

Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A)

MITA: Initiative and Framework

The MITA initiative began with the concept of moving the design and development of Medicaid information systems away from the siloed, sub-system components that comprise a typical MMIS.

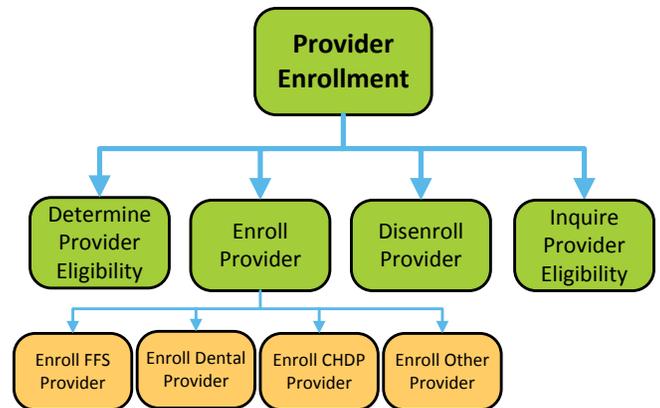
The MITA Framework is a consolidation of principles, models, and guidelines that combine to form a template for the States to use to develop their own enterprise architecture. It describes a structure for the Medicaid Enterprise that includes business operations, information exchange, and technological services. The Framework includes three (3) parts:

1. Business Architecture (BA)
2. Information Architecture (IA)
3. Technical Architecture (TA)



SS-A: What is it?

- The SS-A is a process that a State uses to measure current processes and capabilities against the standard MITA business, information and technical capabilities, and ultimately develop target capabilities for the next 5 years.
- Medi-Cal specific business processes will be mapped to the MITA standard business process templates.
- Each Medi-Cal business process will then be evaluated based upon the current maturity level, according to the MITA business capability matrix, to create the “As-Is” view.
- Information and technical capabilities will be assessed across the business area.
- Strategic planning influences will be incorporated to construct a 5 year “To-Be” view of Medi-Cal business, information and technical capabilities along with a MITA Roadmap to define the implementation plan.
- CMS “requires states to align to and advance increasingly in MITA maturity...” and “to complete and make measurable progress in implementing their MITA roadmaps.” (Seven Standards & Conditions for enhanced federal funding)



MITA Business Capability Matrix				
Level 1	Level 2	Level 3	Level 4	Level 5
The agency focuses on compliance with regulatory requirements for enrollment of providers and members, and payment of claims within a specified timeframe to encourage the participation of providers and thereby promote access to care.	Improved health care outcomes are a by-product of new, creative programs primarily focused on managing costs, e.g., managed care and waiver programs. Increased automation and standardization in business process.	Widespread adoption and use of national standards for administrative data, and sharing of business services that provides a better base for comparing outcomes. Coordination and collaboration across intrastate health care programs contributes to improved outcomes.	All stakeholders have access to clinical data that produces a major leap forward in analysis of health care outcomes , which empowers member and providers to make decisions affecting outcomes.	Integration of state and federal exchanges. Agency coordination is seamless and data exchange is real-time. Focus is on fine-tuning and optimizing program management with national (and international) interoperability for continued improvement.