4 (Staff)	CM07 CM08 CM09	▪ Real-time response rate (time), ▪ Accuracy with which services are approve or denied (%)
	4.07 Recommendations to improve customer outcomes	NA	NA	▪ TBD
Benefit Plan Management	4.08 Health benefit information, health plan information, and state plan management	EligibilityEnroll-TT (Customer) & PriorAuth-3 (Provider)	PL02 PL03 PL04 PL06	▪ Turnaround time to access information (minutes)
	4.09 Rate setting management	MedProvPymts-2 (Provider)	PL07 PL08	▪ Time to establish/update rate update request (hours) ▪ Accuracy of rate results (% of time)
	4.10 Capitation payment rate analysis	CapRates-2 (MCO) & CapRates-4 (MCO)	FM11	▪ Error rate in capitation rate (% of time)

1 Detailed step-by-step module mapping to journey already completed by Staff Augmentation Team
2 Example metrics may be updated to reflect outcomes-based certification metrics

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DS Module View Outputs (key business functionality details)

DS Component	Key business functionality	Details	Example
Data Analytics, Business Intelligence, and non-federal reporting	1.01 Dashboards with export capabilities	Dynamic operational and financial dashboards that visually present data and track historical trends (and projections) of key metrics, including performance and fiscal indicators. These dashboards will provide high-level snapshots of different program areas, and include filtering, drill-down and export capabilities.	Internal staff can see a dashboard that shows enrollment volume by month for the past 24 months. The staff can apply filters to that dashboard, such as county, eligibility group, and MCO.
	1.02 Business Intelligence with notifications	Data exploration tools and analytics capabilities that will allow HSD and partner agencies to better understand their data and leverage that data to support the improvement of program outcomes. These capabilities include, but are not limited to, automated "anomaly analysis" that highlight when values stray far from expectations, review of population groups, understanding population needs, evaluation of care management programs, and comparative analysis of providers. Tools include IBM Cognos Analytics, Tableau, and IBM Flexible Analytics.	Staff are notified when Medicaid spend on a particular procedure is more than 50% higher than the spend on the same procedure the year before. This notification includes a link to the relevant report/dashboard to support investigation
	1.03 Operational Reporting	Standard recurring reports that can be scheduled to run as needed (with the ability for authorized users to subscribe to a report and receive it directly via email), as well as self-service parameterized queries that enable users to produce standard reports based on the parameter values selected.	A monthly report of claims denial volumes and outcomes (e.g., denial upheld or reversed) is automatically generated for internal staff consumption
	1.04 Ad-hoc Reporting	On-demand and one-off reports, dashboards, and queries, created as needed using Cognos, Tableau, Python, and direct database access to fulfill requests that may arise from leadership, the Legislative Finance Committee, federal agencies, or other stakeholders. Data Marts will be created to support ad hoc reporting.	Legislative Finance Committee asks HSD to produce an ad-hoc report on flu vaccination rates for the year. A data analyst uses the data mart of creates a database query to generate this data.
	1.05 Public Facing Dynamic Reporting	Interactive web-based reports that allow members of the public to view non-Personally-Identifiable-Information (PII) data based on the filters and time period selected.	A New Mexican can compare the clinical quality of each MCO for treating clients with end-stage renal failure
Federal reporting	1.06 CMS and non-CMS Federal Reporting	Development, testing and delivery of federally mandated reports. These include reports submitted to CMS, such as quarterly reports on Medicaid and CHIP expenditures and projected costs, as well as non-CMS reports, such as reports submitted to SAMHSA on the Community Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant.	The quarterly CMS64 (expenditures) report is automatically generated for HSD review before sending to CMS.
Enterprise Data Warehouse	1.07 Storage and sharing of data from other modules and departments	The Enterprise Data Warehouse (EDW) will receive, store and merge data from multiple source systems across the HHS 2020 Enterprise as well as the other MMISR modules, providing a centralized repository for reporting and analytics.	A physical therapy provider submits her address during enrollment to BMS through the UP. Another module vendor, QA, is able to use this data to review future claims by this provider for fraud
	1.08 Data dictionary and schema maintenance	Ongoing maintenance of the EDW data dictionary, containing all information about the data for the solution such as description, data type, valid values of data objects, and ongoing maintenance to the EDW schemas, with the flexibility to update and extend schemas and models to incorporate new data fields as needed.	Module vendors know how to locate a member's address in a database, and the module vendors know that the address data field includes city and zip code.
	1.09 Data audit trail	For data lineage, the EDW will maintain a record of all data-integration, data-acquisition, and data-cleansing activities. It will also provide database- and application-level user audit logging to monitor access to PII.	A year ago, an orthopedic surgery practice moved physical addresses, and the system can produce the details of the update (e.g., date updated, who submitted the request)
Training + Communication	1.10 Ongoing Training	Training to support state resources in becoming operationally self-sufficient and to assist HSD and partner agencies in becoming data-driven organizations. This will be achieved through quarterly user groups, technical tool training, guided sessions, Blackboard training, delivery of newsletters, and performance of surveys to assess organizational maturity.	A new data analyst receives training on how to update standard report queries
Additional outcomes-based studies	1.11 Custom analytics and presentations	Analysis, delivered in a series of two releases, utilizing the most current data available in the Enterprise Data Warehouse and focusing on healthcare topics such as flu vaccinations, chronic condition prevalence, and maternity analysis. All analytics will be conducted on a one-time basis by IBM, followed by a formal presentation, a summary of the results, and a copy of the coding.	DS vendor is asked to perform a one-off analysis of members being prescribed a deadly combination of three drugs (opiates, benzodiazepines, and muscle relaxers).

DS Module View Outputs (journeys and MITA)

DS Components	Key business functionality	Primary BTC redesigned journey(s)[1]	MITA Business Process Codes	Example metrics[2]
Data Analytics, Business Intelligence, and non-federal reporting	1.01 Dashboards with export capabilities	Reporting-TT, MedProvPymts-2, CapRates-2, TPLMgt-2, PerfMeasures-3, IssueMgmt-5, PharmBen-6, JUSTHealth-8, BenMgmtSrvcs-10, EPSDT-11,	NA	NA
	1.02 Business Intelligence with notifications	Reporting-TT, PriorAuth-3, CMS37-4, ContractCompPen-7	NA	NA
	1.03 Operational Reporting	Reporting-TT, TPLMgt-2, IntFinRpts-6, RACMgmt-8, IDTtrust-8, EPSDT-11	NA	NA
	1.04 Ad-hoc Reporting	Reporting-TT, AuditMgmt-7	NA	NA
	1.05 Public Facing Dynamic Reporting	QualReport-3, ValuPurchasing-5,	NA	NA
Federal reporting	1.06 CMS and non-CMS Federal Reporting	CMS64-2, QualReport-3, CMS37-4, DrugRebMgmt-9	OM28	Time to complete reporting process
Enterprise Data Warehouse	1.07 Storage and sharing of data from other modules and departments	Applicable for all data-related journeys	OM28	Data error rate (%)
	1.08 Data dictionary and schema maintenance	Applicable for all data-related journeys	NA	NA
	1.09 Data audit trail	Applicable for all data-related journeys	NA	NA
Training + Communication	1.10 Ongoing Training	ProcessTraining-1	NA	NA
Additional outcomes-based studies	1.11 Custom analytics and presentations	NA	NA	NA

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QA Module View Outputs (key business functionality details)

QA Component	Key business functionality	Details	Example
Fraud, Waste, and Abuse	2.01 Customer fraud, waste, and abuse	Identify customers (current and in the application process) who misrepresent themselves to receive benefits (e.g., misleading levels of income).	Customer applying for Medicaid benefits misrepresents level of income on application and is appropriately assessed
	2.02 Provider and MCO fraud, waste, and abuse	Algorithmically identify potentially unnecessary claims (to investigate for fraud), investigating incorrect provider application information, and resolve fraudulent payments with providers	A provider systematically misrepresents numbers of hours performing services and is appropriately penalized
	2.03 Quality and operational metrics assessment	Sample and review quality for several business processes including payments, eligibility determinations, and case management data quality. Show results in dashboard	To test process and system accuracy, a sample of claims are manually reviewed and compared to original editing decisions
Quality Reporting	2.04 Internal clinical outcome data reporting	Collect MCO and FFS quality data to report for CMS (e.g., HEDIS scores) and assess internal outcomes	A data report is pulled to assess frequency of hospital readmissions for the entire Medicaid population
	2.05 External quality data management	Support outcomes improvements by capturing, managing, and distributing quality reports from external sources (e.g., PQRS, CAHPS survey data). Includes comparisons with State quality metrics	A report is generated comparing New Mexico average admission rates to readmission rates from other state Medicaid populations
Audit Coordination and Compliance	2.06 Audit and hearing coordination	Aid auditors in completing their work in assessing compliance with state or federal statutes and rules. Includes consolidated view of audit activities (e.g., financial, MCO, CMS audits). Activities includes monitoring audits, tracking actions, and notifying individuals	An auditor requests prior authorization accuracy data, and FS identifies existing data/reports, notifies relevant stakeholders, and assigns responsibilities to stakeholders
Third-Party Liability (TPL)	2.07 TPL record detection	Using internal and external data sources (e.g., DMV, HIX, VA, ASPEN eligibility) identify third party liability situations (e.g., Commercial Insurance, Medicaid, Worker's Compensation, Medicare, Casualty, Estate)	Using data from external data (e.g., police reports), an orthopedic physician visit claim is flagged as potentially liable for a car insurance company
	2.08 TPL payment recovery	Request and collect liabilities from 3rd parties or adjust payments to providers (as appropriate)	For an orthopedic claim from a car accident, the payment is either directly recovered from insurance company or the provider is notified
Recovery Audit Contracting (RAC)	2.09 Overpayment and underpayment detection	Algorithmically identify potential claims where Medicaid or MCO overpaid or underpaid	After a utilization review audit, a hospital bill is flagged as potentially overpaid due to shorter duration in the hospital than indicated on bill
	2.10 Overpayment and under-payment investigation and collection	Review details of potential overpaid/underpaid claims and validate. Follow-up with providers to resolve overpayment/underpayment	An overbilled hospital payment is confirmed after review, and overpayment is resolved via a credit against future payment for services to the hospital

QA Module View Outputs (journeys and MITA)

QA Components	Key business functionality	Primary BTC redesigned journey(s)[1]	MITA Business Process Codes	Example metrics[2]
Fraud, Waste, and Abuse	2.01 Customer fraud, waste, and abuse	MemFraudMgmt-10, EligibilityEnroll-TT	**PE01**	Compliance Incident resulting in corrective action, settlement, or collection (%) Time to complete review process (hours)
	2.02 Provider and MCO fraud, waste, and abuse	FraudWasteAbuse-7	**PE01** **PE03**	Compliance Incident resulting in corrective action, settlement, or collection (%) Time to complete review process (hours)
	2.03 Quality and operational metrics assessment	RideAlong-1, PerfMeasures-3, QualReport-3	**PL05**	Effort to produce performance measures (hours)
Quality Reporting	2.04 Internal clinical outcome data reporting	PerfMeasures-3, QualReport-3	**PL05**	Effort to produce outcome measures (hours)
	2.05 External quality data management	PerfMeasures-3, QualReport-3	NA	NA
Audit Coordination and Compliance	2.06 Audit and hearing coordination	AuditMgmt-7	NA	NA
Third-Party Liability (TPL)	2.07 TPL record detection	TPLMgt-2, IDTrust-8	**FM02** **FM03**	False recovery demands (%), Amount of dollars recovered (%)
	2.08 TPL payment recovery	TPLMgt-2, IDTrust-8, PymtRec-9	**FM02** **FM03**	False recovery demands (%), Amount of dollars recovered (%)
Recovery Audit Contracting (RAC)	2.09 Overpayment and underpayment detection	RACMgmt-8	**FM01**	Accuracy with which recoupments are applied (%) Consistency of decisions on suspended claims/encounters (%)
	2.10 Overpayment and underpayment investigation and collection	RACMgmt-8, PymtRec-9	**FM01**	Accuracy with which recoupments are applied (%) Consistency of decisions on suspended claims/encounters (%)

1 Example metrics may be updated to reflect outcomes-based certification metrics; 2 Detailed step-by-step module mapping to journey already completed by Staff Augmentation Team

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CCMS Module View Outputs (key business functionality details)

C/CMS Component		Key business functionality	Details	Example
Case / Care Management Services	3.01	Member / stakeholder communication and coordination	Outreach to member and other stakeholders to provide education about improving health, gain member buy-in, and coordinate across state agencies and programs. Stakeholders include case managers, consultants, members, providers, ACOs, etc.	A client with multiple chronic conditions is contacted by contact center to follow-up if she missed a behavioral health appointment
	3.02	Integration with external Case Management Platforms (e.g., MCOs)	Includes State's Health Information Exchange (HIX) and MCO Care/Case Management Platforms and their Care Coordination Platforms.	When contacting a client about a missed behavioral health appointment, a care coordinator references a discussion that the client had with the MCO care coordinator about taking medications
	3.03	Configurable and automated case creation & tracking	Includes workflow tools (e.g., generating "to-do" lists and assigning “to-dos” to other users) and automatically pulling in relevant information.	CCSC creates a “case” for a complex provider request. The case is assigned to an HSD employee for resolution, and the HSD employee can see provider issue history (e.g., additional information about request, time of request)
	3.04	Critical Incident Reports management	Reporting from multiple sources with required documentation; Tracking and monitoring of internal and external task completion; Escalation for Legal/Judicial follow up and tracking.	A client enters the emergency department of a hospital with an acute behavioral health issue. A provider submits a critical incident report to the system, which alerts all relevant stakeholders (e.g., MCO, primary care provider)
	3.05	Special program (Mi Via, DD, MF, 1115, LTS, HIV/AIDS) administration	Member prescreening, waitlist assignment and monitoring allocation to eligible services (e.g., including waiver programs)	A client on the Long Term Services (LTS) waiver program waitlist receives automated messages to provide updated information

CCMS Module View Outputs (journeys and MITA)

C/CMS Component	Key business functionality	Primary BTC redesigned journey(s)[1]	MITA Business Process Codes	Example metrics[2]
Case / Care Management Services	3.01 Member / stakeholder communication and coordination	BenMgmtCC-1, CorresGen-7	**CM01 CM02 CM03 CM06**	Communications successfully delivered (%)
	3.02 Integration with external Case Management Platforms (e.g., MCOs)	ProviderEnroll-1, MCEnroll-3	**CM02 CM04**	Case update frequency
	3.03 Configurable and automated case creation & tracking	EligibilityEnroll-TT, EscalationInquiry-TT, CCSCUse-2, IssueMgmt-5, ProviderEnroll-5, FairHearings-10, NMAC-TT, MADForms-1, 3rdPartyAppl-9	NA	NA
	3.04 Critical Incident Reports management	MemCareMgmt-9	NA	NA
	3.05 Special program (Mi Via, DD, MF, 1115, LTS, HIV/AIDS) administration	LOC-2	NA	NA

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FS Module View Outputs (key business functionality details)

FS Component	Key business functionality	Details	Example
Financial Processing	5.01 Payment processing (accounts payable)	Complete payments to FFS providers, non-Medicaid vendors, MCOs, and other contractors	An approved fee-for-service claim is paid to the provider organization and remittance advice is generated
	5.02 Transaction accounting and financial audit	Interface with SHARE (Statewide Human Resources Accounting Reporting) to share necessary financial transaction information and ensure data consistency across state financial systems	When a provider fee-for-service claim payment is paid, an internal accounting record is updated in the accounting system with all pertinent details
	5.03 Collections (accounts receivable)	Generate invoices, track and accept payments from outside organizations (e.g., third party liability, provider overpayments)	After identifying an overpayment to a provider, an invoice and generated and submitted to the provider
Claims Processing	5.04 Claims acceptance, routing to MCO (if needed), and review	Accept claims from clearinghouses (or directly from provider), determine responsible organization for claim (e.g., MCO), asses claim for necessary conditions/documentation, and determine final payment amounts	An claim for an MCO patient is submitted through the portal. After scanning the claim for completeness, MMISR electronically routes the claim to the correct MCO for submission
	5.05 Claim denial / adjustment reconsideration management	Follow-up with provider organization for denied and adjusted claims, providing rationale and requesting additional information needed. Reconsider denial decision after additional information is submitted	A fee-for-service claim is rejected for lacking relevant supporting documentation. The submitting provider receives a notification explaining the rationale and potential remediation steps
Data Exchange and Reporting	5.06 Financial data sharing, collection, and reporting	Provide all financial and claims data to other modules. Ingest Enterprise Data to support claims adjudication. Reports include transactional reporting, audit trails, remittance advices, adjudication cycle reports)	The Data Services modules needs to create a dashboard for claims by provider type, and the system shares the required data
Pharmacy Benefit Management (PBM) & Drug Rebate	5.07 Drug authorization, real-time adjudication, real-time drug utilization review	Approve/deny drug prior authorization, real-time adjudication of pharmacy claims, and real-time utilization review (e.g., clinical edits to detect potential duplication, duration correction, proposing lower cost alternatives)	When a client drops off a brand-name drug prescription at Walgreens, the prescription is edited to dispense a low-cost generic equivalent drug
	5.08 Drug rebate collections	Identify drug rebate need and values, invoice drug manufacturers, track rebate payment status, and resolve rebate-related disputes with manufacturer	On a quarterly basis, the drug rebates for Pfizer is calculated and invoiced to Pfizer

FS Module View Outputs (journeys and MITA)

FS Component	Key business functionality	Primary BTC redesigned journey(s)[1]	MITA Business Process Codes		Example metrics[2]
Financial Processing	**5.01 Payment processing (accounts payable)**	MedProvPymts-2, SmlPurchase-1, ClaimsEncMgmt-4, PharmBen-6	**OM14** **OM27** **OM18** **FM09** **FM10**	**FM11** **FM12** **FM13** **FM14** **FM15**	Payment error rate (%)
	5.02 Transaction accounting and financial audit	IntFinRpts-6, MedProvPymts-2, SmlPurchase-1	**FM16** **FM17** **FM18**		Accuracy of data and decisions (%)
	5.03 Collections (accounts receivable)	TPLMgt-2, DrugRebMgmt-9, RACMgmt-8, PymtRec-3, IDTtrust-8	**FM06** **FM07**		Average days outstanding of accounts receivable (days)
Claims Processing	**5.04 Claims acceptance, routing to MCO (if needed), and review**	MedProvPymts-2, ClaimsEncMgmt-4	**OM07**		Accuracy with which edits, audits and pricing algorithms are applied and paid amount is calculated (%)
	5.05 Claim denial / adjustment reconsideration management	MedProvPymts-2	**OM07**		Consistency of decisions on suspended claims (%)
Data Exchange and Reporting	**5.06 Financial data sharing, collection, and reporting**	IntFinRpts-6	**FM19**		Time to complete financial report
Pharmacy Benefit Management (PBM) & Drug Rebate	**5.07 Drug authorization, real-time adjudication, real-time drug utilization review**	PharmBen-6, ClaimsEncMgmt-4	NA		NA
	5.08 Drug rebate collections	DrugRebMgmt-9	**FM04**		Amount of drug rebate dollars collected quarterly ($)

1 Detailed step-by-step module mapping to journey already completed by Staff Augmentation Team
2 Example metrics may be updated to reflect outcomes-based certification metrics

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External Portal Module View Outputs (key business functionality details)

UP Components	Key business functionality	Details	Example
Learning about benefits	7.01 Assessment of needs and assistance offers	Provide personalized matching of programs relevant to the applicant based on questions about demographics and personal situation	A client answers a series of questions and then receives personalized matches of programs to apply for
	7.02 Map extension	Allow clients to route to the nearest location for assistance, locate providers, and meet with community partners	Customer can search for assistance based on zip code (e.g., closest behavioral health provider accepting Medicaid)
Applying for benefits	7.03 Eligibility & Enrollment Integration	Unified portal links to HSD eligibility and enrollment backend systems (e.g., ASPEN) for all programs client is eligible for. Client is automatically enrolled in programs for which he/she is eligible	The client receives a real-time determination of eligibility for SNAP and is automatically enrolled
	7.04 Digital assister	Integrated digital assister that can help walk clients through the application process and provide prompts or tips to help reach completion. Also assists with quickly resolving errors in an application.	As client fills in income information, assister offers pop-up with common mistakes to avoid
	7.05 Consolidated applications with auto-populated information	Single application form for all benefits. Income, demographic, and household information automatically populated across all relevant applications	Iinformation of a current Medicaid client is automatically populated in SNAP application
	7.06 Easy document upload	Clients never need to provide paper documents. Any required documentation can be uploaded using a smartphone.	The demographic information of a current Medicaid client is automatically populated in the application when she applies for SNAP
Engaging with & Extending benefits	7. Mobile apps	Develop client-facing apps with a mobile-first mindset and provide clients access to the functions via native mobile apps	A client checks smartphone app for EBT card balance and status of LIHEAP application
	8. "My Account"	One interface for customers to obtain 360degree view of their enrollment status, assistance levels and outstanding balances, and eligibility across all programs	Client logs in to check status of SNAP application and check outstanding child support payment
	7.09 User preferences	Provide users a robust set of preferences for clients based on which assistance program they are working with	Users provided different channels for notifications
	7.10 Simplified renewals	Automatic reminders when customer action is required for to renew benefits. System only asks for information needed to update renewal	Client receives text message notification that recertification for SNAP is required
Getting help with benefits	7.11 Real-time support through bots and CCSC integration	Ability to reach a virtual or human support representative from the CCSC through live chat to address questions and support completing application	Client asks question about documentation she is required to submit for SNAP
	7.12 Client helpers	Presumptive eligibility determiners and community partners can complete application for assistance on behalf of client using a customized interface	Local NGO supports person experience homelessness in submitting a SNAP benefit
Interface with other modules	7.13 Interface with other modules	Provides integration with other modules, especially BMS and C/CMS, to allow providers and MCOs to access functionalities such as provider sign-ups and benefit or case management	Provider logs into portal and signs up to participate in Medicaid

Internal Portal Module View Outputs (key business functionality details)

UP Components	Key business functionality	Details	Example
Basic Functions	6.01 Alerts and notifications	Mediate, deliver and dispose of real-time alerts for workers	A worker receives an alert and opens a corresponding window to undertake an activity connected to the notification
	6.02 Work queue management	Mechanism for workers to track and dispose of tasks, whether owned individually or pulled electively from a common pool	A supervisor can report on work queue content, task age, and aggregate metrics
	6.03 Role-based access to applications and file shares	Feature links to applications a worker uses, based on role	A worker can move files to and from these file shares via the user's Portal interface
	6.04 Data lookups	Include a centralized mechanism to undertake searches from multiple data sources	A worker can search for client demographic record
	6.05 Mainframe emulation	Supply staff access to legacy functions operating today on a mainframe computer	A worker can transfer a file to the legacy systems via FTP or SFTP
	6.06 Reports access	Support accessing reports via the Portal Interface	A worker can access a report via a service call to a reporting engine
	6.07 Email and calendar	Integrate Outlook and calendar into Internal Portal	A worker can check their Outlook email and calendar without leaving the Internal Portal
	6.08 Self-organization	Mechanism for workers to organize links to favorite functions and locations on their workspace	A worker can organize most commonly used functions
Reporting and Data Analysis	6.09 Data Service Module Reports	Integration with data services dashboards so worker can access full suite of reports for Medicaid enterprise	Worker logs in to pull custom report to address question from LFC
	6.10 360 degree client view	Ability to see complete set of specific, individual client demographics, including history of program enrollment, assistance used, and current enrollments.	CCSC worker can pull up complete customer profile to assist in addressing customer's eligibility questions

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CCSC Module View Outputs (key business functionality details)

CCSC Components	Key business functionality	Details	Example
Self-Service	8.01 Single toll-free number	Provide customers across multiple programs a single toll-free number	A customer with questions on TANF and Child Support can call one phone number
	8.02 IVR self-service	Provide a series of prompts for callers to select where they would like to be routed	A client listens to a recording and chooses to be routed to a particular department
	8.03 Voicemail system	Configure voicemail across call center to keep track of callers and to allow customers to leave messages for representatives	A client calls past call center business hours and is sent to voicemail to leave a message
	8.04 Scheduled callbacks	Allow the caller to choose a specific time slot for a future conversation	A client calls during peak time and decides schedule a call back for a later time
Customer Service	8.05 Call queue	Configure one call queue or separate customized call queues for each department	A customer contacting the call center is put into a queue before speaking to a representative
	8.06 Automatic call distribution	Allow representatives to effectively route callers to the most appropriate agent or department based on pre-defined information	A customer is transferred from one representative to another without having to redial
	8.07 Customer relationship management	Provide representatives with detailed information about the caller	A representative can see the name, demographics, and call history of the client
	8.08 Knowledge management system	Provide representatives with answers to the most frequently-asked customer questions	A representative has a script to answer customer questions across divisions
	8.09 Single call/contact resolution	Seamless integration between multiple channels	A customer with questions on TANF and Child Support can have both queries resolved in one call
Performance Evaluation	8.10 Real-time metrics	Provide data like service level, average wait time, longest wait time, average handle time, number of available agents	A representative can view the average abandon rate for that week
	8.11 Historical reporting	Provide representatives with comprehensive historical performance metrics	A representative can view the performance of their department over time