MITA Concept of Operations

Vermont Agency of Human Services

2024

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1 Revision History

.01	1/07/2019	Kaitlin Epstein, Rebecca Rivard-Darby, David Ladouceur	Document Created.
.02	5/05/2020	MITA Team	Fixed error -added missing diagrams under Operational Scenarios
.03	2/17/2021	MITA Team	Updated language
.04	1/24/2022	MITA Team	Updated language
.05	11/21/2023	MITA Team	Updated IE&E VT-TIES
.06	7/18/2024	MITA Team	Updated IE&E VT-TIES language

2 Introduction

Scope/Purpose:

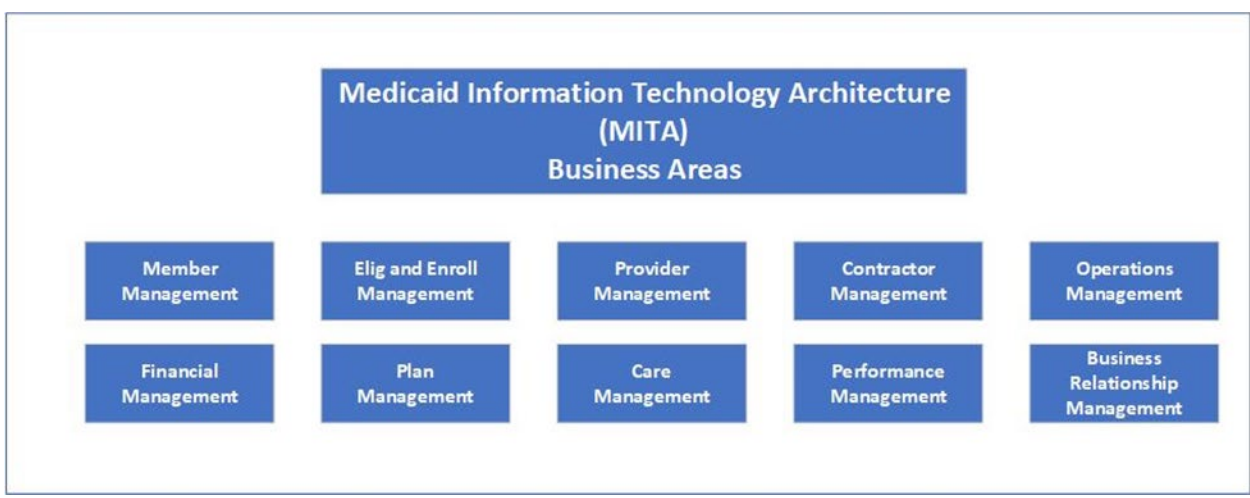
A Concept of Operations (COO) is a structure that helps organizations document their As-Is (current) operations and define To-Be (future) transformations. The Medicaid Information Technology Architecture (MITA) COO is a comprehensive vision of the future that describes required improvements to stakeholder interactions within the Medicaid Enterprise, the quality and content of data exchanges, and the State Medicaid Agency (SMA) business capabilities.

The purpose of this MITA COO is to document the Vermont Medicaid Enterprise vision of the future and describe the impact of planned improvements on Medicaid operations and healthcare outcomes.

The current scope of the Vermont Medicaid Enterprise, and this document, includes both the Medicaid Management Information System (MMIS) Program and the Integrated Eligibility and Enrollment (IE&E) Program. In the future, Health Information Exchange (HIE) investments will also be aligned or integrated with the Medicaid Enterprise.

Goals/Objectives:

The Centers for Medicare and Medicaid Services (CMS) is Vermont's federal partner regarding the State Medicaid Enterprise. CMS has established MITA Business Areas for State Medicaid Agencies. These business areas consist of capabilities and services that support the business needs. All these capabilities and services are in scope for Vermont as possible opportunities for improvement and enhancement.



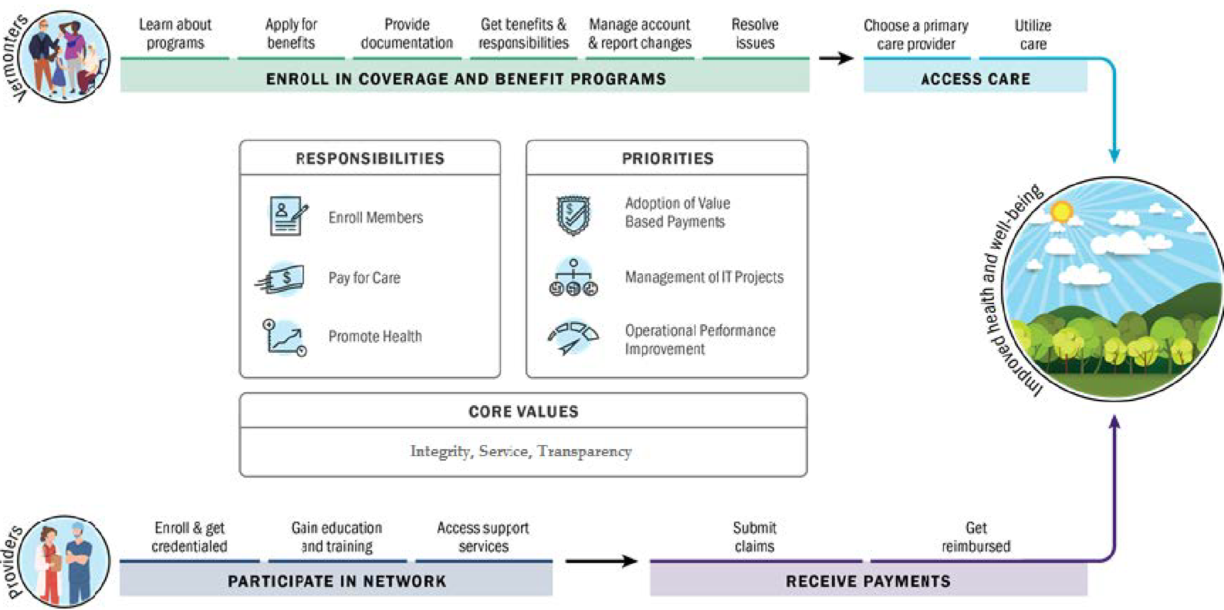
The State of Vermont has been engaged in a modular approach to transform its legacy systems into an environment of coordinated and integrated service delivery. By connecting information and promoting collaboration in a service-oriented-architectural (SOA) environment, Vermont will yield better and more cost-effective outcomes for its citizens, the State, and its federal partners.

According to MITA 3.0 (the current version) the Medicaid Enterprise mission and goals are as follows: The Medicaid mission is to provide quality healthcare to members by providing access to the right services for the right people at the right time for the right cost. Medicaid's goal is to improve healthcare outcomes for Medicaid members and to ensure efficient, effective, and economical management of the Medicaid Program. The mission and goals of the Vermont Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) are well aligned with this. The core purpose of AHS is to help every Vermonter who needs help. AHS strives to protect our most vulnerable citizens and assist in developing their fullest potential. The mission at AHS is to improve the health and well-being of Vermonters today and tomorrow and to protect those among us who are unable to protect themselves.

DVHA is responsible for the management of Vermont's publicly funded health insurance programs. The mission of DVHA is to improve the health and well-being of Vermonters by providing access to

healthcare cost effectively. DVHA's priorities are adoption of value-based payments, management of information technology projects, and operational performance improvement. Leadership at DVHA is committed to ensuring that supportive, cost-effective, health information technology systems are in place to provide tools and resources designed to improve the health of Medicaid members.

DVHA continues to pursue modern Medicaid and integrated eligibility systems changes in small, manageable modules to minimize risk and provide immediate business value. DVHA is focused on improving and streamlining the customer experience for the Medicaid member and the provider community. The development and implementation of these initiatives will continue over several years. It will be focused on repairing and/or replacing legacy infrastructure, operational and technical changes impacting the staff experience, and technological and operational optimization. CMS certification or approval is a primary goal for all Vermont solutions or modules.



Vermont's Enterprise aims to create a place where the member, not the program is at the focal point. Vermont is transitioning to a model of true integrated service delivery that will:

- Align with the Triple Aim
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations, and
  - Reducing the per capita cost of health care
- Improve the members service experience for Vermonters.
- Improve the members' service experience for health and human services providers.
- Improve efficiency and effectiveness of Medicaid operations.

The MITA Framework has defined the following mission, goals, and objectives statements in response to the Medicaid Enterprise mission and goals. Through the realization of these goals and objectives, MITA aids states in achieving their Medicaid mission and goals.

The MITA mission is to establish a national framework of enabling technologies and processes that support improved program administration for the Medicaid Enterprise and for stakeholders dedicated to improving healthcare outcomes and administrative procedures for Medicaid beneficiaries.

The MITA Framework and process was developed by CMS to standardize the way in which State Medicaid Agencies define, document, and track the business processes performed by a current Medicaid system or solution. In addition to identifying the current MITA status of a Medicaid system, MITA is used by State Medicaid Agencies (SMAs) to plan the technology capabilities of their future systems or solutions. The MITA maturity scale ranges from one to five with one being a manual system with little, if any, support from technology, with a focus on local or state-only use of the technology. Five is a completely automated system that is fully supported by technology and can be used significantly beyond just the borders of the SMA.

MITA promotes improvements in the Medicaid enterprise and systems that support it through collaboration between CMS and SMAs. MITA provides a blueprint consisting of models, guidelines, and principles to be used by states as they implement enterprise solutions.

The table below shows how the DVHA mission and priorities, discussed above, align with the key MITA objectives as defined by CMS. This is meant to illustrate some examples of alignment, and it is not intended to serve as an exhaustive comparison.

Key MITA Objectives as defined by CMS	**Alignment with DVHA Mission or Priorities**
• Promote reusable components • Adopt data and industry standards	• Provide access to healthcare cost effectively • Prioritizing the management of information technology projects
• Efficient, effective data sharing • Support interoperability, integration, and open architecture • Support integration of clinical and administrative data	Focused on improving and streamlining the customer experience for the Medicaid member and the provider community
• Provide a beneficiary-focus	• Improve the health and well-being of Vermonters • Improve and streamline the customer experience • Adoption of value-based payments

Key MITA Objectives as defined by CMS	Alignment with DVHA Mission or Priorities
• Promote good practices — Capability Maturity Model, etc. • Promote secure data exchange	• Priority to manage IT projects • Prioritizing operational performance improvement

CMS has defined the following goals for MITA:

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

The goals and objectives of the MITA Initiative further translate into the below **Guiding Principles**:

- Business-driven enterprise transformation.
- Accommodation of commonalities and difference between agencies.
- Standards applied to improve cost effectiveness.
- Built-in security and privacy capabilities.
- Data consistency across the enterprise.

Note, the goals stated in this section are long-term, high-level and visionary. They are meant to apply to multiple components of the future Medicaid Enterprise. Some more precise examples of Vermont's current Enterprise goals include:

Goals	Alignment w/MITA
Allow eligible Vermonters to apply for and receive health coverage and financial assistance benefits through a single point of access by 2025	Aligns with MITA objective to provide a beneficiary-centric focus

Goals	Alignment w/MITA
Reduced the provider enrollment timeframe from an average of 120 days to below 30 days in 2019	Aligns with MITA objective for efficiency
Comply with the 21st Century Cures Act by implementing Electronic Visit Verification (EVV) for Personal Care Services by 2020 and Home Health Care Services by 2023	Aligns with MITA objective to adopt standards

For additional specific information on the timeline and objectives of the program modules and initiatives planned and in flight, please reference the Vermont MITA State Self-Assessment (SS-A), or the most recent approved Advanced Planning Documents (APDs).

3 As-Is Operations

While Vermont has made major strides towards operational alignment with MITA and the goals of enterprise architecture, current systems continue to present challenges and gaps towards achieving the State's long-term goals.

The MITA maturity framework is based on assessing four different areas (business architecture, information architecture, technical architecture, and alignment with the CMS standards and conditions). While the State of Vermont (SoV) has adopted the MITA 3.0 framework, it has chosen to re-organize the MITA business processes into workstreams for business process alignment that is unique to Vermont, as shown in the figure below. In this context, workstream refers to the SoV's unique MITA business processes that share common focus and information. This crosswalk defines the state's Business Process Model and how it aligns with or differs from the MITA Business Process Model.

This section contains a high-level summary of as-is operations. For more detailed information on the as-is status, see the maturity profiles in sections 10 through 13 or the Vermont MITA State-Self Assessment (SS-A). Note, Vermont is taking an incremental approach to updating our MITA SS-A. A detailed revision history is present in the SS-A and this MITA Concept of Operations will be updated as needed to support alignment.

Business Architecture

Challenges:

Manual processes are costly and inefficient to perform. All processes do not have formal, agreed upon, targets, metrics, or measurements. Manual entry and other inefficiencies within business processes hamper process completion. In general, the systems used by AHS and vendors are primarily transactional and do not support current workflows. Performance management processes are still maturing. Administrative and planning functions lack automation for data sharing and integration with operational solutions.

Strengths:

Considerable progress has been made in requirements definition, establishment and tracking of Key Performance Indicators (KPIs) and Service Level Agreements (SLAs).

Technical Architecture

Challenges:

Key transactional systems have long been supported by technology, but many programs lack standardization and automation in how information is collected and maintained. Clinical and functional best practices and industry-standard tools and techniques cannot be maintained or updated within legacy systems. The Vermont Medicaid Enterprise is supported by a number of agencies, departments, and organizational units that augment core MMIS and Eligibility and Enrollment system functionality with unique processes and technology. While serving specific program and member needs, these unique systems lack standardizations or an objective of reusability. Older legacy systems pre-date modern standards and architectures (e.g. SOA) and extending functionality is difficult and costly. Separation of the business rules from the application code is not consistent across systems.

Strengths:

Systems support HIPAA and Vermont standards. Legacy systems use many HIPAA-compliant and CMS-dictated industry standards.

Information Architecture

Challenges:

Struggle with data collection, analysis and measurement to support performance monitoring and improvement. There is a need for more evidence-based decision-making and there is a lack of data and tools to support it. Siloed and aging systems have resulted in disparate data collection systems, manual and spreadsheet-based records, and cumbersome analysis and reporting. Current systems have minimal reporting tools. Data access and management is dispersed across systems and organizations. Enterprise data management, including Master Data Management (MDM) disciplines, are nonexistent. There are no easy ways for relevant leaders and administrators to access and conduct analysis on clinical measures. It is very difficult to conduct program performance analysis, and cross-program analysis as data quality is poor or unavailable and few tools are available. As a result of programmatic silos, department, unit, and program-level systems have been acquired to meet specific needs, causing redundancies and challenges for data management and reporting across the agency.

Strengths:

- Business process compliance with state and federal regulations is achieved with necessary reports and data extracts. Tactical (de facto) data management is effective within each system silo (MMIS, Vermont Chronic Care Initiative [VCCI], and Pharmacy Benefits Management [PBM]).
- AHS has recently implemented a data governance structure to drive standards and decision making across the enterprise. There are efforts to implement a data governance structure at

the state-level across all agencies. The AHS has committed to working toward an "Agency of One," providing for greater collaboration and sharing of data across Vermont agencies/business units and supporting the MITA goal to promote an enterprise view.

Standards and Conditions

Challenges:

Legacy systems in use at the SoV are lacking in the State's ability to meet the S&C set forth by CMS. These legacy systems do not readily allow for modularity, MITA, current industry standards or reuse. These legacy systems have some capabilities for reporting, interoperability and business results, but lack many of the modern, industry standard tools. The aged infrastructure has limitations on the ability to electronically interface and interoperate with the applications running in these environments as well as limiting the options for which data centers these mainframe legacy systems can run in.

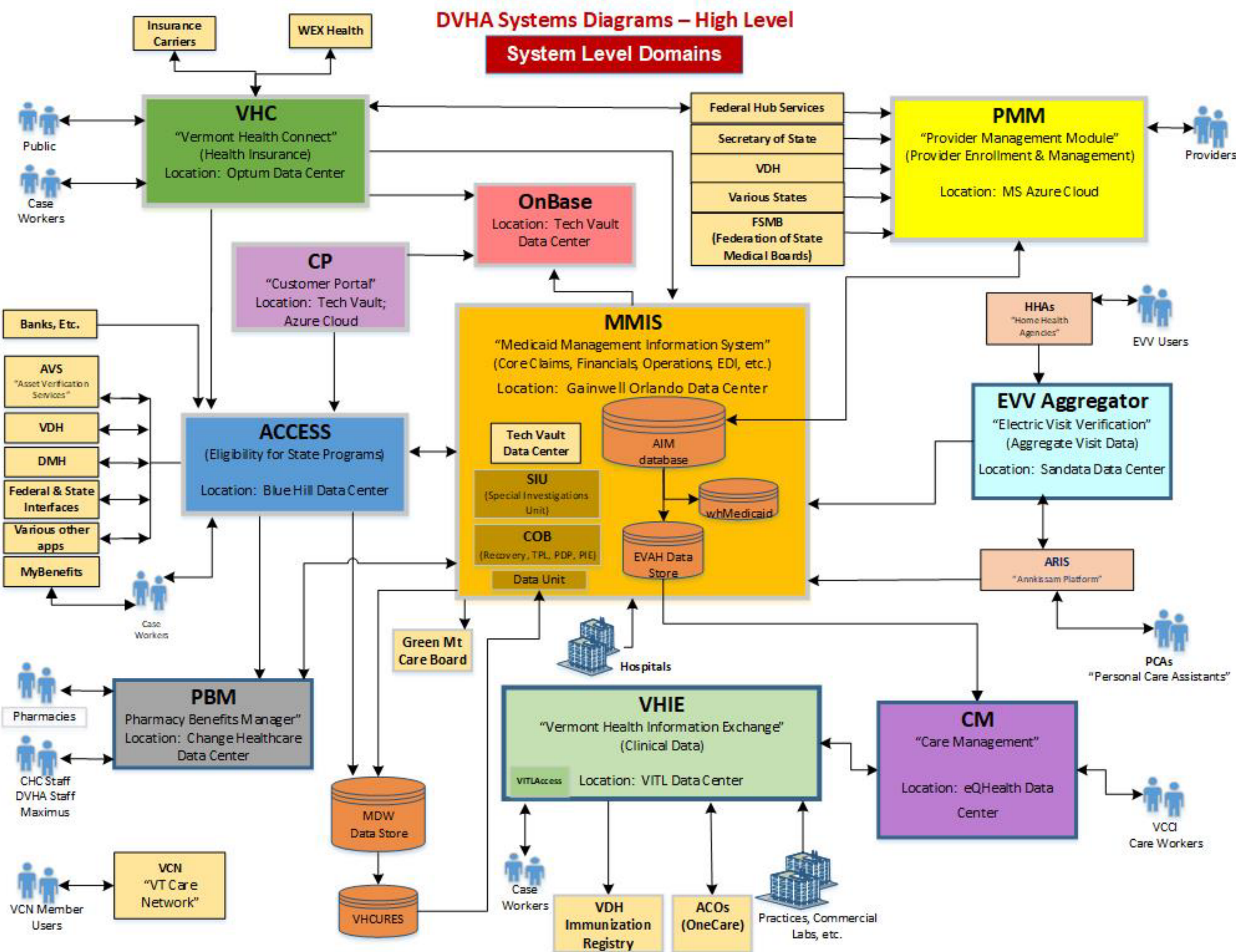
Strengths:

Considerable progress has been made in acquisition of MITA-compliant systems. AHS has implemented stringent procurement and contracting policies to ensure that vendors deploy systems with modern architectures, comply with standards, and have higher MITA maturity levels than the legacy systems. The Agency requires all new vendors to commit to alignment with MITA goals when establishing agreements. Vermont is committed to meeting the Standards and Conditions for new modules. See section 8 for further details.

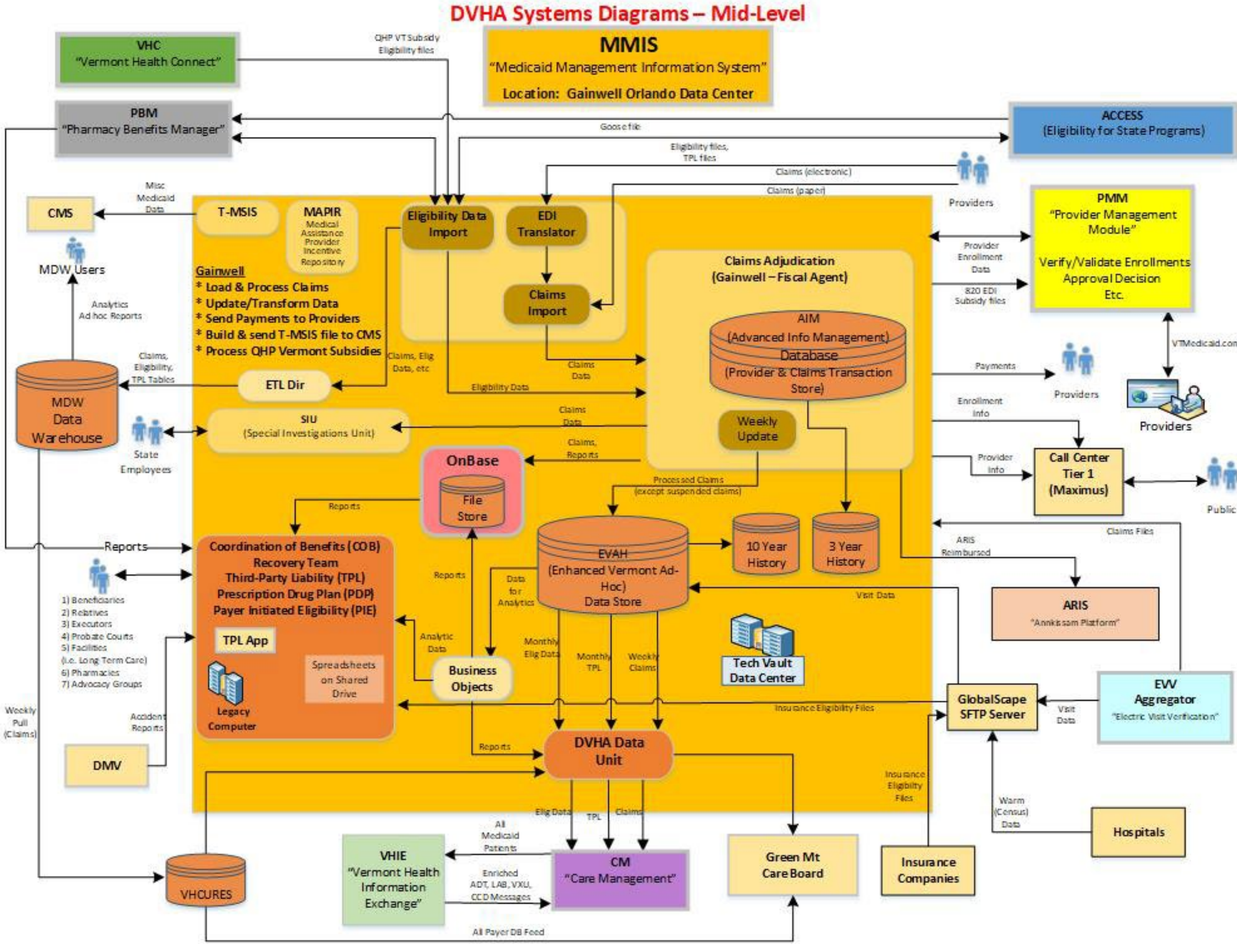
The following architectural diagrams provided (in order):

- DVHA Systems Diagram- High Level
- MMIS Systems Diagram

Note, diagrams will be updated and expanded in future iterations to support this and other planning documents. There may be potential enhancements for clarity purposes in future versions.

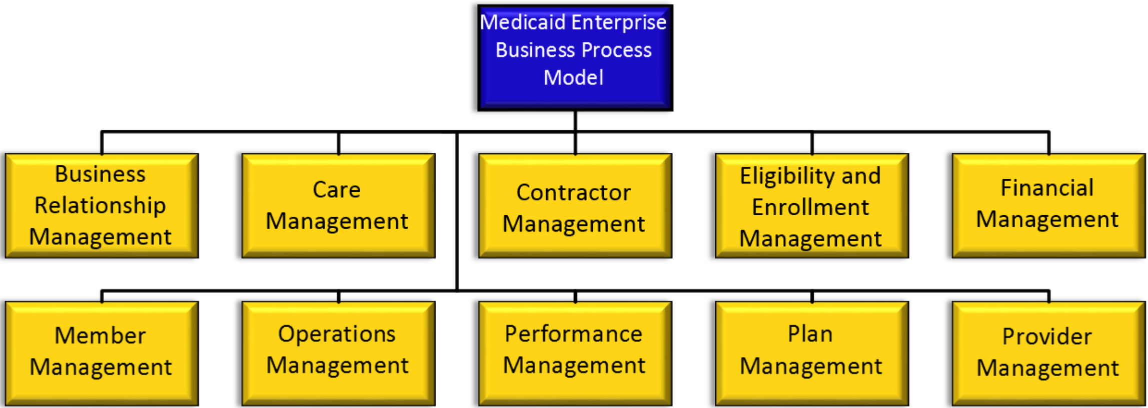


DVHA Systems Diagrams – High Level
System Level Domains
Insurance Carriers
WEX Health
VHC
"Vermont Health Connect"
(Health Insurance)
Location: Optum Data Center
Public
Case Workers
Federal Hub Services
Secretary of State
VDH
Various States
FSMB (Federation of State Medical Boards)
PMM
"Provider Management Module"
(Provider Enrollment & Management)
Location: MS Azure Cloud
Providers
OnBase
Location: Tech Vault Data Center
CP
"Customer Portal"
Location: Tech Vault; Azure Cloud
Banks, Etc.
AVS
VDH
DMH
Federal & State Interfaces
Various other apps
MyBenefits
ACCESS
(Eligibility for State Programs)
Location: Blue Hill Data Center
MMIS
"Medicaid Management Information System"
(Core Claims, Financials, Operations, EDI, etc.)
Location: Gainwell Orlando Data Center
Tech Vault Data Center
AIM database
SIU
COB
Data Unit
whMedicaid
EVAH Data Store
HHAs
EVV Users
EVV Aggregator
"Electric Visit Verification"
(Aggregate Visit Data)
Location: Sandata Data Center
ARIS
PCAs
"Personal Care Assistants"
Hospitals
Green Mt Care Board
PBM
Pharmacy Benefits Manager"
Location: Change Healthcare Data Center
Pharmacies
CHC Staff
DVHA Staff
Maximus
VHIE
"Vermont Health Information Exchange"
(Clinical Data)
Location: VITL Data Center
CM
"Care Management"
Location: eQHealth Data Center
VCCI Care Workers
MDW Data Store
VHCURES
VCN
"VT Care Network"
VCN Member Users
Case Workers
VDH Immunization Registry
ACOs (OneCare)
Practices, Commercial Labs, etc.

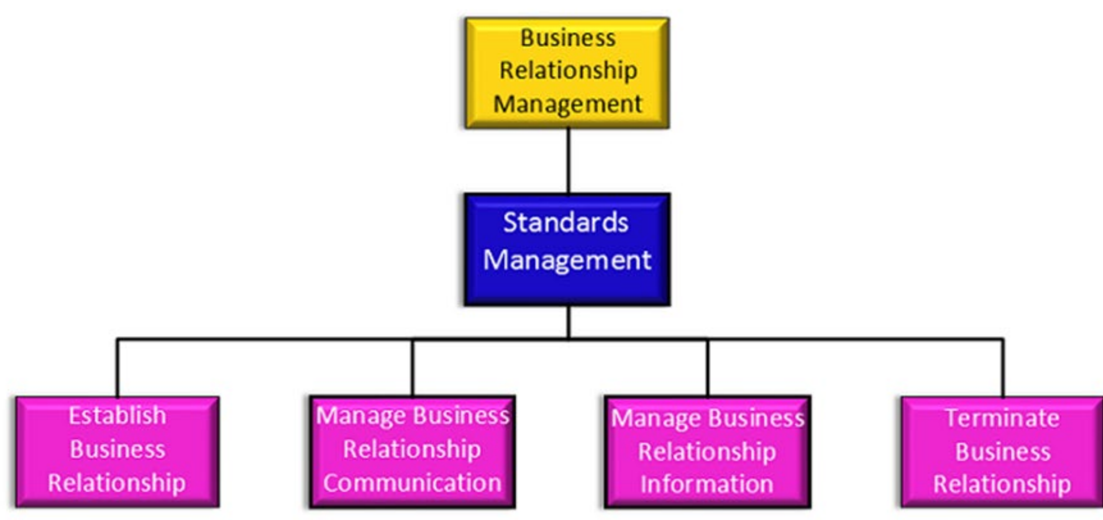


The Vermont Enterprise strives to support the MITA goals:

- To implement COTS, cloud-based, seamless and integrated modules that communicate effectively to achieve common Medicaid goals through interoperability and;
- To promote an environment that is flexible, adaptable, and enables rapid response to changes in programs and technology.



The current understanding of as-is operations for the MITA business processes is summarized below.



The **Business Relationship Management** business area is a collection of business processes that facilitates the coordination of standards of interoperability. This business area defines the exchange of information and Trading Partner Agreements (TPA) between the SMA and its partners, including collaboration among intrastate agencies, interstate agencies, and federal agencies. These agreements contain functionality for interoperability, establishment of inter-agency Service Level Agreements (SLA), identification of the types of information exchanged, and security and privacy requirements. The

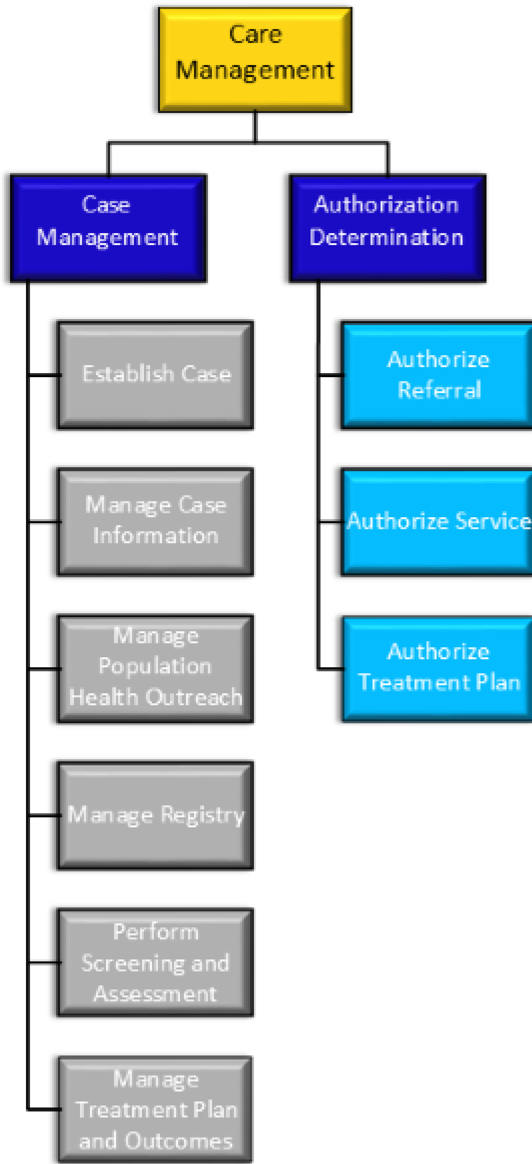
Business Relationship Management business area has a common focus (e.g., data exchange standards and SLA) and is responsible for the business relationship data store.

Business Area Challenges

- No automation exists to support business agreements.
- Standards and processes are internally developed and vary by area.
- There are no current approaches to proactively manage agreements, and performance measures – issues are largely managed on an exception basis.

Business Area Strengths

- Business Relationships are closely aligned with contracting practices and will benefit from new standardization and automation initiatives.
- DVHA Business Office has developed processes to effectively manage these capabilities.



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

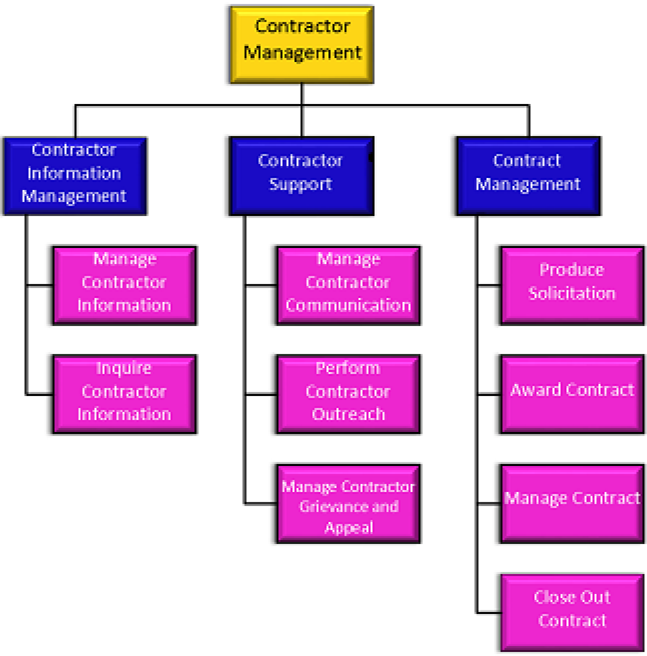
Care Management includes disease management, Catastrophic Case Management, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), population management, patient self-directed care management, national health registries, and waiver program case management. The Care Management business area is responsible for the case management, authorizations, referrals, and treatment plans data stores. Care Management also contains business processes for authorization determination including authorizing referrals, service and treatment plans.

Business Area Challenges

- No case integration exists across business programs within the Agency.

Business Area Strengths

- Case documentation and care management within Vermont Chronic Care Initiative (VCCI) is highly automated.
- VCCI recently expanded its population, increasing its impact and cost benefit. VCCI evaluates the Vermont Medicaid population and focuses on the top utilizers of the healthcare system which includes screening and stratification for social determinants of health (mental health, substance use, inter-partner violence, housing stability, and food security). VCCI proactively conducts outreach to new Medicaid beneficiaries using verbal, telephonic screening tools to help stratify them into low, medium, high, and very high risk. Based on the level of risk, beneficiaries are connected with primary care, community-based self-management programs and human service providers or engaged in complex care management using the same tools as the local care teams facilitated through the Blueprint for Health and Accountable Care Organization (ACO).
- Industry-standards and best practices are incorporated into VCCI's workflows and performance metrics.
- VCCI interfaces with Vermont Information Technology Leaders (VITL), Vermont's Health Information Exchange (HIE).



The **Contractor Management business area** accommodates a SMA that has managed care contracts or a variety of outsourced contracts. The Contractor Management business area has a common focus on Medicaid contractors (e.g., managed care, at-risk mental health or dental care, primary care physician), is responsible for contractor data store, and uses business processes that have a common purpose (e.g., fiscal agent, enrollment broker, Fraud Enforcement Agency, and third-party recovery).

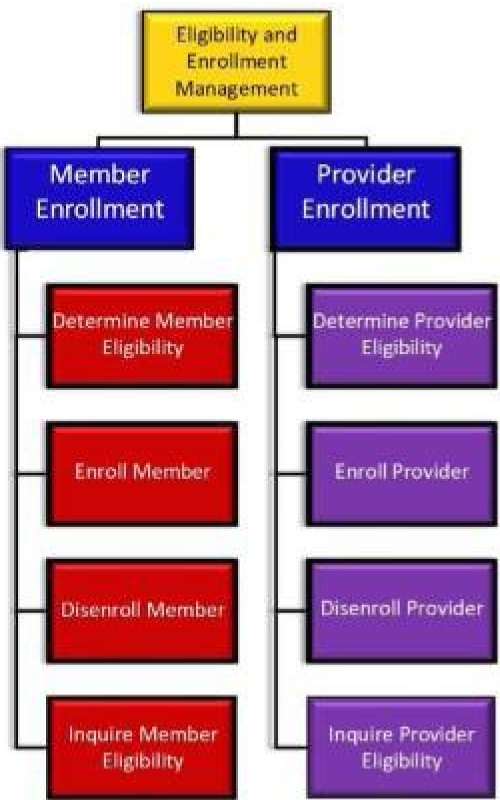
Business Area Challenges

- Electronic Bulletin Board (EBB) or Vermont Bid System has very limited functionality – DVHA uses workarounds to enhance this functionality.
- Structure outside of traditional contracting relationships is vaguely defined.
- No automation exists to support contracts or agreements.
- Standards and processes are internally developed.
- There are no current approaches to proactively manage contracts, and performance measures – issues are largely managed on an exception basis.
- Errors and lack of timeliness result from a largely manual process.

Business Area Strengths

- EBB is well established and utilized for contracting and solicitation communication.

- Contracts are available digitally.
- DVHA Business Office has developed processes to effectively manage these capabilities



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

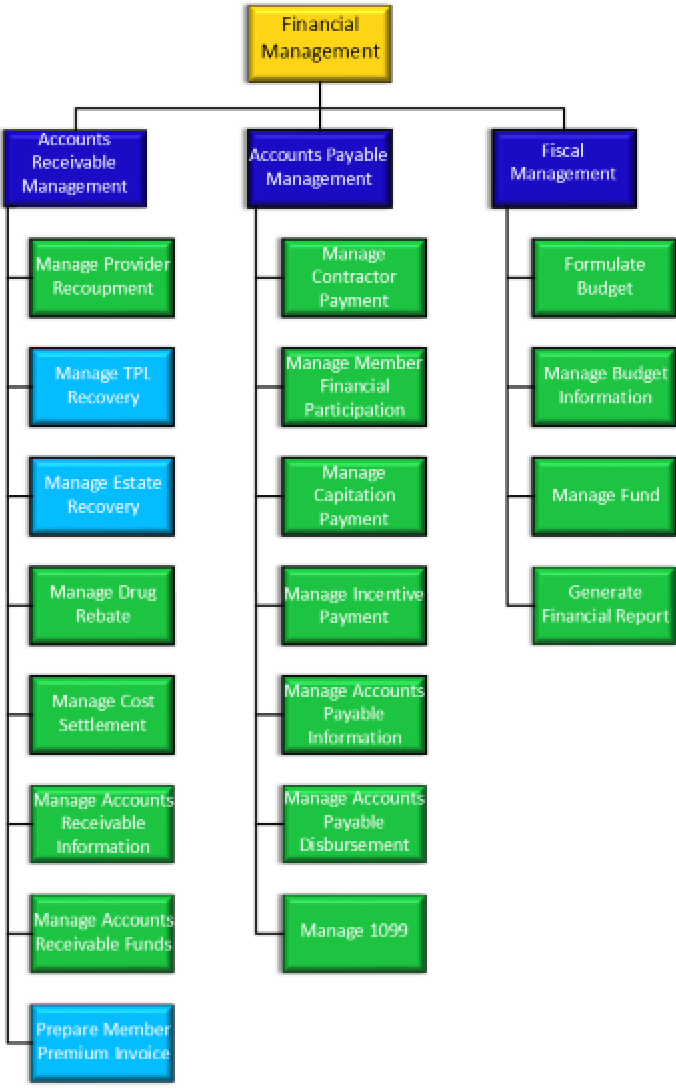
Business Area Challenges

- Eligibility rules are maintained in code and difficult to manage and modify.

- Medicaid eligibility determinations (MAGI and Non-MAGI) take place in two different systems.
- Access to data from other states for provider eligibility and enrollment was not meeting all business goals at self- assessment time.

Business Area Strengths

- Member eligibility determination and enrollment are heavily automated.
- Provider eligibility and enrollment for the Agency is centralized and highly standardized.
- Implementation of VHC continues to raise level of automation and standardization.
- It takes 30 days or less to enroll a new provider with new automated PMM.



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

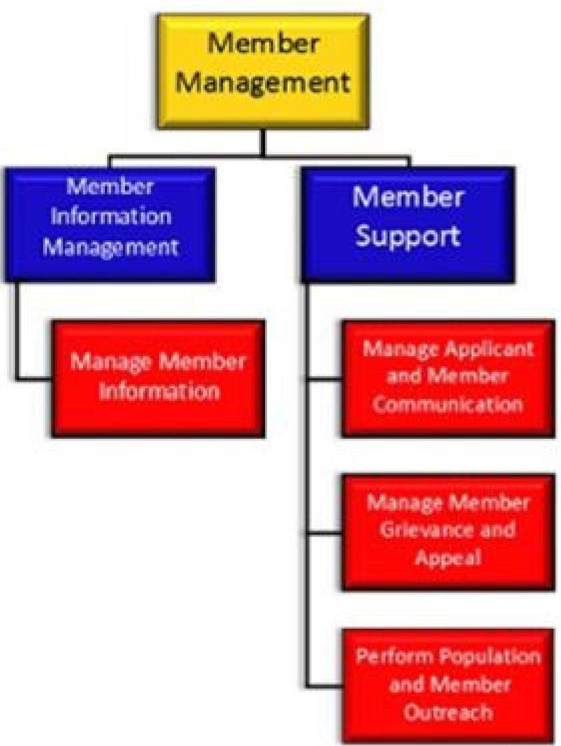
Business Area Challenges

- There are weak linkages between the MMIS and the State financial system Vision requiring significant State and vendor involvement in financial information transmission.

- Budgeting and fund management activities are highly manual and depend on a complex effort through spreadsheets at multiple organizational levels.
- Coordination of Benefits (COB) recovery processes are manually intensive and lack automation.

Business Area Strengths

- Accounts payable processes are well defined and executed.
- Financial management is seen as accurate and reliable.



The **Member Management business area** is a collection of business processes involved in communications between the SMA and the prospective or enrolled member and actions that the agency takes on behalf of the member. This business area is responsible for managing the member data store, coordinating communications with both prospective and current members, outreach to current and potential members, and dealing with member grievance and appeals issues.

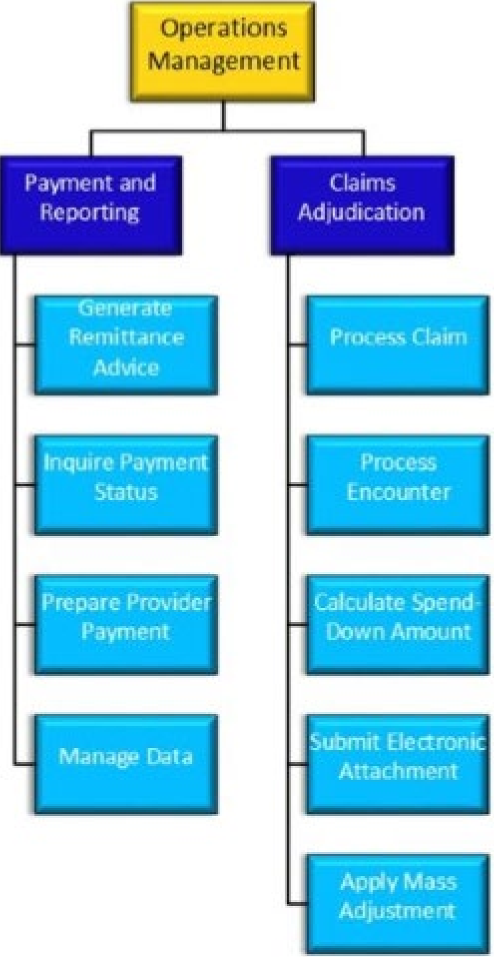
Note, SMAs are still awaiting MITA guidance on this business area including business process model details and capability information.

Business Area Challenges

- Lack of an Agency communications plan has resulted in multiple and redundant notices to members, complex outreach actions, and decreases in member satisfaction.
- Member communication is primarily limited to mail, phone, and some email.

Business Area Strengths

- Member data is maintained digitally and largely accessible through reporting tools.



The **Operations Management business area** is a collection of business processes that manage claims and prepare premium payments. This business area uses a specific set of claims-related data and includes processing (i.e., editing, auditing, and pricing) a variety of claim forms including professional,

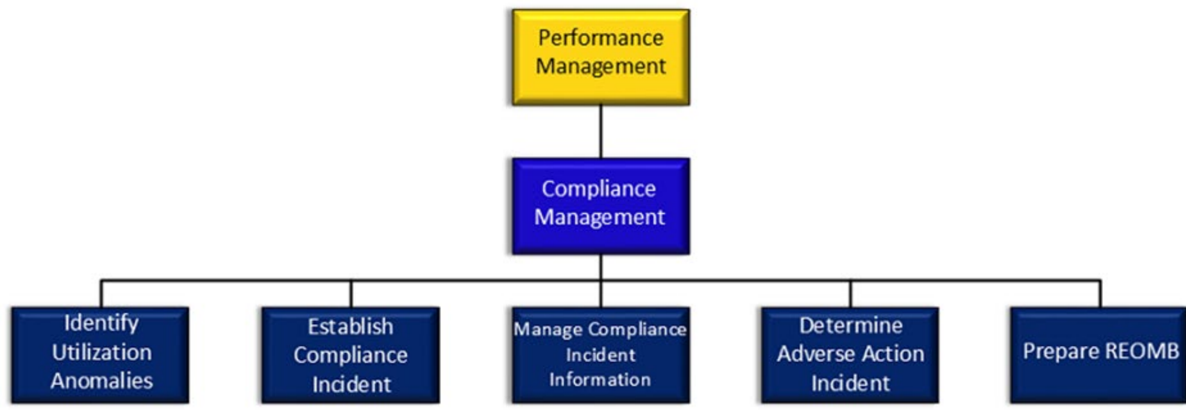
dental, institutional, drug and encounters, as well as sending payment information to the provider. All claim processing activity incorporates compatible methodologies of the National Correct Coding Initiative (NCCI). The Operations Management business area is responsible for the claims data store.

Business Area Challenges

- There are processes that are not automated in the current MMIS (e.g., attachments, adjustments, spend-down tracking) and are error prone and complex.
- The legacy system is less flexible than contemporary systems, requires additional time and investment to maintain and enhance the system for both system efficiencies and State and Federal mandates.

Business Area Strengths

- Most operational processes are supported by mature claims and payment processing technology.
- The MMIS / Fiscal Agent provides all of the primary operational needs of the Agency.
- Required system and process changes are able to be completed within the necessary timeframes.



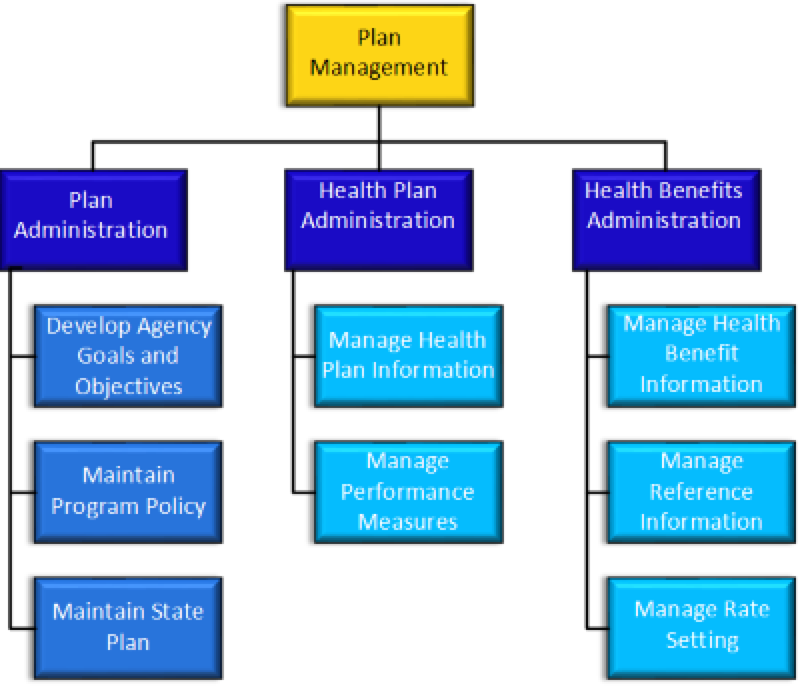
The **Performance Management business area** is a collection of business processes involved in the assessment of program compliance (e.g., auditing and tracking medical necessity and appropriateness of care, quality of care, patient safety, fraud and abuse, erroneous payments, and administrative anomalies).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

Business Area Challenges

- There is no use of predictive analytics to identify anomalies – all analyses are retrospective.
- The Program Integrity unit currently has no PI-specific technology support.
- The PI unit provides services through a combination of workarounds and largely manual processes.
- The lack of integrated case management and analytics tools results in increased errors, timeframes, and manual case tracking.
- Recipient Explanation of Benefits (REOMB) do not generate a significant number of leads, likely due to non-user-friendly content.

Business Area Strengths

- There are documented workflow and organizational processes for identification and establishment of compliance incidents.
- Program Integrity (PI) functional needs and requirements are clearly defined.



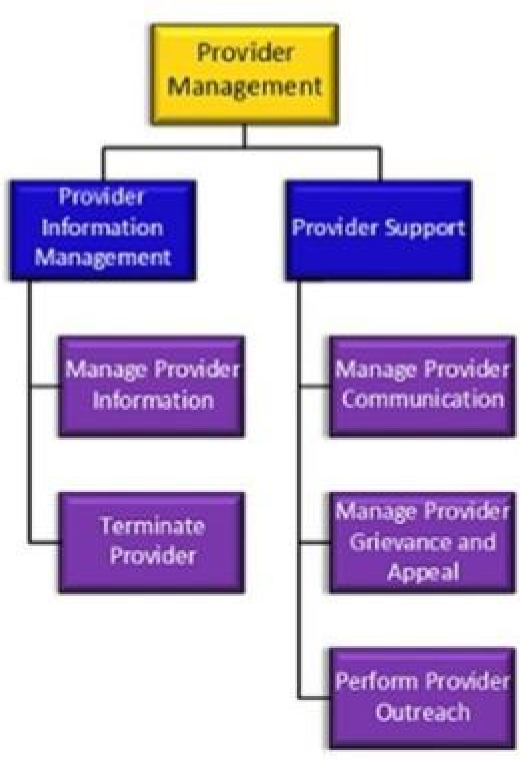
The **Plan Management business area** includes the strategic planning, policymaking, monitoring, and oversight business processes of the agency. This business area is responsible for the primary data stores (e.g., Medicaid State Plan, health plans, and health benefits) as well as performance measures,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

Business Area Challenges

- Annual planning and updates are largely manual processes.
- Communication to, within, and from the policy units is not yet fully coordinated and can be standardized.
- Policy artifacts (laws, rules, guidance, etc.) are not consolidated, harmonized, or searchable leading to inefficiencies in the team.

Business Area Strengths

- The State utilizes Federal portals for reporting as much as possible.
- There is a desire to reuse existing State automation and tools (e.g. VDH scorecard system, Oracle Policy Automation) to support a number of processes.
- Internally developed processes and tools provide a base level of effectiveness within the Agency.



The Provider Management business area is a collection of business processes involved in communications between the SMA and the prospective or enrolled provider and actions that the agency takes on behalf of the provider. Business processes focus on terminating providers, communications with providers, dealing with provider grievances and appeals issues, and performing outreach services to providers. The Provider Management business area is responsible for the provider data store.

Business Area Challenges

- Current provider outreach and recruitment lacks data analytics to identify areas of need based on specialty or geography.

Business Area Strengths

- Provider management is closely associated with provider Eligibility and Enrollment processes and supported by modern technology with the Provider Management Module.
- There are well documented workflows and policies for management of these capabilities.
- There is centralized control of policies and procedures for provider-related processes.
- The Provider Manual is digitally available and is frequently updated.
- PMM provides one place for providers to apply for enrollment, revalidate enrollment, and reenrollment as well as maintain their information via a web portal.

Our State Self-Assessment also included a section on **Pharmacy Benefits Management**. Vermont accepted an opportunity to conduct an As-Is Outcomes Based Assessment experiment with CMS and MITRE for Pharmacy. This experiment explored whether an outcomes-based assessment would be less burdensome and more useful than a traditional SS-A. The hypothesis was that If outcome-based questions can be used to self-assess current SMA business processes and support deriving a "to be" technology vision for the business process , then SMAs will have a more efficient and effective means of evaluating their current state and planning their technology-enabled business improvements and roadmap using outcomes.

Vermont received approval from the Data Systems Group (CMS) to pilot this experiment and include the results in our SS-A instead of the traditional questions for Pharmacy only. Vermont submitted its results and overall feedback to CMS and MITRE in May of 2019. Note, Pharmacy is not its own business area in MITA. We have added it here in order to include the described as-is assessment in the overall scope and story of our SS-A and MITA Concept of Operations. This section takes the place of the Manage Drug Rebate business process normally found under Financial Management.

The Vermont Pharmacy business area's current business capabilities meet the majority of the outcomes and associated as-is questions in the experimental pilot. A small percentage of questions were rated as not applicable and partially meets. Only one question was rated with does not meet.

4 Drivers and Enablers for Transformation

The MITA Framework describes drivers as concepts of technological design principles and enablers as technological advancement. In this section, a more vernacular understanding of the term drivers and enablers has been taken to illustrate two important points:

1. What are the goals or issues driving the Enterprise towards transformation?
2. What will enable the Enterprise to successfully reach its transformation goals?

Drivers:	
Strategy, Goals & Governance	CMS direction & guidance along with the State Medicaid Agency's mission and priorities set the policy, goals, and vision driving the transformation.
Legislation & Compliance	New and current Federal and State legislation, regulations and standards set the requirements and mandates driving the transformation. Examples include, but are not limited to: • The 21st Century Cures Act driving Electronic Visit Verification (EVV) implementation. • Vermont Act 116 driving reduction of the number of days it takes to enroll a provider and implementation of the Provider Management Module (PMM) • Standards and conditions outlined in 42 CFR §433 Subpart C and MITA 3.0 driving the transformation along with the requirements and methodologies
Outdated Technology	25 to 30-year-old legacy systems driving an overall need for transformation and change, because it's difficult to support or make changes to aging systems that are not up to current industry standards
Operational & Beneficiary Needs	Business/stakeholder/functional requirements and beneficiary-centric outlook driving transformation Examples include, but are not limited to, a desire to improve reporting capabilities, efficiency, accuracy, quality, stakeholder satisfaction, and experience
Shifts in Demographics & Revenue	Demographic shifts, such as an aging population, and fluctuation in available funding, highlight the need to find cost savings and efficiencies at the State and Federal level with a focus on meeting needs and

Drivers:	
	determining future needs Examples of cost-saving drivers focused on meeting needs include, but are not limited to, reduction or elimination of manual processes, payment reform, and finding ways for reuse and integration

Both Drivers & Enablers:	
Documentation & Guidance:	Provides both a model or roadmap to drive change and enables through communication, performance tracking, and accountability • Examples include, but are not limited to, MITA 3.0, MITA State Self-Assessment, MITA Technical Management Strategy, MITA Data Management Strategy/AHS Data Governance Manual, MITA Concept of Operations; MMIS Concept of Operations; IE&E Concept of Operations, Medicaid Enterprise Certification Toolkit (MECT) and Medicaid Eligibility & Enrollment Toolkit (MEET), Medicaid Enterprise Certification Lifecycle (MECL) & Medicaid Eligibility & Enrollment Lifecycle (MEELC)
Recommendations & Key Roles:	Staff and contractors can both drive direction towards transformation and enable a successful implementation by providing recommendations, reviewing deliverables, and performing their responsibilities. • Examples of important key roles include, but are not limited to, Independent Verification and Validation (IV&V), Subject Matter Experts in Medicaid business, Organizational Change Management, Business Analysis, Technical

Both Drivers & Enablers:	
	Analysis, Enterprise Architecture, Testing and Quality Analysis, Project Management Office/Program and Project Management, Security, and Vendor Management
Interoperability & Access Services:	Enterprise Architects (EA) are now assigned to the Enterprise programs on a fulltime, permanent basis. The EAs will drive and enable system interoperability in several ways including the implementation of an Integration Platform (IP) (aka Enterprise Service Bus (ESB)) and providing input and recommendations on the interoperability, functionality and procurement of MMIS modules. This team is also leading an Identity and Access Management effort across the entire MMIS area to allow more complete access to modules while moving the SoV toward a true single sign-on (SSO) model. The EA team has implemented preference of cloud-first, service-oriented architecture approach to the state's procurement of modules, while allowing for exceptions to this direction when justified. These decisions lay the groundwork for modular implementations while allowing the Agency of Digital Services (ADS) to reduce the infrastructure footprint within the State's data centers.
Reuse, Collaboration & Integration:	Both a driving principle leading to transformation and can enable success • Examples of opportunities for reuse, collaboration and integration may be found intrastate, with other states, or nationally
Performance Measures:	Service level requirements/agreements, Key Performance Indicators (KPIs) can drive change in order to meet them and enable success

<table>
<tr><th colspan="2">Enablers:</th></tr>
<tr><td>Technology & Services:</td><td>Industry Standards, Emerging Technologies
Cloud Services, Service-Oriented Architecture, State Implemented IP/ESB Service and Modular Technology Implementations will all enable the SoV, its users and citizens to transform from legacy applications and architecture to modern, state-of-art seamless solutions.
Technical Assistant (TA), Customer Relationship Management (CRM) for our case management capabilities, Medicaid Data Warehouse, and Master Data Management platform will resolve data quality concerns while ensuring more accurate data, analytics and reporting.</td></tr>
<tr><td>Key Support:</td><td>CMS, and State leadership participation and support including:
CMS Regional and Central Office
Vermont Agency of Digital Services (ADS) leadership
ADS Technical Support
ADS Enterprise Architecture Team
Enterprise Program Steering Committees
AHS Secretary's Office
Department Commissioners & Deputy Commissioners
AHS Data Governance Board</td></tr>
</table>

5 To-Be Environment

The State Medicaid Agency will transform from a siloed environment with legacy systems to a modular environment with integration, interfacing, and interoperability.

Vermont is modernizing its Medicaid Enterprise (Enterprise) through the implementation of innovative, flexible, and interoperable modules. The development of Vermont's Enterprise involves enhancing MMIS, Health-IT/Health Information Exchange (HIT/HIE), and Integrated Eligibility and Enrollment (IE&E) activities to meet the core needs of each area while reaping the benefits of coordination, and reuse of technologies/capabilities where applicable. Vermont expects that the enterprise approach will reduce risks in development and operations of business process and systems, lower implementation

and maintenance costs, and improve overall quality of Medicaid systems. These efforts will also drive improved data usage and administration of our Medicaid program.

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

The development of Vermont's Enterprise is expected to provide a multitude of benefits including:

- The ability (when appropriate) to view a member's complete AHS record and understand the benefits they are receiving or may be eligible to receive.
- Provide "no wrong door" so a Vermonter can easily enter any of the Agency's inlets (online portal, in-person office meeting, etc.) and their request for assistance can be acted upon
- Provide timely and accurate programmatic reporting to maximize opportunities to leverage funding for enriched services for Vermonters.
- Provide analytical output for policy and program planning.
- Provide ability to minimize inappropriate benefit delivery.
- Support care delivery and care coordination with appropriate data and data tools

Please refer to Section 10 through 13 Maturity Profiles, the Vermont MITA State Self-Assessment (SS-A) and MITA roadmap for detailed information on the to-be environment.

The Vermont Enterprise strives to support the MITA goals:

- To implement COTS, cloud-based, seamless and integrated modules that communicate effectively to achieve common Medicaid goals through interoperability and;
- To promote an environment that is flexible, adaptable, and enables rapid response to changes in programs and technology.

Overall Enterprise To-Be Overview

- **Business Concept of Operations**: The State of Vermont will move towards more automation and away from manual processes, improving efficiency and accuracy. Improved technology and information management is leveraged for overall business process improvement, stakeholder satisfaction, and monitoring of performance.

- **Technical Concept of Operations**: The State will take advantage of new technology in replacement of legacy systems and follow the MITA Technical Management Strategy. Proposed or planned initiatives, such as Identity and Access Management (IAM) security features, a provider portal allowing for online enrollment, revalidation and changes, and a single online portal for applying for and maintaining benefits, will further improve the Vermont Enterprise's Access and Delivery capabilities. Additionally, an integration platform (IP), IAM and IE&E Uploader for verification documents will further improve the Enterprise's Intermediary and interface capabilities. An IP, Master Person Index (MPI), and Master Data Management (MDM) will contribute to improving the Enterprise's Integration and Utility capabilities.

- **Information Concept of Operations:** The State is working towards improved coordination of data and the ability to effectively and efficiently report on it. The AHS Data Governance Manual has been reused to serve as the MITA Data Management Strategy. This document and the policies planned by the AHS Data Governance Board illustrate the to-be environment for the Enterprise's data management strategy, data modeling, and data standards. The MITA Data Management Strategy is linked in the References section.

- **Standards and Conditions**: The goal is to replace legacy systems with modules that meet the standards and conditions. For more information on Vermont's plans for meeting standards and conditions, see section 8.

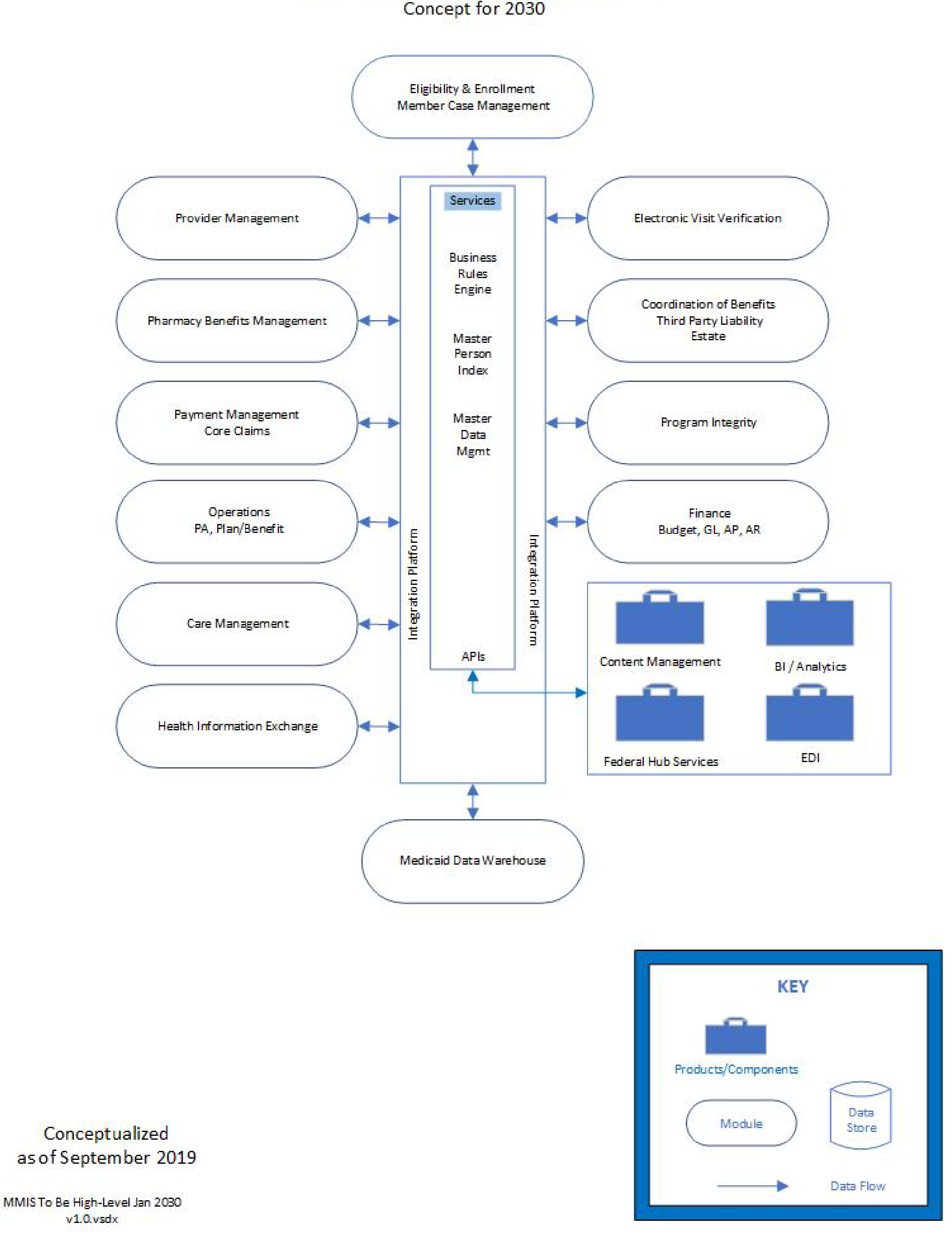
MMIS:

In the future, the Vermont MMIS integration will allow Vermont Medicaid to secure services that can interoperate and communicate without relying on a common platform or technology. The next steps for advancing the MMIS level of MITA maturity will be connecting services and infrastructures, as well as developing integration standards. When these activities are complete, the Agency will be prepared to introduce modern modules into the MMIS.

Vermont Medicaid will interoperate and integrate essential Medicaid Enterprise services and infrastructures regardless of the underlying platforms, software architectures, and network protocols. This new integration will offer greater functionality and capability over existing data exchange processes. Through increased flexibility and interoperability, the Vermont MMIS advances in MITA maturity as it moves beyond point to point data interfaces and integrates using a modern IP.

A key component of the MMIS modernization includes the design and development of Medicaid Data Warehouse and Analytics Solution (MDWAS). These data sources will include historical data, data required for real-time operational data stores, and analytical tools to access the data to provide advanced and predictive data analytics. The State will leverage OnBase as its Enterprise Content Management (ECM) system to house all digital content of MMIS modules.

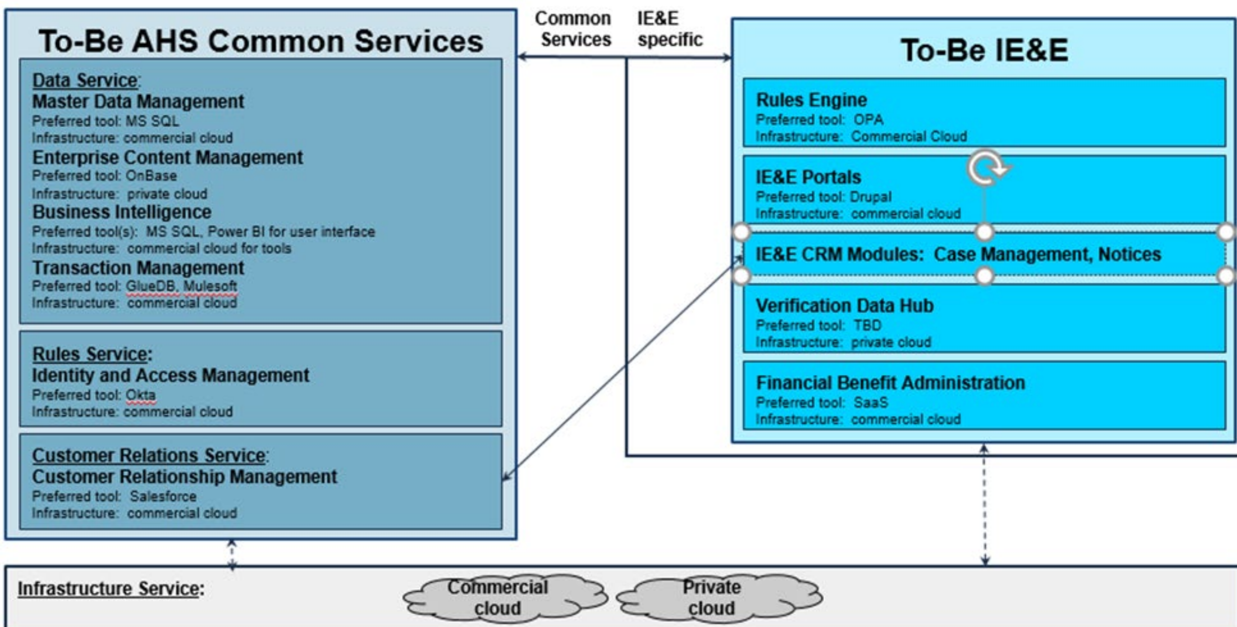
Note, there may be potential enhancements for clarity purposes in future versions of the below diagram.



IE&E:

The goal of the Integrated Eligibility and Enrollment (IE&E) Program is to allow eligible Vermonters to

apply for and receive health coverage and financial assistance benefits through a single point of access. The envisioned IE&E system will encompass eligibility and enrollment functionality for all in-scope programs. This effort will migrate and optimize eligibility and enrollment functionality for all in-scope programs from current eligibility and enrollment systems, including the State's Legacy ACCESS system and its Health Insurance Exchange, VHC.



The "To-Be AHS Common Services" depicted in the roadmap are services that are already, or will be, leveraged by programs across AHS. OnBase (Enterprise Content Management (ECM) and Microsoft SQL Server (BI) are in use today and are already leveraged by all in scope IE&E programs except QHP and MAGI Medicaid. IE&E's technical approach involves expanding their functionality to onboard these additional programs and sunsetting the associated Oracle stack components.

The SoV's technical vision for IE&E includes the following:

- Building seamless, configurable, interoperable, extensible, and maintainable systems.
- Modular and incremental modernization of system functionality.
- Leverage open standards with "low code" and highly configurable modular development.
- A preference to reuse existing SoV technology platforms where possible but open to alternatives with justification.
- Build technology that would also be reusable within and among states.

Business Area To-Be Overview

Business Relationship Management:

Maturity is planned to increase from primarily manual and organically developed processes to standardized and technology-supported processes. In order to achieve this, AHS will need to:

- Harmonize between contracting, business relationships and communications and relationship management.
- Explore standardization of Memorandums of Understanding (MOUs) and Intergovernmental Agreements (IGAs) across AHS and Statewide.
- Plan for procurement and implementation of a contracting and business relationship management system.

Care Management:

Our current system is highly automated and is better able to meet business needs improving automation, information access and therefore business outcomes. In order to further improve this process area, AHS will need to:

- Proceed with Certification of the Care Management (CM) Module.
- Continue to work on implementing ideas for reuse.
- Set up standardization of Maintenance and Operations.
- Proceed with planned Master Person Index (MPI) and Master Data Management, increasing accuracy for the CM Module.
- Continue to improve on reporting capabilities and information exchange with HIE.

Contractor Management:

Maturity is planned to increase from primarily manual and organically developed processes to standardized and technology-supported processes. In order to achieve this, AHS will need to:

- Harmonize between contracting, business relationships and communications and relationship management.
- Plan for procurement and implementation of a contracting and business relationship management system with performance management capabilities.

Eligibility and Enrollment Management:

Procurements and performance management will further enhance the existing technology support and better align with the standards and conditions. Current technology and the planned procurement of solutions that are better able to meet business needs will contribute to increasing the overall maturity levels in this business area. The Vermont IE&E Program envisions a future where eligible Vermont residents have a straightforward and convenient method to apply for, access, and manage their healthcare and economic assistance benefits. The VT-IES Project aims to enhance the customer experience for both Vermonters and State Staff by focusing on achieving the following top three outcomes:

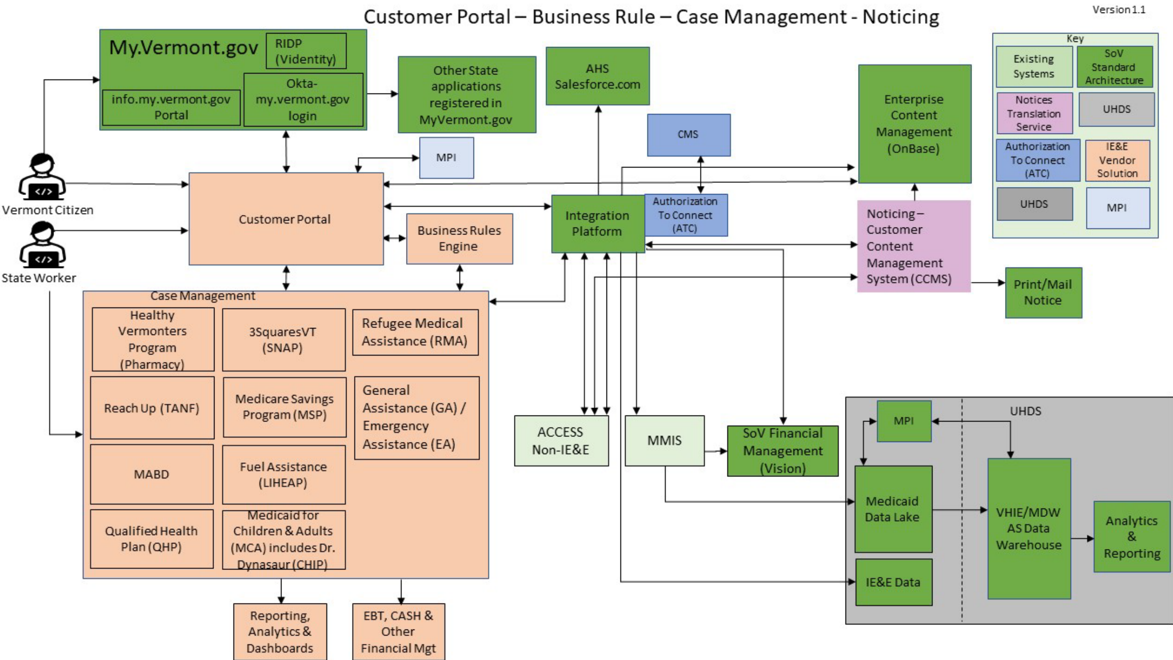
- **Simplified and Streamlined Application Process:** The VT-IES Project seeks to create a more user-friendly and efficient application process, reducing the need to submit redundant information and navigate numerous systems. This outcome aims to make it easier for individuals to apply for multiple benefits, resulting in a more cohesive and coordinated enrollment process.

- **Seamless Access to Benefits:** The project aims to ensure that eligible Vermonters can easily access the healthcare and economic assistance benefits they need without facing unnecessary hurdles. By implementing the new IES system and its functional modules, individuals will have a centralized access point that provides comprehensive information about available benefits and enables them to manage their coverage. This outcome aims to reduce confusion and provide a more user-centric approach to benefit access.

- **Improved Efficiency and Effectiveness for State Staff:** The VT-IES Project recognizes the challenges faced by State Staff in delivering services to Vermonters. By implementing a modernized system with a customer portal, case management capabilities, and a rules engine, the project aims to enhance the effectiveness and efficiency of State Staff in managing eligibility and enrollment processes. This outcome aims to reduce manual and labor-intensive tasks, enable better coordination across programs, increase data quality, and simplify procedures for State Staff, improving their ability to serve Vermonters.

In order to achieve a higher maturity level for the member enrollment and provider enrollment business categories, AHS will need to:

- Develop performance metrics and implement performance management plans.
- Proceed with modular, agile approach to Integrated Eligibility & Enrollment, delivering a streamlined E&E experience for health coverage and financial benefit programs.



Financial Management:

Procuring a new modular MMIS will enhance financial management support beyond the existing use of Excel and reliance on Fiscal Agent support. In order to achieve this, AHS will need to:

- Identify and prioritize opportunities for budgeting management and automation.
- Automate and standardize financial information management and data flows.
- Implement a budgeting tool, providing data and analysis to support planning, impact analysis and performance metrics.
- Integrate performance metrics in a Medicaid Enterprise Performance Measurement Framework.

Member Management:

Existing technology provides support that will be further enhanced by the procurement of IE and MMIS solutions including enhanced member communication and grievance, appeals and fair hearings. In order to achieve this, AHS will need to:

- Centralize and standardize grievance and appeals, providing case management support and tools.
- Develop a Member Communications Plan, defining workflows and policies for all member notices and outreach.

Operations Management:

An MMIS procurement will build on existing successes and provide enhancements to critical pieces of the business area. In order to achieve this, AHS will need to:

- Expand the scope of MMIS procurement to provide enhanced automation and standardization to all operational processes, and further align with the Standards and Conditions.
- Proceed with an integrated rules engine that will support maintenance and modification operational processing rules and will support impact analysis and performance planning.
- Proceed with an MMIS procurement that will reduce reliance of redundant functionality in disparate systems within the Agency.

Performance Management:

A PI solution will provide needed technology support, processes and business outcomes and fully automate processes where possible. Information sharing with State partners will enhance the maturity of the capabilities. Mature and extensive analytics capabilities will enhance the ability to identify and operationalize performance and operational improvements. In order to achieve this, AHS will need to:

- Procure Agency Performance Management solution that will provide a higher level of program integrity throughout the Medicaid Enterprise.
- Establish a regional collaborative to share best practices, analytics and information with State partners (i.e. New Hampshire, New York, Massachusetts).

Plan Management:

Current standardization and consolidation efforts will enhance maturity scores, and prepare the State for technology support, which will further enhance the maturity levels. In order to achieve this, AHS will need to:

- Document, communicate, and monitor Agency performance metrics to provide inputs to the planning processes.
- Provide content management and advanced policy searching and analysis tools.

- Automate aspects of Agency planning, including data collection, collaboration, and versioning, which will reduce errors and improve timeliness.

Provider Management:

Execution of the Provider Management Module (PMM) will accomplish the following:

- Proceed with certification of the Provider Management Module.
- Develop performance metrics and implement performance management plans.
- Continue to improve sharing of information with other states in region.

Pharmacy Management:

Vermont's general status is good overall for the pharmacy business area based on the as-is questions. DVHA recognizes additional needs for improvement in monitoring utilization of opioids, particularly in provider and patient level retrospective monitoring and reporting.

6 Operational Scenarios

Vermont requirements management is accomplished by first identifying the applicable solution development lifecycle for a given project and then determining the business analysis strategy for the project. This strategy encompasses requirements lifecycle management. The business analysis planning and monitoring approach (including requirements management) is documented in a Business Analysis Plan if requirements management is under control of the State, or a corresponding deliverable if requirements management is performed by a vendor partner. Project-specific methods, inputs, processes, outputs, timing, gateways, controls, tools, and requirements attributes are identified in the project Business Analysis Plan or requirements management plan. The Business Analysis Plan also specifies requirements governance, including change management and roles and authorization. Communication and stakeholder strategies may be included in the Business Analysis Plan or documented in one or more separate deliverables.

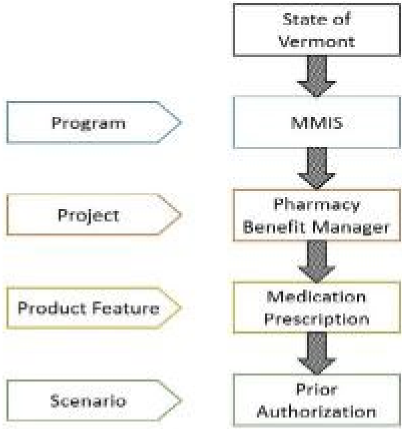
Business analysis may be executed within a prescriptive, adaptive, or hybrid framework. Regardless of the approach, requirements follow a standard set of activities for identification and development. Needs are elicited from the stakeholders to identify business, stakeholder, solution, and (where applicable) transition requirements. Draft requirements are verified through peer review to ensure adherence to quality and process standards. Verified requirements are then validated with stakeholders to ensure a complete and correct set of baseline requirements. Approved baseline requirements are subject to the project's change control process.

Tasks and outputs identified in the Business Analysis Plan are incorporated into the larger project work plan and/or work schedule. Outputs are also incorporated into the project RACI matrix which explains the different roles held by those involved in the deliverables of a project.

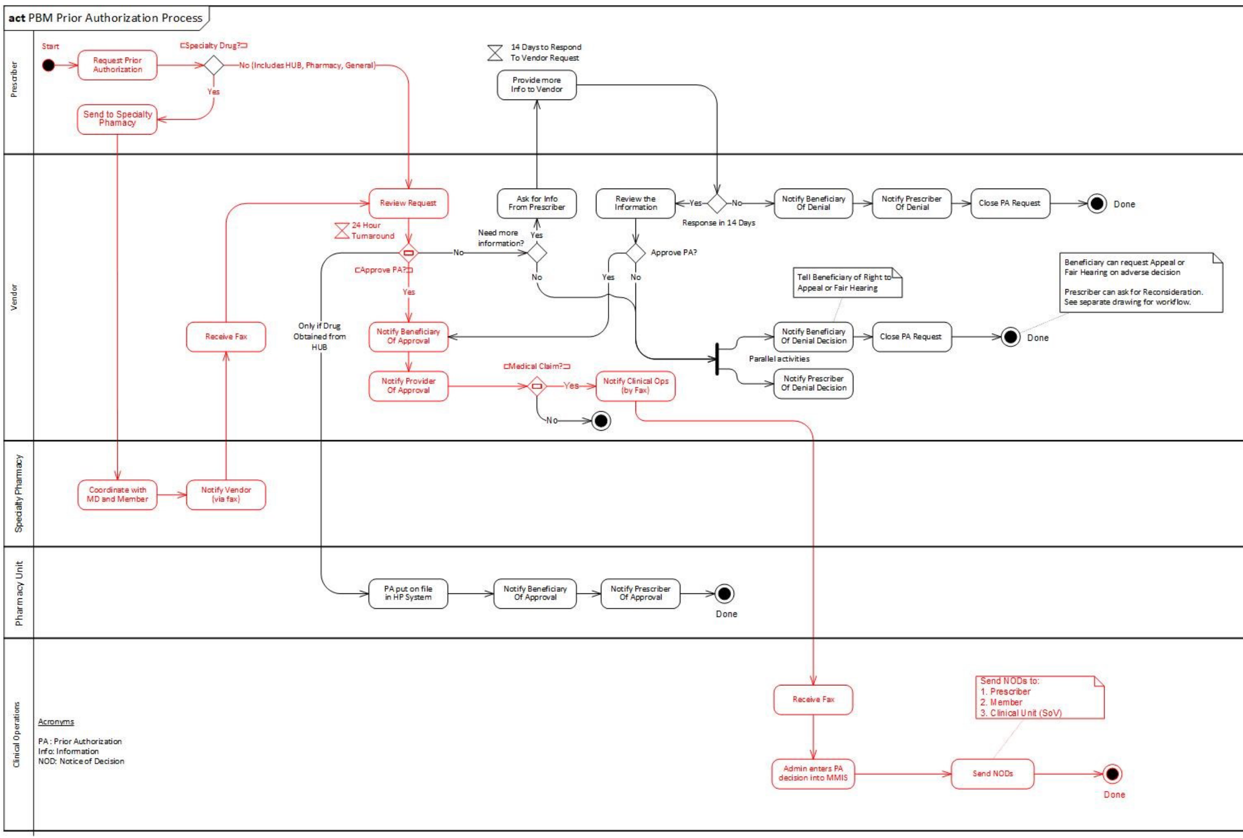
Solution work products are verified and validated against the specified requirements. The coverage of testing deliverables against requirements is documented in a requirements traceability matrix (RTM). The relationship model (i.e., RTM model) and tool are specified in the Business Analysis Plan or Requirements Management Plan. Analysis of the RTM informs gap analysis between the identified needs (requirements) and the delivered solution.

According to the MITA Framework, operational scenarios show the dynamics of the business operations from the stakeholders' point of view. The scenarios describe the what, where, when, why, and how of future SMA operations. At a high level, the Vermont Medicaid Enterprise would like to adhere as much to the MITA framework as possible. For more information, please cross reference the business processes outlined in Part I Appendix C Business Process Model Details 3.0 Update found here, https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html. The Business Process Model Details provides step-by step descriptions of how the SMA should operate.

The future state of each business area is modeled as part of the project or projects that impact that business area and its processes. Inclusion of exhaustive detailed scenario analyses is not in scope for an Enterprise-level concept of operations document. An example scenario analysis modeled as an Activity Diagram is presented below.



SCENARIO ANALYSIS



Note: Flow highlighted in RED is the main success scenario to ensure successful completion

- Goal of the Scenario:
  - Successful authorization of a prescribed procedure, service, or medication on receiving a request from a qualified provider.
- Stakeholders part of the Scenario:

Stakeholder	External (External to State of Vermont)	Internal (Internal/ within State of Vermont)
Prescriber	X	
PBM vendor	X	

Stakeholder	External (External to State of Vermont)	Internal (Internal/ within State of Vermont)
Specialty Pharmacy	X	
Pharmacy Unit		X
Clinical Operations Unit		X

- Timeline of the Scenario: Within 48 hours of receiving a review request for a prior authorization.
- Alternate path in the Scenario:
  - A Prior Authorization request is denied

7 Impacts on Stakeholders

The new Vermont Medicaid Enterprise will improve Medicaid stakeholder satisfaction. Medicaid stakeholders includes, but is not limited to, Medicaid beneficiaries, providers, CMS and other federal agencies, State of Vermont (SoV) citizens, staff from the DVHA, AHS staff, ADS staff, Agency of Education (AOE), other States, other payers, and contractors or vendors. A detailed table describing stakeholder impacts is below.

Stakeholders	Impacts
Medicaid Beneficiaries and Providers	Improved customer satisfaction by improved data quality and availability and improved service experience; improved timeliness of provider enrollment, improved provider data quality, traceable adherence to the ACA requirements and elimination of manual provider application processing and inefficiencies

Stakeholders	Impacts
CMS, Other Federal Agencies and Regulators	Improved satisfaction with Vermont's compliance with standards and conditions, improved reporting capabilities enhances knowledge and decision-making
Vermont Citizens & General Public (nationally)	Improved cost benefit/efficiency
AHS/ADS Staff	Improved efficiency and timeliness to focus on exception and performance improvement, improved data sharing and case management
AHS Secretary and Department Commissioners	Improved reporting capabilities allows for improvements in evidence-based decision making; improved stakeholder satisfaction allows more time to focus on exception and performance improvement
Vermont and Federal Legislatures	Improved satisfaction with Vermont's compliance and management of operations and IT projects; improved cost/benefit efficiency may allow for funding shifts to focus on quality and performance improvements; reporting capabilities enhances evidence-based decision making
Other States and Agencies	Improved collaboration and data sharing ability; standardized data collection and interpretation
Other Payers	Improved provider application processing and timeliness will increase provider collaboration and enrollment in the Accountable Care Organization (All-Payer model)

Stakeholders	Impacts
Contractors/Vendors	Improved understanding of Vermont's direction and requirements for contracts and certification

8 Summary of Improvements

Vermont's new Enterprise will:

- Improve the customer service experience for Vermonters.
- Improve the customer service experience for health and human services providers.
- Improve efficiency and effectiveness of Medicaid operations.
- Reduce cost using cloud-based modular implementations while enabling for more vendor independence with the implementation of smaller modules.
- Enable the SoV to actively participate in and influence tool and technology standardized selections.
- Support enhanced Master Person Index capabilities with a goal to identify and combine multiple person records into a single golden record.
- Master Data Management to track services and treatment across multiple modules and applications while identifying a single individual across multiple environments.
- Implement a modernized IP (aka Enterprise Service Bus (ESB)) to enable enhanced integration and interoperability as the SoV continues to implement modules that meet the MITA framework.

Mapping Medicaid Business Goals to MITA Goals
Improved healthcare quality and outcomes will be achieved by developing seamless and integrated systems that effectively communicate to achieve common Medicaid goals through interoperability and common standards.
Expanded access to healthcare will be achieved by promoting an environment that supports flexibility and adaptability and rapid response to changes.

Mapping Medicaid Business Goals to MITA Goals
Delivery of the right services to the right people at the right time will be achieved by promoting an enterprise view that supports enabling technologies that align with Medicaid business processes and technologies.
Increased efficiency in program administration will be achieved by providing data that is timely, accurate, usable, and easily accessible in order to support analysis and decision making for healthcare management and program administration.
Improved program accountability will be achieved by providing performance measurement for accountability and planning.

9 Standards and Conditions

#	Conditions and Standards	Vermont Approach
1.	Modularity Condition. Use a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming; and the availability of business rules in both human and machine-readable formats.	Modularity is the key design principle that drives Vermont's architecture. • Business processes, using Federal standards, including Federal Enterprise Architecture (FEA), MITA, and National Human Services Interoperability Architecture (NHSIA), are designed with common steps and interfaces and then specialized for individual programs so that as business conditions evolve the processes can be prioritized for replacement and improvement modularly. • Technical systems and applications are designed with a Service Oriented Architecture (SOA) approach. • Applications are designed to expose documented Application Programming Interfaces (APIs) that can be consumed by other parts of the system. • Model, View, and Controller are discrete elements of

#	Conditions and Standards	Vermont Approach
		design, keeping data systems (database), display (web or desktop applications), and control logic (rules engine) separated. • The principles of modularity are explicitly required by non-functional requirements (NFRs) as part of all contracted development and integration work. • Modular principles are enforced in design work on both State and vendor teams as part of acceptance process. • Vermont employs an iterative System Development Life Cycle (SDLC) process that modularly deploys functionality, continuously incorporates feedback and appreciates opportunities for improvement, and thereby, reduces risk, by being adaptive to best solutions to meet business problems at any particular moment in time. • All system interfaces will be open and documented.
2.	MITA Condition. Align to and advance increasingly in MITA maturity for business, architecture, and data.	MITA is a central design standard that drives state work and is a written requirement incorporated into contracts with implementation partners. • Business Process modeling follows the MITA functional taxonomy. • Requirements are organized and related by MITA processes. • The State Self-Assessment (SS-A) is an ongoing tool for the State to understand current state and prioritize improvement.
3.	Industry Standards Condition. Ensure alignment with, and incorporation of, industry standards; the Health Insurance Portability and Accountability Act of 1996 security, privacy and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for	All contracted work, as documented by a contract's statement of work (SOW) or statement of objectives (SOO) explicitly requires compliance to a set of federal and industry open standards including: • ADA and Section 508 Compliance • Health Insurance Portability and Accountability Act (HIPAA) • Health Information Technology for Economic and Clinical Health Act of 1996 • Privacy Act of 1974 • Patient Protection and Affordable Care Act (ACA) of 2010, Section 1561 • Safeguarding and Protecting Tax Returns and Return Information (26 U.S, C. 6130 and related provisions)

#	Conditions and Standards	Vermont Approach
	individuals with disabilities, and compliance with Federal civil rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 15691 of the Affordable Care Act.	• National Institution of Standards & Technology (NIST) Special Publications. NIST's Special Publications are available at: http://csrc.nist.gov/publications/PubsSPs.html • National Security Agency (NSA) Security Recommendation Guide
4.	Leverage Condition. Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states.	Enabled by the Modularity Standard, reuse is a key priority of the Medicaid Enterprise, whereby the same processes and technologies can be leveraged across health and human services domains when possible. By maintaining a broad design perspective, each implementation is conceived to be extensible and scalable, to bring on additional service programs as funding and development opportunities become available. Where possible the modules that are being developed for the project will leverage existing State and Agency infrastructure and systems. For instance, the Business Rules Management project begins with health-care focused programs, but the design and implementation of the rules modeling and automation tools are being made in context of the complete catalog of agency policy and programs. An Enterprise Master Client Index is being developed to ensure that client management services are deployed throughout the Medicaid and human services enterprise. Every attempt will be made to adhere to using these already existing systems with each new module developed. Where practical, it is intended that all new modules will be developed in a way that their software will be released under an open source license and could be reused by any other state or human services organization.
5.	Business Results Condition. Support accurate and timely processing of claims (including claims of	By thoroughly understanding policy and other program constraints, desired outcomes, and business functions documented as business processes, Vermont has positioned itself to understand if its business is achieving its desired result.

#	Conditions and Standards	Vermont Approach
	eligibility), adjudications, and effective communications with providers, beneficiaries, and the public.	A good example of this dynamic is the integration of the eligibility services with real time determination, verification, and enrollment with robust reporting capability. Every effort on the roadmap has specific associated business metrics. These metrics focus on employee efficiency, reduction of error rate, enhanced client experience, and additional system automation where possible. There are multiple milestones dedicated to increasing the amount of system automation. In addition, the roadmap has improvements for applicants using self-service methods for application and renewal.
6.	Reporting Condition. Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.	In order for the agency to understand if it is making progress towards its goals, compliant to the constraints governing its operations, or performing adequately to other expectations and able to recognize opportunities for improvement, robust data and reporting systems must be available to facilitate analytics. Reporting requirements, both prebuilt and ad hoc, are foundational to our project requirements, and Vermont's architecture is driven by principles of transparency and accountability that can only be realized through mature reporting capabilities.
7.	Interoperability Condition. Ensure seamless coordination and integration with the exchange (whether run by the state or federal government), and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.	The culmination of all the design standards and principles that drive the State's architecture is towards a capability of interoperability. Business and technical systems must operate seamlessly together, with high efficiency and accuracy, to enable a client-centric approach that yields a good understanding of client need and circumstances and high-capability to understand how to best meet that need. Given the mixed array of legacy and modern systems across public and private domains, it is challenging to link and exchange information. This dynamic has led to prioritization of master-data tools and indexes, identity and access, and consent management.

10 Gap Analysis

The following is a summarized gap analysis based on what has been completed for the State Self-Assessment (SS-A). The gap analysis defines the specific action needed to transform from the as-is to the to-be state. Vermont will continue to add on to the gap analysis as the SS-A is updated.

Business Architecture

CM -- Care Management

For the business processes, Establish Case (CM01), Manage Case Information (CM02), Manage Population Health Outreach (CM03), Manage Registry (CM04), Perform Screening and Assessment (CM05), and Manage Treatment Plans and Outcomes (CM06), in order to reach the To-Be levels forecasted, the Care Management area would need to have a fully automated system. SoV will need to implement more reusable business services for improved collaboration with other agencies and entities. The timeliness and accuracy of information used in the processes will need to improve. There needs to be an easy interface with other entities and agencies, such as VITL. There would also need to be an increase in efficiency, accuracy of results and improved stakeholder satisfaction.

EE -- Eligibility & Enrollment Management

For the business processes, Determine Provider Eligibility (EE05), Enroll Provider (EE06), Inquire Provider Information (EE08) and Disenroll Provider (EE07), access to data from more states will further enhance the Provider Management Module and advance maturity. This is planned in an upcoming release. Maturing of Service Level Agreements (SLAs) and the Performance Management processes may also contribute to process improvements. More automated decision-making may also improve these processes further.

FM -- Financial Management

For the business process: Manage TPL Recovery (FMO2): Automation, integration and removal of manual processes will help further mature this process in every capability question including cost effectiveness, accuracy, timeliness and efficiency. More automation will improve overall process, increase recoveries and improve quality of data received from the process. Additionally, the improvement gap for stakeholder satisfaction is specific to state staff workflow, because other stakeholders, such as beneficiaries and their families, are satisfied with this process. More automated

and modern tools to perform job duties will increase stakeholder satisfaction. Most recovery is currently payer-to-payer versus payer-to-provider, and this process has been improved further through the Payer Initiated Eligibility (PIE) project. However, any way to increase payer-to-payer recoveries further and remove exceptions, to extent possible, will improve how Vermont conducts Coordination of Benefits (COB) and allow COB to assist more beneficiaries.

For the business process, Manage Estate Recovery (FM03), Automation, to extent possible, standardization and modern technology will help further mature this process in every capability question including cost effectiveness, accuracy, timeliness and efficiency. More standardized and accepted standard information elements to allow application to application updates and the Probate System coming online for improved collaboration and coordination would improve maturity in terms of integration. The improvement gap for stakeholder satisfaction is specific to state staff workflow, because other stakeholders, such as beneficiaries and their families, are satisfied with this process. A more automated and less duplicative process would increase stakeholder satisfaction maturity.

For the business process Manage Member Financial Preparation (FM10), Maturity gaps to improve this process include increasing automation along with a more synchronized workflow and interconnections. This would alleviate staff from dedicating as much time to reconciling and resolving issues and improve efficiency along with other business capability areas. Furthermore, the ability for the State to send its own electronic transactions, such as to other payers, would improve this process. Improvements in accuracy of CMS data in accretion/Medicare Buy-In process would increase maturity in areas such as information used in process and efficiency. Additionally, improvements to the frequency and timing of the files sent and received by the State of Vermont to CMS for CMS Medicare Savings Plans, Low Income Subsidy (LIS) and other file transfers would allow benefits to be coordinated more quickly, would prevent the need for manual intervention and the BAE process, and improve the identification and correction of inaccuracies.

For the business process, Generate Financial Reports (FM19), the capability for these business processes will improve as a result of:

- More automation and less manual work
- A solution for improved Enterprise Data Storage and Analytics
- A solution for a Claims Processing Module
- Integration and unified reporting capabilities

PM -- Provider Management

For the business processes, Manage Provider Information (PM01), Manage Provider Communication (PM02), Perform Provider Outreach (PM03) and Terminate Provider (PM08), access to data from more states will further enhance the Provider Management Module and advance maturity. This is planned in

an upcoming release. Maturing of Service Level Agreements (SLAs) and the Performance Management processes may also contribute to process improvements. Additionally, more formalized processes or business rules for outreach would help improve this area.

Information Architecture

For the State to reach the overall To-Be maturity level of 2, from the current overall level of 1, much of the work will need to be done by the AHS Data Governance Council. The policies need to be established, and then followed by all project teams as they move toward updating the various modules for the Medicaid Agency. Things like data models and dictionaries will need to be used and kept up to date on a more regular basis, and data standards will need to be more official. Currently, many of the parts for a more mature Information Architecture are created but are not used to their full potential. Each module is created to conform to federal laws and regulations, but there is no policy in place that says all modules must conform to a specific set of open standards.

The Enterprise Architecture team is also currently working on assessing a web service integration platform. The implementation from MuleSoft is expected to have a trial system in 2019. This will serve as an Enterprise Service Bus.

Technical Architecture

For the category, Access and Delivery, in order for the State to achieve the maturity levels outlined in the To-Be scores, moving from an overall score of 1 to a score of 3, many new technologies need to be implemented. The current systems for the Medicaid agency are outdated and need to be updated. The State does have policies in place that outline how the Access and Delivery items should be handled, but since many of the systems still have manual processes involved, or the technology is outdated, it is not possible to apply the necessary pieces to achieve a higher score.

It is worth noting that the processes that are up and running in new environments, and systems that are not too outdated have implemented features that would allow for a higher score. Given that information the State is very hopeful in achieving the optimistic goals set forth as the To-Be scores.

For the category, Intermediary and Interface, note, it could take longer than five years for some parts of the Enterprise to mature due to the length of time to fully replace and transition from legacy systems. New modules and software applications will be closer to achieving to-be maturity or higher. Generally, continued modular replacement and introduction of modern technology will help the State improve.

The following could help improve maturity for this component:

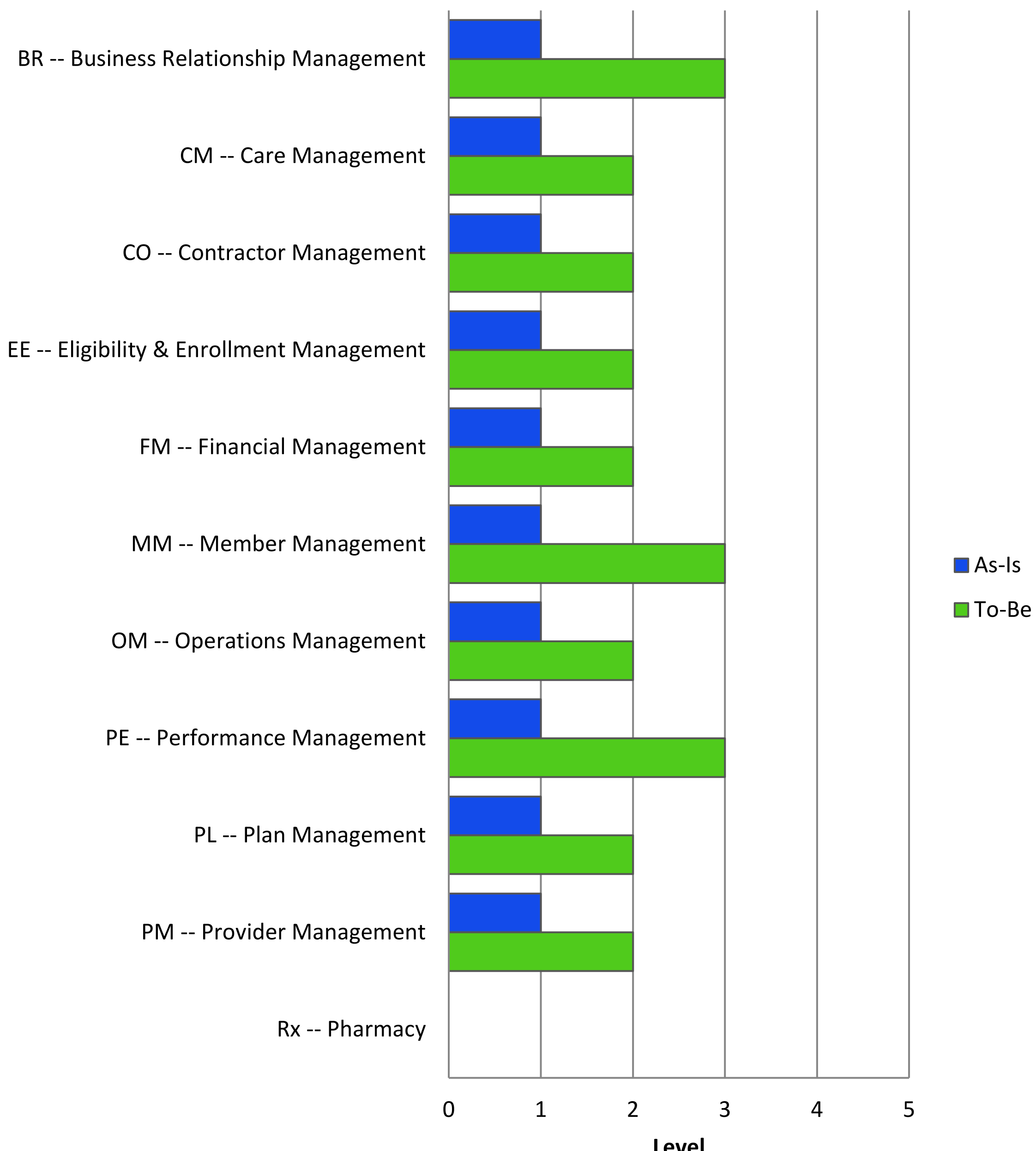
- Solution for an Integration Platform and enable Agency-wide integration, interoperability and standards for new modules, legacy applications and infrastructure to interface with one another and enable streamlined sharing of standardized data
- Further integration of the MITA Framework and conformance with Business Process Modeling (BPM) Standards
- Solution for Identity and Access Management (IAM)
- Integrated Eligibility and Enrollment's implementation of an Uploader for verification documentation (Customer Portal Phase 1)
- Continuing to move to the Agency of Digital Services' (ADS) desired file transfer mechanism (Globalscape) and a consistent method of file exchange
- Further migration to RESTful or SOAP based web services

For the category, Integration and Utility, The State has projected a to-be of level three for Decision Management, Logging and Utility. Note, it could take longer than five years for some parts of the Enterprise to mature due to the length of time to fully replace and transition from legacy systems. New modules and software applications will be closer to achieving higher maturity. Generally, continued modular replacement and introduction of modern technology will help the State improve.

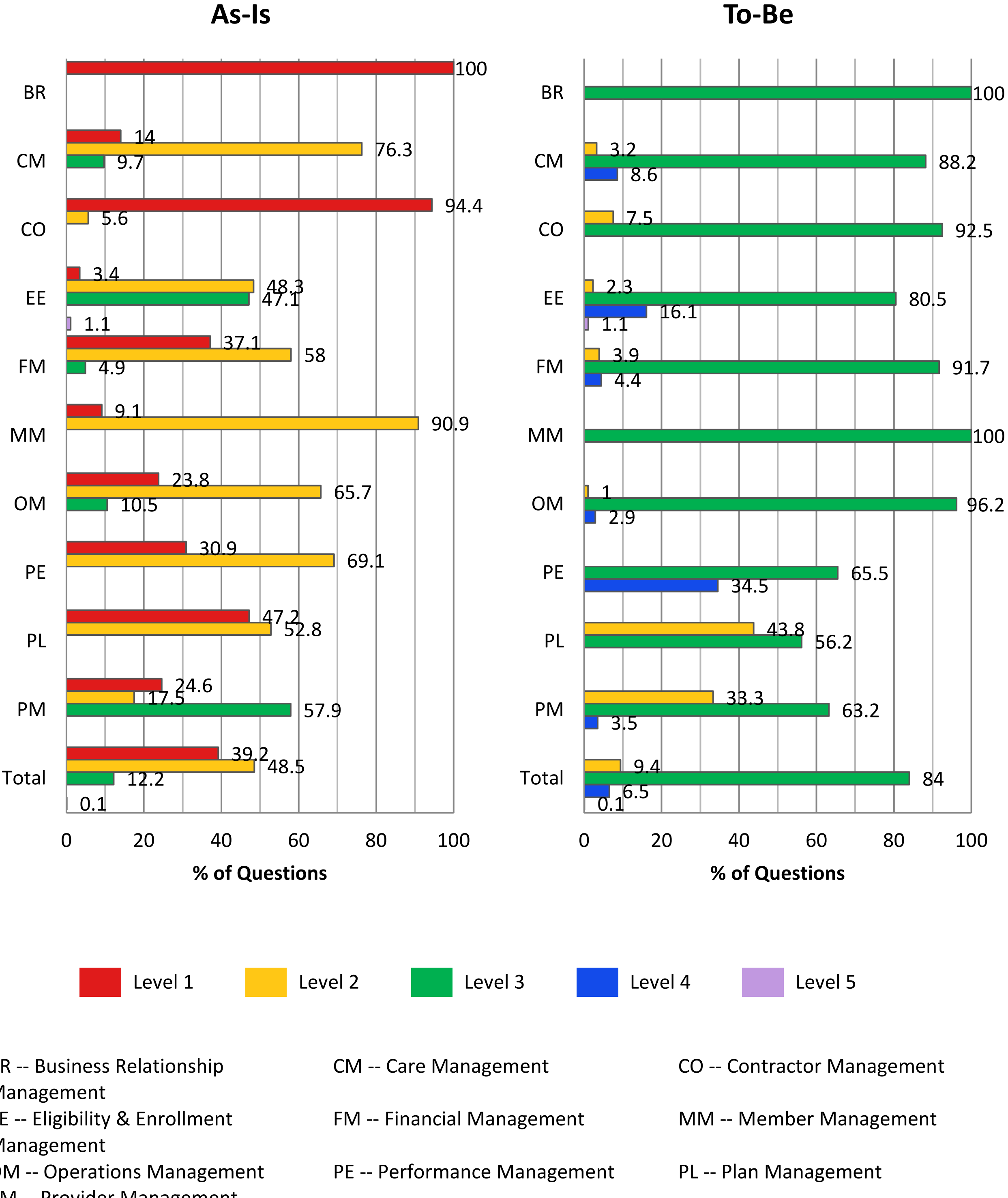
The following could also help improve maturity for this component:

- Solutions for Integration Platform and Master Person Index (MPI)
- Master Data Management (MDM) and continued maturity of AHS Data Governance Council and Policies
- Integrated Eligibility and Enrollment Customer Portal phased implementations
- Leverage replicable models for information exchange and standards from relevant implemented modules
- Business Rules Engine implementation
- Continued progress on adoption of industry standards and maturation of SDLC governance

11 Business Architecture



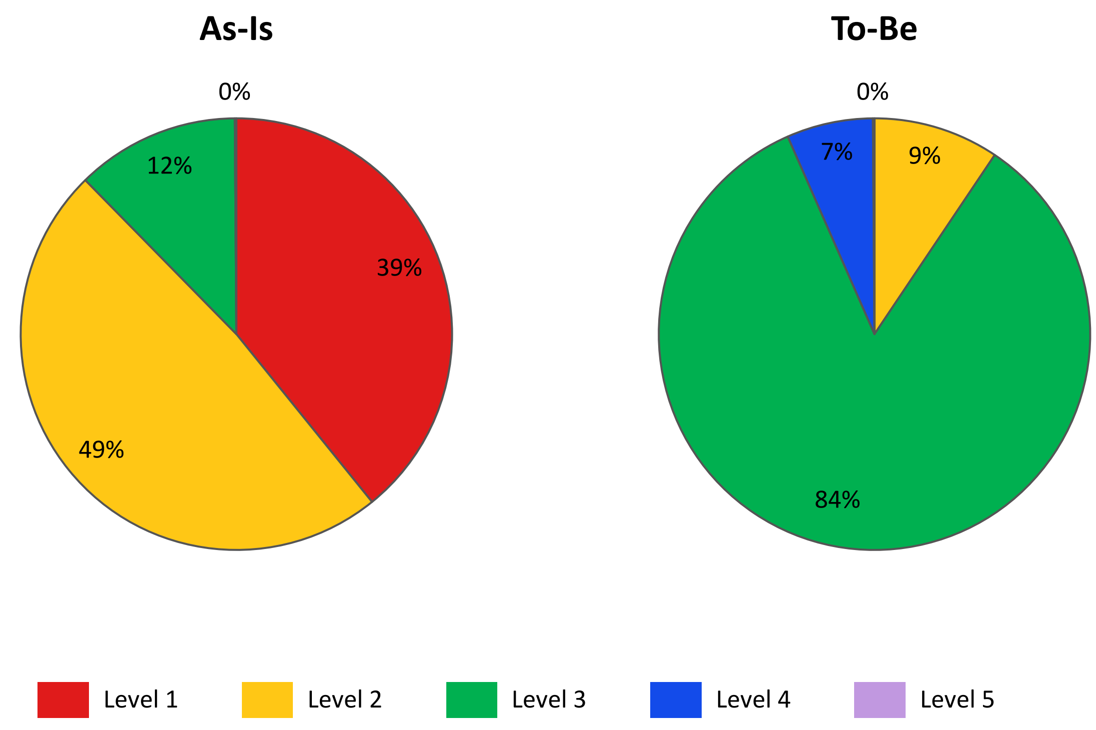
Comparison of Distribution by Business Area 2022 As Is vs. To Be



BR -- Business Relationship Management
CM -- Care Management
CO -- Contractor Management
EE -- Eligibility & Enrollment Management
FM -- Financial Management
MM -- Member Management
OM -- Operations Management
PE -- Performance Management
PL -- Plan Management
PM -- Provider Management

Capability Question Distribution by Maturity Level

	As-Is Questions		To-Be Questions	
	Number	Percentage	Number	Percentage
Level 1	333	39.2%	0	0.0%
Level 2	412	48.5%	80	9.4%
Level 3	104	12.2%	714	84.0%
Level 4	0	0.0%	55	6.5%
Level 5	1	0.1%	1	0.1%



11.1 BR -- Business Relationship Management

11.1.1 Maturity Profile

Table 1 BR -- Business Relationship Management Maturity Profile

Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
BR01	Establish Business Relationship	As-Is		To-Be		
BR02	Manage Business Relationship Communication	As-Is		To-Be		
BR03	Manage Business Relationship Information	As-Is		To-Be		
BR04	Terminate Business Relationship	As-Is		To-Be		

11.2 CM -- Care Management

11.2.1 Maturity Profile

Table 2 CM -- Care Management Maturity Profile

Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
CM01	Establish Case		As-Is To-Be			
CM02	Manage Case Information		As-Is	To-Be		
CM03	Manage Population Health Outreach		As-Is	To-Be		
CM04	Manage Registry		As-Is	To-Be		
CM05	Perform Screening and Assessment		As-Is	To-Be		
CM06	Manage Treatment Plans and Outcomes		As-Is	To-Be		
CM07	Authorize Referral	As-Is		To-Be		
CM08	Authorize Service		As-Is	To-Be		
CM09	Authorize Treatment Plan	As-Is		To-Be		

11.3 CO -- Contractor Management

11.3.1 Maturity Profile

Table 3 CO -- Contractor Management Maturity Profile

Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
CO01	Manage Contractor Information	As-Is	To-Be			
CO04	Inquire Contractor Information	As-Is	To-Be			
CO02	Manage Contractor Communication	As-Is		To-Be		
CO03	Perform Contractor Outreach	As-Is		To-Be		
CO09	Manage Contractor Grievance and Appeal	As-Is		To-Be		
CO05	Produce Solicitation	As-Is	To-Be			
CO06	Award Contract	As-Is	To-Be			
CO07	Manage Contract	As-Is		To-Be		
CO08	Close Out Contract	As-Is		To-Be		

11.4 EE -- Eligibility & Enrollment Management

11.4.1 Maturity Profile

Table 4 EE -- Eligibility & Enrollment Management Maturity Profile

Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
EE01	Determine Member Eligibility	As-Is		To-Be		
EE02	Enroll Member		As-Is	To-Be		
EE03	Disenroll Member	As-Is		To-Be		
EE04	Inquire Member Eligibility		As-Is	To-Be		
EE05	Determine Provider Eligibility		As-Is To-Be			
EE06	Enroll Provider		As-Is To-Be			
EE07	Disenroll Provider		As-Is	To-Be		
EE08	Inquire Provider Information			As-Is To-Be		

11.5 FM -- Financial Management

11.5.1 Maturity Profile

Table 5 FM -- Financial Management Maturity Profile

Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
FM01	Manage Provider Recoupment		As-Is	To-Be		
FM02	Manage TPL Recovery	As-Is	To-Be			
FM03	Manage Estate Recovery	As-Is	To-Be			
FM04	Manage Drug Rebate	As-Is		To-Be		
FM05	Manage Cost Settlement	As-Is		To-Be		
FM06	Manage Accounts Receivable Information	As-Is		To-Be		
FM07	Manage Accounts Receivable Funds	As-Is		To-Be		
FM08	Prepare Member Premium Invoice		As-Is	To-Be		
FM09	Manage Contractor Payment	As-Is		To-Be		
FM10	Manage Member Financial Participation		As-Is	To-Be		
FM11	Manage Capitation Payment	As-Is		To-Be		
FM12	Manage Incentive Payment		As-Is	To-Be		
FM13	Manage Accounts Payable Information	As-Is		To-Be		
FM14	Manage Accounts Payable Disbursement		As-Is	To-Be		
FM15	Manage 1099	As-Is		To-Be		
FM16	Formulate Budget	As-Is		To-Be		
FM17	Manage Budget Information	As-Is	To-Be			
FM18	Manage Fund	As-Is	To-Be			
FM19	Generate Financial Report	As-Is		To-Be		

11.6 MM -- Member Management

11.6.1 Maturity Profile

Table 6 MM -- Member Management Maturity Profile

Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
ME03	Perform Population & Member Outreach	As-Is		To-Be		

11.7 OM -- Operations Management

11.7.1 Maturity Profile

Table 7 OM -- Operations Management Maturity Profile

Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
OM14	Generate Remittance Advice		As-Is	To-Be		
OM18	Inquire Payment Status		As-Is	To-Be		
OM27	Prepare Provider Payment		As-Is	To-Be		
OM28	Manage Data	As-Is		To-Be		
OM07	Process Claim	As-Is		To-Be		
OM29	Process Encounter		As-Is	To-Be		
OM20	Calculate Spend-Down Amount	As-Is	To-Be			
OM04	Submit Electronic Attachment	As-Is		To-Be		
OM05	Apply Mass Adjustment	As-Is		To-Be		

11.8 PE -- Performance Management

11.8.1 Maturity Profile

Table 8 PE -- Performance Management Maturity Profile

Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PE01	Identify Utilization Anomalies	As-Is		To-Be		
PE02	Establish Compliance Incident	As-Is		To-Be		
PE03	Manage Compliance Incident Information	As-Is		To-Be		
PE04	Determine Adverse Action Incident	As-Is		To-Be		
PE05	Prepare REOMB	As-Is		To-Be		

11.9 PL -- Plan Management

11.9.1 Maturity Profile

Table 9 PL -- Plan Management Maturity Profile

Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PL01	Develop Agency Goals and Objectives	As-Is	To-Be			
PL02	Maintain Program Policy	As-Is	To-Be			
PL03	Maintain State Plan	As-Is	To-Be			
PL04	Manage Health Plan Information	As-Is		To-Be		
PL05	Manage Performance Measures	As-Is	To-Be			
PL06	Manage Health Benefit Information		As-Is To-Be			
PL07	Manage Reference Information		As-Is To-Be			
PL08	Manage Rate Setting		As-Is	To-Be		

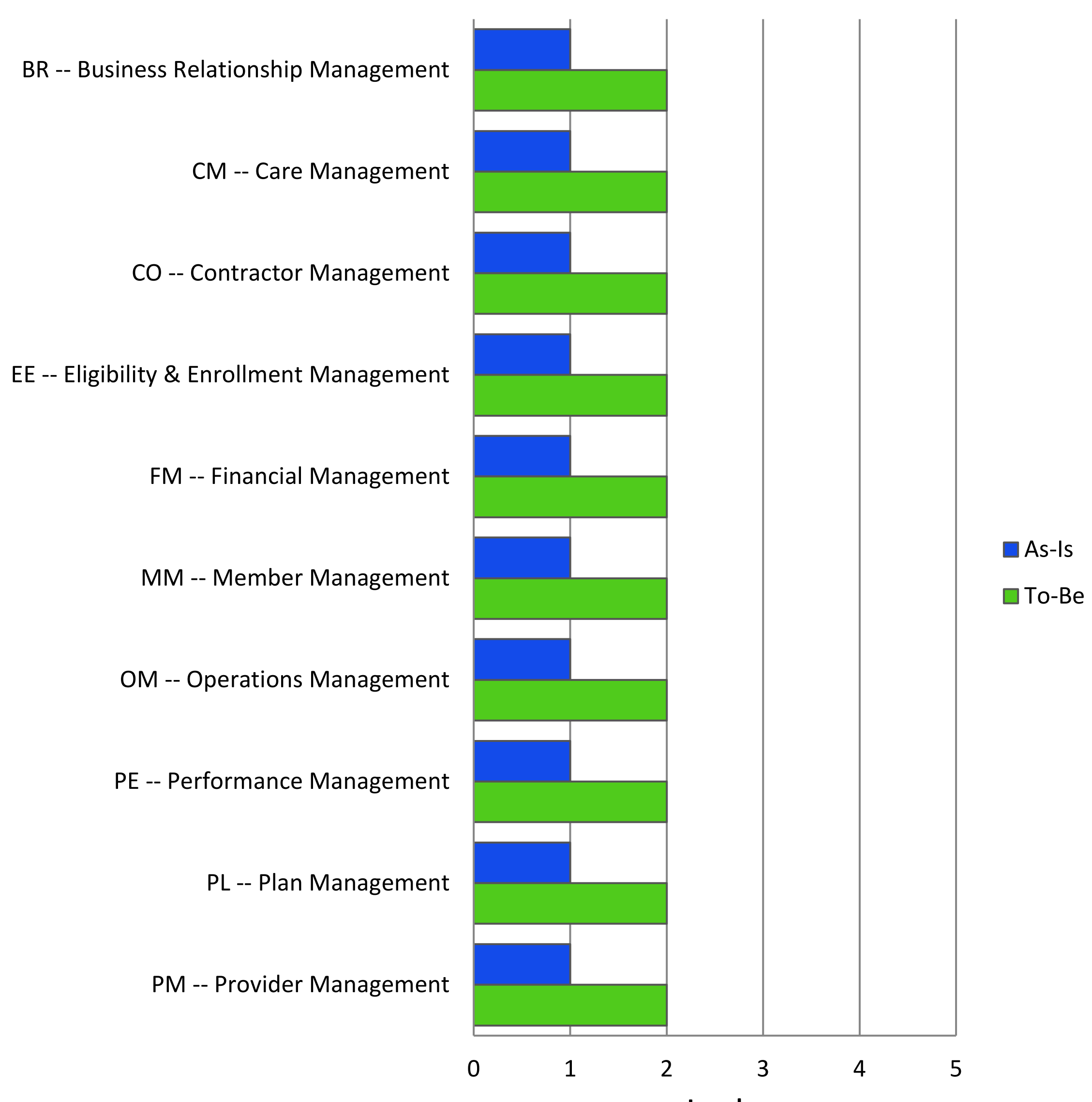
11.10 PM -- Provider Management

11.10.1 Maturity Profile

Table 10 PM -- Provider Management Maturity Profile

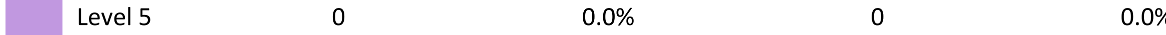
Reference	Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PM01	Manage Provider Information		As-Is To-Be			
PM08	Terminate Provider		As-Is To-Be			
PM02	Manage Provider Communication		As-Is To-Be			
PM07	Manage Provider Grievance and Appeal	As-Is	To-Be			
PM03	Perform Provider Outreach	As-Is	To-Be			

12 Information Architecture

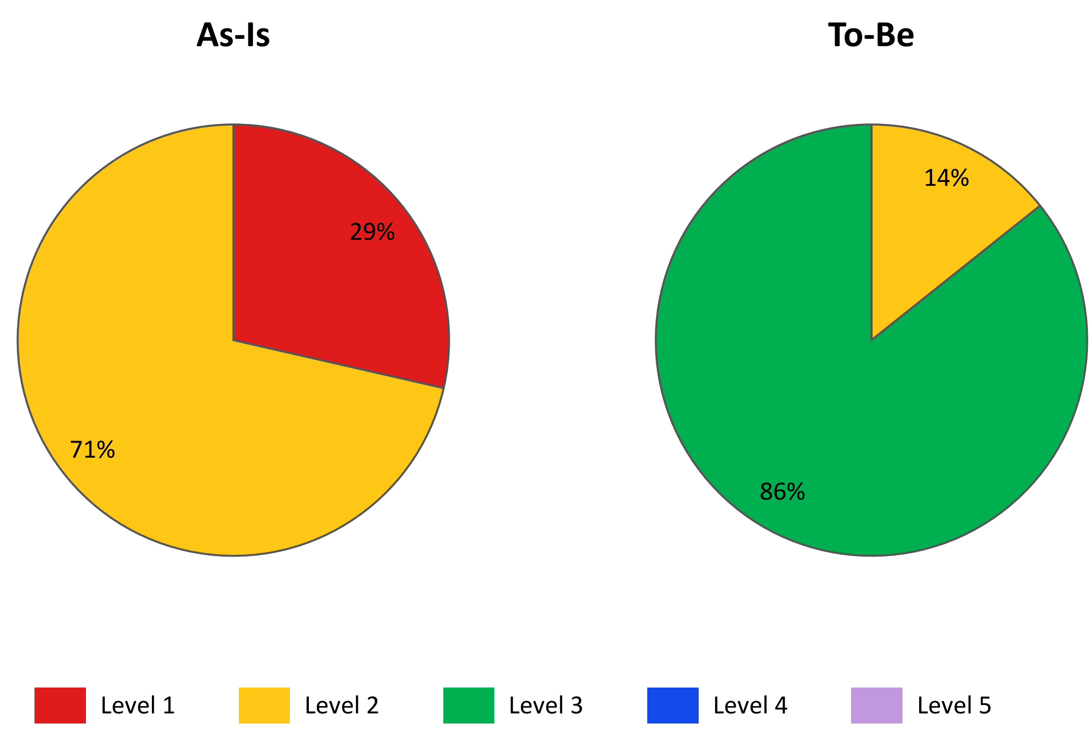


Component Question Distribution by Maturity Level

	As-Is Questions		To-Be Questions	
	Number	Percentage	Number	Percentage
Level 1	20	28.6%	0	0.0%
Level 2	50	71.4%	10	14.3%
Level 3	0	0.0%	60	85.7%
Level 4	0	0.0%	0	0.0%



Level 5	0	0.0%	0	0.0%



12.1 BR -- Business Relationship Management

12.1.1 Maturity Profile

Table 11 BR -- Business Relationship Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

12.2 CM -- Care Management

12.2.1 Maturity Profile

Table 12 CM -- Care Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

12.3 CO -- Contractor Management

12.3.1 Maturity Profile

Table 13 CO -- Contractor Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

12.4 EE -- Eligibility & Enrollment Management

12.4.1 Maturity Profile

Table 14 EE -- Eligibility & Enrollment Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

12.5 FM -- Financial Management

12.5.1 Maturity Profile

Table 15 FM -- Financial Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

12.6 MM -- Member Management

12.6.1 Maturity Profile

Table 16 MM -- Member Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

12.7 OM -- Operations Management

12.7.1 Maturity Profile

Table 17 OM -- Operations Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

12.8 PE -- Performance Management

12.8.1 Maturity Profile

Table 18 PE -- Performance Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

12.9 PL -- Plan Management

12.9.1 Maturity Profile

Table 19 PL -- Plan Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

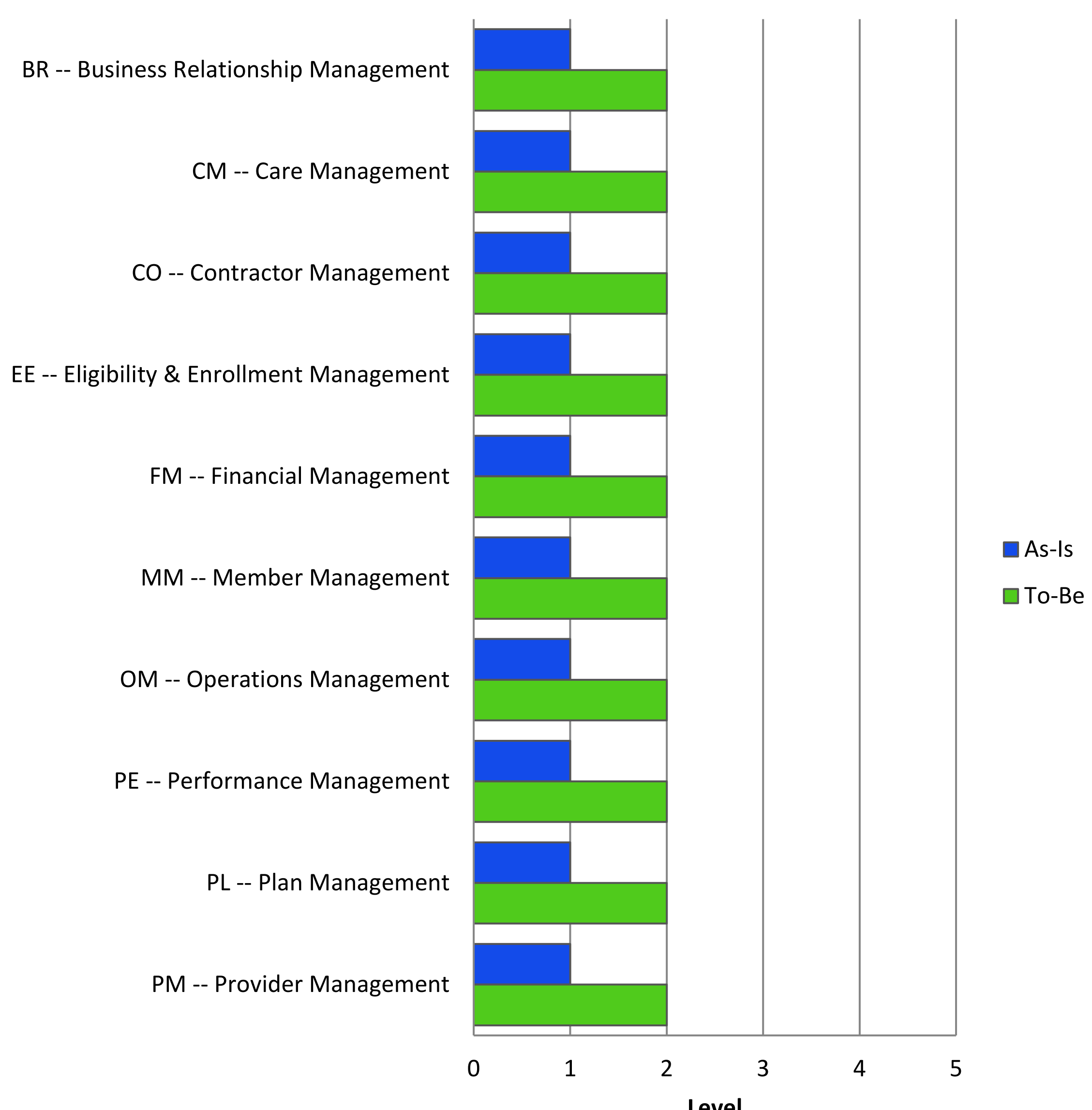
12.10 PM -- Provider Management

12.10.1 Maturity Profile

Table 20 PM -- Provider Management Maturity Profile

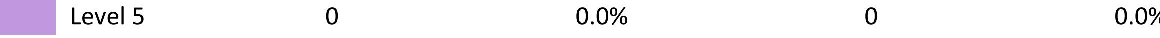
Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Data Management Strategy (DMS)	As-Is	To-Be			
	Conceptual Data Model (CDM)		As-Is	To-Be		
	Logical Data Model (LDM)	As-Is		To-Be		
	Data Standards		As-Is	To-Be		

13 Technical Architecture

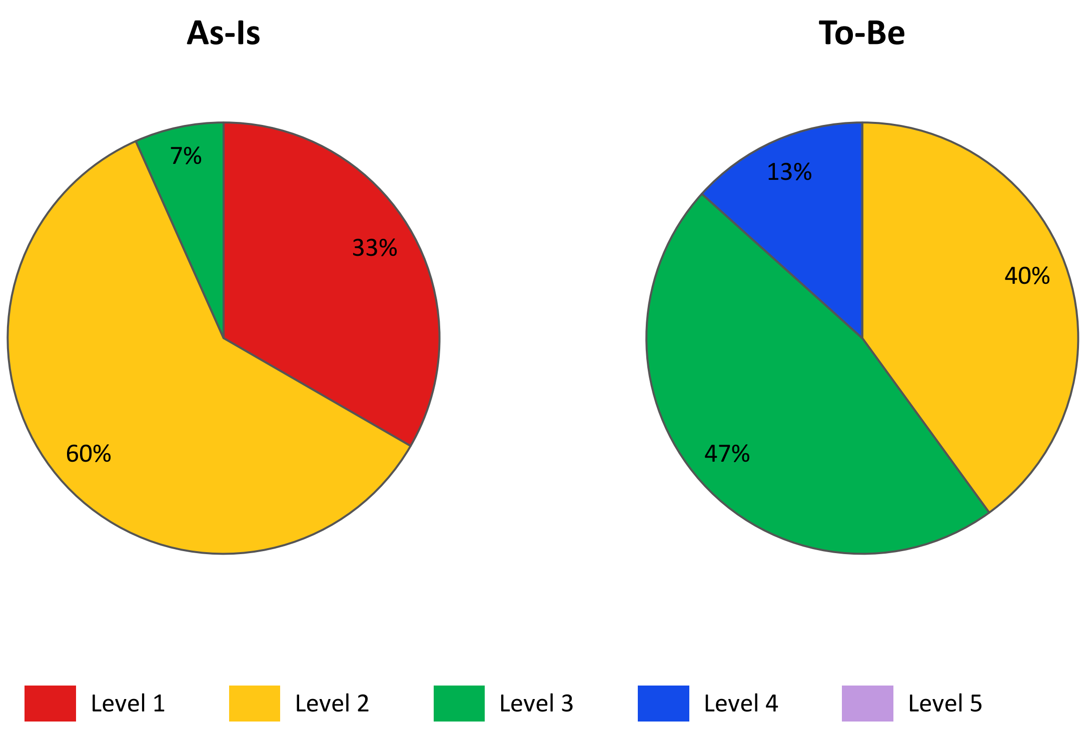


Component Question Distribution by Maturity Level

	As-Is Questions		To-Be Questions	
	Number	**Percentage**	**Number**	**Percentage**
Level 1	50	33.3%	0	0.0%
Level 2	90	60.0%	60	40.0%
Level 3	10	6.7%	70	46.7%
Level 4	0	0.0%	20	13.3%



Level 5	0	0.0%	0	0.0%



13.1 BR -- Business Relationship Management

13.1.1 Maturity Profile

Table 21 BR -- Business Relationship Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

13.2 CM -- Care Management

13.2.1 Maturity Profile

Table 22 CM -- Care Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

13.3 CO -- Contractor Management

13.3.1 Maturity Profile

Table 23 CO -- Contractor Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

13.4 EE -- Eligibility & Enrollment Management

13.4.1 Maturity Profile

Table 24 EE -- Eligibility & Enrollment Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

13.5 FM -- Financial Management

13.5.1 Maturity Profile

Table 25 FM -- Financial Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

13.6 MM -- Member Management

13.6.1 Maturity Profile

Table 26 MM -- Member Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

13.7 OM -- Operations Management

13.7.1 Maturity Profile

Table 27 OM -- Operations Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

13.8 PE -- Performance Management

13.8.1 Maturity Profile

Table 28 PE -- Performance Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

13.9 PL -- Plan Management

13.9.1 Maturity Profile

Table 29 PL -- Plan Management Maturity Profile

Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

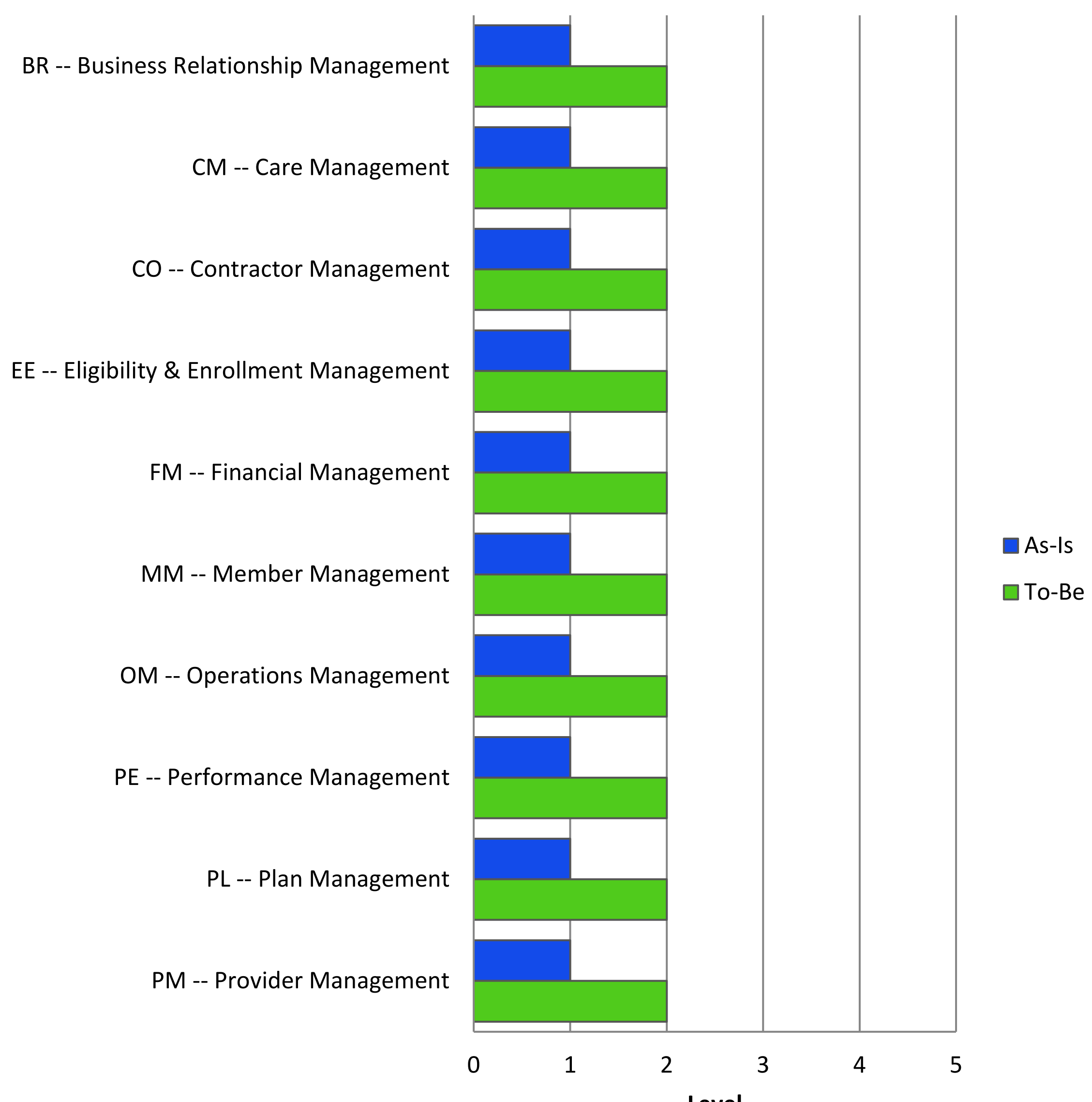
13.10 PM -- Provider Management

13.10.1 Maturity Profile

Table 30 PM -- Provider Management Maturity Profile

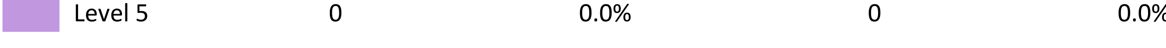
Reference	Component Metric	Level 1	Level 2	Level 3	Level 4	Level 5
	Access and Delivery	As-Is		To-Be		
	Intermediary and Interface	As-Is	To-Be			
	Integration and Utility		As-Is To-Be			

14 Standards and Conditions

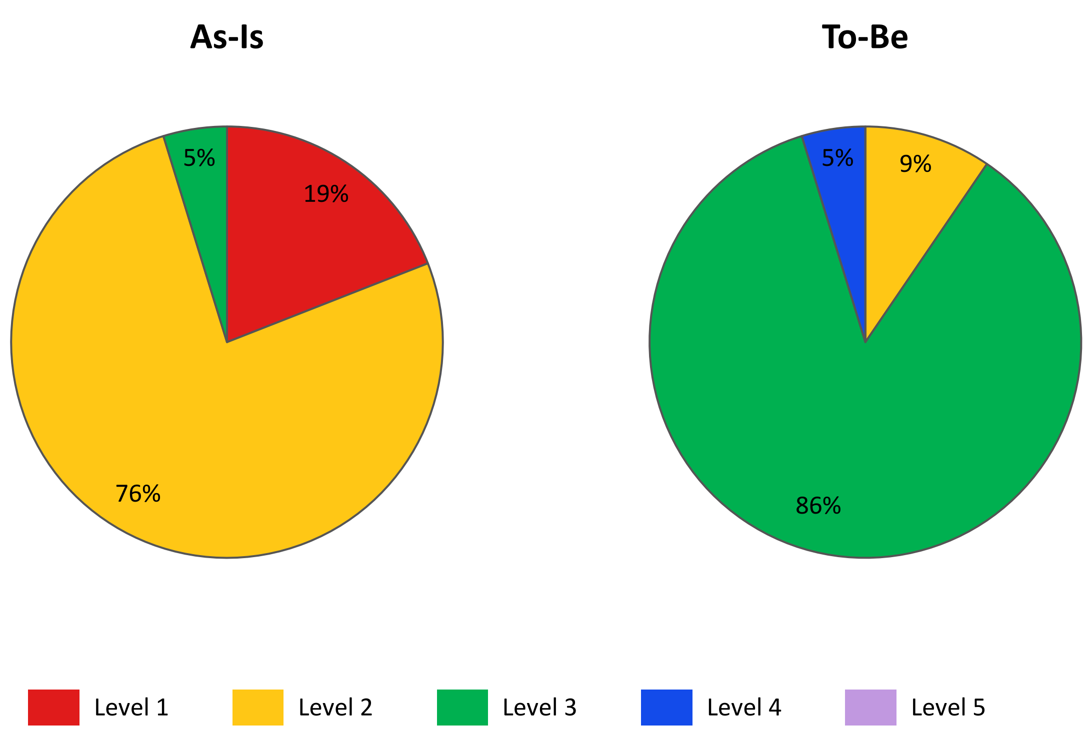


Component Question Distribution by Maturity Level

	As-Is Questions		To-Be Questions	
	Number	Percentage	Number	Percentage
Level 1	40	19.0%	0	0.0%
Level 2	160	76.2%	20	9.5%
Level 3	10	4.8%	180	85.7%
Level 4	0	0.0%	10	4.8%



Level 5	0	0.0%	0	0.0%



14.1 BR -- Business Relationship Management

14.1.1 Maturity Profile

Table 31 BR -- Business Relationship Management Maturity Profile

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

14.2 CM -- Care Management

14.2.1 Maturity Profile

Table 32 CM -- Care Management Maturity Profile

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

14.3 CO -- Contractor Management

14.3.1 Maturity Profile

Table 33 CO -- Contractor Management Maturity Profile

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

14.4 EE -- Eligibility & Enrollment Management

14.4.1 Maturity Profile

Table 34 EE -- Eligibility & Enrollment Management Maturity Profile

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

14.5 FM -- Financial Management

14.5.1 Maturity Profile

Table 35 FM -- Financial Management Maturity Profile

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

14.6 MM -- Member Management

14.6.1 Maturity Profile

Table 36 MM -- Member Management Maturity Profile

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

14.7 OM -- Operations Management

14.7.1 Maturity Profile

Table 37 OM -- Operations Management Maturity Profile

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

14.8 PE -- Performance Management

14.8.1 Maturity Profile

Table 38 PE -- Performance Management Maturity Profile

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

14.9 PL -- Plan Management

14.9.1 Maturity Profile

Table 39 PL -- Plan Management Maturity Profile

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

14.10 PM -- Provider Management

14.10.1 Maturity Profile

Table 40 PM -- Provider Management Maturity Profile

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

15 References

Links will be added once documents are finalized.

Vermont MITA State-Self Assessment (SS-A)

Vermont MMIS Program Concept of Operations

Vermont MMIS Modernization Strategy

Vermont Eligibility and Enrollment (E&E) Concept of Operations

Vermont MMIS Project Partnership Understanding (PPU)

Vermont E&E PPU

Vermont MITA Data Management Strategy

Vermont MITA Technical Management Strategy

MITA 3.0 Framework

16 Glossary of Terms and Acronyms

ACA – Affordable Care Act

ADS- Agency of Digital Services

AHS – The AHS was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within state government.

API – Application Programming Interface

BPM- Business Process Modeling

CMS – Centers for Medicare and Medicaid Services

COO – Concept of Operations

DVHA – The Department of Vermont Health Access is responsible for the management of Vermont's publicly funded health insurance programs.

EBB – Electronic Bulletin Board

EDW – Electronic Data Warehouse

E&E – Eligibility and Enrollment

EHR – The Electronic Health Record

EMR – Electronic Medical Record

ESB- Enterprise Service Bus

FEA – Federal Enterprise Architecture

HIE – Health Information Exchange

HIPAA – Health Insurance Portability and Accountability Act of 1996

IAM- Identity Access Management

IE&E – Integrated Eligibility and Enrollment

IP-Integration Platform

IV&V - Independent Verification and Validation

MAGI – Modified Adjusted Gross Income

MDM – Master Data Management

MITA – Medicaid Information Technology Architecture; an initiative to promote improvements in the Medicaid enterprise and systems that support it through collaboration between CMS and SMAs. MITA is also a framework that provides a blueprint consisting of models, guidelines, and principles to be used by states as they implement enterprise solutions.

MMIS – Medicaid Management Information System

MPI- Master Person Index

NCCI – National Correct Coding Initiative

NFR – non-functional requirements

NHSIA – National Human Services Interoperability Architecture

NIST – National Institution of Standards & Technology

NSA – National Security Agency

PBM – Pharmacy Benefits Management

PHR – Personal Health Record

PI – Program Integrity

PPU – Project Partnership Understanding

SDLC – System Development Life Cycle

SLA- Service Level Agreement

SMA – State Medicaid Agency

SOA - Service-Oriented Architecture

SOO – statement of objectives

SOV - State of Vermmont

SOW – statement of work

SS-A – State Self-Assessment

TA- Technical Assistant. Also known as Technical Assistance Consultant. Refer to MMIS Modernization Strategy or MMIS Concept of Operations for more details.

TPA – Trading Partner Agreement

VCCI – Vermont Chronic Care Initiative

VDH – Vermont Department of Health

VHC – Vermont Health Connect, refers to the Health Insurance Exchange system

VITL – Vermont Information Technology Leaders; Vermont's Health Information Exchange