NORTH HIGHLAND

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES
MEDICAID ENTERPRISE SYSTEM PLANNING

Gap Analysis Report

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Version History

Date	Author	Version	Comments
01/12/2023	North Highland	.001	Initial draft Gap Analysis Report for Executive Office of Health and Human Services (EOHHS) review
01/31/2023	North Highland	.002	Final draft Gap Analysis Report for EOHHS review
02/13/2023	North Highland	1.00	Final Gap Analysis Report
01/26/2024	North Highland	1.10	Draft Financial Management Update for EOHHS Review
2/19/2024	North Highland	2.0	Final Gap Analysis Report with Financial Management

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1 Introduction

The Executive Office of Health and Human Services (EOHHS, Agency) is Rhode Island's single state Medicaid agency, with a mission to assure access to high quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders. Through its fee-for-service (FFS) and managed care networks, EOHHS administers and facilitates the delivery of healthcare services for over 350,000 of the state's residents.

EOHHS anticipates sustained growth in both the number of Medicaid members and the cost to administer services. Additionally, Rhode Island's Medicaid Program and the policies and regulations that shape it continue to evolve and become more complex. To help address these realities and demands, the Agency seeks to transform its legacy Medicaid Management Information System (MMIS) to a modern, modular Medicaid Enterprise System (MES) which is highly scalable, adaptable, and capable of driving improvements in the efficiency and effectiveness of program operations and the experience of Medicaid members and providers.

To define a strategy and roadmap for the future MES, EOHHS has undertaken the Medicaid Enterprise System Planning Project. The project provides the Agency with important artifacts to guide planning, decision-making, and work to be completed in subsequent phases of the transformation effort, including:

- A definition of current state Medicaid business processes, technical architecture (TA), and information architectures (IA)
- An overview of viable MES approaches and product and service offerings in the market today
- A clear articulation of improvements, enhancements, and changes EOHHS would like to make to Medicaid business processes and technical and information architectures in the future
- An assessment of the gap between the current technology, information, and operational capabilities and what is needed to achieve the future state
- A roadmap and implementation plan to transition from the legacy MES to the future MES which could involve initiatives to replace, modernize, strengthen, or supplement the existing system functionality and technical and information architecture.

As with any major transformation, the move to a modular MES will not be simple or easy. However, careful planning will help ensure EOHHS implements a solution that meets its needs and the needs of Medicaid Enterprise stakeholders for years to come.

Gap Analysis

In order to design the MES roadmap and strategy, it is important to determine the changes from the As-Is and To-Be Assessments. The purpose of the Gap Analysis is to identify the functional and technical changes from the As-Is and To-Be Assessments as gaps and develop a high-level set of requirements to address these gaps.

The scope of the Gap Analysis covers gaps and high-level requirements related to functional business areas, as well as technical areas. The functional Gap Analysis includes nine key functional areas and, across these functional areas, 43 major business processes. The scope of the technical and information Gap Analysis includes all systems, applications, data repositories, and integration technology supporting the MMIS and supporting systems.

Section 2 of the Gap Analysis covers the following functional areas:

- Member Management
- Provider Management
- Claim and Encounter Processing
- Third Party Liability
- Pharmacy Drug Management
- Program Integrity
- Enterprise Data Warehouse
- Electronic Visit Verification
- Financial Management

Section 2 of the Gap Analysis introduces each functional area with a summary of the business actors and technology and tools that will apply to the future state, as well as a summary of the process improvements planned for the functional area. These summaries precede a presentation of the gaps and requirements. The gaps and requirements are presented with the corresponding as-is and to-be activity descriptions, on which the gaps are based.

Sections 3 and 4 cover the gap-analysis of the technical and information architectures. The objective is to determine the differences between current “As-Is” state and the planned “To-Be” architectures. This is a determination between the baseline architecture and the target, or between the baseline and any intervening transition architectures.

The technical gap-analysis reviews the technology, architecture, and application design aspects of the core systems and components in MMIS. Systems are analyzed and gaps identified for eight (8) key technical architecture requirements of the next generation MES. The information architecture focuses on the data, data management, data models, and data migration requirements of the future state data repositories.

Section 5 contains supplemental information, including a glossary of terms and a list of the requirements from the functional areas. The list of requirements includes all the requirements identified to cover gaps in functional areas.

The Gap Analysis is performed using the as-is and to-be business processes and technology and information architectures. The functional gap analysis identifies and describes the gaps between the as-is business processes and the optimized to-be business processes to be supported by the new MES. The results of the gap analysis are used to develop an initial set of high-level MES future-state requirements. The technical gap analysis identifies and documents gaps between the current- and future-state technical and information architectures and lists the opportunities that must be planned and executed as per the business priorities to achieve the final state.

Summary Findings

The functional gap analysis highlights the process improvement opportunities from the To-Be Assessment Report and identifies gaps between the current- and future-state at the business process level. The gaps identified inform the high-level solution requirements which will be leveraged in future MES procurement documents, tasking MES vendors to bring innovative solutions to Rhode Island's Medicaid Program. The functional gap analysis outlines the state's desire for an MES that leverages innovative solutions focused on increased automation, improved configurability, streamlined communication channels, and enhanced workflow management tools to improve the efficiency of Medicaid operations.

Key findings of the technical and information gap analysis are as follows:

- The MMIS system architecture is extremely diverse, including some antiquated systems and others that are outdated and not user friendly.
- The technology mix ranges from early generation mainframe technology to client server technology, web-based technology, and a modern technology ecosystem.
- The ease with which systems can be modified will vary across the scope of future change intentions but will be most dependent upon application architecture and associated maintainability factors.
- Custom-developed, monolithic applications contain the most gaps.
- Investments in enterprise data and analytics solutions are on the rise and best demonstrated via the agency's Data Ecosystem project.

2 Functional Gap Analysis

2.1 Member Management

Member Management functionality includes accepting Members into Medicaid FFS, enrolling and assigning Members into Managed Care Organizations (MCOs), when appropriate, managing Member information and changes, managing prior authorization requests, and disenrolling and terminating members when they become ineligible. Member management encompasses the activities and processes EOHHS and MES Vendors perform once Members have been deemed eligible for Medicaid benefits, either through Rhode Island's integrated eligibility system, RIBridges, or another method. Member management is performed primarily by EOHHS and MES Vendors.

The Member Management functional area includes the following processes:

1. Enroll and Assign Member
2. Assign to Program via Screens
3. Perform Member Merge
4. Manage Changes
5. Manage Prior Authorizations (PAs)
6. Disenroll Member / Update Plan Choice
7. Terminate Member

2.1.1 Business Actors

Exhibit 1: Member Management Business Actors includes the actors, i.e., people, vendors, and/or organizations, that support the Member Management business processes.

Actor	Description
Department of Human Services (DHS)	DHS is the State agency responsible for determining eligibility for multiple programs, including Medicaid and public assistance programs, using RIBridges.
EOHHS	EOHHS is the single State agency designated to administer the Medicaid program in Rhode Island. The EOHHS Customer Resolution Team (CRT) receives and processes Member enrollment forms.
Fiscal Agent	In the future state, EOHHS may contract with multiple vendors that will perform the functions of the current Fiscal Agent, including operations and maintenance of the MES, provider and member enrollment and support, claims processing and payment, and customer service / call center support.
Managed Care Organization (MCO)	Rhode Island contracts with MCOs ("managed care organizations," also referred to as "managed care plans") that provide comprehensive medical coverage to Medicaid Members. MCOs accept a set per member per month payment for these services and are at financial risk for the Medicaid services specified in their contracts.
Member	A Medicaid Member, or Medicaid beneficiary, is a person who has been determined to be eligible for Medicaid.

Actor	Description
Office of Healthy Aging (OHA)	OHA is Rhode Island's designated state unit on aging, advocating for older Rhode Islanders and adults living with disabilities. OHA administers homecare, daycare, and mental health services for Medicaid Members.
Prior Authorization Vendors	Prior Authorization Vendors manage prior authorizations for high-tech radiology and inpatient services for Medicaid Members
Provider / Prescriber	The physicians, hospitals, and other healthcare providers who are contracted or authorized to provide covered services to Medicaid members. A Provider is the individual providing / rendering medical and dental services for Medicaid Members. A Prescriber orders or prescribes the medical and dental services for Medicaid Members.

Exhibit 1: Member Management Business Actors

2.1.2 Technology and Tools

Exhibit 2: Member Management Technology and Tools describes the technology and tools used to perform the Member Management processes.

System Name	Description
Long Term Services and Supports (LTSS) Care Management System	The LTSS care management system is a cloud-based solution for all ancillary functions that establishes an LTSS e-record at the point of entry and provides information that follows the person as they move across agencies, providers, and the service continuum.
MCO Member portal	The MCO Member portal is a secure, internet portal used by Members managed by MCOs to manage their care including conducting searches for participating providers and updating their demographics.
MCO payer system	Each MCO uses its own payer system to receive and adjudicate claims sent by Providers for services rendered to the MCO's Members.
MES	The MES is an integrated group of subsystems / modules with open Application Programming Interfaces (APIs) which leverage an integration platform to enable interoperability with other modules. The MES is operated by a single or multiple vendors and will support EOHHS in administering the state Medicaid program.
PA Vendors' systems	PA Vendors use their systems to support the management of prior authorizations.
Prescriber's Electronic Medical Record (EMR) system	Prescribers use their EMR systems to automate, store and retrieve patient (Member) medical records.
Provider Portal	A component of the MES, Providers use the Provider Portal to access information, applications, eligibility verification, remittance advice, prior authorization, and claim status. Healthcare Providers and billing agents can enroll as a Trading Partner with Rhode Island

System Name	Description
	Medicaid. Enrollment as a new Trading Partner is completed electronically through the Provider Portal.
RIBridges	RIBridges is Rhode Island's integrated eligibility system which supports eligibility determination for Medicaid and public assistance programs in the State. The RIBridges customer portal is a secure, internet portal used by Medicaid Members to manage their care including conducting searches for participating providers and updating their demographics.
Workflow management system	The workflow management tool is a software solution that enables the automation of tasks and processes.

Exhibit 2: Member Management Technology and Tools

2.1.3 Process Improvement Opportunities

Exhibit 3: Member Management Process Improvement Opportunities describes the improvement opportunities incorporated across the to-be Member Management processes.

Opportunity	Description
Send Medicaid welcome packet	In addition to a Medicaid identification card once they are deemed eligible for Medicaid, the Member will also be sent a welcome packet with information on benefits. The Medicaid welcome packet will also be available on the EOHHS website.
Streamline MCO enrollment timelines	Streamlining MCO enrollment timelines will support simplification of the MCO enrollment process.
Send MCOs 834 file daily	Currently, the EDI 834 file is sent to MCOs daily for RIte Care and twice monthly for all other programs. In future state, the EDI 834 file will be sent daily for all programs. This change requires alignment in MCO contracts.
Receive 834 file from MCOs	The MES will receive an EDI 834 file from MCOs to capture information on individuals enrolled in Dual Eligible Special Needs Plans (D-SNPs).
Receive near real-time eligibility information	The MES will receive near real-time eligibility information from RIBridges to improve access to services for Members.
Transition mailing of "pause letter" to RIBridges	The 19-day "pause letter" which makes Medicaid Members eligible for MCO enrollment aware that they have 19 days to select a plan will be mailed by RIBridges in an effort to make this process more efficient and for member notice tracking.
Enable improved role-based configurability	The MES will have improved configurability, whereby role-based access control can be enabled to assign permissions to users based on their role.

Opportunity	Description
Implement master data management	The implementation of master data management, including a master person index will reduce the number of duplicate Member records found in the MES.
Produce master merge file on a more consistent / frequent basis	In an effort to merge Member records, the EOHHS Analytics team produces a master merge file, weekly, for review by the EOHHS CRT.
Build workflow management into the MES	Users may have the ability to manage error reports and other tasks via workflow management built into the MES.
Submit Medicaid Health Plan Change Request Forms	Medicaid Health Plan Change Request Forms should be submitted by Members and HealthSource RI (at the request of the member) only. Medicaid Health Plan Change Request Forms submitted by providers and health plans will not be accepted.
Enhance Member communications	In addition to, or instead of the communications received by mail, Members may have the option to receive communications via text, email or through RIBridges depending on their preferences. RIBridges may share communication preferences with the MES, which may reduce the paper generated by MES operations.
Leverage the Claims Portal to communicate with Providers	The Claims Portal may potentially be used by Providers as an alternative for submission of prior authorization requests and for receiving communications from EOHHS on prior authorization determinations as well as other materials.

Exhibit 3: Member Management Process Improvement Opportunities

2.1.4 Gap Analysis by Business Process

Exhibit 4: Member Management Level 0 Process Map provides a high-level depiction of the end-to-end scope and boundaries of the Member Management functional area. Note: Processes in the Level 0 Process Map may not necessarily occur in the sequential order shown.

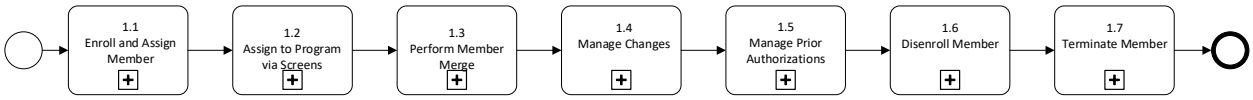


Exhibit 4: Member Management Level 0 Process Map

A gap analysis for each process is documented in the sections below, including the following information:

- **Process Description** – High-level definition of the scope and purpose of the business process
- **Gaps** – List of major changes from As-Is to To-Be assessments
- **High-level Requirements** – Statements of necessary conditions to close gaps

2.1.4.1 Enroll and Assign Member

In the future state, the Enroll and Assign Member business process describes the process to enroll and assign Medicaid Members to either the FFS program or an MCO. Rhode Island assigns approximately 90 percent of Members to three contracted MCOs. The Enroll and Assign Member process starts with receiving information into the MES from RIBridges or an automated feed from the Provider Portal once the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH) approves enrollment for the Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program. The process ends with enrolling the Member in Medicaid fee-for-service, and then enrolling the Member, if eligible, into an MCO.

Process Gaps and Requirements

Exhibit 5: Enroll and Assign Member Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Enroll and Assign Member process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The MMIS receives Home and Community Based Services (HCBS) program information from CRM and CSM via automated feeds.	The MES receives HCBS program information, including enrollments and authorizations, from the LTSS care management system via an automated feed.	The LTSS care management system sends program information, including enrollments and authorizations, for the HCBS program to the MES.	The MES will automatically receive program information, including enrollments and authorizations, for the HCBS program from the LTSS care management system. The LTSS care management system will send program information, including enrollments and authorizations, for the HCBS program to the MES.
Members are accepted in Medicaid FFS once they are deemed eligible for Medicaid. The amount of time they are in FFS depends on their program and the timing of the transaction.	Members are accepted in Medicaid FFS once they are deemed eligible for Medicaid. The amount of time they are in FFS depends on their program and the timing of the transaction. Streamlining MCO enrollment timelines will support simplification	The MES streamlines timelines for MCO enrollment and transactions to simplify the MCO enrollment process.	The MES will streamline timelines for Medicaid FFS enrollment and transactions to simplify the MCO enrollment process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
	of the MCO enrollment process.		
The Fiscal Agent mails all Members Medicaid identification cards.	RIBridges mails all Members Medicaid welcome packets, which include Medicaid identification cards. Welcome packets will also be available on the EOHHS website.	RIBridges automatically sends all new members Medicaid welcome packets, which are also available electronically for members to access.	RIBridges will mail new Medicaid member welcome packets.

Exhibit 5: Enroll and Assign Member Process Gaps and Requirements

Enroll and Assign Member to MCO

In the future state, the subprocess of enrolling and assigning a Member to an MCO is contingent upon the Member being eligible for an MCO based on program criteria. The Member can select an MCO or health plan during the eligibility process. If the Member does not select an MCO during the eligibility process, RIBridges reaches out to the Member to encourage the Member to select a plan. If the Member does not select a plan within a specific timeframe, the Fiscal Agent auto assigns the Member to a plan, and updates the MES, RIBridges, and the selected MCO with Member and/or plan information.

Process Gaps and Requirements

Exhibit 6: Enroll and Assign Member to MCO Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Enroll and Assign Member to MCO process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent receives information from RIBridges on Members eligible for MCO enrollment via 1a and 1b transactions.	The Fiscal Agent receives near real-time information from RIBridges on Members eligible for MCO enrollment via 1a and 1b transactions.	The Claim and Encounter Processing (CEP) Vendor automatically receives near-real time 1a and 1b transactions.	The MES will automatically receive near-real time Member eligibility information via 1a and 1b transactions. RIBridges will send near-real time Member eligibility information to MES via 1a and 1b transactions.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The MMIS determines the appropriate line of business, pay level, and start date for the Member, with the MCO.	The MES determines the appropriate line of business, pay level, and start date for the Member, with the MCO, on a daily basis.	The MES makes daily determinations of the appropriate line of business, pay level, and start date for the Member, with the MCO.	The MES will determine the appropriate line of business, pay level, and start date for the Member, with the MCO, on a daily basis.
If the Member selected a plan during the eligibility process, the MMIS sends the selected plan an 834 file, daily (RIteCare) or twice per month (all other programs), with the Member's information so the MCO may complete enrollment.	If the Member selected a plan during the eligibility process, the MES sends the selected plan an 834 file, daily (for all programs), with the Member's information so the MCO may complete enrollment.	If the Member selected a plan during the eligibility process, MES sends the selected MCO an 834 file with Member's information via EDI on a daily basis for the MCO to complete enrollment.	If the Member selected a plan during the eligibility process, MES will send the selected MCO an 834 file with Member's information via EDI on a daily basis for the MCO to complete enrollment. MCOs will receive and process member information via 834 files on a daily basis.
If the Member selects a plan within 19 days in response to the "pause letter," proceed to Update MMIS with plan choice. If the Member does not select a plan within that 19-day period, proceed to Member enrolled with a plan in last 60 days.	If the Member did not select a plan during the eligibility process, DHS / RIBridges mails the Member a "pause letter" asking the Member to select a plan. This "pause letter" pauses the auto-enrollment process; it does not pause or prevent the Member from receiving benefits. If the Member selects a plan within 19 days in response to the "pause letter," proceed to Update MES with plan choice. If the Member does not select a plan within that 19-day period, proceed to Member enrolled with a plan in last 60 days.	RIBridges sends the "pause letter" to Members who did not select a plan during the eligibility process.	RIBridges will send the "pause letter" to Members who did not select a plan during the eligibility process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Once the MMIS is updated with the Member's plan, the MMIS sends a file to RI Bridges with an update to the Member's plan choice, including the start date.	Once the MES is updated with the Member's plan, the MES sends a file to RIBridges with an update to the Member's plan choice, including the line of business and start date.	The MES file sent to RIBridges with the Member's plan choice also contains the line of business, in addition to the start date.	The MES file with the Member's plan choice will contain the start date and the line of business.
Not a Current State Activity	The MES will receive an EDI 834 file from MCOs to capture information on individuals enrolled in D-SNPs.	The MES will receive an EDI 834 file from MCOs to capture information on individuals enrolled in D-SNPs.	MES will receive an EDI 834 file from MCOs to capture information on individuals enrolled in D-SNPs. MCO will send EDI 834 file to MES to transfer information on individuals enrolled in D-SNPs.
Not a Current State Activity	The Fiscal Agent validates the information received from the 834 file to ensure Member eligibility. Update MES with plan choice.	The Fiscal Agent validates the information received from the 834 file to ensure Member eligibility.	The Fiscal Agent will validate the information received from the 834 file to ensure Member eligibility.

Exhibit 6: Enroll and Assign Member to MCO Process Gaps and Requirements

2.1.4.2 Assign to Program via Screens

In the future state, Members are assigned to programs via screens if program information cannot be updated via the RIBridges interface or if EOHHS or the Fiscal Agent are notified that a manual program update to a Member's record is required. If the Fiscal Agent is notified that a manual program update is required, the Fiscal Agent manually updates the program information. If EOHHS is notified that a manual program update is required, EOHHS either makes the update in the MES (REEN or LTEI screen), or they submit a workflow ticket to the Fiscal Agent with a request to update the Member's record with the correct program information.

Process Gaps and Requirements

Exhibit 7: Assign to Program via Screens Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Assign to Program via Screens process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS receives a notification that a manual program update is required. This may occur due to an issue with a transaction from RIBridges. EOHHS may also receive emails from the DHS, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Department of Children, Youth, and Families (DCYF).	EOHHS receives a notification that a manual program update is required. This may occur due to an issue with a transaction from RIBridges. EOHHS may also receive emails from DHS, BHDDH, and DCYF. Efforts will be made to automate feeds from partner agencies as much as possible to reduce the need for manual program updates.	EOHHS automatically updates program information based on various agencies' requests. The incoming emails will be streamlined using automation to allow for improved efficiency and success in updating program information.	MES will use automated workflows to support updates program information based on various agencies' requests. MES will complete program updates via automated feeds from other agencies.
If EOHHS is able to update the Member's program, the update is made in the REEN screen, with the exception of Members in nursing homes where the update is made in the LTEI screen.	Enabling improved role-based configurability, EOHHS will update the Member's program information in the MES.	MES uses role-based configuration to update Member's program information.	MES will use role-based configuration to update Member's program information.

Exhibit 7: Assign to Program via Screens Process Gaps and Requirements

2.1.4.3 Perform Member Merge

In the future state, Member merges are performed when potentially duplicate records and/or household composition changes are identified. This process begins with the Fiscal Agent receiving the merge report from RIBridges or EOHHS identifying or receiving notification of potentially duplicate records. Once EOHHS verifies the records are duplicates, they either merge the Member records in RIBridges, if possible, or contact the DHS (Tier 3) staff to complete the merge. EOHHS then updates the MES, and if the Member is enrolled in an MCO, EOHHS notifies the impacted MCO of the merge.

Process Gaps and Requirements

Exhibit 8: Perform Member Merge Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Perform Member Merge process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS identifies or receives notification from an MCO of potentially duplicate Member records. This may also include identifying changes to household composition.	EOHHS identifies or receives notification from an MCO of potentially duplicate Member records. This may also include identifying changes to household composition. The implementation of master data management, including a master person index will reduce the number of duplicate Member records found.	EOHHS implements a master data management system to support the identification of duplicate Member records.	MES will use RIBridges master person index in order to reduce duplicate Member records.

Exhibit 8: Perform Member Merge Process Gaps and Requirements

2.1.4.4 Manage Changes

Managing Member Changes encompasses the processes to Update Demographics and Request Plan Change. Exhibit 9: Manage Changes Process Diagram provides the Business Process Modeling Notation (BPMN) diagram for the to-be Manage Changes business process. The business process highlighted in yellow does not have changes associated with it and will not be discussed in this document.

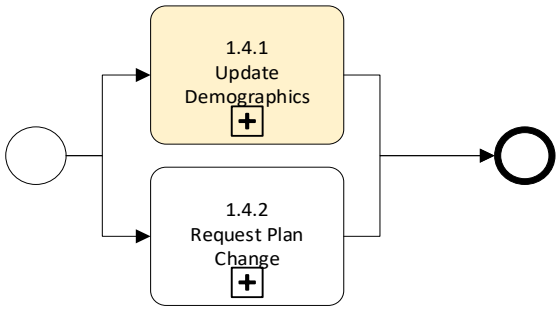


Exhibit 9: Manage Changes Process Diagram

Request Plan Change

In the future state, the Request Plan Change process occurs outside of open enrollment or the 90-day change period following initial enrollment in Medicaid. The process begins when the Member submits the plan change request form to the MCO or the EOHHS CRT. The EOHHS CRT reviews the request to change plans for “good cause” and either approves or denies the request. Requests to change plans may be approved if the Member has moved out of the health plan’s service area or lacks access to services covered under the contract, the existing health plan does not cover services due to moral or religious objections, care providers have changed their participating status to out-of-network with the health plan,

or the Member is experiencing poor quality of care. If the request is approved, the EOHHS CRT and/or Fiscal Agent processes the changes as detailed in Section 7: Disenroll Member / Update Plan Choice. If the request is denied, the EOHHS CRT notifies the Member.

Process Gaps and Requirements

Exhibit 10: Request Plan Change Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Request Plan Change process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The EOHHS Enrollment Team receives the Medicaid Health Plan Change Request Form via mail or email from a Member, Provider, Health Plan or HealthSource RI. This form must be submitted if a plan change is being requested outside of open enrollment or the 90-day change period following initial enrollment. A plan change may occur based on an eligibility category change.	The EOHHS CRT receives the Medicaid Health Plan Change Request Form via mail or email from a Member or HealthSource RI (on behalf of a Member). This form must be submitted if a plan change is being requested outside of open enrollment or the 90-day change period following initial enrollment. A plan change may occur based on an eligibility category change.	Providers and Health Plans no longer submit Medicaid Health Plan Change Request Forms.	Providers and Health Plans will no longer submit Medicaid Health Plan Change Request Forms.
If the request is denied, the EOHHS Enrollment Team notifies the Member by sending a denial letter.	If the request is denied, the EOHHS CRT notifies the Member by sending a denial letter. Members may have the option to receive communications via text, email, mail or through RIBridges.	RIBridges offers Members the option to receive communications, including denials, via text, email, and mail.	RIBridges will offer Members the option to receive communications, including denials, via text, email, and mail. RIBridges will automate Member communications based on Member preferences.

Exhibit 10: Request Plan Change Process Gaps and Requirements

2.1.4.5 Manage Prior Authorizations

In the future state, EOHHS, the Fiscal Agent and PA Vendors collaborate across the Manage Prior Authorizations processes. The State receives requests for Pharmacy, Dental, DME, Nutrition, Hearing Aids, Oxygen, Vision, and Out-of-State Inpatient Services, Homecare, Daycare, and Mental Health Services, and High-Tech Radiology and Inpatient Services. Exhibit 11: Manage Prior Authorizations Process Diagram shows the BPMN diagram for the to-be Manage Prior Authorizations process.

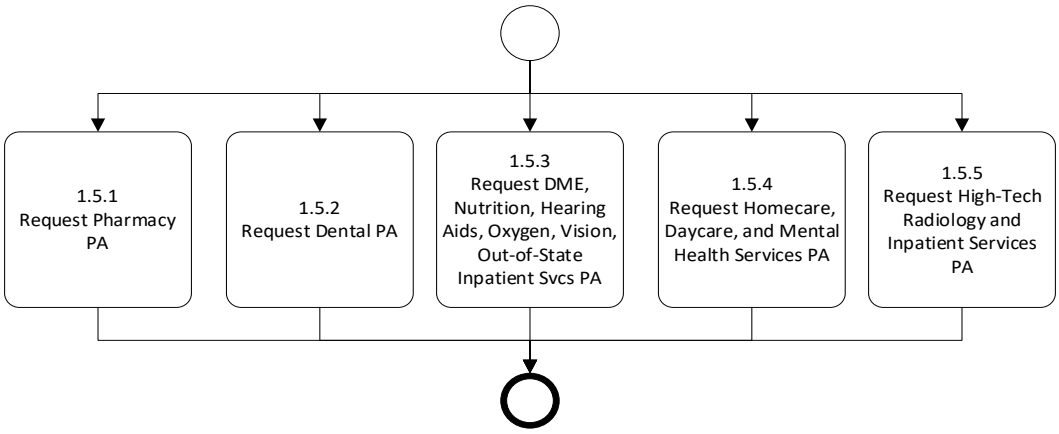


Exhibit 11: Manage Prior Authorizations Process Diagram

Request Pharmacy PA

Requests for pharmacy PAs are submitted via fax by the Prescriber. The PAs are reviewed by the Fiscal Agent's pharmacy team and/or the EOHHS Medical Director, and a determination is made and communicated to the Prescriber and/or Member.

Process Gaps and Requirements

Exhibit 12: Request Pharmacy PA Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Request Pharmacy PA process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Prescriber submits the request for prior authorization via fax.	The Prescriber submits the request for prior authorization via fax. The Claims Portal may potentially be used as an	The Prescriber may automatically submit PA requests through the Claims Portal.	The Claims Portal will be able to receive electronic PA requests from Prescribers with fax as a backup method.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
	alternative for submission of PA requests.		
The Fiscal Agent notifies the Prescriber of the approval via fax.	The Fiscal Agent notifies the Prescriber of the approval via fax. The Claims Portal may potentially be used as an alternative for communicating the approval to the Prescriber.	The Fiscal Agent automatically notifies the Prescriber of approval of the PA request via fax or Claims Portal.	The Claims Portal will be able to notify the Prescriber of PA request approval.
The Fiscal Agent gathers relevant information on the PA and the Member and sends it to the EOHHS Medical Director for review.	The Fiscal Agent gathers relevant information on the PA and the Member and sends it to the EOHHS Medical Director for review via the MES.	The Fiscal Agent automatically sends documents to the Medical Director via the MES, increasing efficiency.	The Claims Portal will use automated workflows to share documents, including PA data, between appropriate entities including EOHHS and solution vendor staff.
The EOHHS Medical Director reviews the information provided by the Fiscal Agent and provides feedback / recommendations on approval or denial of the PA.	The EOHHS Medical Director reviews the information provided by the Fiscal Agent and provides feedback / recommendations on approval or denial of the PA via the Claims Portal.	The EOHHS Medical Director shares feedback/recommendations on approval or denial of the PA via the MES, increasing automation.	The MES will use automated workflows to support capturing and sending feedback on PA approval or denial from EOHHS to Prescribers.
The Fiscal Agent notifies the Prescriber of the denial via fax. A letter is automatically generated and sent to the Member, notifying him/her of the denial.	The Fiscal Agent notifies the Prescriber of the denial via fax. The Claims Portal may potentially be used as an alternative for communicating the denial to the Prescriber. A letter is automatically generated and sent to the Member, notifying him/her of the denial. The Member may also be notified via email, text or through RIBridges.	The Fiscal Agent notifies the Prescriber of the denial through the Claims Portal to enhance communication. Once a letter is automatically generated for communicating the denial, MES sends the letter to the Member via the Member's preferred method of communication based on preferences captured in RIBridges, which may include email, text or via	The Claims Portal will be able to use automated workflows to notify the Prescriber of the denial. MES will send the denial letter to the Member via the Member's preferred method of communication based on preferences captured in RIBridges, which may include email,

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
		the RIBridges customer portal.	text or via the RIBridges customer portal.
The Fiscal Agent faxes a cover sheet to the Prescriber requesting the submission of additional clinical information.	The Fiscal Agent faxes a cover sheet to the Prescriber requesting the submission of additional clinical information. The Claims Portal may potentially be used as an alternative for communicating the denial reason to the Prescriber.	The Fiscal Agent communicates PA denial reason with the Prescriber via automated systems, which may include the Claims Portal to enhance communication.	The Claims Portal will be able to communicate PA denial reason to the Prescriber via automated systems.

Exhibit 12: Request Pharmacy PA Process Gaps and Requirements

Request Dental PA

The Request Dental PA process occurs when a Dental Provider seeks approval from EOHHS for dental services (s)he deems as necessary for the Member. The process begins when the Provider submits the PA request via fax or mail. The Fiscal Agent enters the PA into the MES in a suspended status and forwards the documents to the EOHHS for review. EOHHS makes the determination, and the Fiscal Agent enters the approval or denial information in the MES.

Process Gaps and Requirements

Exhibit 13: Request Dental PA Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Request Dental PA process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Dental Provider submits the PA request via fax or mail.	The Dental Provider submits the PA request via fax or mail. The Claims Portal may potentially be used as an alternative for submission of PA requests.	The Provider may submit the PA request through the Claims Portal to ensure receipt and enhance communication.	Claims Portal will be able to support PA submission from Providers.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent sends the documents to EOHHS via interoffice mail.	The Fiscal Agent sends the PA request to EOHHS via the MES.	The Fiscal Agent automatically sends PA request to EOHHS through the MES.	The MES will use automated workflows to support sending PA requests from Fiscal Agent to EOHHS.
EOHHS makes the determination, i.e., approves or denies the PA request, and returns the documents to the Fiscal Agent with the determination noted.	EOHHS makes the determination, i.e., approves or denies the PA request, and returns the PA request to the Fiscal Agent, via the MES, with the determination noted.	EOHHS automatically returns the PA determination to the Fiscal Agent through the MES.	The MES will use automated workflows to support sending PA determination from EOHHS to Fiscal Agent.
The Fiscal Agent enters the approval into the MMIS. The requesting Provider can view the determination via the Healthcare Portal (HCP).	The Fiscal Agent enters the approval into the MES. The requesting Provider is notified of the approval and can view the approval using the Claims Portal.	The Fiscal Agent automatically notifies the Provider of PA approval via the Claims Portal.	The Claims Portal will support automatically sending PA determination to requesting Provider.
The Fiscal Agent enters the denial into the MMIS. A letter is automatically generated and sent to the Member, notifying him/her of the denial. The requesting Provider can view the determination via the Healthcare Portal. The Provider can resubmit the PA request with additional documentation as needed.	The Fiscal Agent enters the denial into the MES. The Claims Portal may potentially be used to communicate the denial to the Provider. A letter is automatically generated and sent to the Member, notifying him/her of the denial. The Member may also be notified via email, text or through RIBridges. The Provider can resubmit the PA request with additional documentation as needed.	The Fiscal Agent may notify the Prescriber of the denial through the Claims Portal to enhance communication. Once a letter is automatically generated for communicating the denial, MES sends the letter to the Member via the Member's preferred method of communication based on preferences captured in RIBridges which may include email, text or via the RIBridges customer portal.	The Claims Portal will be able to notify the Prescriber of the denial to enhance communication. MES will send the denial letter to the Member via the Member's preferred based on preferences captured in RIBridges, which may include email, text or via the RIBridges customer portal.

Exhibit 13: Request Dental PA Process Gaps and Requirements

Request DME, Nutrition, Hearing Aids, Oxygen, Vision, and Out-of-State Inpatient Services PA

The Request DME, Nutrition, Hearing Aids, Oxygen, Vision, and Out-of-State Inpatient Services PA process occurs when a Provider seeks approval from EOHHS for services. The process begins when the Provider submits the PA request via fax or mail. The Fiscal Agent reviews and pre-screens the request. If the request passes the pre-screening, the Fiscal Agent and/or EOHHS approves or denies the PA. If the request does not pass the pre-screening, the Fiscal Agent contacts the Provider to request an update to the form and the Provider must resubmit the PA request form for consideration.

Process Gaps and Requirements

Exhibit 14: Request DME, Nutrition, Hearing Aids, Oxygen, Vision, and Out-of-State Inpatient Services PA Process Gaps and Requirements

describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Request DME, Nutrition, Hearing Aids, Oxygen, Vision, and Out-of-State Inpatient Services PA process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Provider submits the PA request via fax or mail.	The Provider submits the PA request via fax or mail. The Claims Portal may potentially be used as an alternative for submission of PA requests.	Providers submit the PA request via fax, mail, or the Claims Portal to ensure receipt.	The Claims Portal will be able to support PA submission via Provider's preferred means of communication, which may include fax, mail, or email.
The Fiscal Agent denies the PA request and a letter is automatically generated and sent to the Member, notifying him/her of the denial. The Fiscal Agent notifies the Provider of the denial via fax or mail.	The Fiscal Agent denies the PA request and a letter is automatically generated and sent to the Member, notifying him/her of the denial. The Member may also be notified via email, text or through RIBridges. The Fiscal Agent notifies the Provider of the denial via fax or mail. The Claims Portal may potentially be used to communicate with the Provider.	The Fiscal Agent notifies Providers of denials via fax, mail, email, or the Claims Portal. The Fiscal Agent notifies Members via mail, email, text, or the RIBridges Customer Portal.	The Claims Portal will be able to notify Providers of PA denials via the Provider's preferred means of communication, which may include fax, mail, or email. MES will notify Members of PA denials via the Member's preferred means of communication, including mail, email, text, or the RIBridges Customer Portal.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent sends the PA request and any relevant supporting information to EOHHS.	The Fiscal Agent sends the PA request and any relevant supporting information to EOHHS via the MES.	The Fiscal Agent sends PA request and supporting documents automatically via the MES.	The MES will be able to send PA requests and supporting documents from Fiscal Agent to EOHHS.
The Fiscal Agent sends a request to the Provider, via fax or mail, to update / correct the form.	The Fiscal Agent sends a request to the Provider, via fax or mail, to update / correct the form. The Claims Portal may potentially be used to communicate with the Provider.	The Fiscal Agent requests PA updates or correction from Providers via Provider's preferred means of communication, which may include fax, mail, email, or the Claims Portal.	The Claims Portal will be able to support sending PA updates or correction requests to Providers via Provider's preferred means of communication, which may include fax, mail, or email.

Exhibit 14: Request DME, Nutrition, Hearing Aids, Oxygen, Vision, and Out-of-State Inpatient Services PA Process Gaps and Requirements

Request Homecare, Daycare, and Mental Health Services PA

The Request Homecare, Daycare, and Mental Health Services PA process occurs when a Provider seeks approval, through OHA, to provide homecare, daycare, and mental health services. The process begins when the Fiscal Agent receives a request for authorization from OHA. OHA sends approved PAs to the Fiscal Agent so the Fiscal Agent can key the approved PAs into the MES.

Process Gaps and Requirements

Exhibit 15: Request Homecare, Daycare, and Mental Health Services PA Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Request Homecare, Daycare, and Mental Health Services PA process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent receives an authorization request from OHA via a weekly spreadsheet. This spreadsheet contains PAs that have been approved by OHA.	The Fiscal Agent receives an authorization request from OHA. While this is currently sent via a weekly spreadsheet which includes PAs that have been approved by OHA, there is the potential to	OHA sends the Fiscal Agent authorization requests via an automated feed, depending on OHA capabilities.	OHA will send an automated feed of authorization requests to the MES depending on OHA capabilities. The MES will be able to

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
	send authorization requests via an automated feed.		receive an automated feed of authorization requests from OHA depending on OHA capabilities.
The Fiscal Agent keys the approved PA into the MMIS.	The Fiscal Agent keys the approved PA into the MES. If the MES is able to receive an automated feed from OHA, approved PAs would no longer need to be keyed into the MES.	The Fiscal Agent no longer manually keys in approved PA into the MES due to automated feeds from OHA.	OHA will send an automated feed of authorization requests to the MES. The MES will be able to receive an automated feed of authorization requests from OHA depending on OHA capabilities.

Exhibit 15: Request Homecare, Daycare, and Mental Health Services PA Process Gaps and Requirements

Request High-Tech Radiology and Inpatient Services PA

The Request High-Tech Radiology and Inpatient Services PA process occurs when a Provider seeks approval to provide high-tech radiology and inpatient services to Medicaid Members. The process begins when the PA Vendor receives a PA request and makes the determination. If the PA request is approved, the PA Vendor uploads the PA file to a secure FTP site, where it is retrieved and uploaded to the MES. If the PA request is denied, the PA vendor notifies the Provider of the denial.

Process Gaps and Requirements

Exhibit 16: Request High-Tech Radiology and Inpatient Services PA Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Request High-Tech Radiology and Inpatient Services PA process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
If the PA is denied, IPRO notifies the Provider of the denial via email. Evicore notifies the Provider of the denial via fax and mail.	If the PA is denied, the PA Vendors notify the Provider of the denial via email, fax, or mail. The Claims Portal may potentially be used to	The PA Vendor(s) automatically notifies the Provider of PA denial via Provider's preferred means of communication, which may include fax,	The PA Vendor(s) will automatically notify the Provider of updates via Provider's preferred means of communication, which may include fax,

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
	communicate the denial to the Provider.	mail, email, or the Claims Portal.	mail, email, or the Claims Portal.

Exhibit 16: Request High-Tech Radiology and Inpatient Services PA Process Gaps and Requirements

2.1.4.6 Disenroll Member / Update Plan Choice

In the future state, disenrolling a Member may occur if the Member is no longer eligible for participation in a particular program due to a change in circumstances, or if the Member's continued enrollment seriously impairs the plan's ability to provide services to either the Member or to other Members or if a plan change request was approved. The Disenroll Member / Update Plan Choice process begins with the Fiscal Agent being notified of a change in the Member's eligibility, EOHHS receiving a paper form requesting disenrollment of a Member, or a Medicaid Health Plan Change Request Form being approved. If the Fiscal Agent receives notification of an eligibility change via a transaction, the Fiscal Agent then notifies the health plan of the disenrollment via an EDI 834 transaction. If EOHHS receives a paper form or the Medicaid Health Plan Change Request Form is approved, EOHHS either updates the MES or submits a workflow ticket to process the enrollment changes. The impacted health plan(s) are then notified of the enrollment changes via an EDI 834 transaction.

There are specific instances where providers or health plans / MCOs may request plan changes:

- Health plans / MCOs may request disenrollments for dual eligibles when they are being enrolled in the dual eligible program.
- Health plans / MCOs may request disenrollments "with cause."
- Providers (nursing homes) may request disenrollments for payment purposes.
- Providers or health plans / MCOs may request PACE disenrollment as needed.
- Authorized representatives are sometimes providers and may request plan changes on the Member's behalf.

Process Gaps and Requirements

Exhibit 17: Disenroll Member / Update Plan Choice Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Disenroll Member / Update Plan Choice process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent notifies the impacted health plan(s) of enrollment changes via EDI 834 transactions.	The Fiscal Agent notifies the impacted health plan(s) of enrollment changes via a daily EDI 834 transaction.	The Fiscal Agent automatically notifies impacted health plans of enrollment changes on a daily basis via the MES.	MES will support daily EDI 834 notification of enrollment changes to impacted health plans.
EOHHS updates the MMIS with an end date to disenroll the Member from his/her existing plan/program. If a request for a plan change has been approved, EOHHS also enrolls the Member in a new plan.	Enabling improved role-based configurability, EOHHS updates the MES with an end date to disenroll the Member from his/her existing plan/program. If a request for a plan change has been approved, EOHHS also enrolls the Member in a new plan.	MES uses role-based configuration to update end date to disenroll Members and enroll Members in new plan.	MES uses role-based configuration to update end date to disenroll Members and enroll Members in new plan.

Exhibit 17: Disenroll Member / Update Plan Choice Process Gaps and Requirements

2.1.4.7 Terminate Member

In the future state, the Terminate Member process occurs when the Member is deemed ineligible for Medicaid through to the point of terminating the Member in the MES. The process begins either with the receipt of new eligibility information in RIBridges or EOHHS determining the Member is ineligible. If the eligibility information is updated in RIBridges, the transaction is sent to the MES via the daily eligibility file and the MES processes a 4b transaction to terminate the Member in the MES. If the process begins with EOHHS determining the Member is ineligible, EOHHS may send the information to DHS with a request to update RIBridges if that update has not yet been made, or EOHHS may submit a workflow ticket to the Fiscal Agent to terminate the Member. The Fiscal Agent will then process the workflow ticket, terminating the Member in the MES.

Process Gaps and Requirements

The Provider Management function is performed by the Provider Management Vendor(s) and EOHHS and includes Provider eligibility, enrollment, and disenrollment, as well as the management of Provider information, inquiries, communications, and grievances and appeals.. Exhibit 18: Terminate Member Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for Terminate Member process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The EOHHS Enrollment Team resolves errors from the daily error report, adding an end date, thereby terminating the Member in the MMIS.	The EOHHS CRT resolves errors from the daily error report.	EOHHS CRT no longer manually adds an end date to resolve errors from the daily error report and terminate the Member in the MES.	MES will allow EOHHS CRT to resolve errors in the daily error report.
The EOHHS Enrollment team completes and submits a Fiscal Agency Control Number (FACN) to the Fiscal Agent, requesting that the Fiscal Agent terminates the Member in the MMIS.	The EOHHS CRT terminates the Member in the MES	EOHHS CRT terminates the Member in the MES, rather than using FACN to request Fiscal Agent to terminate the Member.	MES will allow EOHHS CRT to terminate Members.

Exhibit 18: Terminate Member Process Gaps and Requirements

2.2 Provider Management

The Provider Management function is performed by the Provider Management Vendor(s) and EOHHS and includes Provider eligibility, enrollment, and disenrollment, as well as the management of Provider information, inquiries, communications, and grievances and appeals.

The Provider Management functional area includes provider enrollment and provider management business processes, including:

1. Determine Provider Eligibility Fee Requirement
2. Determine Provider Eligibility and Enrollment
3. Manage Provider Information Inquiry
4. Manage Provider Information
5. Manage Provider Communication
6. Disenroll Provider
7. Manage Provider Enrollment and Revalidation Grievance/Appeal

2.2.1 Business Actors

Exhibit 19: Provider Management Business Actors includes the actors, i.e., people, vendors, and/or organizations that support the Provider Management business processes.

Actor	Description
EOHHS	EOHHS is the single State agency designated to administer the Medicaid program in Rhode Island.
Provider Vendor(s)	EOHHS will contract with one or more vendors to provide Provider Enrollment and Management services. The functions may be procured as part of a contract that includes only the Provider Enrollment and Management functions or a contract that includes the Provider Management functions as well as other MES functions.
Provider	The physicians, hospitals, and other healthcare Providers who are contracted or authorized to provide covered services to Medicaid members. A prospective Provider is a provider who is applying to be in the Medicaid program.
Provider Services	Provider Services is responsible for updating and maintaining Provider data storage producing Provider reports, allowing online access to Provider data. The functions may be internal or procured as part of a contract that includes only the Provider Management functions or a contract that includes the Provider Management functions as well as other MES functions.

Exhibit 19: Provider Management Business Actors

2.2.2 Technology and Tools

Exhibit 20: Provider Management Technology and Tools describes the technology and tools used to perform the Provider Management processes.

System Name	Description
Provider Portal	A component of the MES, Providers use the Provider Portal to access information, applications, eligibility verification, remittance advice, prior authorization, and claim status. Healthcare Providers and billing agents can enroll as a Trading Partner with Rhode Island Medicaid. Enrollment as a new Trading Partner is completed electronically through the Provider Portal. The functions may be procured as part of a contract that includes only the Provider Management functions or a contract that includes the Provider Management functions as well as other MES functions.
MES	MES manages the State's Medicaid program. MES supports Provider Enrollment and Provider Management by receiving new enrollment, reenrollment, and revalidation applications from Provider Portal, communicating with Providers regarding fees and application status, validating applications, and storage of Providers applications decision and data profile information. The functions may be procured as part of a contract that includes only the Provider Management functions or a contract that includes the Provider Management functions as well as other MES functions.

System Name	Description
Workflow Management System	The workflow management tool is a software solution that enables the automation of tasks and processes.
Office of Inspector General (OIG) Search	The OIG Website Search identifies individuals or entities that have been excluded from participation in Medicare, Medicaid, or other federal healthcare programs. When/if an individual or an entity is restored back to the program and the exclusion is lifted, the individual or entity is removed from the list. The OIG maintains and updates the list monthly, and it includes name, Provider type, state, authority, and Social Security Number (SSN) or Employer Identification Number (EIN).

Exhibit 20: Provider Management Technology and Tools

2.2.3 Process Improvement Opportunities

Exhibit 21: Provider Management Process Improvement Opportunities summarizes the major changes highlighted in the gap analysis.

Opportunity	Description
Conduct centralized credentialing	Conduct credentialing of all Medicaid Providers, including for all managed care organizations, in one module and by one entity. This will eliminate redundant credentialing by individual managed care organizations for the same Provider.
Improve engagement with Provider community	Leverage technology to communicate with Providers in more and better ways by enhancing the Provider Portal to increase transparency around enrollment applications, claims, and grievances. This also includes automatic, periodic revalidation of profile information using the Provider Portal.
Improve Provider onboarding process	Automate back-office processes for processing Provider enrollment applications, centralize credentialing, and expand use of Provider Portal for documentation and correspondence.
Eliminate paper applications	End the use of paper applications and move all future provider enrollment applications to Provider Portal.
Improve Provider Portal	Expand functionality for bidirectional communication of enrollment-related documents and correspondence, fee payments, and grievances.
Implement Provider dashboard	Implement Provider-facing dashboard summarizing Provider interactions with the Medicaid programs, including enrollment status, fee payments, information inquiries, and grievance status.
Configure enrollment standards by Provider type	Implement Provider enrollment business rules in human and machine-readable forms that are flexible enough to account for state certification standards and role-based to configure at the level of Provider type.

Exhibit 21: Provider Management Process Improvement Opportunities

2.2.4 Gap Analysis by Business Process

Each process is documented separately in the sections below. Exhibit 22: Provider Management Level 0 Process Map provides a high-level depiction of the end-to-end scope and boundaries of the Provider Management functional area. Note: the processes in the map may not necessarily occur in the sequential order shown.

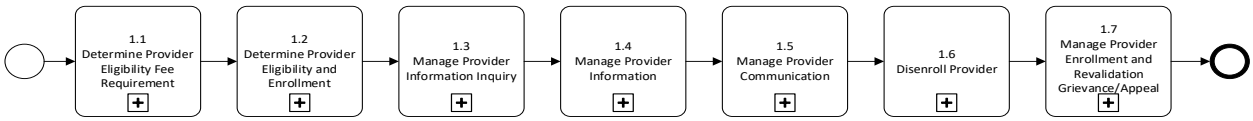


Exhibit 22: Provider Management Level 0 Process Map

The Gap Analysis work product is composed of the following elements for each process area:

- **Process Description** – High-level definition of the scope and purpose of the business process
- **Gaps** – List of major changes from As-Is to To-Be assessments
- **High-level Requirements** – Statements of necessary conditions to close gaps

2.2.4.1 Determine Provider Eligibility Fee Requirement

To enroll and participate in the Medicaid program, Providers first must meet eligibility requirements. The Determine Provider Eligibility Fee Requirement process receives Provider enrollment applications through mail or the Provider Portal. The process determines Provider eligibility fee requirement and feeds to downstream business processes such as Provider Eligibility and Enrollment, Manage Provider Communication, Manage Provider Information, and Manage Provider Enrollment and Revalidation Grievance/Appeal. The process collects information on Provider types who are required to pay the eligibility fee for both Medicaid FFS and MCO Providers. Should a Provider already be enrolled in Medicare, or if a Provider has paid an eligibility fee to another State Medicaid Agency (SMA), the Provider is exempted from paying the eligibility fee again.

Process Gaps and Requirements Exhibit *23*: Determine Provider Fee Requirement Process **Gaps and Requirements**

Exhibit 23: Determine Provider Fee Requirement Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Determine Provider Fee Requirement process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Provider submits application to enroll or reenroll through the HCP or mail. Note: Providers can identify if they participate in Medicare	Provider submits application to enroll or reenroll through the Provider Portal; paper applications are not accepted. Note: Providers	New Providers enrolling into existing group electronically submits supporting information, which will be	Provider Portal will support Provider application entry and submission.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
(optional step in the application).	can identify if they participate in Medicare (optional step in the application).	automatically updated into the MES.	
Applications are reviewed by Fiscal Agent to determine the fee applicability. The process collects information on Provider types who are required to pay the eligibility fee. If a Provider is already enrolled in Medicare, or if a Provider has paid an eligibility fee to another SMA, the Provider is exempt from paying the eligibility fee again. If the fee was paid to another State, proof of payment must be submitted.	Applications are reviewed by the Provider Vendor(s) to determine the fee applicability. Fewer legibility issues are anticipated with the shift to an entirely electronic process. The process collects information on Provider types who are required to pay the eligibility fee. If a Provider is already enrolled in Medicare, or if a Provider has paid an eligibility fee to another SMA, the Provider is exempt from paying the eligibility fee again. If the fee was paid to another State, proof of payment must be submitted.	Provider Vendor(s) automatically complete electronic review of applications, resulting in fewer legibility issues and less time required to review the enrollment application before sending a decision.	Provider Portal will support Provider application entry and submission.
Correspondence is sent to the Provider including the application fee amount, fee waiver criteria, and any related proof of payment requirements.	Correspondence including the application fee amount, fee waiver criteria, and any related proof of payment requirements is sent automatically to the Provider via the Provider's preferred communication means	Provider Vendor(s) utilizes several automated forms of communication, e.g., email and mail.	Provider Portal will automatically send correspondence, including the application fee amount, fee waiver criteria, and any related proof of payment requirements, to the Provider via the Provider's preferred communication means. Provider Portal will capture the Provider's preferred communication means.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
If the Provider type falls into the category to pay the fee, the Provider pays the amount indicated in the Provider application notification.	If the Provider type falls into the category to pay the fee, the Provider pays the amount indicated in the Provider application notification via electronic payment in the Provider Portal or check.	The New Provider pays the fee electronically since the Post Office delivery services can be subject to delays or loss.	Provider Portal will accept electronic payments for fees.
If the Provider determines they are eligible for a fee exemption due to either participating in Medicare or having paid an enrollment fee to another SMA, the provider must submit proof of payment.	If the Provider determines they are eligible for a fee exemption due to either participating in Medicare or having paid an enrollment fee to another SMA, the Provider must submit proof of payment or attestation.	If the New Provider has already made a payment to another SMA or is a Medicare participant, the New Provider needs to submit an electronic proof of payment with the initial application to expedite the process.	Provider Portal will capture and route fee exemption attestation from Provider to EOHHS.

Exhibit 23: Determine Provider Fee Requirement Process Gaps and Requirements

2.2.4.2 Determine Provider Eligibility and Enrollment

The Determine Provider Eligibility and Enrollment business area is a collection of business processes that involves activities including enrolling, reenrolling, and revalidating Providers to Medicaid through Provider Portal. This process is initiated when the Determine Provider Eligibility Fee Requirement process is completed. The types of applications received by the Provider Vendor(s) for Provider Enrollment are as follows:

- Provider Enrollment – Provider Portal Application (new enrollment, reenrollment, or Ordering, Prescribing, and Referring (OPR))
- Provider Revalidation – Provider Portal

The Provider Vendor(s) has an automated process that sends the state's MCOs a file containing all enrolled Medicaid Providers, the status of applications in process, and Provider terminations.

The Provider Vendor(s) also maintains the Medicaid Provider Directory available on the EOHHS website. For FFS providers, there is an automated process that updates the enrollment data available in the Medicaid Provider Directory daily. For MCO Providers, each MCO sends the Provider Vendor(s) monthly files containing Medicaid MCO Providers. The Provider Vendor(s) has an automated process to update the

encounter database which is used by the Medicaid Provider Directory as the data source for MCO Providers[1].

In the current state, a paper application for Rhode Island Medicaid provider enrollment is only allowed when adding a new FFS Provider to an existing enrolled Provider group/practice in the MES. In the future state, paper applications will be eliminated in favor of the Provider Portal enrollment process.

Exhibit 24: Provider Application Types provides information on the types of applications received by the Provider Vendor(s) for Provider Enrollment.

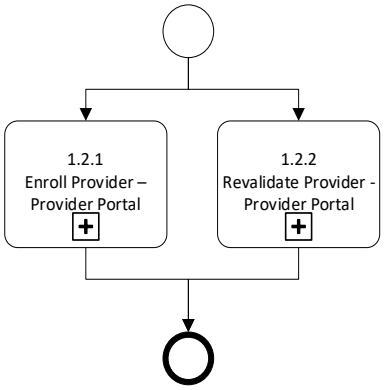


Exhibit 24: Provider Application Types

Provider Enrollment – Provider Portal Application

Providers can enroll as a new Provider with the Rhode Island Medicaid program by accessing the Provider Portal and completing an electronic application. In this process, the Provider Vendor(s) receives an application for a new Provider enrollment, a reenrollment, or an OPR Provider. The Provider Vendor(s) is responsible for processing applications, evaluating Provider types, specialties, status, and history of applications, if any. The Provider Vendor(s) is also responsible for sending the application status notifications to Providers and providing EOHHS with the necessary information to make enrollment decisions.

The Provider Enrollment process is the same for FFS and MCO Providers, except if a Provider chooses to only enroll to be an MCO Provider, they do not have to provide EFT information since claims are paid by the MCO. In addition, MCO only Providers do not need to provide a W9.

[1] Note the current process does not validate if the Providers sent by the MCOs have been enrolled in Medicaid, however there is a project underway to address this as part of the effort to enroll MCO Providers.

Process Gaps and Requirements

Exhibit 25: Provider Enrollment – Provider Portal Application Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Provider Enrollment Provider Portal Application process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent manually reviews the application information to ensure all fields have been completed accurately in HCP application by cross-checking various databases.	The Provider Vendor(s) automatically reviews the application information to ensure all fields have been completed accurately in Provider Portal application by cross-checking various databases.	Provider Vendor(s) automatically completes OPR Enrollment Checklist which includes checking several mandated databases.	Provider Portal will automatically review Provider application for completeness and accuracy.
The Fiscal Agent manually performs a quality review of all MMIS screens relevant to the application. During this process, all quality checking-related modifications are resolved as needed.	The Provider Vendor(s) automatically performs a quality review of all MES screens relevant to the application. During this process, all quality checking-related modifications are resolved as needed.	Provider Vendor(s) automatically reviews information entered in MES for a quality check.	Provider Portal will perform automatic quality reviews on all MES Provider application screens.
The Fiscal Agent requests missing information from the Provider after reviewing the application.	The Provider Vendor(s) requests missing information from the Provider via all available means after reviewing the application.	Provider Vendor(s) uses Provider Portal to reach out for missing information.	Provider Vendor(s) will request missing application information from Provider based on Provider's preferred communication method.
The EOHHS enters the enrollment denial and reasons for denial into the MMIS.	The Provider Vendor(s) automatically enters the enrollment denial and reasons for denial into the MES.	Provider Vendor(s) automatically selects denial reason for automatic update.	Provider Portal will use Workflow Management System to enter application denial and reason into MES.

Exhibit 25: Provider Enrollment – Provider Portal Application Process Gaps and Requirements

Provider Revalidation – Provider Portal

Federal guidelines require all Medicaid Providers to revalidate their active statuses with EOHHS every five years. Actively enrolled Providers request recertification every five years through the Provider Revalidation process to maintain enrolled status in Medicaid. If a certification is expired for more than five years, a Provider must apply to reenroll rather than revalidate the certification. If a Provider fails to provide sufficient information to Provider Vendor(s) for revalidation, EOHHS has the statutory authority to approve, terminate, or suspend a Provider.

Process Gaps and Requirements

Exhibit 26: Provider Revalidation – Provider Portal Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Provider Revalidation – Provider Portal process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Require-ment
The Fiscal Agent reviews the application information to ensure all fields have been completed accurately in the HCP application by cross-checking various databases.	The Provider Vendor(s) automatically reviews the application information to ensure all fields have been completed accurately in the Provider Portal application by cross-checking various databases.	Provider Vendor(s) automatically review several federally mandated databases for validation.	Provider Portal will automatically review Provider application for completeness and accuracy.
The Fiscal Agent performs a quality review of the MMIS screens relevant to the application before forwarding the application for revalidation approval.	The Provider Vendor(s) automatically performs a quality review of the MES screens relevant to the application before forwarding the application for revalidation approval.	Provider Vendor(s) automatically review information entered into MES for quality check.	Provider Portal will perform automatic quality reviews on all MES Provider application screens.
The Fiscal Agent must contact the Provider and request the missing information needed to process the revalidation application.	The Provider Vendor(s) must contact the Provider via the Provider's preferred communication method and request the missing information needed to process the	Provider Vendor(s) must request that the Provider submit all data in HCP to ensure enrollment does not revert to a manual process.	Provider Vendor(s) will request missing application information from Provider based on Provider's preferred communication method.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
	revalidation application.		
The Provider receives notification that additional information is needed to process the revalidation application within 35 days from the time the revalidation application is submitted.	The Provider receives notification via the Provider's preferred communication method that additional information is needed to process the revalidation application within 35 days from the time the revalidation application is submitted.	Provider must submit all required data in HCP to ensure enrollment remains an automated process.	Provider Vendor(s) will request missing application information from Provider based on Provider's preferred communication method.
To move forward with the revalidation process, the Provider must respond to the Fiscal Agent's request for more paperwork. If the Provider submits the additional information needed, the process goes to Perform quality review. If the Provider does not submit the additional information needed, the process goes to Send request to EOHHS for further direction.	To move forward with the revalidation process, the Provider must respond to the Provider Vendor(s)'s request for more paperwork via the Provider Portal. If the Provider submits the additional information needed, the process goes to Perform quality review. If the Provider does not submit the additional information needed, the process goes to Request to EOHHS for further direction.	The Provider will utilize multiple forms of automated communication, causing fewer processing efforts.	Provider Portal will capture Provider response to information request.
After reviewing the document, EOHHS decides whether to terminate the Provider due to lack of information provided for revalidation. If a decision is made to terminate the Provider, the process goes to Enter termination with	After reviewing the document, EOHHS decides whether to terminate the Provider due to lack of information provided for revalidation. If a decision is made to terminate the Provider, the process	The State must automatically terminate the Provider in the MES after receiving the decision from EOHHS.	Provider Portal will use the Workflow Management System to record and route termination decision.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
denial date in MMIS. If the Provider will not be terminated, the process goes to Suspend revalidation application.	automatically goes to Enter termination with denial date into MES. If the Provider will not be terminated, the process automatically goes to Suspend revalidation application.		
The EOHHS notifies the Fiscal Agent to terminate the Provider. The Fiscal Agent enters the termination date into MMIS.	The EOHHS notifies the Provider Vendor(s) to terminate the Provider. The Provider Vendor(s) automatically enters the termination date into MES.	Provider Vendor(s) completes an automatic data entry of termination state.	Provider Portal will use the Workflow Management System to record and route termination decision.

Exhibit 26: Provider Revalidation – Provider Portal Process Gaps and Requirements

2.2.4.3 Manage Provider Information Inquiry

The Manage Provider Information Inquiry business process receives and responds to inquiries from current Providers, prospective Providers, and Medicaid Members. Inquiries are received and addressed by the Provider Vendor(s). Inquiries that the Provider Vendor(s) cannot address are forwarded to EOHHS for resolution. Once the Provider Vendor(s) receives inquiry resolution from EOHHS, the Provider Vendor(s) forwards the information to the requestor via the same method of communication based on preferences captured in RIBridges. Examples of inquiries relevant to this process include but are not limited to:

- Current Providers or prospective Providers inquiring about status of enrollment, reenrollment, revalidation applications, and information regarding claim submission or claim status.
- Members inquiring about in-network provider information, enrollment start and end dates, provider type, and specific specialties provided.

Process Gaps and Requirements

Exhibit 27: Manage Provider Information Inquiry Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Provider Information Inquiry process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent creates a case number, assesses, and classifies the inquiry, and routes the inquiry to a specialist type.	The Provider Vendor(s) automatically creates a case number, assesses, and classifies the inquiry, and routes the inquiry to a specialist type	Provider Vendor(s) will automatically track and respond to inquiries.	Provider Portal will automatically assign case number and assesses, classifies, and routes inquiry to a specialist.
The Member or Provider inquiry is responded to using the same communication method as it was submitted.	The Member or Provider inquiry is automatically responded to using the same communication method as it was submitted.	Provider Vendor(s) will automatically track and respond to inquiries.	Provider Portal will automatically send response to Provider inquiry using the same communication method as the inquiry.

Exhibit 27: Manage Provider Information Inquiry Process Gaps and Requirements

2.2.4.4 Manage Provider Information

The Manage Provider Information business process is responsible for maintaining the profiles for current Providers. Current providers contact the Provider Vendor(s) by mail, phone, or email with requests to create, delete, or modify profile information. Examples of changes requested include but are not limited to name, address, taxonomy, tax identification number, etc. All requests must be accompanied by supporting documentation and the NPI number. The Provider Vendor(s) is responsible for reviewing and validating the supporting documentation for completeness and accuracy and updating the Provider profile as appropriate. If the request is valid, the Provider Vendor(s) updates the current Provider information in the MES as requested.

Process Gaps and Requirements

Exhibit 28: Manage Provider Information Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Provider Information process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
A current Provider submits a request to update the Provider profile. Requests may include but are not limited to an update to the Provider's name, address, taxonomy, tax	A current Provider submits a request to update the Provider profile via the Provider Portal. Requests may include but are not limited to an update to the Provider's name,	Provider submits profile update requests via the Provider Portal.	Provider Portal will capture Provider information update requests.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
identification number, etc. All change requests must be accompanied by an NPI and supporting documentation.	address, taxonomy, tax identification number, etc. All change requests must be accompanied by an NPI and supporting documentation.		
The Fiscal Agent reviews the request and verifies the Provider information. The Fiscal Agent uses NPI and appropriate supporting information to verify the Provider is active in MMIS before accepting the change request.	The Provider Vendor(s) automatically reviews the request and verifies the Provider information. The Provider Vendor(s) uses NPI and appropriate supporting information to verify the Provider is active in MES before accepting the change request.	Provider Vendor(s) will automatically verify the Provider is active.	MES will automatically review information update request and verify the Provider information. MES will use NPI and other information to verify Provider status before accepting change request.
If the Provider status is active and the NPI is verified, the Fiscal Agent verifies the changes requested by checking the information provided is valid.	If the Provider status is active and the NPI is verified, the Provider Vendor(s) automatically verifies the changes requested by checking the information provided is valid.	Provider Vendor(s) validate information by automatically updating MES screens and attaching supporting documentation.	MES will automatically validate requested information changes with external sources.
The Fiscal Agent verifies the information provided within the supporting documentation submitted by the Provider. If the information is verified, the process goes to Update Provider data profile. If the information is not verified, the process goes to Receive notification of	The Provider Vendor(s) automatically verifies the information provided within the supporting documentation submitted by the Provider. If the information is verified, the process goes to Update provider data profile. If the information is not verified, the process goes to Provider receives notification of	Provider Vendor(s) conducts quality checks via an automated inspection of the information entered into the MES.	Provider Portal will automatically validate requested information changes with external sources.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
missing/incorrect information.	missing/incorrect information.		
If the Provider status is active, NPI verified, and the supporting documentation is complete, the Fiscal Agent updates the Provider's data profile.	If the Provider status is active, NPI verified, and the supporting documentation is complete, the Provider Vendor(s) automatically updates the Provider's data profile.	The Provider Vendor(s) automatically updates the Provider's data profile if verified.	Provider Portal will automatically update Provider profile after validating change request.
If the Provider status is inactive, the Fiscal Agent notifies the Provider that the request cannot be completed due to Provider's inactive status.	If the Provider status is inactive, the Provider Vendor(s) automatically notifies the Provider that the request cannot be completed due to Provider's inactive status.	Provider Vendor(s) automatically informs Provider of inactive status.	Provider Portal will automatically notify Provider if request cannot be completed.
The Fiscal Agent notifies the Provider via email, mail, or phone regarding any missing or incorrect information in the change request. The Fiscal Agent requests updated information or additional supporting documentation to make the requested changes to the profile.	The Provider Vendor(s) automatically notifies the Provider via their preferred communication method regarding any missing or incorrect information in the change request. The Provider Vendor(s) requests updated information or additional supporting documentation to make the requested changes to the profile.	Provider Vendor(s) automatically informs Provider of their missing/incorrect information.	Provider Portal will automatically notify the Provider via their preferred communication method regarding any missing or incorrect information in the change request and will request the new information or additional documentation to update their profile accordingly.

Exhibit 28: Manage Provider Information Process Gaps and Requirements

2.2.4.5 Manage Provider Communication

The Manage Provider Communication business process conducts coordinated global communications to all Rhode Island Medicaid Providers regarding changes to guidelines and procedures, upcoming projects,

and any additional relevant Medicaid program information. The Provider Vendor(s) is responsible for drafting and distributing communications. Prior to distribution, EOHHS reviews, edits, and approves the planned global communications.

Communication packages are sent weekly or monthly according to the established communications plan. Some communications are sent on an ad hoc basis, as determined by EOHHS request. Forms of communication include email, the EOHHS website (Provider Updates page), or written correspondence.

Exception: There are occasions when EOHHS distributes communications directly to Providers, such as communications to MCOs managed by the EOHHS MCO Oversight Group.

Process Gaps and Requirements

Exhibit 29: Manage Provider Communication Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Provider Communication process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent sends a draft of the global communication package or ad hoc communication to EOHHS for review.	The Provider Vendor(s) automatically sends a draft of the global communication package or ad hoc communication to EOHHS for review.	Provider Vendor(s) automatically prepare Global communications	Provider Portal will automatically email global or ad hoc communication package draft to EOHHS for review. Provider Portal will use workflows to route correspondence between Provider Vendor(s) and EOHHS.
The EOHHS reviews the draft communications and makes any necessary edits before approving and sending the revised version to the Fiscal Agent for communication distribution.	The EOHHS reviews the draft communications and makes any necessary edits before approving and automatically sending the revised version to the Provider Vendor(s) for communication distribution.	EOHHS automatically sends Global communication updates to the Provider Vendor(s).	After reviewing and editing, EOHHS will automatically send revised communications to Provider Vendor(s) for distribution. Provider Portal will use automated workflows to route correspondence between Provider Vendor(s) and EOHHS.

Exhibit 29: Manage Provider Communication Process Gaps and Requirements

2.2.4.6 Disenroll Provider

The Disenroll Provider business process is responsible for managing disenrollment of Medicaid Providers. This business process includes tracking of disenrollment requests and validating that the disenrollment complies with the state's rules. The Provider Vendor(s) sends notification of the disenrollment effective end date to the Provider and updates the corresponding information in the MES once validated.

Process Gaps and Requirements

Exhibit 30: Manage Disenroll Provider Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Provider Disenroll Provider process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Provider seeking disenrollment from the Medicaid program sends a disenrollment request to the Fiscal Agent via mail, phone, or email.	The Provider seeking disenrollment from the Medicaid program sends a disenrollment request to the Provider Vendor(s) via the Provider Portal.	Provider initiates disenrollment process, using several automated forms of communication to reduce processing effort.	Provider Portal will capture Provider disenrollment request.
The Fiscal Agent validates the requestor's authority to submit the disenrollment request by reviewing requestor's credentials in MMIS. Note: If the Fiscal Agent is unable to validate requestor authority, the disenrollment request is nullified and the request becomes invalid.	The Provider Vendor(s) automatically validates the requestor's authority to submit the disenrollment request by reviewing requestor's credentials in MES. Note: If the Provider Vendor(s) is unable to validate requestor authority, the disenrollment request is nullified and the request becomes invalid.	Provider Vendor(s) automatically validate the requestor's authority to submit the disenrollment request.	Provider Portal will automatically verify requestor's credentials in the MES in order to validate authority to submit disenrollment request.
The Fiscal Agent enters the effective end date for the provider's Medicaid services into the MMIS.	The Provider Vendor(s) automatically enters the effective end date for the Provider's Medicaid services into the MES.	Provider Vendor(s) automatically enter data of effective date into the MES.	Provider Portal will automatically capture effective end date for Provider's Medicaid services.
Prior to completing the disenrollment, the Fiscal Agent performs a quality review of the request to	Prior to completing the disenrollment, the Provider Vendor(s) automatically performs a quality review	Provider Vendor(s) automatically review the	Provider Portal will automatically review

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
ensure accuracy. During this process, all quality checking-related modifications are resolved as needed.	of the request to ensure accuracy. During this process, all quality checking-related modifications are resolved as needed.	information entered in MES for a quality check.	disenrollment request for accuracy.
If the Fiscal Agent cannot validate the information and/or more information is needed to process the disenrollment request, the Fiscal Agent sends an information request correspondence to the Provider. This process continues until the Provider sends the updated information to the Fiscal Agent to complete the disenrollment request.	If the Provider Vendor(s) cannot validate the information and/or more information is needed to process the disenrollment request, the Provider Vendor(s) sends an information request correspondence to the Provider via the Provider's preferred communication method. This process continues until the Provider sends the updated information to the Provider Vendor(s) to complete the disenrollment request.	Provider Vendor(s) automatically validate Provider information and supporting documentation.	Provider Portal will request additional information from Provider via Provider's preferred communication method.
The Provider sends the updated/missing information requested to the Fiscal Agent to complete the disenrollment request that complies with the state's rules.	The Provider sends the updated/missing information requested via the Provider Portal to the Provider Vendor(s) to complete the disenrollment request that complies with the state's rules.	The Provider initiates an automated process of sending information and documentation to the Provider Vendor(s).	Provider Portal will capture updated/missing information provided by Provider in response to information requests.

Exhibit 30: Manage Disenroll Provider Process Gaps and Requirements

2.2.4.7 Manage Provider Enrollment and Revalidation Grievance/Appeal

The Manage Provider Enrollment and Revalidation Grievance/Appeal business process handles Provider appeals of adverse decisions or grievances. The process starts with a prospective or current Provider initiating an appeal to review an enrollment or revalidation denial. The Provider Vendor(s) receives, logs, and sends the appeal to EOHHS for review and a final decision. When an approval or denial decision is received, the decision is entered into the MES. Prospective and current Providers can also file a grievance/appeal through the State of Rhode Island Governor's office.

Process Gaps and Requirements

Exhibit 31: Manage Provider Enrollment and Revalidation Grievance/Appeal Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Provider Enrollment and Revalidation Grievance/Appeal process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The prospective/current Provider submits a grievance/appeal request to the Fiscal Agent regarding an enrollment decision. Requests are submitted by Providers via email, mail, or phone.	The prospective/current Provider submits a grievance/appeal request to the Provider Vendor(s) regarding an enrollment decision. Providers submit requests via the Provider Portal.	The Provider uses an automatic, single form of communication to lessen processing effort.	Provider Portal will capture grievance/appeal requests.
The Fiscal Agent logs and reviews the grievance/appeal request sent by the Provider or EOHHS. The Fiscal Agent validates the Provider authentication and denial reason of the initial application for enrollment or revalidation. The Fiscal Agent performs research and analysis on the appeal before sending findings and supporting documentation to the EOHHS for review and final decision.	The Provider Vendor(s) automatically logs and reviews the grievance/appeal request sent by the Provider or EOHHS. The Provider Vendor(s) validates the Provider authentication and denial reason of the initial application for enrollment or revalidation. The Provider Vendor(s) performs research and analysis on the appeal before sending findings and supporting documentation to the EOHHS for review and final decision.	The Provider Vendor(s) utilize an automatic process of logging the request into the system, based on the initial submission process through HCP. This process will entail automatic data entry before sending the appeal file to EOHHS for review.	Provider Portal will automatically log and review grievance/appeal request.
If the grievance/appeal was received by mail or fax, the Fiscal Agent submits the grievance/appeal to the	If the grievance/appeal was received by mail or fax, the Provider Vendor(s) automatically submits the grievance/appeal to the EOHHS for review via the	The Workflow Management System is automatically prepared and sent to EOHHS by the Provider Vendor(s).	Provider Portal will use automated workflows to route grievance/appeal request to EOHHS for review.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS for review via the FACN process.	Workflow Management System process.		
If the enrollment or revalidation appeal is approved, the EOHHS sends the decision to Fiscal Agent via FACN or MMIS. The Fiscal Agent enters the approval correspondence and supporting provider details into the MMIS.	If the enrollment or revalidation appeal is approved, EOHHS automatically sends the decision to Provider Vendor(s) via Workflow Management System or MES. The Provider Vendor(s) enters the approval correspondence and supporting Provider details into the MES.	Provider Vendor(s) automatically enter enrollment and revalidation decision into the MES.	Provider Portal will use automated workflows to route grievance/appeal request from EOHHS for distribution.
End Process: The Fiscal Agent sends a notification to the prospective/current Provider that the appeal was denied via the same method as the appeal was received.	End Process: The Provider Vendor(s) automatically sends a notification to the prospective/current Provider that the appeal was denied via the same method as the appeal was received.	The Provider uses an automatic, single form of communication to lessen processing effort.	Provider Portal will use automated workflows to route denial to Provider.

Exhibit 31: Manage Provider Enrollment and Revalidation Grievance/Appeal Process Gaps and Requirements

2.3 Claim and Encounter Processing

The Claim and Encounter Processing (CEP) function is primarily performed by the CEP Vendor(s) (CEP Vendor(s)) and includes receiving, editing, auditing, pricing, and adjudication of FFS claims for payment to providers, as well as for processing encounter data received from managed care organizations (MCOs) for reporting purposes. In addition, the function processes claim and encounter adjustments, including individual adjustments and mass adjustments.

In addition to the Rhode Island Medicaid Program, claims are also received and processed for non-Medicaid healthcare and medication assistance programs administered by the following agencies / payers:

- Department of Corrections (DOC)
- Department of Children, Youth, and Families (DCYF)
- Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
- Office of Healthy Aging (OHA)
- Department of Health (DOH)

BHDDH, DOC, and DCYF healthcare claims are received in electronic data interchange (EDI) and paper format and processed in the same manner as Medicaid non-pharmacy claims. DOH and OHA medication assistance program claims are received point-of-sale (POS) in National Council for Prescription Drug Programs (NCPDP) format and processed in the same manner as Medicaid pharmacy claims.

The CEP functional area consists of five key business processes:

1. Receive Claim / Encounter
2. Process Claim
3. Process Encounter
4. Perform Mass Adjustment
5. Perform Adjustment

2.3.1 Business Actors

Exhibit 32: Claim and Encounter Processing Business Actors includes the actors, i.e., people, vendors, and/or organizations, that support CEP business processes.

Actor	Description
Executive Office of Health and Human Services	EOHHS is the single State agency designated to administer the Medicaid program in Rhode Island.
Clearinghouse	A clearinghouse is a company that provides electronic data interchange transaction services and other interactive transactions for providers. Medicaid providers may contract with a clearinghouse to prepare and submit claims on their behalf and help ensure claims get processed properly by the CEP Vendor(s).
Claim and Encounter Processing Vendor(s)	The EOHHS contracts with a CEP Vendor(s) to provide CEP services to meet the needs of Rhode Island's Medicaid Program. EOHHS will contract with one or more vendors to provide CEP services. The functions may be acquired through a procurement for only CEP functions or through a procurement that includes the CEP functions as well as other MES functions.
Managed Care Organizations	Rhode Island EOHHS contracts with MCOs (also referred to as "managed care plans") that provide comprehensive medical coverage to Medicaid beneficiaries. MCOs accept a set per member per month payment for these services and are at financial risk for the Medicaid services specified in their contracts.
Other State Agency	Other State Agency includes DCYF, DOC, BHDDH, OHA and DOH. DCYF, DOC and BHDDH submit non-Medicaid healthcare claims for which they administer / are the payer. These claims are received in EDI and paper format and processed by the CEP Vendor(s) / MES. Note: The CEP Vendor(s) also processes electronic claims and encounters submitted by pharmacies via NCPDP transactions. Claims are submitted real-time at POS and can include claims for OHA and DOH medication assistance programs (Rhode Island Pharmaceutical Assistance to Elders (RIPAE) and AIDS Drug Assistance Program (ADAP)).
Provider	Providers are physicians, hospitals, and other healthcare providers who are contracted or authorized to provide covered services to Medicaid members. A prospective provider is a provider who is applying to be in the Medicaid Program.

Exhibit 32: Claim and Encounter Processing Business Actors

2.3.2 Technology and Tools

Exhibit 33: Claim and Encounter Processing Technology and Tools includes the technology and tools used to perform the CEP business processes.

System Name	Description
EDI / NCPDP | File Exchange	EDI / NCPDP | File Exchange represents the system and/or applications used by providers, MCOs, clearinghouses, other state agencies, and pharmacies to prepare and submit electronic claims / encounters.
Imaging System	The CEP Vendor(s)' imaging system is used to scan paper claims.
Claims Portal	The Claims Portal is a secure, internet portal used by healthcare providers can inquire on the status of claims, verify eligibility, upload electronic claim files, etc.
Medicaid Enterprise System	The MES is an integrated group of subsystems / modules with open APIs which leverage an integration platform to enable interoperability with other modules. The MES is operated by a single or multiple vendors and will support EOHHS in administering the state Medicaid program.
Approved Claim Transaction Entry Software	Approved Claim Transaction Entry Software is a free software provided by the CEP Vendor(s) and used by providers to create and submit Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic 837 transaction claim files. The Approved Claim Transaction Entry Software can be downloaded using a link found on the EOHHS website. Note: Providers have the option to approved software from other vendors to create HIPAA-compliant electronic 837 transaction claim files. In this document, the Approved Claim Transaction Entry Software represents the software provided by the CEP Vendor(s), as well as any other approved software providers are using to create the claim files.
Cumulative Error Reporting Tool	The Cumulative Error Reporting tool provides a detailed analysis on submitted claims and encounters that contain errors. These reports are used for analytical purposes as well as making the MCO or provider aware of the denied claims to aid in the remediation of errors when providers are preparing to resubmit claims. The distribution of the cumulative error report may be automated or made available as a provider dashboard.

Exhibit 33: Claim and Encounter Processing Technology and Tools

2.3.3 Process Improvement Opportunities

Exhibit 34: Claim and Encounter Processing Process Improvement Opportunities describes the improvement opportunities incorporated across the to-be CEP business processes.

Opportunity	Description
Bring claim edits forward in the submission process	Bringing claim edits forward in the submission process will enable providers to identify and remediate errors prior to claim submission. These edits may include Strategic National Implementation Process (SNIP) edits and post-SNIP edits. As it relates to pharmacy claims, these edits must be executed real time at the point-of-sale system in order to have a clean transaction.
Minimize paper claims	Reducing the use of paper for claims and adjustments will reduce errors, processing time, resource working hours and postage costs.
Optimize edit processing	Optimizing real time edit processing to support the maximum number of edits being processed during each pass of a claims resolution cycle will minimize

Opportunity	Description
	the burden on providers, reducing the number of cycles of correcting and resubmitting claims.
Simplify communications on claims status	Simplifying communications on claim denial reasons will allow Providers to correct claims more effectively.
Provide cumulative error report	Generating a detailed error readout and distributing it to providers via the cumulative error report will help providers in correcting denied claims more efficiently. The cumulative error report may be automated or made available as a provider dashboard.

Exhibit 34: Claim and Encounter Processing Process Improvement Opportunities

2.3.4 Gap Analysis by Business Process

Exhibit 35: Claim and Encounter Processing Level 0 Process Map depicts the scope of the CEP functional area. Note: Processes in the Level 0 Process Map may not necessarily occur in the sequential order shown, and not all processes are applicable to all claims and encounters.

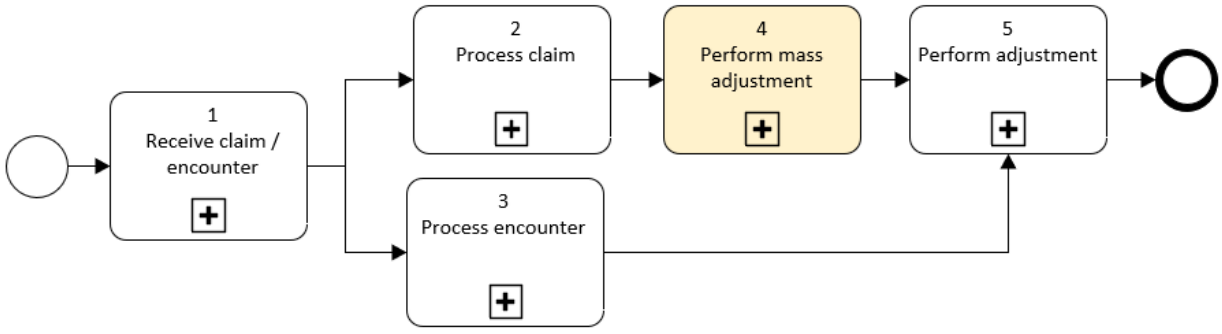


Exhibit 35: Claim and Encounter Processing Level 0 Process Map

A gap analysis for each process is documented in the sections below, including the following information is provided for each of the business processes:

- **Process Description** – High-level definition of the scope and purpose of the business process
- **Gaps** – List of major changes from As-Is to To-Be assessments
- **High-level Requirements** – Statements of necessary conditions to close gaps

There are no changes between the as-is and to-be Perform Mass Adjustment business process; therefore, this process is excluded from the gap analysis.

2.3.4.1 Receive Claim / Encounter

The Receive Claim / Encounter business process is performed by the provider / MCO / clearinghouse / other state agency and the CEP Vendor(s) and includes receiving electronic and paper claims and encounters and preparing them for processing. This process includes applying preliminary edits on the submitted claims and encounters to ensure that they are valid, in the correct format, and meet HIPAA standards. Additionally, all claims and encounters are translated into a common proprietary file structure for processing. Claims and encounters that do not pass the preliminary, pre-processing edits are rejected and returned to the provider / MCO / clearinghouse / other state agency for correction.

Many of these activities are occurring within and automated by the MES. The Rhode Island Medicaid Program provides the following options for submitting claims / encounters:

- EDI (claim / encounter)
- Claims Portal (claim)
- Paper (claim)
- NCPDP (pharmacy claim)

Claims and encounters received include institutional, professional, and dental claims and encounters. Per EOHHS policy, the CEP Vendor(s) must receive a claim for services for Medicaid members with no other health insurance and no previous denial within 12 months from the date the service was provided. Claims with third party insurance must be submitted within 90 days from the process date of the other payer. Claims that were previously denied must be submitted within 90 days from the date on the remittance advice. If these requirements are not met, the claim will be denied for timely filing.

The Receive Claim/Encounter process includes the following subprocesses:

- Receive Claim / Encounter (EDI)
- Receive Claim (Paper)
- Receive Claim (Claims Portal)
- Receive Claim / Encounter (NCPDP)

The gap analysis for these subprocesses is provided in the sections below.

Receive Claim / Encounter (EDI)

Providers, MCOs, clearinghouses, and other state agencies may submit non-pharmacy claims and encounters via EDI through secure file transfer protocol (SFTP) using HIPAA mandated X12N 5010 transaction standards (X12 files can also be uploaded through the web portal). During the process, outbound responses (TA1, 277, 277U, 999) are generated that report the status of and information about the claims and encounters to the provider / MCO / clearinghouse / other state agency, herein referred to generally as “acknowledgements.”

Process Gaps and Requirements

Exhibit 36: Receive Claim / Encounter (EDI) Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Receive Claim / Encounter (EDI) subprocess.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Process	The CEP vendor runs a set of preliminary validation edits (e.g., SNIP and other edits) on the claim file.	The CEP vendor runs a set of preliminary validations edits (e.g., SNIP and other edits) on the claim file.	The CEP System will run SNIP level and other edits prior to claim submission.
Not a Current State Process	After running the preliminary validation edits, the CEP vendor provides rapid feedback to the Provider, MCO, Clearinghouse, or Other State Agency.	The CEP Vendor(s) provides error messages that are written in plain English and are tailored / descriptive to the specific claim and error. Additionally, a cumulative error report is generated and distributed and/or a cumulative error dashboard is populated.	The CEP System will provide electronic claim error feedback messages in plain English. The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error. The CEP System will generate and distribute a claims cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.
Not a Current State Process	The Provider, MCO, Clearinghouse, or Other State Agency corrects the claim file (go to Submit electronic claim / encounter).	The Provider, MCO, Clearinghouse, or Other State Agency corrects the claim file before resubmitting the claim.	The Provider, MCO, Clearinghouse, or Other State Agency will correct errors identified in the claim file during the preliminary editing process before resubmitting the claim.

Exhibit 36: Receive Claim / Encounter (EDI) Process Gaps and Requirements

Receive Claim (Paper)

Providers and other state agencies may submit non-pharmacy claims via a paper claim form, including CMS-1500, UB-04, Dental, and Waiver claim forms.

Process Gaps and Requirements

Exhibit 37: Receive Claim (Paper) Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Receive Claim (Paper) subprocess.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The provider / other state agency completes the claim form and mails the claim to the Fiscal Agent using the United States Postal Service (USPS) or a courier. Claims must be submitted on the standard, approved paper claim form for the corresponding type of service.	The provider / other state agency completes the claim form and mails the claim to the CEP Vendor(s) using USPS or a courier. Claims must be submitted on the standard, approved paper claim form for the corresponding type of service. The submission of paper claims will be minimized; instead, most providers will be directed to submit claims electronically.	The Provider and other State Agencies will submit claims electronically to reduce postage costs, potential for errors, and overall processing time/costs.	CEP System will support electronic claims submission. CEP System will direct providers to submit claims electronically. CEP System will support paper claims processing as a secondary process for claims submission.
If it is determined that fields are completed incorrectly or blank, the Fiscal Agent rejects the claim form. The rejected claim form is returned to the provider via USPS, along with an acknowledgement that identifies the errors that need to be corrected. The acknowledgement identifies the exceptions found during the compliance checks to facilitate correction. Claims that are rejected must be corrected and resubmitted.	If it is determined that fields are completed incorrectly or blank, the CEP Vendor(s) rejects the claim form. The rejected claim form is returned to the provider via USPS, along with an acknowledgement that identifies the errors that need to be corrected. The acknowledgement identifies the exceptions found during the compliance checks to facilitate correction. Claims that are rejected must be corrected and resubmitted. Simplifying communications on the denial reasons, by providing feedback on the claim / encounter and error in plain English, will allow the provider to correct the claim more efficiently.	The CEP Vendor(s) provides error messages that are written in plain English and are tailored / descriptive to the specific claim and error. Additionally, a cumulative error report is generated and distributed and/or a cumulative error dashboard is populated.	The CEP System will provide electronic claim error feedback messages in plain English. The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error. The CEP System will generate and distribute a claims cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.

Exhibit 37: Receive Claim (Paper) Process Gaps and Requirements

Receive Claim (Claims Portal)

Providers may submit non-pharmacy claims electronically via a file upload to the web-based Claims Portal.

Process Gaps and Requirements

Exhibit 38: Receive Claim (Claims Portal) Process Gaps and Requirements describes the process steps for the to-be Receive Claim (Claims Portal) business process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Process	The CEP Vendor(s) runs a set of preliminary validation edits (e.g., SNIP and other edits) on the claim file.	The CEP Vendor(s) runs a set of preliminary validations edits (e.g., SNIP and other edits) on the claim file.	The CEP System will run SNIP level and other edits prior to claim submission.
Not a Current State Process	After running the preliminary validation edits, the CEP Vendor(s) provides rapid feedback to the Provider, MCO, Clearinghouse, or Other State Agency.	The CEP Vendor(s) provides error messages that are written in plain English and are tailored / descriptive to the specific claim and error. Additionally, a cumulative error report is generated and distributed and/or a cumulative error dashboard is populated.	The CEP System will provide electronic claim error feedback messages in plain English. The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error. The CEP System will generate and distribute a claims cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.
Not a Current State Process	The Provider, MCO, Clearinghouse, or Other State Agency corrects the claim file (go to Submit electronic claim / encounter).	The Provider, MCO, Clearinghouse, or Other State Agency corrects the claim file before resubmitting the claim.	The Provider, MCO, Clearinghouse, or Other State Agency will correct errors identified in the claim file during the preliminary editing process before resubmitting the claim.

Exhibit 38: Receive Claim (Claims Portal) Process Gaps and Requirements

Receive Claim and Encounter (NCPDP)

Pharmacy claims are submitted real-time electronically at POS using NCPDP D.0 standard transactions and include both Medicaid claims as well as non-Medicaid claims for the RIPAE Program and ADAP.

Process Gaps and Requirements

Exhibit 39: Receive Claim and Encounter (NCPDP) Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Receive Claim and Encounter (NCPDP) business process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The pharmacy submits a real-time POS claim in the NCPDP transaction format.	The pharmacy submits a real-time POS claim in the NCPDP transaction format. The claim will run real time edits to ensure accuracy during the submission process, which will reduce the number of errors identified downstream.	The CEP Vendor(s) automatically edits real-time NCPDP POS claims submissions and returns errors to Provider.	The CEP System will provide electronic error feedback electronically to Providers, Clearinghouses, and Other State Agencies on SNIP level and other edits prior to claim submission. The CEP System will provide electronic claim error feedback messages in plain English. The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error.
The Fiscal Agent rejects the claim and returns an acknowledgement to the pharmacy in NCPDP format that identifies the exceptions found during the compliance checks to facilitate correction. Claims that are rejected must be corrected and resubmitted by the pharmacy.	The CEP Vendor(s) rejects the claim and returns an acknowledgement to the pharmacy in NCPDP format that identifies the exceptions found during the compliance checks to facilitate correction. Claims / encounters that are rejected must be corrected and resubmitted. Simplifying communications on the denial reasons, by providing feedback on the	The CEP Vendor(s) provides error messages that are written in plain English and are tailored / descriptive to the specific claim and error. Additionally, a cumulative error report is generated and distributed and/or a cumulative error dashboard is populated.	The CEP System will provide electronic claim error feedback messages in plain English. The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error. The CEP system will generate and distribute a claims cumulative error

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
	claim / encounter and error in plain English, will allow the provider to correct the claim more efficiently.		report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.

Exhibit 39: Receive Claim and Encounter (NCPDP) Process Gaps and Requirements

2.3.4.2 Process Claim

The Process Claim business process involves reviewing the claim for accuracy and validity, pricing the claim, and making a final determination on whether to approve or deny the claim for payment. This process is performed by the CEP Vendor(s) and many of the activities are automated through the MES.

Process Gaps and Requirements

Exhibit 40: Process Claim Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Process Claim business process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent runs edits against the claim to validate the current required claim data against information / allowable values in the MMIS. Some examples include provider information, member information, procedure codes, and diagnosis codes.	The CEP Vendor(s) runs edits against the claim prior to submission to validate the claim data. If errors are identified, clear and descriptive feedback is returned to Providers, Clearinghouses, and Other State Agencies for remediation.	CEP Vendor(s) provide feedback to Providers, Clearinghouses, and Other State Agencies on edit errors prior to claim submission. Error messages are written in plain English and are tailored / descriptive to the specific claim and error.	The CEP System will provide electronic error feedback electronically to Providers, Clearinghouses, and Other State Agencies on edits prior to claim submission. The CEP System will provide electronic claim error feedback messages in plain English. The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error.
The Fiscal Agent sends an acknowledgement to the provider, clearinghouse, or other state agency with the disposition of the claim.	If the claim has been denied, the CEP Vendor(s) sends an acknowledgement to the provider, clearinghouse, or	The CEP Vendor(s) provides error messages that are written in plain English and are tailored /	The CEP System will provide electronic claim error feedback messages in plain English.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
	other state agency that reflects the claim has been denied for payment. The acknowledgement clearly and simply identifies claim errors to facilitate correction. Simplifying communications on the denial reasons, by providing feedback on the claim / encounter and error in plain English, will allow the provider to correct the claim more efficiently.	descriptive to the specific claim and error. Additionally, a cumulative error report is generated and distributed and/or a cumulative error dashboard is populated.	The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error. The CEP System will generate and distribute a claims cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.

Exhibit 40: Process Claim Process Gaps and Requirements

2.3.4.3 Process Encounter

The Process Encounter business process involves reviewing the encounter for accuracy and validity and making a final determination on whether to accept or reject the encounter. This process is performed by the CEP Vendor(s), and many of the activities are automated through the MES.

Process Gaps and Requirements

Exhibit 41: Process Encounter Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Process Encounter business process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent runs edits against the encounter to validate the encounter data against information / allowable values in the MMIS. Some examples include provider information, member information, procedure codes, and diagnosis codes. Encounter edits are either set to deny or ignore (an edit is not set).	The CEP Vendor(s) runs edits against the encounter prior to submission to validate the encounter data. If errors are identified, clear and descriptive feedback is returned to MCOs for remediation.	The CEP Vendor(s) provides feedback to MCOs on errors prior to encounter submission. Error messages are provided in plain English and are tailored / descriptive to the specific encounter and error.	The CEP System will provide error feedback electronically to MCOs on edits prior to encounter submission. The CEP System will provide encounter error feedback messages in plain English. The CEP System will provide encounter error

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
			feedback messages that are descriptive and tailored to the specific encounter and error.
The Fiscal Agent sets the encounter disposition to Denied and sends an acknowledgement to the MCO that reflects the encounter has been denied / rejected. The acknowledgement identifies the encounter errors to facilitate correction. The MCO must correct the encounter before resubmitting.	The CEP Vendor(s) sets the encounter disposition to Denied and sends an acknowledgement to the MCO that reflects the encounter has been denied / rejected. The acknowledgement identifies the encounter errors to facilitate correction. The provider must correct the encounter before resubmitting. Simplifying communications on the denial reasons, by providing feedback on the claim / encounter and error in plain English, will allow the provider to correct the claim more efficiently.	The CEP Vendor(s) sends error messages that are written in plain English and are tailored / descriptive to the specific encounter and error. The CEP Vendor(s) generates and distributes a cumulative error report and/or populates a cumulative error dashboard to facilitate encounter correction and to identify opportunities for education and process improvement.	The CEP System will provide encounter error feedback messages in plain English. The CEP System will provide encounter error feedback messages that are descriptive and tailored to the specific encounter and error. The CEP System will generate and distribute a cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.

Exhibit 41: Process Encounter Process Gaps and Requirements

2.3.4.4 Perform Adjustment

In the future state, the Perform Adjustment business process involves receiving and verifying changes to paid or partially paid Medicaid and non-Medicaid claims and to submitted encounters. Providers / clearinghouses / other state agencies / MCOs can adjust previously adjudicated claims and encounters due to edit modifications, repricing, policy changes, etc. Adjustment requests may be submitted electronically via EDI or the Claims Portal or by paper using a claim adjustment form. Adjustments to a paid claim, over a year old, will be accepted up to 90 days from the remittance advice date that the original claim payment was posted. Adjustments for claims over one year old, cannot be adjusted to pay at a higher amount than originally paid.

Once the adjustment is received and accepted, it follows the normal claim and encounter processing workflow. Additionally, any required accounts receivable or payable transactions associated with an adjustment are described in the To-be Financial Management Process Flow Diagrams and Narratives.

The Perform Adjustment process includes the following subprocesses:

- Receive Electronic Adjustment
- Receive Paper Adjustment

The gap analysis for these subprocesses is provided in the sections below.

Receive Electronic Adjustment

Providers / Clearinghouses / Other State Agencies / MCOs may submit electronic claim and encounter adjustments via EDI or the Claims Portal. Electronic adjustments are submitted along with new claims and encounters. Once the electronic adjustment is received and validated, the original claim or encounter is identified and voided, and the adjusted claim or encounter is released for processing.

Process Gaps and Requirements

Exhibit 42: Receive Electronic Adjustment Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Receive Electronic Adjustment business process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Process	The CEP Vendor(s) runs a set of preliminary validation edits (e.g., SNIP and other edits) on the claim or encounter file.	The CEP Vendor(s) runs a set of preliminary validations edits (e.g., SNIP and other edits) on the claim or encounter file.	The CEP System will run SNIP level and other edits prior to claim or encounter submission.
Not a Current State Process	After running the preliminary validation edits, the CEP Vendor(s) provides rapid feedback to the Provider, MCO, Clearinghouse, or Other State Agency.	The CEP Vendor(s) provides error messages that are written in plain English and are tailored / descriptive to the specific claim or encounter and error. Additionally, a cumulative error report is generated and distributed and/or a cumulative error dashboard is populated.	The CEP System will provide electronic claim or encounter error feedback messages in plain English. The CEP System will provide electronic claim or encounter error feedback messages that are descriptive and tailored to the specific claim and error. The CEP System will generate and distribute a claim or encounter cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Process	The Provider, MCO, Clearinghouse, or Other State Agency corrects the claim file (go to Submit electronic claim / encounter).	The Provider, MCO, Clearinghouse, or Other State Agency corrects the claim file before resubmitting the claim or encounter.	The Provider, MCO, Clearinghouse, or Other State Agency will correct errors identified in the claim or encounter file during the preliminary editing process before resubmitting the claim.

Exhibit 42: Receive Electronic Adjustment Process Gaps and Requirements

Receive Paper Adjustment

Providers and other state agencies submit paper claim adjustments using the Claim Adjustment Request Form. Once the paper adjustment is received and validated, the original claim is identified and voided, and the adjusted claim is entered and released for processing.

Process Gaps and Requirements

Exhibit 43: Receive Paper Adjustment Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Receive Paper Adjustment business process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The provider / other state agency completes the adjustment form and mails the form to the Fiscal Agent using the USPS or a courier. Claims must be submitted on the approved adjustment form for the corresponding type of service.	The provider / other state agency completes the paper claim adjustment form and mails the form to the CEP Vendor(s) using USPS or a courier. Claim adjustments must be submitted on the approved adjustment form for the corresponding type of service. Claim adjustments that do not meet the criteria for a paper adjustment are rejected.	The Provider and other State Agencies will submit claim adjustments electronically to reduce postage costs, potential for errors, and overall processing time/costs. Acceptable exceptions to an electronic claim adjustment are clearly defined.	The CEP Vendor(s) will process paper claim adjustments that meet EOHHS criteria for paper claim adjustments. The CEP Vendor(s) will reject any claim adjustments submitted by paper that do not meet EOHHS criteria for paper claim adjustments.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
If it is determined that fields are completed incorrectly or blank, the Fiscal Agent rejects the adjustment. The rejected adjustment is returned to the provider / other state agency via USPS, along with an acknowledgement that identifies the errors that need to be corrected. The acknowledgement identifies the exceptions found during the compliance checks to facilitate correction. Adjustments that are rejected must be corrected and resubmitted.	If it is determined that fields are completed incorrectly or blank, the CEP Vendor(s) rejects the adjustment. The rejected adjustment is returned to the provider / other state agency via USPS, along with an acknowledgement that clearly identifies the errors that need to be corrected to facilitate correction. Adjustments that are rejected must be corrected and resubmitted. The acknowledgement identifies the encounter errors to facilitate correction. The provider must correct the encounter before resubmitting.	The CEP Vendor(s) sends error messages that are written in plain English and are tailored / descriptive to the specific claim and error. The CEP Vendor(s) generates and distributes a cumulative error report and/or populates a cumulative error dashboard to facilitate claim correction and to identify opportunities for education and process improvement.	The CEP System will provide claim error feedback messages in plain English. The CEP System will provide claim error feedback messages that are descriptive and tailored to the specific claim and error. The CEP System will generate and distribute a cumulative error report. The CEP System will populate a cumulative error report dashboard.

Exhibit 43: Receive Paper Adjustment Process Gaps and Requirements

2.4 Third Party Liability

Third Party Liability (TPL) refers to the legal obligation of third parties, including individuals, entities, health plans, or programs, to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. EOHHS will primarily work with the Fiscal Agent and the Legal Solutions Vendor to conduct TPL activities to ensure Medicaid is the payer of last resort.

TPL functional area includes the following processes to ensure that third party payers are held liable for all qualifying claims and that Medicaid is only liable as the payer of last resort:

1. Identify TPL Information
2. Conduct Cost Avoidance
3. Manage Recoupment
4. Identify Trauma Case
5. Manage Recovery
6. Recover Trauma / Casualty
7. Recover Mass Tort Case

2.4.1 Business Actors

Exhibit 44: Third Party Liability Business Actors includes the actors, i.e., people, vendors, and/or organizations, that support the TPL business processes.

Actor	Description
EOHHS	EOHHS is the single State agency designated to administer the Medicaid program in Rhode Island.
EOHHS Legal	In the Recovery process, EOHHS Legal refers to attorneys, paralegals, and other direct employees of the legal department. EOHHS Legal handles more complex and higher value recoveries over $15k where the surviving family is nonresponsive or has no intent to open Probate.
Third Party Liability Vendor(s)	EOHHS will contract with one or more TPL vendors to provide TPL services. The functions may be procured as part of a contract that includes only TPL functions or a contract that includes TPL functions as well as other MES functions.
Provider	The physicians, hospitals, and other healthcare Providers who are contracted or authorized to provide covered services to Medicaid Members. Providers are responsible for obtaining medical insurance information from Members and providing that information to EOHHS.
TPL Clearinghouse	One or more vendors will operate this data clearinghouse to provide TPL Match and Recovery Services for EOHHS. The functions may be procured as part of a contract that includes only the TPL functions or a contract that includes the TPL functions as well as other MES functions.
Health Plans	Affordable Care Act Health Plans provide plan and coverage information for Members who are enrolled in both a Health Plan and Medicaid. Health Plan insurance is classified as a third party in TPL.

Actor	Description
Legal Solutions Vendor	The Legal Solutions Vendor will provide legal services for EOHHS to support the recovery of funds from mass tort cases.
Liable Third Party / Member Attorney	A Liable Third Party (e.g., an insurance company) / Member Attorney represents themselves or a Medicaid member and are responsible for making and/or communicating required payment of medical claims related to trauma or a casualty.

Exhibit 44: Third Party Liability Business Actors

2.4.2 Technology and Tools

Exhibit 45: Third Party Liability Technology and Tools describes the technology and tools used to perform the Third Party Liability processes.

System Name	Description
RIBridges	RIBridges is Rhode Island's web-based eligibility system used to determine eligibility for Medicaid and other affordable coverage options offered by HealthSource RI, the state's marketplace for health insurance coverage. RIBridges updates the MES monthly with Member enrollment information used to determine Medicaid claim liability, if any.
TPL File	The TPL file is the monthly output of the TPL clearinghouse that provides data regarding Member TPL coverage. The Fiscal Agent sends a spreadsheet of enrolled Members to the TPL clearinghouse, which returns a file with current Member Third Party Other Insurance (TPOI) data. This data is updated in the MES in an automated fashion.
Medicare Modernization Act (MMA) File	The MMA file provides monthly automated updates of Medicare Part D prescription drug plan coverages for Members also enrolled in Medicaid. The current state MMA file does not contain Medicare Part A or B information.
Medicaid Enterprise System	The MES is an integrated group of subsystems / modules with open APIs which leverage an integration platform to enable interoperability with other modules. The MES is operated by a single or multiple vendors and will support EOHHS in administering the state Medicaid program. The MES receives new and updated third party insurance information from multiple data sources. Member claim information is also ingested by the MES. The MES executes edits and audits to compare claim data to TPL data to identify when a Member claim should be covered by a third party. These edits and audits identify future and historical payments and coverages to protect Medicaid's status as the payer of last resort across the full lifecycle of claims management.
Medicaid Recovery Network (MRN)	All insurance companies who conduct business in the State of Rhode Island are required to participate in the MRN Program. MRN electronically matches Rhode Island Medicaid Members with liability and workers' compensation insurance claims. Insurance companies and attorneys have the option of performing either a data match or utilizing the MRN interactive lookup system. MRN is designed to intercept payments of $500 or more for reimbursement to the State of Rhode Island's Medicaid Program.

System Name	Description
Provider Portal	A component of the MES, Providers use the Provider Portal to access information, applications, eligibility verification, remittance advice, prior authorization, and claim status. Healthcare Providers and billing agents can enroll as a Trading Partner with Rhode Island Medicaid. Enrollment as a new Trading Partner is completed electronically through the Provider Portal.

Exhibit 45: Third Party Liability Technology and Tools

2.4.3 Process Improvement Opportunities

Exhibit 46: Third Party Liability Process Improvement Opportunities describes the improvement opportunities incorporated across the to-be TPL processes.

Opportunity	Description
Implement MCO come behind services	MCO come behind refers to an additional round of recovery or recoupment attempts. In this case, if MCOs are unable to recoup or recover TPL for a defined time period, MCOs will transfer the recovery or recoupment to the Medicaid agency for recovery or recoupment.
Use technology and data to more effectively identify TPL, particularly prior to claims adjudication	Leveraging technical resources to improve TPL performance including improving the quality and number of matches; stratifying TPL results by number of matches; increasing the frequency of the TPL monthly file updates; increasing the reliability of TPL data, e.g., matching appropriate coverage to corresponding claims; and increasing the frequency of TPL matching done before claims payment.
Leverage additional data sources	Add additional TPL data sources to help improve pre- and post-payment TPL activities.
Improve MCO-EOHHS communication on TPL	Improving TPL related communications between the state's MCOs and EOHHS to include regular communication on processes, status, and trends in TPL matches, recoupments, and recoveries; exchanging TPL data bidirectionally between MCOs and EOHHS; adding TPL data for claims and encounters, pay and chase status (i.e., pending cases, success rate, etc.); and more regular updates on Medicaid member TPL information. Tools to do this include, but are not limited to dashboards, ad hoc reports, status reports, and data files.
Improve MCO TPL performance transparency	Improving TPL performance transparency by developing performance standards and reporting on TPL performance according to industry standards. The goal of these standards is to incentivize MCOs to prioritize TPL. Any new standards developed will need to be added to MCO contracts with reporting standards, such as a TPL dashboard report.
Grade TPL matches	Grading TPL matches for quality involves assessing the match by the likelihood of valid TPL recovery or recoupment. This can be an automated process as part of identifying TPL to add the match grade to the results. Based on the grades, TPL matches can be stratified, and limits can be implemented around which matches to pursue by grade.

Opportunity	Description
Verify TPL information	Verifying TPL information includes increasing TPL reporting from providers, encouraging members to self-report, verifying self-reported TPL information automatically with third parties, MCOs verifying TPL information with members, and MCOs contacting third parties to verify coverage before processing payment.
Improve TPL information completeness	Improving TPL information completeness seeks to ensure that all TPL information includes a start date, an end date, and the type of insurance coverage. When new coverage is added overlapping with previous coverage with no end date, the old coverage should be end dated. This also includes data cleansing by looking for duplicate coverage types during the TPL information verification process. Finally, all systems must account for multiple coverage types.
Process mandatory FFS claims rather than delay due to TPL	For certain mandatory FFS services, rather than delaying a claim in adjudication due to TPL, the claim should be processed and referred for pay and chase. This includes adding a toggle in TPL logic to indicate whether to check for TPL pre- or post-payment and when the claims module has bypassed pre-payment TPL results.

Exhibit 46: Third Party Liability Process Improvement Opportunities

2.4.4 Gap Analysis by Business Process

Exhibit 47: Third Party Liability Level 0 Process Map provides a high-level depiction of the end-to-end scope and boundaries of the TPL functional area. Note: the processes in the map may not necessarily occur in the sequential order shown.

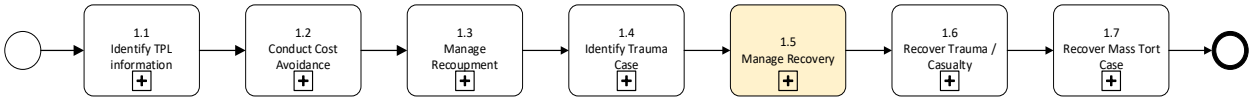


Exhibit 47: Third Party Liability Level 0 Process Map

The following information is provided for each of the five business processes:

- **Process Description** – High-level definition of the scope and purpose of the business process
- **Gaps** – List of major changes from As-Is to To-Be assessments
- **High-level Requirements** – Statements of necessary conditions to close gaps

There are no changes between the as-is and to-be Manage Recovery business process; therefore, this process is excluded from the gap analysis.

2.4.4.1 Identify TPL Information

Identification of TPL information is the process by which the MES is loaded with Member TPL information from various sources. Most data sources are loaded monthly in an automated fashion; however, some information is manually entered ad hoc. Sources of TPL information that are loaded in an automated fashion include Medicaid program enrollment, Providers, the TPL Clearinghouse, and Medicare. Member

coverage can change frequently and the efficiency of the TPL process depends on the currency and accuracy of coverage information. Manual entries are performed to update the MES with information in between monthly updates and from other sources not integrated into the automated data feed.

Process Gaps and Requirements

Exhibit 48: Identify TPL Information Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Identify TPL Information process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
MMIS updates TPL information with data from the MMA File and RIBridges. The financial calendar dictates what day of the month the TPL update cycle begins.	MES updates TPL information with data from the MMA File and RIBridges. The financial calendar dictates what day of the month the TPL update cycle begins.	Fiscal Agent increases frequency of TPL reporting to support synchronization of coverage date data.	MES will retrieve TPL data updates on a monthly or semi-monthly basis.
The Fiscal Agent manually initiates the HMS file update monthly by providing a list of enrolled Members to the HMS clearinghouse.	The Fiscal Agent manually initiates the TPL file update monthly by providing a list of enrolled Members to the TPL clearinghouse. Establish bidirectional interfaces between TPL vendor(s) and the Fiscal Agent to more frequently trigger automatic updates, reducing the frequency or obviating the need for this step.	Fiscal Agent establishes bidirectional interfaces between TPL vendor(s) and the Fiscal Agent to more frequently trigger automatic updates, reducing the frequency or obviating the need for this step.	MES will interface with TPL Clearinghouse bidirectionally to exchange lists of enrolled Members. MES will use automated workflows to trigger interface updates on a regular basis. MES will implement a procedure to end-date TPL segments when members lose Medicaid eligibility.
The Fiscal Agent initiates Provider outreach to obtain the latest TPL information for Members if not provided via other ingestion methods.	The Fiscal Agent automatically initiates Provider outreach to obtain the latest TPL information for Members if not provided via other ingestion methods.	Fiscal Agent automates updates and receives more frequent third-party updates	MES will automatically contact Providers via Provider's preferred means of communication (phone, email, or Provider Portal) to obtain additional TPL information, when needed.
The Fiscal Agent obtains Member coverage	The Fiscal Agent obtains Member coverage	Fiscal Agent automatically uploads TPL information	TPL information from Health Plans will

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
information from health plans (e.g., Neighborhood). Health plans provide data in spreadsheets and send them via email, and the Fiscal Agent manually performs updates in the MMIS.	information from health plans (e.g., Neighborhood). Health plans provide data in spreadsheets and send them via email or a more direct method, and the Fiscal Agent automatically updates in the MES.	sent by Health Plans into the MES.	automatically be uploaded to the MES.

Exhibit 48: Identify TPL Information Process Gaps and Requirements

2.4.4.2 Conduct Cost Avoidance

Conducting Cost Avoidance is the first step in maintaining Medicaid's status as the payer of last resort. The process is designed to ensure Providers are billing all relevant sources of TPOI for claims submitted to Medicaid prior to claim adjudication. Appropriate billing of TPOI maximizes the likelihood that all relevant TPOI coverages have been fully exhausted prior to Medicaid paying a claim.

Process Gaps and Requirements

Exhibit 49: Conduct Cost Avoidance Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Conduct Cost Avoidance process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
When a claim is submitted, the Fiscal Agent conducts a review in the system to identify TPOI coverage related to the claim.	When a claim is submitted, the Fiscal Agent and/or TPL Vendor(s) conducts a review in the system to identify TPOI coverage related to the claim. Better data synchronization from more frequent TPL updates will reduce the need for manual review.	Fiscal Agent increases frequency of TPL reporting to support synchronization of coverage date data.	MES will retrieve TPL data updates on a monthly or semi-monthly basis.
The Fiscal Agent verifies that TPOI was billed correctly by the Provider with an accurate	The Fiscal Agent automatically verifies that TPOI was billed correctly by the Provider with an accurate EOB	The Fiscal Agent automatically reviews claims to ensure TPOI was billed correctly, and the EOB is accurate.	The MES will automatically review claims to ensure TPOI was billed correctly, and the EOB is accurate.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Explanation of Benefits (EOB).			

Exhibit 49: Conduct Cost Avoidance Process Gaps and Requirements

2.4.4.3 Manage Recoupment

The Manage Recoupment business process is initiated according to the financial calendar which determines when the BenV cycle is run. The process is designed to serve as a second layer of defense to preserve Medicaid as the payer of last resort. The BenV cycle is a series of reports generated by MES to identify claims overpayments where there is TPOI that should have been applied prior to the Medicaid payment.

Process Gaps and Requirements

Exhibit 50: Manage Recoupment Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Recoupment process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Once the monthly BenV cycle is triggered, the Fiscal Agent utilizes BenV to identify overpayments where Medicaid was not the payer of last resort, retrieves these claims, payments, and TPOI information. The Fiscal Agent reviews the report and manually identifies claims marked with both “Paid” and TPL.	Once the monthly BenV cycle is triggered, the Fiscal Agent and/or TPL Vendor(s) utilizes BenV to identify overpayments where Medicaid was not the payer of last resort and automatically retrieves these claims, payments, and TPOI information. The Fiscal Agent and/or TPL Vendor(s) reviews the report and automatically identifies claims marked with both “Paid” and TPL.	Fiscal Agent and/or TPL Vendor(s) automatically retrieve and review the claim, payment, and TPOI information and automatically identifies claims marked with both "Paid" and TPL.	MES and/or TPL System will automatically retrieve and review the claim, payment, and TPOI information. MES and/or TPL System will automatically identify claims marked with both "Paid" and TPL.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
If funds are not recouped within the 60-day timeline, the amount overpaid by Medicaid is written off.	If funds are not recouped within the 60-day timeline, the amount overpaid by Medicaid is written off. Add reason code for claim write-offs.	Fiscal Agent and/or TPL Vendor(s) adds reason code for overpayment write-off after 60-day timeframe to support root cause analysis.	MES and/or TPL System will add reason code for overpayment write-off after 60-day timeframe to support root cause analysis.

Exhibit 50: Manage Recoupment Process Gaps and Requirements

2.4.4.4 Identify Trauma Cases

The Identify Trauma Cases business process is responsible for identifying recoverable Member claims involving accident / trauma diagnoses. The Fiscal Agent and/or TPL Vendor(s) reviews a report of Member trauma claims to identify those that are potentially recoverable. The Fiscal Agent and/or TPL Vendor(s) obtains medical records from Providers for each claim and forwards the information to EOHHS. EOHHS determines if the Medicaid Member was at-fault and excludes those claims as non-recoverable. Recoverable claims proceed to the Recover Trauma / Casualty process.

Process Gaps and Requirements

Exhibit 51: Identify Trauma Cases Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Identify Trauma Cases process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Provider questionnaire regarding trauma incidents report is automatically generated, and medical record requests are mailed to Providers.	The Provider questionnaire regarding trauma incidents report is automatically generated, and medical record requests are sent to Providers via the Provider Portal.	Fiscal Agent sends Provider questionnaire regarding trauma incidents to Providers via Provider Portal.	The Provider questionnaire regarding trauma incidents report will be sent to Providers via the Provider Portal.
The Fiscal Agent receives the medical records and forwards them via interoffice mail to EOHHS.	The Fiscal Agent and/or TPL Vendor(s) receives the medical records and forwards them via email to EOHHS.	Fiscal Agent and/or TPL Vendor(s) emails medical records to EOHHS to eliminate dependencies on USPS and improve security of HIPAA information.	MES and/or TPL System will securely email medical records to EOHHS for determination of trauma case.

Exhibit 51: Identify Trauma Cases Process Gaps and Requirements

2.4.4.5 Recover Trauma / Casualty

The Recover Trauma / Casualty business process helps the EOHHS ensure Medicaid is the payer of last resort when another liable party should pay for medical claims related to trauma or a casualty. The EOHHS is responsible for this business process and uses a tool called MRN to assist with the process of imposing liens and receiving payments from liable third parties.

Process Gaps and Requirements

Exhibit 52: Recover Trauma / Casualty Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Recover Trauma / Casualty process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The EOHHS updates an Excel file with the payment information (amount, check number, release, and closing date).	The EOHHS updates an Excel file with the payment information (amount, check number, release, and closing date). Move to MRN as single system of record.	EOHHS updates MRN with payment data.	MRN will allow payment data updates from EOHHS.

Exhibit 52: Recover Trauma / Casualty Process Gaps and Requirements

2.4.4.6 Recover Mass Tort Case

The Recover Mass Tort Case business process helps the EOHHS ensure Medicaid is the payer of last resort when another liable party should pay for medical claims related to a mass tort case. The EOHHS is responsible for this business process and works with the Legal Solutions Vendor to help identify potential cases and recover money owed back to the State.

Process Gaps and Requirements

Exhibit 53: Recover Mass Tort Case Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Recover Tort Claims process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The EOHHS receives a list of claimants from Epiq via email, typically once or twice a month. The list includes names, Social	The EOHHS receives a list of claimants from the Legal Solutions Vendor via email, typically once or twice a month. The list	Legal Solution Vendor establishes interface with MES for list of tort claimants.	Legal Solution System will interface with MES to transmit a list of tort claimants.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Security Numbers, and dates of injury.	includes names, Social Security Numbers, and dates of injury. Consider establishing an interface with the Legal Solutions Vendor.		
The EOHHS updates the list received from Epiq to indicate Medicaid eligibility status.	The EOHHS updates the list received from the Legal Solutions Vendor to indicate Medicaid eligibility status. If an interface with the Legal Solutions Vendor exists, then updates can be automated.	MES automatically updates a list with Medicaid eligibility status.	Legal Solution System will interface with MES to update tort claimants list with Medicaid eligibility status.
The EOHHS compiles the relevant claims information for the Medicaid Members on the list received from Epiq.	The EOHHS compiles the relevant claims information for the Medicaid Members on the list received from the Legal Solutions Vendor. If an interface with the Legal Solutions Vendor exists, then updates can be automated.	MES automatically compiles claims information for Medicaid Members included on the tort claimants list from the Legal Solutions Vendor.	MES will automatically compile claims information for Medicaid Members included on the tort claimants list from the Legal Solutions System.
The EOHHS sends the updated list and any associated claims for Medicaid Members back to Epiq.	The EOHHS sends the updated list and any associated claims for Medicaid Members back to the Legal Solutions Vendor. If an interface with the Legal Solutions Vendor exists, then the update can be automated.	MES sends an updated list of tort claimants based on Medicaid eligibility status and any associated claims to Legal Services Vendor.	MES will send an updated list of tort claimants based on Medicaid eligibility status and any associated claims to Legal Services System via interface.

Exhibit 53: Recover Mass Tort Case Process Gaps and Requirements

2.5 Pharmacy Drug Management

The Pharmacy Drug Management (PDM) function is performed by the PDM Vendor(s) to manage prescription drug benefits, on behalf of EOHHS, for Rhode Island's Medicaid Members. The PDM Vendor(s) is responsible for maintaining drug formularies, updating, and maintaining the Medicaid FFS

preferred drug list, monitoring, tracking, and reporting on rebate payments, and conducting drug utilization reviews to reduce clinical abuse and misuse of prescription drugs covered under the Rhode Island Medicaid Program.

The Pharmacy Drug Management functional area consists of five process functions:

1. Manage Drug Formulary
2. Manage Preferred Drug List (PDL)
3. Manage Drug Rebate
4. Generate Drug Rebate Reports
5. Conduct Drug Utilization Review (DUR)

2.5.1 Business Actors

Exhibit 54: Pharmacy Drug Management Business Actors includes the actors, i.e., people, vendors, and/or organizations, which support the PDM business processes.

Actor	Description
Drug Manufacturer	For the purposes of PDM, drug manufacturers refer to the manufacturers currently participating in the Medicaid Drug Rebate Program (approximately 780). The program requires a drug manufacturer to enter into, and have in effect, a National Drug Rebate Agreement (NDRA) with the Secretary of the Department of Health and Human Services (HHS) in exchange for state Medicaid coverage of most of the manufacturer's drugs.
Centers for Medicare & Medicaid Services (CMS)	CMS is the federal agency that runs the Medicare, Medicaid, Children's Health Insurance Programs (CHIP), and the federally facilitated Marketplace. Each State administers their own Medicaid and CHIP program; however, CMS is responsible for establishing regulations and guidance for Medicaid and CHIP.
EOHHS	EOHHS is the single State agency designated to administer the Medicaid program in Rhode Island.
Pharmacy Data Vendor (PDV)	The PDV may be a subcontractor to the PDM Vendor and provides pharmacy drug files used to update the preferred drug list and drug formularies. The PDV drug files are also used to support prospective DUR claims edits.
PDM Vendor(s)	The PDM Vendor(s) will provide pharmacy support such as managing the supplemental drug rebates, providing the PDL updates, and participating in the Pharmacy and Therapeutics (P&T) Committee meetings. EOHHS will contract with one or more PDM vendors to provide Pharmacy Drug Management services. The functions may be procured as part of a contract that includes only the Pharmacy Drug Management functions or a contract that includes the Pharmacy Drug Management functions as well as other MES functions.

Exhibit 54: Pharmacy Drug Management Business Actors

2.5.2 Technology and Tools

Exhibit 55: Pharmacy Drug Management Technology and Tools includes the technology and tools used by the PDM processes.

System Name	Description
Business Objects	Business Objects is a querying and reporting tool.
CMS Website (CMS Medicaid Drug Rebate Portal)	The CMS Website provides information and data such as the drug rebate file and provides a drug rebate portal for required reports.
Email	The PDM Vendor(s), EOHHS, drug manufacturers, and other actors use email as a communication tool to distribute reports and data that does not contain protected health information (PHI).
EOHHS Website	The EOHHS website contains information for Medicaid members and providers.
Medicaid Enterprise System	The MES is an integrated group of subsystems / modules with open APIs which leverage an integration platform to enable interoperability with other modules. The MES is operated by a single or multiple vendors and will support EOHHS in administering the state Medicaid program.
PDM Vendor(s) Systems and Tools	The PDM Vendor leverages its systems and tools including databases to support certain PDM tracking and reporting activities.
Secure File Transfer Protocol	The PDM Vendor(s) uses SFTP to post manufacturer drug rebate invoices.
Toad	Toad is a database management toolset.
Word	The PDM Vendor(s) creates Word documents describing updates and changes made.

Exhibit 55: Pharmacy Drug Management Technology and Tools

2.5.3 Process Improvement Opportunities

Exhibit 56: Pharmacy Drug Management Process Improvement Opportunities describes the improvement opportunities incorporated across the to-be Pharmacy Drug Management processes. Changes to as-is business processes are denoted by yellow highlights in the to-be process diagrams.

Opportunity	Description
Enhance automation	The EOHHS PDM Vendor(s) will enhance automation by implementing new systems and tools which will reduce the manual nature of these processes.

Employ robust reporting tools	The State will improve reporting metrics and systems due to the PDM Vendor(s) implementing robust reporting tools.
Obtain in-house pharmacy expertise	The State requires deep pharmacy expertise for multiple PDM processes and may look to bring in an internal resource.
Consolidate data entry	The EOHHS PDM Vendor(s) will reduce duplicative data entry by incorporating more automated processes.

Exhibit 56: Pharmacy Drug Management Process Improvement Opportunities

2.5.4 Gap Analysis by Business Process

Exhibit 57: Pharmacy Drug Management Level 0 Process Map depicts the scope and full lifecycle of the PDM. Note: the processes in the map may not necessarily occur in the sequential order shown.

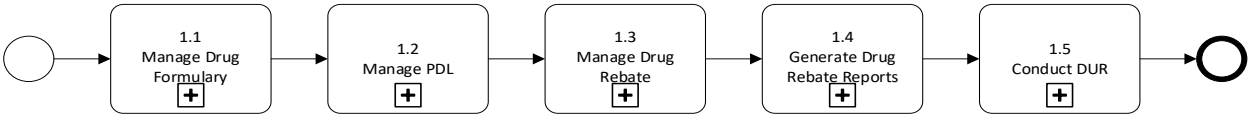


Exhibit 57: Pharmacy Drug Management Level 0 Process Map

A gap analysis for each process is documented in the sections below, including the following information:

- **Process Description** – High-level definition of the scope and purpose of the business process
- **Gaps** – List of major changes from As-Is to To-Be assessments
- **High-level Requirements** – Statements of necessary conditions to close gaps

2.5.4.1 Manage Drug Formulary

The Manage Drug Formulary process maintains and updates the drug formularies of the Department of Health ADAP and the RIPAE Program. ADAP provides coverage for FDA-approved HIV drugs to Ryan White HIV/AIDS program members. RIPAE pays a portion of the cost of RIPAE-approved medications purchased during the deductible stage of a Medicare Part D plan for participating members. The state does not have a drug formulary for the Medicaid Program and uses the PDL for covered drugs; however, states are required to cover any drug where CMS has a rebate contract with the drug manufacturer. EOHHS works with the PDM Vendor(s), the Rhode Island Office of Healthy Aging, AIDS Clinical Task Force, and others as needed to determine which drugs are included in each drug formulary for ADAP and RIPAE (updates are rare for RIPAE).

There are two separate drug formularies used by the PDM Vendor(s) to determine what drugs are approved for use and covered by ADAP and RIPAE. The PDM Vendor(s) uses the PDV file and accompanying report to obtain the information needed to update the ADAP and RIPAE formularies. Updates are made on a weekly basis for ADAP if a new National Drug Code (NDC), Generic Code Number (GCN), and/or therapeutic class is available, and on an infrequent basis for RIPAE, typically only if a new NDC is available. In addition, the PDM Vendor(s) may also receive updates for the ADAP and RIPAE formularies from EOHHS (updates are rare for RIPAE).

The PDM Vendor is responsible for maintaining the drug formularies and reference files used by the MES and has a blanket approval from EOHHS to make updates to the formularies as needed.

Process Gaps and Requirements

Exhibit 58: Manage Drug Formulary Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Drug Formulary process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent determines if there are any updates for the ADAP formulary based on the review of the FDB file.	The PDM Vendor(s) can leverage automated tools to determine if there are any updates for the ADAP formulary based on the review of the PDV file.	The PDM Vendor(s) automatically reviews the PDV file to determine if ADAP formulary updates are required and leverages in-house pharmacy expertise when appropriate.	PDM System will automatically review PDV file to determine ADAP formulary updates. PDM System will use in-house pharmacy expertise to verify ADAP formulary updates.

Exhibit 58: Manage Drug Formulary Process Gaps and Requirements

2.5.4.2 Manage PDL

The Manage PDL process involves updating and maintaining the FFS, PDL, which includes a listing of therapeutic classes and associated drugs managed by the P&T Committee. In addition, the PDL includes information about drugs that require prior authorization; however, it is not an all-inclusive list of covered medications in the Medicaid FFS program.

EOHHS's PDM Vendor(s) maintains and implements updates to the PDL on a weekly and quarterly basis. Weekly PDL updates are made using the data received from the PDV. Quarterly PDL updates are made based on the P&T recommended PDL updates approved by EOHHS.

Note: The PDM Vendor(s) also provides P&T Committee support including preparing and presenting therapeutic drug class reviews at committee meetings, developing recommendations for PDL inclusion, identifying clinical program impacts, and an annual presentation of P&T program impacts.

Process Gaps and Requirements

Exhibit 59: Manage PDL Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage PDL processes.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Weekly Process			
The Fiscal Agent manually reviews the FDB report for updates to the PDL. This step requires Medicaid pharmacy expertise.	The PDM Vendor(s) automatically reviews the PDV report for updates to the PDL. This activity requires Medicaid pharmacy expertise, which may require the engagement of an EOHHS resource.	The PDM Vendor(s) automatically reviews the PDV report for PDL updates, leveraging in-house pharmacy expertise when appropriate.	PDM System will automatically review PDV file to determine PDL updates. PDM System will use in-house pharmacy expertise to verify PDL updates.
The Fiscal Agent prepares for the PDL updates using a spreadsheet. This step also includes reviewing existing data in the MMIS/PDM module to determine where in the system updates are required.	The PDM Vendor(s) prepares the PDL updates using its systems and tools. This activity also includes reviewing existing data in the MES to determine where in the system updates are required.	The PDM Vendor(s) automatically prepares PDL updates using the PDM Vendor(s)' systems and tools to reduce the risk of version control.	PDM Vendor(s) will prepare PDL updates with the PDM Vendor's systems and tools.
The Fiscal Agent processes the new Magellan file for review using an Access DB to compare the new and previous file.	The PDM Vendor(s) processes the new file for review using its systems and tools to automatically compare the new and previous file.	The PDM Vendor(s) automatically compares the new and old PDV files to reduce version control risks.	The PDM System will automatically compare the new and old PDV files to reduce version control risks.
The Fiscal Agent reviews the processed Magellan data to determine PDL updates that are needed. Updates include drugs to be added, terminated, and/or status changes (preferred to non-preferred and vice versa).	The PDM Vendor(s) reviews the processed PDL data against the PDV list, via automated tools, to determine necessary PDL updates. Updates include drugs to be added, terminated, and/or status changes (preferred to non-preferred and vice versa).	The PDM Vendor(s) automatically reviews the PDL data against the PDV list to determine updates.	The PDM System will automatically review the PDL data against the PDV list to determine updates.
The Fiscal Agent prepares for the PDL updates using a spreadsheet. In addition, the Fiscal Agent uses the	The PDM Vendor(s) prepares the PDL updates using its systems and tools. In addition, the PDM	The PDM Vendor(s) automatically prepare updates to PDL data using	The PDM System will automatically prepare updates to PDL data using

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
MMIS/PDM Module and spreadsheets to determine where PDL updates are needed.	Vendor(s) uses the MES and its systems and tools to determine where PDL updates are needed.	PDM and MES tools and systems.	PDM and MES tools and systems.
The Fiscal Agent makes the required PDL updates in the MMIS/PDM Module.	The PDM Vendor(s) makes the required PDL updates, which are available in the MES.	The PDM Vendor(s) automatically update PDL data in MES.	The PDM System will automatically update PDL data in MES.
Quarterly Process			
Magellan makes the required updates to the file they send to the Fiscal Agent.	The PDM Vendor(s) makes the required and approved PDL updates using its systems and tools.	The PDM Vendor(s) automatically update the PDL data via PDM systems and tools to reduce the manual process of this activity.	The PDM System will automatically update the PDL data via PDM systems and tools to reduce the manual process of this activity.
The Fiscal Agent starts a subprocess to verify and compare the updates included in the Magellan list.	The PDM Vendor starts a subprocess to verify and compare the updates to determine if PDL updates to the summary of changes document and the EOHHS website are needed.	The PDM Vendor(s) automatically verifies the updates by comparing PDL updates in the summary of changes document to the EOHHS website.	The PDM System automatically verifies the updates by comparing PDL updates in the summary of changes document to the EOHHS website.
The Fiscal Agent updates the formal PDL list and summary of changes document that is posted to the EOHHS website for the provider community.	The PDM Vendor(s) updates the PDL list and summary of changes document using its systems and tools.	The PDM Vendor(s) automatically updates the PDL list using its systems and tools, reducing the manual process of this activity.	If PDL updates are needed, the PDM System will update the PDL summary of changes document.

Exhibit 59: Manage PDL Process Gaps and Requirements

2.5.4.3 Manage Drug Rebate

The Manage Drug Rebate business process covers Medicaid FFS, managed care, ADAP, and RIPAE. The process receives quarterly drug rebate information from CMS, compares drug rebate information to quarterly payment history information, identifies drug information matches based on manufacturer and drug codes, applies the rebate factor and volume indicators, calculates the total rebate per manufacturer, prepares drug rebate invoices, sorts the invoices by manufacturer and drug code, sends the invoice information, and monitors, tracks, and reports on rebate payments. This process collects drug rebates for Medicaid FFS, managed care, ADAP, and RIPAE. Rebates are collected for pharmacy claims and physician administered drugs. Medicaid FFS and managed care drug claims associated with the 340b program are excluded from drug rebates.

The Manage Drug Rebate business process also supports requests from manufacturers to provide claim level details to validate drug rebate requests and disputes. Typically, disputes are related to billing errors and code conversion issues. The dispute process can take a significant amount of time. Disputes determined in the favor of EOHHS require the manufacturers to pay the amount owed, plus any interest that accrues during the dispute process.

EOHHS delegates the entire Manage Drug Rebate process to the PDM Vendor(s). The PDM Vendor(s) manages the federal drug rebate program and the supplemental drug rebate program for EOHHS. The supplemental drug rebate program includes Rhode Island in the National Medicaid Pooling Initiative and includes submission of supplemental rebates, associated dispute resolution, and financial program impacts. (Note: all functions performed for the federal drug rebate program are also expected to be performed for the supplemental drug rebate program, as applicable.)

Process Gaps and Requirements

Exhibit 60: Manage Drug Rebate Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Drug Rebate processes.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Generate Invoices			
The Fiscal Agent compares the file to the corresponding claims history extract for the same quarter. Note: Part of this step includes determining if any prior quarter adjustments are needed. If so, those will be picked up in Step 3	The PDM Vendor(s) compares the file to the corresponding claims history extract for the same quarter using its systems and tools to reduce manual processes. Note: Part of this activity includes determining if any prior quarter adjustments	The PDM Vendor(s) automatically compares the drug rebate file to the corresponding claims history extract for the same quarter, including determining if any prior quarter adjustments are needed, using its systems and tools to reduce the	The PDM System will automatically compare the drug rebate file to the corresponding claims history extract for the same quarter, including determining if any prior quarter adjustments are needed, using its systems and tools to reduce the

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
(Select and sort drug claims matching the manufacturer and drug codes).	are needed. If so, those will be picked up in Select and sort drug claims matching the manufacturer and drug codes.	manual process of this activity.	manual process of this activity.
The Fiscal Agent selects the drug claims matching the manufacturer and drug codes based on the CMS drug product data (by matching the NDCs from claims to the corresponding NDCs in CMS data).	The PDM Vendor(s) selects the drug claims matching the manufacturer and the system automatically sorts the drug codes for invoicing based on the CMS drug product data (by matching the NDCs from claims to the corresponding NDCs in CMS data).	The PDM Vendor(s) automatically sort the drug codes for invoicing using its systems and tools to reduce the manual process of this activity.	The drug claims will match the drug claims with the manufacturer and drug codes based on the CMS drug product data in order to be sorted for invoicing. The NDCs from claims will correspond to the NDCs in CMS data.
Manufacturer Requests			
N/A - No changes made			
Process Dispute Form (if applicable)			
N/A - No changes made			
Process Payments			
The Fiscal Agent generates a drug rebate report that includes FFS, managed care organization (MCO), J-codes, invoice numbers, manufacturer name and labeler code, and the value of invoices. Note: J-codes are part of the Healthcare Common Procedure Coding System (HCPCS) Level II set of procedure codes.	The PDM Vendor(s) generates a drug rebate report, using robust reporting tools, that includes FFS, MCO, J-codes, invoice numbers, manufacturer name and labeler code, and the value of invoices. Note: J-codes are part of the HCPCS Level II set of procedure codes.	The PDM Vendor(s) implement robust reporting tools to generate the drug rebate report.	The PDM System will generate reports that include FFS, managed care organization, J-codes, invoice numbers, manufacturer name, labeler code, and value of invoices in order to process drug rebate payments.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent manually converts the report into an Excel format and imports the Excel spreadsheet into an Access DB. Note: Any invoice changes are included in the spreadsheet.	The PDM Vendor(s) will import the report into its systems and tools which may include a database or spreadsheet. Note: Any invoice changes are included in the spreadsheet.	The PDM Vendor(s) imports the drug rebate report into the PDM Module.	The PDM System will import the drug rebate report into the PDM Module.
The Fiscal Agent posts the payments in the Access DB (i.e., enters the payment information).	The PDM Vendor(s) posts the payments in the MES/PDM Module and in its internal system as needed (i.e., enters the payment information).	The PDM Vendor(s) posts drug rebate payments in the MES/PDM Module.	The PDM System will post drug rebate payments in the MES/PDM Module.
Supplemental Drug Rebate			
At the end each quarter Magellan sends the Fiscal Agent a list of NDC numbers eligible for drug rebate. Magellan has supplemental rebate contracts with manufacturers and pools Rhode Island Medicaid with other states as part of the National Medicaid Pooling Initiative.	At the end each quarter, the PDM Vendor(s) generates a list of NDC numbers eligible for drug rebate, using its robust reporting tools. The PDM Vendor(s) has supplemental rebate contracts with manufacturers and pools Rhode Island Medicaid with other states as part of the National Medicaid Pooling Initiative.	The PDM Vendor(s) automatically generates a list of NDC numbers eligible for drug rebate usings robust reporting tools.	The PDM System will generate a list of NDC numbers eligible for drug rebate at the end of each quarter.
The MMIS compares the Magellan list to FFS-only claims that have been gathered for the quarter (the same used to invoice for the CMS quarterly portion of the process), removes any claims that Magellan sent, and	The MES compares the PDM Vendor(s) list to FFS-only claims that have been gathered for the quarter (the same used to invoice for the CMS quarterly portion of the process), removes any claims that the PDM Vendor(s) sent, and automatically creates an	The PDM Vendor(s) will automatically receive an output file, generated from the MES.	The MES will compare the PDM Vendor(s) list of NDC numbers eligible for drug rebate to FFS-only claims that have been gathered for the quarter, removes any claims that were sent, and automatically creates an output file for PDM Vendor(s).

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
creates an output file for Magellan.	output file for PDM Vendor(s).		The MES will automatically send the drug rebate output file to the PDM System. The PDM System will automatically receive the drug rebate output from the MES.

Exhibit 60: Manage Drug Rebate Process Gaps and Requirements

2.5.4.4 Generate Drug Rebate Reports

The Generate Drug Rebate Reports business process produces periodic reports to support drug rebate management, including rebate money collected and owed, program offsets, and required CMS utilization reports. On a biweekly (every two weeks) and quarterly basis, the PDM Vendor(s) generates reports covering the rebate money collected and owed for the EOHHS Financial Staff. Each quarter the PDM Vendor(s) generates a drug rebate offset report for the EOHHS Financial Staff and on a quarterly basis, will generate the CMS required drug utilization report that is sent to CMS.

The PDM Vendor(s) is responsible for the entirety of this process.

Process Gaps and Requirements

Exhibit 61: Generate Drug Rebate Reports Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Generate Drug Rebate processes.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Biweekly and Quarterly Reports			
The Fiscal Agent generates biweekly and quarterly drug rebate reports for EOHHS Financial Staff based on the approved financial calendar.	The PDM Vendor(s) automatically generates biweekly and quarterly drug rebate reports for EOHHS Financial Staff based on the approved financial calendar, using its robust reporting tools. The data for the biweekly and quarterly reports is the same, however the quarterly report is a	The PDM Vendor(s) uses its robust reporting tools to automatically generate biweekly and quarterly drug rebate reports for the EOHHS Financial Staff.	PDM System will automatically generate biweekly and quarterly drug rebate ports for EOHHS Financial Staff according to the EOHHS-approved financial calendar.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
	summary for the quarter. The approved financial calendar that EOHHS approved is used to determine when to generate reports.		
The Fiscal Agent generates the drug rebate status reports. There are reports for FFS, MCO, CHIP, and Medical Assistance. The reports include pharmacy and physician administered (J-codes) information.	The PDM Vendor(s) generates the drug rebate status reports, leveraging its robust reporting tools. There are reports for FFS, MCO, CHIP, and Medical Assistance. The reports include pharmacy and physician administered (J-codes) information.	The PDM Vendor(s) automatically generates drug rebate status reports.	The PDM System will generate separate drug rebate reports for FFS, MCO, CHIP, and Medical Assistance populations, including pharmacy and physician administered (J-codes) information.
Quarterly Unit Rebate Offset Amount Reports			
N/A - No changes made			
Quarterly CMS Utilization Dataset			
N/A - No changes made			

Exhibit 61: Generate Drug Rebate Reports Process Gaps and Requirements

2.5.4.5 Conduct DUR

The Conduct DUR business process supports efforts to reduce clinical abuse and misuse of outpatient prescription drugs covered under the Rhode Island Medicaid Program. Rhode Island's DUR program interprets patterns of drug use in Medicaid programs and includes prospective drug review, retrospective drug use review, data assessment of drug use against predetermined standards, and ongoing educational outreach activities.

In Rhode Island, the PDM Vendor(s) is responsible for DUR activities for the FFS Medicaid members and the MCOs manage their own comparable DUR programs for managed care members. For the FFS Medicaid population, the PDM Vendor(s) provides oversight of the retrospective DUR subcontractors, and coordinates and facilitates quarterly DUR meetings.

Prospective DUR activities include electronic monitoring to screen prescription drug claims at the point-of-sale (prior to dispensing prescriptions) to identify problems such as: potential and actual adverse effects; therapeutic duplication; drug-disease interactions and contraindications; incorrect dosage frequency, or duration of treatment; clinical misuse or abuse; drug-drug interactions; medication appropriateness; incorrect drug dosage; duration or overutilization and underutilization of drug treatment; and pregnancy alerts. The PDM Vendor(s) contracts with the PDV to obtain the data needed for prospective DUR claims edits. In addition, the PDM Vendor(s) produces monthly prospective DUR reports, such as cost avoidance reports.

Retrospective DUR activities include ongoing and periodic review of claims data to identify patterns of therapeutic appropriateness; adverse events; appropriate use of generic products; incorrect duration of treatment; utilization and inappropriate or medically unnecessary care; gross overuse; and fraud and abuse. The PDM Vendor(s) conducts the retrospective DUR reviews, and there is an automated process to establish claims level detail to support DUR activities. The PDM Vendor(s) manages communication with providers and conducts related DUR reporting.

EOHHS uses the P&T and DUR meetings to analyze drug related data and information to determine rules for prior approvals for specific drugs. Any updates or new prior approval rules are provided to the PDM Vendor(s) and the PDM Vendor(s) makes the required configuration changes in the MES.

The Conduct DUR process also produces the annual DUR reporting to CMS. Annual DUR reports include the nature and scope of the prospective and retrospective DUR programs, a summary of DUR interventions, information about cost savings generated from Rhode Island's DUR programs, information about program operations, activities related to the adoption of innovative DUR practices, and a description of DUR board activities. The PDM Vendor(s) extracts FFS data from the MES and works alongside EOHHS for additional reporting content. EOHHS works with the MCOs to obtain the required managed care information needed for the annual CMS DUR report.

Process Gaps and Requirements

Exhibit 62: Conduct DUR Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Conduct DUR process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Conduct DUR (Prospective Reporting)			
The Fiscal Agent pulls relevant cost avoidance information out of the report including prior authorization, denials, approvals, etc. Note: This information is also used for the annual DUR CMS report.	The PDM Vendor(s) uses its robust reporting tools to pull relevant cost avoidance information out of the report including prior authorization, denials, approvals, etc. Note: This information is also used for the annual DUR CMS report.	The PDM Vendor(s) automatically pulls relevant cost avoidance information out of the report using its robust reporting tools to reduce the manual process of this activity.	The PDM System will use its own reporting tools to pull relevant cost avoidance information out of the report. The PDM Vendor(s) will use the relevant cost avoidance information in the annual DUR CMS report.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Conduct DUR (Prospective Reporting)			
Conduct DUR (Monthly Lock-in Report)			
The Fiscal Agent reviews the data for accuracy and make corrections if needed.	The PDM Vendor(s) reviews the data for accuracy and make corrections if needed, using its robust reporting tools to reduce manual processes.	The PDM Vendor(s) automatically reviews and corrects the accuracy of the monthly lock-in report data using robust reporting tools to reduce the manual process of this activity.	The PDM System will automatically review and correct the accuracy of the monthly lock-in report data using robust reporting tools to reduce the manual process of this activity.
Conduct DUR (Annual CMS Report)			
The Fiscal Agent compares claims data to the CMS drug source file to determine the total quantities, costs, percent of generic, percent of brands, and percent of multi-source brands.	The PDM Vendor(s) automatically compares claims data to the CMS drug source file to determine the total quantities, costs, percent of generic, percent of brands, and percent of multi-source brands.	The PDM Vendor(s) automatically compares claims data to the CMS drug source file, reducing the manual process of this activity.	The PDM System will automatically compare claims data to the CMS drug source file to determine the total quantities, costs, percent of generic, percent of brands, and percent of multi-source brands.

Exhibit 62: Conduct DUR Process Gaps and Requirements

2.6 Program Integrity

The Office of Program Integrity (OPI) within EOHHS ensures compliance, efficiency, and accountability within the Rhode Island Medicaid Program by detecting, preventing, and investigating fraud, waste, and abuse to ensure that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws. EOHHS OPI performs a wide range of activities to ensure the integrity of the Medicaid Program, and those activities are informed by information received from program stakeholders and through sophisticated data mining and modeling techniques. As a result of the Office's program integrity efforts, providers may be required to refund payments that were found to be erroneous, offered training to improve their billing practices, and/or be referred to the applicable licensing board, the Office of the Attorney General's Medicaid Fraud Control and Patient Abuse Unit (MFCU), or law enforcement if fraud is indicated.

EOHHS OPI delegates certain program integrity responsibilities and functions to the Program Integrity Vendor(s). Additionally, managed care program integrity functions are delegated to Managed Care Organizations (MCOs) contractually. Although EOHHS requires the Program Integrity Vendor(s) and MCOs to perform program integrity functions, the agency continues to be responsible for ensuring program integrity for both the fee-for-service (FFS) and managed care service delivery systems.

The Program Integrity functional area consists of three process functions:

1. Prevent Fraud, Waste, and Abuse
2. Identify and Investigate Fraud, Waste, and Abuse
3. Generate Program Integrity Reports

2.6.1 Business Actors

Exhibit 63: Program Integrity Business Actors includes the actors, i.e., people, vendors, and/or organizations, which support the Program Integrity business processes.

Actor	Description
Centers for Medicare & Medicaid Services (CMS)	CMS is the federal agency that runs the Medicare, Medicaid, Children's Health Insurance Programs, and the federally facilitated Marketplace. Each State administers their own Medicaid and CHIP program; however, CMS is responsible for establishing regulations and guidance for Medicaid and CHIP.
Claim and Encounter Processing (CEP) Vendor(s)	EOHHS will contract with one or more vendors to provide Claim and Encounter Processing services. The functions may be procured as part of a contract that includes only the Claim and Encounter Processing functions or a contract that includes the Claim and Encounter Processing functions as well as other MES functions.
Executive Office of Health and Human Services	EOHHS is the single State agency designated to administer the Medicaid program in Rhode Island.
EOHHS Office of Program Integrity (OPI)	The EOHHS OPI ensures compliance, efficiency, and accountability for the health and human services programs administered by the State of Rhode Island, including Medicaid. They are responsible for detecting and preventing fraud, waste, and program abuse, along with ensuring State and Federal dollars are spent appropriately, responsibly, and in accordance with applicable laws.
Managed Care Organization	Rhode Island contracts with MCOs (also referred to as "managed care plans") that provide comprehensive medical coverage to Medicaid beneficiaries. MCOs accept a set per member per month payment for these services and are at financial risk for the Medicaid services specified in their contracts.
MCO Special Investigations Unit (SIU)	The MCO SIU is responsible for program integrity efforts for their respective Medicaid member and provider populations.
Medicaid Fraud Control and Patient Abuse Unit (MFCU)	The MFCU is part of the Rhode Island Attorney General's Office and enforces the laws pertaining to fraud in the state Medicaid program and prosecutes cases of abuse, neglect, or mistreatment of patients in all state healthcare facilities. The Unit prosecutes criminal activity, pursues civil remedies where appropriate and participates with federal and state authorities in a variety of inter-agency investigations.

Actor	Description
Provider	The physicians, pharmacists, dentists, hospitals, and other healthcare providers who are contracted or authorized to provide covered services to Medicaid members. A prospective provider is a provider who is applying to be in the Medicaid program.
Provider Management Vendor(s)	EOHHS will contract with one or more vendors to provide Provider Enrollment and Management services. The functions may be procured as part of a contract that includes only the Provider Enrollment and Management functions or a contract that includes the Provider Management functions as well as other MES functions.
Program Integrity Vendor(s)	The Program Integrity Vendor(s) supports the State's program integrity efforts and is responsible for operating and maintaining the Program Integrity management system according to State and Federal requirements. This vendor(s) performs activities to proactively detect potential fraud, abuse, or misuse by all providers and members.

Exhibit 63: Program Integrity Business Actors

2.6.2 Technology and Tools

Exhibit 64: Program Integrity Technology and Tools includes the key technology and tools used by the Program Integrity processes.

System Name	Description
Business Objects	Business Objects is a tool that supports ad hoc querying and reporting. EOHHS OPI uses Business Objects to access the Medicaid Analytics Database, which is a combined FFS and managed care claim set.
Workflow tool	The Program Integrity Vendor(s), EOHHS OPI, and other actors use the workflow tool as a communication tool and to distribute reports and data that does not contain PHI
Program Integrity research tool	EOHHS OPI uses the Program Integrity research tool for internal program integrity research. This tool is populated with the State's Transformed Medicaid Statistical Information System (T-MSIS) data (this is the same dataset sent to CMS).
Mail / Courier / Hand Delivery	The US mail, couriers, or hand delivery is used to send and receive documentation and correspondence in support of Medicaid business processes.
Medicaid Enterprise System	The MES is an integrated group of subsystems / modules with open APIs which leverage an integration platform to enable interoperability with other modules. The MES is operated by a single or multiple vendors and will support EOHHS in administering the state Medicaid program.
Program Integrity reporting tool	The Program Integrity reporting tool is a query, reporting, and analysis tool employed by the Program Integrity Vendor(s) that uses information from the MES as its primary data source. The tool's primary function is to run comparisons of similar providers and members to identify outliers / significant differences across peer groups.

System Name	Description
Telephone	The telephone is used to send and receive information in support of Medicaid Program business processes.

Exhibit 64: Program Integrity Technology and Tools

2.6.3 Process Improvement Opportunities

Exhibit **65**: Program Integrity Process Improvement Opportunities describes the improvement opportunities incorporated across the to-be Program Integrity business processes.

Opportunity	Description
Increase use of analytics	Increase the use of descriptive and predictive analytics to identify utilization anomalies more effectively.
Leverage the All-Payer Claims Database (APCD)	Leverage the APCD for instances when further investigation is needed to identify fraud, waste, and abuse.
Leverage new data sources	Use technology and new data sources to identify, detect, prevent, and investigate fraud, waste and abuse more effectively.
Implement a workflow / case management tool to automate workflow and improve tracking	Implement an enhanced workflow / case management tool to effectively document, track and maintain visibility for ongoing reviews.

Exhibit 65: Program Integrity Process Improvement Opportunities

2.6.4 Gap Analysis by Business Process

Exhibit 66: Program Integrity Level 0 Process Map depicts the scope and full lifecycle of Program Integrity. Note: the processes in the map may not necessarily occur in the sequential order shown.

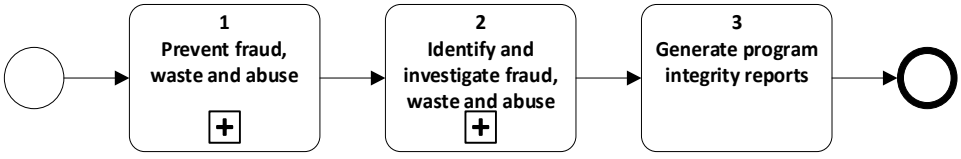


Exhibit 66: Program Integrity Level 0 Process Map

The Gap Analysis work product is composed of the following elements for each process area:

- **Process Description** – High-level definition of the scope and purpose of the business process
- **Gaps** – List of major changes from As-Is to To-Be assessments
- **High-level Requirements** – Statements of necessary conditions to close gaps

2.6.4.1 Prevent Fraud, Waste and Abuse

The Prevent Fraud, Waste and Abuse business process is performed by EOHHS OPI, the Program Integrity Vendor(s), the Provider Management Vendor(s), and the Claim and Encounter Processing Vendor(s) and includes a range of activities to deter fraud, waste, and abuse. Many of these activities are performed by the state's Vendor(s) as part of their routine Provider Management, Member Management, Pharmacy Drug Management, and Claim and Encounter Processing business processes to ensure medical necessity, claims accuracy, appropriate utilization of medications, and provider eligibility. EOHHS OPI and the Program Integrity Vendor(s) 's prevention efforts focus primarily on conducting reviews of Medicaid FFS claims prior to payment. Prevention efforts related to the potential overuse/abuse of prescription drugs are handled by the drug utilization review efforts described in the Pharmacy Drug Management functional area.

Process Diagram

Exhibit 67: Prevent Fraud, Waste and Abuse Process Diagram provides the BPMN diagram for the to-be Prevent Fraud, Waste and Abuse business process.

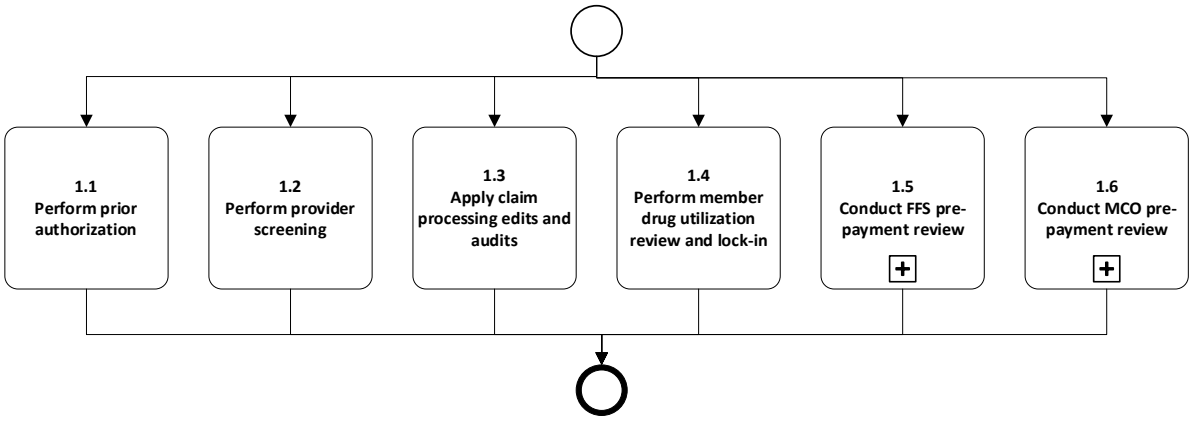


Exhibit 67: Prevent Fraud, Waste and Abuse Process Diagram

Process Gaps and Requirements

Exhibit 68: Prevent Fraud, Waste and Abuse Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Prevent Fraud, Waste and Abuse business process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent uses claims information to identify Medicaid members who show a pattern of excessive and uncoordinated use of	The Program Integrity Vendor(s) uses claims information to identify Medicaid members who show a pattern of excessive and	Program Integrity Vendor(s) uses automated workflows to place members identified by a pattern of excessive or uncoordinated use of	Program Integrity System will use automated workflows to place members identified by a pattern of excessive or uncoordinated use of

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
prescription. If a member triggers certain criteria, such as using multiple pharmacies within a short period of time, the member is placed in a Pharmacy Lock-In Program that limits the member to only one pharmacy to fill their Medicaid prescriptions. See Pharmacy Drug Management functional area for more information.	uncoordinated use of prescription. If a member triggers certain criteria, such as using multiple pharmacies within a short period of time, the member is placed in a Pharmacy Lock-In Program that limits the member to only one pharmacy to fill their Medicaid prescriptions. See Pharmacy Drug Management functional area for more information.	prescriptions in a Pharmacy Lock-In Program.	prescriptions in a Pharmacy Lock-In Program.
The SUR Team reviews Medicaid provider FFS claims prior to payment to ensure claims are accurate.	The Program Integrity Vendor(s) reviews Medicaid provider FFS claims prior to payment to ensure claims are accurate.	Program Integrity Vendor(s) uses automated workflows to review Medicaid provider FFS claims prior to payment to ensure claims accuracy.	Program Integrity System will use automated workflows to review Medicaid provider FFS claims prior to payment to ensure claims accuracy.
The MCOs must request EOHHS OPI approval before conducting a review of Medicaid provider managed care claims prior to payment.	The MCOs must request EOHHS OPI approval before conducting a review of Medicaid provider managed care claims prior to payment.	EOHHS OPI and MCOs use automated workflows to request and grant approval for conducting a review of Medicaid provider managed care claims prior to payment.	EOHHS OPI and MCOs will use automated workflows to request and grant approval for conducting a review of Medicaid provider managed care claims prior to payment.

Exhibit 68: Prevent Fraud, Waste and Abuse Process Gaps and Requirements

Conduct FFS Pre-Payment Review

In performing routine and follow-up reviews and in response to receiving tips, complaints, and/or referrals, the Program Integrity Vendor(s) conducts pre-payment reviews of a Medicaid provider's FFS claims. The Program Integrity Vendor(s) must obtain the approval of EOHHS OPI before initiating a pre-payment review and before issuing findings and taking any corrective action. Pre-payment reviews are time-consuming, and the initial period of review is commonly 6 months. At the completion of the review, the Program Integrity Vendor(s) prepares findings and recommendations. Recommendations may be to close the review (provider has addressed concerns), to continue the review (provider has improved but still needs oversight), or to terminate the provider (provider has shown no improvement). Note: If at any time during this process EOHHS OPI determines an act of fraud has been committed, the process is terminated, and a referral is made to MFCU, law enforcement, or the appropriate board.

Process Gaps and Requirements

Exhibit 69: Prevent Fraud, Waste and Process *Abuse* and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Conduct FFS Pre-Payment Review subprocess.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The SUR Team can initiate a pre-payment review based on various triggers, including, but not limited to, the execution of a routine or follow-up review; receipt of tips, complaints, and referrals from members, MCOs, other providers, EOHHS employees, and Fiscal Agent employees; or the results of data analysis and data mining. Note: If a tip / complaint / referral is related to a FFS provider, EOHHS OPI / SUR Team conducts a preliminary investigation to validate the tip / complaint / referral and if valid, conducts an investigation. EOHHS OPI assesses the impact to all managed care plans and the FFS program and coordinates / communicates the information across impacted stakeholders accordingly.	The Program Integrity Vendor(s) can initiate a pre-payment review based on various triggers, including, but not limited to, the execution of a routine or follow-up review; receipt of tips, complaints, and referrals from members, MCOs, other providers, EOHHS employees, and Program Integrity Vendor(s) employees; or the results of data analysis and data mining. Note: If a tip / complaint / referral is related to a FFS provider, EOHHS OPI / Program Integrity Vendor(s) conducts a preliminary investigation to validate the tip / complaint / referral and if valid, conducts an investigation. EOHHS OPI assesses the impact to all managed care plans and the FFS program and coordinates / communicates the information across impacted stakeholders accordingly.	Program Integrity Vendor(s) uses automated workflows to initiate a pre-payment review based on various triggers, including, but not limited to, the execution of a routine or follow-up review; receipt of tips, complaints, and referrals from members, MCOs, other providers, EOHHS employees, and Program Integrity Vendor(s) employees; or the results of data analysis and data mining.	Program Integrity System will use automated workflows to initiate a pre-payment review based on various triggers, including, but not limited to, the execution of a routine or follow-up review; receipt of tips, complaints, and referrals from members, MCOs, other providers, EOHHS employees, and Program Integrity Vendor(s) employees; or the results of data analysis and data mining.
The SUR Team submits a request to initiate a pre-payment review to EOHHS OPI via email. The SUR Team requires EOHHS OPI's approval before	The Program Integrity Vendor(s) submits a request to initiate a pre-payment review to EOHHS OPI using the workflow tool. The Program Integrity	The Program Integrity Vendor(s) uses automated workflows to improve the tracking of requests for pre-payment review.	The Program Integrity System will use automated workflows to improve the tracking of requests for pre-payment review.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
initiating a pre-payment review.	Vendor(s) requires EOHHS OPI's approval before initiating a pre-payment review.		
The EOHHS OPI reviews the pre-payment request. The supporting case information may be sent along with the email request, or EOHHS OPI may review the case in Case Tracker.	The EOHHS OPI reviews the pre-payment request. EOHHS OPI may review the case in the workflow tool while also leveraging the APCD when conducting the review.	EOHHS OPI uses automated workflows to review pre-payment review requests. EOHHS OPI leverages the APCD to support pre-payment reviews.	The Program Integrity System will use automated workflows to allow EOHHS OPI to review pre-payment review requests. The Program Integrity System will support use of APCD for pre-payment reviews.
The EOHHS OPI sends a response to the SUR Team either approving or rejecting the request.	The EOHHS OPI sends a response to the Program Integrity Vendor(s) either approving or rejecting the request.	EOHHS OPI uses automated workflows to pre-payment review request response by implementing an automated workflow tool to approve or reject the request.	The Program Integrity System will use automated workflows to allow EOHHS OPI to send pre-payment review request response to the Program Integrity Vendor.
The SUR Team closes the request / does not pursue the request further.	The Program Integrity Vendor(s) closes the request / does not pursue the request further.	The Program Integrity System uses automated workflows to close the request.	The Program Integrity System will use automated workflows to close requests if EOHHS OPI rejects pre-payment review request.
The SUR Team notifies the Claims Team that a pre-payment review was approved by OPI. The specific details are provided for the Claims Team to suspend the provider's claims for the review.	The Program Integrity Vendor(s) notifies the Claim and Encounter Processing Vendor(s) that a pre-payment review was approved by OPI. The specific details are provided for the Claim and Encounter Processing Vendor(s) to suspend the provider's claims for the review.	The Program Integrity Vendor(s) uses automated workflows to notify the Claim and Encounter Processing Vendor(s) that payment review was approved.	The Program Integrity System will implement automated workflows to notify the Claim and Encounter Processing Vendor(s) that payment review was approved if EOHHS OPI approves pre-payment review request.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The SUR Team sends a request to the provider to notify them of the pre-payment review and to request supporting documentation for the claims under review. Note: This is the same letter used for a recoupment, adapted for the pre-payment review process.	The Program Integrity Vendor(s) sends a request to the provider to notify them of the pre-payment review and to request supporting documentation for the claims under review. This step will also be updated in the workflow tool. Note: This is the same letter used for a recoupment, adapted for the pre-payment review process.	The Program Integrity Vendor(s) uses automated workflows to notify providers regarding pre-payment review and request supporting documentation.	The Program Integrity System will use automated workflows to notify providers regarding pre-payment review and request supporting documentation.
The provider submits the requested documentation. The provider must submit the requested documentation within 2 weeks / 10 days. Note: Undocumented claims are subject to recoupment. If no supporting documentation is received, the SUR Team will note this in their findings with a recommendation to deny the claims.	The provider submits the requested documentation. The provider must submit the requested documentation within 2 weeks / 10 days. Note: Undocumented claims are subject to recoupment. If no supporting documentation is received, the Program Integrity System will note this in their findings with a recommendation to deny the claims.	The Provider uses automated workflows to submit requested documentation.	The Program Integrity System will allow Providers to submit supporting documentation for pre-payment review with automated workflow tool.
The SUR Team pulls the suspended claims and conducts the pre-payment review using the claims and any supporting documentation received, referencing Medicaid policy.	The Program Integrity Vendor(s) pulls the suspended claims and conducts the pre-payment review using the claims and any supporting documentation received, referencing Medicaid policy. The Program Integrity Vendor(s) may also leverage the APCD as appropriate.	The Program Integrity Vendor(s) uses automated workflow tools to conduct pre-payment reviews. EOHHS OPI leverages the APCD to support pre-payment reviews.	The Program Integrity System will use automated workflow tools to conduct pre-payment reviews based on claims, supporting documentation, Medicaid policy. The Program Integrity System will support use of APCD for pre-payment reviews.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The SUR Team notifies the Claims Team that the claims under review can be processed.	The Program Integrity Vendor(s) notifies the Claim and Encounter Processing Vendor(s) that the claims under review can be processed.	The Program Integrity Vendor(s) uses automated workflows to notify the Claim and Encounter Processing Vendor(s) to release claims for processing.	The Program Integrity System will use automated workflows to notify the Claim and Encounter Processing Vendor(s) to release claims for processing after passing pre-payment review.
The SUR Team sends its pre-payment review findings and recommendations to EOHHS OPI for review and approval.	The Program Integrity Vendor(s) sends its pre-payment review findings and recommendations to EOHHS OPI for review and approval.	The Program Integrity Vendor(s) uses automated workflows to send pre-payment review findings to EOHHS OPI to improve tracking of requests and reviews.	The Program Integrity System will use automated workflows to send pre-payment review findings to EOHHS OPI.
EOHHS OPI reviews the findings and recommendations. If needed, EOHHS OPI may review the case in Case Tracker.	EOHHS OPI reviews the findings and recommendations. If needed, EOHHS OPI may review the case in the workflow tool.	EOHHS OPI uses automated workflows to review the pre-payment review findings and recommendations.	The Program Integrity System will use automated workflows to allow EOHHS OPI to review the pre-payment review findings and recommendations.
EOHHS OPI approves or rejects the findings and recommendations and sends the decision to the SUR Team.	EOHHS OPI approves or rejects the findings and recommendations and sends the decision to the Program Integrity Vendor(s).	EOHHS OPI uses automated workflows to send approval / rejection decision to the Program Integrity Vendor(s).	The Program Integrity System will use automated workflows to allow EOHHS OPI to send pre-payment review decision to the Program Integrity Vendor(s).
The SUR Team sends a request to the Claims Team to deny the claims.	The Program Integrity Vendor(s) sends a request to the Claim and Encounter Processing Vendor(s) to deny the claims using the workflow tool.	The Program Integrity Vendor(s) uses automated workflows to send claims denials.	The Program Integrity System will use automated workflows to send a request to the Claim and Encounter Processing Vendor(s) to deny claims if indicated by EOHHS OPI decision.

Exhibit 69: Prevent Fraud, Waste and Process Abuse and Requirements

MCOs may also conduct pre-payment reviews Conduct MCO Pre-Payment Review on a Medicaid provider's managed care claims. Prior to conducting a pre-payment review, the MCO must request and receive EOHHS OPI approval.

Process Gaps and Requirements

Exhibit 70: Conduct MCO Pre-Payment Review Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Conduct MCO Pre-Payment Review subprocess.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The MCO SIU submits a request to initiate a pre-payment review to EOHHS OPI via email. The MCO SIU requires EOHHS OPI's approval before initiating a pre-payment review.	The MCO SIU submits a request to initiate a pre-payment review to EOHHS OPI via the workflow tool. The MCO SIU requires EOHHS OPI's approval before initiating a pre-payment review.	The MCO SIU uses automated workflows to submit prepayment review requests.	MCOs will use automated workflows to submit request to initiate pre-payment review. The Program Integrity System will allow MCOs to submit pre-payment review requests.
The EOHHS OPI sends a response to the MCO SIU either approving or rejecting the request.	The EOHHS OPI sends a response to the MCO SIU either approving or rejecting the request.	EOHHS OPI uses automated workflows to send responses to MCO SIU and improve tracking of responses.	The Program Integrity System will use automated workflows to allow EOHHS OPI to send pre-payment review initiation decision to MCO SIU.
The MCO SIU conducts the pre-payment review.	The MCO SIU conducts the pre-payment review leveraging all data sources including the APCD as needed.	The MCO SIU uses all available data sources, including APCD, when conducting the pre-payment review.	The MCO will use all available data sources, including APCD, when conducting the pre-payment review.
As the result of errors identified as part of the pre-payment review, the MCO SIU sends requests to deny payment to EOHHS OPI for approval.	As the result of errors identified as part of the pre-payment review, the MCO SIU sends requests to deny payment to EOHHS OPI for approval.	MCO SIU uses automated workflows to send request to deny payment to EOHHS OPI for approval.	The MCO will use automated workflows to send payment denial requests to EOHHS OPI. The Program Integrity System will allow MCO's

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
			to send payment denial requests to EOHHS OPI.
The EOHHS OPI sends the MCO OPI an approval or rejection of the deny payment request.	The EOHHS OPI sends the MCO OPI an approval or rejection of the deny payment request.	EOHHS OPI uses automated workflows to send the MCO OPI an approval or rejection of the deny payment request.	The Program Integrity System will use automated workflows to allow EOHHS OPI to send the MCO OPI an approval or rejection of the deny payment request.
The MCO SIU receives EOHHS OPI's approval / rejection of the deny payment request.	The MCO SIU receives EOHHS OPI's approval / rejection of the deny payment request.	The MCO SIU uses automated workflows to receive EOHHS OPI's approval / rejection of the deny payment request,	The MCO will use automated workflows to receive EOHHS OPI's approval / rejection of the deny payment request.

Exhibit 70: Conduct MCO Pre-Payment Review Process Gaps and Requirements

2.6.4.2 Identify and Investigate Fraud, Waste and Abuse

The EOHHS OPI is charged with identifying and investigating fraud, waste, and abuse occurring within the Medicaid FFS and managed care service delivery systems and determining the appropriate resolution. The Identify and Investigate Fraud, Waste and Abuse business process is performed by EOHHS OPI and the Program Integrity Vendor(s) and includes a range of activities to detect and investigate fraud, waste, and abuse. These activities include receiving provider self-audit results, receiving tips, referrals, and complaints from Medicaid stakeholders, performing data mining, analysis, and queries, conducting post-payment and follow-up reviews, and performing MCO oversight.

Process Gaps and Requirements

Exhibit 71: Generate Program Integrity Reports Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Identify Fraud, Waste and Abuse business process. Note: If at any time during this process EOHHS OPI determines an act of fraud has been committed, the process is terminated, and a referral is made to MFCU, law enforcement, or the appropriate board.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The SUR Team initiates an Explanation of Medicaid Benefits (EOMB) mailing to FFS Medicaid members (up to 500	The Program Integrity Vendor(s) initiates an EOMB mailing to FFS Medicaid members (up to 500 letters) each month. A	The Program Integrity Vendor(s) uses automated workflows to review responses to EOMB information and sends	The Program Integrity System will use automated workflows to review responses to EOMB information and send

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
letters) each month. A different provider type is selected each month, including providers who have had a claim within the previous month. The SUR Team sends an email with the provider type identified to the Fiscal Agent's Operations Team who then generates the EOMB letters and transfers them to the mailroom for mailing. Medicaid members are asked to review and confirm the EOMB information. Responses are reviewed by the SUR Team and investigated to first validate any responses that may indicate fraud, waste, and abuse. If fraud, waste, and abuse is indicated, the SUR Team continues the investigation.	different provider type is selected each month, including providers who have had a claim within the previous month. The Program Integrity Vendor(s) sends an email with the provider type identified to the MES Operations Team who then generates the EOMB letters and transfers them to the mailroom for mailing. Medicaid members are asked to review and confirm the EOMB information. Responses are reviewed by the Program Integrity Vendor(s) and investigated to first validate any responses that may indicate fraud, waste, and abuse. If fraud, waste, and abuse is indicated, the Program Integrity Vendor(s) continues the investigation.	message with provider type identified to the MES Operations Team.	message with provider type identified to the MES Operations Team.
The SUR Team performs scheduled quarterly data mining and analysis on FFS claims and payments. EOHHS OPI performs more of the ad hoc and targeted data analysis and queries, including FFS claims and payments as well as managed care encounter data. However, in response to tips / complaints received and as directed by EOHHS OPI, the SUR Team also runs ad hoc queries and reports. The data mining,	The Program Integrity Vendor(s) performs scheduled quarterly data mining and analysis on FFS claims and payments. EOHHS OPI performs more of the ad hoc and targeted data analysis and queries, including FFS claims and payments as well as managed care encounter data. However, in response to tips / complaints received and as directed by EOHHS OPI, the Program Integrity Vendor(s) also runs ad	The Program Integrity Vendor(s) uses automated workflows to produce the quarterly analysis of FFS claims and payments.	The Program Integrity System will use automated workflows to perform the quarterly analysis of FFS claims and payments.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
analysis, and queries are designed to identify outliers, trends, and patterns that indicate potential fraud, waste, and abuse. Claims and payments that meet certain criteria are investigated further.	hoc queries and reports. The data mining, analysis, and queries are designed to identify outliers, trends, and patterns that indicate potential fraud, waste, and abuse. Claims and payments that meet certain criteria are investigated further.		
The EOHHS OPI receives self-audit results from Medicaid FFS providers that identify deficiencies in their processes that may result in program integrity issues, such as claim over / underpayments. Note: Providers rarely submit self-audit results. However, they do regularly advise EOHHS OPI / SUR Team of recoupments being made / checks being sent as a result of provider internal audit findings.	The EOHHS OPI receives self-audit results from Medicaid FFS providers that identify deficiencies in their processes that may result in program integrity issues, such as claim over / underpayments. Note: Providers rarely submit self-audit results. However, they do regularly advise EOHHS OPI / Program Integrity Vendor(s) of recoupments being made / checks being sent as a result of provider internal audit findings.	EOHHS OPI uses automated workflows to receive provider self-audit results.	The Program Integrity System will use automated workflows to support EOHHS OPI receiving provider self-audit results.
The EOHHS OPI / SUR Team receive tips, complaints, and referrals for suspected fraud, waste, and abuse from Medicaid program stakeholders, including MCOs, providers, members, and EOHHS and Fiscal Agent employees. Most tips / complaints, and referrals come from the managed care plans via email using the Tip Form. Note: EOHHS OPI / SUR Team conducts a	The EOHHS OPI / Program Integrity Vendor(s) receive tips, complaints, and referrals for suspected fraud, waste, and abuse from Medicaid program stakeholders, including MCOs, providers, members, and EOHHS and Program Integrity Vendor(s) employees. Most tips / complaints, and referrals come from the managed care plans via the workflow tool using the Tip Form.	EOHHS OPI / Program Integrity Vendor(s) uses automated workflows to receive tips, complaints, and referrals from managed care plans.	The Program Integrity System will use automated workflows to support EOHHS OPI receiving tips, complaints, and referrals from MCOs, Providers, Members, EOHHS, and Program Integrity Vendor(s).

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
preliminary investigation to validate the tip / complaint / referral and, if valid, conducts an investigation. If the tip / complaint / referral is related to a provider that participates across multiple plans, EOHHS OPI assesses with which managed care and FFS plans the provider is enrolled and shares / communicates the information accordingly. The managed care plans then have the option of opening their own investigation. Managed care plans are contractually required to notify EOHHS OPI of identified fraud within 5 days. EOHHS OPI shares all valid tips with MFCU and EOHHS Office of Inspector General.	Note: EOHHS OPI / Program Integrity Vendor(s) conducts a preliminary investigation to validate the tip / complaint / referral and, if valid, conducts an investigation. If the tip / complaint / referral is related to a provider that participates across multiple plans, EOHHS OPI assesses with which managed care and FFS plans the provider is enrolled and shares / communicates the information accordingly. The managed care plans then have the option of opening their own investigation. Managed care plans are contractually required to notify EOHHS OPI of identified fraud within 5 days. EOHHS OPI shares all valid tips with MFCU and EOHHS Office of Inspector General.		
The EOHHS OPI / SUR Team conduct reviews of paid FFS claims to determine if the claims and payment are accurate, unduplicated, and appropriate. When an overpayment is identified, the provider is required to repay the Medicaid funds or to have the overpayment amount deducted from the next reimbursement. Post-payment reviews are performed quarterly by the SUR Team to identify fraud, waste, and abuse	The EOHHS OPI / Program Integrity Vendor(s) conduct reviews of paid FFS claims to determine if the claims and payment are accurate, unduplicated, and appropriate. When an overpayment is identified, the provider is required to repay the Medicaid funds or to have the overpayment amount deducted from the next reimbursement. Post-payment reviews are performed quarterly by the Program Integrity	EOHHS OPI / Program Integrity Vendor(s) uses automated workflows to conduct post-payment reviews of FFS claims.	The Program Integrity System will use automated workflows to support EOHHS OPI and the Program Integrity Vendor(s) post-payment review of FFS claims.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
through ongoing, routine operations. Post-payment reviews are also performed ad hoc by the EOHHS OPI and SUR Team to investigate a tip, referral, complaint, data flag, etc. that has been received. Note: The SUR Team uses a peer evaluation approach from a variety of different provider types to select claims for post payment review each quarter. New providers also are included as part of the routine reviews. All (100 percent) of claims are reviewed for the past 15 months (or more) for routine reviews. EOHHS OPI uses a random sampling approach and specific provider and procedure codes when conducting their more focused, targeted reviews. The review findings based on the sample are then extrapolated to the sample universe for recoupment.	Vendor(s) to identify fraud, waste, and abuse through ongoing, routine operations. Post-payment reviews are also performed ad hoc by the EOHHS OPI and Program Integrity Vendor(s) to investigate a tip, referral, complaint, data flag, etc. that has been received. Note: The Program Integrity Vendor(s) uses a peer evaluation approach from a variety of different provider types to select claims for post payment review each quarter. New providers also are included as part of the routine reviews. All (100 percent) of claims are reviewed for the past 15 months (or more) for routine reviews. EOHHS OPI uses a random sampling approach and specific provider and procedure codes when conducting their more focused, targeted reviews. The review findings based on the sample are then extrapolated to the sample universe for recoupment.		
The EOHHS, including EOHHS OPI and other divisions, perform oversight of managed care contracts to ensure capitation payments are appropriate, provider networks are adequate, claims are being processed correctly, utilization is managed, and	The EOHHS, including EOHHS OPI and other divisions, perform oversight of managed care contracts to ensure capitation payments are appropriate, provider networks are adequate, claims are being processed correctly, utilization is managed, and	EOHHS uses an automated workflow tool to ensure all managed care contractual requirements are being met.	The Program Integrity System will support EOHHS oversight of MCOs, including ensuring capitation payments are appropriate, provider networks are adequate, claims are being processed correctly, utilization is managed, and administrative and other

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
administrative and other contractual requirements are being met. EOHHS OPI handles the managed care fraud, waste, and abuse related monitoring. The EOHHS Managed Care Oversight Team handles compliance-related monitoring.	administrative and other contractual requirements are being met. EOHHS OPI handles the managed care fraud, waste, and abuse related monitoring. The EOHHS Managed Care Oversight Team handles compliance-related monitoring.		contractual requirements are being met.
The EOHHS OPI / SUR Team conducts reviews / audits as a follow-up action from an earlier review / audit to validate that issues identified in an earlier investigation have been resolved / continue to be resolved. Note: This also covers follow-up activities associated with a Consent Order which documents the activities required to resolve errors / issues from a prior review).	The EOHHS OPI / Program Integrity Vendor(s) conducts reviews / audits as a follow-up action from an earlier review / audit to validate that issues identified in an earlier investigation have been resolved / continue to be resolved. Note: This also covers follow-up activities associated with a Consent Order which documents the activities required to resolve errors / issues from a prior review).	The EOHHS OPI / Program Integrity Vendor(s) uses automated workflows to support follow-up audit / review.	The Program Integrity System will use automated workflows to support follow-up audit / review of post-payment review issue resolution.

Exhibit 71: Generate Program Integrity Reports Process Gaps and Requirements

Conduct Post-Payment Review

A post-payment review may be conducted to identify fraud, waste, and abuse or as a response to suspected fraud, waste, and abuse. Post-payment reviews are performed by both EOHHS OPI and the Program Integrity Vendor(s) and may be either desk or onsite reviews. Note: If at any time during this process EOHHS OPI determines an act of fraud has been committed, the process is terminated, and a referral is made to MFCU, law enforcement, or the appropriate board. The process is similar for both the EOHHS OPI and Program Integrity Vendor(s); however, as a contractor, the Program Integrity Vendor(s) must obtain EOHHS OPI approval before initiating a review or issuing findings and recommendations.

Process Gaps and Requirements

Exhibit 72: Conduct Post-Payment Review Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Conduct Post-Payment Review subprocess.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS OPI / SUR Team opens a new case for the post-payment review.	EOHHS OPI / Program Integrity Vendor(s) opens a new case for the post-payment review.	EOHHS OPI / Program Integrity Vendor(s) uses automated workflows to open up a new post-payment review case.	The Program Integrity System will use automated workflows to support opening a new post-payment review case.
The SUR Team requests approval to conduct a level I/II post-payment review. The SUR Team must request EOHHS OPI approval prior to initiating a level I/II post-payment review.	The Program Integrity Vendor(s) requests approval to conduct a level I/II post-payment review. The Program Integrity Vendor(s) must request EOHHS OPI approval prior to initiating a level I/II post-payment review.	The Program Integrity Vendor(s) uses automated workflows to add a post-payment review audit trail, ensure requests are reviewed, and responses are provided in a timely manner.	The Program Integrity Vendor(s) will use automated workflows to add a post-payment review audit trail, ensure requests are reviewed, and responses are provided in a timely manner.
EOHHS OPI reviews the post-payment review request.	EOHHS OPI reviews the post-payment review request.	The Program Integrity Vendor(s) uses automated workflows to add a post-payment review audit trail, ensure requests are reviewed, and responses are provided in a timely manner.	The Program Integrity System will use automated workflows to add a post-payment review audit trail, ensure requests are reviewed, and responses are provided in a timely manner.
EOHHS OPI either approves or rejects the level I/II post-payment review request and sends the decision to the SUR Team.	EOHHS OPI either approves or rejects the level I/II post-payment review request and sends the decision to the Program Integrity Vendor(s).	The Program Integrity Vendor(s) uses automated workflows to add a post-payment review audit trail, ensure requests are reviewed, and responses are provided in a timely manner.	The Program Integrity Vendor(s) will use automated workflows to add a post-payment review audit trail, ensure requests are reviewed, and responses are provided in a timely manner.
Without the approval of EOHHS OPI, the SUR Team closes the case.	Without the approval of EOHHS OPI, the Program Integrity Vendor(s) closes the case.	The Program Integrity Vendor(s) uses automated workflows to close the case.	The Program Integrity System will use automated workflows to close post-payment review.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The SUR Team revises the level I/II post-payment review request.	The Program Integrity Vendor(s) revises the level I/II post-payment review request.	The Program Integrity Vendor(s) uses automated workflows to revise post-payment review requests.	The Program Integrity System will use automated workflows to revise post-payment review requests.
EOHHS OPI / SUR Team conducts a level I/II post-payment review. For a level I/II review, EOHHS OPI / SUR Team reviews the provider's paid claims activity across a period of time in order to identify any fraud, waste, or abuse. Note: Because the level I/II review does not require the provider to submit records, the provider is not notified of the level I/II post-payment review.	EOHHS OPI / Program Integrity Vendor(s) conducts a level I/II post-payment review. For a level I/II review, EOHHS OPI / Program Integrity Vendor(s) reviews the provider's paid claims activity across a period of time in order to identify any fraud, waste, or abuse. Note: Because the level I/II review does not require the provider to submit records, the provider is not notified of the level I/II post-payment review.	EOHHS OPI and the Program Integrity Vendor(s) use automated workflows to conduct the post-payment review.	The Program Integrity System will use automated workflows to conduct the post-payment review.
EOHHS OPI / SUR Team documents the review findings and makes recommendations on how the errors / issues can be addressed / resolved. Recommendations may include provider education, recoupment of overpayments, claim adjustments, continued or follow-up review, referral to law enforcement, the Office of Inspector General, or the appropriate board. If a recoupment is recommended, A Findings and Recoupment Letter is prepared that describes the claim errors and	EOHHS OPI / Program Integrity Vendor(s) documents the review findings and makes recommendations on how the errors / issues can be addressed / resolved. Recommendations may include provider education, recoupment of overpayments, claim adjustments, continued or follow-up review, referral to law enforcement, the Office of Inspector General, or the appropriate board. If a recoupment is recommended, A Findings and Recoupment Letter is prepared that describes	EOHHS OPI and the Program Integrity Vendor(s) use automated workflows to prepare pre-payment review findings and recommendations.	The Program Integrity System will use automated workflows to prepare pre-payment review findings and recommendations, including how errors and issues can be addressed / resolved.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
associated recoupment amounts.	the claim errors and associated recoupment amounts.		
The SUR Team sends the findings and recommendations to EOHHS OPI for review and approval. If a recoupment is recommended, a Findings and Recoupment Letter is included.	The Program Integrity Vendor(s) sends the findings and recommendations to EOHHS OPI for review and approval. If a recoupment is recommended, a Findings and Recoupment Letter is included.	The Program Integrity System will use automated workflows to send post-payment review findings and recommendations.	The Program Integrity System will use automated workflows to send post-payment review findings and recommendations to EOHHS OPI for review and approval.
The EOHHS OPI reviews the findings and recommendations.	The EOHHS OPI reviews the findings and recommendations.	EOHHS OPI uses automated workflows to support post-payment review findings and recommendations from Program Integrity Vendor(s).	The Program Integrity System will use automated workflows to support EOHHS OPI's post-payment review findings and recommendations from Program Integrity Vendor(s).
The EOHHS OPI either approves or rejects the findings and recommendations and sends the decision to the SUR Team. If a recoupment is approved, the Findings and Recoupment Letter is signed and included.	The EOHHS OPI either approves or rejects the findings and recommendations and sends the decision to the Program Integrity Vendor(s). If a recoupment is approved, the Findings and Recoupment Letter is signed and included.	EOHHS OPI uses automated workflows to approve or reject findings and recommendations from Program Integrity Vendor(s).	The Program Integrity System will use automated workflows to support EOHHS OPI approving or rejecting findings and recommendations from Program Integrity Vendor(s).
The EOHHS OPI / SUR Team sends the Findings and Recoupment Letter to the provider. The Findings and Recoupment Letter includes the review findings and associated recoupment amount, as well as the provider's rights to appeal and	The EOHHS OPI / Program Integrity Vendor(s) sends the Findings and Recoupment Letter to the provider. The Findings and Recoupment Letter includes the review findings and associated recoupment amount, as well as the provider's	EOHHS OPI uses automated workflows to send post-payment review findings and recoupment letter to Providers.	The Program Integrity System will use automated workflows to support EOHHS OPI sending post-payment review findings and recoupment letter to Providers.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
instructions on how to request a hearing.	rights to appeal and instructions on how to request a hearing. This activity is marked in the workflow tool as "complete" upon the letter being sent.		
EOHHS OPI / SUR Team makes a request to the Fiscal Agent's Claims Team to perform the recoupment.	EOHHS OPI / Program Integrity Vendor(s) makes a request to the Claim and Encounter Processing Vendor(s) to perform the recoupment.	EOHHS OPI / Program Integrity Vendor(s) use automated workflows to request that Claim and Encounter Processing perform recoupment.	EOHHS OPI / Program Integrity System will use automated workflows to request that Claim and Encounter Processing perform recoupment.
EOHHS OPI / SUR Team closes the case. Note: If there are no findings, the provider is not notified.	EOHHS OPI / Program Integrity Vendor(s) closes the case. Note: If there are no findings, the provider is not notified.	The Program Integrity Vendor(s) uses automated workflows to close the case.	The Program Integrity Vendor(s) uses automated workflows to close post-payment review.
EOHHS OPI / SUR Team conducts a level III onsite post-payment review. This activity is a collapsed subprocess. See Conduct Onsite Level III Review subprocess for additional details.	EOHHS OPI / Program Integrity Vendor(s) conducts a level III onsite post-payment review. This activity is a collapsed subprocess. See Conduct Onsite Level III Review subprocess for additional details.	EOHHS OPI and the Program Integrity Vendor(s) use automated workflows to conduct the post-payment review.	The Program Integrity System will use automated workflows to initiate the Onsite Level III post-payment review.
EOHHS OPI / SUR Team requests supporting documentation for the claims under review.	EOHHS OPI / Program Integrity Vendor(s) requests supporting documentation for the claims under review.	The Program Integrity Vendor(s) uses automated workflows to notify providers regarding pre-payment review and request supporting documentation.	The Program Integrity System will use automated workflows to notify providers regarding pre-payment review and request supporting documentation.
The provider gathers and sends the supporting documentation for the	The provider gathers and sends the supporting documentation for the	The Provider sends the supporting documentation	The Program Integrity System will enable Providers to send

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
claims under review. Note: The provider has 10 business days to provide the supporting documentation to the SUR Team after the initial request and up to two follow up requests. Therefore, it can take over 6 weeks to receive this documentation. If the provider does not respond within that time, the SUR Team continues with the review. When conducting a more focused, targeted review, EOHHS OPI may not allow the provider as much time to respond if the situation Is more urgent. Undocumented claims are subject to recoupment. If a provider does not submit the requested documentation, this lack of participation will be captured in the findings and recommendations, along with a recommendation / decision to deny / recoup the claims under review.	claims under review. Note: The provider has 10 business days to provide the supporting documentation to the Program Integrity Vendor(s) after the initial request and up to two follow up requests. Therefore, it can take over 6 weeks to receive this documentation. If the provider does not respond within that time, the Program Integrity Vendor(s) continues with the review. When conducting a more focused, targeted review, EOHHS OPI may not allow the provider as much time to respond if the situation is more urgent. Undocumented claims are subject to recoupment. If a provider does not submit the requested documentation, this lack of participation will be captured in the findings and recommendations, along with a recommendation / decision to deny / recoup the claims under review.	for post-payment review via automated workflow.	supporting documentation for post-payment review via automated workflow.
EOHHS OPI / SUR Team conducts a level III post-payment desk review.	EOHHS OPI / Program Integrity Vendor(s) conducts a level III post-payment desk review.	EOHHS OPI / Program Integrity Vendor(s) uses automated workflows to conduct level III post-payment desk review.	EOHHS OPI / Program Integrity System will use automated workflows to conduct level III post-payment desk review.
EOHHS OPI / SUR Team documents the review findings and makes	EOHHS OPI / Program Integrity Vendor(s) documents the review	EOHHS OPI / Program Integrity Vendor(s) uses automated workflows to	EOHHS OPI / Program Integrity System will use automated workflows to

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
recommendations on how the errors / issues can be addressed / resolved. Recommendations may include provider education, recoupment of overpayments, claim adjustments, continued or follow-up review, referral to law enforcement, the Office of Inspector General, or the appropriate board.	findings and makes recommendations on how the errors / issues can be addressed / resolved. Recommendations may include provider education, recoupment of overpayments, claim adjustments, continued or follow-up review, referral to law enforcement, the Office of Inspector General, or the appropriate board.	document the review findings and makes recommendations on how the errors / issues can be addressed / resolved.	document the review findings and makes recommendations on how the errors / issues can be addressed / resolved.
The SUR Team sends the findings and recommendations to EOHHS OPI for review and approval. If a recoupment is recommended, a Findings and Recoupment Letter is included.	The Program Integrity Vendor(s) sends the findings and recommendations to EOHHS OPI for review and approval. If a recoupment is recommended, a Findings and Recoupment Letter is included.	The Program Integrity System will send post-payment review findings and recommendations. using automated workflows.	The Program Integrity System will use automated workflows to send post-payment review findings and recommendations to EOHHS OPI for review and approval.
The EOHHS OPI reviews the findings and recommendations.	The EOHHS OPI reviews the findings and recommendations.	EOHHS OPI uses automated workflows to support post-payment review findings and recommendations from Program Integrity Vendor(s).	The Program Integrity System will use automated workflows to support EOHHS OPI's post-payment review findings and recommendations from Program Integrity Vendor(s).
The EOHHS OPI either approves or rejects the findings and recommendations and sends the decision to the SUR Team. If a recoupment is approved, the Findings and Recoupment Letter is signed and included.	The EOHHS OPI either approves or rejects the findings and recommendations and sends the decision to the Program Integrity Vendor(s). If a recoupment is approved, the Findings and Recoupment Letter is signed and included.	EOHHS OPI uses automated workflows to approve or reject post-payment review findings and recommendations from Program Integrity Vendor(s).	The Program Integrity System will use automated workflows to support EOHHS OPI approving or rejecting post-payment review findings and recommendations from Program Integrity Vendor(s).

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The EOHHS OPI / SUR Team sends the findings and recoupment letter to the provider.	The EOHHS OPI / Program Integrity Vendor(s) sends the findings and recoupment letter to the provider. This activity is marked in the workflow tool as "complete" upon the letter being sent.	EOHHS OPI uses automated workflows to send findings and recoupment letter to Providers.	The Program Integrity System will use automated workflows to support EOHHS OPI sending post-payment review findings and recoupment letter to Providers.
EOHHS OPI / SUR Team closes the case. Note: If there are no findings, the provider is not notified.	EOHHS OPI / Program Integrity Vendor(s) closes the case. Note: If there are no findings, the provider is not notified.	The Program Integrity Vendor(s) uses automated workflows to close the case.	The Program Integrity System will use automated workflows to close post-payment review.
The provider sends additional supporting documentation to address the findings.	The provider sends additional supporting documentation to address the findings.	The Provider use automated workflows to send the supporting documentation for post-payment review.	The Program Integrity System will use automated workflows to enable Providers to send supporting documentation for post-payment review.
EOHHS OPI / SUR Team reviews the additional supporting documentation submitted by the provider.	EOHHS OPI / Program Integrity Vendor(s) reviews the additional supporting documentation submitted by the provider. These documents are uploaded in the workflow tool with the corresponding status of "in review" assigned.	EOHHS OPI / Program Integrity Vendor(s) uses automated workflows to review supporting documentation for pre-payment review.	EOHHS OPI / Program Integrity System will use automated workflows to review supporting documentation for pre-payment review.
EOHHS OPI / SUR Team closes the case. Note: If there are no findings, the provider is not notified.	EOHHS OPI / Program Integrity Vendor(s) closes the case. Note: If there are no findings, the provider is not notified.	The Program Integrity Vendor(s) uses automated workflows to close the case.	The Program Integrity System will use automated workflows to close post-payment review.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The provider requests and schedules a formal hearing. Note: The formal hearing must be requested within 30 days of the date the findings and recommendations are sent.	The provider requests and schedules a formal hearing. Note: The formal hearing must be requested within 30 days of the date the findings and recommendations are sent.	The Provider requests and schedules a formal hearing through automated workflows.	The Program Integrity System will enable Providers to request and schedule a formal hearing through automated workflows.
EOHHS OPI / SUR Team closes the case.	EOHHS OPI / Program Integrity Vendor(s) closes the case.	The Program Integrity Vendor(s) uses automated workflows to close the case.	The Program Integrity System uses automated workflows to close post-payment review.

Exhibit 72: Conduct Post-Payment Review Process Gaps and Requirements

Conduct Onsite Level III Review

While most post-payment reviews are desk reviews, EOHHS OPI / Program Integrity Vendor(s) may choose to conduct a post-payment level III review onsite. The Conduct Onsite Level III Review process is a collapsed subprocess. Note: If at any time during this process EOHHS OPI determines an act of fraud has been committed, the process is terminated, and a referral is made to MFCU, law enforcement, or the appropriate board.

Process Gaps and Requirements

Exhibit 73: Conduct Onsite Level III Review Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Conduct Onsite Level III Review subprocess.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The EOHHS OPI / SUR Team sends the provider a notification of the onsite level III review. The notification details the date(s) of the review and the claims under review so the supporting documentation can be pulled ahead of time.	The EOHHS OPI / Program Integrity Vendor(s) sends the provider a notification of the onsite level III review. The notification details the date(s) of the review and the claims under review so the supporting documentation can be	EOHHS OPI / Program Integrity Vendor(s) uses automated workflows to send a notification to the Provider of the onsite level III review.	EOHHS OPI / Program Integrity System will use automated workflows to send a notification to the Provider of the onsite level III review.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Note: Usually providers are notified when an onsite visit will occur and the claims and payments to be reviewed are identified so the provider can pull the supporting documentation ahead of time to help expedite the review. When EOHHS OPI believes a more serious, sensitive problem may exist, the provider likely would not be notified, as it provides the opportunity for them to modify documentation in advance.	pulled ahead of time. This step is also marked as complete within the workflow tool for tracking purposes. Note: Usually providers are notified when an onsite visit will occur and the claims and payments to be reviewed are identified so the provider can pull the supporting documentation ahead of time to help expedite the review. When EOHHS OPI believes a more serious, sensitive problem may exist, the provider likely would not be notified, as it provides the opportunity for them to modify documentation in advance.		
The EOHHS OPI / SUR Team conducts a level III onsite review of the claims and supporting documentation.	The EOHHS OPI / Program Integrity Vendor(s) conducts a level III onsite review of the claims and supporting documentation.	EOHHS OPI and the Program Integrity Vendor(s) use automated workflows to conduct the post-payment review.	The Program Integrity System will use automated workflows to conduct the Onsite Level III post-payment review.

Exhibit 73: Conduct Onsite Level III Review Process Gaps and Requirements

2.6.4.3 Generate Program Integrity Reports

The EOHHS OPI, MFCU, and the Program Integrity Vendor(s) generate several reports to support the state's Medicaid program integrity business processes, federal requirements, and ongoing reviews (e.g., Payment Error Rate Measurement (PERM)). Program integrity reports are developed on a reoccurring and ad hoc basis, depending on the report. Most program integrity reporting is manual and Excel-based; however, some reports are automated. In addition, MCO SIUs provide ongoing reporting that accounts for all open investigations and associated activities. The MCO reports are reviewed and approved by EOHHS.

Process Gaps and Requirements

Exhibit 74: Generate Program Integrity Reports Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Generate Program Integrity Reports process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS OPI prepares the reporting spreadsheets and/or other templates.	EOHHS OPI prepares reporting spreadsheets and/or other templates by pulling in data from sources and databases in an automated fashion.	EOHHS OPI automatically pulls in data from other sources to prepare the reporting spreadsheet.	The Program Integrity System will support EOHHS OPI in pulling data automatically to prepare reporting spreadsheets and other templates.
If additional data is needed to generate the program integrity report(s), go to Gather and supply requested data**.** If EOHHS OPI does not need to request additional data to generate the program integrity report(s), go to Produce report(s).	If additional data is needed to generate the program integrity report(s), go to Gather and supply requested data. If EOHHS OPI does not need to request additional data to generate the program integrity report(s), go to Produce report(s).	EOHHS OPI uses automated workflows to route decisions around supporting documentation requests.	The Program Integrity System will support EOHHS OPI routing decisions around supporting documentation requests with automated workflows.
The Fiscal Agent gathers the requested program integrity information and sends this data back to EOHHS OPI.	The Program Integrity Vendor(s) gathers the requested program integrity information and sends this data back to EOHHS OPI.	The Program Integrity Vendor(s) sends the data back to EOHHS OPI via the workflow tool.	The Program Integrity System will gather and send requested program integrity information to EOHHS OPI with automated workflows.
EOHHS OPI distributes the program integrity report(s).	EOHHS OPI distributes the program integrity report(s).	EOHHS OPI distributes the report(s) via the workflow tool.	The Program Integrity System will support EOHHS OPI to distribute program integrity reports using automated workflows.

Exhibit 74: Generate Program Integrity Reports Process Gaps and Requirements

2.7 Enterprise Data Warehouse and Analytics

EOHHS Data and Analytics, the EOHHS centralized data and analytics business unit, provides support for the Medicaid Program, as well as other EOHHS agencies and programs. EOHHS Data and Analytics also supports the Department of Labor and Training, Department of Corrections, and the Office of the Health Insurance Commissioner. The Medicaid Program previously had an analytics organization, but that team merged with the EOHHS Data and Analytics team to create a more centralized operation.

In addition to the support provided to the Medicaid Program by the EOHHS Data and Analytics team, Medicaid's Unified Health Infrastructure Project (UHIP) team provides analytics and reporting support related to programmatic and eligibility data.

The Enterprise Data Warehouse (EDW) and Analytics functional area includes the following processes:

1. Request Data/Report from EOHHS Data and Analytics
2. Request Data/Report from UHIP Analytics Team

2.7.1 Business Actors

Exhibit 75: EDW and Analytics Business Actors includes the actors, i.e., people, vendors, and/or organizations, that support the EDW and Analytics business processes.

Actor	Description
EOHHS Analyst	The EOHHS Analyst is responsible for the evaluation and fulfillment of data requests. The EOHHS Analyst creates reports for the Requester(s) leveraging EOHHS databases and performing analysis as needed.
Analytics Administrator	The Analytics Administrator acts as a liaison between the Requester and the EOHHS Analyst by reviewing requests, granting approvals, and conveying output expectations.
Requester	The Requester solicits data/reports from the EOHHS Analyst. The Requester may be an external entity such as a state official's office or internal to EOHHS.
UHIP Analyst	The UHIP Analyst is responsible for fulfilling ad hoc data requests, providing standardized reporting on a set cadence, and communicating with stakeholders once data requests are received.
EDW Vendor(s)	EOHHS will contract with the EDW Vendor(s) to provide data warehouse, reporting, and data analysis services. These functions may be acquired through a procurement for only EDW and Analytics functions or through a procurement that includes EDW and Analytics as well as other MES functions.

Exhibit 75: EDW and Analytics Business Actors

2.7.2 Technology and Tools

Exhibit 76: EDW and Analytics Technology and Tools describes the technology and tools used to perform the EDW and Analytics processes.

System Name	Description
Toad	Cross-platform, self-service, data-integration tool that simplifies data access, preparation, and provisioning.
SAS	Integrated software suite for advanced analytics, business intelligence, data management, and predictive analytics.
Tableau	Data visualization tool used for data analysis and business intelligence.
Power BI	Primary interactive data visualization software used by the EOHHS Data and Analytics team.
Secure File Transfer Protocol (SFTP)	SFTP is technology used to deposit and transmit secured data such as reports.
MS SharePoint	MS SharePoint is a web-based collaboration system that uses workflow applications and other web features to collaborate and store data.
Workflow Tool (TBD)	The workflow management tool is a software solution that enables the automation of tasks and processes.
Email	The EDW Vendor(s), EOHHS, and other actors use email as a communication tool and to distribute reports and data that does not contain PHI

Exhibit 76: EDW and Analytics Technology and Tools

2.7.3 Process Improvement Opportunities

Exhibit 77: EDW and Analytics Process Improvement Opportunities describes the improvement opportunities incorporated across the to-be EDW and Analytics business processes.

Opportunity	Description
Implement a workflow tool to organize, distribute, and capture requests	Having a workflow tool allows EOHHS to track submitted requests, determine priority, capture pertinent details around the request, and provide the status of the request throughout its lifecycle. This will reduce the use of email and enable a more seamless process from initiation to application for all parties involved.
Implement a centralized repository for active reports to allow for customization of existing reports	Having an easily accessible and searchable repository of prior data reports allows the analyst to leverage the artifacts for quicker report creation, reduce the number of duplicate reports, and provide access to self-service options.
Provide analytics training to appropriate business stakeholders	Providing stakeholders with the appropriate level of training allows them to access compiled reports in a repository made available to a wider audience resulting in enhanced self-service options and less workload on the analyst.
Provide analyst with details around the intended use of the reports being created and the application impact	As reports are accepted and applied to their intended business need by the requester, it is beneficial for the analyst to understand the impact and application of the report to have additional context when fulfilling future requests. With a workflow system, this can be configured in the intake request form where the requester can elaborate on these details.
Develop a data governance organization and implement data management	Having an internal organization oversee data governance for EOHHS increases the efficiency of reporting, improve data quality, and manage the data in enterprise systems, based on internal data standards and policies that also control data usage. Effective data governance ensures that data is consistent, trustworthy, and used effectively.

Exhibit 77: EDW and Analytics Process Improvement Opportunities

2.7.4 Gap Analysis by Business Process

Exhibit 78: EDW and Analytics Level 0 Process Map provides a high-level depiction of the end-to-end scope and boundaries of the Enterprise Data Warehouse (EDW) and Analytics functional area. Note: Processes in the Level 0 Process Map may not necessarily occur in the sequential order shown.

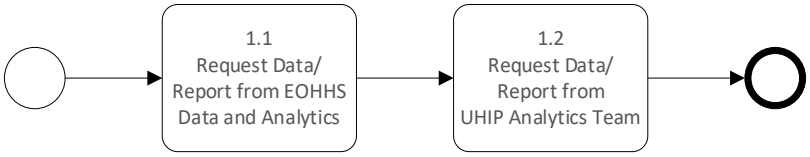


Exhibit 78: EDW and Analytics Level 0 Process Map

The Gap Analysis for each process is documented in the sections below, including the following information:

- **Process Description** – High-level definition of the scope and purpose of the business process
- **Gaps** – List of major changes from As-Is to To-Be assessments
- **High-level Requirements** – Statements of necessary conditions to close gaps

2.7.4.1 Request Data/Report from EOHHS Data and Analytics

In the future state, the Request Data/Report from EOHHS Data and Analytics process begins with the Requester submitting the request based on a business need. This Requester may be internal or external to the organization. If the request is deemed urgent, the approval process is expedited. All other requests are submitted via the workflow tool to the Analytics Administrator for review. Depending on the data requested (if originating externally or if a large data request is received from a sister agency), a data use agreement (DUA) needs to be in place. The Analytics Administrator then determines the extent to which the request can be fulfilled and contacts the Requester with any follow-up questions. The request is then transitioned to and worked by the EOHHS Analyst who, after completing the data analysis or report, has a peer analyst review it for quality control purposes. Once finalized, the report is sent to the Requester via email, or SFTP if the data contains PHI. The report is reviewed to ensure it meets the Requester's needs.

Process Gaps and Requirements

Exhibit 79: Request Data/Report from EOHHS Data and Analytics Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Request Data/Report from EOHHS Data and Analytics process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Requester determines a need to access data housed in the Human Services Data Warehouse (HSDW) for reporting or analytical functions and submits the request to the	The Requester determines a need to access data housed in the HSDW for reporting or analytical functions and submits the request to the EOHHS Data and Analytics team using the workflow tool.	The Requester initiates the analytics request by submitting the request via the workflow tool.	Data and analytics requests will be documented, submitted, routed for review and approval via workflow management tool / application.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS Data and Analytics team, via email.			
The Requester sends an email to the EOHHS Director of Data and Analytics using the completed e-form describing the nature of the request.	The Requester transmits the request to the Analytics Administrator. This activity will be facilitated via the use of a workflow tool and capture pertinent information in the required fields.	The Requester will use the workflow tool to instill an automated, standardized form for requests.	Data and analytics requests will be documented via workflow management tool / application using a standard request format.
The Analytics Administrator communicates with the Requester based on the nature of the request, data available, timelines, and DUA to set expectations and accommodate the request to the extent possible (if not fully).	The Analytics Administrator communicates with the Requester based on the nature of the request, data available, timelines, and DUA to set expectations and accommodate the request to the extent possible (if not fully). With formal data governance in place these determinations will be managed more effectively/efficiently.	EOHHS integrates Analyst into analytics communications for enhanced understanding of the analytics request. EOHHS establishes formal data governance to manage requests more efficiently and effectively.	Communications, including questions and answers regarding the request, status of the request, prioritization level, etc. will be documented and routed using a workflow management tool. Data standards and governance will be implemented to ensure effective and efficient handling of data requests and consistency of reporting, etc.
The EOHHS Director of Data and Analytics formally approves the request and places it in the queue of an EOHHS Analyst.	The Analytics Administrator formally approves the request and places it in the queue of an EOHHS Analyst. High priority requests are marked as high priority / urgent in the workflow tool.	The workflow management tool enables high priority requests to be flagged as urgent to ensure EOHHS Analysts can address these requests in a timely manner.	The workflow management tool will be used to identify high priority / urgent requests.
The EOHHS Analyst uses the queried data to analyze and create report.	The EOHHS Analyst uses the queried data to analyze and create report. This data is first checked against a centralized report repository to ensure duplicate reports are not being executed or to leverage similar existing reports for the analysis.	Analytics tool automatically checks the queried data against the centralized report repository to ensure duplicate reports are not being executed or to leverage similar existing reports for analysis.	Once a data query is initiated by the Analyst, an application / tool will cross-reference a centralized report repository to determine if an exact or similar report exists based on the queried data.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The EOHHS Analyst transmits the report to the Requester via email.	The EOHHS Analyst transmits the report to the Requester via email or uploads to SharePoint as the preferred method for ease of storage, referencing, and transmission.	The EOHHS Analyst transmits the report to the Requester via SharePoint upload or, as a backup, email.	SharePoint will be used to support report upload and transmission between EOHHS and Requester, with email being used only as a backup.
The Requester uses the data/report for the business need.	The Requester uses the data/report for the business need. The Requester provides feedback on how the data was applied to provide valuable insight to the analyst for future requests.	To gain insights for future requests, the Requester provides feedback to the EOHHS Analyst on how the data was applied.	Before a data and analytics request is closed, the workflow management tool will collect feedback from the Requester on how data was applied in order to inform future requests.

Exhibit 79: Request Data/Report from EOHHS Data and Analytics Process Gaps and Requirements

2.7.4.2 Request Data/Report from UHIP Analytics Team

The UHIP Analytics team provides support for the Medicaid Program by leveraging data from the Human Services Data Warehouse and RIBridges. The UHIP Analytics team provides both ad hoc and periodic reporting support for the Medicaid Program.

In the future state, the Request Data/Report from UHIP Analytics Team process is initiated by the Requester identifying a business need requiring the use of data analytics. A request is sent via the workflow tool intake form to a UHIP Analyst where (s)he confirms the ask, presents any clarifying questions, reviews the central report repository to identify similar or duplicate reports, and determines if additional access is needed to complete the analysis. Based on the level of access required, the UHIP Analyst, with support from the Data Administrator, may solicit data access approval from the EDW Vendor(s). Upon accessing the data, the UHIP Analyst conducts the analysis and provides the Requester with a minimum viable product (MVP) to confirm if the report appears to satisfy the needs outlined in the initial dialogue. Once the report reaches a more finalized state it will be distributed according to its type and classification (secured vs. unsecured) or put into a SharePoint repository if the report is to be prepared and delivered on a predetermined cadence. Upon distribution, the Requester reviews the report and determines whether the report satisfies business needs.

Process Gaps and Requirements

Exhibit 80: Request Data/Report from UHIP Analytics Team Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Request Data/Report from UHIP Analytics Team process narrative.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Requester sends a detailed email to the UHIP Analyst requesting the data/report.	The Requester initiates the request to the UHIP Analyst within the workflow tool intake form. By having a workflow tool intake form, these requests are entered in an automated and detailed fashion.	The Requester initiates the analytics request via the workflow tool intake form.	Data and analytics requests will be documented, submitted, routed for review and approval via workflow management tool / application.
The UHIP Analyst confirms the data/report needed, format of the report, and other specifics.	The UHIP Analyst confirms the data/report needed, format of the report, and other specifics. All details are captured on the request intake form.	The Requester initiates the analytics request via the workflow tool intake form.	Data and analytics requests will be documented via workflow management tool / application using a standard request format.
The UHIP Analyst queries the database.	The UHIP Analyst checks the central report repository to determine whether a similar report exists. If one exists, the UHIP Analyst modifies the existing report to meet the current need. If one does not exist, the UHIP Analyst queries the database to extract the data needed to create the report.	The UHIP Analyst checks central report repository to find similar report and modify to meet needs before querying database.	Once a data query is initiated by the Analyst, an application / tool will cross-reference a centralized report repository to determine if an exact or similar report exists based on the queried data.
The Fiscal Agent sends a “Reply all” email to the UHIP Analyst and Data Administrator advising them that data access has been granted.	The EDW Vendor(s) advises the UHIP Analyst and Data Administrator that data access has been granted via the workflow tool, expediting the process. There may be an opportunity for internal resources to manage access requests, expediting turnaround time and enhancing data control.	The EDW Vendor(s) automatically sends notification of data access request to the UHIP Analyst and Data Administrator.	Communications, including questions and answers regarding the request, status of the request, prioritization level, etc. will be documented and routed using a workflow management tool.

Exhibit 80: Request Data/Report from UHIP Analytics Team Process Gaps and Requirements

2.8 Electronic Visit Verification

EOHHS has implemented an Electronic Visit Verification (EVV) program to comply with the 21st Century Cures Act. The Act requires state EVV programs to capture the following visit information to electronically verify service delivery for Medicaid personal care services as well as home health care services:

- The type of service performed

- The individual receiving the services
- The date of the services
- The location of service delivery
- The individual providing the service
- The time the service begins and ends

To offer impacted Medicaid providers the opportunity to preserve investments they have made in EVV technology, EOHHS selected an “open vendor” model for Rhode Island’s Medicaid Program. With this design model, EOHHS has procured an EVV system and implemented it statewide, giving those providers with existing EVV systems the option to use either the state’s solution or their own system, as long as it is compliant with federal regulations and guidelines. To support the “open vendor” model, the state’s EVV system must successfully aggregate data from multiple external third-party systems. The state’s EVV system electronically schedules and tracks member visits end-to-end from submission of the visit data through to claim adjudication and payment. If a provider chooses to use an alternate EVV system, they are required to set up and verify that the data can be aggregated by the state’s EVV system in the standard format provided by EOHHS.

The EVV functional area includes the following processes:

1. Administer EVV - Register New Provider Agency
2. Schedule Visit
3. Conduct Visit
4. Generate and Submit Claim
5. Administer EVV - Manage Centers for Medicare & Medicaid Services (CMS) Key Performance Indicator (KPI) Reporting
6. Administer EVV - Request Fixed Visit Verification (FVV) Device
7. Administer EVV - Replace / Return FVV Device

2.8.1 Business Actors

Exhibit 81: Electronic Visit Verification Business Actors includes the actors, i.e., people, vendors, and/or organizations, that support the EVV business processes.

Actor	Description
Alternate EVV Vendor	An Alternate EVV Vendor is contracted by a Provider Agency to provide an EVV system to be used in the delivery of home-based services. An Alternate EVV Vendor must adhere to the technical specifications defined by the EOHHS EVV Vendor to enable integration.
Caregiver	A Caregiver is employed or contracted by a Provider Agency to administer personal care, homemaker, and/or home health care services.
Claim and Encounter Processing Vendor(s)	EOHHS will contract with a Claim and Encounter Processing Vendor(s) to provide Claim and Encounter Processing services to meet the needs of Rhode Island’s Medicaid Program. EOHHS will contract with one or more vendors to provide Claim and Encounter Processing services. The functions may be procured as part of a contract that includes

	only the Claim and Encounter Processing functions or a contract that includes the Claim and Encounter Processing functions as well as other MES functions.
EOHHS	EOHHS is the single State agency designated to administer the Medicaid program in Rhode Island.
EOHHS EVV Vendor	EOHHS will contract with a vendor to provide the EOHHS EVV system used in the delivery of home-based services. EOHHS offers the use of the EOHHS EVV Vendor's system to Provider Agencies in Rhode Island at no cost.
Managed Care Organizations (MCOs)	Rhode Island contracts with MCOs (also referred to as "managed care plans") that provide comprehensive medical coverage to Medicaid Members. MCOs accept a set per member per month payment for these services and are at financial risk for the Medicaid services specified in their contracts.
Member	A Medicaid Member, or Medicaid beneficiary, is a person who has been determined to be eligible for Medicaid.
Provider Agency	An agency or organization contracted with Rhode Island EOHHS to provide personal care services, homemaker services and/or home health care services to Medicaid Members. Agencies have the option of using the state supplied EOHHS EVV Vendor system or an Alternate EVV Vendor system.

Exhibit 81: Electronic Visit Verification Business Actors

2.8.2 Technology and Tools

Exhibit 82: Electronic Visit Verification Technology and Tools describes the technology and tools used to perform the Electronic Visit Verification processes.

System Name	Description
Alternate EVV system	An Alternate EVV system is a third-party in-home visit scheduling and tracking system that employs controls within the delivery of home-based services. An Alternate EVV system is administered by an Alternate EVV Vendor, which is contracted directly with a Provider Agency. Alternate EVV systems may have multiple options for usage including a mobile app, telephony, or a fixed device.
Business Objects	Business Objects is a querying and reporting tool.
EOHHS EVV Vendor's Learning Management System (LMS)	The EOHHS EVV Vendor's LMS is a software application administered and managed by the EOHHS EVV Vendor that delivers and tracks EVV training for users (e.g., Provider Agencies) of the EOHHS EVV system.
EOHHS EVV system	The EOHHS EVV system is an in-home visit scheduling, tracking and billing system that employs controls within the delivery of home-based services to ensure client's quality of care. Provider Agencies have three options for using the EOHHS EVV system: a mobile app, telephony, or the FVV device.
EVV aggregator	The EVV aggregator is a centralized database managed by the EOHHS EVV Vendor that collects, validates, and stores EVV visit and claims data, including from alternate EVV systems.

System Name	Description
Claims Portal	The Claims Portal is a secure, internet portal used by healthcare providers can inquire on the status of claims, verify eligibility, upload electronic claim files, etc.
Microsoft Excel	MS Excel is used to compile the CMS KPI reporting.
Online form	An online form will be used to collect data from stakeholders, including Provider Agencies.
MCO payer system	Each MCO uses its own payer system to receive and adjudicate claims sent by Providers for services rendered to the MCO's Members.
Medicaid Enterprise System	The MES is an integrated group of subsystems / modules with open APIs which leverage an integration platform to enable interoperability with other modules. The MES is operated by a single or multiple vendors and will support EOHHS in administering the state Medicaid program.
Approved Claim Transaction Entry Software	Approved Claim Transaction Entry Software is a free software provided by the Claim and Encounter Processing Vendor(s) and used by providers to create and submit Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic 837 transaction claim files. The Approved Claim Transaction Entry Software can be downloaded using a link found on the EOHHS website. Note: Providers have the option to approved software from other vendors to create HIPAA-compliant electronic 837 transaction claim files. In this document, the Approved Claim Transaction Entry Software represents the software provided by the Claim and Encounter Processing Vendor(s), as well as any other approved software providers are using to create the claim files.

Exhibit 82: Electronic Visit Verification Technology and Tools

2.8.3 Process Improvement Opportunities

Exhibit 83: Electronic Visit Verification Process Improvement Opportunities describes the improvement opportunities incorporated across the to-be Electronic Visit Verification processes.

Opportunity	Description
Streamline Member records	The EOHHS EVV Vendor will use Medicaid ID numbers when creating Member records in the EOHHS EVV system.
Automate removal of ineligible Members from EVV Vendor system	If Members are deceased or no longer eligible, the EOHHS EVV Vendor will automatically remove / deactivate their records from the EOHHS EVV Vendor system, on a periodic basis, to ensure only eligible Members receiving services have active records.
Improve fraud prevention measures	Caregivers will only be able to check in at a single location within any given time period, regardless of whether they are employed by multiple Provider Agencies.

Opportunity	Description
Reduce manually entered / modified visits	The EOHHS EVV Vendor will provide and encourage Provider Agencies to complete ongoing training to minimize the number of manually entered / modified visits.
Implement operating level agreements (OLAs)	EOHHS will include OLAs in vendor contracts to support specific Service Level Agreement (SLA) goals when multiple entities are involved in achieving that SLA. This allows the State to better track resolution and timeliness of tickets when multiple ticketing systems may be used to resolve incidents. The State will also require Alternate EVV vendors to work with the EOHHS EVV Vendor in a collaborative manner to resolve incidents.
Improve severity level definitions in EVV contract	The State will improve the definitions of the severity levels in the EVV contract and include examples of defects that are critical, high, medium, and low.
Conduct automated claims validation	The EOHHS EVV vendor will work with the state's MCOs to streamline how edits are being applied across MCO claims and implement automated claims validation as needed. Language on implementing automated claims validation will be incorporated into MCO contracts as needed. Conducting automated claims validation will also simplify and improve the CMS KPI reporting process to allow the Claim and Encounter Processing Vendor(s) to report on claims matching data versus conducting a more manual matching process.
Route FVV device requests to the EOHHS EVV Vendor	Provider Agencies will submit requests for new, replacement, or returned FVV devices directly to the EOHHS EVV Vendor.
Conduct outreach to Provider Agencies on inactive FVV devices	EOHHS will review FVV device usage and contact Provider Agencies to determine whether inactive FVV devices should be returned to the EOHHS EVV Vendor.

Exhibit 83: Electronic Visit Verification Process Improvement Opportunities

2.8.4 Gap Analysis by Business Process

Exhibit 84: Electronic Visit Verification Level 0 Process Map provides a high-level depiction of the end-to-end scope and boundaries of the EVV functional area. Note: Processes in the Level 0 Process Map may not necessarily occur in the sequential order shown.

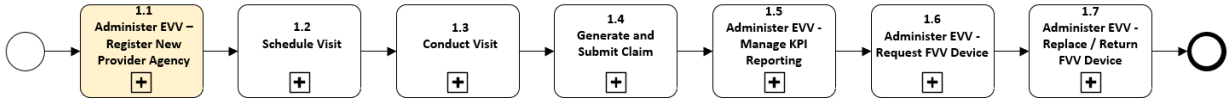


Exhibit 84: Electronic Visit Verification Level 0 Process Map

The Administer EVV - Register New Provider Agency process does not have any changes associated with it, so this process will not be discussed in this document.

The following information is provided for each of the seven business processes:

- **Process Description** – High-level definition of the scope and purpose of the business process
- **Gaps** – List of major changes from As-Is to To-Be assessments
- **High-level Requirements** – Statements of necessary conditions to close gaps

2.8.4.1 Schedule Visit

Scheduling an EVV visit is the process by which a Provider Agency schedules its caregivers to render personal care, homemaker, and/or home health care services to active Medicaid Members who have been authorized to receive these services. Visits are scheduled in the EOHHS EVV Vendor's system or an Alternate EVV Vendor's system prior to conducting the visit.

Process Gaps and Requirements

Exhibit 85: Schedule Visit Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Schedule Visit process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The EOHHS EVV Vendor receives prior authorizations (PAs) for covered services from the Fiscal Agent or MCO.	The EOHHS EVV Vendor receives prior authorizations for covered services from the Claim and Encounter Processing Vendor(s) or MCO. For Home Health Care service codes that do not require a prior authorization, the EOHHS EVV Vendor may receive a notification that the Member requires these services. In the short-term, the EOHHS EVV Vendor will allow the Provider Agency to manually enter a member and authorization for services that do not require a prior authorization.	The EOHHS EVV Vendor receives notifications that Members require Home Health Care Services that do not require PA for scheduling these services.	For services that do not require a PA, the EOHHS EVV System will receive a notification from the Provider that a Member requires Home Health Care Services in order to schedule these services.
The prior authorization is associated with an existing record in the EOHHS EVV	The prior authorization is associated with an existing record in the EOHHS EVV system, and the record is	The EOHHS EVV Vendor ensures records are up to date by automatically end-	The EOHHS EVV System will search the Master Person / Patient Index and automatically end-date

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
system, and the record is updated.	updated. The MES will include date of death in the data exchange with the EOHHS EVV Vendor to disable the member record if the member is deceased.	dating Members who are deceased.	Members who are deceased.

Exhibit 85: Schedule Visit Process Gaps and Requirements

2.8.4.2 Conduct Visit

During the Conduct Visit process, the Caregiver uses the EOHHS EVV system or an alternate EVV system to record the six elements of the visit that are required by the 21st Century Cures Act. The Caregiver checks in at the Medicaid Member's location, performs the authorized services and checks out at the Medicaid Member's location upon completion of rendering services. Once the visit is recorded, the Provider Agency is ready to generate and submit the claim associated with the visit.

Process Gaps and Requirements

Exhibit 86: Conduct Visit Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Conduct Visit process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Caregiver uses the EOHHS EVV system or an alternate EVV system to check in at the Medicaid Member's location. If the Caregiver uses the EOHHS EVV system, (s)he has the option to use the mobile app, telephony, or the FVV device to check in.	The Caregiver uses the EOHHS EVV system or an alternate EVV system to check in at the Medicaid Member's location. If the Caregiver uses the EOHHS EVV system, (s)he has the option to use the mobile app, telephony, or the FVV device to check in. Ongoing training is encouraged to enable providers to minimize the number of manually entered / modified visits.	EVV Vendor conducts ongoing training to enable Providers with excessive numbers of manually entered visits to minimize the number of manually entered/modified visits.	The EOHHS EVV Vendor will conduct ongoing training for Providers with excessive numbers of manually entered visits to enable Providers to minimize the number of manually entered/modified visits.
If the Provider Agency uses the EOHHS EVV system, the visit is	If the Provider Agency uses the EOHHS EVV system, the visit is	EOHHS constructs OLAs to support specific SLA goals, reduce the multiple	The EOHHS EVV System will adhere to and report on OLAs to support SLA

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
recorded in the EOHHS EVV system.	recorded in the EOHHS EVV system. If a Provider Agency has an issue that requires multiple vendors to resolve, these vendors will work in concert to meet the state's SLAs.	ticketing workstreams, and improve tracking of ticket resolution and timeliness. EOHHS improves clarity of defect severity levels and provides examples of defects at each severity level. If a Provider Agency has an issue that requires multiple vendors to resolve, these vendors work in concert to meet the state's SLAs.	goals, reduce multiple ticketing workstreams, and improve tracking of ticket resolution and timeliness. The EOHHS EVV System will coordinate and collaborate with other vendors to ensure resolution of Provider Agency issues.

Exhibit 86: Conduct Visit Process Gaps and Requirements

2.8.4.3 Generate and Submit Claim

The Generate and Submit Claim business process is initiated once the visit is conducted. Visit information is sent to the EVV aggregator and a claim is generated and submitted to either the Claim and Encounter Processing Vendor(s) or the appropriate MCO. The Claim and Encounter Processing Vendor(s) or the MCO adjudicates the claim and sends the claim information to the EVV aggregator.

Process Gaps and Requirements

Exhibit 87: Generate and Submit Claim Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Generate and Submit Claim process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Activity	The Claim and Encounter Processing Vendor(s) conducts automated claims validation for FFS claims. This ensures FFS claims are matched to visits recorded by Provider Agencies. Claims which are flagged for potentially fraudulent activity	The Claim and Encounter Processing Vendor(s) conducts automated claims validation for FFS claims. This ensures FFS claims are matched to visits recorded by Provider Agencies. Claims which are flagged for potentially fraudulent activity will be	Claim and Encounter Processing System will conduct automated claims validation for FFS claims to match FFS claims to corresponding visits that are captured in the EVV System. EVV FFS Claims which are flagged during automatic claims validation for potentially fraudulent

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
	will be suspended prior to payment.	suspended prior to payment.	activity will be suspended prior to payment.

Exhibit 87: Generate and Submit Claim Process Gaps and Requirements

2.8.4.4 Administer EVV - Manage CMS KPI Reporting

The Manage CMS KPI Reporting business process is the process by which EOHHS compiles and submits KPI reporting data required by CMS. Most KPIs are required quarterly, except the Privacy and Security KPI, which is required annually. The EOHHS EVV system was certified in May 2022, and the State must continue to submit quarterly KPI reporting to maintain their federal financial participation. CMS requires reporting on five KPIs:

1. Association of EVV record to claim / encounter
2. EVV record match against approved services, providers, and units
3. EVV records without manual edits
4. EVV system availability
5. Privacy and security

Process Gaps and Requirements

Exhibit 88: Administer EVV – Manage CMS KPI Reporting Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Administer EVV – Manage CMS KPI Reporting process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS compiles a quarterly report of EVV data, which includes visit information for Medicaid fee-for-service Members.	The CEP Vendor sends EOHHS a report with EVV data, including claims matching against visits. This data informs the quarterly report that EOHHS submits to CMS to maintain federal funding.	The CEP Vendor automatically compiles a report based on existing monthly and quarterly reports that will be emailed to CMS.	The CEP System will aggregate monthly data required for federal EVV reporting (claim-EVV record match) and provide to EOHHS on a quarterly basis.

Exhibit 88: Administer EVV – Manage CMS KPI Reporting Process Gaps and Requirements

2.8.4.5 Administer EVV - Request FVV Device

The Provider Agency requests an FVV Device if the Medicaid Member does not have a home phone or cell phone that can be used by the Caregiver during visits. The Medicaid Member must also have an

active authorization for at least two weeks from the date of the request for the FVV device, and the Medicaid Member must have an active status with EOHHS. Once the Provider Agency makes the request for the FVV device, the EOHHS EVV Vendor evaluates the request and determines whether the request meets program criteria. Once the request is approved, the EOHHS EVV Vendor distributes the FVV device to the Member's home or the Provider Agency.

Process Gaps and Requirements

Exhibit 89: Administer EVV – Request FVV Device Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Administer EVV – Request FVV Device process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Provider Agency submits the FVV device request form to EOHHS.	The Provider Agency submits the FVV device request to the EOHHS EVV Vendor via the EOHHS EVV system.	The Provider Agency submits the FVV device request form via automated workflows. The EOHHS EVV Vendor reviews the FVV device request and approves based on FVV device need criteria.	The EOHHS EVV System will allow Provider Agencies to request FVV devices for Members who are active, have service authorization for 2+ weeks, and who (or the request) meet program criteria.

Exhibit 89: Administer EVV – Request FVV Device Process Gaps and Requirements

2.8.4.6 Administer EVV - Replace / Return FVV Device

A Provider Agency may need to replace or return an FVV device due to the FVV device being lost or damaged, or the Medicaid Member becoming ineligible for Medicaid or no longer receiving home and community-based services. The process begins with the EOHHS EVV Vendor generating an FVV usage report which identifies inactive devices. The EOHHS EVV Vendor automatically contacts the Provider Agency, via the EOHHS EVV system to determine whether the FVV devices are needed. The Provider Agency responds to the EOHHS EVV Vendor via the EOHHS EVV system and if the FVV device is not needed, the Provider Agency initiates a return of the device. The EOHHS EVV Vendor sends a pre-addressed stamped envelope to the Provider Agency, and the Provider Agency returns the FVV device to the EOHHS EVV Vendor. Once the FVV device is received, the EOHHS EVV Vendor de-registers the old FVV device. If a replacement is requested, the EOHHS EVV Vendor ships a replacement FVV device to the Member's home or the Provider Agency.

Process Gaps and Requirements

Exhibit 90: Administer EVV – Replace / Return FVV Device Process Gaps and Requirement describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Administer EVV – Replace / Return FVV Device process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Activity	The EOHHS EVV Vendor automatically generates an FVV usage report identifying devices that have not been used in the past 90 days.	The EOHHS EVV Vendor automatically generates an FVV usage report identifying devices that have not been used in the past 90 days.	The EOHHS EVV System will automatically generates an FVV usage report identifying devices that have not been used in the past 90 days.
Not a Current State Activity	The EOHHS EVV Vendor contacts the Provider Agency, via the EOHHS EVV system, to determine whether the agency plans to use the FVV device or if it should be returned to the EOHHS Vendor.	The EOHHS EVV Vendor contacts the Provider Agency, via the EOHHS EVV system, to determine whether the agency plans to use the FVV device or if it should be returned to the EOHHS Vendor.	The EOHHS EVV System will send a communication to Provider Agencies notify them of FVV devices inactive 90+ days that requests a response that the FVV is still required or that the FVV needs to be replaced / returned.
The Provider Agency completes the FVV device replacement / return form and submits it to EOHHS.	The Provider Agency initiates the FVV device replacement / return by responding to the EOHHS EVV Vendor via the EOHHS EVV system.	Automated workflow and an online form in the EOHHS EVV System to enable the Provider Agency to notify the EVV EOHHS Vendor that the Provider Agency needs to return / replace a FVV device.	The EOHHS EVV System will provide an online form that the Provider Agency can use to notify EOHHS of the need to replace/return an inactive FVV device.
Not a Current State Activity	If the Provider Agency continues to provide services for the Member who the device was registered to, the Provider Agency uses either the EOHHS EVV mobile app or telephony when rendering services.	If the Provider Agency continues to provide services for the Member who the device was registered to, the Provider Agency uses either the EOHHS EVV mobile app or telephony when rendering services.	The EOHHS EVV System will send a communication to Provider Agencies notify them of FVV devices inactive 90+ days that requests a response that the FVV is still required or that the FVV needs to be replaced / returned.

Exhibit 90: Administer EVV – Replace / Return FVV Device Process Gaps and Requirement

2.9 Financial Management

The Financial Management (FM) functional area supports the payment of providers, managed care organizations (MCOs), insurers, Medicare, and employer-sponsored insurance premiums, as well as the receipt of payments from other insurers, providers, and member premiums and financial participation.

The scope of the Financial Management functional area includes business and technical analyses related to the following business processes:

- Accounts Payable (A/P) Management
- Accounts Receivable (A/R) Management
- Fiscal Management

2.9.1 Actors

Exhibit *91*: Actors includes the actors, i.e., people, vendors, and/or organizations, which support the FM business processes.

Actor	Description
Centers for Medicare & Medicaid Services (CMS)	CMS is the federal agency that administers the Medicare, Medicaid, Children's Health Insurance Programs (CHIP), and the federally facilitated Marketplace. Each State administers their own Medicaid program and CHIP; however, CMS is responsible for establishing regulations and guidance for Medicaid and CHIP.
Department of Administration (DOA) Accounts and Control	The Office of Accounts and Control within the Department of Administration is responsible for administering the State's accounting and recording system, maintaining control accounts of assets for all departments and agencies, operating financial, accounting, and cost systems for all departments and agencies, conducting a preaudit of state expenditures, approving vouchers drawn on the Treasury, and preparing financial statements required by departments and agencies, the Governor, or the General Assembly.
Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)	BHDDH provides services to Rhode Islanders living with mental illness and/or substance use conditions, have developmental disabilities, or need Long Term Acute Care in one of the state hospitals. BHDDH also administers funds which support a statewide network of prevention and mental health promotion initiatives.
Department of Human Services (DHS)	DHS is the State agency responsible for determining eligibility for multiple programs, including Medicaid and public assistance programs, using RIBridges.
Division of Information Technology (DoIT)	DoIT is responsible for oversight, coordination and development of all IT staff and resources within the Executive Branch of government. The DoIT Computer Center formats, prints, and mails forms, including 1099s, on behalf of Rhode Island departments and agencies.

Eleanor Slater Hospital (Slater)	Eleanor Slater Hospital is a public hospital operated by the Rhode Island BHDDH.
EOHHS	EOHHS is the single State agency designated to administer the Medicaid program in Rhode Island.
EOHHS Customer Resolution Team (CRT)	The EOHHS Customer Resolution Team is comprised of three units: the Reconciliation Unit, the Medicare Premium Payment (MPP)/Supplemental Security Income (SSI) Unit, and the Enrollment Unit. Each unit performs specific functions to ensure that members have access to appropriate benefits.
EOHHS Finance, Budget and Policy	EOHHS Finance, Budget and Policy manages the financial, accounting, and budgetary functions for EOHHS.
EOHHS Managed Care Oversight	The EOHHS Managed Care Oversight team is responsible for monitoring contractual oversight of the Medicaid managed care program.
EOHHS RIte Share Team	The EOHHS RIte Share Team manages Rhode Island's Health Insurance Premium Payment (HIPP) Program, RIte Share.
Federally Qualified Health Center (FQHC)	FQHCs are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless.
Core Module Vendor	The EOHHS contracts with the Core Module Vendor to provide services to meet the needs of Rhode Island's Medicaid Program. Some of the Core Module Vendor's functions include operations and maintenance of the Medicaid Management Information System (MMIS), provider and member enrollment and support, claims processing and payment, and customer service / call center support.
Core Module Vendor's Bank	The Core Module Vendor's Bank is the financial institution used by the Core Module Vendor to conduct financial transactions, including deposits and payments.
House Fiscal Staff	The House Fiscal Staff performs fiscal research and analysis for the House, its committees, and individual legislators. Duties include examination of revenues, review of appropriations and expenditures, and analysis of the state's indebtedness and Capital Improvement Program.
Managed Care Organization	Rhode Island contracts with MCOs (also referred to as "managed care plans") that provide comprehensive medical coverage to Medicaid beneficiaries. MCOs accept a set per member per month payment for these services and are at financial risk for the Medicaid services specified in their contracts.
Member	A Medicaid member, or Medicaid beneficiary, is a person who has been determined to be eligible for Medicaid.
Nursing Home	A nursing home is an inpatient facility providing medical care to Rhode Islanders.

Office of Management and Budget (OMB)	OMB provides ongoing, transparent fiscal analysis, management support, and analytical research to the public, the Governor, the General Assembly, and State departments and agencies.
Social Security Administration (SSA)	SSA administers the Social Security retirement, survivors, and disability insurance programs. They also administer the Supplemental Security Income program for the aged, blind, and disabled.
Tavares Pediatric and Education Center (Tavares)	Tavares is a nursing home providing medical care to pediatric residents.
Third Party Liability (TPL) Module Vendor	The EOHHS contracts with the TPL Module Vendor to provide services to meet the needs of Rhode Island's Medicaid Program. Some of the TPL Module Vendor's functions include TPL identification, management, and recovery.

Exhibit 91: Actors

2.9.2 Process Improvement Opportunities

Exhibit *92*: Process Improvement Opportunities describes the improvement opportunities incorporated across the to-be Financial Management processes. Changes to to-be business processes are denoted by yellow highlights in the to-be process diagrams.

Opportunity	Description
State Accounting System integration with the MES	Creating interfaces between State Accounting System and the MES will allow for a reduction in manual and duplicate entries of financial transactions across both systems.
Automated adjustments of claims with rate changes	Once changes to provider rates are made by the Core Module Vendor, the MES will automatically adjust impacted claims.
Build workflow management tool into the MES	Users may have the ability to manage tasks via a workflow management tool built into the MES.
Vendor management of RIte Share program	The TPL Module Vendor will be the primary entity managing the RIte Share program.
Improved reporting customization and formatting	Reports generated by the Core Module Vendor are more automated, customizable, and formatted according to state standards.
Simplified transmission of the detailed Medicare Premium Payment invoice to EOHHS	Removing DoIT's involvement in transmitting the detailed Medicare Premium Payment invoice file to EOHHS creates a more simplified process.
Increased automated notifications	Sending automated notifications to various parties including the Treasury and EOHHS Finance, Budget and Policy at appropriate points in the provider payment processes reduces manual effort.

Exhibit 92: Process Improvement Opportunities

2.9.3 Gap Analysis by Business Process

Gaps in each business process are documented separately in the sections below. Exhibit 93: Level 0 Process Map provides a high-level depiction of the end-to-end scope and boundaries of the FM functional area. Note: Processes in the Level 0 Process Map may not necessarily occur in the sequential order shown.

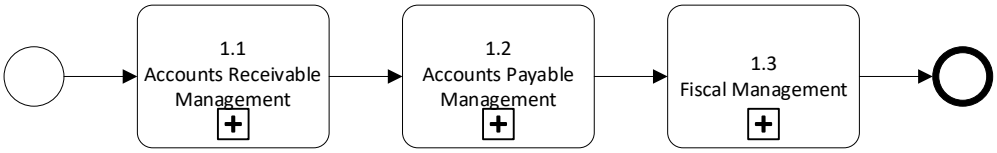


Exhibit 93: Level 0 Process Map

A gap analysis for each process is documented in the sections below, including the following information:

- **Process Description** – High-level definition of the scope and purpose of the business process
- **Gaps** – List of major changes from As-Is to To-Be assessments
- **High-level Requirements** – Statements of necessary conditions to close gaps

2.9.3.1 Accounts Receivable Management

Accounts Receivable Management includes the following processes:

- Prepare Sherlock Member Premium Invoice (No gaps)
- Manage RIte Share Member A/R (No gaps)
- Manage A/R Funds
- Manage Cost Settlement
- Process Fair Rental Value (FRV) Adjustment

2.9.3.2 Manage Member Payment Process

The Manage Member Payment process describes the activities the Core Module Vendor and EOHHS Finance, Budget and Policy perform to send invoices to members, and receive and apply payments.

Process Gaps and Requirements

Exhibit 94: Manage Member Payment Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Member Payment process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent receives a weekly tax intercept file from the Rhode Island Division of Taxation. This file includes information on members whose taxes were intercepted.	The Core Module Vendor receives a weekly tax intercept file from the Rhode Island Division of Taxation. This file includes information on members whose tax refunds were intercepted.	The Core Module Vendor replaces the Fiscal Agent. The Core Module Vendor receives a weekly tax intercept file from the Rhode Island Division of Taxation, including information on members whose tax refunds were intercepted.	The Core Module Vendor will receive a weekly tax intercept file from the Rhode Island Division of Taxation, including information on members whose tax refunds were intercepted.
The Fiscal Agent deposits payment into the EOHHS General Fund via an automated process. The Fiscal Agent also sends a weekly spreadsheet to EOHHS Finance, Budget and Policy, as well as a monthly summary of payments.	The Core Module Vendor deposits payment into the EOHHS General Fund via an automated process. The Core Module Vendor transmits weekly and monthly payment reports to EOHHS Finance, Budget and Policy.	The Core Module Vendor replaces the Fiscal Agent. Core Module Vendor transmits weekly and monthly payment reports to EOHHS Finance, Budget, and Policy.	Core Module Vendor will transmit weekly and monthly payment reports to EOHHS Finance, Budget and Policy.
End Process: The Fiscal Agent applies the payment to the open A/R.	The Core Module Vendor applies the payment to the open A/R. The payment is automatically reflected in State Accounting System.	The Core Module Vendor and State Accounting System integrate to automatically update the State Accounting System for member payments.	The Core Module Vendor will integrate with the State Accounting System to automatically update the State Accounting System for member payments.
Not a Current State Activity	The Core Module Vendor send a loopback file to RIBridges containing updates to member account balances.	The Core Module Vendor sends a loopback file to RIBridges containing updates to member account balances.	The Core Module Vendor will send a loopback file to RIBridges containing updates to member account balances.
Not a Current State Activity	End Process: Department of Human Services updates member file to reflect account balance and create alert for use in subsequent eligibility determinations.	Department of Human Services updates member file to reflect account balance and create alert for use in subsequent eligibility determinations.	The Core Module Vendor will allow Department of Human Services to update member file to reflect account balance and create alert for use in subsequent eligibility determinations.

Exhibit 94: Manage Member Payment Process Gaps and Requirements

2.9.3.3 Manage Accounts Receivable Funds

The Manage Accounts Receivable Funds process describes the activities EOHHS and the Core Module Vendor complete to manage recoupments, from initiating the recoupment request to receiving the payments and applying these payments against the A/R.

Process Gaps and Requirements

Exhibit 95: Manage Accounts Receivable Funds Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Accounts Receivable Funds process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Start Process: An EOHHS stakeholder initiates the recoupment request via a Fiscal Agent Control Number (FACN).	Start Process: An EOHHS stakeholder initiates the recoupment request via the workflow tool.	The Core Module Vendor will use automated workflows to allow EOHHS to initiate recoupment requests.	The Core Module Vendor will use automated workflows to allow EOHHS to initiate recoupment requests.
The Fiscal Agent submits the FACN to EOHHS Finance, Budget and Policy for review and approval.	The Core Module Vendor routes the recoupment request to EOHHS Finance, Budget and Policy for review and approval via the workflow tool.	The Core Module Vendor replaces the Fiscal Agent and FACN process with automated workflows to route recoupment requests.	The Core Module Vendor will use automated workflows to route recoupment requests to EOHHS for review and approval.
EOHHS Finance, Budget and Policy reviews the FACN.	EOHHS Finance, Budget and Policy reviews the recoupment request.	EOHHS reviews recoupment requests instead of FACN.	The Core Module Vendor will enable EOHHS to review recoupment requests.
EOHHS Finance, Budget and Policy follows up with the Fiscal Agent on any questions on the FACN.	EOHHS Finance, Budget and Policy follows up with the Core Module Vendor on any questions on the recoupment request.	EOHHS follows up on recoupment requests instead of FACN.	The Core Module Vendor will enable EOHHS to follow up on any questions on recoupment requests. The Core Module Vendor will response to EOHHS questions on recoupment requests.
The Fiscal Agent responds to questions via email. Go to Activity 1.1.3.4.	The Core Module Vendor responds to questions via the workflow tool. Go to Activity 1.1.3.4.	The Core Module Vendor uses automated workflows to respond to questions instead of FACN.	The Core Module Vendor will us automated workflows to respond to EOHHS questions on recoupment requests.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Decision Point: If EOHHS Finance, Budget and Policy approves the FACN, go to Activity 1.1.3.11. If EOHHS Finance, Budget and Policy, go to Activity 1.1.3.10.	Decision Point: If EOHHS Finance, Budget and Policy approves the recoupment request, go to Activity 1.1.3.11. If EOHHS Finance, Budget and Policy do not approve the recoupment request, go to Activity 1.1.3.10.	EOHHS follows up on recoupment requests instead of FACN.	The Core Module Vendor will enable EOHHS to follow up on any questions on recoupment requests.
End Process: If EOHHS Finance, Budget and Policy does not approve the FACN, the Fiscal Agent cancels the FACN.	End Process: If EOHHS Finance, Budget and Policy does not approve the recoupment request, the Core Module Vendor is notified, and the request is cancelled.	The Core Module Vendor uses automated workflows to receive notification of EOHHS decisions on recoupment requests and resolve recoupment requests.	The Core Module Vendor will use automated workflows to receive notification of EOHHS decisions on recoupment requests and resolve recoupment requests.

Exhibit 95: Manage Accounts Receivable Funds Process Gaps and Requirements

2.9.3.4 Manage Cost Settlement

The Manage Cost Settlement process includes the following processes as depicted in Exhibit 96: Manage Cost Settlement Process Diagram:

- Manage Cost Settlement - Tavares
- Manage Cost Settlement - Slater
- Manage Cost Settlement – FQHC

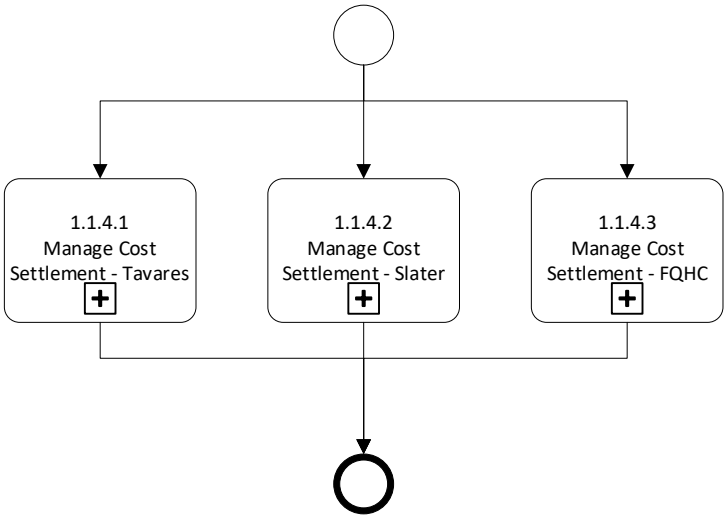


Exhibit 96: Manage Cost Settlement Process Diagram

2.9.3.4.1 Manage Cost Settlement – Tavares

The Manage Cost Settlement – Tavares process describes the activities the State performs on an annual basis to conduct rate determinations and make cost settlements with the Tavares Pediatric Center ("Tavares"), licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Process Gaps and Requirements

Exhibit 97: Manage Cost Settlement – Tavares Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Cost Settlement – Tavares process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS Finance, Budget and Policy prepares and submits an FACN to implement rates and mass adjust claims alternatively and preferably retroactively adjust claims based on revised rates. An A/R or lumpsum payment could arise from the retroactive adjustment of all claims. If the A/R is substantial, the A/R may be recouped over a few payment cycles subject to decision by EOHHS	EOHHS Finance, Budget and Policy submits a request, via the workflow tool, to implement rates and adjust claims based on revised rates. An A/R or lump sum payment could arise from the retroactive adjustment of all claims. If the A/R is substantial, the A/R may be recouped over a few payment cycles subject to decision by EOHHS.	EOHHS submits rate and claims adjustment requests via automated workflows instead of FACN.	The Core Module Vendor will enable EOHHS to submit rate and claims adjustment requests using automated workflows.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Mass adjustments may be made as “offline payments.” In the future, once the rates are adjusted, claims may be reprocessed, and “offline payments” eliminated.	End Process: The Core Module Vendor implements rates, and claims are adjusted automatically based on revised rates.	The Core Module Vendor implements rate adjustments based on EOHHS requests. The Core Module Vendor adjusts claims automatically based on revised rates after processing rate adjustment requests.	The Core Module Vendor will implement rate adjustments based on EOHHS requests. The Core Module Vendor will adjust claims automatically based on revised rates after processing rate adjustment requests.

Exhibit 97: Manage Cost Settlement – Tavares Process Gaps and Requirements

2.9.3.4.2 Manage Cost Settlement – Slater

The Manage Cost Settlement – Slater process describes the activities the State performs on an annual basis to conduct rate determinations and make cost settlements with the Eleanor Slater Hospital (Slater), a public hospital operated by BHDDH.

Process Gaps and Requirements

Exhibit 98: Manage Cost Settlement – Slater Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Cost Settlement – Slater process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS Finance, Budget and Policy submits the FACN to implement the new rates and mass adjust claims.	EOHHS Finance, Budget and Policy submits the request, via the workflow tool, to implement the new rates and adjust claims.	EOHHS submits rate and claims adjustment requests via automated workflows instead of FACN.	The Core Module Vendor will enable EOHHS to submit rate and claims adjustment requests using automated workflows.
End Process: Link to the Perform Mass Adjustment process.	End Process: The Core Module Vendor implements rates, and claims are adjusted automatically based on revised rates.	The Core Module Vendor implements rate adjustments based on EOHHS requests. The Core Module Vendor adjusts claims automatically based on revised rates after processing rate adjustment requests.	The Core Module Vendor will implement rate adjustments based on EOHHS requests. The Core Module Vendor will adjust claims automatically based on revised rates after processing rate adjustment requests.

Exhibit 98: Manage Cost Settlement – Slater Process Gaps and Requirements

2.9.3.4.3 Manage Cost Settlement – FQHC

The Manage Cost Settlement – FQHC process describes the activities the State performs to conduct rate determinations for FQHCs upon request.

Process Gaps and Requirements

Exhibit 99: Manage Cost Settlement – FQHC Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Cost Settlement – FQHC process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS Finance, Budget and Policy submits the FACN to implement the new rates and mass adjust claims.	EOHHS Finance, Budget and Policy submits the request, via the workflow tool, to implement the new rates and adjust claims.	EOHHS submits rate and claims adjustment requests via automated workflows instead of FACN.	The Core Module Vendor will enable EOHHS to submit rate and claims adjustment requests using automated workflows.
End Process: Link to the Perform Mass Adjustment process.	End Process: The Core Module Vendor implements rates, and claims are adjusted automatically based on revised rates.	The Core Module Vendor implements rate adjustments based on EOHHS requests. The Core Module Vendor adjusts claims automatically based on revised rates after processing rate adjustment requests.	The Core Module Vendor will implement rate adjustments based on EOHHS requests. The Core Module Vendor will adjust claims automatically based on revised rates after processing rate adjustment requests.

Exhibit 99: Manage Cost Settlement – FQHC Process Gaps and Requirements

2.9.3.5 Process Fair Rental Value Adjustment

The Process Fair Rental Value (FRV) Adjustment process describes the activities EOHHS Finance, Budget and Policy and the Core Module Vendor must perform once a Nursing Home requests an FRV adjustment. EOHHS approves rate changes if a Nursing Home can demonstrate significant changes in operating costs resulting from capital renovations or expansion.

Process Gaps and Requirements

Exhibit 100: Process Fair Rental Value Adjustment Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Process Fair Rental Value Adjustment process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS Finance, Budget and Policy submits an FACN with a request to mass adjust claims and implement new rates.	Once the Nursing Home has been notified of the FRV adjustment, EOHHS Finance, Budget and Policy submits the request, via the workflow tool, to implement the new rates and adjust claims.	EOHHS submits rate and claims adjustment requests via automated workflows instead of FACN.	The Core Module Vendor will enable EOHHS to submit rate and claims adjustment requests using automated workflows.
End Process: Link to Perform Mass Adjustment process.	End Process: The Core Module Vendor implements rates, and claims are adjusted automatically based on revised rates.	The Core Module Vendor implements rate adjustments based on EOHHS requests. The Core Module Vendor adjusts claims automatically based on revised rates after processing rate adjustment requests.	The Core Module Vendor will implement rate adjustments based on EOHHS requests. The Core Module Vendor will adjust claims automatically based on revised rates after processing rate adjustment requests.

Exhibit 100: Process Fair Rental Value Adjustment Process Gaps and Requirements

2.9.3.6 Accounts Payable Management

Accounts Payable Management includes the following processes as depicted in Exhibit 101: Accounts Payable Management Process Diagram:

- Manage Member Financial Participation
- Manage Rate Change
- Prepare FFS Provider Payment
- Manage Capitation Payment
- Manager Contractor Payment (No gaps)
- Manage Incentive Payment
- Generate Remittance Advice (No gaps)
- Manage 1099 Payment

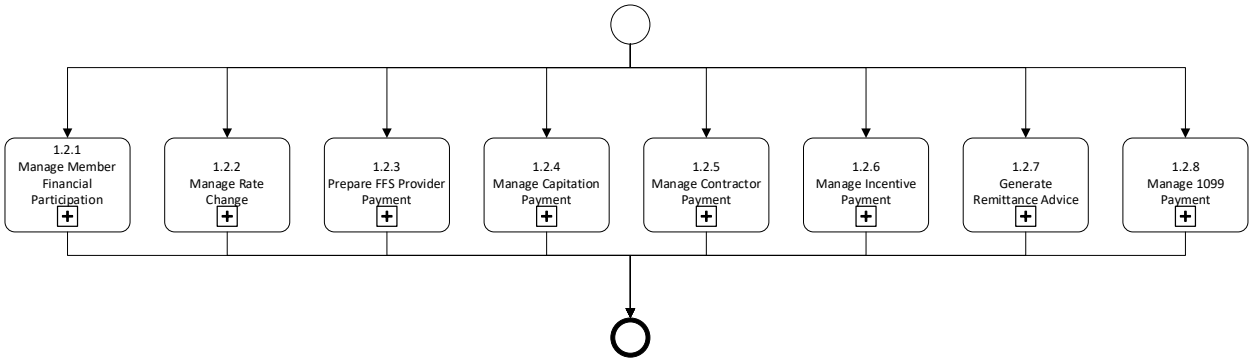


Exhibit 101: Accounts Payable Management Process Diagram

2.9.3.6.1 Manage Member Financial Participation

Manage Member Financial Participation includes the following processes as depicted in Exhibit 102: Manage Member Financial Participation Process Diagram:

- Manage Medicare Premium Payment (MPP) Program (No gaps)
- Prepare Medicare Premium Payment
- Review Detailed Medicare Premium Payment Invoice
- Prepare RIte Share Premium

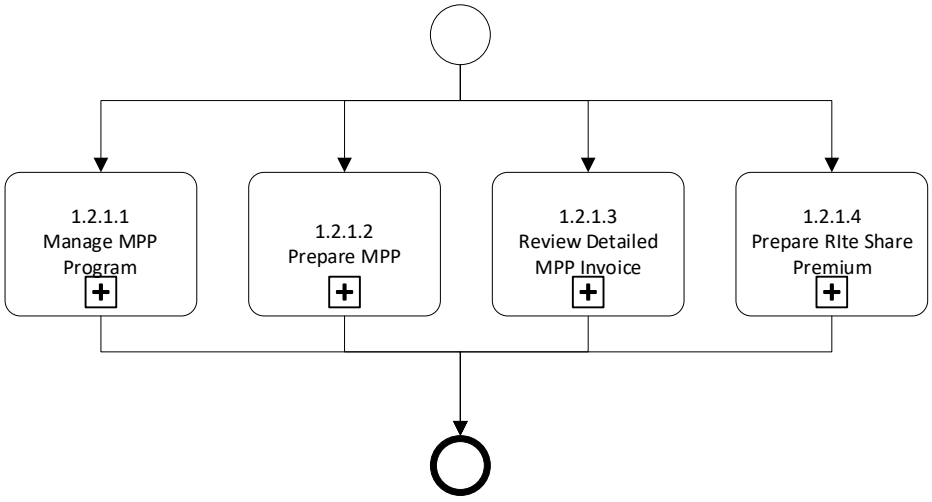


Exhibit 102: Manage Member Financial Participation Process Diagram

2.9.3.6.2 Prepare Medicare Premium Payment

The Prepare Medicare Premium Payment describes the activities the State performs to pay the monthly invoice generated by CMS for Medicare buy-in members, i.e., the State is paying the Medicare beneficiary's share of premium costs.

Process Gaps and Requirements

Exhibit 103: Prepare Medicare Premium Payment Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Prepare Medicare Premium Payment process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
On a monthly basis, EOHHS Finance, Budget and Policy emails the Fiscal Agent with RIFANS expenditure data. An automated notification is sent to Treasury to pay the invoice.	An automated notification is sent to Treasury to pay the invoice.	The Core Module Vendor uses automated workflows to send invoice payment request notification to Treasury.	The Core Module Vendor will use automated workflows to send invoice payment request notifications to Treasury.
End Process: The Fiscal Agent manually updates the MMIS with RIFANS expenditure data.	End Process: The MES is automatically updated with expenditure data once the invoice is uploaded to the State Accounting System.	The Core Module Vendor processes updates to expenditure data after uploading invoice to State Accounting System.	The Core Module Vendor will process updates to expenditure data after uploading Medicare premium payment invoices to the State Accounting System.

Exhibit 103: Prepare Medicare Premium Payment Process Gaps and Requirements

2.9.3.6.3 Review Detailed Medicare Premium Payment Invoice

The Review Detailed Medicare Premium Payment Invoice process describes the activities that take place monthly to validate the monthly invoice received by CMS and determine and correct any discrepancies identified.

Process Gaps and Requirements

Exhibit 104: Review Detailed Medicare Premium Payment Invoice Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Review Detailed Medicare Premium Payment Invoice process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
DHS receives and transmits the files to DoIT via a secure link	DHS receives and transmits the files to EOHHS via a secure link	DHS securely receives and transmits files to EOHHS instead of DoIT.	The Core Module Vendor will allow DHS / RIBridges to securely receive and transmit Medicare premium payment files to EOHHS.
DoIT uploads the files to a shared folder to allow EOHHS to access the files.	The EOHHS CRT (MPP/SSI Unit) leverages the MES to review the monthly invoices and determine if there are any discrepancies. The MPP/SSI unit uses the detailed MPP invoice for appeals, CMS audits.	The EOHHS CRT (MPP/SSI Unit) uses the MES to review the monthly invoices and determine if there are any discrepancies, instead of using a shared folder with DoIT.	The Core Module Vendor will allow EOHHS CRT (MPP/SSI Unit) to review the monthly Medicare premium payment invoices and determine if discrepancies exist.

Exhibit 104: Review Detailed Medicare Premium Payment Invoice Process Gaps and Requirements

2.9.3.6.4 Prepare RIte Share Premium

The Prepare RIte Share Premium process describes the activities the State and the TPL Module Vendor must perform to enroll members in RIte Share from the point of the TPL Module Vendor receiving eligibility information from RIBridges through issuing payment to RIte Share members and generating appropriate payment reports.

Process Gaps and Requirements

Exhibit 105: Prepare RIte Share Premium Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Prepare Rite Share Premium process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Activity	Start Process: The TPL Module Vendor receives eligibility information from RIBridges for members who are employed more than 30 hours/week. This information also includes whether they would be eligible for Employer Sponsored Insurance (ESI), household composition, and the employer's name and employer identification number (EIN).	The TPL Module Vendor receives eligibility information from RIBridges for members who are employed more than 30 hours/week. This information also includes whether they would be eligible for ESI, household composition, and the employer's name and employer identification number (EIN).	The TPL Module Vendor will receive eligibility information from RIBridges for members who are employed more than 30 hours/week, including whether the members would be eligible for ESI, household composition, and the employer's name and employer identification number (EIN).

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Activity	Decision Point: If the ESI information is on file, go to Activity 1.2.1.4.4. If the ESI is not on file, go to Activity 1.2.1.4.3.	TPL Vendor automatically checks if ESI information is on file.	The TPL Module Vendor will automatically check if ESI information is on file for members who may be eligible for RIte Share.
Not a Current State Activity	The TPL Module Vendor contacts the employer / employee for ESI information. Employers must contact the TPL Module Vendor, using an online portal, to supply information. Members (employee) must contact the EOHHS RIte Share team or the TPL Module Vendor to provide the ESI information.	The TPL Module Vendor contacts the employer / employee for ESI information, if ESI is not on file. Employers must contact the TPL Module Vendor, using an online portal, to supply information. Members (employee) must contact the EOHHS RIte Share team or the TPL Module Vendor to provide the ESI information.	The TPL Module Vendor will contact the employer / employee for ESI information, if ESI is not on file. The TPL Module Vendor will enable employers to contact the TPL Module Vendor, using an online portal, to supply ESI information. The TPL Module Vendor will enable members (employee) to contact the EOHHS RIte Share team or the TPL Module Vendor to provide the ESI information.
Not a Current State Activity	Decision Point: Employers have 30 days to respond to a request. If the employers send the ESI information within 30 days, go to Activity 1.2.1.4.8. Otherwise, go to Activity 1.2.1.4.5.	If ESI is on file, employers have 30 days to respond to a request. TPL Module allows employers 30 days to respond to insurance information requests. TPL Module vendor uses automated workflows to determine and process RIteShare eligibility and payments.	The TPL Module Vendor will enable employers to response to information requests within 30 days. The TPL Module Vendor will use automated workflows to determine and process RIteShare eligibility and payments.
Not a Current State Activity	Decision Point: If the employer is a Medicaid provider, go to Activity 1.2.1.4.6. If the employer is not a Medicaid provider, go to Activity 1.2.1.4.9.	TPL Module vendor uses automated workflows to determine and process RIteShare eligibility and payments.	The TPL Module Vendor will use automated workflows to determine and process RIteShare eligibility and payments.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Activity	End Process: The TPL Module Vendor generates a report of unresponsive Medicaid providers and sends it to EOHHS.	If the employer does not send requested insurance information within 30 days and is a Medicaid provider, then TPL Module Vendor generates report of unresponsive Medicaid provider and sends to EOHHS.	The TPL Module Vendor will generate report of unresponsive Medicaid provider and sends to EOHHS, if the employer does not send requested insurance information within 30 days and is a Medicaid provider.
Not a Current State Activity	The TPL Module Vendor uses their cost-effectiveness tool to determine whether the ESI is cost-effective for the state.	The TPL Module Vendor determines whether ESI is cost-effective for the state.	The TPL Module Vendor will determine whether ESI is cost-effective for the state.
Not a Current State Activity	Decision Point: If the employer plan is cost-effective, go to Activity 1.2.1.4.10. Otherwise, go to Activity 1.2.1.4.9.	TPL Module Vendor uses automated workflows to process determine and process RIteShare eligibility and payments.	TPL Module vendor will use automated workflows to process determine and process RIteShare eligibility and payments.
Not a Current State Activity	End Process: No changes are made to the member's enrollment if the employer plan is not cost-effective.	If the employer does not send requested insurance information within 30 days and is not a Medicaid provider, then the TPL Module and Core Module allow MCO enrollment to continue.	The TPL Module allows MCO enrollment to continue, if the employer does not send requested insurance information within 30 days and is not a Medicaid provider. The Core Module allows MCO enrollment to continue, if the employer does not send requested insurance information within 30 days and is not a Medicaid provider.
Not a Current State Activity	The TPL Module Vendor sends a notice to the member to enroll in the ESI, highlighting it is a condition of their Medicaid eligibility. If the member does not respond within 30 days from the day the letter is sent, the member is sanctioned, i.e., Medicaid eligible people over 19 who are not pregnant are terminated.	The TPL Module Vendor, instead of the Fiscal Agent, sends notice to member to enroll in ESI.	The TPL Module Vendor sends notice to member to enroll in ESI, highlighting it is a condition of their Medicaid eligibility. The TPL Module Vendor sanctions member, if the member does not respond within 30 days from the day the letter is sent, i.e., terminating Medicaid eligible people over 19 who are not pregnant.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Activity	The member completes and submits the paperwork to enroll in the ESI plan. The paperwork is submitted to the TPL Module Vendor.	The member completes and submits ESI enrollment paperwork to the TPL Module Vendor, instead of the Fiscal Agent.	The TPL Module Vendor enables members to complete and submit ESI enrollment paperwork to the TPL Module Vendor.
Not a Current State Activity	The TPL Module Vendor receives the paperwork and enrolls the member in RIte Share.	The TPL Module Vendor receives the ESI enrollment paperwork and enrolls the member in RIte Share.	The TPL Module Vendor will receive the ESI enrollment paperwork and enroll the member in RIte Share.
Not a Current State Activity	End Process: The TPL Module Vendor sends the transaction to the Core module in real-time with appropriate disenrollment dates. Prior to the implementation of the Core module, the TPL Module Vendor sends the transaction to the MMIS (legacy system) via batch files.	The TPL Module Vendor sends the transaction to the Core module in real-time with appropriate disenrollment dates. Prior to the implementation of the Core module, the TPL Module Vendor sends the transaction to the MMIS (legacy system) via batch files.	The TPL Module Vendor will send the RIte Share enrollment transaction to the Core module in real-time with appropriate disenrollment dates. Prior to the implementation of the Core module, the TPL Module Vendor will send the transaction to the MMIS (legacy system) via batch files.
Not a Current State Activity	Decision Point: If a premium collection deduction was applied, go to Activity 1.2.1.4.15. Otherwise, go to Activity 1.2.1.4.16.	The TPL Module Vendor uses automated workflows to process determine and process RIteShare eligibility and payments.	The TPL Module Vendor will use automated workflows to process determine and process RIteShare eligibility and payments.
Not a Current State Activity	The TPL Module Vendor calculates the premium deduction, indicating whether payment is the full reimbursement, or a cost share was deducted.	The TPL Module Vendor calculates the premium deduction, indicating whether payment is the full reimbursement, or a cost share was deducted.	The TPL Module Vendor will calculate the premium deduction, indicating whether payment is the full reimbursement, or a cost share was deducted.
Not a Current State Activity	The TPL Module Vendor calculates the payment.	The TPL Module Vendor calculates the RIteShare premium payment.	The TPL Module Vendor will calculate the RIteShare premium payment.
Not a Current State Activity	The TPL Module Vendor automatically posts payment information to the employer insurance history table.	The TPL Module Vendor, instead of the Fiscal Agent, automatically posts payment information to the employer insurance history table.	The TPL Module Vendor will automatically post payment information to the employer insurance history table.
Not a Current State Activity	End Process: The TPL Module Vendor issues the payment via EFT or check.	The TPL Module Vendor issues the RIteShare premium payment via EFT or check.	The TPL Module Vendor will issue the RIteShare premium payment via EFT or check.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Activity	End Process: The TPL Module Vendor generates payment reports on an aggregate and individual basis and submits to EOHHS. These payment reports inform two reports that are required by legislation.	The TPL Module Vendor generates RIteShare payment reports on an aggregate and individual basis and submits to EOHHS. These payment reports inform two reports that are required by legislation.	The TPL Module Vendor will generate RIteShare payment reports on an aggregate and individual basis and submits to EOHHS. These payment reports inform two reports that are required by legislation.
Not a Current State Activity	End Process: On a monthly basis, the TPL Module Vendor mails the payment report to the RIte Share member. This payment report will include details on the premium, cost share deduction, if applicable, and the payment.	On a monthly basis, the TPL Module Vendor mails the RIteShare payment report to the RIte Share member. This payment report will include details on the premium, cost share deduction, if applicable, and the payment.	On a monthly basis, the TPL Module Vendor will mail the RIteShare payment report to the RIte Share member. This payment report will include details on the premium, cost share deduction, if applicable, and the payment.

Exhibit 105: Prepare RIte Share Premium Gaps and Requirements

2.9.3.7 Manage Rate Change

The Manage Rate Change process describes the activities to update the MES with a rate change for a specific group of providers. The process begins with EOHHS reviewing the appropriation bill, through to the point at which a state plan amendment (SPA) is submitted and approved, if required, and the Core Module Vendor processes the request to make the rate change effective.

Process Gaps and Requirements

Exhibit 106: Manage Rate Change Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Rate Change process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS completes an FACN to update relevant rates and submits it to the Fiscal Agent for processing.	EOHHS completes a request, via the workflow tool, to update relevant rates and submits it to the Core Module Vendor for processing.	EOHHS requests rate changes via automated workflows, instead of FACN.	The Core Module Vendor will enable EOHHS to request rate changes via automated workflows.
End Process: The Fiscal Agent processes the FACN which makes the rate change effective.	End Process: The Core Module Vendor receives the request via the workflow tool and processes it, which makes the rate change effective.	The Core Module Vendor receives the rate change request via automated workflows, instead of FACN.	The Core Module Vendor will receive the rate change request via automated workflows.

Exhibit 106: Manage Rate Change Process Gaps and Requirements

2.9.3.8 Prepare FFS Provider Payment

The Prepare FFS Provider Payment process documents the management of electronic and paper-based reimbursement for fee-for-service providers. It includes determining the payment amount, completing system checks and balances, transmitting the relevant payment cycle file to the Core Module Vendor's bank, and issuing payment via EFT or check.

Process Gaps and Requirements

Exhibit 107: Prepare FFS Provider Payment Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Prepare FFS Provider Payment process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS submits an FACN requesting the provider payout to the Fiscal Agent for processing.	EOHHS submits a request, via the workflow tool, to the Core Module Vendor to process the provider payout.	EOHHS requests provider payout via automated workflows, instead of FACN.	The Core Module Vendor will enable EOHHS to request provider payouts via automated workflows.
The Fiscal Agent receives the FACN and submits it to EOHHS Finance, Budget and Policy for approval.	The Core Module Vendor receives the request and submits it to EOHHS Finance, Budget and Policy for approval, using the workflow tool.	The Core Module Vendor receives the provider payout request via automated workflows, instead of FACN.	The Core Module Vendor receives the provider payout request via automated workflows.
EOHHS Finance, Budget and Policy reviews the FACN to determine whether the provider payout is needed.	EOHHS Finance, Budget and Policy reviews the request to determine whether the provider payout is needed.	EOHHS reviews the provider payout request, instead of FACN.	The Core Module Vendor will enable EOHHS to review provider payout requests.
EOHHS Finance, Budget and Policy follows up with the Fiscal Agent on any questions regarding the FACN. If the Fiscal Agent is unable to resolve EOHHS Finance, Budget and Policy's questions, EOHHS Finance, Budget and Policy may follow up with other agencies with questions and necessary documentation request.	EOHHS Finance, Budget and Policy follows up with the Core Module Vendor on any questions regarding the request. If the Core Module Vendor is unable to resolve EOHHS Finance, Budget and Policy's questions, EOHHS Finance, Budget and Policy may follow up with other agencies with questions and necessary documentation request.	The Core Module Vendor replaces the Fiscal Agent. EOHHS follows up with the Core Module Vendor for any questions. EOHHS uses information requests, instead of FACN.	The Core Module Vendor will enable EOHHS to follow up on provider payment requests.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
The Fiscal Agent responds to questions received from EOHHS Finance, Budget and Policy.	The Core Module Vendor responds to questions received from EOHHS Finance, Budget and Policy.	The Core Module Vendor replaces the Fiscal Agent. The Core Module Vendor responds to EOHHS questions on provider payments.	The Core Module Vendor will respond to EOHHS questions on provider payments.
Decision Point: If EOHHS Finance, Budget and Policy approves the FACN, proceed to Activity 1.2.3.10. Otherwise, if EOHHS Finance decides not to pursue the payout, go to Activity 1.2.3.9.	Decision Point: If EOHHS Finance, Budget and Policy approves the request, proceed to Activity 1.2.3.10. Otherwise, if EOHHS Finance decides not to pursue the payout, go to Activity 1.2.3.9.	EOHHS uses requests for provider payouts, instead of FACN.	The Core Module Vendor will enable EOHHS to request provider payouts via automated workflows.
End: The Fiscal Agent cancels the FACN.	End: The Core Module Vendor cancels the request.	The Core Module Vendor replaces the Fiscal Agent. Provider payout requests replace FACN. The Core Module Vendor cancels provider payout requests if EOHHS does not approve the payment.	The Core Module Vendor will cancel provider payout requests, if EOHHS does not approve the payment.
The Fiscal Agent processes the FACN.	The Core Module Vendor processes the request.	The Core Module Vendor replaces the Fiscal Agent. Provider payout requests replace FACN. The Core Module Vendor processes the provider payout, if EOHHS approves the payment.	The Core Module will process the provider payout, if EOHHS approves the payment.
EOHHS Finance, Budget and Policy makes a journal entry in RIFANS with the relevant transaction details.	EOHHS Finance, Budget and Policy makes a journal entry in the State Accounting System with the relevant transaction details. Note: The State will need to identify which transactions from State Accounting System flow into the MES. A notification of the journal entry will be automatically sent to the Core Module Vendor.	EOHHS makes a journal entry with relevant transaction details in the State Accounting System. The State will need to identify which transactions from State Accounting System flow into the MES. A notification of the journal entry will be automatically sent to the Core Module Vendor.	The Core Module Vendor will receive notification of the EOHHS provider payment journal entry from the State Accounting System.
The Fiscal Agent notifies EOHHS Finance, Budget and Policy of the payment request, biweekly.	The Core Module Vendor sends an automated notification to EOHHS Finance, Budget and Policy of the payment request, biweekly.	The Core Module Vendor replaces the Fiscal Agent. The Core Module Vendor sends an automated notification of payment requests to EOHHS on a biweekly basis.	The Core Module Vendor will send an automated notification of payment requests to EOHHS on a biweekly basis.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS Finance, Budget and Policy manually uploads the documents associated with the financial cycle into RIFANS.	EOHHS Finance, Budget and Policy automatically uploads the documents associated with the financial cycle into the State Accounting System.	EOHHS automatically uploads financial cycle documents to the State Accounting System, instead of manually uploading.	The Core Module Vendor will enable EOHHS to automatically upload financial cycle documents to the State Accounting System.
EOHHS Finance, Budget and Policy notifies the Treasury to fund the Fiscal Agent's bank account, including relevant payment details.	Once the financial cycle is uploaded to the State Accounting System, an automated notification is sent to the Treasury to fund the Core Module Vendor's bank account, including relevant payment details.	The Core Module Vendor automatically, instead of manually, notifies Treasury to fund the Core Module Vendor's bank account, including relevant payment details, after uploading the financial cycle to the State Accounting System.	The Core Module Vendor will automatically notify Treasury to fund the Core Module Vendor's bank account, including relevant payment details, after uploading the financial cycle to the State Accounting System.

Exhibit 107: Prepare FFS Provider Payment Process Gaps and Requirements

2.9.3.9 Manage Capitation Payment

The Manage Capitation Payment process describes the activities to prepare and issue payments to MCOs.

Process Gaps and Requirements

Exhibit 108: Manage Capitation Payment Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Capitation Payment Process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS runs a query to determine the payment amount for the health plan, i.e., the difference between what should have been paid and what was paid to the health plan.	EOHHS runs a query to determine the payment amount for the health plan, i.e., the difference between what should have been paid and what was paid to the health plan. This query will have the ability to include a member-level record of payment.	EOHHS' query for the difference between actual and expected health plan payments will include member-level record of payment.	The Core Module Vendor will provide a query for the difference between actual and expected health plan payments, which will include member-level record of payment.
EOHHS completes the FACN with the aggregate data for each managed care plan.	EOHHS completes the request, via the workflow tool, with the aggregate data for each managed care plan.	EOHHS completes requests to process capitation payments, instead of FACN, and submits via automated workflows.	The Core Module Vendor will enable EOHHS to complete and automatically submit capitation payment requests.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS submits the FACN to the Fiscal Agent for processing.	EOHHS submits the request to the Core Module Vendor for processing.	EOHHS submits the capitation payment request, instead of FACN. The Core Module Vendor replaces the Fiscal Agent.	The Core Module Vendor enables EOHHS to submit capitation payment requests.
The Fiscal Agent applies the payment to a specific policy / plan.	The Core Module Vendor receives the request via the workflow tool and applies the payment to a specific policy / plan.	The Core Module vendor receives capitation payment requests automatically, instead of FACN.	The Core Module Vendor will receive capitation payment requests.
The Fiscal Agent notifies EOHHS Finance, Budget and Policy of the payment request, biweekly.	The Core Module Vendor sends an automated notification to EOHHS Finance, Budget and Policy of the payment request, biweekly.	The Core Module Vendor, instead of Fiscal Agent, sends an automated notification to EOHHS Finance, Budget and Policy of the payment request, biweekly.	The Core Module Vendor will send an automated notification to EOHHS Finance, Budget and Policy of the payment request, biweekly.
EOHHS Finance, Budget and Policy manually uploads the documents associated with the financial cycle into RIFANS.	EOHHS Finance, Budget and Policy automatically uploads the documents associated with the financial cycle into the State Accounting System.	EOHHS automatically, instead of manually, uploads financial cycle documents to the State Accounting System.	The Core Module Vendor will enable EOHHS to automatically upload financial cycle documents to the State Accounting System.
EOHHS Finance, Budget and Policy notifies the Treasury to fund the Fiscal Agent's bank account, including relevant payment details.	Once the financial cycle is uploaded to the State Accounting System, an automated notification is sent to the Treasury to fund the Core Module Vendor's bank account, including relevant payment details.	The Core Module Vendor automatically, instead of manually, notifies Treasury to fund the Core Module Vendor's bank account, including relevant payment details, after uploading the financial cycle to the State Accounting System.	The Core Module Vendor will automatically notify Treasury to fund the Core Module Vendor's bank account, including relevant payment details, after uploading the financial cycle to the State Accounting System.

Exhibit 108: Manage Capitation Payment Process Gaps and Requirements

2.9.3.10 Manage Incentive Payment

The Manage Incentive Payment process describes the activities to administer incentive payments to MCOs and accountable entities.

Process Gaps and Requirements

Exhibit 109: Manage Incentive Payment Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Incentive Payment process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS Managed Care Oversight submits supporting documentation with payment tracker, payment worksheet and FACN to EOHHS Finance, Budget and Policy.	EOHHS Managed Care Oversight submits the payment request with supporting documentation including the payment tracker and worksheet to EOHHS Finance, Budget and Policy for review and approval.	EOHHS submits incentive payment requests, instead of FACN.	The Core Module Vendor will enable EOHHS to submit incentive payment requests.
EOHHS Finance, Budget and Policy follows up with the original requester with questions. The requester responds to questions via email and resubmits the FACN to the Fiscal Agent.	EOHHS Finance, Budget and Policy follows up with the original requester with questions. The requester responds to questions via the workflow tool.	The incentive payment requester responds to questions via the workflow tool.	The Core Module Vendor will enable incentive payment requesters to respond to EOHHS questions via automatic workflows.
The Fiscal Agent processes the FACN, either through the typical financial cycle or separately (preference is for these payments to be managed outside of the typical financial cycle).	The Core Module Vendor processes the payment request, either through the typical financial cycle or separately (preference is for these payments to be managed outside of the typical financial cycle).	The Core Module Vendor replaces the Fiscal Agent. The Core Module Vendor processes the payment request, either through the typical financial cycle or separately (preference is for these payments to be managed outside of the typical financial cycle).	The Core Module Vendor will process the inventive payment request, either through the typical financial cycle or separately (preference is for these payments to be managed outside of the typical financial cycle).
The Fiscal Agent notifies EOHHS Finance, Budget and Policy of the payment request, biweekly.	The Core Module Vendor sends an automated notification to EOHHS Finance, Budget and Policy of the payment request, biweekly.	The Core Module Vendor, instead of Fiscal Agent, sends an automated notification to EOHHS Finance, Budget and Policy of the payment request, biweekly.	The Core Module Vendor sends an automated notification to EOHHS Finance, Budget and Policy of the payment request, biweekly.
EOHHS Finance, Budget and Policy manually uploads the documents associated with the financial cycle into RIFANS.	EOHHS Finance, Budget and Policy automatically uploads the documents associated with the financial cycle into the State Accounting System.	EOHHS automatically, instead of manually, uploads financial cycle documents to the State Accounting System.	The Core Module Vendor will enable EOHHS to automatically upload financial cycle documents to the State Accounting System.
EOHHS Finance, Budget and Policy notifies the Treasury to fund the Fiscal Agent's bank account, including relevant payment details.	Once the financial cycle is uploaded to the State Accounting System, an automated notification is sent to the Treasury to fund the Core Module Vendor's bank account, including relevant payment details.	The Core Module Vendor automatically, instead of manually, notifies Treasury to fund the Core Module Vendor's bank account, including relevant payment details, after uploading the financial cycle to the State Accounting System.	The Core Module Vendor will automatically notify Treasury to fund the Core Module Vendor's bank account, including relevant payment details, after uploading the financial cycle to the State Accounting System.

Exhibit 109: Manage Incentive Payment Process Gaps and Requirements

2.9.3.11 Prepare 1099

The Prepare 1099 process describes the activities the State performs both at the beginning of the calendar year and upon request from a provider / contractor to generate 1099s through to mailing the 1099 forms and submitting the 1099 data to the Internal Revenue Service (IRS).

Process Gaps and Requirements

Exhibit 110: Prepare 1099 Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Prepare 1099 Process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Start Process: At the beginning of each year, the Fiscal Agent generates 1099 reporting based on the records maintained over the previous calendar year, and reviews for accuracy.	Start Process: At the beginning of each year, the Core Module Vendor generates 1099 reporting based on the records maintained over the previous calendar year, and reviews for accuracy. Appropriate checks and balances will be conducted prior to sending the file to the State.	The Core Module Vendor conducts appropriate checks and balances on the 1099 reporting before sending to EOHHS.	The Core Module Vendor will conduct appropriate checks and balances on the 1099 reporting before sending to EOHHS.

Exhibit 110: Prepare 1099 Process Gaps and Requirements

2.9.4 Fiscal Management

Fiscal Management includes the following processes as depicted in Exhibit 111: Fiscal Management Process Diagram:

- Formulate and Manage Budget
- Manage Fund
- Generate Financial Report

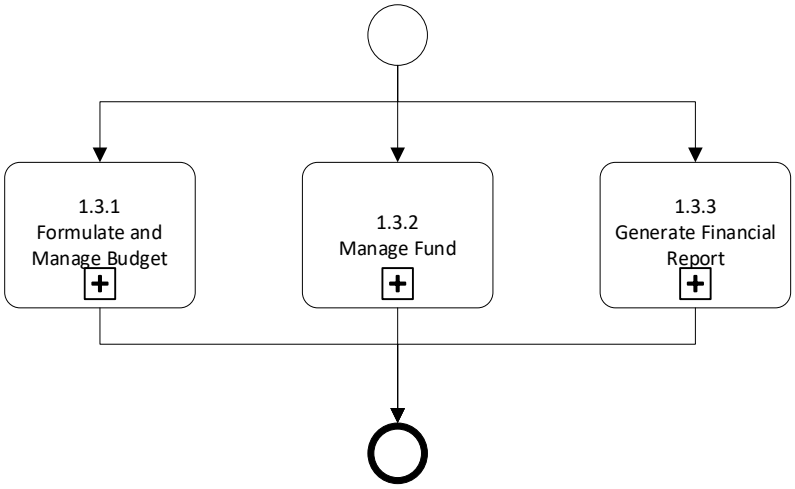


Exhibit 111: Fiscal Management Process Diagram

2.9.4.1 Formulate and Manage Budget

The Formulate and Manage Budget process describes the activities that must take place to develop the budget planning document. The process starts with EOHHS receiving the notification from the Governor's Office to prepare the budget transmittal for legislative approval and documents the activities through the point at which OMB uploads the enacted budget to the State Accounting System and notifies EOHHS that the budget has been uploaded.

Process Gaps and Requirements

Exhibit 112: Formulate and Manage Budget Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Formulate and Manage Budget process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Not a Current State Activity	EOHHS submits a request to the Core Module Vendor to upload the enacted budget file to the MES to enable improved reporting.	EOHHS submits a request to the Core Module Vendor to upload the enacted budget file to the MES to enable improved reporting.	The Core Module Vendor will enable EOHHS to submit a request to upload the enacted budget file.
Not a Current State Activity	The Core Module Vendor uploads the enacted budget file to the MES.	The Core Module Vendor uploads the enacted budget file to the MES.	The Core Module Vendor will upload the enacted budget file to the MES at EOHHS' request.

Exhibit 112: Formulate and Manage Budget Process Gaps and Requirements

2.9.4.2 Manage Fund

The Manage Fund process encompasses the activities to oversee Medicaid funds. Manage Fund includes the following subprocesses as depicted in Exhibit *113*: Manage Fund Process Diagram.

- Manage Fund – Medical Assistance
- Manage Federal Medical Assistance Percentages (FMAP)

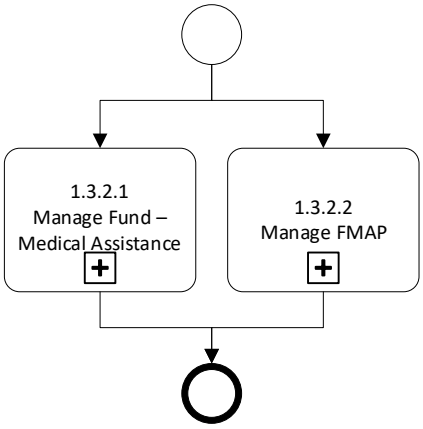


Exhibit 113: Manage Fund Process Diagram

2.9.4.2.1 Manage Fund – Medical Assistance

The Manage Fund – Medical Assistance process describes the activities that EOHHS Finance, Budget and Policy performs to oversee and report on Medical Assistance expenditures.

Process Gaps and Requirements

Exhibit 114: Manage Fund – Medical Assistance Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage Fund ‑ Medical Assistance process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
On a monthly basis, EOHHS Finance, Budget and Policy consolidates the global waiver report sent by the Fiscal Agent and the Discoverer report into a cumulative total report for the quarter.	On a monthly basis, EOHHS Finance, Budget and Policy leverages the MES to automatically consolidate the global waiver report and the Discoverer report into a cumulative total report for the quarter.	The Core Module automatically, instead of EOHHS manually, consolidates the global waiver report and the Discoverer report into a into a cumulative total report for the quarter.	The Core Module will automatically consolidate the global waiver report and the Discoverer report into a into a cumulative total report for the quarter.
On a monthly basis, EOHHS Finance, Budget and Policy reconciles consolidated (cumulative total) report to financial cycle reports to ensure all expenditures are accounted for.	On a monthly basis, EOHHS Finance, Budget and Policy leverages the MES to reconcile consolidated (cumulative total) report to financial cycle reports to ensure all expenditures are accounted for.	The Core Module, instead of EOHHS, reconciles consolidated (cumulative total) report to financial cycle reports to ensure all expenditures are accounted for.	The Core Module will reconcile consolidated (cumulative total) reports to financial cycle reports to ensure all expenditures are accounted for.

Exhibit 114: Manage Fund – Medical Assistance Process Gaps and Requirements

2.9.4.2.2 Manage FMAP

The Manage FMAP process describes the activities that EOHHS Finance, Budget and Policy performs to update FMAP rates annually, apply FMAP to total expenditures, and draw down FMAP funds biweekly.

Process Gaps and Requirements

Exhibit 115: Manage FMAP Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Manage FMAP process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
EOHHS Finance, Budget and Policy notifies the Fiscal Agent of the new rates by completing and submitting an FACN.	EOHHS Finance, Budget and Policy notifies the Core Module Vendor of the new rates via the workflow tool.	EOHHS Finance, Budget and Policy uses automated workflow to notify the Core Module Vendor of the new rates.	The Core Module Vendor will enable EOHHS Finance, Budget and Policy to use automated workflow to notify the Core Module Vendor of the new rates.
The Fiscal Agent processes the FACN, uploading the new rates into the MMIS.	The Core Module Vendor processes the request, uploading the new rates into the MES.	The Core Module Vendor replaces the Fiscal Agent. The Core Module vendor processes rate change requests, instead of FACN.	The Core Module vendor will process rate change requests.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
End Process: EOHHS makes a journal entry in RIFANS reflecting the deposit into the General Fund.	End Process: The Core Module Vendor automatically transmits financial cycle information to the State Accounting System, reflecting the deposit into the General Fund.	The Core Module Vendor automatically, instead of EOHHS manually, transmits financial cycle information to the State Accounting System, reflecting the deposit into the General Fund.	The Core Module Vendor will automatically transmit financial cycle information to the State Accounting System, reflecting the deposit into the General Fund.

Exhibit 115: Manage FMAP Process Gaps and Requirements

2.9.4.3 Generate Financial Report

The Generate Financial Report process outlines the activities that take place to produce and customize the various financial reports required by EOHHS, including those required for federal reporting.

Process Gaps and Requirements

Exhibit 116: Generate Financial Report Process Gaps and Requirements describes the process gaps between the As-Is and To-Be processes and high-level requirements to close the gaps for the Generate Financial Report process.

As-Is Activity Description	To-Be Activity Description	Gap	High-Level Requirement
Start Process: EOHHS receives the report from the Fiscal Agent.	Start Process: EOHHS receives the report from the Core Module Vendor. Reports generated by the Core Module Vendor are more automated, customizable and formatted according to state standards. The MES is also leveraged to support budget planning and trend reporting.	The Core Module Vendor provides automated, customizable, and preformatted reports, according to state standards. The Core Module Vendor supports budget planning and trend reporting.	The Core Module Vendor will provide automated, customizable, and preformatted reports, according to state standards. The Core Module Vendor will support budget planning and trend reporting.

Exhibit 116: Generate Financial Report Process Gaps and Requirements

3 Technical Architecture Gap Analysis

The Technical Architecture Gap Analysis evaluates existing systems relative to the future state technical architecture across the following future state architecture standards:

- Service-Oriented Architecture (SOA)/Integration Platform
- Maintainability
- Business Services
- Data Services
- Technical Services
- Portal Integration
- Single Sign-On
- Cloud Connectivity

The assessment also considers how the systems encompass application maintainability factors such as: source code, modularity, on-premises versus cloud, code brittleness, and availability of modern APIs.

A gap matrix and a narrative are provided for each system gap identified.

Exhibit 117: Systems Evaluated lists the systems included in the Technical Architecture gap analysis.

System Name	Description
Consumer Directed Module (CDM)	CDM is a system utilized for self-directed / personal choice of Medicaid benefits and service management.
Core	The Rhode Island MMIS is an integrated group of procedures and subsystems/modules operated by the Fiscal Agent to help manage the state's Medicaid program.
Community Supports Management	CSM is a tool for level of care data and forms that centers around Admission, Discharge, and Change in Acuity for long-term plans. CSM is supported and maintained by Gainwell.
Healthcare Portal	The Healthcare Portal is a secure, internet portal used by healthcare providers to inquire on the status of claims, verify eligibility, upload electronic claim files, etc.
Medicaid Recovery Network (MRN)	MRN is a tool which assist with the process of imposing liens and receiving payments from liable third parties.
Third Party Liability	TPL refers to the legal obligation of third parties, including individuals, entities, health plans or programs, to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. EOHHS primarily works with the Fiscal Agent and Epiq, a legal and business services provider to conduct TPL activities to ensure Medicaid is the payer of last resort.
Pharmacy Drug Management	The Pharmacy Drug Management function is performed by the Fiscal Agent and its subcontractors to manage prescription drug benefits, on behalf of EOHHS, for Rhode Island's Medicaid Members. The Fiscal Agent is responsible for maintaining drug formularies, updating, and maintaining the Medicaid FFS preferred drug list, monitoring, tracking, and reporting on rebate payments, and conducting drug utilization review to

System Name	Description
	reduce clinical abuse and misuse of prescription drugs covered under the Rhode Island Medicaid Program.
Surveillance Utilization Review	SUR Profiler is a query, reporting, and analysis tool employed by the SUR Team that uses information from the MMIS as its primary data source. The tool's primary function is to run comparisons of similar providers and members to identify outliers / significant differences across peer groups. Case Tracker is a case management tool that is used to assist with identifying and tracking fraud, waste, and abuse within the Medicaid Program.
Enterprise Document Management (EDM)	Enterprise Document Management utilizes IBM Content Manager OnDemand as document repository and document retrieval. Document capture is completed through iScan/iCapture which is a scan, index, and OCR tool.
Electronic Visit Verification	The EOHHS EVV system is an in-home visit scheduling, tracking and billing system that employs controls within the delivery of home-based services to ensure client's quality of care. The EOHHS EVV system is administered by Sandata Technologies, LLC. Provider Agencies have three options for using the EOHHS EVV system: a mobile app, telephony, or the FVV device.
Enterprise Data Warehouse (HSDW)	Human Services Data Warehouse is the Enterprise Data Warehouse for the EOHHS MESs used to support decision support and analytic activities
Enterprise Data Warehouse – Data Ecosystem	EDW-Data Ecosystem combines data from the HSDW, All Payer Claims Database and several external programs to support Agency analytics and reporting.

Exhibit 117: Systems Evaluated

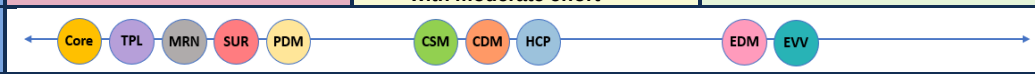
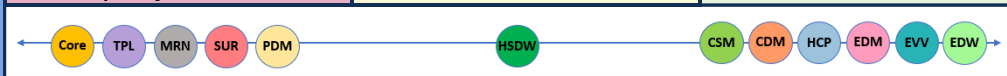
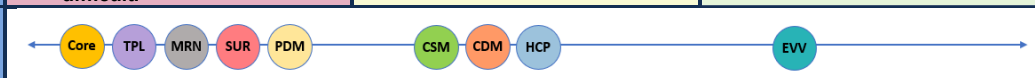
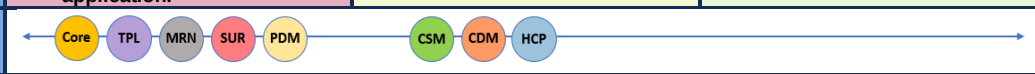
Based on the evaluation, the systems were rated using the following criteria:

- Antiquated – A system that would require significant effort, or a complete rewrite, to be considered for the future state architecture.
- Better – A system that would require a medium to high level of effort to be considered for the future state architecture.
- Best – A system that is either already compliant with the future state architecture, or one that would require a low to moderate level of effort to be considered for the future state architecture

Additionally, we have identified a couple situations that were in-between of Better-Best, which would be a system that could be brought up to future state architecture with a low to medium level of effort to make the changes needed to make it consistent with the future state architecture

3.1 Gap Analysis Matrix by System

Exhibit 118: Technical Architecture Gap Matrix presents the system ratings per the defined criteria. The rating of antiqued, better, and best indicates where each system gap falls within the matrix. Each system is defined in the legend and represented by a circle on the matrix line. Each row represents a technical architectural component of the to-be architecture which the systems were evaluated against.

Technical Architecture	Antiquated	Better	Best
Service-Oriented Architecture / Integration Platform	• Tight application coupling • Monolithic systems Architecture • Programming Language not adaptable to SOA • Application architecture not adaptable to SOA	• Lower coupling Some modularity between applications • Programming Language adaptable to SOA with medium to high level of effort • Architecture based on Multi-Tier / Can convert to SOA with moderate effort	• Loose coupling between applications, modules, and services • Programming language supports SOA or is easily adaptable to SOA • Multi-tier architecture that is easily converted to SOA
			
Maintainability	• Older programming language • Diminishing resource pool • High degree of code complexity	• Modern programming language • Strong resource pool • Moderate code complexity	• Modern day programming language • Strong resource pool • Low code complexity
			
Business Services	• Monolithic application design with tightly coupled components and User Interface (UI) directly connected to the DB. • Application re-write, or significant enhancements, to expose functionality as Business Services. • Business Logic written in multiple locations such as the User Interface, business layer, and database making sharing and re-use very difficult.	• Multi-tier monolithic application with no Business Services or Services that are not easily re-useable. • Moderate to high-level of coding to expose business services.	• Multi-tier non-monolithic application. May already be running in distributed environment. • Business services currently exists, or application easily modified to expose Business Services.
			
Data Services	• Data Services not used to access database. • Data services and data access directly from the User interface and/or business tier. • Re-writing app to utilize business services would require large re-write or new application.	• Data services are currently contained in the "Business-Tier" (AKA, middle tier) of the application. • Language supports migration to business services with moderate to high level of effort.	• Data services are detached and decoupled from the consumers of the service. Typical consumers would be the business tier and /or user interface tier.
			
Technical Services	• Technical services either do not exist or are not reusable to other parts of the system.	• Technical services available but not easily re-useable to other applications or modules in the system and requires mid to high level of effort	• Reusable technology services
			

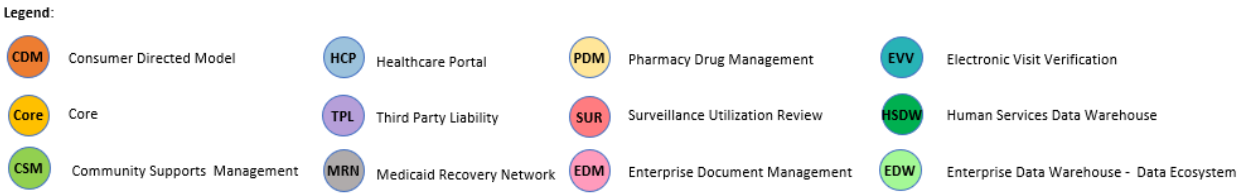


Exhibit 118: Technical Architecture Gap Matrix

3.2 Gap Summary by System

Exhibit 119: Technical Architecture Gap Summary by System describes the gaps between the as-is and to-be Information Architecture by system.

Information Architecture	Rating	Gap Summary
CDM		
Service-Oriented Architecture / Integration Platform	Better	The CDM programming language is based on a modern .Net framework (VB.Net 4.6.2) which has strong native support for SOA architectures.
Maintainability	Best	The programming language is still widely supported. The skilled resource pool in the marketplace is in line with the rest of the market. The Database (Microsoft SQL Server 2016) is current and is currently scheduled to be supported through July 14, 2026. The system has approximately 35,000 lines of code all of which are of a low level of complexity. The CDM can be maintained with a low to medium level of effort.
Business Services	Better	The programming language and framework (.Net) can natively support the common designs and implementations (SOA, RESTful, Messaging) used for Business Services.
Data Services	Better	The programming language natively supports Data Services.
Technical Services	Better	The programming language natively supports Technical Services.
Portal Integrations	Better	This is an ASP.Net application and could be updated to current State approved standards.
Single Sign-On	Better	The system framework can support SSO with low to medium level of effort.
Cloud Connectivity	Better	The .Net framework is available on the Azure and the Amazon (AWS) Cloud. There is strong potential to utilize an Infrastructure as a Service (IaaS) and possibly Platform as a Service (PaaS) cloud deployments.
Core		
Service-Oriented Architecture / Integration Platform	Antiquated	The Core's monolithic architecture and programming languages, COBOL, C, and PowerBuilder do not lend it to being adaptable to a SOA.
Maintainability	Antiquated	The system is primary written in languages for which there is a diminishing talent pool of programming expertise. There are over 2.8 million lines of code of which approximately 20% of the executable code that is of a high complexity rating. These factors make the system challenging and costly to maintain.
Business Services	Antiquated	The design of the system has tightly coupled code which access the user interface and database directly. Business Rules are embedded within the code. Due to these limitations the system is not adaptable to the use of business services.

Information Architecture	Rating	Gap Summary
Data Services	Antiquated	The Monolithic architecture of the current Core of the MMIS provides a significantly high barrier to expose the system data through Data Services.
Technical Services	Antiquated	The Monolithic architecture creates a significantly high barrier to provide for re-useable technical services.
Portal Integrations	Antiquated	The technology used, (Cobol, PowerBuilder) does not easily convert to a web-based application based on the State defined standards.
Single Sign-On	Antiquated	Based on the diverse technology landscape, the application(s) do not easily lend themselves to SSO.
Cloud Connectivity	Antiquated	The technology (Cobol, PowerBuilder, C, etc.), Architecture (Monolithic), and complexity makes a cloud migration not practical for the Core.
CSM		
Service-Oriented Architecture / Integration Platform	Better	The CSM system is built on the Java programming language with an Oracle Database. Java applications, if not already using a SOA architecture, can be converted into a SOA architecture.
Maintainability	Better	The Java programming language is still widely supported. The skilled resource pool in the marketplace is in line with the rest of the market. The Database (Oracle 11g) is either at or near the end of life which is why the maintainability is not Best. This system could be maintained with medium level of effort. The system contains approximately 60,000 lined of executable code of which 5% is of a high level of complexity
Business Services	Better	The Java programming language supports the common approaches (SOA, RESTful, Messaging) used for Business Services.
Data Services	Better	Java supports Data Services through SOA and RESTful architectures.
Technical Services	Better	Java supports Technical Services through SOA, RESTful, Messaging, and integration with many libraries and components.
Portal Integrations	Better	The Web application is built on Java and could be updated to the State approved standards.
Single Sign-On	Better	The system framework can support SSO.
Cloud Connectivity	Better	Java is currently capable of running on many Clouds including Azure, AWS Amazon (AWS), Oracle and other Cloud providers. There is strong potential to utilize an Infrastructure as a Service (IaaS) and possibly Platform as a Service (PaaS) cloud deployment.
HCP		
Service-Oriented Architecture / Integration Platform	Better	The HCP programming language is based on a modern .Net framework (VB.Net 4.6.2) which has strong native support for SOA architectures.
Maintainability	Best	The programming language is still widely supported. The skilled resource pool in the marketplace is in line with the rest of the market. The Database (Microsoft SQL Server 2016) is current and, as of this writing, scheduled to be supported through July 14, 2026. This system could be maintained with a low to medium level of effort. The system has approximately a million lines of code of which only 5% are of a high level of complexity.
Business Services	Better	The programming language and framework (.Net) natively supports the common designs and implementations (SOA, RESTful, Messaging) used for Business Services.
Data Services	Better	The programming framework (.Net) natively supports Data Services through SOA and RESTful architectures

Information Architecture	Rating	Gap Summary
Technical Services	Better	The programming framework (.Net) natively supports Technical Services and also integrates with many other technical service libraries and components.
Portal Integrations	Better	The Web application is built on ASP.Net and could be updated to the State approved standards.
Single Sign-On	Better	The system framework can support SSO.
Cloud Connectivity	Better	The .Net framework is available on the Azure and the Amazon (AWS) Cloud. There is strong potential to utilize an Infrastructure as a Service (IaaS) and possibly Platform as a Service (PaaS) cloud deployment.
TPL		
Service-Oriented Architecture / Integration Platform	Antiquated	TPL is functionality with the Core system and has the same constraints as found in the Core section above. The programming languages and systems architecture do not lend it to being adaptable to a SOA.
Maintainability	Antiquated	This system is part of core so there is no individual complexity rating provided.
Business Services	Antiquated	The design of the system has tightly coupled code which access the user interface and database directly. Business Rules are embedded within the code. Due to these limitations the system is not adaptable to the use of business services.
Data Services	Antiquated	The Monolithic architecture of the current Core of the MMIS would make accessing system data through Data Services a very costly change with a high degree of complexity.
Technical Services	Antiquated	The Monolithic architecture creates a significantly high barrier to provide for re-useable technical services.
Portal Integrations	Antiquated	The technology used, (Cobol, PowerBuilder) does not easily convert to a web-based application based on the State defined standards.
Single Sign-On	Antiquated	Based on the diverse technology landscape, the application(s) do not easily lend themselves to SSO.
Cloud Connectivity	Antiquated	The technology (Cobol, PowerBuilder, C, etc.), Architecture (Monolithic), and complexity makes a cloud migration not practical for the Core.
PDM		
Service-Oriented Architecture / Integration Platform	Antiquated	The PDM applications and processes are written in a spread out and archaic solution utilizing multiple tools (Access DB, Excel) that are not conducive to SOA.
Maintainability	Antiquated	The combination of utilizing some features of MMIS Core, Excel, Access Databases and much manual manipulation and movement of data makes the solution very difficult to maintain.
Business Services	Antiquated	The PDM is highly disjointed and not running on technology that would easily or properly convert into Business Services without significant re-write of the applications involved in the PDM processes.
Data Services	Antiquated	For the same reason that Business Services are considered antiquated, the Data services fall in the same antiquated category.
Technical Services	Antiquated	For the same reason that Business Services are considered antiquated, the Technical Services fall in the same antiquated category.
Portal Integrations	Antiquated	Much of the manual work and processes are spread across disjointed systems that do not work with typical UI implementations nor the State approved standards.

Information Architecture	Rating	Gap Summary
Single Sign-On	Antiquated	Based on the diverse technology landscape, the application(s) do not easily lend themselves to SSO.
Cloud Connectivity	Antiquated	There are no viable options to port this to an IaaS or PaaS cloud without rewriting the system.
SUR		
Service-Oriented Architecture / Integration Platform	Antiquated	SUR is functionality within the Core system and has the same constraints as found in the Core section above. The programming languages and systems architecture do not lend it to being adaptable to a SOA.
Maintainability	Antiquated	SUR is tightly coupled with the Core systems and primarily written in languages for which there is a diminishing talent pool of programming expertise. The system has approximately 33,000 lines of code of which 7% have a high level of complexity.
Business Services	Antiquated	The design of the system has tightly coupled code which access the user interface and database directly. Business Rules are embedded withing the code. Due to these limitations the system is not adaptable to the use of business services.
Data Services	Antiquated	The Monolithic architecture of the Core/SUR of the MMIS provides a significantly high barrier to expose the system data through Data Services.
Technical Services	Antiquated	The Monolithic architecture creates a significantly high barrier to provide for re-useable technical services.
Portal Integrations	Antiquated	The technology used, (Cobol, PowerBuilder) does not convert to a web-based application based on the State defined standards.
Single Sign-On	Antiquated	Based on the diverse technology landscape, the application(s) do not easily lend themselves to SSO.
Cloud Connectivity	Antiquated	The technology (Cobol, PowerBuilder, C, etc.), Architecture (Monolithic), and complexity makes a cloud migration not practical for the Core/SUR.
EDM		
Service-Oriented Architecture / Integration Platform	Best	The EDM systems is the IBM OnDemand solution. This solution is a modern system that offers multiple API's and could support a SOA architecture.
Maintainability	Best	This is a COTS product, so the maintainability is in the best category as there is no code to maintain from an EOHHS perspective.
Business Services	NA	The EDM is a standalone external system which does to not access nor update any operational data, so it is not applicable to this category.
Data Services	NA	The EDM is a standalone external system which does to not access nor update any operational data, so it is not applicable to this category.
Technical Services	NA	The EDM is a standalone external system which does to not access nor update any operational data, so it is not applicable to this category.
Portal Integrations	NA	IBM OnDemand is a COTS product and has its own user interface.
Single Sign-On	Better-Best	This product supports a SSO integration and can integrate with a future SSO with a low to medium-low level of complexity.
Cloud Connectivity	Best	IBM OnDemand currently offers a cloud-based solution.
EVV		
Service-Oriented Architecture / Integration Platform	Best	The EVV is an outsourced solution that has API interfaces available for SOA integration.
Maintainability	Best	This is a completely outsourced solution. EOHHS maintenance is not required.

Information Architecture	Rating	Gap Summary
Business Services	Best	The exposed APIs of the EVV solution enable integration at a business services level.
Data Services	NA	Data Services via EVV are not applicable in the current and future architecture.
Technical Services	NA	Technical Services via EVV are not applicable in the current and future architectures.
Portal Integrations	NA	EVV provides is own portal and therefore is not applicable.
Single Sign-On	Best	EVV already can integrate with SSO solutions and will be able to integrate with future solutions.
Cloud Connectivity	Best	EVV is outsourced and available in cloud-based models.
HSDW		
Service-Oriented Architecture / Integration Platform	NA	SOA is not applicable for the HSDW as the data warehouse is not part of transactional processing.
Maintainability	Better	The Oracle platform is still widely supported. The skilled resource pool in the marketplace is in line with the rest of the market. The HSDW could be maintained with a low to medium level of effort.
Business Services	NA	The HSDW is not transactional and therefore Business Services are not applicable.
Data Services	NA	Date services are not applicable to the HSDW. Data access is provided through BI tools such as Business Objects.
Technical Services	NA	Technical services are not applicable in the HSDW.
Portal Integrations	Better	Portal integration, and all user interfaces, are provide by BI tools such as Business Objects.
Single Sign-On	Better	HSDW and the associated BI tools provide for SSO integration.
Cloud Connectivity	Better	HSDW runs on the Oracle database which is possible to migrate to a Cloud solution with a medium level of effort.
EDW - Data Ecosystem		
Service-Oriented Architecture / Integration Platform	NA	SOA is not applicable for the Data Ecosystem as the data warehouse is not part of transactional processing.
Maintainability	Best	The Data Ecosystem runs on modern day cloud-based technologies. There are skilled resources in the marketplace.
Business Services	NA	The Data Ecosystem is not transactional and therefore Business Services are not applicable.
Data Services	NA	Date services are not applicable to the Data Ecosystem. Data access is provided through BI tools such as PowerBI and others.
Technical Services	NA	Technical services are not applicable in the Data Ecosystem.
Portal Integrations	Best	Given the current day technologies used in the Data Ecosystem, Portal integration consistent with the State standards would be a low barrier placing this in the best category.
Single Sign-On	Best	The Data Ecosystem is running on the AWS cloud which allows for multiple options for a SSO integration.
Cloud Connectivity	Best	The Data Ecosystem is currently running in the cloud on AWS.

Exhibit 119: Technical Architecture Gap Summary by System

4 Information Architecture Gap Analysis

The Information Architecture Gap Analysis evaluates existing systems relative to the future state information architecture. Existing systems supporting Rhode Island's Medicaid Program were analyzed against the following areas of the future state Information Architecture:

- Operational Data Store
- Legacy Replication
- Reverse Legacy Replication
- Data Modeling

A gap matrix and a narrative are provided for each system gap identified.

Exhibit 120: Systems Evaluated lists the systems included in the Information Architecture gap analysis.

System Name	Description
Consumer Directed Module	CDM is a system utilized for self-directed / personal choice of Medicaid benefits and service management.
Core	The Rhode Island MMIS is an integrated group of procedures and subsystems/modules operated by the Fiscal Agent to help manage the state's Medicaid program.
Community Supports Management	CSM is a tool for level of care data and forms that centers around Admission, Discharge, and Change in Acuity for long-term plans. CSM is supported and maintained by Gainwell.
Healthcare Portal	The Healthcare Portal is a secure, internet portal used by healthcare providers to inquire on the status of claims, verify eligibility, upload electronic claim files, etc.
Medicaid Recovery Network	MRN is a tool which assist with the process of imposing liens and receiving payments from liable third parties.
Third Party Liability	TPL refers to the legal obligation of third parties, including individuals, entities, health plans or programs, to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. EOHHS primarily works with the Fiscal Agent and Epiq, a legal and business services provider to conduct TPL activities to ensure Medicaid is the payer of last resort.
Pharmacy Drug Management	The Pharmacy Drug Management function is performed by the Fiscal Agent and its subcontractors to manage prescription drug benefits, on behalf of EOHHS, for Rhode Island's Medicaid Members. The Fiscal Agent is responsible for maintaining drug formularies, updating, and maintaining the Medicaid FFS preferred drug list, monitoring, tracking, and reporting on rebate payments, and conducting drug utilization review to reduce clinical abuse and misuse of prescription drugs covered under the Rhode Island Medicaid Program.
Surveillance Utilization Review	SUR Profiler is a query, reporting, and analysis tool employed by the SUR Team that uses information from the MMIS as its primary data source. The tool's primary function is to run comparisons of similar providers and members to identify outliers / significant differences across peer groups. Case Tracker is a case management tool that is used to assist with identifying and tracking fraud, waste, and abuse within the Medicaid Program.
Enterprise Document Management	Enterprise Document Management utilizes IBM Content Manager OnDemand as document repository and document retrieval. Document capture is completed through iScan/iCapture which is a scan, index, and OCR tool.
Electronic Visit Verification	The EOHHS EVV system is an in-home visit scheduling, tracking and billing system that employs controls within the delivery of home-based services to ensure client's quality of

System Name	Description
	care. The EOHHS EVV system is administered by Sandata Technologies, LLC. Provider Agencies have three options for using the EOHHS EVV system: a mobile app, telephony, or the FVV device.
Enterprise Data Warehouse (HSDW)	Human Services Data Warehouse is the Enterprise Data Warehouse for the EOHHS MESs used to support decision support and analytic activities
Enterprise Data Warehouse – Data Ecosystem	EDW-Data Ecosystem combines data from the HSDW, All Payer Claims Database and several external programs to support Agency analytics and reporting.

Exhibit 120: Systems Evaluated

Based on the evaluation, the systems were rated using the following criteria:

- Antiquated – A system that would require significant effort, or a complete rewrite, to be considered for the future state architecture.
- Better – A system that would require a medium to high level of effort to be considered for the future state architecture.
- Best – A system that is either already compliant with the future state architecture, or one that would require a low to moderate level of effort to be considered for the future state architecture

4.1 Gap Analysis Matrix By System

Exhibit 121: Information Architecture Gap Matrix summarizes the results of the analysis for each system by the component of the to-be information architecture it was evaluated against.

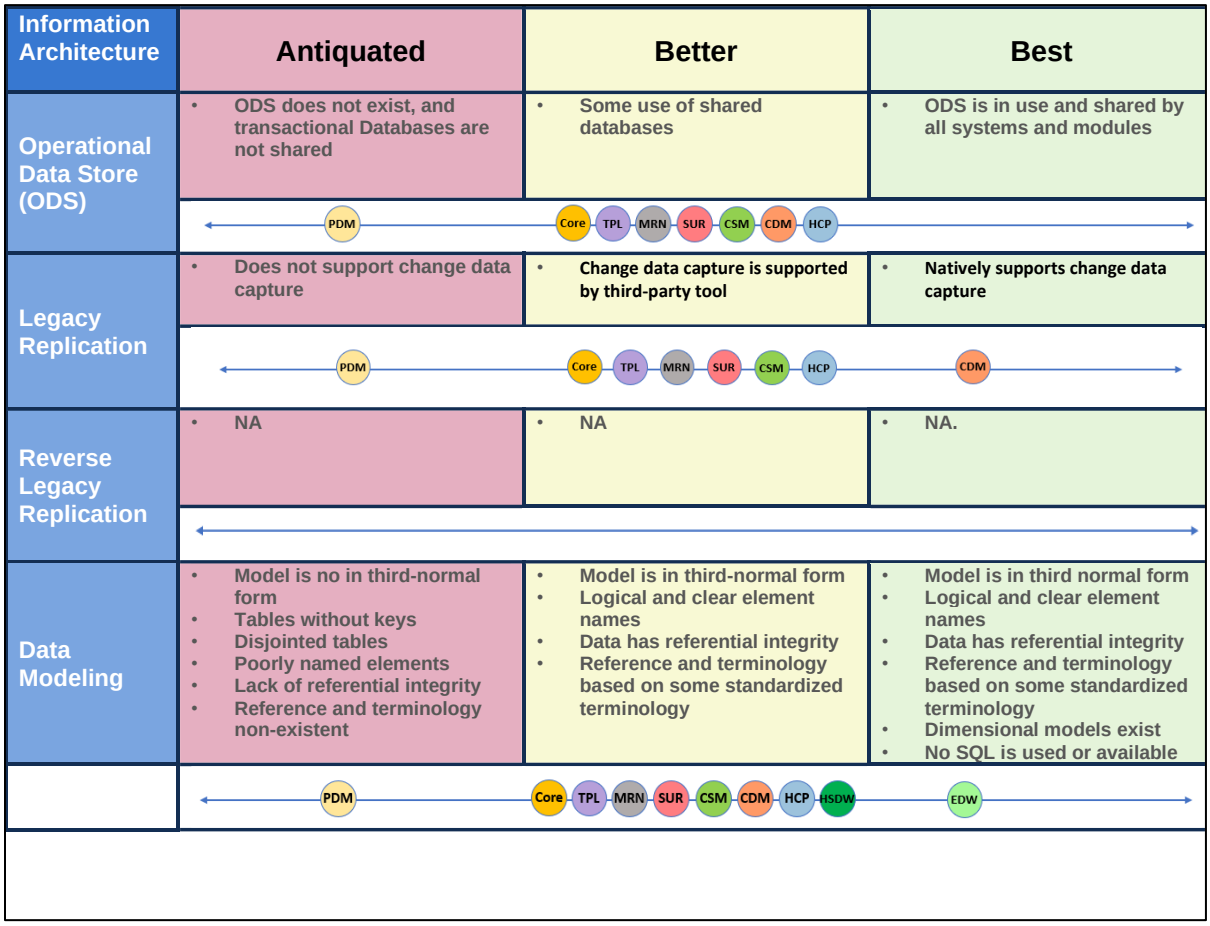


Exhibit 121: Information Architecture Gap Matrix

4.2 Gap Summary by System

Exhibit 122: Information Architecture Gap Summary by System describes the gaps between the as-is and to-be Information Architecture by system.

Information Architecture	Rating	Gap Summary
CDM		
Operational Data Store	Better	The system utilizes a SQL Server database which can have its schema easily migrated to an ODS.

Information Architecture	Rating	Gap Summary
Legacy Replication	Best	The system utilizes a SQL Server database which natively supports Change Data Capture. This will enable legacy replication with minimal effort.
Reverse Legacy Replication	NA	Reverse legacy replication cannot be evaluated until the end-state solution is determined.
Data Modeling	Better	The data model is acceptable for use in the new architecture. It will be evaluated for any potential improvements and enhancements.
Core		
Operational Data Store	Better	The system utilizes an Oracle database which can have its schema easily migrated to an ODS.
Legacy Replication	Better	The system utilizes an Oracle database which natively supports Change Data Capture. This will enable legacy replication with minimal effort.
Reverse Legacy Replication	NA	Reverse legacy replication cannot be evaluated until the end-state solution is determined.
Data Modeling	Better	The data model is acceptable for use in the new architecture. It will be evaluated for any potential improvements and enhancements.
CSM		
Operational Data Store	Better	The system utilizes an Oracle database which can have its schema easily migrated to an ODS.
Legacy Replication	Better	The system utilizes an Oracle database which natively supports Change Data Capture. This will enable legacy replication with minimal effort.
Reverse Legacy Replication	NA	Reverse legacy replication cannot be evaluated until the end-state solution is determined.
Data Modeling	Better	The data model is acceptable for use in the new architecture. It will be evaluated for any potential improvements and enhancements.
HCP		
Operational Data Store	Better	The system utilizes a SQL Server database which can have its schema easily migrated to an ODS.
Legacy Replication	Better	The system utilizes a SQL Server database which natively supports Change Data Capture. This will enable legacy replication with minimal effort.
Reverse Legacy Replication	NA	Reverse legacy replication cannot be evaluated until the end-state solution is determined.
Data Modeling	Better	The data model is acceptable for use in the new architecture. It will be evaluated for any potential improvements and enhancements.
TPL		
Operational Data Store	Better	The system utilizes an Oracle database which can have its schema easily migrated to an ODS.
Legacy Replication	Better	The system utilizes an Oracle database which natively supports Change Data Capture. This will enable legacy replication with minimal effort.
Reverse Legacy Replication	NA	Reverse legacy replication cannot be evaluated until the end-state solution is determined.
Data Modeling	Better	The data model is acceptable for use in the new architecture. It will be evaluated for any potential improvements and enhancements.
PDM		
Operational Data Store	Antiquated	The system utilizes an Access database which cannot have its schema easily migrated to an ODS.
Legacy Replication	Antiquated	The system utilizes an Access database which does not support Change Data Capture. This will prevent legacy replication without significant effort.

Information Architecture	Rating	Gap Summary
Reverse Legacy Replication	NA	Reverse legacy replication cannot be evaluated until the end-state solution is determined.
Data Modeling	Antiquated	The data model is not acceptable for use in the new architecture.
SUR		
Operational Data Store	Better	The system utilizes an Oracle database which can have its schema easily migrated to an ODS.
Legacy Replication	Better	The system utilizes an Oracle database which natively supports Change Data Capture. This will enable legacy replication with minimal effort.
Reverse Legacy Replication	NA	Reverse legacy replication cannot be evaluated until the end-state solution is determined.
Data Modeling	Better	The data model is acceptable for use in the new architecture. It will be evaluated for any potential improvements and enhancements.
EDM		
Operational Data Store	NA	The EDM system does not access or maintain any operational data, so it is not applicable to this category.
Legacy Replication	NA	The EDM system does not access or maintain any operational data, so it is not applicable to this category.
Reverse Legacy Replication	NA	The EDM system does not access or maintain any operational data, so it is not applicable to this category.
Data Modeling	NA	The EDM system does not access or maintain any operational data, so it is not applicable to this category.
EVV		
Operational Data Store	NA	The EVV is a standalone external system which does to not access nor update any operation data, so it is not applicable to this category.
Legacy Replication	NA	The EVV is a standalone external system which does to not access nor update any operation data, so it is not applicable to this category.
Reverse Legacy Replication	NA	The EVV is a standalone external system which does to not access nor update any operation data, so it is not applicable to this category.
Data Modeling	NA	The EVV is a standalone external system which does to not access nor update any operation data, so it is not applicable to this category.
HSDW		
Operational Data Store	NA	The system utilizes its own unique schema is based on the operational data base scheme and is therefore not applicable to this category.
Legacy Replication	NA	The system is populated through the operational data store and will not require legacy replication.
Reverse Legacy Replication	NA	The system is populated through the operational data store and will not require legacy replication.
Data Modeling	Better	The data model is acceptable for use in the new architecture. It will be evaluated for any potential improvements and enhancements.
EDW - Data Ecosystem		
Operational Data Store	NA	The system utilizes its own unique schema and is therefore not applicable to this category.
Legacy Replication	NA	The system is populated through the operational data store and other sources and will not require legacy replication.
Reverse Legacy Replication	NA	The system is populated through the operational data store and other sources and will not require legacy replication.
Data Modeling	Best	The data model is acceptable for use in the new architecture. It will be evaluated for any potential improvements and enhancements.

Exhibit 122: Information Architecture Gap Summary by System

5 Appendices

Appendix A – Glossary

Exhibit 123: Glossary provides a definition for the acronyms used throughout the Gap Analysis Report.

Acronym	Definition
ACT	Assertive Community Treatment
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
AKA	Also Known As
APCD	All-Payer Claims Database
APIs	Application Programming Interfaces
ASP	Application Service Provider
AWS	Amazon Web Services
BHDDH	Behavioral Healthcare, Developmental Disabilities & Hospitals
BPMN	Business Process Modeling Notation
CDM	Consumer Directed Module
CEP	Claim and Encounter Processing
CHIP	Children's Health Insurance Programs
CMS	Centers for Medicare & Medicaid Services
COBOL	Common Business-Oriented Language
COTS	Commercial-off-the-Shelf
CRT	Customer Resolution Team
CSM	Community Supports Management
DB	Database
DCYF	Department of Children, Youth, and Families
DHS	Department of Human Services
DME	Durable Medical Equipment
DOC	Department of Corrections
DOH	Department of Health
D-SNPs	Dual Eligible Special Needs Plans
DUA	Data Use Agreement
DUR	Drug Utilization Review
EDI	Electronic Data Interchange

Acronym	Definition
EDM	Enterprise Document Management
EDW	Enterprise Data Warehouse
EFT	Electronic Funds Transfer
EIN	Employer Identification Number
EMR	Electronic Medical Record
EOB	Explanation of Benefits
EOHHS	Executive Office of Health and Human Services
EOMB	Explanation of Medicaid Benefits
ESI	Employer Sponsored Insurance
EVV	Electronic Visit Verification
FACN	Fiscal Agent Control Number
FDA	Food and Drug Administration
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FRV	Fair Rental Value
FVV	Fixed Visit Verification
GCN	Generic Code Number
HCP	Healthcare Portal
HCPCS	Healthcare Common Procedure Coding System
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HSDW	Human Services Data Warehouse
IA	Information Architectures
IaaS	Infrastructure as a Service
ICF / IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IHH	Integrated Health Home
KPI	Key Performance Indicator
LMS	Learning Management System
MCO	Managed Care Organizations
MES	Medicaid Enterprise System
MFCU	Medicaid Fraud Control and Patient Abuse Unit
MMA	Medicare Modernization Act

Acronym	Definition
MMIS	Medicaid Management Information System
MPP	Medicaid Premium Payment
MRN	Medicaid Recovery Network
MVP	Minimum Viable Product
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NDRA	National Drug Rebate Agreement
NPI	National Provider Identifier
OCR	Optical Character Recognition
ODS	Operational Data Store
OHA	Office of Healthy Aging
OIG	Office of Inspector General
OLAs	Operating Level Agreements
OPI	Office of Program Integrity
OPR	Ordering, Prescribing, and Referring
P&T	Pharmacy and Therapeutics
PA	Prior Authorizations
PaaS	Platform as a Service
PACE	Program of All-Inclusive Care for the Elderly
PDL	Preferred Drug List
PDM	Pharmacy Drug Management
PDV	Pharmacy Data Vendor
PERM	Payment Error Rate Measurement
PHI	Protected Health Information
POS	Point-of-Sale
RIPAE	Rhode Island Pharmaceutical Assistance to Elders
SFTP	Secure File Transfer Protocol
SIU	Special Investigations Unit
SLA	Service Level Agreement
SMA	State Medicaid Agency
SNIP	Strategic National Implementation Process
SOA	Service-Oriented Architecture
SQL	Structured Query Language

Acronym	Definition
SSN	Social Security Number
SSO	Single Sign-On
SUR	Surveillance and Utilization Review
TA	Technical Architecture
T-MSIS	Transformed Medicaid Statistical Information System
TPL	Third Party Liability
TPOI	Third Party Other Insurance
UHIP	Unified Health Infrastructure Project
UI	User Interface
USPS	United States Postal Service

Exhibit 123: Glossary

Appendix B – List of Requirements

Exhibit 124: Functional Requirements provides a consolidated list of high-level requirements by functional area and business process / subprocess.

High-Level Requirements by Process / Subprocess
Member Management
Enroll and Assign Member
The MES will automatically receive program information, including enrollments and authorizations, for the HCBS program from the LTSS care management system.
The LTSS care management system will send program information, including enrollments and authorizations, for the HCBS program to the MES.
The MES will streamline timelines for Medicaid FFS enrollment and transactions to simplify the MCO enrollment process.
RIBridges will mail new Medicaid member welcome packets.
The MES will automatically receive near-real time Member eligibility information via 1a and 1b transactions.
RIBridges will send near-real time Member eligibility information to MES via 1a and 1b transactions.
The MES will determine the appropriate line of business, pay level, and start date for the Member, with the MCO, on a daily basis.
If the Member selected a plan during the eligibility process, MES will send the selected MCO an 834 file with Member's information via EDI on a daily basis for the MCO to complete enrollment.
MCOs will receive and process member information via 834 files on a daily basis.
RIBridges will send the “pause letter” to Members who did not select a plan during the eligibility process.
The MES file with the Member’s plan choice will contain the start date and the line of business.
MES will receive an EDI 834 file from MCOs to capture information on individuals enrolled in D-SNPs.

MCO will send EDI 834 file to MES to transfer information on individuals enrolled in D-SNPs.
The Fiscal Agent will validate the information received from the 834 file to ensure Member eligibility.
Assign to Program via Screens
MES will use automated workflows to support updates program information based on various agencies' requests.
MES will complete program updates via automated feeds from other agencies.
MES will use role-based configuration to update Member's program information.
Perform Member Merge
The master data management system will include a master person index in order to reduce duplicate Member records.
Manage Changes
Providers and Health Plans will no longer submit Medicaid Health Plan Change Request Forms.
RIBridges will offer Members the option to receive communications, including denials, via text, email, and mail.
RIBridges will automate Member communications based on Member preferences.
Manage Prior Authorizations: Request Pharmacy PA
The Claims Portal will be able to receive electronic PA requests from Prescribers with fax as a backup method.
The Claims Portal will be able to notify the Prescriber of PA request approval.
The Claims Portal will use automated workflows to share documents, including PA data, between appropriate entities including EOHHS and solution vendor staff.
The Claims Portal will use automated workflows to support capturing and sending feedback on PA approval or denial from EOHHS to Prescribers.
The Claims Portal will be able to use automated workflows to notify the Prescriber of the denial.
MES will send the denial letter to the Member via the Member's preferred method of communication based on preferences captured in RIBridges, which may include email, text or via the RIBridges customer portal.
The Claims Portal will be able to communicate PA denial reason to the Prescriber via automated systems.
Manage Prior Authorizations: Request Dental PA
Claims Portal will be able to support PA submission from Providers.
The MES will use automated workflows to support sending PA requests from Fiscal Agent to EOHHS.
The MES will use automated workflows to support sending PA determination from EOHHS to Fiscal Agent.
The MES will support automatically sending PA determination to requesting Provider.
The Claims Portal will be able to notify the Prescriber of the denial to enhance communication.
MES will send the denial letter to the Member via the Member's preferred method of communication based on preferences captured in RIBridges, which may include email, text or via the RIBridges customer portal.
Manage Prior Authorizations: Request DME, Nutrition, Hearing Aids, Oxygen, Vision, and Out-of-State Inpatient Services PA
The Claims Portal will be able to support PA submission via Provider's preferred means of communication, which may include fax, mail, or email.

The Claims Portal will be able to notify Providers of PA denials via the Provider's preferred means of communication, which may include fax, mail, or email.
MES will notify Members of PA denials via the Member's preferred means of communication, including mail, email, text, or the RI Bridges Customer Portal.
The Claims Portal will be able to send PA requests and supporting documents from Fiscal Agent to EOHHS.
The Claims Portal will be able to support sending PA updates or correction requests to Providers via Provider's preferred means of communication, which may include fax, mail, or email.
Manage Prior Authorizations: Request Homecare, Daycare, and Mental Health Services PA
OHA will send an automated feed of authorization requests to the MES depending on OHA capabilities.
OHA will send an automated feed of authorization requests to the MES.
The MES will be able to receive an automated feed of authorization requests from OHA depending on OHA capabilities.
Manage Prior Authorizations: Request High-Tech Radiology and Inpatient Services PA
The PA Vendor(s) will automatically notify the Provider of updates via Provider's preferred means of communication, which may include fax, mail, email, or the Claims Portal.
Disenroll Member / Update Plan Choice
MES will support daily EDI 834 notification of enrollment changes to impacted health plans.
MES uses role-based configuration to update end date to disenroll Members and enroll Members in new plan.
Terminate Member
MES will allow EOHHS CRT to resolve errors in the daily error report.
MES will allow EOHHS CRT to terminate Members.
Provider Management
Determine Provider Eligibility Fee Requirement
Provider Portal will support Provider application entry and submission.
Provider Portal will automatically send correspondence, including the application fee amount, fee waiver criteria, and any related proof of payment requirements, to the Provider via the Provider's preferred communication means.
Provider Portal will capture the Provider's preferred communication means.
Provider Portal will accept electronic payments for fees.
Provider Portal will capture and route fee exemption attestation from Provider to EOHHS.
Determine Provider Eligibility and Enrollment: Provider Enrollment – Provider Portal Application
Provider Portal will automatically review Provider application for completeness and accuracy.
Provider Portal will perform automatic quality reviews on all MES Provider application screens.
Provider Vendor(s) will request missing application information from Provider based on Provider's preferred communication method.
Provider Portal will use Workflow Management System to enter application denial and reason into MES.
Determine Provider Eligibility and Enrollment: Provider Re-validation – Provider Portal
Provider Portal will automatically review Provider application for completeness and accuracy.

Provider Portal will perform automatic quality reviews on all MES Provider application screens.
Provider Vendor(s) will request missing application information from Provider based on Provider's preferred communication method.
Provider Portal will capture Provider response to information request.
Provider Portal will use the Workflow Management System to record and route termination decision.
Manage Provider Information Inquiry
Provider Portal will automatically assign case number and assesses, classifies, and routes inquiry to a specialist.
Provider Vendor(s) will automatically respond to Provider inquiry using the same communication method as the inquiry.
Manage Provider Information
Provider Portal will capture Provider information update requests.
MES will automatically review information update request and verify the Provider information.
MES will use NPI and other information to verify Provider status before accepting change request.
MES will automatically validate requested information changes with external sources.
MES will automatically update Provider profile after validating change request.
Provider Vendor(s) will automatically notify Provider if request cannot be completed.
Provider Vendor(s) will automatically notify the Provider via their preferred communication method regarding any missing or incorrect information in the change request and will request the new information or additional documentation to update their profile accordingly.
Manage Provider Communication
Provider Vendor(s) will automatically email global or ad hoc communication package draft to EOHHS for review.
MES will use workflows to route correspondence between Provider Vendor(s) and EOHHS.
After reviewing and editing, EOHHS will automatically send revised communications to Provider Vendor(s) for distribution.
MES will use Workflow Management System to route correspondence between Provider Vendor(s) and EOHHS.
Disenroll Provider
Provider Portal will capture Provider disenrollment request.
Provider Vendor(s) will automatically verify requestor's credentials in the MES in order to validate authority to submit disenrollment request.
MES will automatically capture effective end date for Provider's Medicaid services.
MES will automatically review disenrollment request for accuracy.
Provider Vendor(s) will request additional information from Provider via Provider's preferred communication method.
Provider Portal will capture updated/missing information provided by Provider in response to information requests.
Manage Provider Enrollment and Revalidation Grievance/Appeal
Provider Portal will capture grievance/appeal requests.
MES will automatically log and review grievance/appeal request.

MES will use Workflow Management System to automatically route grievance/appeal request to EOHHS for review.
MES will use the Workflow Management System to automatically route grievance/appeal request from EOHHS for distribution.
Provider Vendor(s) will use Workflow Management System to automatically route denial to Provider.
Claim and Encounter Processing
Receive Claim / Encounter: Receive Claim / Encounter (EDI)
The CEP System will run SNIP level and other edits prior to claim submission.
The CEP System will provide electronic claim error feedback messages in plain English.
The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error.
The CEP System will generate and distribute a claims cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.
The Provider, MCO, Clearinghouse, or Other State Agency will correct errors identified in the claim file during the preliminary editing process before resubmitting the claim.
Receive Claim / Encounter: Receive Claim (Paper)
CEP System will support electronic claims submission.
CEP System will direct providers to submit claims electronically.
CEP System will support paper claims processing as a secondary process for claims submission.
The CEP System will provide electronic claim error feedback messages in plain English.
The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error.
The CEP System will generate and distribute a claims cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.
Receive Claim / Encounter: Receive Claim (Claims Portal)
The CEP System will run SNIP level and other edits prior to claim submission.
The CEP System will provide electronic claim error feedback messages in plain English.
The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error.
The CEP System will generate and distribute a claims cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.
The Provider, MCO, Clearinghouse, or Other State Agency will correct errors identified in the claim file during the preliminary editing process before resubmitting the claim.
Receive Claim / Encounter: Receive Claim and Encounter (NCPDP)
The CEP System will provide electronic error feedback electronically to Providers, Clearinghouses, and Other State Agencies on SNIP level and other edits prior to claim submission.
The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error.
The CEP System will provide electronic claim error feedback messages in plain English.

The CEP system will generate and distribute a claims cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.
Process Claim
The CEP System will provide electronic error feedback electronically to Providers, Clearinghouses, and Other State Agencies on edits prior to claim submission.
The CEP System will provide electronic claim error feedback messages in plain English.
The CEP System will provide electronic claim error feedback messages that are descriptive and tailored to the specific claim and error.
The CEP System will generate and distribute a claims cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.
Process Encounter
The CEP System will provide error feedback electronically to MCOs on edits prior to encounter submission.
The CEP System will provide encounter error feedback messages in plain English.
The CEP System will provide encounter error feedback messages that are descriptive and tailored to the specific encounter and error.
The CEP System will generate and distribute a cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.
Perform Adjustment: Receive Electronic Adjustment
The CEP System will run SNIP level and other edits prior to claim or encounter submission.
The CEP System will provide electronic claim or encounter error feedback messages in plain English.
The CEP System will provide electronic claim or encounter error feedback messages that are descriptive and tailored to the specific claim and error.
The CEP System will generate and distribute a claim or encounter cumulative error report and/or populate a cumulative error dashboard to support the claim correction process and to identify opportunities for education and process improvement.
The Provider, MCO, Clearinghouse, or Other State Agency will correct errors identified in the claim or encounter file during the preliminary editing process before resubmitting the claim.
The CEP Vendor(s) will process paper claim adjustments that meet EOHHS criteria for paper claim adjustments. .
The CEP Vendor(s) will reject any claim adjustments submitted by paper that do not meet EOHHS criteria for paper claim adjustments.
The CEP System will provide claim error feedback messages in plain English.
The CEP System will provide claim error feedback messages that are descriptive and tailored to the specific claim and error.
The CEP System will generate and distribute a cumulative error report.
The CEP System will populate a cumulative error report dashboard.
Third Party Liability
Identify TPL Information
MES will retrieve TPL data updates on a monthly or semi-monthly basis.
MES will interface with TPL Clearinghouse bidirectionally to exchange lists of enrolled Members.

MES will use Workflow Management System to automatically trigger interface updates on a regular basis.
MES will automatically contact Providers via Provider's preferred means of communication (phone, email, or Provider Portal) to obtain additional TPL information, when needed.
TPL information from Health Plans will automatically be uploaded to the MES.
Conduct Cost Avoidance
MES will retrieve TPL data updates on a monthly or semi-monthly basis.
The MES will automatically review claims to ensure TPOI was billed correctly, and the EOB is accurate.
Manage Recoupment
MES and/or TPL System will automatically retrieve and review the claim, payment, and TPOI information.
MES and/or TPL System will automatically identify claims marked with both "Paid" and TPL.
MES and/or TPL System will add reason code for overpayment write-off after 60-day timeframe to support root cause analysis.
Identify Trauma Cases
The Provider questionnaire regarding trauma incidents report will be sent to Providers via the Provider Portal.
MES and/or TPL System will securely email medical records to EOHHS for determination of trauma case.
Recover Trauma / Casualty
MRN will allow payment data updates from EOHHS.
Recover Mass Tort Case
Legal Solution System will interface with MES to transmit a list of tort claimants.
Legal Solution System will interface with MES to update tort claimants list with Medicaid eligibility status.
MES will automatically compile claims information for Medicaid Members included on the tort claimants list from the Legal Solutions System.
MES will send an updated list of tort claimants based on Medicaid eligibility status and any associated claims to Legal Services System via interface.
Pharmacy Drug Management
Manage Drug Formulary
PDM System will automatically review PDV file to determine ADAP formulary updates.
PDM System will use in-house pharmacy expertise to verify ADAP formulary updates.
Manage PDL Weekly Process
PDM System will automatically review PDV file to determine PDL updates.
PDM System will use in-house pharmacy expertise to verify PDL updates.
PDM Vendor(s) will prepare PDL updates with the PDM Vendor's systems and tools.
The PDM System will automatically compare the new and old PDV files to reduce version control risks.
The PDM System will automatically review the PDL data against the PDV list to determine updates.

The PDM System will automatically prepare updates to PDL data using PDM and MES tools and systems.
The PDM System will automatically update PDL data in MES.
Manage PDL: Quarterly Process
The PDM System will automatically update the PDL data via PDM systems and tools to reduce the manual process of this activity.
The PDM System automatically verifies the updates by comparing PDL updates in the summary of changes document to the EOHHS website.
If PDL updates are needed, the PDM System will update the PDL summary of changes document.
Manage Drug Rebate: Generate Invoices
The PDM System will automatically compare the drug rebate file to the corresponding claims history extract for the same quarter, including determining if any prior quarter adjustments are needed, using its systems and tools to reduce the manual process of this activity.
The drug claims will match the drug claims with the manufacturer and drug codes based on the CMS drug product data in order to be sorted for invoicing.
The NDCs from claims will correspond to the NDCs in CMS data.
Manage Drug Rebate: Process Payments
The PDM System will generate reports that include FFS, managed care organization, J-codes, invoice numbers, manufacturer name, labeler code, and value of invoices in order to process drug rebate payments.
The PDM System will import the drug rebate report into the PDM Module.
The PDM System will post drug rebate payments in the MES/PDM Module.
Manage Drug Rebate: Supplemental Drug Rebate
The PDM System will generate a list of NDC numbers eligible for drug rebate at the end of each quarter.
The MES will compare the PDM Vendor(s) list of NDC numbers eligible for drug rebate to FFS-only claims that have been gathered for the quarter, removes any claims that were sent, and automatically creates an output file for PDM Vendor(s).
The MES will automatically send the drug rebate output file to the PDM System.
The PDM System will automatically receive the drug rebate output from the MES.
Generate Drug Rebate Reports: Biweekly and Quarterly Reports
PDM System will automatically generate biweekly and quarterly drug rebate ports for EOHHS Financial Staff according to the EOHHS-approved financial calendar.
The PDM System will generate separate drug rebate reports for FFS and MCO populations, including pharmacy and physician administered (J-codes) information.
Conduct DUR: Conduct DUR (Prospective Reporting)
The PDM System will use its own reporting tools to pull relevant cost avoidance information out of the report.
The PDM Vendor(s) will use the relevant cost avoidance information in the annual DUR CMS report.
Conduct DUR: Conduct DUR (Monthly Lock-in Report)
The PDM System will automatically review and correct the accuracy of the monthly lock-in report data using robust reporting tools to reduce the manual process of this activity.
Conduct DUR: Conduct DUR (Annual CMS Report)

The PDM System will automatically compare claims data to the CMS drug source file to determine the total quantities, costs, percent of generic, percent of brands, and percent of multi-source brands.
Program Integrity
Prevent Fraud, Waste and Abuse
Program Integrity System will use automated workflows to place members identified by a pattern of excessive or uncoordinated use of prescriptions in a Pharmacy Lock-In Program.
Program Integrity System will use automated workflows to review Medicaid provider FFS claims prior to payment to ensure claims accuracy.
EOHHS OPI and MCOs will use automated workflows to request and grant approval for conducting a review of Medicaid provider managed care claims prior to payment.
Prevent Fraud, Waste and Abuse: Conduct FFS Pre-Payment Review
Program Integrity System will use automated workflows to initiate a pre-payment review based on various triggers, including, but not limited to, the execution of a routine or follow-up review; receipt of tips, complaints, and referrals from members, MCOs, other providers, EOHHS employees, and Program Integrity Vendor(s) employees; or the results of data analysis and data mining.
The Program Integrity System will use automated workflows to improve the tracking of requests for pre-payment review.
The Program Integrity System will use automated workflows to allow EOHHS OPI to review pre-payment review requests.
The Program Integrity System will support use of APCD for pre-payment reviews.
The Program Integrity System will use automated workflows to allow EOHHS OPI to send pre-payment review request response to the Program Integrity Vendor.
The Program Integrity System will use automated workflows to close requests if EOHHS OPI rejects pre-payment review request.
The Program Integrity System will implement automated workflows to notify the Claim and Encounter Processing Vendor(s) that payment review was approved if EOHHS OPI approves pre-payment review request.
The Program Integrity System will use automated workflows to notify providers regarding pre-payment review and request supporting documentation.
The Program Integrity System will allow Providers to submit supporting documentation for pre-payment review with automated workflow tool.
The Program Integrity System will use automated workflow tools to conduct pre-payment reviews based on claims, supporting documentation, Medicaid policy.
The Program Integrity System will use automated workflows to notify the Claim and Encounter Processing Vendor(s) to release claims for processing after passing pre-payment review.
The Program Integrity System will use automated workflows to send pre-payment review findings to EOHHS OPI.
The Program Integrity System will use automated workflows to allow EOHHS OPI to review the pre-payment review findings and recommendations.
The Program Integrity System will use automated workflows to allow EOHHS OPI to send pre-payment review decision to the Program Integrity Vendor(s).
The Program Integrity System will use automated workflows to send a request to the Claim and Encounter Processing Vendor(s) to deny claims if indicated by EOHHS OPI decision.
Prevent Fraud, Waste and Abuse: Conduct MCO Pre-Payment Review
MCOs will use automated workflows to submit request to initiate pre-payment review.
The Program Integrity System will allow MCOs to submit pre-payment review requests.

The Program Integrity System will use automated workflows to allow EOHHS OPI to send pre-payment review initiation decision to MCO SIU.
The MCO will use all available data sources, including APCD, when conducting the pre-payment review.
The MCO will use automated workflows to send payment denial requests to EOHHS OPI.
Identify and Investigate Fraud, Waste and Abuse
The Program Integrity System will allow MCO's to send payment denial requests to EOHHS OPI.
The Program Integrity System will use automated workflows to allow EOHHS OPI to send the MCO OPI an approval or rejection of the deny payment request.
The MCO will use automated workflows to receive EOHHS OPI's approval / rejection of the deny payment request.
The Program Integrity System will use automated workflows to review responses to EOMB information and send message with provider type identified to the MES Operations Team.
The Program Integrity System will use automated workflows to perform the quarterly analysis of FFS claims and payments.
The Program Integrity System will use automated workflows to support EOHHS OPI receiving provider self-audit results.
The Program Integrity System will use automated workflows to support EOHHS OPI receiving tips, complaints, and referrals from MCOs, Providers, Members, EOHHS, and Program Integrity Vendor(s).
The Program Integrity System will use automated workflows to support EOHHS OPI and the Program Integrity Vendor(s) post-payment review of FFS claims.
The Program Integrity System will support EOHHS oversight of MCOs, including ensuring capitation payments are appropriate, provider networks are adequate, claims are being processed correctly, utilization is managed, and administrative and other contractual requirements are being met.
The Program Integrity System will use automated workflows to support follow-up audit / review of post-payment review issue resolution.
Identify and Investigate Fraud, Waste and Abuse: Conduct Post-Payment Review
The Program Integrity System will use automated workflows to support opening a new post-payment review case.
The Program Integrity Vendor(s) will use automated workflows to add a post-payment review audit trail, ensure requests are reviewed, and responses are provided in a timely manner.
The Program Integrity System will use automated workflows to add a post-payment review audit trail, ensure requests are reviewed, and responses are provided in a timely manner.
The Program Integrity System will use automated workflows to close post-payment review.
The Program Integrity System will use automated workflows to revise post-payment review requests.
The Program Integrity System will use automated workflows to conduct the post-payment review.
The Program Integrity System will use automated workflows to prepare pre-payment review findings and recommendations, including how errors and issues can be addressed / resolved.
The Program Integrity System will use automated workflows to send post-payment review findings and recommendations to EOHHS OPI for review and approval.
The Program Integrity System will use automated workflows to support EOHHS OPI's post-payment review findings and recommendations from Program Integrity Vendor(s).
The Program Integrity System will use automated workflows to support EOHHS OPI approving or rejecting findings and recommendations from Program Integrity Vendor(s).
The Program Integrity System will use automated workflows to support EOHHS OPI sending post-payment review findings and recoupment letter to Providers.

EOHHS OPI / Program Integrity System will use automated workflows to request that Claim and Encounter Processing perform recoupment.
The Program Integrity Vendor(s) uses automated workflows to close post-payment review.
The Program Integrity System will use automated workflows to initiate the Onsite Level III post-payment review.
The Program Integrity System will use automated workflows to notify providers regarding pre-payment review and request supporting documentation.
The Program Integrity System will enable Providers to send supporting documentation for post-payment review via automated workflow.
EOHHS OPI / Program Integrity System will use automated workflows to conduct level III post-payment desk review.
EOHHS OPI / Program Integrity System will use automated workflows to document the review findings and makes recommendations on how the errors / issues can be addressed / resolved.
The Program Integrity System will use automated workflows to support EOHHS OPI approving or rejecting post-payment review findings and recommendations from Program Integrity Vendor(s).
The Program Integrity System will use automated workflows to enable Providers to send supporting documentation for post-payment review.
EOHHS OPI / Program Integrity System will use automated workflows to review supporting documentation for pre-payment review.
The Program Integrity System will enable Providers to request and schedule a formal hearing through automated workflows.
The Program Integrity System uses automated workflows to close post-payment review.
Identify and Investigate Fraud, Waste and Abuse: Conduct Onsite Level III Review
EOHHS OPI / Program Integrity System will use automated workflows to send a notification to the Provider of the onsite level III review.
The Program Integrity System will use automated workflows to conduct the Onsite Level III post-payment review.
Generate Program Integrity Reports
The Program Integrity System will support EOHHS OPI in pulling data automatically to prepare reporting spreadsheets and other templates.
The Program Integrity System will support EOHHS OPI routing decisions around supporting documentation requests with automated workflows.
The Program Integrity System will gather and send requested program integrity information to EOHHS OPI with automated workflows.
The Program Integrity System will support EOHHS OPI to distribute program integrity reports using automated workflows.
Enterprise Data Warehouse and Analytics
Request Data/Report from EOHHS Data and Analytics
Data and analytics requests will be documented, submitted, routed for review and approval via workflow management tool / application.
Data and analytics requests will be documented via workflow management tool / application using a standard request format.
Request Data/Report from EOHHS Data and Analytics
Communications, including questions and answers regarding the request, status of the request, prioritization level, etc. will be documented and routed using a workflow management tool.

Data standards and governance will be implemented to ensure effective and efficient handling of data requests and consistency of reporting, etc.
The workflow management tool will be used to identify high priority / urgent requests.
Once a data query is initiated by the Analyst, an application / tool will cross-reference a centralized report repository to determine if an exact or similar report exists based on the queried data.
SharePoint will be used to support report upload and transmission between EOHHS and Requester, with email being used only as a backup.
Before a data and analytics request is closed, the workflow management tool will collect feedback from the Requester on how data was applied in order to inform future requests.
Data and analytics requests will be documented, submitted, routed for review and approval via workflow management tool / application.
Data and analytics requests will be documented via workflow management tool / application using a standard request format.
Once a data query is initiated by the Analyst, an application / tool will cross-reference a centralized report repository to determine if an exact or similar report exists based on the queried data.
Electronic Visit Verification
Schedule Visit
For services that do not require a PA, the EOHHS EVV System will receive a notification from the Provider that a Member requires Home Health Care Services in order to schedule these services.
The EOHHS EVV System will search the Master Person / Patient Index and automatically end-date Members who are deceased.
Conduct Visit
The EOHHS EVV Vendor will conduct ongoing training for Providers with excessive numbers of manually entered visits to enable Providers to minimize the number of manually entered/modified visits.
The EOHHS EVV System will adhere to and report on OLAs to support SLA goals, reduce multiple ticketing workstreams, and improve tracking of ticket resolution and timeliness.
The EOHHS EVV System will coordinate and collaborate with other vendors to ensure resolution of Provider Agency issues.
Generate and Submit Claim
Claim and Encounter Processing System will conduct automated claims validation for FFS claims to match FFS claims to corresponding visits that are captured in the EVV System.
EVV FFS Claims which are flagged during automatic claims validation for potentially fraudulent activity will be suspended prior to payment.
Administer EVV - Manage CMS KPI Reporting
The CEP System will aggregate monthly data required for federal EVV reporting (claim-EVV record match) and provide to EOHHS on a quarterly basis.
The EOHHS EVV System will allow Provider Agencies to request FVV devices for Members who are active, have service authorization for 2+ weeks, and who (or the request) meet program criteria.
The EOHHS EVV System will automatically generates an FVV usage report identifying devices that have not been used in the past 90 days.
The EOHHS EVV System will send a communication to Provider Agencies notify them of FVV devices inactive 90+ days that requests a response that the FVV is still required or that the FVV needs to be replaced / returned.
The EOHHS EVV System will provide an online form that the Provider Agency can use to notify EOHHS of the need to replace/return an inactive FVV device.

Financial Management
Manage Member Payment Process
The Core Module Vendor will receive a weekly tax intercept file from the Rhode Island Division of Taxation, including information on members whose tax refunds were intercepted.
Core Module Vendor will transmit weekly and monthly payment reports to EOHHS Finance, Budget and Policy.
The Core Module Vendor will integrate with the State Accounting System to automatically update the State Accounting System for member payments.
The Core Module Vendor will send a loopback file to RIBridges containing updates to member account balances.
The Core Module Vendor will allow Department of Human Services to update member file to reflect account balance and create alert for use in subsequent eligibility determinations.
Manage Accounts Receivable
The Core Module Vendor will use automated workflows to allow EOHHS to initiate recoupment requests.
The Core Module Vendor will use automated workflows to route recoupment requests to EOHHS for review and approval.
The Core Module Vendor will enable EOHHS to review recoupment requests.
The Core Module Vendor will enable EOHHS to follow up on any questions on recoupment requests.
The Core Module Vendor will response to EOHHS questions on recoupment requests.
The Core Module Vendor will us automated workflows to respond to EOHHS questions on recoupment requests.
The Core Module Vendor will enable EOHHS to follow up on any questions on recoupment requests.
The Core Module Vendor will use automated workflows to receive notification of EOHHS decisions on recoupment requests and resolve recoupment requests.
Manage Cost Settlement – Tavares
The Core Module Vendor will enable EOHHS to submit rate and claims adjustment requests using automated workflows.
The Core Module Vendor will implement rate adjustments based on EOHHS requests.
The Core Module Vendor will adjust claims automatically based on revised rates after processing rate adjustment requests.
Manage Cost Settlement – Slater
The Core Module Vendor will enable EOHHS to submit rate and claims adjustment requests using automated workflows.
The Core Module Vendor will implement rate adjustments based on EOHHS requests.
The Core Module Vendor will adjust claims automatically based on revised rates after processing rate adjustment requests.
Manage Cost Settlement – FQHC
The Core Module Vendor will enable EOHHS to submit rate and claims adjustment requests using automated workflows.
The Core Module Vendor will implement rate adjustments based on EOHHS requests.
The Core Module Vendor will adjust claims automatically based on revised rates after processing rate adjustment requests.

Process Fair Rental Value (FRV) Adjustment
The Core Module Vendor will enable EOHHS to submit rate and claims adjustment requests using automated workflows.
The Core Module Vendor will implement rate adjustments based on EOHHS requests.
The Core Module Vendor will adjust claims automatically based on revised rates after processing rate adjustment requests.
Prepare Medicare Premium Payment
The Core Module Vendor will use automated workflows to send invoice payment request notifications to Treasury.
The Core Module Vendor will process updates to expenditure data after uploading Medicare premium payment invoices to the State Accounting System.
Review Detailed Medicare Premium Payment
The Core Module Vendor will allow DHS / RIBridges to securely receive and transmit Medicare premium payment files to EOHHS.
The Core Module Vendor will allow EOHHS CRT (MPP/SSI Unit) to review the monthly Medicare premium payment invoices and determine if discrepancies exist.
Prepare RIte Share Premium
The TPL Module Vendor will receive eligibility information from RIBridges for members who are employed more than 30 hours/week, including whether the members would be eligible for ESI, household composition, and the employer's name and employer identification number (EIN).
The TPL Module Vendor will automatically check if ESI information is on file for members who may be eligible for RIte Share.
The TPL Module Vendor will contact the employer / employee for ESI information, if ESI is not on file.
The TPL Module Vendor will enable employers to contact the TPL Module Vendor, using an online portal, to supply ESI information.
The TPL Module Vendor will enable members (employee) to contact the EOHHS RIte Share team or the TPL Module Vendor to provide the ESI information.
The TPL Module Vendor will enable employers to response to information requests within 30 days.
The TPL Module Vendor will use automated workflows to determine and process RIteShare eligibility and payments.
The TPL Module Vendor will use automated workflows to determine and process RIteShare eligibility and payments.
The TPL Module Vendor will generate report of unresponsive Medicaid provider and sends to EOHHS, if the employer does not send requested insurance information within 30 days and is a Medicaid provider.
The TPL Module Vendor will determine whether ESI is cost-effective for the state.
TPL Module vendor will use automated workflows to process determine and process RIteShare eligibility and payments.
The TPL Module allows MCO enrollment to continue, if the employer does not send requested insurance information within 30 days and is not a Medicaid provider.
The Core Module allows MCO enrollment to continue, if the employer does not send requested insurance information within 30 days and is not a Medicaid provider.
The TPL Module Vendor sends notice to member to enroll in ESI, highlighting it is a condition of their Medicaid eligibility.
The TPL Module Vendor sanctions member, if the member does not respond within 30 days from the day the letter is sent, i.e., terminating Medicaid eligible people over 19 who are not pregnant.

The TPL Module Vendor enables members to complete and submit ESI enrollment paperwork to the TPL Module Vendor.
The TPL Module Vendor will receive the ESI enrollment paperwork and enroll the member in RIte Share.
The TPL Module Vendor will send the RIte Share enrollment transaction to the Core module in real-time with appropriate disenrollment dates. Prior to the implementation of the Core module, the TPL Module Vendor will send the transaction to the MMIS (legacy system) via batch files.
The TPL Module Vendor will use automated workflows to process determine and process RIteShare eligibility and payments.
The TPL Module Vendor will calculate the premium deduction, indicating whether payment is the full reimbursement, or a cost share was deducted.
The TPL Module Vendor will calculate the RIteShare premium payment.
The TPL Module Vendor will automatically post payment information to the employer insurance history table.
The TPL Module Vendor will issue the RIteShare premium payment via EFT or check.
The TPL Module Vendor will generate RIteShare payment reports on an aggregate and individual basis and submits to EOHHS. These payment reports inform two reports that are required by legislation.
On a monthly basis, the TPL Module Vendor will mail the RIteShare payment report to the RIte Share member. This payment report will include details on the premium, cost share deduction, if applicable, and the payment.
Manage Rate Change
The Core Module Vendor will enable EOHHS to request rate changes via automated workflows.
The Core Module Vendor will receive the rate change request via automated workflows.
Prepare FFS Provider Payment
The Core Module Vendor will enable EOHHS to request provider payouts via automated workflows.
The Core Module Vendor receives the provider payout request via automated workflows.
The Core Module Vendor will enable EOHHS to review provider payout requests.
The Core Module Vendor will enable EOHHS to follow up on provider payment requests.
The Core Module Vendor will respond to EOHHS questions on provider payments.
The Core Module Vendor will enable EOHHS to request provider payouts via automated workflows.
The Core Module Vendor will cancel provider payout requests, if EOHHS does not approve the payment.
The Core Module will process the provider payout, if EOHHS approves the payment.
The Core Module Vendor will receive notification of the EOHHS provider payment journal entry from the State Accounting System.
The Core Module Vendor will send an automated notification of payment requests to EOHHS on a biweekly basis.
The Core Module Vendor will enable EOHHS to automatically upload financial cycle documents to the State Accounting System.
The Core Module Vendor will automatically notify Treasury to fund the Core Module Vendor's bank account, including relevant payment details, after uploading the financial cycle to the State Accounting System.
Manage Capitation Payment

The Core Module Vendor will provide a query for the difference between actual and expected health plan payments, which will include member-level record of payment.
The Core Module Vendor will enable EOHHS to complete and automatically submit capitation payment requests.
The Core Module Vendor enables EOHHS to submit capitation payment requests.
The Core Module Vendor will receive capitation payment requests.
The Core Module Vendor will send an automated notification to EOHHS Finance, Budget and Policy of the payment request, biweekly.
The Core Module Vendor will enable EOHHS to automatically upload financial cycle documents to the State Accounting System.
The Core Module Vendor will automatically notify Treasury to fund the Core Module Vendor's bank account, including relevant payment details, after uploading the financial cycle to the State Accounting System.
Manage Incentive Payment
The Core Module Vendor will enable EOHHS to submit incentive payment requests.
The Core Module Vendor will enable incentive payment requesters to respond to EOHHS questions via automatic workflows.
The Core Module Vendor will process the inventive payment request, either through the typical financial cycle or separately (preference is for these payments to be managed outside of the typical financial cycle).
The Core Module Vendor sends an automated notification to EOHHS Finance, Budget and Policy of the payment request, biweekly.
The Core Module Vendor will enable EOHHS to automatically upload financial cycle documents to the State Accounting System.
The Core Module Vendor will automatically notify Treasury to fund the Core Module Vendor's bank account, including relevant payment details, after uploading the financial cycle to the State Accounting System.
Prepare 1099
The Core Module Vendor will conduct appropriate checks and balances on the 1099 reporting before sending to EOHHS.
Formulate and Manage Budget
The Core Module Vendor will enable EOHHS to submit a request to upload the enacted budget file.
The Core Module Vendor will upload the enacted budget file to the MES at EOHHS' request.
Manage Fund – Medical Assistance
The Core Module will automatically consolidate the global waiver report and the Discoverer report into a into a cumulative total report for the quarter.
The Core Module will reconcile consolidated (cumulative total) reports to financial cycle reports to ensure all expenditures are accounted for.
Manage FMAP
The Core Module Vendor will enable EOHHS Finance, Budget and Policy to use automated workflow to notify the Core Module Vendor of the new rates.
The Core Module vendor will process rate change requests.
The Core Module Vendor will automatically transmit financial cycle information to the State Accounting System, reflecting the deposit into the General Fund.

Generate Financial Report
The Core Module Vendor will provide automated, customizable, and preformatted reports, according to state standards.
The Core Module Vendor will support budget planning and trend reporting

Exhibit 124: Functional Requirements