

MITA Information Series

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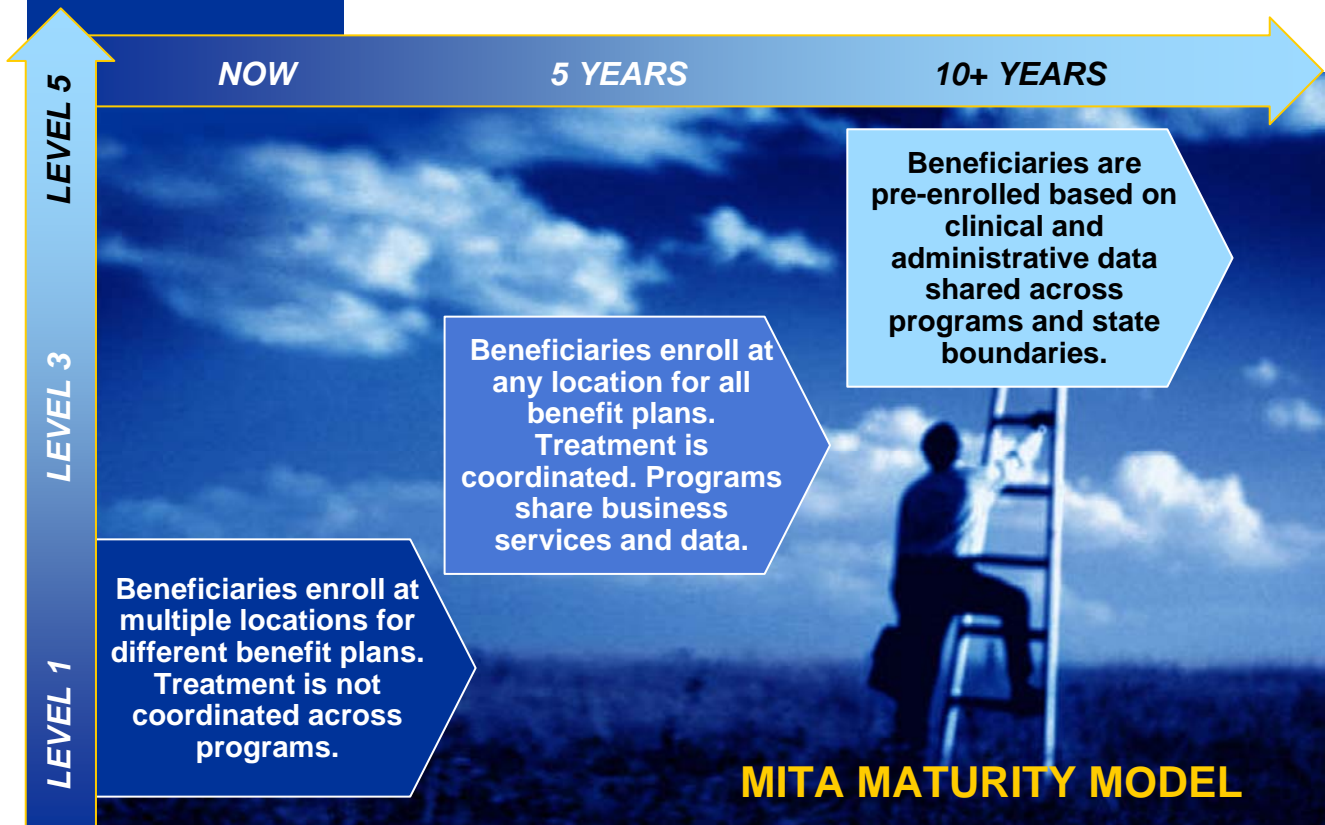
The MITA Maturity Model

This paper presents the Medicaid Information Technology Architecture (MITA) Maturity Model (MMM) and explains its role in the MITA architectural framework and how it is used by the MITA team, the Centers for Medicare and Medicaid Services (CMS), states, and vendors.

What Is a Maturity Model?

Figure 1
A Maturity Model has two dimensions: time and space (levels)

A Maturity Model shows improvement and transformation of a business over time.¹ It is a two-dimensional model showing change related to time and space (Figure 1). The temporal dimension shows a progression from the present time to a realistic future time. The spatial dimension captures how the business looks, what capabilities it exhibits, at each progressively higher level.



¹ In the MMM, time is loosely associated with five milestones ranging from the present to 10+ years from now. Predictions are well grounded at the 5-year marker but are dependent on new enablers in the future. Therefore, the time estimates are less certain beyond the midpoint.

The Maturity Model is used in contemporary methodologies (e.g., CMM¹) to establish goals for achieving and measuring progress. Maturity models typically focus on individual enterprises; e.g., a single state Medicaid program. However, MITA has to accommodate 51 individual Medicaid enterprises. We need a Maturity Model useful to all state Medicaid agencies, adaptable to any state at any level of maturity, and able to show different levels of maturity for different business processes within a single state. Such a model did not exist. The MITA team has adapted industry standards for maturity models to the needs of the multistate Medicaid enterprise.

This white paper describes the MITA Maturity Model and covers the following topics:

- The Model's time and space dimensions and general statements about the levels
- Relationship between the Maturity Model and both business and technical capabilities
- Relationship between the Maturity Model and Medicaid mission and goals
- Relationship between the Maturity Model and MITA goals and objectives
- General description and qualities of each level
- Uses of the Maturity Model
- An example of business capabilities for a business process (Enroll Provider) derived from the general MITA Maturity Model definitions and qualities

Time and Space Dimension

The MITA Maturity Model incorporates five levels of maturity over a 10+ year timeline.

Why five Levels and 10+ years?

- The Medicaid enterprise is complex; there are many moving parts. We need a maturity model that adequately encompasses the breadth and depth of Medicaid business processes
- A 10-year vision is the right target given our current understanding of technology, policy, and stakeholder drivers
- We want to show a reasonable progression; ten steps over 10 years are too many; two steps are too few; five intervals allow for differentiations, targets for progress that we can understand and implement.

¹ The Software Engineering Institute (SEI) developed the Capability Maturity Model (CMM) for IT organizations.

Time Dimension

The MITA Maturity Model projects a 10+ year timeline. The assumptions for the timeline include dependencies on technology advances, state and federal policies, and legislation.

We feel reasonably certain regarding predictions within the next 5 years. The 10-year target is also possible but less predictable due to dependencies on adoption of enablers. Recognizing the many obstacles in the way of achieving goals, we take the conservative position of 10+ years. Figure 2 illustrates the planned progression for state Medicaid agencies over the next 10 years.



Figure 2
Maturity Model
Timeline for MITA

Levels 1 and 2: As-Is

All technology, policy, and statutory enablers exist and are widely used. Agency complies with baseline requirements.
Level 2 shows improved capabilities over Level 1.

Levels 3: 5 Years

Healthcare industry begins to use technology already available in other business sectors. Adopts policy to promote collaboration, data sharing, consolidation of business processes.

**Levels 4 and 5:
To-Be 8–10+ years**

Technology, policy under development. Cannot be certain of timeframe. When available, will cause profound change and improvement in business processes.

**Space Dimension
(Levels of
Maturity)**

Within the 10-year time frame, the Maturity Model predicts a transformation of the Medicaid enterprise from a current level of capability to a future state. This dimension is explained through a narrative description of the business capabilities at a defined point in time. These progressive steps of maturity are referred to as *levels*. Each level has a distinct definition that differentiates it from other levels. The model provides a narrative description of the state of the Medicaid enterprise at each level. For example, take the MITA goal to “promote an environment which supports flexibility and adaptability and rapid response to changes in programs and technologies.” Figure 3 shows how progressive levels of maturity improve the agency’s ability to meet the goal.

**Figure 3
Example of Levels
of Maturity**

Level 1	Level 2	Level 3	Level 4	Level 5
Agencies comply with mandatory changes but lack technical flexibility. Program changes are costly and time consuming to implement.	Agencies introduce elements of flexibility in program design and selection of technology driven by requirements to manage costs and implement new programs.	Agencies improve on flexibility and adaptability through implementation of shared and extensible business services, adoption of national standards, increased collaboration among intra-state agencies, and use of state/regional information exchange.	Agencies benefit from immediate access to clinical data to speed up response time and improve accuracy of results in critical business processes.	Agencies extend the capability of flexibility and adaptability through national interoperability. Agencies collaborate on response to changes and share solutions intra- and inter-state.



The MITA Maturity Model

The MMM is the Keystone of the MITA Business and Technical Capabilities

The MMM shows how the Medicaid program will evolve and be transformed over time. It applies the general definition of a maturity model to the complexities of the Medicaid program as manifested in 51 jurisdictions.

The MMM takes the Medicaid mission and goals and places them in a structure designed to show the future (To-Be) vision and the intermediary steps (levels) that the agency must achieve in order to reach the To-Be objectives. The MMM shows a pathway of continuous business improvement leading to a realistic future state. Each higher level incorporates the best practices of the level below and more importantly introduces higher level capabilities.

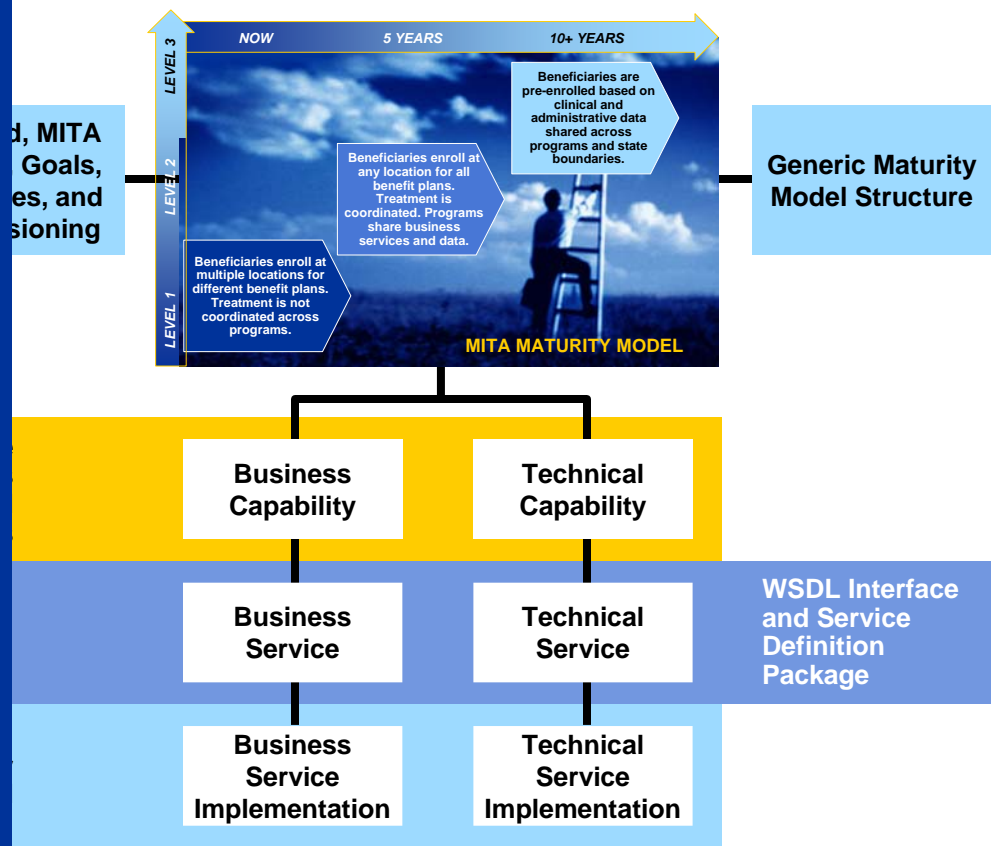


Figure 4
MMM establishes the vision and direction for the MITA Transformation Path

Figure 4 shows the relationship of the Maturity Model to the MITA transformation path. As shown in the figure, there are two separate tracks under the MITA Maturity Model: business and technical. The business track maps directly to processes in the MITA business process model. The technical track is the enabler for the business services and also maps to the MITA goals and objectives. It is critical to understand that MITA only specifies the technology needed for the *interoperability* of the business services, it does not mandate the technology used to *implement* business processes.

For example, the MITA team in collaboration with states can develop a business service for the Authorize Service business process at Level 3. The business service definition package will contain specifications for the inputs and outputs written in Web Service Definition Language (WSDL), which all implementers agree to follow, but will not contain a specific implementation approach. States and vendors are free to choose a J2EE or a dot.net approach, develop software or use a commercial off-the-shelf (COTS) software, and limit or expand functionality as long as the service uses the trigger and result WSDL.

Note: This paper presents the MITA Maturity Model and shows how it is used in building Business Capabilities. There is a separate capability matrix for technology, not included in this paper, that will be seen in the MITA Framework, Release 2.0

This approach ensures interoperability of services while still allowing the maximum flexibility for states and vendors during implementation. An individual state is responsible for selecting the appropriate technology for their specific implementation. This selection is based on the state's goals, objectives, priorities, budgets, and IT environment. As long as the implementation matches the MITA interoperability requirements, the state will be MITA-compliant regardless of the specific implementation methods used. In order to be technology neutral for the implementation, MITA does not map the technology or technical services to the business processes. The technology is mapped by a state at implementation time as part of the solution set for the service.

The MITA team will maintain a repository that will define a service and its interfaces (using WSDL) and will keep track of the solution sets used to implement the services. States will use this repository to determine whether the service has already been implemented and, if so, using what technologies. The repository will also provide recommended technologies and standards to be used during the implementation of the services.

For each Business Process and each Technical Function, we define capabilities that conform to the Maturity Model. For example, a Level 3 Business Capability adheres to the general description of Maturity Level 3 and exhibits the same Level 3 qualities. The following text explains the traceability from Maturity Model to Business Capabilities.



Medicaid Mission and Goals

The MMM begins with the definition of the Medicaid mission and goals. This is a statement in business terms that establishes the long-range vision of the Medicaid program. The Medicaid Mission expresses a vision of the future. The future is achievable as the agency matures aided by technology, policymaking, and legislation.

Medicaid mission and goals are described for each level of maturity (Figure 5). These will illustrate what improvements are expected to be found at each higher level. Medicaid mission and goals have been shaped by “visioning” sessions conducted with several state agencies and by recent national initiatives such as the National Health Information Network.

Note: This paper contains excerpts from the Medicaid and MITA Goals and Objectives, and the MITA Maturity Model and Business Capability Matrix. The full model and the Business Capability Matrix are included in MITA Framework, Release 2.0.

Medicaid Goal	Level 1	Level 2	Level 3	Level 4	Level 5
Improve Healthcare Outcomes for Medicaid Beneficiaries	The agency focuses on payment of provider claims to encourage participation of providers and, thereby, promote access to care.	Improved healthcare outcomes are a byproduct of programs focused on managing costs, e.g., managed care and waiver programs.	The agency adopts national data standards, collaborates with other agencies, and shares business services resulting in a better base for comparing outcomes.	All stakeholders have access to clinical data resulting in a major leap forward in analysis of healthcare outcomes.	The agency has access to data nationally to compare outcomes across a broad spectrum of other agencies and states.

Figure 5
Example of a Medicaid goal realized at different levels of maturity

MITA Mission, Goals, and Objectives

The MITA mission, goals, and objectives support the Medicaid mission and goals. The Medicaid Mission draws upon a variety of sources including policymaking, strategic planning, and legislation. MITA is one of the key supports for achieving the Medicaid mission. MITA has its own mission statement, objectives, and goals that align with the Medicaid mission and with federal standards, e.g., Federal Health Architecture (FHA) and the National Health Information Network (NHIN) initiative. The Medicaid mission and the MITA mission are interwoven in the fabric of the MITA framework. The realization of the Medicaid mission and MITA objectives is described at each level of maturity. This is the capstone of the MITA Maturity Model.

MITA Goal	Level 1	Level 2	Level 3	Level 4	Level 5
Provide data that is timely, accurate, usable, and easily accessible in order to support analysis and decision making for healthcare management and program administration.	The source of data is primarily the claim. Data is accessible via a request/response process. Data is non-standard. Data is primarily used to manage operations. Data timeliness may be subject to delays.	Claim and encounter data are accessible. Decision support tools improve analysis. Data standards are mandated by HIPAA but are not widely used in internal processes. Data timeliness improves.	Data standards are adopted nationally. Shared repositories of data improve efficiency of access and accuracy of data used resulting in better business process results.	Access to standardized clinical data through regional data exchange enhances the decision-making process. With clinical evidence, decisions can be immediate, consistent, and decisive.	Data exchange on a national scale optimizes the decision-making capabilities of the state agency.

Figure 6
Example of a MITA goal represented at different levels of maturity

MITA Maturity Model General Description and Qualities for Each Level

The MMM takes the Maturity Model timeline shown in Figure 6 and the description of levels of achievement of the goals and objectives (in Figures 1 through 3) and distills them into a consolidated, general description of each level of maturity. The general description is accompanied by a set of *qualities* to provide more detail in characterizing the individual level. The general description and the companion qualities are generic and cover all Medicaid business areas. Figure 7 captures the general description of each level of maturity.

Level 1	Level 2	Level 3	Level 4	Level 5
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. The focus on managing costs leads to program innovations.	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 healthcare service delivery. The agency promotes usage of intra-state data exchange.	At Level 4, widespread and secure access to clinical data enables the agency to improve healthcare outcomes, empower beneficiary and provider stakeholders, measure quantitative objectives, and focus on program improvement.	At Level 5, national (and international) interoperability combined with the previous improvements automates routine operations and allows the agency to focus on fine tuning and optimizing program management, planning, and evaluation.

**Figure 7
Definition of
Medicaid levels of
maturity**

Medicaid in any state is a complex program. It is difficult to capture the essence of the Medicaid program at a level of maturity in a few words in the Maturity Model. To help illustrate the goals of each level and to differentiate between levels, we have added a layer of qualities to illustrate in more detail the nature of each level.

Qualities of Each Level of Maturity

- **Timeliness of Process** — Time lapse between initiation of a business process/capability and the desired result; e.g., length of time to enroll a provider, assign a member, pay for a service, respond to an inquiry, make a change, report on outcomes
- **Data Access and Accuracy of Data** — Ease of access to data required by the process/capability, and timeliness and accuracy of the data used by the process
- **Effort to Perform; Efficiency** — Level of effort to perform this business process/capability; resource requirements, burden
- **Cost Effectiveness** — Ratio of effort and cost to outcome
- **Quality of Process Results** — Demonstrable benefits resulting from the business process/capability
- **Utility or Value to Stakeholders** — Impact of the business process/capability on the individual (member, provider, Medicaid staff)

Figure 8
Example of
Timeliness as a
Quality Applied to
the Five Levels to
Maturity

Qualities defined for each level should clearly differentiate between levels and show a progression of improvement. Figure 8 illustrates the quality of Timeliness of Process.

Quality: Timeliness of Process				
Level 1	Level 2	Level 3	Level 4	Level 5
Business processes meet threshold, mandated requirements for timeliness; i.e., the results are achieved within the time specified by law or regulation.	Business process timeliness is enhanced through use of Web portal, EDI. Business processes that result in cost savings are prioritized. Timeliness exceeds legal requirements.	Timeliness improves via collaboration, data-sharing standards, and use of state/regional information exchange.	Clinical data is available in real time. Processes using clinical data result in immediate action, response, and outcomes. State or regional stakeholders are interoperable, optimizing timeliness.	Processes are further enhanced through connectivity with other states and federal agencies. Most business processes are executed at the point of service. Results are as close to immediate as we can envision at this time.

Uses of the MITA Maturity Model

The MMM is a Reference Model that the MITA team can use to define business capabilities associated with business processes. The MMM defines the parameters for each level.

State Self-Assessment and the Assignment of Levels

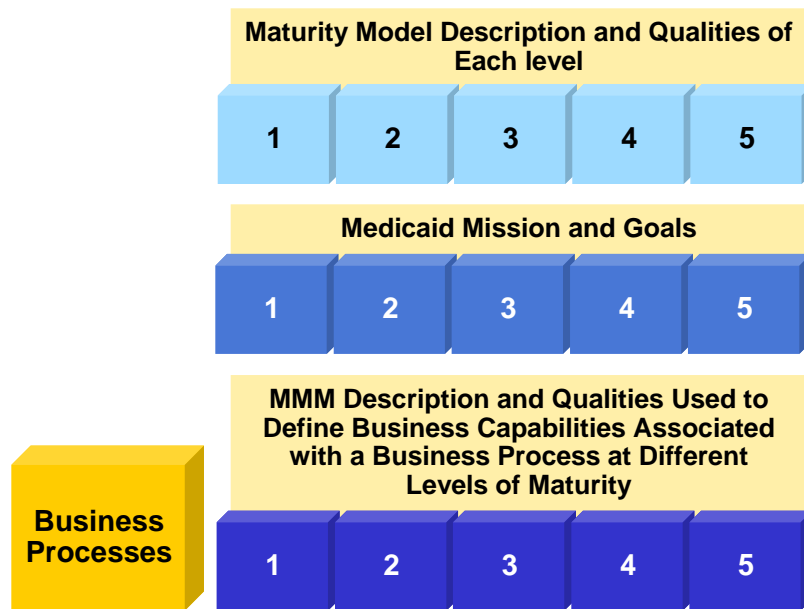
- The MMM serves as a guidebook for the MITA team in the development of the business capabilities. Business capabilities at Level 3 and above are the basis for the development of business services, which is one of the goals of the MITA framework.
- The MMM shows traceability from the mission and goals to the business capabilities. It shows how each lower level is aligned with its higher level.
- MMM provides the framework for a common definition of each level and model qualities for further detail. It provides a baseline and grounding for the levels of maturity.
- It provides consistency; e.g., all Level 3 descriptions have a common base.
- In the future, CMS will use the MMM to adjust the business capabilities and maintain alignment with the mission and goals.
- In the future, CMS could use the business capabilities to measure performance of Medicaid agencies; in this case, the MMM serves as a reference establishing the basis of the measurement.
- States and vendors can refer to the MMM to clarify their understanding of business capabilities. [Note: States will use the business capabilities to do their self-assessment; the MMM is only a reference model.]

Note: This series includes other papers that are associated with the MMM paper; e.g., Business Process Model, Service-Oriented Architecture, and Transition.

In applying the MITA Business Capability Matrix to an individual state, it is expected that any state will find that it has a mix of business capabilities at different levels of maturity, primarily Levels 1 and 2. Even within a single business area, individual business processes may be mapped to different maturity levels. States will make decisions regarding how and when to improve their business outcomes. For example, a state may decide (due to funding, legislation, or resource restrictions) to undertake improvements in the Provider Management business area or only the Enroll Provider business process, and defer changes to other business areas for a later date. Over time, however, CMS hopes that states will come closer together as they bring their capabilities in line with Maturity Levels 3, 4, and 5. At these higher levels, states will agree on common data standards, jointly develop business services, and adopt NHIN standards for interoperability and data.

At Level 3 and above, states will begin to share services and exchange data in increasingly more uniform ways. At the same time, state individuality is preserved and vendor solutions can continue to compete. Enabling technology, legislation, and policy decisions are needed before any state can move to Levels 4 and 5. For Level 3, the technology exists and is used in other industries, e.g., banking, but has not been widely introduced in the U.S. healthcare sector.

Putting It All Together



1. The Maturity Model provides a framework consisting of a timeline (roughly 10+ years) and levels of maturity to be achieved as the business matures.
2. The MMM describes the Medicaid business in general at five levels of maturity. The description includes a list of qualities to clarify the intent of each level.
3. The levels of maturity are applied to the Medicaid and MITA mission statements.
4. The levels of maturity are then applied to the MITA Business Process Model at the individual Business Process level.
5. Using the MMM as a guide, the MITA team will create business capability statements for each Business Process at Levels 1 through 5. Business capabilities at each level can be traced back to the corresponding MMM Maturity Level. Business capability statements mirror the MMM general description and detailed qualities. States will use the Business Capability Matrix (a table of business capabilities for each business process at each level where they apply) to perform a self-assessment.
6. Over time, states will collaborate with the MITA team to refine the business capabilities. At the point where business and technology come together in the definition of a business service, and later in the implementation of a specific service, the resulting solutions will be maintained in a MITA repository for re-use by other states. The level and qualities of the solution will be captured in the Service Definition package.



Figure 9
Shows the
Application of the
Maturity Model to a
specific business
process; i.e., Enroll
Provider (1 of 4)

The Provider Management Business Area services the provider network through outreach, enrollment, information management, communications, and support services. The Business Objectives for this Business Area are **improve quality of provider network, match needs of the population with availability of appropriate services, satisfy providers and consumers, prevent illness, improve outcomes.**

Enroll Provider	Level 1	Level 2	Level 3	Level 4	Level 5
General Statement	Provider enrollment staff meet state and federal requirements for processing applications. They receive and process paper enrollment applications and manually apply the agency's business rules resulting in creating and maintaining a provider network that provides access to benefits for eligible members.	Provider enrollment staff receive and process paper and automated applications and automatically apply some business rules resulting in creating and maintaining a provider network that complies with state and federal law and policy; meets members' clinical, cultural, and linguistic needs faster and more accurately; supports the needs of managed care and waiver programs; and delivers overall improvements in quality of care.	Medicaid agency provider enrollment staff collaborate with other agencies to receive standardized, electronic enrollment applications; apply standardized, automated business rules; access federated registries; and perform all verifications (e.g., credentialing) electronically, resulting in creating and maintaining a robust, coordinated provider network that meets quality and effectiveness objectives, supports integrated monitoring of provider performance, and allows members to have direct interaction with the provider.	Provider enrollment staff augment the capabilities of Level 3 by refining the verification and validation process via automated access to providers' clinical records resulting in creating and maintaining a robust, coordinated, clinically sound provider network that exceeds Level 3 goals of quality, cultural appropriateness, accurate credentialing, and adequacy for the needs of the population.	Provider enrollment staff augment the capabilities of Levels 3 and 4 through full automation of the enrollment process and access to all provider registries nationally via data sharing and interoperability agreements resulting in optimizing the provider network, providing maximum compatibility with members' needs and choices. At Level 5, all enrollment application edits are automated; staff only handle exceptions. This and transforms staff into a professional oversight and consumer satisfaction role.

Figure 9
(2 of 4)

The Provider Management Business Area services the provider network through outreach, enrollment, information management, communications, and support services. The Business Objectives for this Business Area are **improve quality of provider network, match needs of the population with availability of appropriate services, satisfy providers and consumers, prevent illness, improve outcomes.**

Enroll Provider	Level 1	Level 2	Level 3	Level 4	Level 5
Qualities					
1. Timeliness of Process	Decisions on application may take several days.	Process takes less time than Level 1.	Turnaround time on application decision can be immediate.	Turnaround time is immediate.	Turnaround time is immediate on a national scale.
2. Data Access and Accuracy	<p>Application data and format are indeterminate.</p> <p>Some enrollment records are stored electronically, but storage is not centralized. Provider data, including ID and taxonomy, is not comparable across provider types and programs, reducing ability to monitor performance or detect fraud and abuse.</p>	<p>Application data is standardized within the agency.</p> <p>Enrollment records for different programs are stored separately. Providers have different IDs per program and cannot be cross-matched. Although data comparability is improved and supports use of performance measures to evaluate providers, performance data is only periodically measured and requires sampling and statistical calculation.¹</p>	<p>Application data is standardized nationally.</p> <p>Enrollment records are stored in either a single provider registry or federated provider registries that can be accessed by all applications.</p> <p>The NPI is the identifier of record.</p> <p>Providers, members, and state enrollment staff have secure access to appropriate data on demand.</p>	<p>Medicaid provider registries are federated with regional data exchange networks.</p> <p>Authorized, authenticated parties have virtual, instant access to provider data locally.</p> <p>Access to clinical data improves capability to select providers that meet quality standards.</p>	<p>Medicaid provider registries are federated with regional data exchange networks across the country and, if desired, internationally.</p> <p>Authorized, authenticated parties have virtual, instant access to provider data nationally.</p>
3. Effort to Perform; Efficiency	Staff contact external and internal credentialing and verification sources via phone and fax. A large staff is required to meet targets for manual enrollment of providers.	<p>Enrollment processes continue to be handled by siloed programs according to program-specific rules.</p> <p>Providers can submit on paper and electronically via a portal which improves turnaround time.</p> <p>Verifications are a mix of manual and automated steps.</p>	<p>Applications are only submitted electronically. Medicaid centralizes all provider enrollment processes; has a single set of enrollment rules.</p> <p>Manual steps may continue only for exceptions.</p> <p>Services created for the enrollment process can be shared among states.</p>	<p>Any data-exchange partner can send a notification regarding a provider enrolled with the state Medicaid program.</p> <p>External and internal validation sources automatically send notice of change in provider status, eliminating the need to reverify; supports detection of sanctioned providers in real time.</p>	<p>Any data-exchange partner can send a notification regarding a provider enrolled with any program in the U.S.</p> <p>Nationally interoperable validation sources automatically send notice of change in provider status, eliminating the need to reverify; supports detection of sanctioned providers in real time anywhere in the U.S.</p>

¹There is inconsistent reporting to National Provider Data Bank or to the HIPAA Health Integrity Protection Database.

Figure 9
(3 of 4)

The Provider Management Business Area services the provider network through outreach, enrollment, information management, communications, and support services. The Business Objectives for this Business Area are **improve quality of provider network, match needs of the population with availability of appropriate services, satisfy providers and consumers, prevent illness, improve outcomes.**

Enroll Provider	Level 1	Level 2	Level 3	Level 4	Level 5
Qualities					
4. Cost Effectiveness	Requires large numbers of staff.	Process requires fewer staff than Level 1 and produces better results.	Process requires fewer staff than Level 2 and improves on results. Shared services and inter-agency collaboration contribute to streamline the process.	Full automation of the process, plus access to clinical data, reduces staff requirements to a core team of professionals who monitor provider network performance.	Same as Level 4.
5. Accuracy of Process Results	<p>Much of the application information is manually validated.</p> <p>Decisions may be inconsistent.</p> <p>Due to limited monitoring and reverification of enrolled providers' status, sanctioned providers may continue to be enrolled.¹</p>	<p>Automation of business rules improves accuracy of validation and verification.</p> <p>The emphasis on managed care and waiver programs encourages more scrutiny of and reporting to national databases.</p>	<p>All verifications can be automated and conducted via standardized interfaces.</p> <p>Consistent enrollment rules and standardized data available from a single source support continuous performance measures that can be used to adjust rates in real time. The agency sends verification inquiries to any other agency regarding the status of a provider.</p> <p>The quality of the provider network is improved.</p>	<p>Prospective monitoring of program integrity during adjudication improves detection of fraud and abuse, resulting in timelier sanctioning.</p> <p>Clinical data can be accessed and monitored for measuring performance.</p> <p>Performance measures can be shared via federated provider registries.</p>	<p>Same as Level 4, on a national scale.</p> <p>Performance measures can be shared via federated provider registries nationally.</p>

¹There is inconsistent reporting to National Provider Data Bank or to the HIPAA Health Integrity Protection Database.

Figure 9
(4 of 4)

The Provider Management Business Area services the provider network through outreach, enrollment, information management, communications, and support services. The Business Objectives for this Business Area are **improve quality of provider network, match needs of the population with availability of appropriate services, satisfy providers and consumers, prevent illness, improve outcomes.**

Enroll Provider	Level 1	Level 2	Level 3	Level 4	Level 5
Qualities					
6. Utility or Value to Stakeholders	Focus is on building a provider network that meets needs of the members. Staff do not have time to focus on cultural and linguistic compatibility, member satisfaction, or provider performance.	In managed care and waiver settings, guidelines ensure adequacy of network (i.e., ratio of number, type, and location of provider to size and demographics of member population). Cultural and linguistic matches are made. Members are assigned to PCPs to coordinate their care.	Members interact directly with providers and can view provider profiles and locations; make informed choices. Cultural and linguistic indicators improve selection of appropriate providers. Provider and member satisfaction improves because of speed and accuracy of enrollment process.	Providers, members, and care managers access standardized provider registries and view clinical performance indicators to make informed decisions regarding provider selection and provider referrals.	Same as Level 4 on a national scale, where appropriate.

For further information, please contact:

Denise Bazemore, Technical Director
 Division of State Systems, CMSO
 Center for Medicare and Medicaid Services
 U.S. Department of Health and Human Services
 Phone: 410.786.4449
dbazemore@cms.hhs.gov

Thank you for your interest.