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The MITA Touch: State CIOs and Medicaid IT Transformation

Consuming nearly a third of state budgets nationwide, Medicaid serves as the country's largest insurance program. As of FY 2007, over 55 million people were Medicaid beneficiaries and approximately $355 billion dollars per year are spent by federal and state governments to administer Medicaid services.[1] With these numbers burgeoning every year, the nation's top state officials have watched federal action regarding Medicaid with a careful eye. Governors have consistently placed Medicaid issues among their top priorities, along with other areas of healthcare, particularly since its costs began to take a significant toll on state budgets.

Now, state CIOs across the country are recognizing that Medicaid and Medicaid reform initiatives affect their offices and policies as well. Perhaps one of the largest federally-initiated Medicaid reform efforts to affect the state CIO is the creation, development and emerging implementation of the Medicaid IT Architecture (MITA). Since Medicaid is a state-administered program, every state manages Medicaid differently—the passage of the federal Deficit Reduction Act (DRA) in 2006 only widened disparities between the states. The enactment of the DRA brought, among other changes, more flexibility for states to make certain determinations regarding Medicaid eligibility and service, and its passage was pushed in part by the National Governors Association.[2]

However, the inconsistencies among state Medicaid systems goes beyond the effects of the DRA—there is no collective way to process Medicaid claims or exchange data among state agencies and their stakeholders, nor between state and federal agencies. These disparities led the federal Department of Health & Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS) to formulate the MITA vision, which seeks to connect organizational silos

and align Medicaid with IT to focus on healthcare outcomes and data uniformity across the enterprise.[3]

In recent years, state CIOs across the country have begun to take an active role in state health IT efforts as initiatives such as electronic medical records, data exchange and interoperability issues have made collaboration with IT departments critical for success. Similar to the importance of CIO involvement in these initiatives, participation in the MITA process is essential as well. ***Implementation of MITA is certain to affect state CIOs, particularly as agency and department CIOs look to the state CIO to provide an enterprise view on linking disparate agency silos in order to implement the MITA framework.***

The MITA Vision: A View From The Top

MITA is a business-driven enterprise architecture the employs service-oriented architecture (SOA).[4] Traditional Medicaid Management Information Systems (MMIS) are costly, require users to navigate through multiple functional systems to perform a single task, and are historically largely "platform-dependent" and do not communicate easily across functional or technical boundaries—making information difficult to share or reuse functionality.[5] These independent systems, coupled with a lack of data standards, present challenges in garnering a holistic view of the services utilized by Medicaid beneficiaries and in sharing information across system platforms or inter/intra state boundaries.[6]

MITA is a national framework that provides a blueprint consisting of models, guidelines and principles to be used by states as they implement enterprise solutions.[7] ***The MITA initiative envisions moving from traditional MMIS to web-based, patient-centric systems that are interoperable within and across all levels of government.*** The goals of MITA seek to do the following:

- Improve health care outcomes
- Align with Federal Health Architecture
- Ensure patient-centric views not constrained by organizational barriers
- Make use of common IT and data standards
- Foster interoperability between and within state Medicaid organizations
- Provide web-based access and integration while respecting patient privacy and confidentiality concerns
- Support software reusability with commercial off-the-shelf (COTS) software
- Integrate seamlessly clinical and public health data.[8]

MITA is driven by three core Architectures—Business, Technical and Information—coming together to form a system that aligns with unique state or organizational needs, but relies on common industry standards to make it work. Each architecture hosts a Working Group comprised of various stakeholders, from vendors and private organizations to state participants; some Working Groups have hundreds of members, with all contributing and providing input on processes. ***These architectures intertwine with one another and are inter-dependent for success—all are crucial components to the "three-legged" stool that will hold up MITA.***

MITA's Three Architectures

Business Architecture (BA): The BA describes the needs and goals of individual states, provides a collective vision of the future and is a conceptual construct that comprises models, matrices and templates.[9] Considered to be the most mature of the three architectures, the BA includes the following components: Operations Concept, the MITA Maturity Model, the Business Process Model, the Business Capability Matrix, the MITA State Self-Assessment and MITA Business Services. Using the BA, states can assess their current capabilities and formulate a vision for the future.

Technical Architecture (TA): The TA includes the MITA Application Architecture, MITA Data Architecture, Technology Architecture, Technical Capability Matrix, and MITA standards. The TA is meant to provide IT staff (either state or vendor) with guidance and specifics on how to implement MITA and must not only support the MITA vision, but also business strategies and plans, and link technology choices to business needs.[10]

Information Architecture (IA): Driven by the Business Architecture's Business Process Model, the IA is a consolidation of principles, models, and guidelines that form a template for the States to use to develop their own enterprise information architecture.[11] The IA deals with the management, organization and integration of data, and uses the Health Level 7 (HL7) Reference Information Model (RIM) as a basis for identifying the standard data elements that are used by states in the development of MITA business services.[12] The BA and the IA work together to map enterprise data to processes and are meant to be different views of the integrated enterprise architecture.[13] *The methodology employed to define the MITA IA has been tailored from several industry-accepted models including NASCIO's Enterprise Architecture Toolkit.*[14]

MITA in the States: Opportunities and Challenges

- **The Opportunities of MITA in Medicaid Transformation**

A Focus on the Outcomes: Consistent with other health IT-related initiatives, MITA offers states much more than a technical architecture or business process—it also offers the potential to reduce costs and improve the quality of care. With approximately one out of every five health care dollars invested into the Medicaid program[15], states are beginning to take a significant interest in the return on investment of these dollars. Implementing MITA, and thereby moving

toward an eventual goal of an interoperable network that will communicate across organizational boundaries, could help identify where duplicative dollars are being spent and how more targeted care for the individual may be achieved. This horizontal use of data that MITA would enable could potentially lead to significant cost savings across the enterprise, in addition to health benefits to the individual.

A Focus on Health IT Initiatives: A significant driver for states to begin incorporating health IT aspects into Medicaid were the Medicaid Transformation Grants handed down from Congress in 2005. These grants were awarded to 33 states, and totaled $150 million to allow states to work on health IT and HIE initiatives.[16] These programs are beginning to sunset and the grant fund money will soon run dry—currently, CMS is not opposed to administrating another round of grants to sustain these programs, but it will depend on future Congressional action and funding.

Texas Uses Medicaid Transformation Grant Money for Foster Children

In April of 2008, the state of Texas unveiled the **Texas' Health Passport** program for its approximately 27,000 children in foster care. This program keeps track of a child's diagnoses, treatments and prescriptions with data collected mostly from Medicaid.[17] This program allows children in the foster care program to avoid duplicative tests and treatments, and also allows foster parents know of any medical conditions at the outset so that the children may receive the best and most relevant care possible.

The Health Passport program reduces Medicaid costs by eliminating unnecessary care and was funded by a $4 million Medicaid Transformation Grant from CMS. CMS estimates that the average monthly Medicaid cost for a foster child is five times higher than for a non-foster child. For behavioral services, the cost for foster

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children soars to 40 times that of non-foster children.[18] Texas has developed this web-based application, accessible only by doctors and foster parents, and is currently the only program of this nature in the country. ***Texas' enterprise data warehouse was designed to be MITA-consistent using their Medicaid Transformation Grant money to link several organizational silos together.***

In lieu of universal federal standards, the states have played a large role in steering health IT and health information exchange efforts. Many states have well-developed regional health information organizations, and others have statewide health information exchange systems already in place. These existing initiatives largely focus on public-partnerships between state and private hospitals with physician offices and not on public health specifically. However, shrinking state budgets, rising Medicaid costs and the cost-saving nature of these innovative practices have caused a natural turn inward as states begin to think about integrating these revolutionary Health Information Technology and Health Information Exchange (HIT/HIE) initiatives such as e-prescribing and electronic health records into their Medicaid program.

South Carolina Medicaid Records Go Online

South Carolina's 700,000+ Medicaid beneficiaries saw their medical records go online in July of 2008. This program, dubbed the **South Carolina Health Information Exchange**, or SCIEx, was built by the state Budget and Control Board's Office of Research and Statistics. The SCIEx links hospitals, doctors, clinics and other health-care providers with the medical records and the state is hoping for a reduction in paper, printing and storage costs by eliminating paper records.[19]

The South Carolina Department of Health and Human Services administers the Medicaid program and provided the

funding for this program. Additionally, the South Carolina Hospital Association, the South Carolina Primary Care Association, the Office of Rural Health and other health care provider groups have signed onto SCIEx. While it is too early to tell the ROI on this program, this program in South Carolina indicates a fundamental shift toward sweeping Medicaid reform efforts in the states that incorporate health IT initiatives.

For more information on SCIEx, or other South Carolina's Medicaid reform efforts, please visit www.dhhs.state.sc.us/dhhsnew/index.asp.

A Focus on Interoperability: The MITA framework is intended to foster integrated business and IT transformation across the Medicaid enterprise to improve administration.[20] MITA focuses on connecting the silos that exist between state agencies, and between state and federal agencies, in order to create information-sharing on a scale that has never been done before. Medicaid beneficiaries commonly receive public services other than Medicaid. By allowing these agencies that may service the same beneficiaries to communicate with one another could provide a multitude of benefits for both citizen and government.

■ **The Challenges of MITA**

Organizational Resistance When Connecting Silos*:* In any sweeping reform effort that encompasses government agencies at all levels, and particularly those reforms that require agencies to share data and collaborate at an unprecedented magnitude, connecting organizational silos is significantly easier said than done. Cross-boundary collaboration is a popular buzzword in IT and its successes are widely hailed as significant accomplishments because it can be very difficult to achieve.

The amount of collaboration required for MITA to become fully operational is

monumental and may be met with considerable resistance at the outset. Organizations that previously managed these programs in their individual silo may feel territorial toward the development and administration of new initiatives, or may be resistant to change altogether. ***People, not technology, often serve as the biggest hurdle to overcome in MITA implementation.***

Blending Technology and Business Processes: MITA is, at its core, a business process and not a specific technology solution. It is meant to be a framework, a tool-kit and a roadmap for states to follow—each state builds its own IT solution based on standards, models and processes contained within the MITA framework.[21] However, it is obviously a process that will require a significant overhaul of a major IT legacy system. ***Due to the absolute blend between the technical and business aspects, MITA implementation becomes an inherently complicated challenge.*** State CIOs must understand that this can be a daunting task and will require considerable collaboration between state agencies and vendors, and a substantial modernization of current IT systems and also business practices and processes.

Technical challenges arise regarding SOA and the knowledge gaps that may exist within agencies in regards to building or purchasing SOAs. MITA employs SOA, however, neither the technology nor the governance to tie different SOAs together are fully developed yet, making the maturity of SOA a significant challenge. Another technical challenge is that since states are in different stages with their current Medicaid systems, some may be ready to replace with a fully SOA-enabled system while others are not. Therefore, part of the SOA challenge is how to SOA-enable legacy systems until they can be "ripped and replaced" with a fully SOA-enabled system. State CIOs must think about how to engage old mainframe legacy or client-service systems, so that in even if a SOA-enabled system is not implemented immediately, the long-term benefits remain.

Adapting COTS packages to current and evolving business processes entails considerable challenges. One of the challenges with a COTS package is the necessity to adopt the underlying business rules that have been programmed into a purchased package. Unless the application has been built to afford the ability populate the system business rules defined by the enterprise through a table driven approach, the enterprise will have to adapt to the system by adopting the foundational business rules upon which the system was built.

The Long and Winding Road: MITA implementation is not a process that will go rapidly—nor is it intended to do so. CMS has been working on MITA for approximately five years, and estimates that it will take five to ten more years to arrive at a fully implemented and interoperable system. ***This is an initiative that will outlast political administrations and will require dedication and funding for a substantial period of time.*** Incremental progress is the name of the game and acknowledging and anticipating that MITA will require a "slow and steady" approach and planning its progress as such may help decrease "are we there yet?" frustrations that may arise.

Find Me the Money: Funding MITA

States have significant concerns regarding funding MITA—particularly in light of recent state budget worries across the country. With states responsible for the initial outlay of money, in times of fiscal stress, states may grapple with how to provide adequate funding up front in order to receive matching rates. There are several scenarios in which CMS envisions its role in funding MITA implementation—the sums of funding vary between models and depend on the type and the extent of collaboration between Medicaid agencies and non-Medicaid agencies.

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BUSINESS AREA	BUSINESS PROCESS	MATURITY LEVELS				
		1	2	3	4	5
Member Management	Enroll Member	■	■			
Provider Management	Enroll Provider		■	■		
Contractor Management	Manage Contract Information	■	■			
Operations Management	Edit/Claim Encounter		■	■		
Program Management	Maintain Benefit/Reference Info	■		■		
Care Management	Establish Case		■		■	
Program Integrity	Identify Case		■	■		
Relationship Management	Manage Business Relationship	■	■			

State Self-Assessment

The State Self-Assessment: In 2007, CMS introduced its State Self-Assessment (SS-A) to serve as a key component in obtaining Federal Financial Participation (FFP) dollars to update or replace existing MMIS systems—all states are supposed to complete the SS-A in order to establish a baseline on the current state of their MMIS systems. This will serve as the basis on which the match rates will be set. *The SS-A captures a snapshot of the state's current "as is" and future "to be" progress in regards to the MITA maturity levels.*

The maturity models range from Level 1 in which the agency performs the basic functions of enrollment and claims processing to Level 5 which is an interoperable national system of the Medicaid enterprise—Level 5 is several years away from actual attainment. Future enhancements to MMIS systems must be tied to the functionality of the system, relative to the maturity model, in order to achieve enhanced funding—the APD must clearly demonstrate that funds will lead to advancement in the MITA maturity model in order to get approval from CMS. *For more details on the MITA Maturity Model, please see Appendix II.*

The States and the SS-A

Massachusetts: In early 2008, the Commonwealth of Massachusetts' Executive Office of Health and Human Services (EOHHS) began addressing the SS-A in three components, each funded through separate APD's at the 90% FFP level. Component One is the "as-is" status of MassHealth's (the Massachusetts Medicaid program) business; Component Two is the "as-is" and the "to-be" assessment of the Department's of Public Health, Mental Health and Mental Retardation; Component Three is the "to-be" status of MassHealth following implementation of the NewMMIS.

One of the benefits that EOHHS hopes to achieve from Component One is the total inventorying and indexing of the operations documentation that supports MassHealth into the MITA software Toolkit. The Toolkit and eventual document repository will be supplemented from the Component Two MITA Project documents, and will also be updated during Component Three for MassHealth "to-be" future requirements planning [post-NewMMIS], and will be maintained indefinitely by the EOHHS Office of Compliance.

Coming out of the MITA study should be the basic understanding of what is needed for an EOHHS-wide common case record for each member/recipient/client, the need for a common client index, and the plan for information exchange between users. Identifying common business functions, and providing common systems solutions, will assist in implementing the SOA/open solutions/shared resources that constitutes the target IT architectural vision for the Commonwealth. Massachusetts anticipates the SS-A process to be complete by early 2011.

Advanced Planning Document (APD) Process: The SS-A is meant to be submitted with an APD to CMS' regional offices, and is prepared by the agency that houses Medicaid—state CIO offices do not generally have responsibility for its preparation, although this may change as MITA continues to evolve. While state CIOs may not typically have a hand directly in the funding aspect of Medicaid and MITA implementation, they need to ensure that, in the APD process, that the requests made by the Medicaid agency are in line with the state enterprise architecture. Also, state CIOs or their staff may be called upon to help prepare or contribute to components of the SS-A or the APD.

For the most part, states are just beginning to embark on the MITA journey. However, there are numerous ways that the journey will lead to a better destination in Medicaid delivery and beyond. *For state CIOs, the MITA implementation investment will have returns in its reusable components across the enterprise.* MITA as a business function will reach across Medicaid programs nationwide and beyond into multiple program areas, such as behavioral health, and can drive process standardization across the enterprise. For example, provider registration, client indexes and common intake are reusable components that can be leveraged by other programs. While there will always be core features to a Medicaid system, many of the features of those systems can be applied at an enterprise level across various silos.

Call to Action: What State CIOs Can Do Today

While Medicaid reform is far from an emerging trend, state CIO involvement in healthcare at any level is a relatively recent phenomenon. It was not long ago when a state CIO would have never imagined that their position would play a key role in healthcare delivery or reform. *While serving as a chief administrator of MITA is not always feasible for a state CIO, it is imperative that they be involved in these efforts as their state works to develop and implement this business process which will lead to a sweeping technical overhaul.* MITA has been in existence for only five years, and states are, for the most part, just beginning to plan for its implementation. By making a choice to be involved in MITA at the beginning phase, state CIOs will be in a better position to help make decisions and shape policies that will likely affect them eventually.[22]

- **Get Informed**: Become fully informed on the MITA plan in your state and explore its implication on your state—this must be done before anything else. Reach out to your state's Medicaid agency, or the department that is responsible for administering the current MMIS system, and find out where they are in MITA development and implementation. *For a list of MITA State Contacts, please see Appendix I.*

- **Collaborate, Educate, and Facilitate:** Due to their enterprise view, state CIOs can serve as a convener among disparate state agency CIOs, and can work to foster relationships between the agencies that could potentially benefit from an interoperable MITA system. Helping to drive these disparate agencies toward collaboration, and serving as an educator for those agency CIOs or other officials about the MITA initiative, can increase a collaborative spirit once the enterprise-wide benefits are realized. Working to help facilitate this process is something that the state CIO is

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uniquely poised to do. State CIOs can also act as a broker between states and the vendor community.

- **Get Engaged:** The MITA State Self-Assessment is a good starting point from which to assess where your state is currently at in terms of implementing a MITA system and next steps for future transformation to higher level of maturity. While 2/3 of states are in the process of planning for or completing this assessment, this also means that 1/3 of states are not. Find out if your state is moving forward on beginning the self-assessment or how far your state may be down the tracks on this project. Gauging the status of this will help determine the overall status on Medicaid modernization efforts in your state.

- **Align Enterprise Architecture:** It is imperative that state CIOs rationalize the MITA architecture against their state enterprise architecture. Careful consideration must be given to all three architectural layers – business, information and technical architectures. Policies and standards outlined within the state enterprise architecture will contribute toward proper governance for state implementations of MITA within the state enterprise. This governance will include architectural principles for conceptual and logical modeling, information exchange, records management and preservation, security, disaster recovery, and SOA.

Security architecture will demand special emphasis. State CIOs must look at their current security architecture and determine how to ensure implementation of MITA will comply with that architecture. *In this respect, state CIO involvement in the technical and information architecture components of MITA (of the three Architectures outlined above), becomes more significant.* State CIOs, when working to connect agency silos and gauging the status of those systems, can begin to determine if the systems are conducive to eventual collaboration on the large scale that MITA would require.

- **Look Outside At The Customer:** An important component of MITA is the impact on the citizen user, and state officials must ask themselves what MITA adoption will mean to them. *Making sure that the infrastructure is available, scalable and secure is a critical aspect of state CIO involvement in MITA development.* Ultimately, state government implementation of MITA implementation must be centered on benefiting the citizen. The widespread collaboration that is MITA's goal will lead to many of the same goals of other health IT initiatives—performance management and accountability, coordination with public health and health outcomes, providing an environment that is adaptable and responsive to changing business and technology drivers, elimination of medical error, increasing information quality and availability to improve decision making in health care management and program administration, reduction of duplicative care thereby reducing costs, and a more complete medical history in order to help physicians make the most informed decisions possible.

Ultimately, MITA encompasses and emphasizes many of the same goals that state IT works to carry out every day—to collaborate across agencies, connect disparate silos and improve citizen service as a result of these efforts. State CIOs understand these common threads that connect public agencies across the state and their unique enterprise view lends itself to involvement in MITA. As key public officials, state CIOs must be aware of emerging trends that will affect their states, as well as those trends that will affect their offices directly. By recognizing what the goals of the MITA initiative are, and by ensuring that state enterprise architecture systems and standards are in line with these goals, state CIOs can help bridge the gap between agencies and work to make Medicaid reform through MITA implementation a reality in their state.

Appendix I: MITA State & Federal Contacts

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Appendix II: The MITA Maturity Model

MITA MATURITY MODEL DESCRIPTION AND CHARACTERISTICS					
General Description	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Brief description that captures essence of the Maturity Level; description is high level and covers all Business Areas	At Level 1, the agency focuses on meeting compliance thresholds dictated by state and federal regulations. It primarily targets accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.	At Level 2, the agency focuses on cost management and improving quality of and access to care within structures designed to manage costs, e.g., managed care, catastrophic care management, disease management.	At Level 3, the agency focuses on coordination with other agencies and collaboration in adopting national standards and developing shared business services as a means to improving cost effectiveness of health care service delivery. The agency promotes usage of intra-state data exchange.	At Level 4, widespread and secure access to clinical data enables the Medicaid enterprise to improve healthcare outcomes, empower beneficiary and provider stakeholders, measure quantitative objectives, and focus on program improvement.	At Level 5, national (and international) interoperability allows the Medicaid enterprise to focus on fine tuning and optimizing program management, planning, and evaluation.

The MITA State Self-Assessment (SS-A) captures a snapshot of the state's current "as is" and future "to be" progress in regards to the MITA maturity levels…future enhancements to MMIS systems must be tied to the functionality of the system, relative to the maturity model, in order to achieve enhanced funding—the APD must clearly demonstrate that funds will lead to advancement in the MITA maturity model in order to get approval from CMS.

Appendix III: Endnotes

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