Part I - BUSINESS ARCHITECTURE
Appendix C – BUSINESS PROCESS MODEL DETAILS

NOTE: **This DRAFT MITA 3.0 Supplement should not be considered final and is subject to change. CMS will finalize the supplement after a 30-day review period for state comment.**

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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MITA
Medicaid Information Technology Architecture

Introduction

Part I, Appendix C contains the MITA Framework artifacts of the Business Process Model (BPM). The MITA team identifies business processes for common State Medicaid Agency (SMA) operations corresponding to the ten (10) MITA Business Areas. Collaboration between the States and Centers for Medicare & Medicaid Services (CMS) is necessary to refine and improve all processes. Ongoing work in the MITA Business Architecture (BA) include mapping business processes to the Conceptual Data Model (CDM), reviewing and refining the details contained in the templates, and adding new processes identified by States.

Business processes are often a consolidation of several similar processes. For example, Determine Provider Eligibility is a single process accommodating any kind of provider. The process steps are similar for all provider types even though the specific information requirements and business rules are different from type to type. This consolidation allows the MITA team to keep the BPM at a manageable size and accommodate commonalties among States.

The BPM does not include the processes that manage **incoming** and outgoing transactions from any media, apply privacy and security rules, log and perform initial edits, and translate or prepare the information for subsequent processing. They belong to a special category of business and technical services defined in Part III, Technical Architecture.

Part I, Appendix D contains the companion Business Capability Matrix. Each business process has a set of corresponding business capabilities. The MITA team uses the business processes in conjunction with the business capabilities to define the boundaries of the activity in the Business Process Template (BPT).

How to Read the Business Process Template

Table C-1 below shows the format of the BPT utilized by the MITA team. The title and tier number of the business process link to the business areas shown in the next section.

In the BPM, the business processes represent the typical operations of a SMA. These processes evolve over time. As the SMA matures, some processes transform and others are replaceable. Stakeholders develop new business processes for effectiveness and efficiency.

Table C-1 illustrates the MITA BPT.

Table C-1. MITA Business Process Template

Tier 1: Business Area Abbreviation - Tier 2: Business Category Title ***Tier 3: Business Process Title***	
Item	**Details**
Description	A brief statement that describes active roles and the activity the role conducts

Tier 1: Business Area Abbreviation - Tier 2: Business Category Title *Tier 3: Business Process Title*	
Item	**Details**
	during the business process.
Trigger Event	• One or more events that directly start a business process (e.g., receive a request, phone call, or a scheduled date). • The Trigger is defined information.
Result	• One or more outcomes from the execution of the Business Rules (results define *data in motion* and are the immediate output from the business process, not the ultimate, downstream result). • The Result is defined information.
Business Process Steps	A sequence of steps that execute the successful completion of the business process (steps start with a verb).
Shared Data	Shared data is *data at rest* (i.e., data stores accessed to complete a step in the business process). Shared data is a defined data store with specific information.
Predecessor	The preceding business process to the activity conducted in this process. The result of the previous business process is a trigger to this business process.
Successor	The succeeding business process to the activity conducted in this process. The result of this business process is a trigger for the next business process.
Constraints	Conditions that CMS expects States to meet for this generalized process to execute (e.g., enrolling institutional providers requires different information from enrolling pharmacies).
Failures	• An identification of the exit points throughout the business process where the Business Rule specifies that the process terminates because of failure of one or more steps.
Performance Measures	A Key Performance Indicator (KPI) may include the following: • **Quantitative indicators** are usually numerical. • **Practical indicators** are those that interface with existing processes. • **Directional indicators** specify whether an agency is getting better or not. • **Actionable indicators** are sufficiently in an agency's control to effect change • **Financial indicators** are those the SMA and CMS use in performance measurement and when looking at an operating index Measures that describe what the SMA can measure, but that are not specific

Tier 1: Business Area Abbreviation - Tier 2: Business Category Title *Tier 3: Business Process Title*	
Item	**Details**
	measures themselves, such as the following examples: • Time to complete process (e.g. real-time response = within ___ seconds; batch response = within ___ days) • Accuracy of decisions = ___% • Consistency of decisions and disposition = ___% • Error rate = ___% or less The MITA business template specifies the type of measure but not the actual benchmark. See Part I, Appendix D, Business Capability Matrix Details for specific benchmarks for business capabilities.

The MITA team uses the following definitions when defining the BPT:

- Trigger designations:
  - **Environment-based** – An interaction caused by a staff interacting with a system or some other environmental occurrence (e.g., staff deciding to query a system; daily notification sent out at 2 A.M.). Environment based trigger events include a textual description of the real world event, as there is no more formal way of defining them.
  - **Interaction-based** – An interaction caused by the receipt of another interaction (e.g., query response). Interaction-based trigger events reference the interaction that triggers them.
  - **State transition-based** – An interaction caused by a change in status (e.g., putting a repeating order on hold to suspend action on that order). State transition-based trigger events reference the association with static model, class, and state transition.
- Transaction designations:
  - **Receive Inbound Transaction** – Receive message, validate, and authenticate inbound Electronic Data Interchange (EDI) transactions from internal or external system. Inbound messages contain encryption methods.
  - **Send Outbound Transaction** – Create message and send outbound EDI transactions to internal or external systems. Outbound messages contain encryption methods.
- Communication designations:
  - **EDI** – The automated exchange of data and documents in a standardized format.
  - **Email** – Electronic mail communicated electronically between systems.
  - **Facsimile** – A fax (short for facsimile) is a document sent over a telephone line.

- **Mail** - Letters and packages conveyed by the postal system.
- **Mobile device** – A portable electronic device used for processing, receiving, and sending data without the need to maintain a wired connection with the internet.
- **Publication** – A copy of a printed work offered for distribution.
- **Telephone** – An electronic device used for two-way talking with other people. This also includes interactive voice response technology.
- **Web** – An Internet site that offer text, graphics, sound, and animation resources through the hypertext transfer protocol.

❖ Message designations:

- **Notification** – A communication (e.g., EDI, email, fax, mobile device, publication, telephone, and web), which gives notice of event to a role (i.e., actor or system).
- **Alert** – A signal created to indicate a condition exists within a system. Can be a variety of solutions such as flag marked, state change, report executed, or message sent.

❖ Business Process Step designations:

- **START** – The triggers for the business process to begin.
- **END** – The results the business process achieves.

The MITA Framework BA includes ten (10) business areas with eighty (80) business processes.

Table C-2 provides the complete MITA Framework BA with business areas, business categories, and business processes. Each process has an assigned sequential identification (e.g., BR01, BR02, BR03, etc.) to catalog each process. As the MITA Framework matures, there is movement of business activity to accommodate a consistently structured and streamlined enterprise framework. The MITA team incorporates additional business activity into the framework to provide full coverage of Medicaid business operations as expected by CMS, while other business activity is no longer necessary or has migrated to existing processes. The MITA team has retired some process identifications (i.e., OM01 through OM05), and added new process identifications (i.e., FM1 through FM19) to the process catalog.

Table C-2. MITA 3.0 Business Architecture

MITA Framework v3.0		
Business Area Title	***Business Category Title***	*AA## Business Process Title*
Business Relationship Management (BR)		
	Standards Management	
		BR01 Establish Business Relationship
		BR02 Manage Business Relationship Communication
		BR03 Manage Business Relationship Information
		BR04 Terminate Business Relationship
Care Management (CM)		
	Case Management	
		CM01 Establish Case
		CM02 Manage Case Information
		CM03 Manage Population Health Outreach
		CM04 Manage Registry
		CM05 Perform Screening and Assessment
		CM06 Manage Treatment Plan and Outcomes
	Authorization Determination	
		CM07 Authorize Referral
		CM08 Authorize Service
		CM09 Authorize Treatment Plan
Contractor Management (CO)		
	Contractor Information Management	
		CO01 Manage Contractor Information
		CO04 Inquire Contractor Information
	Contractor Support	
		CO02 Manage Contractor Communication
		CO03 Perform Contractor Outreach
		CO09 Manage Contractor Grievance and Appeal
	Contract Management	
		CO05 Produce Solicitation
		CO06 Award Contract
		CO07 Manage Contract
		CO08 Close Out Contract
Eligibility and Enrollment Management (EE)		
	Member Enrollment	
		EE01 Determine Member Eligibility
		EE02 Enroll Member
		EE03 Disenroll Member
		EE04 Inquire Member Eligibility

MITA Framework v3.0		
Business Area Title	***Business Category Title***	*AA## Business Process Title*
	Provider Enrollment	
		EE05 Determine Provider Eligibility
		EE06 Enroll Provider
		EE07 Disenroll Provider
		EE08 Inquire Provider Information
Financial Management (FM)		
	Accounts Receivable Management	
		FM01 Manage Provider Recoupment
		FM02 Manage TPL Recovery
		FM03 Manage Estate Recovery
		FM04 Manage Drug Rebate
		FM05 Manage Cost Settlement
		FM06 Manage Accounts Receivable Information
		FM07 Manage Accounts Receivable Funds
		FM08 Prepare Member Premium Invoice
	Accounts Payable Management	
		FM09 Manage Contractor Payment
		FM10 Manage Member Financial Participation
		FM11 Manage Capitation Payment
		FM12 Manage Incentive Payment
		FM13 Manage Accounts Payable Information
		FM14 Manage Accounts Payable Disbursement
		FM15 Manage 1099
	Fiscal Management	
		FM16 Formulate Budget
		FM17 Manage Budget Information
		FM18 Manage Fund
		FM19 Generate Financial Report
Member Management (ME)		
	Member Information Management (Future Release)	
		ME01 Manage Member Information *(Under Development)*
	Member Support (Future Release)	
		ME02 Manage Applicant and Member Communication *(Under Development)*
		ME08 Manage Member Grievance and Appeal *(Under Development)*
		ME03 Perform Population and Member Outreach *(Under Development)*
Operations Management (OM)		
	Payment and Reporting	
		OM14 Generate Remittance Advice
		OM18 Inquire Payment Status

MITA Framework v3.0		
Business Area Title	***Business Category Title***	*AA## Business Process Title*
		OM27 Prepare Provider Payment
		OM28 Manage Data
	Claims Adjudication	
		OM07 Process Claims
		OM29 Process Encounters
		OM20 Calculate Spend-Down Amount
		OM04 Submit Electronic Attachment
		OM05 Apply Mass Adjustment
Performance Management (PE)		
	Compliance Management	
		PE01 Identify Utilization Anomalies
		PE02 Establish Compliance Incident
		PE03 Manage Compliance Incident Information
		PE04 Determine Adverse Action Incident
		PE05 Prepare REOMB
Plan Management (PL)		
	Plan Administration	
		PL01 Develop Agency Goals and Objectives
		PL02 Maintain Program Policy
		PL03 Maintain State Plan
	Health Plan Administration	
		PL04 Manage Health Plan Information
		PL05 Manage Performance Measures
	Health Benefits Administration	
		PL06 Manage Health Benefit Information
		PL07 Manage Reference Information
		PL08 Manage Rate Setting
Provider Management (PM)		
	Provider Information Management	
		PM01 Manage Provider Information
		PM08 Terminate Provider
	Provider Support	
		PM02 Manage Provider Communication
		PM07 Manage Provider Grievance and Appeal
		PM03 Perform Provider Outreach

BUSINESS RELATIONSHIP MANAGEMENT

Establish Business Relationship

BR Standards Management	
Establish Business Relationship	
Item	**Details**
Description	The ***Establish Business Relationship*** business process encompasses activities undertaken by the State Medicaid Agency (SMA) to enter into business partner relationships. Agreements are between state agency and its partners, including collaboration amongst intrastate agencies, the interstate and federal agencies. It contains functionality for interoperability, establishment of inter-agency service agreements, identification of the types of information exchanged, and security and privacy requirements. These include Trading Partner Agreements (TPA), Service Level Agreements (SLA), and Memoranda of Understanding (MOU) with other agencies; Electronic Data Interchange (EDI) agreements with providers, Managed Care Organizations (MCOs), and others; and Centers for Medicare & Medicaid Services (CMS), other federal agencies, and Regional Health Information Organizations (RHIO).
Trigger Event	Environment-based Trigger Events: • Request made for business relationship (e.g., EDI, email, mail, facsimile, telephone). • Identification of the need for a business relationship (e.g., new policy, new program).
Result	• The SMA agrees upon Business Relationship with business partner. • Defined communication protocols for data exchange. • Alert to send notification to business partner of agreement. • Established agreement between business partners (e.g., TPA, SLA, MOU). • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for business relationship from partner. 2. Conduct collection of agreement information with other party. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor completes all required fields. 4. Validate that the provided information is authentic. 5. Decide determination for establishment of relationship. If no agreement, go to step 9. 6. Establish terms of the business relationship (e.g., TPA, SLA, MOU). 7. Establish Key Performance Indicator (KPI). 8. Establish payment agreements. 9. Establish data exchange requirements.

BR Standards Management	
Establish Business Relationship	
Item	**Details**
	10. Establish authentication protocol. 11. Establish security protocol. 12. Establish privacy requirements. 13. Agreement on business relationship. 14. **END:** Send alert to notify business partner of agreement.
Shared Data	Business Partner data store including service agreement information Contractor data store including contract information
Predecessor	**Receive Inbound Transaction** ***Award Contract*** ***Enroll Provider*** ***Maintain Program Policy*** ***Maintain State Plan***
Successor	**Send Outbound Transaction** ***Manage Business Relationship Information*** ***Manage Business Relationship Communication***
Constraints	Federal and state policies and regulations will constrain these agreements.
Failures	• Parties are unable to agree on terms of relationship.
Performance Measures	• Time to complete business process = within __ days • Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Manage Business Relationship Communication

BR Standards Management	
Manage Business Relationship Communication	
Item	**Details**
Description	The ***Manage Business Relationship Communication*** business process receives requests for information, appointments, and assistance from business partners, such as inquiries related to a Service Level Agreement (SLA). This business process includes the log, research, development, approval and delivery of routine or ad hoc messages. Information communicated by a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange

BR Standards Management	
Manage Business Relationship Communication	
Item	**Details**
	(EDI).
Trigger Event	Interaction-based Trigger Events: • Receive requests from other business processes to develop and produce communications for business partners such as alerts from ***Establish Business Relationship*** business process. • Receive inquiries originating from customer help desk through ***Manage Business Relationship Information*** business process. Environment-based Trigger Events: • Receive inquiry from business partner. • Request to send information packages such as a SLA or a Key Performance Indicator (KPI). • Receive request for assistance, such as a request for training or change in business partner information. • Periodic timetable (e.g., monthly) is due for sending information (e.g., within 24 hours of new business partner agreement and periodic communications such as newsletters or other agency communications).
Result	• Business partner receives appropriate assistance, communication, and/or information packages. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for communication. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information is authentic. 4. Agency logs request for communication. 5. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web, or Electronic Data Interchange (EDI)). 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate).
Shared Data	Business Partner data store including service agreements information

BR Standards Management	
Manage Business Relationship Communication	
Item	**Details**
	Contractor data store including contract information
Predecessor	**Receive Inbound Transaction** ***Establish Business Relationship*** ***Manage Business Relationship Information*** ***Terminate Business Relationship*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information***
Successor	**Send Outbound Transaction** ***Manage Performance Measures***
Constraints	The State Medicaid Agency (SMA) and its business partners agree on the content of the communications. Content depends on the business relationship. Content may be standards-based. Communication complies with federal and state regulations that may vary by state. Business partner may have communication barriers such as lack of internet or phone access. Business partner is unable to access needed or requested information.
Failures	• The SMA is unable to provide linguistically, culturally, or competency appropriate information. • Delivery failures due to erroneous contact information or lack of contact information.
Performance Measures	• Time to complete response: By phone __ minutes; by email __hours; by mail __ days • Accuracy of communications = __% • Communications successfully delivered = __%

Manage Business Relationship Information

BR Standards Management	
Manage Business Relationship Information	
Item	**Details**
Description	The ***Manage Business Relationship Information*** business process maintains the agreement between the State Medicaid Agency (SMA) and the other party such as the intrastate, interstate, and federal agencies. This includes routine modifications to required information such as authorized signers, addresses, terms of agreement, Key Performance Indicator (KPI), and data exchange standards.

BR Standards Management	
Manage Business Relationship Information	
Item	**Details**
Trigger Event	Environment-based Trigger Events: • Receive agreement modifications (e.g., create, update, or delete).
Result	• Modified business relationship agreement. • Alert to send notification to business partner of agreement. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive agreement updates. 2. Agency logs request for modification. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields. 4. Validate that the provided information is authentic. 5. Staff records modification to business relationship agreement. 6. **END:** Send alert to notify business partner of modification.
Shared Data	Business Partner data store including service agreement information Contractor data store including contract information
Predecessor	***Establish Business Relationship*** ***Manage Contract***
Successor	**Send Outbound Transaction** ***Manage Business Relationship Communication*** ***Terminate Business Relationship***
Constraints	Modifications include all information in the agreement, and depend on the type of agreement and service level requirements associated with the agreement.
Failures	• Information does not comply with syntax criteria. • Not all required information provided. • Staff is unable to authenticate information provided.
Performance Measures	• Time to complete business process = within __ days • Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Terminate Business Relationship

BR Standards Management	
Terminate Business Relationship	
Item	**Details**
Description	The ***Terminate Business Relationship*** business process cancels the agreement between the State Medicaid Agency (SMA) and the business partner such as the intrastate, interstate and federal agencies.
Trigger Event	Environment-based Trigger Events: • Receive request for termination of agreement from internal or external sources. • Notification that the agreement has expired or a one-time information exchange process is complete. • External sources could be a receipt of a vendor purchased by another.
Result	• Business Relationship terminated. The SMA does not share additional information. • Alert to send notification to business partner of termination. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for business relationship termination. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information authentic. 4. Evaluate impact of termination of business relationship to business operations. 5. Terminate business relationship and related Service Level Agreement (SLA), Memoranda of Understanding (MOU), and such. 6. **END:** Send alert to notify business partner of termination.
Shared Data	Business Partner data store including service agreements information Contractor data store including contract information
Predecessor	**Receive Inbound Transaction** ***Manage Business Relationship Information*** ***Close Out Contract***
Successor	**Send Outbound Transaction** ***Manage Business Relationship Communication***
Constraints	The SMA and its business partners agree on the content of the termination message. Content depends on the business relationship. Content is standards-based.

BR Standards Management	
Terminate Business Relationship	
Item	**Details**
Failures	• Information does not comply with syntax criteria. • Not all required information provided. • Information provided not authenticated.
Performance Measures	• Time to complete business process = within __ days • Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

CARE MANAGEMENT

Establish Case

CM Case Management	
Establish Case	
Item	**Details**

Description	The Care Management, ***Establish Case*** business process uses criteria and rules to:
	• Identify target members for specific programs.
	• Assign a care manager.
	• Assess the member's needs.
	• Select a program.
	• Establish a treatment plan.
	• Identify and confirm provider.
	• Prepare information for communication.
	This business process may establish a case for one individual, a family or a target population such as:
	• Medicaid Waiver program case management
	  o Home and Community-Based Services (HCBS)
	  o Other
	• Disease management
	• Catastrophic cases
	• Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
	• Vaccines for children and adults
	• Population management
	This business process may initiate a case from claim processing indicators such as:
	• Several claims for an individual member over a time interval.
	• New claims close to discharge date.
	• Claims containing one of the with the following:
	  o Place of Service – Certain Places of Service
	  o Discharge Date
	  o Admit Date
	  o PWK - Attachments containing lab results, treatment plans, etc.
	  o NTE - Notes containing discharge plans, goals, treatment plan
	  o EPSDT Referral Claim
	  o Claims containing certain types of the following information:
	  ✓ Principle Diagnosis
	  ✓ Admitting Diagnosis
	  ✓ Patient Reason for Visit
	  ✓ Other Diagnosis Information
	  ✓ Principle Procedure
	  ✓ Other Procedure

CM Case Management	
Establish Case	
Item	**Details**
	✓ Condition Info ✓ Treatment Code o Prescription drug claim o CLIA certification o Home Health claim o Test Result Different criteria and rules, relationships, and information define each type of health care case and require different types of external investigation. The Health Information Exchange (HIE) provides health information and clinical records for member and care coordination with provider and other agencies.
Trigger Event	Environment-based Trigger Events: • Periodic review to scan for new cases is due. • Request to look into a specific case. Interaction-based Trigger Events: • An alert triggered by other events, such as a targeted diagnosis or referral generated from information submitted on a claim. • Receive enrollment of member from ***Enroll Member*** business process. • Receive information to establish a case (e.g., Electronic Data Interchange (EDI)).
Result	• List of members associated with cases and programs. • Assessment of the needs of the member for care management. • Treatment Plan for member. • Associated Providers List. • Case file information. • Communications information for providers and members. • Alert to notify member of care management case. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Identify candidates for new cases with specific criteria (e.g., patient characteristics, medical conditions, location, or age). 2. Identify information requirements and parameters to include such items as periods of time, data elements, and data relationships. 3. Identify new case(s) for care management based on requirements and parameters. 4. Create case record for each new case.

CM Case Management	
Establish Case	
Item	**Details**
	5. Assign care manager. 6. Care manager reviews health and clinical information from Health Information Exchange (HIE). 7. Assess the needs of the member for care management. 8. Based on needs, determine which program(s) is appropriate for the member. 9. Based on needs, establish treatment (care) plan that identifies the services the member needs to receive, the types of providers, the care setting, frequency, and expected results. 10. Based on the treatment plan, select providers to deliver the services, contact and confirm availability, record decisions. 11. Record care management determination and related information. 12. **END:** Send alert to notify member of care management case.
Shared Data	Member data store including demographics Health Information Exchange (HIE) data store including health information, clinical record and clinical information Enterprise Master Patient Index (EMPI) for single and complete view of patient information Provider data store including provider network information Health Benefits data store including programs and services Information
Predecessor	**Receive Inbound Transaction** ***Enroll Member*** ***Manage Applicant and Member Communication*** ***Manage Member Grievance and Appeal*** ***Identify Utilization Anomalies***
Successor	**Send Outbound Transaction** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Authorize Treatment Plan*** ***Manage Treatment Plan and Outcomes***
Constraints	States and programs within States use different criteria to establish cases. Diseases included in Disease Management differ from state to state. States define and treat catastrophic cases differently. States will conform to required Affordable Care Act requirements for EPSDT and immunizations case management.
Failures	• Details of the case are inconsistent with criteria; discontinued case.

CM Case Management	
Establish Case	
Item	**Details**
Performance Measures	• Time required to establish a case. • Effectiveness of selection criteria in determining real cases.

Manage Case Information

CM Case Management	
Manage Case Information	
Item	**Details**
Description	The ***Manage Case Information*** business process uses state-specific criteria and rules to ensure appropriate and cost-effective medical, medically-related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as: • Medicaid Waiver program case management • Home and Community-Based Services (HCBS) • Other agency programs • Disease management • Catastrophic cases • Early Periodic Screening, Diagnosis, and Treatment (EPSDT) • Immunizations for children and adults The ***Establish Case*** business process creates each individual case and treatment plan. The ***Manage Case Information*** business process includes activities to confirm delivery of services and compliance with the plan. It also includes activities such as: • Service planning and coordination. • Facilitation of services (e.g., finding providers, or establishing limits or maximums). • Advocating for the member. • Monitoring and reassessment of services for need and cost effectiveness. o This includes assessing the member's placement and the services received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs. The Health Information Exchange (HIE) provides health information and clinical records for member and care coordination with provider, pharmacist, and other agencies.
Trigger Event	Environment-based Trigger Events:

	• Periodic timetable (e.g. monthly, quarterly) review of a case is due. • Monitor member's case activity. • Receive case modifications (e.g., create, update, or delete). Interaction-based Trigger Events: • Receive information regarding services delivered/not delivered (including claims information). • Receive health plan or health benefit modification that may affect a treatment plan. • Receive information regarding an enrollment modification, including disenrollment. • Receive information regarding modification in member's conditions or situation.

Result	• Updated case history with possible revision to the following:
	  o Case history
	  o Needs assessment
	  o Treatment Plan
	  o Associated Providers List
	  o Case file information (e.g., contact dates and times)
	• Content of communications sent to providers and members.
	• Tracking information as needed for measuring performance and business activity monitoring.

Business Process Steps	1. **START:** Receive request to review case (review of the member's status and needs).
	2. Based on review, take follow-up action, as needed, to:
	  o Identify services delivered, issues impeding delivery of service and/or member's progress.
	  o Establish appointment with member to review case status.
	  o Contact provider(s) to review member's progress.
	  o Review services provided (claims payment information).
	  o Close case for non-chronic conditions or change in member's status.
	3. Revise treatment plan to:
	  o Add or remove services.
	  o Change nature of plan (e.g. shifting drug regimen, shifting from drug to behavioral).
	  o Reassess needs.
	  o Revise expected results.
	4. **END:** Send alert to notify of care management modifications or care coordination updates.

Shared Data	Member data store including demographics Health Information Exchange (HIE) data store including health information, clinical record and clinical data Enterprise Master Patient Index (EMPI) for single and complete view of patient information Provider data store including provider network information Health Benefits data store including programs and services Information Case History data store including action lists, journal notes, reviews and approvals
Predecessor	**Receive Inbound Transaction** ***Perform Screening and Assessment*** ***Establish Case*** ***Authorize Referral*** ***Authorize Service*** ***Authorize Treatment Plan*** ***Manage Treatment Plan and Outcomes***
Successor	**Send Outbound Transaction** ***Authorize Treatment Plan*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Population Health Outreach*** ***Manage Registry*** ***Submit Electronic Attachment*** ***Manage Data***
Constraints	States and programs within States use different criteria to manage cases. Diseases included in Disease Management differ from state to state. States define and treat catastrophic cases differently. States will conform to required Affordable Care Act requirements for EPSDT and immunizations case management.
Failures	• Information required to manage case is not available or is inaccurate.
Performance Measures	• The State Medicaid Agency (SMA) updates cases within the timeframe specified by state policy. • Movements towards desired health care outcomes because of improvements in case management practices.

Manage Population Health Outreach

CM Case Management	
Manage Population Health Outreach	
Item	**Details**
Description	The ***Manage Population Health Outreach*** business process is responsible for the implementation of strategy to improve general population health. The State Medicaid Agency (SMA) identifies target populations or individuals for selection by cultural, diagnostic, or other demographic indicators. The inputs to this business process are census, vital statistics, immigration, and other information sources. This business process outputs materials for: • Campaigns to enroll new members in existing health plan or health benefit. • New health plan or health benefit offering. • Modification to existing health plan or health benefit offering. It includes production of information materials and communications to impacted members, providers, and contractors (e.g., program strategies and materials, etc.). The communication of information includes a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI).
Trigger Event	Environment-based Trigger Events: • Receive information from census, vital statistics, public health departments, immigration, and other information sources. • Periodic timetable (e.g., monthly, quarterly) to distribute information is due. • Receive new population or problem-specific legislated health improvement initiatives. • Receive request for information from other originators (e.g., federal actions or constituency interests). Interaction-based Trigger Events: • Receive alert from Establish Case to place member into care management monitoring.
Result	• The SMA produces outreach communications (e.g., mailing brochures, web pages, email, kiosk, and radio, billboard, and TV advertisements) and distributes to targeted populations or individuals. The SMA may also conduct face-to-face meetings. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for outreach materials or communication. 2. Target population identified and defined by analyzing information, performance measures, feedback from community, and policy directives. 3. Approve, deny, or modify decisions to develop outreach communications. 4. Determine content and method of communication (e.g., email, mail, publication,

CM Case Management	
Manage Population Health Outreach	
Item	**Details**
	mobile device, facsimile, telephone, web or EDI). 5. Determine performance measures. 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message sent to target population. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate).
Shared Data	Member data store including demographic information Provider data store including provider network Information Contractor data store including provider network Information Plan data store including policy information Health Benefit data store including program and service information Data from external agencies including: census, vital statistics, immigration, and various health registries
Predecessor	There are several business processes that can result in the interest or need to reach out to the Medicaid population in an attempt to improve behavior or promote prevention: ***Identify Utilization Anomalies*** ***Manage Performance Measures*** ***Manage Member Grievance and Appeal*** ***Manage Provider Grievance and Appeal*** ***Manage Health Plan Information***
Successor	***Manage Applicant and Member Communication*** ***Perform Population and Member Outreach*** ***Manage Provider Communication*** ***Perform Provider Outreach*** ***Manage Contractor Communication*** ***Manage Performance Measures***
Constraints	Agencies do not coordinate amongst each other in order to share information. Potential political and inter-agency conflicts over appropriate use of health care information.

CM Case Management	
Manage Population Health Outreach	
Item	**Details**
Failures	• Inter-agency agency communication or lack of access to information impairs ability to gather information to support strategies.
Performance Measures	• Time to complete communication: By phone __ minutes; by email __hours; by mail __ days • Accuracy of communications = __% • Communications successfully delivered = __%

Manage Registry

CM Case Management	
Manage Registry	
Item	**Details**
Description	The ***Manage Registry*** business process receives a member's health outcome information, prepares updates for a specific registry (e.g., immunizations, cancer, disease) and responds to inquiries with response information. In the context of MITA, a medical registry consolidates related records from multiple sources (e.g., intrastate, interstate or federal agencies) into one comprehensive data store. This data store may or may not reside within the Medicaid information system.
Trigger Event	Environment-based Trigger Events: • Receive inquiry for health outcome information. Interaction-based Trigger Events: • Receive health outcomes that The State Medicaid Agency (SMA) sends to a registry.
Result	• The SMA prepares and sends response to inquiry for health outcome. • The SMA prepares and sends updated health outcome. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive member's health outcome information. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields. 3. Validate that the provided information is authentic. 4. Prepare submittal for member's health outcome information to registry. 5. **END:** Send member's health outcome information to registry.

CM Case Management	
Manage Registry	
Item	**Details**
	Alternate Path: 1. **START:** Receive request for health outcome information. 2. Validate requestor has authorization to receive desired information. 3. Prepare submittal for member's health outcome information to requestor. 4. **END:** Send member's health outcome information to requestor.
Shared Data	Health Registry data store including health outcomes (e.g., immunizations, cancer, heart, diabetes, or disease) Data sources needed for validation of registry information Enterprise Master Patient Index (EMPI) for single and complete view of patient information
Predecessor	**Receive Inbound Transaction** ***Manage Case Information*** ***Manage Health Plan Information***
Successor	**Send Outbound Transaction** ***Manage Provider Communication*** ***Manage Contractor Communication***
Constraints	State and federal regulations regarding entities authorized to access registry information.
Failures	• The SMA is unable to find registry information to update. • Requestor does not have authorized access to the Registry.
Performance Measures	• Time to complete registry update = __days • Successful delivery rate of responses = __%

Perform Screening and Assessment

CM Case Management	
Perform Screening and Assessment	
Item	**Details**
Description	The ***Perform Screening and Assessment*** business process is responsible for the evaluation of member's health information, facilitating evaluations and recording results. This business process assesses for certain health and behavioral health conditions (e.g., chronic illness, mental health, substance abuse), lifestyle and living conditions (e.g., employment, religious affiliation, living situation) to determine risk

CM Case Management	
Perform Screening and Assessment	
Item	**Details**
	factors. This business process: • Establishes risk categories and hierarchy, severity, and level of need. • Screens for required fields. • Edits required fields. • Verifies information from external sources if available. • Establishes severity scores and diagnoses. • Associates with applicable service needs. Health Information Exchange (HIE) verifies a member's health information.
Trigger Event	Interaction based Trigger Events: • Receive new member enrollment alert from ***Enroll Member*** business process. • Receive redetermination of member enrollment alert from ***Enroll Member*** business process.
Result	• Member notified of applicable services as needed. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive new member or redetermination of member enrollment from ***Enroll Member*** business process. 2. Assign Care Manager. 3. Gather information for history and/or examinations. 4. Determine risk factors and establish risk categories. 5. Conduct needs assessment and determines level of need. 6. Determine health benefits that are appropriate for the member. 7. Staff records screening and assessment results. 8. Associate member to applicable services based on results. 9. **END:** Send alert to notify member of applicable services based on screening and assessment.
Shared Data	Member data store including demographic information Health Information Exchange (HIE) data store including health information, clinical record and clinical data Plan data store including policy information Health Benefit data store including program and service information Case History data store including action lists, journal notes, reviews and approvals

CM Case Management	
Perform Screening and Assessment	
Item	**Details**
Predecessor	***Enroll Member***
Successor	***Manage Case Information*** ***Manage Applicant and Member Communication***
Constraints	States may have different screening requirements and health benefits. Agencies do not coordinate between each other in order to share information. Potential political and inter-agency conflicts over appropriate use of health care information.
Failures	• Care Manager is unable to acquire history and/or examination information.
Performance Measures	• Timeliness to complete process = within __ days • Accuracy with which changes are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Manage Treatment Plan and Outcomes

CM Case Management	
Manage Treatment Plan and Outcomes	
Item	**Details**
Description	The ***Manage Treatment Plan and Outcomes*** business process uses federal and state specific criteria and rules to ensure that the providers/contractors chosen and services delivered optimizes member and member population outcomes. It includes activities to track and assess effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. It also includes ongoing monitoring, management, and reassessment of services and treatment plans for need, appropriateness, and effectiveness, and monitoring of special member populations (e.g., pregnant women and children, and HIV/intravenous drug users). Health Information Exchange (HIE) monitors a member's health information.
Trigger Event	Interaction-based Trigger Events: • Receipt from Health Information Exchange (HIE) of a modification in member's health outcome. • Receive treatment plan from ***Establish Case*** business process. Environment-based Trigger Events: • Periodic review of member's treatment plan is due.

CM Case Management	
Manage Treatment Plan and Outcomes	
Item	**Details**
	• Receive request to review member's treatment plan.
Result	• Member's treatment plan and outcomes are appropriate for their needs. • Send modification (e.g., creates, update, delete) to member's treatment plan sent to Health Information Exchange (HIE). • Member, provider and care coordinators notified of modifications in treatment plan or benefits. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive member's treatment plan from ***Establish Case*** business process. 2. Review of effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. 3. Determine if modifications are necessary for effective treatment outcome. 4. Record required modifications to member's treatment plan. 5. **END:** Send notification to member, provider and other care coordinators of modification in treatment or benefits. <u>Alternate Path:</u> 1. **START:** Receive treatment plan from Health Information Exchange (HIE). 2. Review of effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. 3. Determine if modifications are necessary for effective treatment outcome. 4. Record required modifications to member's treatment plan. 5. Send notification to member, provider, and other care coordinators of modification in treatment or benefits. 6. **END:** Send modification to member's treatment plan or benefits to Health Information Exchange (HIE).
Shared Data	Member data store including demographic and social information Health Information Exchange (HIE) data store including health information, medically-related social and support services, clinical record, and clinical data Case History data store including action lists, journal notes, reviews, and approvals
Predecessor	**Receive Inbound Transaction** ***Establish Case***

CM Case Management	
Manage Treatment Plan and Outcomes	
Item	**Details**
	Authorize Treatment Plan
Successor	**Send Outbound Transaction** ***Authorize Treatment Plan*** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication***
Constraints	Agencies do not coordinate amongst each other in order to share information. Potential political and inter-agency conflicts over appropriate use of health care information.
Failures	• Care Manager is unable to acquire treatment plan information.
Performance Measures	• Timeliness to complete process = within __ days • Accuracy with which changes are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Authorize Referral

CM Authorization Determination	
Authorize Referral	
Item	**Details**
Description	The ***Authorize Referral*** business process is responsible for referrals between providers that the State Medicaid Agency (SMA) approves for payment, based on state policy. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. The SMA uses this business process primarily for Primary Care Case Management programs where additional approval controls deemed necessary by the state. Most States do not require this additional layer of control. **NOTE:** MITA contains three (3) different authorization business processes: 1. ***Authorize Service*** – the standard process of prior authorization of services. 2. ***Authorize Treatment Plan*** – the approval of a treatment plan prepared by a care management team in a care management setting. 3. ***Authorize Referral*** – specifically the approval of a referral to another provider, requested by a primary care physician. The ***Authorize Referral*** business process may encompass both a pre-approved and post-approved referral request, especially in the case where the member required

CM Authorization Determination	
Authorize Referral	
Item	**Details**
	immediate services. This business process may include, but is not limited to, referrals for specific types and numbers of visits, procedures, surgeries, tests, drugs, durable medical equipment, therapies, and institutional days of stay. The SMA evaluates requests based on urgency, state priority requirements, and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state). It validates key information, and ensures that the referral is appropriate and medically necessary. After review, staff approves, modifies, suspends for additional information or denies the request. This business process sends an alert to ***Manage Case Information*** business process. A post-approved referral request is an editing/auditing function that requires review of information after the referral is complete. A review may consist of verifying documentation to ensure that the referral is appropriate, and medically and/or functionally necessary, and validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the ***Process Claim*** or ***Process Encounter*** business processes.
Trigger Event	Interaction-based Trigger Events: • Receive referral request from Health Information Exchange (HIE) via Accredited Standards Committee (ASC) X12 278 Health Care Services Review Request and Response transaction. • Receive referral request from requestor via ASC X12 278 Health Care Services Review Request and Response transaction. Environment-based Trigger Events: • Provider submits a request to refer patient to other service providers in accordance with state policy. • Provider submits additional information for existing referral request.
Result	• Send the authorize referral response to the referring provider and the consulting provider. • Alert to send referral information to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Manage Applicant and Member Communication*** to send notification of authorized referral response. • Alert sent to ***Manage Case Information*** business process for purposes of responding to member inquiries about the status of a referral request or a filing of a grievance or an appeal about the referral response. • Tracking information as needed for measuring performance and business

CM Authorization Determination	
Authorize Referral	
Item	**Details**
	activity monitoring.
Business Process Steps	1. **START:** Receive referral request from authorized provider. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information is authentic. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. 4. Assign a tracking number. 5. Prioritize Referral Authorization Request. 6. Validate the following: 7. Member eligibility– for social service model, this entails assessing member's health, functional, and socio-economic status 8. Eligibility for requesting and referral providers 9. Service coverage and referral requirements 10. Diagnosis code 11. Procedure code/or procedure groupings 12. Check for medical or functional necessity and appropriateness. 13. Check against current referral authorizations for duplicates. 14. Validate completeness of supporting documentation. 15. Deny based on insufficient/erroneous information for referral. Go to step 13. 16. Suspend the referral request based on need for additional information – send request for additional information. Go to step 13. 17. Approve referral request (this includes approved with modifications). 18. Send alert to send referral authorization to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. 19. **END:** Send alert to notify member, referring provider, and referred-to provider of authorization determination. <u>Alternate Path:</u> For the authorization of some services, States may use the post-approval rather than the prior authorization business process. The post-approval business process will cover all steps listed above, but they may execute in a different order depending on state rules.

CM Authorization Determination	
Authorize Referral	
Item	**Details**
Shared Data	Member data store including demographic information Provider data store including provider network Information Health Information Exchange (HIE) data store including health information, clinical record, and clinical data Claims data store including adjudication information Plan data store including health benefits information
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Process Encounter***
Successor	**Send Outbound Transaction** ***Process Claim*** ***Process Encounter*** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Submit Electronic Attachment***
Constraints	The authorize referral request information will conform to the format and content in accordance with state-specific reporting requirements, e.g., using a HIPAA Transaction Standard Companion Guide.
Failures	• The SMA receives incomplete referral request information. • Requestor not authorized to make referral request. • Member not eligible for referred provider services.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which referral authorizations are approved or denied = ___% • Consistency of decisions in approving or denying referral authorizations = ___% • Error rate = __% or less

Authorize Service

CM Authorization Determination	
Authorize Service	
Item	**Details**
Description	The ***Authorize Service*** business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment. Its primary use is in a fee-for-services setting. Prior authorization of a service request is a care management function and begins when a care manager requests a service request by mail, facsimile, telephone, or Accredited Standards Committee (ASC) X12 278 Health Care Services Review Information request transaction. The care manager evaluates requests based on state rules for prioritization such as urgency and type of service/taxonomy (e.g., durable medical equipment, speech, physical therapy, dental, and out-of-state), validates key information, and ensures that requested service is appropriate and medically necessary. After review, staff approves, modifies, denies or suspends for additional information the service requests. The State Medicaid Agency (SMA) sends the appropriate response information for the outbound ASC X12 278 Health Care Services Review Response transaction to the provider using the **Send Outbound Transaction.** **NOTE:** MITA contains three (3) different authorization business processes: 1. ***Authorize Service*** – the standard process of prior authorization of services. 2. ***Authorize Treatment Plan*** – the approval of a treatment plan prepared by a care management team in a care management setting. 3. ***Authorize Referral*** – specifically the approval of a referral to another provider, requested by a primary care physician. A post-approved service request is an editing/auditing function that requires review of information after the service is complete. A review may consist of verifying documentation to ensure that the services were appropriate and medically necessary, and validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the ***Process Claim*** **or** ***Process Encounter*** business processes. **NOTE:** This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, and Off-label use of drugs, Social Service, Experimental Treatments, Out-of-State Services, and Emergencies.
Trigger Event	Interaction-based Trigger Events: • Receive service request from Health Information Exchange (HIE) via ASC X12 278 Health Care Services Review Request and Response transaction. • Receive service request from requestor via ASC X12 278 Health Care Services Review Request and Response transaction. Environment-based Trigger Events: • Provider submits a request for service in accordance with state policy. • Provider submits additional information for existing service authorization request.

CM Authorization Determination	
Authorize Service	
Item	**Details**
Result	• Service authorization response sent to requestor. • Alert to send service information to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Manage Applicant and Member Communication*** to send notification of authorized service response. • Alert sent to ***Manage Case Information*** business process for purposes of responding to provider or member inquiries about the status of service request or a provider or member filing of a grievance or an appeal about the service authorization response. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive service authorization request from authorized provider. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. 3. Validate that the provided information is authentic. 4. Assign a tracking number. 5. Prioritize Service Authorization Request. 6. Validate the following: 7. Member eligibility – for social service model, this entails assessing member's health, functional, and socio-economic status 8. Requesting and servicing providers 9. Service coverage and referral requirements 10. Diagnosis code 11. Procedure code/or procedure groupings 12. Check for medical or functional necessity and appropriateness. 13. Check against current service authorizations for duplicates. 14. Validate completeness of supporting documentation. 15. Deny based on insufficient/erroneous information or authorization for service not

CM Authorization Determination	
Authorize Service	
Item	**Details**
	medically necessary. Go to step 13. 16. Suspend the authorization request based on need for additional information. Go to step 13. 17. Approve service authorization request (this includes approved with modifications. 18. Send alert to send service authorization to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. 19. **END:** Send alert to notify member and requesting provider of service authorization determination. <u>Alternate Path:</u> For the authorization of some services, States may use the post-approval rather than the prior authorization business process. The post-approval business process includes all steps listed above, but process executes in a different order depending on state rules.
Shared Data	Member data store including demographic information Provider data store including provider network Information Health Information Exchange (HIE) data store including health information, clinical record, and clinical data Plan data store including health benefits information Claims data store including adjudication information
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Process Encounter***
Successor	**Send Outbound Transaction** ***Process Claim*** ***Process Encounter*** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Submit Electronic Attachment***
Constraints	The authorize service request information will conform to the format and content in accordance with state-specific reporting requirements, e.g., using a HIPAA Transaction Standard Companion Guide.

CM Authorization Determination	
Authorize Service	
Item	**Details**
Failures	• The SMA receives incomplete service authorization request. • Requestor (provider) is not eligible for enrollment or does not have authority to make service authorization request for particular service. • Member is not eligible for services.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which service authorizations are approved or denied = __% • Consistency of decisions in approving or denying service authorizations = __% • Error rate = __% or less

Authorize Treatment Plan

CM Authorization Determination	
Authorize Treatment Plan	
Item	**Details**
Description	The ***Authorize Treatment Plan*** business process encompasses both a prior authorization and post-approved treatment plan. The State Medicaid Agency (SMA) uses the Authorize Treatment Plans primarily in the care coordination setting where the care management team assesses the member's needs, decides on a course of treatment, and completes the treatment plan. **NOTE:** MITA contains three (3) different authorization business processes: 1. ***Authorize Service*** – the standard process of prior authorization of services. 2. ***Authorize Treatment Plan*** – the approval of a treatment plan prepared by a care management team in a care management setting. 3. ***Authorize Referral*** – specifically the approval of a referral to another provider, requested by a primary care physician. A treatment plan prior-authorizes the named providers or provider types and services or category of services. The SMA prior authorizes individual providers for the service or category of services, and they do not have to submit their own prior authorizations or service requests. A treatment plan typically is a schedule of medical, therapeutic, and /or psychological procedures and appointments that spans a length of time designed to restore a patient's specific health condition. In contrast, the SMA limits an individual service request, primarily associated with fee-for-services payment, to focus on a specific visit, services, or products (e.g., a single specialist office visit, approval for a specific test or particular piece of Durable Medical Equipment (DME)). The prior authorized treatment plan generally begins with the receipt of an authorize treatment plan request from the care management team. The SMA staff then evaluates it based on urgency, state priority requirements, and type of service/taxonomy (speech, physical therapy, home health, behavioral, social), and

CM Authorization Determination	
Authorize Treatment Plan	
Item	**Details**
	validates key information, and ensures that requested plan of treatment is appropriate and medically or behaviorally necessary. After reviewing, staff approves, modifies, suspends for additional information or denies the request. Business process sends an alert to ***Manage Case Information*** business process. A post-approved treatment plan is an audit function that reviews suspended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.
Trigger Event	Interaction-based Trigger Events: • Receive treatment plan request from Health Information Exchange (HIE) via Accredited Standards Committee (ASC) X12 278 Health Care Services Review Request and Response transaction. • Receive treatment plan request from requestor via ASC X12 278 Health Care Services Review Request and Response transaction. Environment-based Trigger Events: • Care manager submits a request for treatment plan authorization. • Provider submits a request for treatment plan authorization in accordance with state policy. • Provider submits additional information for existing treatment plan request.
Result	• The SMA sends the authorization response to requestor. • Alert sent with treatment plan information to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Manage Applicant and Member Communication*** to send notification of authorized treatment plan response. • Alert sent to ***Manage Case Information*** business process for purpose of responding to provider or member inquiry about the status of a treatment plan authorization or member filing of a grievance or an appeal about treatment authorization response. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for Treatment Plan authorization for authorized provider or care manager. 2. Assign a tracking identifier. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all

CM Authorization Determination	
Authorize Treatment Plan	
Item	**Details**
	required fields. 4. Validate that the provided information is authentic. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. 5. Prioritize authorize treatment plan request. 6. Validate the following: 7. Member eligibility 8. Eligibility for requesting and servicing providers 9. Service coverage and plan of treatment requirements 10. Diagnosis code 11. Procedure codes/or procedure groupings 12. Check for medical, social, and behavioral appropriateness. 13. Check against currently authorized treatment plans and service requests for duplication. 14. Coordinate services (check for duplicates) across programs and systems. 15. Validate completeness of supporting documentation. 16. Deny based on insufficient/erroneous information or treatment plan identifying services not medically, socially, and/or behaviorally necessary. Go to step 14. 17. Suspend the treatment plan request based on the need for additional information. Send a request for additional information. Go to step 14. 18. Approve plan of treatment request (this includes approved with modifications) and send approval response information to requesting parties. 19. Send alert to send treatment plan authorization to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. 20. **END:** Send alert to notify member, care manager, and provider of authorization determination.
Shared Data	Member data store including demographic information Provider data store including provider network Information Health Information Exchange (HIE) data store including health information, clinical record, and clinical data Plan data store including health benefits information Claims data store including adjudication information
Predecessor	**Receive Inbound Transaction**

CM Authorization Determination	
Authorize Treatment Plan	
Item	**Details**
	Establish Case ***Manage Case Information*** ***Manage Treatment Plan and Outcomes***
Successor	**Send Outbound Transaction** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Submit Electronic Attachment*** ***Manage Treatment Plan and Outcomes***
Constraints	The authorize treatment plan information will conform to the format and content in accordance with state-specific reporting requirements, e.g., using a HIPAA Transaction Standard Companion Guide.
Failures	• Invalid beneficiary, invalid provider, invalid service, invalid dates, conflicting diagnosis, and treatment plan.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which the SMA approves treatment plan = __% • Consistency of decisions in approving or denying treatment plans = __% • Error rate = __% or less

CONTRACTOR MANAGEMENT

Manage Contractor Information

CO Contractor Information Management	
Manage Contractor Information	
Item	**Details**
Description	The ***Manage Contractor Information*** business process is responsible for managing all operational aspects of the Contractor (e.g., managed care, at-risk mental health or dental care, primary care physician, Recovery Audit Contractor (RAC)) data store. This business process receives a request for addition, deletion, or modification to Contractor information, validates the request, and applies the instruction. **NOTE**: Requires billing agents, clearinghouses, or other alternate payees (as defined by the Secretary) to register with Medicaid agency.
Trigger Event	Environment-based Trigger Events: • Receive request to create, inquire, delete, or modify contractor information from authorized individuals via email, mail, facsimile, telephone or web. • Receive request to verify contractor information from authorized external parties.
Result	• The State Medicaid Agency (SMA) creates, inquires on, deletes, or modifies contractor information. • Alert sent to notify Health Insurance Marketplace (HIX) of provider network modification information. • Alert sent to notify insurance affordability program of provider network modification. • Alert to ***Manage Contractor Communication*** business process to notify contractor of relevant modifications. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request from authorized individuals or agencies to create, inquire, delete or modify contractor information. 2. Agency logs request for contractor information. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 4. Validate authorization of requestor to acquire contactor information. 5. Find appropriate contractor. 6. Create, inquire, delete or modify relevant contractor information. 7. Send alert to notify Health Insurance Marketplace (HIX) of provider network modification. 8. Send alert to notify insurance affordability program of provider network modification. 9. Send alert to ***Manage Contractor Communication*** business process to notify

CO Contractor Information Management	
Manage Contractor Information	
Item	**Details**
	provider of relevant modifications. 10. **END:** The SMA creates, inquires on, deletes, or modifies contractor information.
Shared Data	Contractor data store including contract information
Predecessor	***Manage Contract*** ***Close Out Contract***
Successor	***Perform Contractor Outreach*** ***Manage Contractor Grievance and Appeal*** ***Manage Contractor Communication*** ***Manage Data***
Constraints	Information requirements and data structures for the contractor data store may differ from state to state.
Failures	• The SMA cannot find contractor information. • The SMA cannot respond to a request (e.g., cannot change tax ID because it would change the contracted entity). • Validation failed (e.g., address is not a legal address). • Contract provides incomplete information (e.g., missing required information elements).
Performance Measures	• Timeliness to complete process = within __ days • Accuracy with which changes are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Inquire Contractor Information

CO Contractor Information Management	
Inquire Contractor Information	
Item	**Details**
Description	The ***Inquire Contractor Information*** business process receives requests for contract (e.g., managed care, at-risk mental health or dental care, Primary Care Physician (PCP)) verification from authorized providers, programs or business associates, performs the inquiry, and prepares the response for the **Send Outbound Transaction**.

CO Contractor Information Management	
Inquire Contractor Information	
Item	**Details**
Trigger Event	Interaction-based Trigger Events: • Receive contract verification request from **Receive Inbound Transaction**.
Result	• Contract verification response sent to requestor. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive contract verification request. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information is authentic. 4. Agency logs contract verification request. 5. Determine request status as initial or duplicate. 6. Query contractor data store for requested information. 7. Agency logs contract verification response. 8. **END:** Send contract verification response to requestor.
Shared Data	Contractor data store including contract information
Predecessor	**Receive Inbound Transaction**
Successor	**Send Outbound Transaction** ***Manage Contractor Information***
Constraints	The State Medicaid Agency (SMA) determines what information to share.
Failures	• The SMA is unable to find contractor information. • The SMA is unable to respond to a request. • Validation failed. • Requestor provides incomplete information (e.g., missing required information elements).
Performance Measures	• Time to verify Contractor information and generate response information: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Response Accuracy = ___% • Error rate = __% or less

Manage Contractor Communication

CO Contractor Support	
Manage Contractor Communication	
Item	**Details**
Description	The ***Manage Contractor Communication*** business process receives requests for information, appointments, and assistance from contractors (e.g., managed care, at-risk mental health or dental care, primary care physician) such as inquiries related to modifications in Medicaid Program policies and procedures, introduction of new programs, modifications to existing programs, public health alerts, and contract amendments, etc. This business process includes the log, research, development, approval, and delivery of routine or ad hoc messages. The State Medicaid Agency (SMA) communications a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). **NOTE:** The ***Manage Contractor Communication*** business process handles current contractors by providing assistance and responses to individual entities, i.e., bi-directional communication. The ***Perform Contractor Outreach*** business process targets both prospective and current contractor populations for distribution of information regarding programs, policies, and other issues. Other examples of communications include: • Pay for performance communications – performance measures could affect capitation payments or other reimbursements. • Incentives to improve encounter information quality and submission rates.
Trigger Event	Interaction-based Trigger Events: • Receive request from other business processes to develop and produce communications for contractors such as notifications from ***Manage Contractor Information*** business process. Environment-based Trigger Events: • Receive an inquiry from contractor. • Request to send information packages. • Request for assistance, such as a request for training or modify contractor information. • Periodic timetable (e.g., monthly) is due to send information (e.g., within 24 hours of new contract award and periodic communications such as newsletters or other agency communications).
Result	• Contractor receives appropriate assistance, communications, and/or information packages. • Tracking information as needed for measuring performance and business activity monitoring.

CO Contractor Support	
Manage Contractor Communication	
Item	**Details**
Business Process Steps	1. **START:** Receive request for communication. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information is authentic. 4. Agency logs request for communication. 5. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web, or EDI. 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate).
Shared Data	Contractor data store including contract information Plan data store including health benefit information
Predecessor	**Receive Inbound Transaction** ***Award Contract*** ***Manage Contract*** ***Close Out Contract*** ***Manage Contractor Information*** ***Inquire Contractor Information*** ***Manage Contractor Grievance and Appeal*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Performance Measures***
Successor	**Send Outbound Transaction** ***Manage Performance Measures***
Constraints	Communications will vary by state, by type of contractor, and by type of communication. Contractor may have communication barriers such as lack of internet or phone

CO Contractor Support	
Manage Contractor Communication	
Item	**Details**
	access. Contractor is unable to access needed or requested information.
Failures	• The SMA is unable to provide linguistically, culturally, or competency appropriate information. • Delivery failures due to erroneous contact information or lack of contact information.
Performance Measures	• Time to complete response: By phone __ minutes; by email __hours; by mail __ days • Accuracy of communications = __% • Communications successfully delivered = __%

Perform Contractor Outreach

CO Contractor Support	
Perform Contractor Outreach	
Item	**Details**
Description	The ***Perform Contractor Outreach*** business process is responsible for sending information such as public health alerts, new programs, and/or modifications in the Medicaid Program policies and procedures. For prospective contractors (e.g., managed care, at-risk mental health or dental care, primary care physician), States Medicaid Agency (SMA) develops contractor outreach information for prospective contractors identified by analyzing Medicaid business needs. For currently enrolled contractors, information may relate to public health alerts, public service announcements, and other objectives. The SMA communicates contractor outreach information by a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). The SMA produces, distributes, tracks, and archives all contractor outreach communications according to state rules.

Trigger Event	Environment-based Trigger Events:
	• Executive Management decision to:
	  ○ Fill gaps in health care service and administrative coverage.
	  ○ Solicit updated/new administrative and technical functions.
	  ○ Introduce new programs requiring new types of health or administrative service.
	  ○ Change to existing policies and procedures.
	  ○ Respond to critical need in a specific target population.
	  ○ Identify new populations in need of service (e.g., new immigrant

CO Contractor Support	
Perform Contractor Outreach	
Item	**Details**

	communities).
	• State transition-based trigger events:
	  ○ Alert received from ***Manage Health Plan Information*** business process of addition or modification.
	  ○ Alert received from ***Manage Health Benefit Information*** business process of addition or modification.

Result	• Agency produces outreach communications (e.g., mailing brochure, web page, email, kiosk, radio, billboard, and TV advertisements) and distributes to targeted contractors. Agency may also conduct face-to-face meetings. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for outreach materials or communication. 2. Target population identified and defined by analyzing information, performance measures, feedback from community, and policy directives. 3. Approve, deny, or modify decisions to develop outreach communications. 4. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web or EDI. 5. Determine performance measures. 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate)
Shared Data	Contractor data store including provider network information Plan data store including policy information Health Benefits data store including benefit package and benefits information Performance Measures data store including agency's objectives (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) information)
Predecessor	***Manage Performance Measures*** ***Identify Utilization Anomalies*** ***Maintain State Plan*** ***Manage Health Plan Information***

CO Contractor Support	
Perform Contractor Outreach	
Item	**Details**
	Manage Health Benefit Information
Successor	**Send Outbound Transaction** ***Manage Contractor Communication*** ***Manage Performance Measures***
Constraints	Communications and information packages will address the needs of the targeted population. Materials will be linguistically and culturally appropriate, legally compliant, appropriate to the targeted group, and meet financial guidelines (re: cost to produce and distribute). Other constraints may be agency priority, availability of resources, and accuracy of contractor contact information. Contractor may have communication barriers such as lack of internet or phone access. Contractor is unable to access needed or requested information.
Failures	• Unable to identify target population based on desired criteria. • Management denies permission for outreach activity. • The SMA cancels health plan or health benefit. • Delivery failures due to erroneous contact information.
Performance Measures	• Time to complete process of developing outreach materials = __days • Accuracy of outreach materials = __% • Successful delivery rate to targeted individuals = __% • Effectiveness of the communication – Outreach results in achieving specified goals

Manage Contractor Grievance and Appeal

CO Contractor Support	
Manage Contractor Grievance and Appeal	
Item	**Details**
Description	The ***Manage Contractor Grievance and Appeal*** business process handles contractor (e.g., managed care, at-risk mental health or dental care, primary care physician) appeals* of adverse decisions or communications of a grievance. The ***Manage Contractor Communication*** business process initiates a grievance or appeal. The State Medicaid Agency (SMA) logs and tracks the grievance or appeal; it triages to appropriate reviewers; it researches it; it may request additional information; it schedules and conducts a hearing in accordance with legal requirements; and it makes a ruling based upon the evidence presented. Staff documents and distributes results of the hearings, and adds relevant documents to the contractor's information. Agency formally notifies contractor of the decision. This business process supports the ***Manage Performance Measures*** business

CO Contractor Support	
Manage Contractor Grievance and Appeal	
Item	**Details**
	process by providing information about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This information used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. Based on the appeal business process, if a contractor wins an appeal that impacts or clarifies a Medicaid State Plan, health plan, or health benefit this process sends that information to ***Maintain State Plan, Manage Health Plan Information*** or ***Manage Health Benefit Information*** business processes to modify the relevant policy or procedure. Disposition could result in legislative change requirements that will be communicated to lawmakers. **NOTE:** States may define grievance and appeal differently, perhaps because of state laws. *****This business process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor can file a grievance or appeal, for example, when agency does not award a contract to contractor. Protests received from prospective contractors are addressed in the ***Award Contract*** business process
Trigger Event	Environment-based Trigger Events: • Receive grievance or appeal alert from ***Manage Contractor Information*** business process. • Receive grievance or appeal alert from ***Award Contract*** business process.
Result	• Alert to send notification of final disposition of grievance or appeal to the contractor. • If applicable, alert sent to ***Establish Compliance Incident*** business process for further investigation. • If applicable, alert sent to ***Maintain State Plan*** business process to modify the relevant policy or procedure. • If applicable, alert sent to ***Manage Health Plan Information*** business process to modify the relevant policy or procedure. • If applicable, alert sent to ***Manage Health Benefit Information*** business process to modify the relevant policy or procedure. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive grievance or appeal. 2. Agency logs grievance or appeal. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields.

CO Contractor Support	
Manage Contractor Grievance and Appeal	
Item	**Details**
	4. Validate that the provided information is authentic. 5. If appropriate, request additional documentation. 6. Determine status as initial, second, expedited or other status as designated by the state. 7. Triage to appropriate personnel for review. 8. Perform research and analysis. 9. If appropriate, schedule hearing within required time limit. 10. If appropriate, conduct hearing within required time limit. 11. Determine disposition. 12. If applicable, send alert to ***Establish Compliance Incident*** business process for further investigation. 13. If applicable, alert sent to ***Maintain State Plan*** business process to modify the relevant policy or procedure. 14. If applicable, alert sent to ***Manage Health Plan Information*** business process to modify the relevant policy or procedure. 15. If applicable, alert sent to ***Manage Health Benefit Information*** business process to modify the relevant policy or procedure. 16. **END:** Send alert to notify contractor of disposition determination. **NOTE:** Some of the above steps may be iterative and a grievance or appeals case may take many months to finalize.
Shared Data	Contractor data store including provider network and contract information Grievance and Appeal data store including case history information Claims data store including claims and premium Information
Predecessor	***Manage Contractor Information*** ***Award Contract***
Successor	***Manage Contractor Communication*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Performance Measures*** ***Establish Compliance Incident***
Constraints	States have different requirements for evidence and the process for conducting the grievance/appeals cases. They have different rules for assigning outcome status and state specific consequences.

CO Contractor Support	
Manage Contractor Grievance and Appeal	
Item	**Details**
Failures	• Grievance and appeal supporting documentation is incomplete. • The SMA cannot schedule or conduct hearing in the required period. • Contractor withdraws grievance or appeal. • Unable to process grievance or appeal per federal or state law.
Performance Measures	• Time to complete process: normal grievance/appeal = __days; second appeal = __ days; expedited appeal = __hours • Accuracy of decisions = __% • Consistency of decisions and disposition = __% • Error rate = __% or less

Produce Solicitation

CO Contract Management	
Produce Solicitation	
Item	**Details**
Description	The ***Produce Solicitation*** business process gathers requirements, develops a solicitation (e.g., Request for Information (RFI), Request for Quotation (RFQ), or Request for Proposals (RFP)), receives approvals for the solicitation, and releases for response.
Trigger Event	Environment-based Trigger Events: • A scheduled date for re-procurement of contract is due. • Request by Executive Management to procure or re-procure a contract.
Result	• The State Medicaid Agency (SMA) produces an Advance Planning Document (APD). • The SMA produces a solicitation for distribution. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive directive to procure or re-procure contract. 2. Gather requirements for services. 3. Determine if CMS requires an APD. a. Produce APD. b. Modify APD as directed. c. Receive approval for APD.

CO Contract Management	
Produce Solicitation	
Item	**Details**
	4. Develop solicitation for the services. 5. Receive internal (state) and federal approvals for solicitation. 6. Advertise solicitation. 7. **END:** The SMA releases solicitation for response.
Shared Data	Plan data store including policy information Health Benefit data store including benefit package and benefit information Contractor data store including provider network Manage Performance Measures data store including agency objectives and business activity Information Technology (IT) Plan
Predecessor	***Manage Health Plan Information***
Successor	***Award Contract***
Constraints	Each state decides what types of contracts to procure. States engage in a wide range of contracts. Statutes that provide the legal framework for procurements govern all States. Each state's statutes are different from all other States. Business process steps differ from state to state.
Failures	• The SMA loses funding for the procurement. • Insufficient responses to solicitation.
Performance Measures	• Time to complete process = ___ months; ___ weeks • Accuracy of information = ___ % • Accessibility of information for creating solicitation = ___ months; ___ weeks • Consistency of decisions and disposition = ___ % • Error rate = __% or less

Award Contract

CO Contract Management	
Award Contract	
Item	**Details**
Description	The ***Award Contract*** business process utilizes requirements, advanced planning documents, requests for information, request for proposal, and sole source documents to request and receive proposals, verify proposal content against

CO Contract Management	
Award Contract	
Item	**Details**
	Request for Proposal (RFP) or sole source requirements, apply evaluation criteria, designate contractor/vendor, post award information, entertain protests, resolve protests, negotiate contracts, and notify parties. In some States, this business process makes a recommendation of award instead of the actual award itself. **NOTE**: The State Medicaid Agency (SMA) requires billing agents, clearinghouses, or other alternate payee (as defined by the Secretary) to register.
Trigger Event	Environment-based Trigger Events: • Receive respondent's proposal or approval for sole source.
Result	• Alert to send notification of award status to respondent. • The SMA negotiates contract with awarded contractor. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive respondent's proposal (e.g., email, mail, web, or Electronic Data Interchange (EDI). 2. Conduct collection of contractor information. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and respondent has completed all required fields for the type of contractor. 4. If applicable, request additional information. 5. Validate information provided is authentic (e.g., corporate status). 6. Validate contractor network, resources, and other requirements and obtain appropriate approvals (i.e., state, federal). 7. Assign identification to the respondent. 8. Verify proposal content against RFP or sole source requirements. 9. Apply evaluation criteria to respondent's proposal. 10. Make determination of awarded contractor. 11. Post award information. 12. Send alert to notify respondent of award results (e.g., award/recommend, deny, or continue negotiations). 13. If applicable, send alert to ***Manage Contractor Grievance and Appeal*** business process to receive protests and disposition protests. 14. **END:** Negotiate contract with contractor, collect additional information required to complete a contract, negotiate, and assign rates or other form of payment.
Shared Data	Contractor data store including provider network and contract information
Predecessor	**Receive Inbound Transaction**

CO Contract Management	
Award Contract	
Item	**Details**
	Produce Solicitation
Successor	**Send Outbound Transaction** ***Manage Contractor Communication*** ***Manage Contract*** ***Manage Contractor Grievance and Appeal***
Constraints	The Contractor application will accommodate the full range of contractor types.
Failures	• Information does not comply with syntax criteria. • Not all required information provided. • Information provided not authenticated. • Parties are unable to negotiate contract (e.g., no agreement on rates). • The SMA loses funding. • Responder successfully protests an award.
Performance Measures	• Time to complete process = ___ months; ___ weeks • Accuracy of information = ___ % • Accessibility of information for creating solicitation = ___ months; ___ weeks • Consistency of decisions and disposition = ___ % • Error rate = __% or less

Manage Contract

CO Contract Management	
Manage Contract	
Item	**Details**
Description	The ***Manage Contract*** business process receives the contract award information, implements contract-monitoring procedures, updates contract if needed, and continues to monitor the terms of the contract throughout its duration.
Trigger Event	Environment-based Trigger Events: • Receive negotiated contract information from ***Award Contract*** business process. • Periodic timetable (e.g., yearly) is due for contract review. • External event (e.g., policy, budget modification) necessitates contract amendment.

CO Contract Management	
Manage Contract	
Item	**Details**
	• Receive contract modifications (e.g., create, updated, or delete). • Receive terminate contract information from ***Close Out Contract*** business process.
Result	• Modified negotiated contract. • If applicable, alert sent to ***Manage Contractor Information*** business process with modification information. • Alert to send notification to contractor of modification to contract. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive contract award information from the ***Award Contract*** business process or contract update information from the ***Manage Contractor Communication*** business process. 2. Implement contract or modifications to contract. 3. If applicable, update contract with amendments. 4. If applicable, send alert to ***Manage Contractor Information*** business process with modified information. 5. **END:** Send alert to ***Manage Contractor Communication*** business process to notify contractor of modifications***.***
Shared Data	Contractor Information Data Store
Predecessor	***Award Contract*** ***Close Out Contract***
Successor	***Manage Contractor Communication*** ***Manage Contractor Information***
Constraints	Business rules and/or policies may differ by state.
Failures	• The State Medicaid Agency (SMA) loses funding. • Responder successfully protests an award. • The SMA fails to negotiate terms of contract or modification. • Information does not comply with syntax criteria. • Not all required information provided. • Information provided not authenticated.
Performance Measures	• Time to complete process = ___ months; ___ weeks • Accuracy of information = ___ %

CO Contract Management	
Manage Contract	
Item	**Details**
	• Accessibility of information for creating solicitation = ___ months; ___ weeks • Consistency of decisions and disposition = ___ % • Error rate = __% or less

Close Out Contract

CO Contract Management	
Close Out Contract	
Item	**Details**
Description	The ***Close Out Contract*** business process begins with an expired contract or an order to terminate a contract. The business process ensures the obligations of the current contract are complete and the turnover to the new contractor proceeds according to contractual obligations.
Trigger Event	Interaction-based Trigger Events: • Receive alert from ***Determine Adverse Action Incident*** business process to cease activities with contractor. Environment-based Trigger Events: • Contract reaches the end of its effective period.
Result	• The contract closes. • Alert sent to notify contractor of termination of contract. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive expired contract or instruction to terminate a contract. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields. 3. If applicable, request additional information. 4. Validate information provided is authentic. 5. Identify all requirements for termination of contract. 6. Monitor closure activities. 7. Officially terminate contract. 8. **END:** Send alert to notify contractor of termination of contract.
Shared Data	Contractor data store including contract information

CO Contract Management	
Close Out Contract	
Item	**Details**
Predecessor	***Award Contract*** ***Determine Adverse Action Incident***
Successor	***Manage Contractor Communication*** ***Manage Contractor Information***
Constraints	Each state may have its own requirements for contract termination.
Failures	• The State Medicaid Agency (SMA) receives incomplete termination instructions. • Contractor data store contains invalid information.
Performance Measures	• Time to complete process = ___ months; ___ weeks • Accuracy of information = ___ % • Accessibility of information for terminating contract = ___ months; ___ weeks • Consistency of decisions and disposition = ___ % • Error rate = __% or less

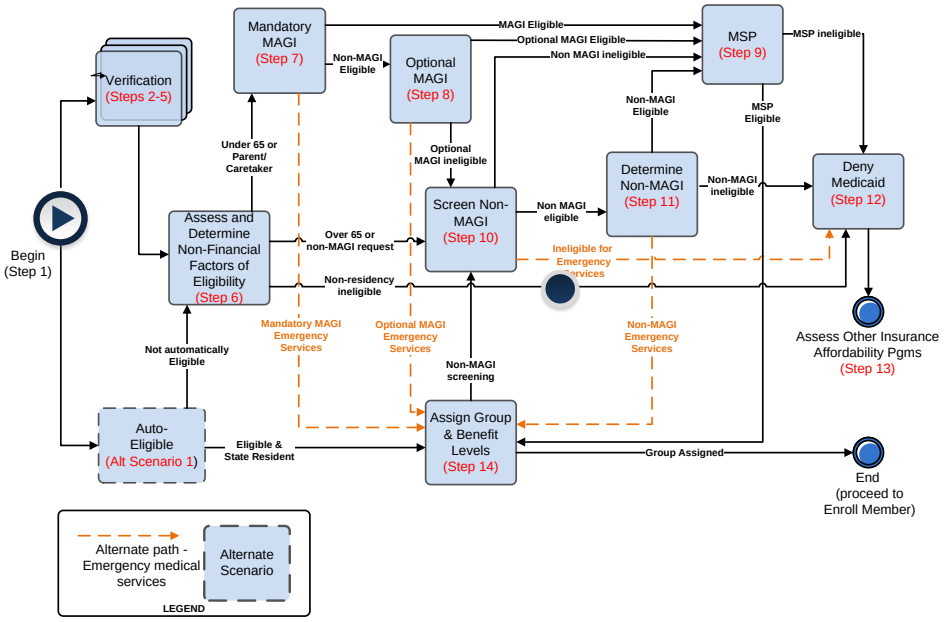
ELIGIBILITY AND ENROLLMENT MANAGEMENT

NOTE: This DRAFT MITA 3.0 Supplement should not be considered final and is subject to change. CMS will finalize the supplement after a 30-day review period for state comment.

Member Enrollment

Determine Member Eligibility

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**
Description	The ***Determine Member Eligibility*** business process is responsible for the operational aspects of determining if an applicant is eligible for Medicaid or potentially eligible for other insurance affordability programs (e.g., Advance Premium Tax Credits through the Health Insurance Marketplace, Children's Health Insurance Program [CHIP], and/or Basic Health Program [BHP]). An applicant submits an application or a member updates account information via online, in person, over the phone, by mail, or by other commonly available electronic means. The business process checks for status (e.g., new, resubmission, redetermination, duplicate, or referral from the Health Insurance Marketplace (HIX) or other agencies administering insurance affordability programs) and verifies applicant information in accordance with the policies established. The business process determines eligibility based on modified adjusted gross income (MAGI) or on a basis other than MAGI methods including group/category (e.g., parents/caretaker relatives, pregnant women, children under 19 year of age). The business process also assigns a Medicaid ID, associates the benefit packages, and produces notifications for coordinated communications. When required, the State Medicaid Agency (SMA) submits applicant or member eligibility information and/or eligibility determination to other agencies administering insurance affordability programs and CMS information systems. This business process could be a Shared Eligibility Service between the Medicaid Agency, the Health Insurance Marketplace (HIX), and other State-based insurance affordability programs such as CHIP or BHP. **NOTE: Applications and Accounts:** An individual seeking eligibility for enrollment in an insurance affordability program completes and submits an application on-line, in person, over the phone, by mail, or paper application for verification and eligibility determination. Accepted application data is managed in an "electronic account" (as defined in 42 CFR 435.4) by the receiving program to enable access to this information during the verification and eligibility determination processes, as well as after the conclusion of the process to support change reporting and for other purposes.
Trigger Event	Interaction-based Trigger Events: • Receipt of referral of Medicaid applicant from the Health Insurance Marketplace (HIX), CHIP or BHP. • Receipt of individuals based on Auto-Eligibility, such as Deemed Newborns, SSI/1634, Title IV-E Foster Care, Adoptions and Guardianship. Environment-based Trigger Events: • Receive application via online, in person, over the phone, by mail, or other commonly available electronic means. • Periodic timetable (e.g., annual) for existing member who is due for redetermination

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**
	of eligibility. Applicant or authorized representative responds to renewal form by providing information via online, in person, over the phone, by mail, or other commonly available electronic means. • Receive modification to application from applicant or authorized representative or change report from member or authorized representative or from other data sources.
Result	• Eligibility is determined as approved, continued, denied, terminated, suspended, or pended for additional information and review. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	Full Eligibility Determination or Renewal **High Level Mapping to Determine Member Eligibility**  1. **START:** a. Receive completed application from applicant via online or by other commonly available electronic means, in person, over the phone, or by mail, or receive initial assessment from another insurance affordability program; or **NOTE:** The use of the internet website (online portal) will include not only field-level edits but will also perform data verification, as appropriate, throughout the application preparation and update process as well as determine if the account already exists (in the Marketplace, Medicaid and/or CHIP) and the status of application/account. b. Initiate renewal process when member's response to renewal notice is received or when changes to existing member account is updated with new information from other data source(s); or c. Receive information about an auto-eligible. Go to Alternate Scenario 1.

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**
	Verifications **NOTE:** Conduct steps 2, 3, and 4 simultaneously or in any order in accordance with State's established verification plan (42 CFR 435.945(j)). Financial Information will be verified if financial assistance is requested and the information is provided. Verify asset information if applicant has requested to be evaluated for Medicaid eligibility based on a non-MAGI group that requires an asset test. **Verify Non-Financial Requirements** 2. Verify the following non-financial requirements for eligibility determination. CMS expects the State to use Federal or local electronic data sources as available. The State may also rely on self-attestation for all eligibility criteria other than citizenship and satisfactory immigration status, as described in Section H of the preamble of the Medicaid Final Eligibility Rule. Resolve discrepancies by identifying non-financial factors that do not meet verification based on data matches or self-attestation and request additional information as necessary. a. Verify State residency. b. Verify the SSN. c. Verify citizenship or satisfactory immigration status. d. If applicable, verify whether individual is an American Indian/Alaska Native, in accordance with established procedure. **Note**: American Indian/Alaska Native status is not a condition of eligibility for Medicaid. e. If applicable, verify individual incarceration status. **Note:** Incarceration status is not a condition of eligibility for Medicaid. f. Pregnancy. **Note**: The Agency must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation. g. Age, date of birth and household size. **Note**: The Agency may accept self-attestation of date of birth and the individuals that comprise an individual's household or may verify through other reasonable verification procedures. h. Other non-financial factors (e.g., full-time student status, categorical eligibility as a parent or other caretaker relative as defined in 42 CFR 435.4). **Verify Other Health Coverage** 3. Verify enrollment in other health coverage, including Medicare, other public programs, as well as private coverage. **Note:** Enrollment in private health coverage is not a barrier to Medicaid eligibility except as an optional targeted low-income child or as a woman needing treatment for breast or cervical cancer. Medicare recipients are exempted from certain eligibility groups, while Medicare coverage is required for certain other eligibility groups. **Verify Financial Information** 4. Verify financial information (42 CFR 435.948) provided by the applicant or member,

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**

including:

a. Information related to wages, net earnings from self-employment, and unearned income and resources with the appropriate source (e.g., State Wage Information Collection Agency (SWICA), IRS, Social Security Administration, State unemployment compensation, and State-administered supplementary payment programs)

b. Information related to the eligibility or enrollment from the Supplemental Nutrition Assistance Program, the State program funded under part A of Title IV of the Act, and other insurance affordability programs.

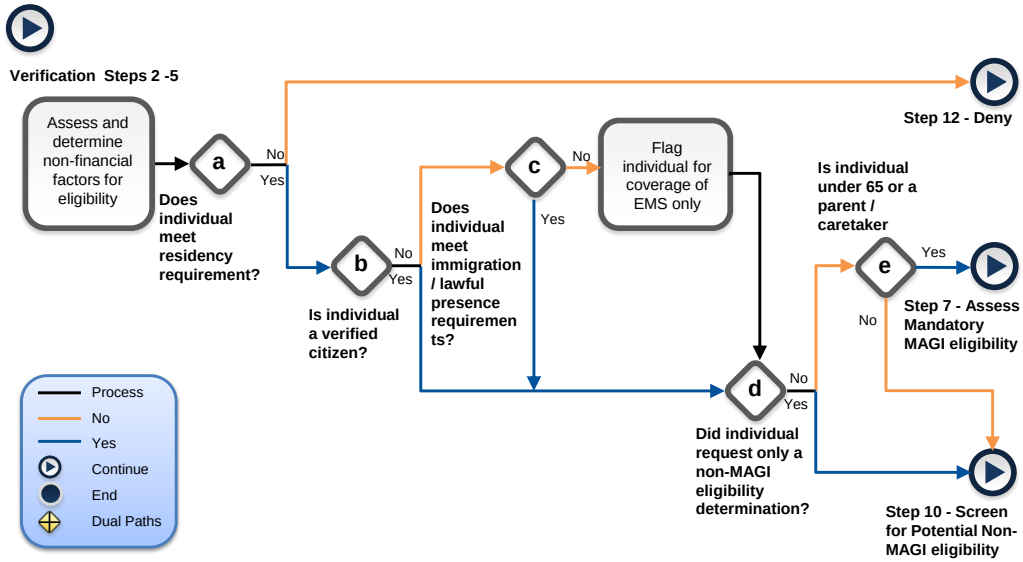
Verify Asset Information

5. Verify asset information if applicant has requested to be evaluated for Medicaid eligibility based on a non-MAGI group that requires an asset test.

Determine Individual Medicaid Eligibility

Assess and Determine Individual Non-Financial Factors of Eligibility

Step 6 - Assess Non-Financial Factors



6. Use results from verification processes and other application data to assess and determine whether the individual meets the non-financial factors for eligibility:

a. If individual meets residency requirement, go to Step 6b. If not, go to Step 12 to deny Medicaid.

b. If individual is a verified citizen, go to Step 6d. If not, continue to Step 6c.

c. If individual meets satisfactory immigration status requirements, go to Step 6d. If not, flag individual for coverage of emergency medical services and proceed to Step 6d.

d. If individual is requesting only a non-MAGI eligibility determination, go to

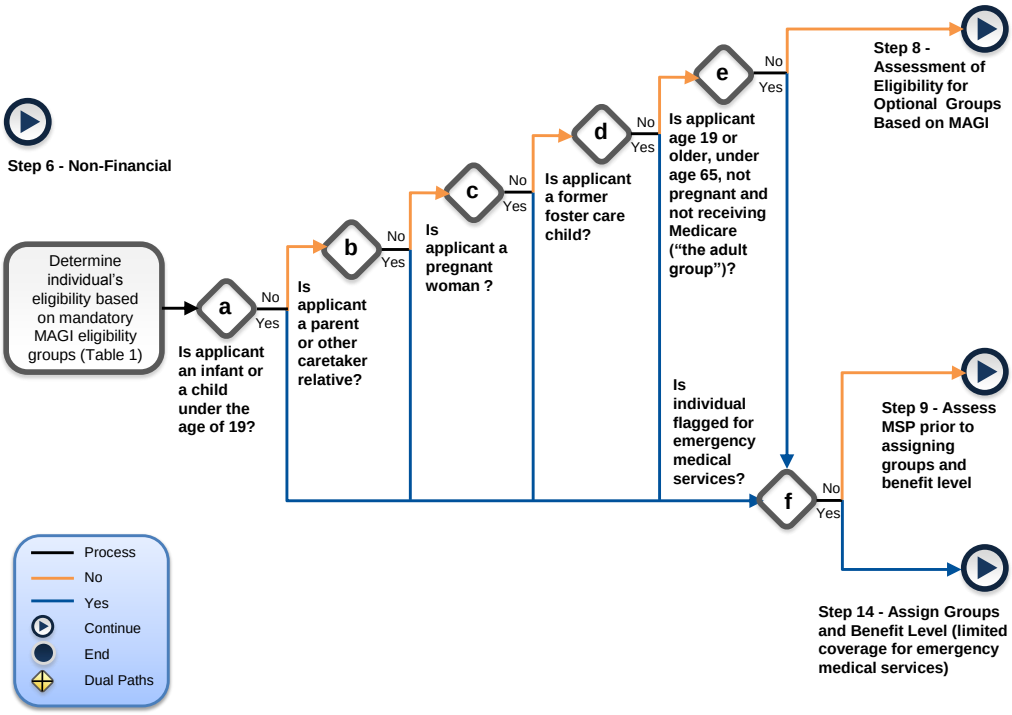
EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**

Step 10 to screen for non-MAGI. If not, go to Step 6e.

e. If individual is under age 65 or a parent / caretaker, go to Step 7 to assess and determine eligibility for mandatory MAGI. If not, go to Step 10 to screen for potential non-MAGI eligibility.

Assess and Determine Eligibility for Mandatory MAGI Eligibility Groups

Step 7 - Mandatory MAGI



7. Determine individual's eligibility based on mandatory MAGI eligibility groups. **Note:** See Mandatory MAGI Groups Table 1.

   a. Assess whether the applicant/member is eligible as an infant or a child under the age of 19. (42 CFR 435.118). If yes, go to Step 7f. If not, go to Step 7b.

   b. Assess whether the applicant/member is eligible as a parent or other caretaker relative (42 CFR 435.110). If yes, go to Step 7f. If not, go to Step 7c.

   c. Assess whether the applicant/member is eligible as a pregnant woman (42 CFR 435.116). If yes, go to Step 7f. If not, go to Step 7d.

   d. Assess whether the applicant/member is eligible as a former foster care child (no income test) (42 CFR 435.150). If yes, go to Step 7f. If not, go to Step 7e.

   e. Assess whether individual is age 19 or older and under age 65, not

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Determine Member Eligibility	
Item	**Details**

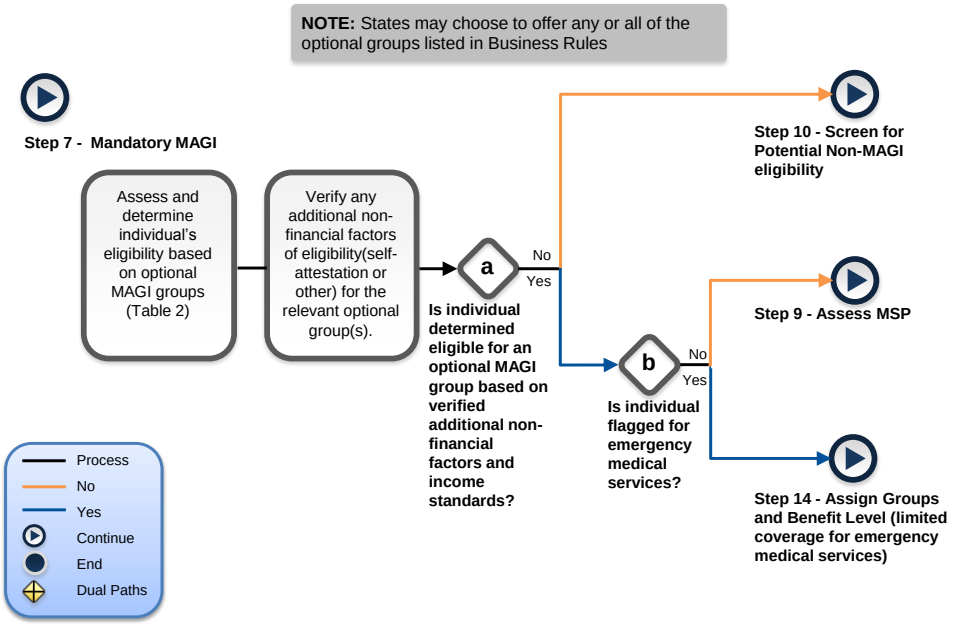
pregnant, is not receiving Medicare (42 CFR 435.119) and is therefore eligible as part of "the adult group". If yes, go to 7f , if not, go to Step 8 to assess individual for optional MAGI groups.

f. If individual is flagged for emergency medical services only, go to Step 14 to assign groups and benefit level (limited coverage for emergency services). If not, go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility prior to assigning groups and benefit level *(however, if the individual is determined eligible as part of the "adult group" they will pass through Step 9 to Step 14).*

Table 1:	Mandatory MAGI Groups
435.118	Less Than 19
435.110	Parent / Caretaker Relative
435.116	Pregnant
435.150	Former Foster Care Child
435.119	Adult Group

Assess and Determine Eligibility for Optional Eligibility Groups Based on MAGI

Step 8 - Optional MAGI



8. Assess and determine individual's eligibility based on optional MAGI groups. States may choose to offer any or all of the optional groups listed in Table 2. Verify (by self-attestation or otherwise) any additional non-financial factors of eligibility for the relevant optional group(s).

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Determine Member Eligibility	
Item	**Details**

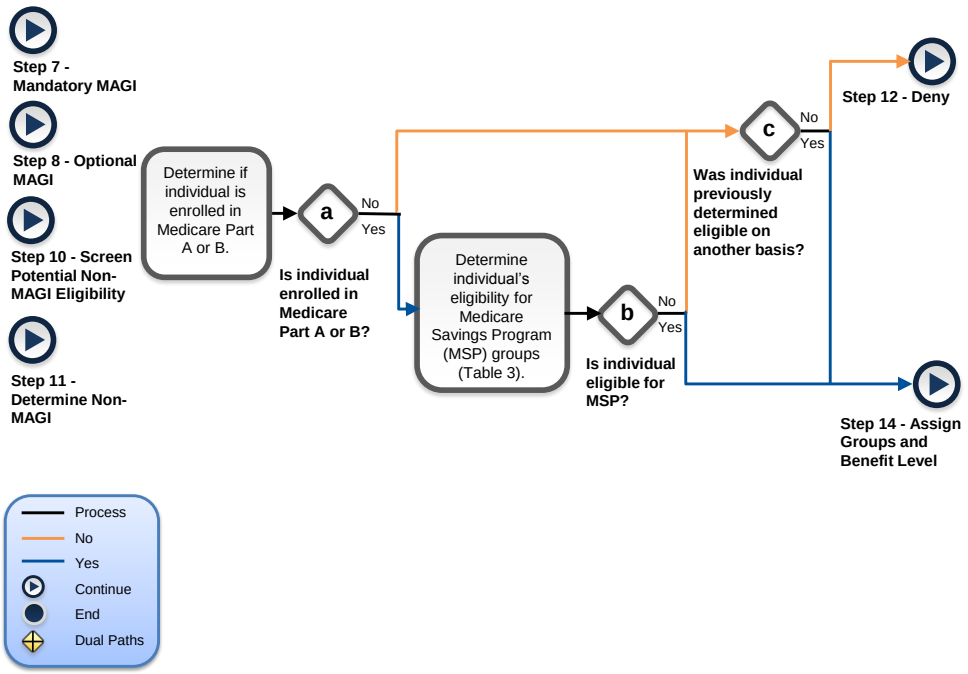
a. If an individual meets non-financial factors and income standards for an optional MAGI group, go to Step 8b. If not, go to Step 10 to screen for potential non-MAGI eligibility.

b. If individual is flagged for emergency medical services only, go to Step 14 to assign groups and benefit level (limited coverage for emergency services). If not, go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility prior to assigning groups and benefit level.

Table 2:	Optional MAGI Groups
435.220	Optional Parent / Caretaker Relative
435.222	Optional Reasonable Classifications of Children <21
435.227	Optional State Adoption Assistance Children <21
435.229	Optional Targeted Low-Income Children <19
435.226	Optional Chafee Independent Foster Care Adolescents <21
435.218	Optional Individuals Above 133% FPL <65
1902(a)(10)(F)	Optional COBRA Continuation Group
435.215	Optional Tuberculosis Group (TB)
435.214	Optional Family Planning Group

Assess and Determine Medicare Savings Program (MSP) eligibility

Step 9 - Assess and Determine MSP



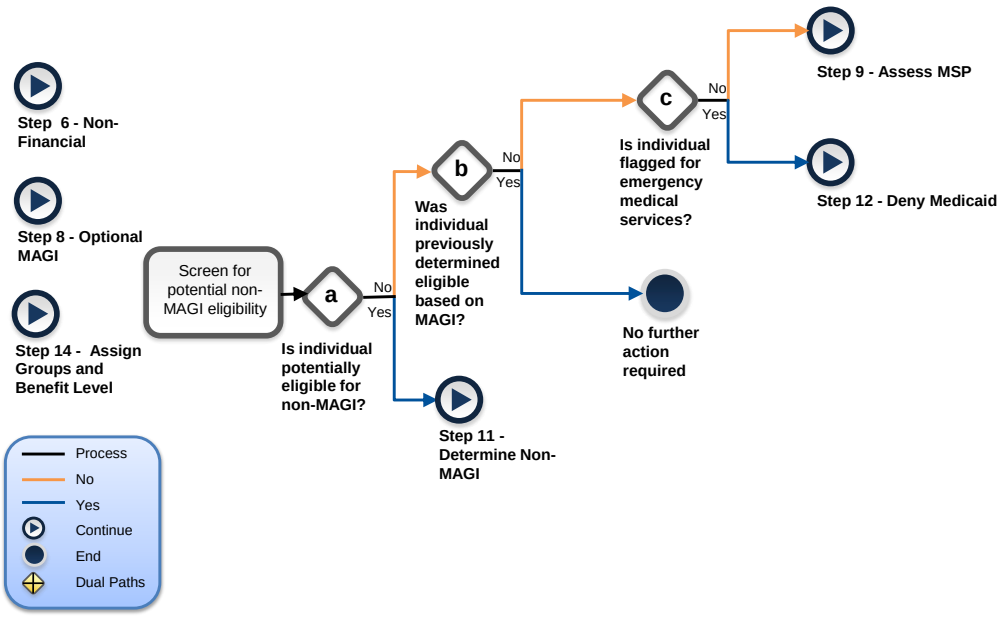
EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**

9. Prior to approving or denying Medicaid eligibility, assess and determine if individual is eligible for a Medicare Savings Program. **Note:** See Medicare Savings Program Groups Table 3.
    a. Determine if individual is enrolled in Medicare Part A or B. If enrolled in Medicare Part A or B, go to Step 9b. If not, go to Step 9c.
    b. Determine if individual is eligible for a Medicare Savings Program Group. If the individual is eligible based on MSP criteria, go to Step 14 to assign groups and benefit level. If not, go Step 9c.
    c. If individual was previously determined eligible on another basis, go to Step 14 to assign groups and benefit level. If not, go to Step 12 to deny Medicaid.

Table 3:	Medicare Savings Program Groups
1902(a)(10)(E)(i), 1905(p)	Qualified Medicare Beneficiary (QMB)
1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii)	Specified Low Income Medicare Beneficiary (SLMB)
1902(a)(10)(E)(iv), 1905(p)(3)(A)(ii)	Qualifying Individuals (QI)
1902(a)(10)(E)(ii), 1905(s), 1905(p)(3)(A)(i)	Qualified Disabled and Working Individuals (QDWI)

Screen for Potential non-MAGI eligibility

Step 10 - Screen Potential Non-MAGI Eligibility



EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**

10. Screen individual for potential non-MAGI eligibility based on application information:

    a. If individual has requested a non-MAGI eligibility determination or application data indicates potential eligibility for non-MAGI (e.g. indicators of disability, blindness, aged, or a need for long term care services), go to Step 11 to determine eligibility on basis other than MAGI. If not, go to Step 10b.

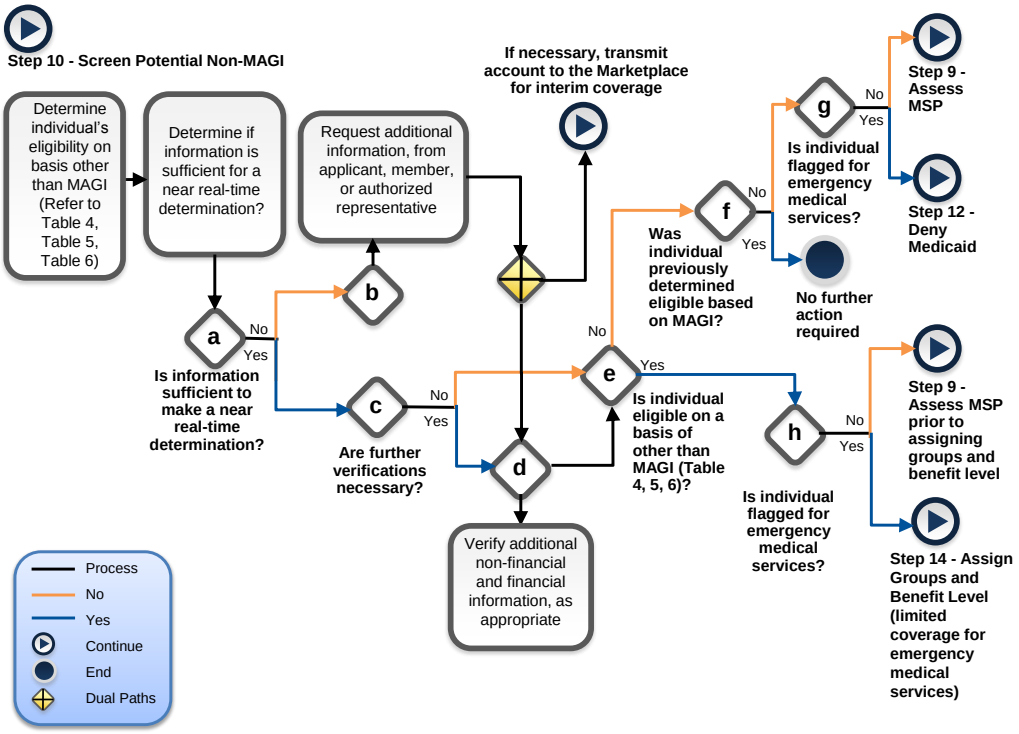
    b. If individual was previously determined eligible based on MAGI, no further action required. If not, go to 10c.

    c. If individual is flagged for emergency medical services only, go to Step 12 to deny Medicaid. If not go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility

    NOTE: Although the individual was flagged for emergency medical services, the individual has failed all other income tests and the screening for potential non-MAGI and should be denied coverage for emergency medical services.

Determine Eligibility on Basis Other than MAGI

Step 11 - Determine Eligibility on Basis Other than MAGI



11. Determine individual's eligibility on basis other than MAGI. **Note:** See Optional Non-MAGI Groups Table 4, Age, Blind, Disabled (ABD) Optional Coverage Groups Table 5 and Medically Needy Groups Table 6.

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**

a. Determine if information is sufficient for a near real-time determination. If yes, go to Step 11c. If not, go to Step 11b.

b. Request additional information from applicant, member, or authorized representative (e.g., electronic verifications for former foster care children). Proceed to Step 11d; and if necessary, transmit account (*Manage Member Information*) to the Marketplace for interim coverage.

c. Determine if further verifications are necessary. If yes, go to Step 11d. If not, go to Step 11e.

d. Verify additional non-financial and financial information (income and assets), as appropriate, according to methodologies for applicants or members who may be eligible on basis other than MAGI. Go to Step 11e.

e. If individual is eligible on a basis of other than MAGI, go to Step 11h. If not, go to Step 11f.

f. If individual was previously determined eligible based on MAGI, no further action is required. If not, go to 11g.

g. If individual is flagged for emergency medical services only, go to Step 12 to deny Medicaid. If not, go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility.

NOTE: Although the individual requested coverage for emergency services, the individual has failed all income tests (MAGI and non-MAGI) and should be denied Medicaid..

h. If individual is flagged for emergency medical services only, go to Step 14 to assign groups and benefit level (limited coverage for emergency services). If not, go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility prior to assigning groups and benefit level.

Table 4:	**Non MAGI Optional Groups**
435.213	Optional Individuals with Breast / Cervical Cancer 21-64 (No Income Test)
435.222	Optional Reasonable Classifications of Children <21 (No Income Test)
435.227	Optional State Adoption Assistance Children <21 (No Income Test)
435.226	Optional Chafee Independent Foster Care Adolescents <21 (No Income Test)
See Table 5	Aged, Blind or Disabled
435.236	Special Income – Level Group
435.217	Individual eligible for Home and Community based services using institutional rules

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**

1902(a)(10)(A)(ii)(XXII), 1915(i)	Individual eligible for Home and Community based services (150% FPL)
1902(a)(10)(A)(ii)(XXII), 1915(i)	Individual eligible for Home and Community based services Special Income Level

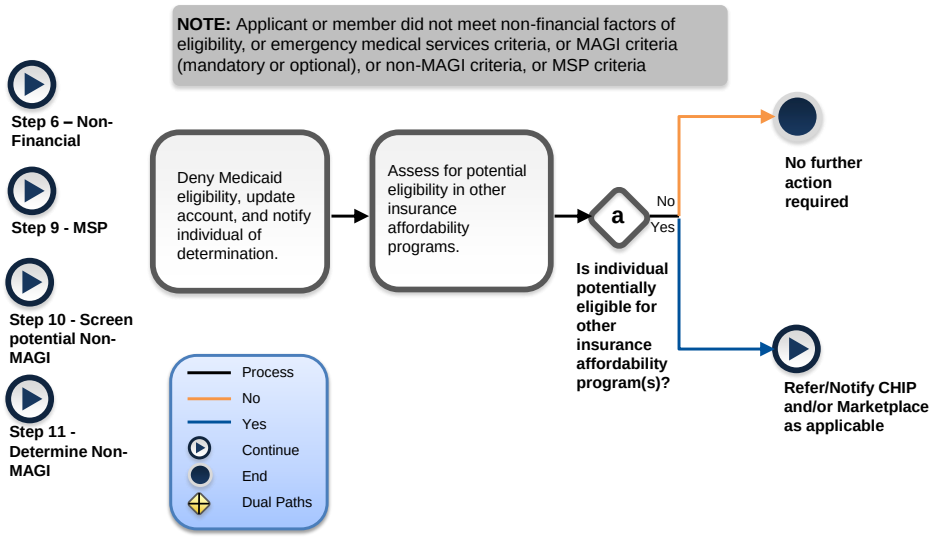
Table 5:	ABD Groups
435.210	Individuals Eligible for but not Receiving Cash
435.211	Individuals Eligible for Cash except for Institutionalization
435.212	Individuals in HMOs Guaranteed Eligibility
1934	Individuals participating in a PACE program under Institutional Rules
1902(a)(10)(A)(ii)(VII), 1905(o)	Individuals Receiving Hospice Care
435.232	Optional State Supplemental Recipients - 1634 States, and SSI Criteria States with 1616 Agreements
435.234	Optional State Supplemental Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements
1902(e)(3)	Qualified Disabled Children under 19 (TEFRA Kids)
1902(a)(10)(A)(ii)(X), 1902(m)(1)	Poverty Level Aged or Disabled
1902(a)(10)(A)(ii)(XIII)	Work Incentives Eligibility Group (BBA)
1902(a)(10)(A)(ii)(XV)	Ticket to Work Basic Group (TWWIIA)
1902(a)(10)(A)(ii)(XVI)	Ticket to Work Medical Improvements Group (TWWIIA MI)
1902(a)(10)(A)(ii)(XIX)	Family Opportunity Act for Children with Disabilities (FOA)

Table 6:	Medically Needy Groups
435.301	Less than 18
435.308	18-20
435.301	Pregnant Women
435.310	Parent / Caretaker Relative
435.320, 435.330	Aged
435.322, 435.330, 435.340	Blind
435.324, 435.330, 435.340	Disabled

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**

Deny Medicaid and Assess for Other Insurance Affordability Programs

Step 12 &13 - Deny Medicaid & Assess for Other Insurance Affordability Program



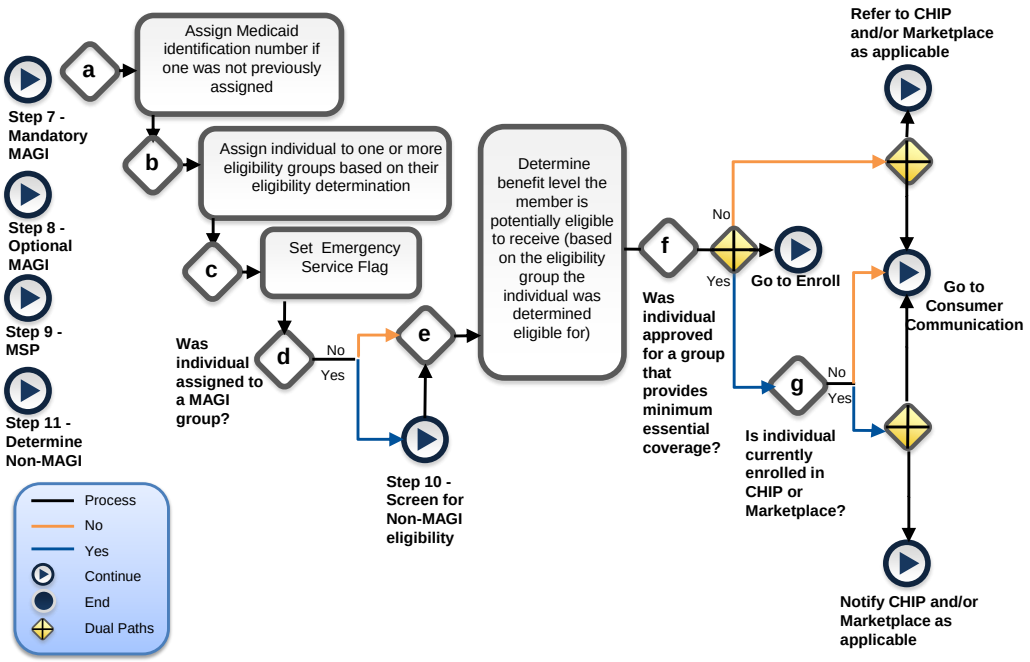
12. Deny Medicaid eligibility, update account *(ME-01 Manage Member Information*) and notify individual (*Manage Applicant and Member Communication*) of determination.
13. Assess individual for other Insurance Affordability Programs
    a. Assess for potential eligibility in other insurance affordability programs. If individual is potentially eligible for other insurance affordability program refer/notify CHIP and/or Marketplace as applicable. *(Manage Member Information).* If not, no further action required.

Assign Groups and Benefit Levels

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**

Step 14 - Assign Group(s) and Benefit Level

NOTE: Individual can be assigned to an MSP group and another eligibility group (i.e. MAGI or Non-MAGI). However, an individual cannot be assigned to both a MAGI and non-MAGI group simultaneously. An individual also cannot be assigned to an MSP group and receive coverage for emergency services simultaneously.



14. Assign group and benefit levels as appropriate.

    a. Assign Medicaid identification number to member if one was not previously assigned.

    b. Assign individual to one or more eligibility groups based on their eligibility determination: MAGI group, Non-MAGI group, and/or Medicare Savings Program (MSP) group.

    NOTE: Individual can be assigned to a Medicare Savings Program (MSP) group and another eligibility group (i.e. MAGI or non-MAGI). However, an individual cannot be assigned to both a MAGI and non-MAGI group simultaneously. An individual also cannot be assigned to an MSP group and receive coverage for emergency services simultaneously.

    c. Flag individuals determined eligibile for emergency medical services.

    NOTE: Individuals eligible for coverage of emergency medical services will receive a limited benefit plan.

    d. If the individual was determined eligible for MAGI go to Step 10 to screen individual for non-MAGI eligibility and proceed to 14e. If not, the individual was determined eligible based on non-MAGI, continue to 14e.

    e. Determine the health benefit level the member is eligible to receive and then proceed to 14f.

    f. Go to Enroll member, to enroll individual in the appropriate eligibility

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**
	group(s); and determine if individual was approved for a group that provides minimum essential coverage. If yes, individual is approved for a group that provides minimum essential coverage, go to 14g. If no, refer to CHIP and/or Marketplace as applicable (Manage Member Information); and notify individual (Manage Applicant and Member Communication) of determination. g. If individual is currently enrolled in CHIP or the Marketplace, notify CHIP and/or the Marketplace as applicable of individual's enrollment in Medicaid for potential disenrollment; and notify individual (Manage Applicant and Member Communication) of determination. If not currently enrolled in CHIP or Marketplace, notify individual of determination. 15. **END** **Alternate Scenario 1 –** Auto Eligible 1. Determine if applicant or member is automatically categorically eligible without a requirement for financial eligibility (e.g., SSI recipients, IV-E children, deemed newborns). Assess if the individual is a State resident. If so, approve Medicaid eligibility and go to step 14. If not, go to step 6. **Note:** See Mandatory Auto Eligible Groups Table 7.

Table 7:	**Auto-Eligible Groups** ***(Not inclusive of Closed Groups)***
1902(e)(4), 435.117	Deemed Newborns
1902(a)(10)(A)(i)(II), 435.120	SSI in a 1634 State
1902(a)(10)(A)(i)(I), 435.145	Title IV-E Foster Care, Adoption and Guardianship
1902(a)(10)(A)(i)(II), 435.120	Individual Receiving SSI
1902(a)(10)(A)(i)(II), 1902(f), 435.121	Aged, Blind, and Disabled in 209(b) States
1619(b), 1902(10)(A)(i)(II), 1905(q)	Working Disabled Individuals
1634(c)	Disabled Adult Children
435.130	Individuals Receiving Mandatory State Supplements
435.135	Individuals who would be eligible for SSI/SSP but for OASDI COLA increases since April, 1977
1634(b), 435.137	Disabled widows and widowers ineligible for SSI due to increase in OASDI

Shared Data	Member data store including demographics and enrollment information

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**
	Plan data store Coordination of Benefits data store
Predecessor	***Receive Inbound Transaction*** ***Manage Applicant and Member Communication***
Successor	***Send Outbound Transaction*** ***Enroll Member*** ***Manage Applicant and Member Communication*** ***Manage Member Information*** ***Manage Performance Measures***
Constraints	The ***Determine Member Eligibility*** business process must be in accordance with federal rules for standard enrollment application and eligibility determination. The State must use minimum and maximum income standards established by the Agency in the Medicaid State Plan.
Failures	A member eligibility application may fail at the following steps: • Duplicate or cancelled application. • Applicant or member fails to provide additional information as requested. • Required fields missing or not correct. • Verification with internal or external sources is not authenticated. **Note**: The ***Determine Member Eligibility*** business process does not fail because the applicant is ineligible.
Performance Measures	Performance measures will be addressed under separate guidance. TBD

Enroll Member

EE Member Enrollment	
Enroll Member	
Item	**Details**
Description	The ***Enroll Member*** business process receives eligibility information from the ***Determine Member Eligibility*** business process, the Marketplace, or any insurance affordability program (e.g., Children's Health Insurance Program [CHIP] or Basic Health Program [BHP]). It determines additional qualifications for enrollment in health benefits for which the member is eligible, and produces notifications for coordination of communications to the member, provider, and to the insurance affordability programs. The Marketplace, Agency or enrollment brokers may perform some or all of the steps in this business process.

EE Member Enrollment	
Enroll Member	
Item	**Details**
	NOTE: There is a separate business process for Disenroll Member. **NOTE: Applications and Accounts:** An individual seeking eligibility for enrollment in a qualified health plan through the Marketplace, advance premium tax credits, cost-sharing reductions, Medicaid, CHIP or BHP completes and submits an on-line, telephone, in-person, or paper application for verification and eligibility determination. The Marketplace or insurance affordability program accepts application data and manages information in an "account" by the receiving program to enable access to this information during the verification and eligibility determination processes, as well as after the conclusion of the process to support change reporting and for other purposes.
Trigger Event	Interaction-based Trigger Events: • Receive enrollment determination from ***Determine Member Eligibility*** business process. Environment-based Trigger Events: • Receive presumptive eligibility determination from provider.
Result	• Enroll eligible member in Medicaid health plans and health benefits. • Alert sent to ***Manage Applicant and Member Communication*** to send welcome package, health plan, if applicable, health benefits, and identification cards. • Alert sent to send enrollment information to contractor. • If applicable, alert sent to ***Manage Member Premium Payment*** for premium payment arrangement. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive eligibility determination to enroll member. 2. Agency associates member with elected health plan, if applicable, and health benefits. 3. Send alert to send enrollment information to contractor. 4. Send alert to send dual eligibility enrollment information to Medicare. 5. If applicable, send alert to ***Manage Member Premium Payment*** for premium payment arrangement. 6. **END:** Send notification to member with welcome package and identification cards via ***Manage Applicant and Member Communication*** business process.
Shared Data	Plan data store including policy information Health Benefit data store including benefit package and benefit information Member data store including demographics and application information

EE Member Enrollment	
Enroll Member	
Item	**Details**
	Provider data store including provider network information Contractor data store including provider network information
Predecessor	**Receive Inbound Transaction** ***Determine Member Eligibility***
Successor	**Send Outbound Transaction** ***Manage Applicant and Member Communication*** ***Manage Member Information***
Constraints	State may have different programs and different enrollment criteria, or may use enrollment brokers for some or all of the business process steps. States may require non-HIPAA covered contractors to use the ANSI X12 834 Benefit Enrollment and Maintenance transaction or may rely on State specific formats for contractor notification.
Failures	• Alert fails to reach member or contractor.
Performance Measures	• Time to complete process: successful applicant is enrolled within __ days • Accuracy of enrollment = ___% • Consistency of enrollments and disposition = ___% • Error rate is __% or less

Disenroll Member

EE Member Enrollment	
Disenroll Member	
Item	**Details**
Description	The ***Disenroll Member*** business process is responsible for the termination of a member's enrollment in a health plan or health benefit. An enrollment termination may occur due to: • A member is no longer eligible based on redetermination of Medicaid eligibility either on an annual basis or as a result of change reporting during the coverage year. • Upon receipt of a notification of incarceration, SMA may suspend eligibility (if State policy indicates to do so). • A member is no longer eligible based on change in residence. • The denial of eligibility for a program that bases eligibility on health status (e.g., an AIDS Drug Assistance Program (ADAP), Home and Community Based

EE Member Enrollment	
Disenroll Member	
Item	**Details**

	Services, a Maternity Case Management, etc.) **NOTE**: The other program may have a funding source separate from Medicaid.
	• A member submits a disenrollment request.
	• Disenrollment request from a provider or contractor due to issues with the member such as moving out of service area, fraud and abuse, disruptive behavior, non-compliance, or death.
	• Member is deceased.
	• Receive disenrollment request from ***Manage Compliance Incident Information*** business process for continued failure to make payments.
	• Receive disenrollment request from ***Determine Adverse Action Incident*** due to fraudulent or abuse activity.
	• The provider or contactor has a change of status or termination that requires a mass disenrollment of members.
	• A health plan or health benefit has a change that requires a mass disenrollment of members.
	• A member modifies their Manage Care Organization (MCO), Primary Care Case Manager (PCCM), or waiver provider:
	  o Member changes information during Open Enrollment period.
	  o As permitted by State rules, such as the following:
	  ✓ Change in member's residence.
	  ✓ A provider whom the member has chosen no longer contracts with current program or MCO.
	  ✓ Medicaid terminates the contract with the member's MCO or PCCM.
	  ✓ Member successfully appeals auto-assignment.
	  ✓ The member has issues with the MCO, PCCM, or waiver provider that may affect quality of care.
	NOTE: Enrollment brokers may perform some of the steps in this business process.

Trigger Event	Interaction-based Trigger Events: • Receive disenrollment request from insurance affordability program. • Receive disenrollment request from ***Manage Compliance Incident Information*** business process for continued failure to make payments. • Receive disenrollment request from ***Determine Adverse Action Incident*** business process to remove member from services. Environment-based Trigger Events: • Receive disenrollment request from member, provider or contractor. • Change in member's information that no longer meets eligibility criteria.

EE Member Enrollment	
Disenroll Member	
Item	**Details**
	• Member modifies their selection of provider, MCO, PCCM or waiver provider. • Provider or contractor modifies network information that alters their service offering. • Modifications in health plan or health benefit that alters service offering.
Result	• Member disenrolled from specific health plans and health benefits. • Member disenrolled from elected provider or contractor. • Alert sent to ***Manage Applicant and Member Communication*** business process to notify member of disenrollment and fair hearing/procedural rights. • Alert sent to ***Perform Population and Member Outreach*** business process to notify affected members with the termination of health plan, health benefit, a provider or a contractor. • Alert sent to send disenrollment information to insurance affordability program. • If applicable, alert sent to ***Manage Member Premium Payment*** to stop premium payment arrangement. • If applicable, alert sent to ***Manage Case Information*** to discontinue care management. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive disenrollment request. 2. Agency logs disenrollment request including source of disenrollment and type of request. 3. Validate request meets State disenrollment rules. 4. If applicable, terminate enrollment in Medicaid health plans and/or health benefits. 5. If applicable, enroll member in alternative health plans and/or health benefits. 6. If applicable, terminate enrollment with provider or contractor. 7. If applicable, enroll member with alternative provider or contractor. 8. Send alert to ***Manage Applicant and Member Communication*** business process to notify member of disenrollment and procedural rights. 9. Send alert to ***Perform Population and Member Outreach*** business process to notify affected members with the termination of health plan, health benefit, a provider or a contractor. 10. If applicable, send alert to ***Manage Member Premium Payment*** to stop premium payment arrangement. 11. If applicable, send alert to ***Manage Case Information*** to discontinue care management.

EE Member Enrollment	
Disenroll Member	
Item	**Details**
	12. Send alert to send disenrollment information to insurance affordability program. 13. **END**
Shared Data	Member data store including demographics and eligibility information Plan data store including health policy information Health Benefit data store including benefit package and benefit information Provider data store including provider network information Contractor data store including provider network information
Predecessor	**Receive Inbound Transaction** ***Determine Member Eligibility*** ***Manage Member Information*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Provider Information*** ***Manage Contractor Information*** ***Manage Compliance Incident Information*** ***Determine Adverse Action Incident***
Successor	**Send Outbound Transaction** ***Manage Member Information*** ***Manage Applicant and Member Communication*** ***Manage Contractor Communication*** ***Manage Provider Communication*** ***Perform Population and Member Outreach***
Constraints	Programs have different termination criteria.
Failures	• Duplicate disenrollment requests — Disregard second request. • Required fields missing or not correct — Request additional or corrected information from member, provider, contractor, Marketplace, or insurance affordability program. • Denial of member request for disenrollment from one health plan, health benefit, provider or contractor due to modifications in circumstances, such as residence, health status, or provider access issues because the request does not meet State rules or the member is not eligible for enrollment in an alternative program. • Denial of program, provider, or contractor request to disenroll the member (e.g.,

EE Member Enrollment	
Disenroll Member	
Item	**Details**
	modified residence, health status or compliance issues because the request does not meet State rules).
Performance Measures	• Time to complete process: member is disenrolled within __ days or __ minutes • Accuracy of decisions • Consistency of decisions and disposition = ___% • Error rate is __% or less

Inquire Member Eligibility

EE Member Enrollment	
Inquire Member Eligibility	
Item	**Details**
Description	The ***Inquire Member Eligibility*** business process receives requests for eligibility verification from Health Insurance Marketplace (HIX), authorized providers, programs or business associates; performs the inquiry; and prepares the Eligibility, Coverage or Benefit Information response. The response information includes but is not limited to benefit status, explanation of benefits, coverage, effective dates, and amount for co-insurance, co-pays, deductibles, exclusions and limitations. The information may include details about the Medicaid health plans, health benefits, and the provider(s) from which the member may receive covered services. **NOTE:** This business process does not include Member requests for eligibility verification. Member initiated requests are handled by the ***Manage Member Information*** business process.
Trigger Event	Interaction-based Trigger Events: • Receive eligibility inquiry from the Health Insurance Marketplace (HIX) via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 Inquiry transaction using the Council for Affordable Healthcare (CAQH®) Committee on Operating Rules for Information Exchange (CORE®) Phase 1 and 2 Rules. • Receive eligibility inquiry from the provider via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 inquiry transaction using CAQH CORE Rules. • Receive eligibility inquiry from the pharmacist via National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Eligibility transaction. • Receive eligibility inquiry via Automated Voice Response System (AVRS).

EE Member Enrollment	
Inquire Member Eligibility	
Item	**Details**
Result	• Response sent to Health Insurance Marketplace (HIX) via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules. • Response sent to provider via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules. • If applicable, response sent to AVRS with eligibility information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive eligibility verification request via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 inquiry transaction using CAQH CORE Rules. 2. Agency logs eligibility verification request. 3. Validate requester's authorization to receive requested information. 4. Find requested member's eligibility information. 5. Agency logs response. 6. If applicable, send response to AVRS with eligibility information. 7. **END:** Send response to requestor via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules.
Shared Data	Member data store including demographics, eligibility and enrollment information
Predecessor	**Receive Inbound Transaction**
Successor	**Send Outbound Transaction**
Constraints	Eligibility verification request can ask for verification at the categorical, health plan, provider, or health benefit level per X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 Inquiry depending on trading partner agreements. Agency must use Council for Affordable Healthcare (CAQH®) Committee on Operating Rules for Information Exchange (CORE®) Phase 1 and 2 Rules.
Failures	• Unauthorized requestor cannot receive requested information at the level asked (e.g., eligibility for mental health program); however, requester may receive more general information such as verification of eligibility for health plan or health benefit coverage. **NOTE:** Responses that a member is not eligible or is not active are not failures to process the request.

EE Member Enrollment	
Inquire Member Eligibility	
Item	**Details**
Performance Measures	• Time to verify eligibility and generate response: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Response Accuracy = ___% • Error rate = __% or less • Usage of CORE certified response = ____ % of the time

Determine Provider Eligibility

EE Provider Enrollment	
Determine Provider Eligibility	
Item	**Details**
Description	The ***Determine Provider Eligibility*** business process collects enrollment application from Health Care Provider, or collects re-enrollment or revalidation information from existing Provider. The business process verifies syntax and semantic of information, checks status tracking (e.g., initial, modification, duplicate, cancelation), requests additional information when necessary, determines screening level (i.e., limited, moderate or high), verifies applicant information with external entities, collects application fees, and notifies Health Care Provider or Provider of enrollment eligibility determination (e.g., accepted, denied, or suspended). ***Determine Provider Eligibility*** business process sends enrollment determination alert signals to subscribing business processes ***Enroll Provider*** and ***Manage Provider Communication. Determine Provider Eligibility*** sends alert signal to ***Manage Accounts Receivable Funds*** business process to collect application fee. The ***Determine Provider Eligibility*** business process works in conjunction with Medicare and the processing of dual eligibles. Medicare agency conducts provider screening activities, application fee collection, and revalidation for those providers who are dual eligible. ***Determine Provider Eligibility*** business process is responsible for the provider screening activities, application fee collection, and revalidation for only Medicaid providers. **NOTE:** External contractors such as quality assurance and credentialing verification services may perform some of these steps.
Trigger Event	Environment-based Trigger Events: • Receive the following from either a Health Care Provider or existing Provider: ○ Requester completes enrollment application information (e.g., Provider name, Provider address, Provider National Provider Identifier (NPI), etc.).

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Determine Provider Eligibility	
Item	**Details**
	○ Requestor resubmits enrollment application information. ○ Requestor modifies or cancels application. ○ Disenrolled Provider submits re-enrollment application information. ○ Requestor submits additional information in support of an enrollment application. • Periodic review is due or receipt of request to: ○ Determine revalidation of credentials. Revalidation takes place every five (5) years except for Durable Medical Equipment Prosthetic, Orthotics & Supplies which is every three (3) years; revalidation also requires an application fee. ○ Monitor sanctions applied to a Provider. ○ Assist in program integrity review.
Result	• Agency accepts, denies, or suspends the requestor's application. • Agency notifies the requestor of enrollment eligibility (i.e., accepted, denied or suspended). • Alert sent to ***Enroll Provider*** business process to assign contracting parameters; establish payment rates and other activities for eligible requestor. • Alert sent to ***Manage Accounts Receivable Funds*** business process to collect application fee. • If applicable, alert sent to ***Disenroll Provider*** business process to remove provider from services. • Alert sent to notify provider via ***Manage Provider Communication*** business process of enrollment eligibility determination. • If applicable, alert sent to notify Medicare of both dual eligible and regular Medicaid providers information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Health Care Provider completes and submits an enrollment application or existing Provider submits enrollment application for revalidation. 2. Requestor identifies Office of the National Coordinator for Health Information Technology (ONC) Authorized Testing and Certification Body (ATCB) certification for electronic health record incentive. 3. Requestor identifies if they are currently participating in Medicare or Children's Health Insurance Program (CHIP). If yes, skip to step 14. 4. Requestor selects application fee payment option including designation of hardship or exclusions from payment. 5. Requestor provides appropriate payment information.

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Determine Provider Eligibility	
Item	**Details**
	6. Receive enrollment application and other pertinent enrollment communication information. 7. Validate application syntax/semantic conformance. a. **END:** If validation fails, business process stops (see Failures). 8. If necessary, request missing information from requestor. Go step 14. 9. Determine submission status by querying the Provider data store. Application status may be initial, resubmitted with modification, or duplicate. a. If resubmitted application, message contains only updated information and process may skip irrelevant steps below. b. **END:** If duplicate application, produce result messages and stop business process (see Failures). c. Other communications may be requests to cancel application, and to deactivate or reactivate enrollment. 10. Determine applicant type/Provider taxonomy (e.g., primary, rendering, pay to, billing, or other). 11. Determine designated categorical risk (e.g., limited, moderate, or high) based on provider/supplier's category. 12. Assess categorical risk to determine appropriate required screening level. a. Limited Risk includes: i. Verification of any provider/supplier-specific requirements established by Medicare ii. License verifications (may include licensure checks across state) iii. Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an Office of the Inspector General (OIG) exclusion; taxpayer identification number; tax delinquency; death of individual practitioner, owner, authorized official, delegated official, or supervising physician) b. Moderate Risk includes: i. Inclusion of Limited Risk screening ii. Unscheduled or Unannounced Site Visits c. High Risk includes: i. Inclusion of Moderate Risk screening ii. Criminal Background Check iii. Fingerprinting 13. Conduct screening based on required screening level with automated transactions except where manual verification if necessary. 14. Determine enrollment eligibility (e.g., accepted, denied, or suspended) based on federal and state rules. 15. Determine if there are enrollment caps due to moratoriums issued. If yes, skip

EE Provider Enrollment	
Determine Provider Eligibility	
Item	**Details**
	to step 19. 16. If Medicaid accepts enrollment application, send alert to ***Enroll Provider*** business process to assign contracting parameters, establish payment rates, and other activities for eligible requestor. 17. Alert sent to ***Manage Accounts Receivable Funds*** business process to collect application fee. 18. If Medicaid denies the enrollment application for existing Provider, send alert to ***Disenroll Provider*** business process to remove provider from services. 19. If applicable, send alert to notify Medicare of both dual eligible and regular Medicaid providers information. 20. **END:** Send enrollment eligibility determination to ***Manage Provider Communication*** business process to send relevant information to requestor. <u>Alternate Business Process Path:</u> ***Determine Provider Eligibility*** business process results in a denial or suspension of an enrollment eligibility request for reasons such as: • Requestor fails to meet screening requirements. • Requestor fails to meet state enrollment requirements. • National Plan and Provider Enumeration System (NPPES) or any other national enumeration systems cannot enumerate Health Care Provider.
Shared Data	Centers for Medicare & Medicaid Services (CMS) Medicare Dual Eligible Provider data store Provider data store including application information (NPI, Provider demographics, Provider taxonomy) NPI and Provider demographics exchanged with the National Plan and Provider Enumeration System (NPPES) and any other national enumeration systems Provider sanction information from: • The OIG or the General Accounting Office (GAO) sanction lists of individuals, vendors, and/or suppliers excluded from participation in Medicare, Medicaid, and other federally funded Sate programs from databases such as the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). • State Provider Licensing Authority • Healthcare Integrity and Protection Data Bank (HIPDB) data store • National Practitioner Databank (NPDB) • State Prescription Monitoring Program (PMP) Tax identifiers: Employer ID Number (EIN), Social Security Number (SSN), Taxpayer Identification Number (TIN) from applicant and verified with tax identifier verification sources and any other information required for Form 1099 production

EE Provider Enrollment	
Determine Provider Eligibility	
Item	**Details**
	Disclosure information including: • Information on ownership and control • Information related to business transactions • Information on persons convicted of crimes • Disclosure by providers and State Medicaid agencies. Multiple office locations, pay to addresses, business associates, and key contract personnel CMS caps and limits moratorium information Insurance Affordability Program data store including eligibility and enrollment information
Predecessor	**Receive Inbound Transaction**
Successor	***Manage Accounts Receivable Funds*** ***Enroll Provider*** ***Disenroll Provider*** ***Manage Provider Communication***
Constraints	The Provider application process will accommodate the full range of Provider types, organizations, specialties, different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., solo office practice, group practice, rural health clinic); as well as, appropriate applications (e.g., New, Modification, Cancellation, Update). Different business rules may apply to each of these different types. Affiliations – Managed Care Organization (MCO) or subpart relationship.
Failures	Enrollment application processing terminates or suspends due to: • Duplicate or cancelled applications. • Failure to validate application edits. • Requires additional information to process application.
Performance Measures	• Time to complete Enrollment process = within __ days • Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Provider Enrollment Variations		
Type	**Subtypes**	**Information**
Institutional Provider	The Institutional Provider application will accommodate a range of institutional Provider types (e.g., inpatient, nursing home, day care), different types of applicants (e.g., the primary	NPI, entity type, taxonomy, type of facility, bed size, equipment, type of institutional services, ownership, trading

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	
	Provider, billing agent, pay-to entity), and care settings (e.g., outpatient, emergency room, assisted living).	partner information, billing and payment information, tax code, Diagnosis Related Group (DRG) or other payment type
Individual Provider	The Individual Billing Provider application will accommodate a range of professional billing Provider types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other).	NPI, entity type, taxonomy, affiliation, location, trading partner information, billing and payment information
Individual Rendering Provider	The Individual Rendering Provider application will accommodate a range of professional rendering Provider types (e.g. Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other) Enumerate a group health practice separately from the individual physicians associated with it.	NPI, entity type, taxonomy, affiliation, location, equipment
Pharmacy	The Pharmacy application will accommodate a range of types (e.g., major chain with hundreds of stores, community pharmacy), different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., retail store, outpatient facility, nursing home). **NOTE:** The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist.	NPI, entity type, ownership, location, unit dose, mail order, Drug Enforcement Administration (DEA) information, Drug Utilization Review (DUR) compliance, trading partner information, billing and payment information
Atypical	The atypical Provider application will accommodate a range of types of programs (e.g., waiver, assistance in the home), different kinds of service Providers (e.g., family care-taker, taxi cab, plumber, carpenter, meals on wheels), different types of relationships (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., in the home, day care center). **NOTE:** The NPI enumeration does not provide ID numbers for atypical Providers at this time.	Provider ID, SSN, specialty, type of service Provider, allowed services, invoicing method
Suppliers	The DME suppliers and manufacturers supply or manufacturers application will accommodate a range of durable medical equipment, prosthetics, orthotics, supplies (DME Ops) types.	NPI, entity type, EIN, DME license, supplies, trading partner information, billing and payment information, ownership
Medical Transportation	The Medical Transportation Provider application will accommodate a range of transportation modes that include Air, Ambulance, Law, Pedestrian, Private or Public Transport. It should accommodate different types of vehicles, aircraft, licensing, and inspection information.	EIN, entity type, license type and number, inspection, vehicle, aircraft, and/or ambulance information

Enroll Provider

EE Provider Enrollment	
Enroll Provider	
Item	**Details**

Description	The ***Enroll Provider*** business process is responsible for enrolling providers into Medicaid that includes:
	• Determination of contracting parameters (e.g., Provider taxonomy, type, category of service that the Provider can bill).
	• Establishment of payment rates and funding sources, taking into consideration service area, incentives or discounts.
	• Alert sent to ***Manage Contract*** business process to negotiate contracts.
	• Supporting receipt and verification of program contractor's Provider enrollment roster information (e.g., from Managed Care Organization (MCO) and Home and Community-Based Services (HCBS)).
	• Alert sent to ***Manage Provider Information*** business process to load initial and modified enrollment information, including Providers contracted with program contractors into the Provider data store.
	• Alert sent to ***Manage Provider Information*** business process to provide timely and accurate notification, or to make enrollment information required for operations available to all parties and affiliated business processes, including:
	  o Alert sent to ***Prepare Provider Payment*** business process for capitation and premium payments.
	  o To prepare Provider Electronic Funds Transfer (EFT) or check with the ***Manage Accounts Payable Disbursement*** business process.
	  o The appropriate communications and outreach processes for follow-up with the affected parties, including informing parties of their procedural rights.
	• Periodic review is due or receipt of request to:
	  o Negotiate payment rates.
	  o Notify Provider of enrollment determination.
	Enroll Provider business process supports receipt and verification of program contractor's Provider enrollment roster information (e.g., name, identification, contract information, type, specialty and services) from Managed Care Organization (MCO) and HCBS organizations.

Trigger Event	Interaction-based Trigger Events: • Receive newly eligible Provider from ***Determine Provider Eligibility*** business process. • Receive newly eligibility contractor from ***Award Contract*** business process. • Receive alert from ***Manage Performance Measures*** to revalidate provider.

EE Provider Enrollment	
Enroll Provider	
Item	**Details**

	Environment-based Trigger Events:
	• Periodic review is due or receipt of to:
	  ○ Renegotiate payment rates.
	  ○ Reevaluate enrollment based criteria such as performance measures, or triggered by date such as anniversary date based on Medicaid policy to verify information based on a contractual duration (e.g. year or months).
	• Receive program enrollment or disenrollment information from Medicaid or CHIP.
	• Receive request for provider's enrollment roster information.

Result	• Enrolled, re-enrolled, suspended, or denied enrollment of provider or contractor into programs. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of enrollment determination. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of enrollment determination. • If applicable, alert sent to ***Manage Contractor Payment*** for payment arrangement. • Alert sent to ***Perform Provider Outreach*** to send relevant state policy information. • Alert sent to ***Manage Contract*** business process to negotiate contract. • If applicable, send response for Provider enrollment roster information. • Alert sent to notify Health Insurance Marketplace (HIX) of provider enrollment information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Determine contracting parameters (e.g., Provider taxonomy, categories of service for which the Provider can bill), eligible Provider types, payment types, contract terms and maximums, member enrollment levels, panel size, and any contractor specific benefit packages and procedures. 2. Assign any identifiers used internally. 3. Determine if there are enrollment limits due to moratoriums issued. If yes, skip to step 9. 4. Assign to programs and determine rates: Includes identifying type of rate (e.g., negotiated, Medicare, percent of charges, case management fee, other via look-ups in the reference and benefit repositories). 5. If applicable, send alert to ***Manage Contractor Payment*** business process for payment arrangement. 6. Send alert to ***Perform Provider Outreach*** business process to send relevant

EE Provider Enrollment	
Enroll Provider	
Item	**Details**
	state policy information. 7. Send alert to ***Manage Contract*** business process to negotiate contract. 8. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of enrollment determination. 9. If applicable, provide response to request for Provider enrollment roster information. 10. Send alert to notify Health Insurance Marketplace (HIX) of provider enrollment information. 11. **END:** Send alert to notify provider via ***Manage Provider Communication*** business process of enrollment determination.

Shared Data	Provider data store including:
	• Provider demographics
	• Provider network
	• Contract information
	  o Type
	  o Specialty
	  o Enrolled Program
	  o Jurisdiction
	  o Payment Information
	• Provider taxonomy
	• Service Location Information
	  o Category of Service
	  o Services
	  o Limitations
	  o Business Arrangement
	Contractor data store including provider network information
	Plan data store including health benefit and fees information
	Moratorium data store including Caps and Limits information
	Health Insurance Marketplace (HIX) including provider enrollment information

Predecessor	***Determine Provider Eligibility*** ***Manage Provider Communication*** ***Manage Performance Measures*** ***Award Contract***

EE Provider Enrollment	
Enroll Provider	
Item	**Details**
Successor	***Manage Provider Information*** ***Manage Provider Communication*** ***Manage Contractor Information*** ***Manage Contractor Communication*** ***Perform Provider Outreach*** ***Manage Contract***
Constraints	The Provider enrollment process will accommodate the full range of Provider types, organizations, specialties, different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., solo office practice, group practice, rural health clinic) as well as different types of applications (e.g., New, Modification, Cancellation, Update). Different business rules may apply to each of these different types. Affiliations – MCO or subpart relationship.
Failures	***Enroll Provider*** business process results in a denied or suspended enrollment request for reasons such as: • Lack of applicable rates. • Provider meets caps or limits moratorium.
Performance Measures	• Time to complete Enrollment process = within __ days • Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Provider Enrollment Variations		
Type	**Subtypes**	**Information**
Institutional Provider	The Institutional Provider application will accommodate a range of institutional Provider types (e.g., inpatient, nursing home, day care), different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., outpatient, emergency room, assisted living).	NPI, entity type, taxonomy, type of facility, bed size, equipment, type of institutional services, ownership, trading partner information, billing and payment information, tax code, DRG or other payment type
Individual Provider	The Individual Billing Provider application will accommodate a range of professional billing Provider types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other).	NPI, entity type, taxonomy, affiliation, location, trading partner information, billing and payment information
Individual Rendering Provider	The Individual Rendering Provider application will accommodate a range of professional rendering Provider types (e.g. Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other) Enumerate a group health practice separately	NPI, entity type, taxonomy, affiliation, location, equipment

EE Provider Enrollment		
Enroll Provider		
Item	Details	
	from the individual physicians associated with it.	
Pharmacy	The Pharmacy application will accommodate a range of types (e.g., major chain with hundreds of stores, community pharmacy), different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., retail store, outpatient facility, nursing home). **NOTE:** The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist.	NPI, entity type, ownership, location, unit dose, mail order, DEA information, DUR compliance, trading partner information, billing and payment information
Atypical	The atypical Provider application will accommodate a range of types of programs (e.g., waiver, assistance in the home), different kinds of service Providers (e.g., family care-taker, taxi cab, plumber, carpenter, meals on wheels), different types of relationships (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., in the home, day care center). **NOTE:** The NPI enumeration does not provide ID numbers for atypical Providers at this time.	Provider ID, SSN, specialty, type of service Provider, allowed services, invoicing method
Suppliers	The DME suppliers and manufacturers supply or manufacturers application will accommodate a range of durable medical equipment, prosthetics, orthotics, supplies (DME Ops) types.	NPI, entity type, EIN, DME license, supplies, trading partner information, billing and payment information, ownership
Medical Transportation	The Medical Transportation Provider application will accommodate a range of transportation modes that include Air, Ambulance, Law, Pedestrian, Private or Public Transport. It should accommodate different types of vehicles, aircraft, licensing, and inspection information.	EIN, entity type, license type and number, inspection, vehicle, aircraft, and/or ambulance information

Disenroll Provider

EE Provider Enrollment	
Disenroll Provider	
Item	Details
Description	The ***Disenroll Provider*** business process is responsible for managing disenrollment in the Medicaid Program. This business process covers the activity of disenrollment including the tracking of disenrollment requests and validation that the disenrollment meets state's rules. Medicaid sends notifications to affected parties (e.g., provider, contractor, business partners) as well as alerts to other business processes to discontinue business activities.
Trigger Event	Interaction-based Trigger Events:

EE Provider Enrollment	
Disenroll Provider	
Item	**Details**
	• Receive disenrollment from insurance affordability program. • Receive disenrollment from ***Determine Provider Eligibility*** business process within ineligible information. • Receive disenrollment from ***Manage Compliance Incident Information*** business process for continued failure to make payments. • Receive disenrollment from ***Manage Provider Information*** business process from provider request. • Receive disenrollment from ***Manage Contractor Information*** business process from contractor request. • Receive alert from ***Determine Adverse Action Incident*** business process to remove provider from services. • Receive alert from ***Close Out Contract*** business process to remove provider from services. Environment-based Trigger Events: • Receive request to disenroll provider. • Receive information from Medicare/Medicaid Sanction, National Practitioner Databank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB), or state licensing boards. • Receive information about a provider's death, retirement, or disability.
Result	• Agency disenrolls Provider or contractor from participation in Medicaid Program. • Alert sent to notify provider via ***Manage Provider Communication*** business process of disenrollment information. • Alert sent to notify contractor via ***Manage Contractor Communication*** business process of disenrollment. • Alert sent to notify Medicare/Medicaid Sanction, National Practitioner Data Bank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB), and state licensing boards via ***Manage Business Relationship Communication*** business process of disenrollment information. • If applicable, alert sent to ***Manage Contractor Payment*** to stop payment arrangement. • Alert sent to ***Close Out Contract*** business process with disenrollment information. • Alert sent to ***Apply Mass Adjustment*** business process to associate members with alternate provider or contractor. • Alert sent to notify Health Insurance Marketplace (HIX) of provider disenrollment information. • Tracking information as needed for measuring performance and business activity monitoring.

EE Provider Enrollment	
Disenroll Provider	
Item	**Details**
Business Process Steps	1. **START:** Receive disenrollment request or relevant information. 2. Validate authenticity of the requestor to have authorization to request disenrollment. 3. Determine disenrollment request or information processing status by querying the Provider data store. Application status may be one of the following: initial, resubmitted with modification, or duplicate. a. If resubmitted application, message contains only updated information and process may skip irrelevant steps below. b. If duplicate application, produce result messages and stop business process (see Failures). c. Other communications may be requests to cancel application, and to deactivate or reactivate enrollment. 4. Verify the disenrollment information. 5. Validate that the disenrollment request meets state rules. 6. Remove provider or contractor from Medicaid participation. 7. Send alert to notify Medicare/Medicaid Sanction, NPDB, HIPDB, and state licensing boards via ***Manage Business Relationship Communication*** business process of disenrollment information. 8. If applicable, send alert to ***Manage Contractor Payment*** business process to stop payment arrangement. 9. Send alert to ***Close Out Contract*** business process with disenrollment information. 10. Send alert to ***Apply Mass Adjustment*** business process to associate members with alternate provider or contractor. 11. Send alert to notify provider via ***Manage Provider Communication*** business process of disenrollment information. 12. Send alert to notify contractor via ***Manage Contractor Communication*** business process of disenrollment. 13. Send alert to notify other insurance affordability programs of the disenrollment from Medicaid. 14. Send alert to notify Health Insurance Marketplace (HIX) of provider disenrollment information. 15. **END:** Agency removes Provider or contractor from participation in Medicaid services.
Shared Data	Provider data store including provider network and contact information (e.g., NPI, provider demographics, provider taxonomy) NPI and provider demographics exchanged with National Plan and Provider Enumeration System (NPPES) Provider sanction information such as:

EE Provider Enrollment	
Disenroll Provider	
Item	**Details**
	a. The Office of Inspector General or the General Accounting Office (OIG/GAO) sanction lists of individuals, vendors, and/or suppliers that are excluded from participation in Medicare, Medicaid, and other federally funded state programs b. State Provider Licensing Authority c. HIPDB d. NPDB Tax identifiers: Employer ID Number (EIN), Social Security Number (SSN), Taxpayer Identification Number (TIN) from applicant and verified with tax identifier verification sources Insurance Affordability Program data store including eligibility and enrollment information
Predecessor	***Determine Provider Eligibility*** ***Manage Compliance Incident Information*** ***Manage Provider Information*** ***Manage Contractor Information*** ***Determine Adverse Action Incident*** ***Close Out Contract***
Successor	***Manage Provider Communication*** ***Manage Provider Information*** ***Manage Contractor Communications*** ***Manage Contractor Information*** ***Manage Business Relationship Communication*** ***Manage Contractor Payment*** ***Close Out Contract*** ***Apply Mass Adjustment***
Constraints	The Provider disenrollment process will accommodate the full range of provider types, organizations, specialties, different types of applicants (e.g., the Primary Provider, Billing Agent, Pay-To Entity), and care settings (e.g., solo office practice, group practice, Rural Health Clinic) as well as different types of application (e.g., New, Modification, Cancellation, Update). Different business rules will apply to each of these different types.
Failures	• Duplicate disenrollment requests. • Requirement for additional information to process disenrollment.
Performance Measures	• Time to complete Disenrollment process = within __ days

EE Provider Enrollment	
Disenroll Provider	
Item	**Details**
	• Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Inquire Provider Information

EE Provider Enrollment	
Inquire Provider Information	
Item	**Details**
Description	The ***Inquire Provider Information*** business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry, and prepares the response information for the **Send Outbound Transaction**.
Trigger Event	Interaction based Trigger Events: • Receive eligibility inquiry via Automated Voice Response System (AVRS). Environment-based Trigger Events: • Receive provider enrollment verification request from **Receive Inbound Transaction**.
Result	• Provider enrollment verification response that may include information such as enrollment start/end dates, provider type, and specific specialties provided. • If applicable, response sent with eligibility inquiry information via AVRS. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive provider enrollment verification information from **Receive Inbound Transaction**. 2. Agency logs enrollment verification request. 3. Validate requestor's authorization to receive requested information. 4. Find requested provider's enrollment verification information. 5. Agency logs response. 6. If applicable, send eligibility inquiry response via AVRS. 7. **END:** Send response to requestor via **Send Outbound Transaction**.
Shared Data	Provider data store including: • Provider demographics • Provider network • Contract information ○ Type

EE Provider Enrollment	
Inquire Provider Information	
Item	**Details**
	○ Specialty ○ Enrolled Program ○ Jurisdiction ○ Payment Information • Provider taxonomy • Service Location Information ○ Category of Service ○ Services ○ Limitations ○ Business Arrangement
Predecessor	**Receive Inbound Transaction**
Successor	**Send Outbound Transaction**
Constraints	States determine what information share and who can access what requested information.
Failures	• Process unable to process the provider information verification request. • Unauthorized requester cannot receive requested information.
Performance Measures	• Time to verify provider information and generate response information: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Response Accuracy = ___% • Error rate = __% or less

FINANCIAL MANAGEMENT

Manage Provider Recoupment

FM Accounts Receivable Management	
Manage Provider Recoupment	
Item	**Details**
Description	The ***Manage Provider Recoupment*** business process manages the determination and recovery of overpayments to providers. The State Medicaid Agency (SMA) initiates provider recoupment upon the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where provider owes monies to the SMA due to fraud or abuse. The business thread begins with discovering the overpayment, then retrieving claims payment information, initiating the recoupment request, or adjudicating a claims adjustment request, and notifying the provider of audit results via the ***Manage Provider Communication*** business process, applying recoupments in the system via the ***Manage Accounts Receivable Information*** business process, and monitoring payment history until the provider satisfies the repayment. The SMA collects recoupments via check sent by the provider or credited against future payments for services.
Trigger Event	Interaction-based Trigger Events: • Adjustment claim by the ***Process Claim*** or ***Process Encounter*** business processes. Environment-based Trigger Events: • Periodic Provider utilization review audit by the ***Identify Utilization Anomalies*** business process is due. • Receive adverse action disposition from the ***Determine Adverse Action Incident*** business process. • Periodic post payment audit by the ***Identify Utilization Anomalies*** business process is due.
Result	• Alert sent to notify provider of recoupment request. • Alert sent to monitor recoupment activities to ***Manage Accounts Receivable Information*** business process. • Alert sent to ***Apply Mass Adjustment*** business process for retroactive modifications. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Discover overpayment as the result of a routine adjustment request, a provider utilization review, fraud and abuse case, or involvement of a third-party payer. 2. Retrieve claims payment information. 3. Initiate recoupment request.

FM Accounts Receivable Management	
Manage Provider Recoupment	
Item	**Details**
	4. Send alert to notify provider of recoupment request (e.g., amount owed). 5. Negotiate agreed upon method of repayment or recoupment. 6. If applicable, send alert to ***Apply Mass Adjustment*** business process for retroactive modifications. 7. **END:** Send alert to monitor recoupment activities to ***Manage Accounts Receivable Information*** business process.
Shared Data	Claims data store including payment information Provider data store including provider network and contract information Plan data store including policy and fee information Health Benefit data store including benefit program and benefit information Member data store including third-party liability information Financial data store including accounts receivable information Compliance Management data store including compliance incident information
Predecessor	***Identify Utilization Anomalies*** ***Process Claim*** ***Process Encounter*** ***Determine Adverse Action Incident***
Successor	**Send Outbound Transaction** ***Manage Accounts Receivable Information*** ***Manage Provider Communication*** ***Apply Mass Adjustment***
Constraints	Policies and procedures differ by state. Integration with state accounting system can greatly affect the state's ability to track receivables established by the recoupment.
Failures	• The SMA is unable to agree on amount owed or method of recoupment.
Performance Measures	• Time to complete provider recoupment process: e.g., Real Time response = within ___seconds, Batch Response = within ___hours • Accuracy with which recoupments are applied = ___ % • Consistency of decisions on suspended claims/encounters = ___% • Error rate = ___% or less

Manage TPL Recovery

FM Accounts Receivable Management	
Manage TPL Recovery	
Item	**Details**
Description	The ***Manage TPL Recovery*** business process begins by receiving Third-Party Liability (TPL) information from various sources such as external and internal information matches, tips, referrals, attorneys, compliance management incident, Medicaid Fraud Control Unit (MFCU), providers, and insurance companies. The business process: • Identifies the provider or TPL carrier, locates recoverable claims. • Creates the coordination of benefits file. • Creates post-payment recovery files. • Sends notification to other payer or provider from the ***Manage Provider Communication*** business process.
Trigger Event	Environment-based Trigger Events: • Receive third-party liability information from outside sources via the ***Determine Member Eligibility*** business process. • Receive third-party liability information from internal and external eligibility information matches. State transition-based Trigger Events: • Receive claims payment information from ***Process Claim*** or ***Process Encounter*** business process.
Result	• Alert sent to notify third-party liability of recovery request. • Alert sent to ***Manage Accounts Receivable Information*** business process to monitor for payment. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive third-party liability information. 2. Identify the provider or TPL carrier. 3. Locate recoverable claims. 4. Create coordination of benefit files. 5. Create post-payment recovery files. 6. Send alert to notify provider or other payer of recovery request. 7. Conduct follow-up necessary and record activities. 8. Send alert to monitor recoupment activities to ***Manage Accounts Receivable Information*** business process. 9. **END:** Close and archive TPL Recovery case file upon conclusion of activities.

FM Accounts Receivable Management	
Manage TPL Recovery	
Item	**Details**
Shared Data	Financial data store including accounts receivable information Member data store including enrollment information Provider data store including provider network and carrier information Health Insurance Marketplace (HIX) data store Compliance Management data store including compliance incident information Other Agency Information: • Department of Motor Vehicles (DMV) • Veterans Administration (VA) • Indian Health Service • Immigration and Naturalization Service • Medicaid Fraud Control Unit (MFCU)
Predecessor	**Receive Inbound Transaction** ***Determine Adverse Action Incident*** ***Determine Member Eligibility*** ***Process Claim*** ***Process Encounter***
Successor	**Send Outbound Transaction** ***Manage Provider Communication*** ***Manage Accounts Receivable Information***
Constraints	States differ in the rules applied to TPL recoveries. Capabilities related to information matches vary and some States utilize recovery services contractors. The state's integration of eligibility determination systems also has significant impact on their ability to cost avoid versus cost recover.
Failures	• Inability to identify third-party payer from received third-party liability information. • Identified third-party payer denies liability or otherwise refuses to pay.
Performance Measures	• Time to complete the process = Real Time response = within __ seconds, Batch Response = within __hours • Accuracy with which the TPL rules are applied = __% • Consistency with which the TPL rules are applied = __% • Amount of dollars recovered = ___% • Error rate (false recovery demands) = __% or less

Manage Estate Recovery

FM Accounts Receivable Management	
Manage Estate Recovery	
Item	**Details**
Description	***Manage Estate Recovery*** is a business process that requires States to recover certain Medicaid benefits correctly paid on behalf of an individual, by filing liens against a deceased member's or deceased spouse's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), or other medical institution. The ***Manage Estate Recovery*** business process begins by receiving estate recovery information from multiple sources (e.g., vital statistics and Social Security Administration (SSA) date of death matches, probate petition notices, tips from caseworkers, and reports of death from nursing homes). It generates correspondence (e.g., demand of notice to probate court via **Send Outbound Transaction**, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the ***Manage Applicant and Member Communication*** business process. In addition, the business process: • Opens a formal estate recovery case based on estate ownership and value of property. • Determines the value of the estate lien. • Files a petition for a lien. • Files an estate claim of lien. • Conducts case follow-up. • Sends an alert to ***Manage Accounts Receivable Information*** business process, releasing the estate lien when recovery is complete. • Sends an alert to ***Manage Member Information*** business process, updating Member data store. **NOTE:** Do not confuse this with settlements that are recoveries for certain Medicaid benefits correctly paid on behalf of an individual because of a legal ruling or award involving accidents.
Trigger Event	Environment-transition Trigger Events: • Receive estate recovery information* from mail, publication, telephone, facsimile or Electronic Data Interchange (EDI). • Receive member or provider death certificates. * Many States have Medicaid Estate Recovery Plans used to recover an equitable amount of the state and federal shares of the cost paid for the member from the estates of members of medical assistance.
Result	• Estate recovery case file closed upon Receive maximum possible payment. • Tracking information as needed for measuring performance and business

FM Accounts Receivable Management	
Manage Estate Recovery	
Item	**Details**
	activity monitoring.
Business Process Steps	10. **START:** Receive estate recovery referral information via several different sources (e.g., vital statistics and Social Security Administration (SSA) date of death match, probate petition notices, eligibility caseworker, and nursing homes). 11. Send demand notice information to member correspondence (e.g., onto probate court). 12. Send alert to notify deceased representative to complete estate recovery questionnaire. 13. Open estate recovery case. 14. Determine value of estate lien by analyzing all Medicaid claims from age 55 forward (e.g., all paid claims equals lien amount). 15. If applicable, member may file an undue hardship waiver based on state regulations. If the State Medicaid Agency (SMA) grants hardship, staff defers or closes the case. 16. Generate estate recovery proceedings information (e.g., lien petition, notice of pendency of action) and send via **Send Outbound Transaction**. 17. Upon court approval, file estate claim of lien. 18. Case follow-up occurs (every 30 to 90 days). 19. Send alert to monitor recovery activities to ***Manage Accounts Receivable Information*** business process. 20. If applicable, send alert to ***Manage Member Information*** business process, updating Member data store. 21. **END:** Closed and archive estate recovery case file upon conclusion of activities.
Shared Data	Financial data store including accounts receivable information Member data store including demographics Claims data store including payment information Vital Statistic records SSA records Centers for Medicare & Medicaid Services (CMS) Medicare/Medicaid Dual Eligibility reporting Health Insurance Marketplace (HIX) data store Judicial records
Predecessor	**Receive Inbound Transaction**
Successor	**Send Outbound Transaction**

FM Accounts Receivable Management	
Manage Estate Recovery	
Item	**Details**
	Manage Applicant and Member Communication ***Manage Accounts Receivable Information*** ***Submit Electronic Attachment***
Constraints	The ***Manage Estate Recovery*** business process will be in accordance with state specific policy.
Failures	• The SMA or member's representative is unable to meet filing timelines.
Performance Measures	• Time to complete the process = e.g., ___ months, ___ weeks or ___ days • Accuracy with which rules are applied = __% • Consistency with which rules are applied = __% • Error rate = __% or less • Amount of dollars recovered = ___%

Manage Drug Rebate

FM Accounts Receivable Management	
Manage Drug Rebate	
Item	**Details**
Description	The ***Manage Drug Rebate*** business process describes the process of managing drug rebate that the State Medicaid Agency (SMA) collects from manufacturers. This business process: • Receives quarterly drug rebate information from Centers for Medicare & Medicaid Services (CMS). • Compares drug rebate to quarterly payment history information. • Identifies drug information matches based on manufacturer and drug code. • 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 to the drug manufacturer via the **Send Outbound Transaction.** • Sends an alert to ***Manage Accounts Receivable Information*** to monitor for rebate payment.
Trigger Event	Interaction-based Trigger Event: • Receive the CMS quarterly drug rebate information from **Receive Inbound**

FM Accounts Receivable Management	
Manage Drug Rebate	
Item	**Details**
	Transaction.
Result	• Alert sent to invoice the drug manufacturer. • Alert sent to ***Manage Accounts Receivable Information*** business process to monitor for payment. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** The state receives a quarterly file from CMS containing the rebate factors by manufacturer, drug code, and volume. 2. Compare file to the corresponding claims history extract for the same quarter. 3. Select drug claims matching the manufacturer and drug codes based on the CMS Drug Product Data. 4. Sort drug claims selected for invoice processing by manufacturer and drug code. 5. Apply the rebate factor and volume indicators to calculate a rebate total per manufacturer. 6. Send alert to invoice manufacturer. 7. **END:** Send alert to monitor payment activities to ***Manage Accounts Receivable Information*** business process.
Shared Data	CMS Unit Rebate Amount (URA) information Claims data store including both professional and drug payment information Reference data store including drug code and manufacturer information Financial data store including accounts receivable information
Predecessor	**Receive Inbound Transaction**
Successor	**Send Outbound Transaction** ***Manage Contractor Communication*** ***Manage Accounts Receivable Information***
Constraints	The ***Manage Drug Rebate*** business process will be in accordance with state-specific drug formulary, business rules, and reporting requirements that may differ by state, and will comply with federal mandates.
Failures	• CMS does not send quarterly drug rebate information. • There are no drug claims for rebate matching the manufacturer and drug codes based on the CMS Drug Product Data for the period. **NOTE**: the process could complete with errors (e.g., errors in rebate rates, drug payment file errors), and the SMA would correct these errors or disputed amounts in the ***Manage Accounts Receivable Information*** business process.

FM Accounts Receivable Management	
Manage Drug Rebate	
Item	**Details**
Performance Measures	• Time to complete the process = e.g., ___ months, ___ weeks or ___ days • Accuracy with which the Drug Rebate rules are applied = __% • Consistency with which the Drug Rebate rules are applied = __% • Amount of drug rebate dollars recovered quarterly = ___% • Error rate = __% or less

Manage Cost Settlement

FM Accounts Receivable Management	
Manage Cost Settlement	
Item	**Details**
Description	The ***Manage Cost Settlement*** business process begins with the submission of the provider's annual Medicare Cost Report to Medicaid. Staff makes inquires for paid, denied, and adjusted claims information in the Claims data store. The business process includes: • Reviewing provider costs and establishing a basis for cost settlements or compliance reviews. • Receiving audited Medicare Cost Report from intermediaries. • Capturing the necessary provider cost settlement information. • Calculating the final annual cost settlement based on the Medicare Cost Report. • Generating the information for notification to the provider. • Verifying the information is correct. • Producing the notifications to providers. • Establishing interim reimbursement rates. **NOTE:** In some States, the State Medicaid Agency (SMA) may make cost settlements through the ***Apply Mass Adjustment*** business process.
Trigger Event	Environment-based Trigger Event: • Receive provider costs from claims history data store. • Receive Medicare Cost Report. • Prompt for annual provider cost review.
Result	• Alert sent to notify provider of cost settlement information. • Alert sent to ***Manage Accounts Receivable Information*** business process to monitor for payment.

FM Accounts Receivable Management	
Manage Cost Settlement	
Item	**Details**
	• Alert sent to ***Manage Rate Setting*** business process of interim reimbursement rates. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive Medicare Cost Report from provider. 2. Request annual claims detail information. 3. Review provider costs. 4. Establish a basis for cost settlements or compliance reviews. 5. Receive audited Medicare Cost Report from intermediaries from **Receive Inbound Transaction.** 6. Receive provider cost settlement information from **Receive Inbound Transaction**. 7. Capture the necessary provider cost settlement information. 8. Calculate the final annual cost settlement based on the Medicare Cost Report and prorate for Medicaid services. 9. Establish interim reimbursement rates. 10. Generate cost settlement information identifying the amount of overpayment or underpayment and the reimbursement rates the SMA would consider for the next year. 11. Verify the information is correct. 12. Send alert to notify providers of cost settlements summary information. 13. Send cost settlement summary information to providers via **Send Outbound Transaction**. 14. Send alert to monitor payment activities to ***Manage Accounts Receivable Information*** (if overpayment) or to ***Manage Accounts Payable Information*** (if underpayment) business processes. 15. Send alert to conduct retroactive modifications to ***Apply Mass Adjustment*** business process. 16. **END:** Send alert of interim reimbursement rates to ***Manage Rate Setting*** business process.
Shared Data	Claims data store including payment information Provider data store including provider network and contract information Financial data store including accounts receivable information Cost log information sent to Centers for Medicare & Medicaid Services (CMS)
Predecessor	**Receive Inbound Transaction**

FM Accounts Receivable Management	
Manage Cost Settlement	
Item	**Details**
Successor	**Send Outbound Transaction** ***Manage Provider Communication*** ***Manage Accounts Receivable Information*** ***Manage Rate Setting*** ***Apply Mass Adjustment***
Constraints	Cost Settlement information will conform to CMS and state-specific reporting requirements.
Failures	• This process has no failure modes that prevent the process from completion. • Delays are the result of delays in the audited Medicare Cost Report. • A provider may file a grievance if it does not agree with established rates or settlement amounts.
Performance Measures	• Time to complete the process = e.g., ___ months, ___ weeks or ___ days • Accuracy with which the SMA applies Cost Settlement rules = __% • Consistency with which the SMA applies Cost Settlement rules = __% • Number of grievances or protests received = __ • Error rate = __% or less

Manage Accounts Receivable Information

FM Accounts Receivable Management	
Manage Accounts Receivable Information	
Item	**Details**
Description	The ***Manage Accounts Receivable Information*** business process is responsible for all operational aspects of collecting money owed to the State Medicaid Agency (SMA). Activities in this business process comply with CFR 45, Cash Management Improvement Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP). Activities included in this business process can be as follows: • Periodic reconciliations between the State Medicaid Enterprise and the state accounting system. • Assign account coding to transactions processed in State Medicaid Enterprise. • Process accounts receivable invoicing (estate recovery, co-pay, drug rebate, recoupment, Third-Party Liability (TPL) recovery, and member premiums). • Manage cash receipting process.

FM Accounts Receivable Management	
Manage Accounts Receivable Information	
Item	**Details**
	• Manage payment-offset process to collect receivables. • Respond to inquiries concerning accounts receivable. **NOTE:** States use a variety of solutions including outsourcing to another department or use of a Commercial Off-the-Shelf (COTS) package.
Trigger Event	Environment-based Trigger Events: • Receive initial invoice from ***Manage Provider Recoupment, Manage TPL Recovery, Manage Estate Recovery, Manage Drug Rebate,*** or ***Manage Cost Settlement*** business processes. • Receive account receivable information from state accounting system. This may be a lien, levy or state judgment from other agencies.
Result	• The SMA modifies account receivables information. • Alert sent to collect payment to ***Manage Accounts Receivable Funds*** business process. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive initial Accounts Receivable invoice to establish the receivable amount and demographic information for the debt owner. 2. Record Accounts Receivable payments to the account balance. 3. Adjust balance for additional Accounts Receivable amounts. An adjustment may increase or decrease the balance. a. The adjustments include settlements, liens, levies, and/or judgments against the Accounts Receivable. b. The SMA may receive the adjustment from ***Manage Provider Recoupment, Manage TPL Recovery, Manage Estate Recovery, Manage Drug Rebate,*** or ***Manage Cost Settlement*** business processes or other state or federal agencies. 4. Produce month-end accounts receivable balance and statement. This includes invoices to the debt owner and summary information for financial reports. 5. Update the state accounting system. 6. Send alert to collect payment to ***Manage Accounts Receivable Funds*** business process. 7. **END:** Send response to requested function.
Shared Data	Financial data store including accounts receivable information Claims data store including premium and payment information Contractor data store including contract information Member data store including demographics, spend-down, cost share, and patient

FM Accounts Receivable Management	
Manage Accounts Receivable Information	
Item	**Details**
	liability information Provider data store including provider network information State accounting system accounts receivable information
Predecessor	**Receive Inbound Transaction** ***Manage Cost Settlement*** ***Manage Drug Rebate*** ***Manage TPL Recovery*** ***Manage Estate Recovery*** ***Manage Provider Recoupment*** ***Prepare Member Premium Invoice***
Successor	**Send Outbound Transaction** ***Manage Accounts Receivable Funds*** ***Generate Financial Report*** ***Manage Data***
Constraints	The SMA will conform to state-specific accounting and financial requirements.
Failures	• Failure to account for expenditures in accordance with GAAP can result in disallowance of Federal Funding Participation (FFP).
Performance Measures	• Time to complete the process = within __ hours • Accuracy with which updates are applied = __% • Consistency with which updates are applied = __% • Error rate = __%

Manage Accounts Receivable Funds

FM Accounts Receivable Management	
Manage Accounts Receivable Funds	
Item	**Details**
Description	The ***Manage Accounts Receivable Funds*** business process is responsible for all operations aspects of the collection of payment owed to the State Medicaid Agency (SMA). Activities in this business process comply with Cash Management Improvement Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP).

FM Accounts Receivable Management	
Manage Accounts Receivable Funds	
Item	**Details**
Trigger Event	Environment-based Trigger Events: • Receive payment (e.g., cash, check, and credit/debit card). Interaction-based Trigger Events: • Receive electronic payment (e.g., electronic funds transfer). • Receive periodic scheduled electronic payments.
Result	• The State Medicaid Agency (SMA) receives payment and applies to accounts receivable. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive payment (e.g., cash, check, credit/debit card, electronic funds transfer). 2. Record the payer and payment amount information. 3. Create payment receipt notice. 4. Notify payer of payment receipt (e.g., email, mail, electronic funds transfer). 5. **END:** Apply payment to accounts receivable.
Shared Data	Financial data store including accounts receivable information Claims data store including premium information Contractor data store including contract information Member data store including demographics, spend-down, cost share, and patient liability information Provider data store including provider network information
Predecessor	**Receive Inbound Transaction** ***Manage Accounts Receivable Information***
Successor	**Send Outbound Transaction** ***Manage Contractor Communication*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication***
Constraints	States may have different payment business rules.
Failures	• Inability or failure to load initial records or update information in existing records in the Financial data store. • The SMA received no payments.

FM Accounts Receivable Management	
Manage Accounts Receivable Funds	
Item	**Details**
Performance Measures	• Time to complete the process = within __ hours, ___ minutes • Accuracy with which updates are applied = __% • Consistency with which updates are applied = __% • Error rate = __% or less

Prepare Member Premium Invoice

FM Accounts Receivable Management	
Prepare Member Premium Invoice	
Item	**Details**
Description	States may implement member cost sharing through the collection of premiums for medical coverage provided under Medicaid and Children's Health Insurance Program (CHIP). The State Medicaid Agency (SMA) formulates the premium amounts on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment. The ***Prepare Member Premium Invoice*** business process begins with a timetable (usually monthly) for scheduled invoicing. The business process includes: • Retrieving member premium information. • Performing required information manipulation according to business rules. • Formatting the results into required output information. • Sending member premium invoice alert to the ***Manage Applicant and Member Communication*** business process. **NOTE:** This business process does not include sending the member premium invoice Electronic Data Interchange (EDI) transaction.
Trigger Event	Environment-based Trigger Events: • Periodic timetable (e.g., monthly) is due for scheduled invoicing. • Periodic timetable (e.g., monthly) is due for scheduled health insurance premiums invoicing. State transition-based Trigger Events: • Periodic timetable (e.g., monthly) is due for insurance premium eligibility redetermination and payments.
Result	• Alert sent to ***Manage Applicant and Member Communication*** business process to send invoice. • Tracking information as needed for measuring performance and business

FM Accounts Receivable Management	
Prepare Member Premium Invoice	
Item	**Details**
	activity monitoring.
Business Process Steps	1. **START:** Periodic timetable is due for scheduled invoicing. 2. Retrieve member premium information. 3. Adjust member premium information based on state criteria. 4. Format the results into required output information. 5. Produce member invoice information. 6. **END:** Send alert to generate invoice via ***Manage Applicant and Member Communication*** business process.
Shared Data	Member data store including demographics, cost share, and premium information Claims data store including premium information Financial data store including accounts receivable information
Predecessor	***Manage Accounts Receivable Information***
Successor	***Manage Applicant and Member Communication*** ***Manage Accounts Receivable Information*** ***Manage Accounts Receivable Funds***
Constraints	The ***Prepare Member Premium Invoice*** business process will conform to the state-specific requirements.
Failures	• Member premium information not available.
Performance Measures	• Time to complete process: e.g., Real Time response = within __seconds, Batch Responses = within __ days • Accuracy of decisions = __% • Consistency of decisions and disposition = __% • Error rate = __% or less

Manage Contractor Payment

FM Accounts Payable Management	
Manage Contractor Payment	
Item	**Details**
Description	The ***Manage Contractor Payment*** business process includes the activities necessary to reimburse contractors for services rendered based on a contract executed between the State Medicaid Agency (SMA) and the contractor. When a contractor renders services on behalf of a Medicaid member, the contractor invoices Medicaid according to the specifics defined in the contract. Agency staff responsible for Contract

FM Accounts Payable Management	
Manage Contractor Payment	
Item	**Details**
	Administration process invoices according to the SMA policy including validation of the invoice content to reimbursement details defined in the contract.
Trigger Event	Environment-based Trigger Events: • Receive invoice from contractor (e.g., email, mail, facsimile). Interaction-based Trigger Events: • Receive electronic invoice from contractor (e.g., Electronic Data Interchange (EDI)).
Result	• Alert sent to ***Manage Accounts Payable Information*** business process to generate contractor payment. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive invoice from contractor. 2. Validate invoice details for reimbursement details defined in the contract. 3. Resolve any invoicing discrepancies discovered with contractor. 4. **END:** Send alert to ***Manage Accounts Payable Information*** business process to generate contractor payment.
Shared Data	Financial data store including accounts payable information and Recovery Audit Contractor (RAC) recovery information Contractor data store including contract information Member data store including eligibility and benefits information Provider data store including provider network & contract information
Predecessor	**Receive Inbound Transaction** ***Prepare Provider Payment***
Successor	***Manage Accounts Payable Information***
Constraints	The ***Manage Contractor Payment*** business process will adhere to the federal and state policies and business rules that may differ by state.
Failures	• Invoice does not match existing contractor information.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which rules are applied =___% • Error rate =___% or less

Manage Member Financial Participation

FM Accounts Payable Management	
Manage Member Financial Participation	
Item	**Details**
Description	The ***Manage Member Financial Participation*** business process is responsible for all operations aspects of preparing member premium payments. This includes premiums for Medicare, also known as Medicare Buy-in, and other health insurance. The business process begins with the alert to determine if the State Medicaid Agency (SMA) should pay a member's premium. The SMA will assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a process referred to as buy-in. Under the buy-in process the SMA, the Social Security Administration (SSA), and U.S. Department of Health & Human Services (HHS) enter into a contract where States pay the Medicare beneficiary share of premium costs, and, in some instances, deductibles, and co-insurance. An exchange of eligibility information between Medicare and the SMA initiates Medicare premium payments. The service agreement between the SMA and business partner determines the intervals for this business process to execute. The business process receives eligibility information from Medicare, performs a matching process against the State Medicaid Enterprise member data store, generates buy-in files to Centers for Medicare & Medicaid Services (CMS) for verification, receives premium payment information from and generates payments to CMS. The SMA will pay the private health insurance premiums for members who have private health insurance benefits, if it determines the insurance to be cost effective. In these circumstances, the SMA prepares and sends a premium to the member's private health insurance company. Health insurance premium payment initiates with an application for Medicaid where the applicant indicates they have third-party health coverage or by receiving eligibility information via referrals from Home and Community-Based Services (HCBS) Offices, schools, community services organizations, or phone calls directly from members. The business process checks for internal eligibility status as well as eligibility with other payers, producing a report identifying individuals where paying premiums would be cost effective, and notifying members via ***Manage Applicant and Member Communication*** business process. **NOTE:** This business process does not include sending the premium payments as an Electronic Data Interchange (EDI) transaction.
Trigger Event	State transition Trigger Events: • Receive alert of Medicare eligibility from Health Insurance Marketplace (HIX). • Receive alert of Medicaid applicant with third-party insurance. Environment-based Trigger Events: • Periodic timetable is due for receipt of Medicare eligibility information. • Periodic timetable (e.g., monthly) is due for insurance premium eligibility redetermination and payments.

FM Accounts Payable Management	
Manage Member Financial Participation	
Item	**Details**
	• Receive insurance information either by the member or through a referral.
Result	• Modification to Medicare buy-in reporting. • Identification of individuals where paying insurance premiums is cost effective. • Alert to send notification of premium payment to member via ***Manage Applicant and Member Communication*** business process. • Alert to send notification of premium payment to Medicaid. • Alert to ***Manage Accounts Payable Information*** business process for conducting premium payment. • If applicable, alert send notification to business partner of member premium payment via ***Manage Business Relationship Communication*** business process. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Alert to determine if the State Medicaid Agency (SMA) should pay a member's premium. 2. Prepare Medicaid Premium Payment. a. Receive State Data Exchange (SDX), Enrollment Data Base (EDB) file, and/or the SSA Beneficiary Data Exchange (BENDEX) eligibility files from the **Receive Inbound Transaction**. b. Perform a matching process against the Member data store. c. Generate buy-in file, containing both Medicare Part A and Medicare Part B members (includes all requests for action including discrepancies from previous month). d. Send buy-in file to CMS. e. Receive CMS responses to the buy-in file (i.e., the Billing File for both Part A and Part B) including eligibles, responses to errors, and Medicare buy-in file information. f. Process CMS responses to the submitted buy-in file and assess the file for accuracy and completeness. g. Post buy-in modifications to the Member data store. h. Produce buy-in reports reflecting potential Medicare eligibles including any additions or deletions to existing Member data store as well as other discrepancies. i. Staff researches unmatched and discrepancies to determine appropriate eligibility. j. Send problem discrepancy form(s) reflecting potential Medicare eligibles, unmatched, and discrepancies to the Buy-in Administration, and update final Medicare buy-in file for internal use.

FM Accounts Payable Management	
Manage Member Financial Participation	
Item	**Details**
	3. Prepare Health Insurance Premium Payment (HIPP): a. Receive insurance information either from an applicant or through a referral. b. Check internal and external eligibility information. c. Edit eligibility information. d. Determine cost effectiveness by collecting information such as policy coverage, past usage, and by making a determination of future need – the requirements for determining cost effectiveness will vary among States. e. Produce a report of individuals where paying premiums is cost effective for the SMA. 4. Send alert to conduct premium payment to ***Manage Accounts Payable Information*** business process. 5. If applicable, send alert to notify member of premium payment via ***Manage Applicant and Member Communication*** business process. 6. If applicable, send alert to notify business partner of member premium payment via ***Manage Business Relationship Communication*** business process. 7. **END:** If applicable, send alert to notify Medicare of member premium payment.
Shared Data	Member data store including demographics, cost share, third-party insurance, and premium information Health Insurance Marketplace (HIX) data store including applicant eligibility and member enrollment information (i.e., dual-eligibility) Financial data store including accounts payable information
Predecessor	**Receive Inbound Transaction** ***Determine Member Eligibility***
Successor	**Send Outbound Transaction** ***Manage Member Information*** ***Manage Applicant and Member Communication*** ***Manage Business Relationship Communication*** ***Manage Accounts Payable Information*** ***Manage Accounts Receivable Information***
Constraints	The ***Manage Member Financial Participation*** business process will adhere to the federal policies and business rules.
Failures	• State Medicaid dual eligibility information does not match Medicare dual eligibility information – errors in BENDEX, EDB, or SDX files.

FM Accounts Payable Management	
Manage Member Financial Participation	
Item	**Details**
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which rules are applied =___% • Consistency with which rules are applied=___% • Error rate =___% or less

Manage Capitation Payment

FM Accounts Payable Management	
Manage Capitation Payment	
Item	**Details**
Description	The ***Manage Capitation Payment*** business process includes the activities to prepare Primary Care Case Management (PCCM) or Managed Care Organization (MCO) capitation payments. Some States offer members the option of enrolling in a PCCM product that requires the selection of a Primary Care Physician (PCP). The PCP receives a Per-Member-Per-Month (PMPM) capitation payment amount for all members that the State Medicaid Agency (SMA) assigns. The provider payment schedule defines the PCCM capitation rates typically actuary based on an age and gender rating or flat rate. Provider may opt in or out of PCCM plan and does not have to belong to the MCO. A prevailing alternative to the SMA integrated managed care model is to delegate specific member populations to MCOs and pay the MCO a PMPM capitation amount for all assigned members. The ***Manage Capitation Payment*** business process interrogates the member, provider, and MCO, member assignment and contract capitation information, and creates the information extract necessary to generate the capitation payment. The data extract includes any processing rules and options including retroactive adjustments to member assignments that affect the capitation payment amount to the provider or MCO.
Trigger Event	Environment-based Trigger Events: • Periodic (e.g., monthly) timetable to conduct capitation information extract.
Result	• Alert sent to ***Manage Accounts Payable Information*** business process to generate Provider/MCO capitation payments. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Timed event triggered on monthly basis to initiate ***Manage Capitation Payment*** business process to invoke capitation information extract. 2. **END:** Send alert to ***Manage Accounts Payable Information*** business process to generate provider/MCO capitation payments.

FM Accounts Payable Management	
Manage Capitation Payment	
Item	**Details**
Shared Data	Financial data store including accounts payable information Contractor data store including contract information Member data store including eligibility and benefits information Provider data store including provider network & contract information
Predecessor	***Enroll Member***
Successor	***Manage Accounts Payable Information***
Constraints	The ***Manage Capitation Payment*** business process will adhere to the federal and state policies and business rules that may differ by state.
Failures	• No PCP information is available. • No PCCM information is available.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which rules are applied =___% • Consistency with which rules are applied=___% • Error rate =___% or less

Manage Incentive Payment

FM Accounts Payable Management	
Manage Incentive Payment	
Item	**Details**
Description	The ***Manage Incentive Payment*** business process accommodates administration of various incentive compensations to payers, providers, and members. Federal or state policy defines the programs, which are typically short duration and limited in scope. The policy defines specific periods, qualification criteria, and certification or verification requirements. The ***Manage Incentive Payment*** business process follows the ***Manage Program Policy*** business process that manages program administrative rules, whether federal or state, and concludes with paying the payer, provider, or member.
Trigger Event	Environment-based Trigger Events: • Receive addition or modification of incentive program based on federal or state policy.
Result	• Alert sent to ***Manage Accounts Payable Information*** business process to generate payer, provider or member payment. • Tracking information as needed for measuring performance and business

FM Accounts Payable Management	
Manage Incentive Payment	
Item	**Details**
	activity monitoring.
Business Process Steps	1. **START:** Receive addition or modification of incentive program based on federal or state policy. 2. The State Medicaid Agency (SMA) disseminates federal or state policy regarding incentive program. 3. Payer, provider, or member applies for incentive. 4. State determines if payer, provider, or member is eligible for incentive program. 5. Payer, provider, or member performs activities defined in incentive program policy. 6. Payer, provider, or member submits artifacts required for compliance. 7. Payer, provider, or member requests payment. 8. State determines appropriate payment based on policy guidelines. 9. **END:** Send alert to ***Manage Accounts Payable Information*** business process to generate payment to payer, provider, or member.
Shared Data	Centers for Medicare & Medicaid Services (CMS) Health Information Technology for Economic and Clinical Health (HITECH) Provider Electronic Health Record (EHR) Incentive Program Registration and Attestation (R&A) System Financial data store including accounts payable information Contractor data store including contract information Member data store including demographics information Provider data store including provider network information
Predecessor	***Manage Program Policy***
Successor	***Manage Accounts Payable Information***
Constraints	The ***Manage Incentive Payment*** business process will adhere to the federal and state policies and business rules that may differ by state.
Failures	• Payer, provider, or member is not eligible for incentive program. • Payer, provider, or member does not perform activities defined in incentive program policy. • Payer, provider, or member does not submit artifacts required for compliance.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which rules are applied =___% • Consistency with which rules are applied=___% • Error rate =___% or less

Manage Accounts Payable Information

FM Accounts Payable Management	
Manage Accounts Payable Information	
Item	**Details**
Description	The ***Manage Accounts Payable Information*** business process is responsible for all operational aspects of money the State Medicaid Agency (SMA) pays. Activities in this business process comply with Cash Management Act, Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP). Activities included in this process may be: • Periodic reconciliations between the State Medicaid Enterprise and the system(s) that performs accounting functions. • Assignment of account coding to transactions processed in the State Medicaid Enterprise. • Processing accounts payable invoices created in the State Medicaid Enterprise. • Processing accounts payable invoices created in state accounting system (gross adjustments or other service payments not processed through the State Medicaid Enterprise, and administrative payables). • Loading accounts payable information (warrant number, date, etc.) into the State Medicaid Enterprise. • Managing canceled/voided/stale dated warrants. • Performing payroll activities. • Disbursing federal administrative costs reimbursements to other entities. • Responding to inquiries concerning accounting activities. **NOTE:** States use a variety of solutions including outsourcing to another department or use of a Commercial-Off-the-Shelf (COTS) package.
Trigger Event	Environment-based Trigger Events: • Receive request for payment. • Receive accounts payable information.
Result	• Modification to accounts payable information. • Alert sent to disburse payment to ***Manage Accounts Payment Disbursement*** business process. • If applicable, alert sent to ***Establish Compliance Incident*** business process for a member's, provider's or contractor's continued failure to make payment. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request and information to make payment. 2. Perform requested function.

FM Accounts Payable Management	
Manage Accounts Payable Information	
Item	**Details**
	3. Produce report. 4. If applicable, alert sent to ***Establish Compliance Incident*** business process for continued failure to make obligated payments. 5. Produce financial transaction. 6. Update financial information. 7. Send alert to make payment to ***Manage Accounts Payment Disbursement*** business process. 8. **END:** Send response to requested function.
Shared Data	State accounting system accounts payable information Financial data store including payroll, general ledger, and accounts payable information Claims data store including payment information Contractor data store including contract information Member data store including demographics information Provider data store including provider network information
Predecessor	**Receive Inbound Transaction** ***Manage Contractor Payment*** ***Manage Incentive Payment*** ***Manage Member Financial Participation*** ***Manage 1099*** ***Manage Capitation Payment***
Successor	**Send Outbound Transaction** ***Manage Accounts Payment Disbursement*** ***Generate Financial Report*** ***Establish Compliance Incident*** ***Manage Data***
Constraints	The SMA will follow federal and state-specific accounting and financial requirements.
Failures	• Failure to account for expenditures in accordance with GAAP can result in disallowance of federal funding participation.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours

FM Accounts Payable Management	
Manage Accounts Payable Information	
Item	**Details**
	• Accuracy with which rules are applied =___% • Consistency with which rules are applied=___% • Error rate =___% or less

Manage Accounts Payable Disbursement

FM Accounts Payable Management	
Manage Accounts Payable Disbursement	
Item	**Details**

Description	The ***Manage Accounts Payable Disbursement*** business process that is responsible for managing the generation of electronic and paper-based reimbursement instruments, includes:
	• Calculation of payment amounts fee-for-service claims, pharmacy point-of-sale, and Home and Community-Based Services (HCBS) based on:
	  o Priced claim, including any Third-Party Liability (TPL), and crossover or member payment adjustments.
	  o Retroactive rate adjustments.
	  o Adjustments for previous incorrect payments, taxes, performance incentives, recoupments, garnishments, and liens based on information in the Provider data store, as well as state accounting and budget rules.
	  o Payroll processing (e.g., for HCBS providers) which includes withholding payments for payroll, federal and state taxes, as well as union dues.
	  o Application of automated or user-defined adjustments based on contract (e.g., adjustments or performance incentives).
	• Disbursement of payment from appropriate funding sources per state and the State Medicaid Agency (SMA) accounting and budget rules including:
	  o Managed Care Organization (MCO) per member per month premium.
	  o Health Insurance Premium Payment (HIPP) Program premium.
	  o Medicare premium.
	  o Primary Care Case Managers (PCCM) fee.
	  o Stop-loss payment.
	  o PCCM management fee.
	  o Health Insurance Flexibility and Accountability (HIFA) waiver small employer refunds (i.e. Parents of children enrolled in Children's Health Insurance Program (CHIP)).
	• If applicable, association of the Electronic Funds Transfer (EFT) with an Accredited Standards Committee (ASC) X12 835 Health Care Claim Payment/Advice or ASC X12 820 Payroll Deducted and Other Group Premium

FM Accounts Payable Management	
Manage Accounts Payable Disbursement	
Item	**Details**
	Payment for Insurance Products transaction. • Routing of the payment per the provider or contractor data store payment instructions for EFT or check generation and mailing. • Alert sent to the ***Manage Accounts Payable Information*** business process with updated suspended and paid claims transaction accounting details. • Alert sent to the ***Manage Accounts Payable Information*** business process with updated suspended and paid premium, fees, and stop-loss claims transaction accounting details. The SMA will support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real-time payments where appropriate (e.g., Pharmacy Point-of-Sale).
Trigger Event	State transition Trigger Events**:** • Receive payment request from the ***Process Claim*** business process. • Receive payment request from the ***Process Encounter*** business process. • Receive premium fee or stop-loss claim information from the ***Manage Member Financial Participation*** or ***Prepare Provider Payment*** business processes. Environment-based Trigger Events: • Receive payment request.
Result	• Provider or contractor received payment either by EFT or check. • Alert sent to send ASC X12 820 Payment Order/Remittance Advice transaction for payment to provider or contractor. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for payment. 2. Prepare provider payment: a. Receive payment information from the ***Process Claim*** or ***Process Encounter.*** b. Apply automated or user-defined payment calculation rules (e.g., deducting tax per rates in provider files, garnishments, and liens) by accessing information from provider files and sending an alert to the ***Manage Accounts Payable Information*** business process. c. For payroll processing, perform tax withholds and generate information for accounting. 3. Prepare premium payment: a. Receive premium payment information from the ***Manage Member Financial Participation*** or ***Prepare Provider Payment*** business processes.

FM Accounts Payable Management	
Manage Accounts Payable Disbursement	
Item	**Details**
	b. Apply automated or user-defined payment calculation rules such as risk adjustment and stop-loss claims, retrospective enrollment, and performance incentives. 4. Disburse funds as specified by the state and the SMA accounting and budget business rules. 5. **END:** Route payments as specified by the provider or contractor pay-to instruction or based on information submitted in the standard claim transactions.
Shared Data	Claims data store including payment information Health Benefit data store including benefit information and fee schedules Provider data store including demographic, tax, pay-to and payment routing instructions, liens, garnishments, adjustments, incentives, rates, and contract information Authorization data store including authorization and treatment plan information Contractor data store including demographic, tax, pay-to and payment routing instructions, liens, garnishments, adjustments, incentives, reimbursement arrangements, rates, stop-loss claim payments, and contract information Financial data store including accounting rules, rates, and funding sources Member data store including demographics information
Predecessor	***Manage Accounts Payable Information*** ***Manage Provider Information*** ***Process Claim*** ***Process Encounter*** ***Manage Performance Measures*** ***Generate Remittance Advice*** ***Manage Member Financial Participation*** ***Prepare Provider Payment***
Successor	**Send Outbound Transaction** ***Manage Accounts Payable Information*** ***Manage Performance Measures***
Constraints	States apply different tax and accounting rules to this business process. Some will not do payroll processing or have performance incentives. Some may associate EFTs with remittance advice transactions. Some will not have an MCO premium or MCO capitation, a PCCM fee, stop-loss, or performance incentives. Some may associate EFTs with premium payment transactions.
Failures	• Calculation of payment and application of payment adjustments may lack

FM Accounts Payable Management	
Manage Accounts Payable Disbursement	
Item	**Details**
	accurate information or be inaccurate. • Entity failed to receive EFT or check, the check is not payable due to insufficient funds, or payee returns the check. • Unable to process payment due to a mutilated, destroyed or stale dated check.
Performance Measures	• Time to complete process = within __ days • Accuracy with which the SMA applies edits = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Manage 1099

FM Accounts Payable Management	
Manage 1099	
Item	**Details**
Description	The ***Manage 1099*** business process describes how the State Medicaid Agency (SMA) handles IRS 1099 forms including preparation, maintenance, and corrections. Any payment or adjustment in payment made to a single Social Security Number (SSN) or federal Tax ID Number (TIN) impacts the business process. The ***Manage 1099*** business process receives payment and/or recoupment information from the ***Process Claim*** business process or from the ***Manage Accounts Payable Information*** business process. The ***Manage 1099*** business process may also receive requests for additional copies of a specific IRS 1099 form or receive notification of an error or a needed correction. The business process provides additional requested copies via the ***Manage Provider Communication*** or ***Manage Contractor Communication*** business processes. Staff researches error notifications and requests for corrections for validity and generate a corrected 1099 or a brief explanation of findings.
Trigger Event	Environment-based Trigger Events**:** • Request from a provider, state or federal agency. • End of the calendar year. State transition Trigger Events: • Receive information from ***Process Claim*** or ***Manage Accounts Payable Information*** business processes indicating payments and/or recoupments. • Receive information from ***Manage Provider Information*** business process for modifications. • Receive information from ***Manage Contractor Information*** business process for modifications.

FM Accounts Payable Management	
Manage 1099	
Item	**Details**
Result	• Updated and/or corrected 1099 information (i.e., form, file, paper, or Electronic Data Interchange (EDI) sent to providers, contractors, Internal Revenue Service (IRS), and other state agencies. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	<u>Preparation/Maintenance</u> 1. **START:** Receive claim payment and adjustment information from ***Process Claim*** or ***Manage Accounts Payable Information*** business process. 2. Match TIN or SSN. 3. Update cumulative totals by applying all payments and recoupments, including those from cost settlements and manual checks. a. Prepare report of those not getting a 1099. b. Produce master report of 1099s. c. Review all 1099 reports for accuracy. 4. Prepare 1099 at close of calendar year. 5. Send 1099 to appropriate providers and contractors prior to January 31. 6. **END:** Submit 1099 information to Internal Revenue Service (IRS). <u>Alternate Path - Additional Requests</u> 1. **START:** Receive request for additional 1099(s). 2. Agency logs request. 3. Verify identity of requesting entity. 4. Re-generate requested 1099(s). 5. Send 1099 to requesting entity. 6. **END:** Agency logs 1099(s) sent. <u>Alternate Path - Corrections</u> 1. **START:** Receive notification of error or modification request from ***Manage Provider Information*** or ***Manage Contractor Information*** business processes 2. Agency logs request. 3. Verify identity of requesting entity. 4. Research error or update request. 5. If no error found, send alert to notify requesting entity of findings. **END:** Business process stops. 6. If error found valid, make necessary modifications.

FM Accounts Payable Management	
Manage 1099	
Item	**Details**
	7. Prepare corrected or updated 1099. 8. Agency logs 1099 sent. 9. Send corrected 1099 to affected parties. 10. **END:** Submit corrected 1099 information to Internal Revenue Service (IRS).
Shared Data	Financial data store including accounts payable information Claim data store including payment information Contractor data store including demographics and 1099 information Provider data store including demographics and 1099 information 1099 Information sent to Internal Revenue Service (IRS)
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Manage Accounts Payable Information*** ***Manage Provider Information*** ***Manage Contractor Information***
Successor	**Send Outbound Transaction** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Manage Accounts Payable Information***
Constraints	The SMA will follow IRS regulations regarding 1099 requirements.
Failures	• Invalid format or media used.
Performance Measures	• Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours • Accuracy of decisions = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Formulate Budget

FM Fiscal Management	
Formulate Budget	
Item	**Details**
Description	The ***Formulate Budget*** business process: • Examines the current budget revenue stream and trends, and expenditures. • Assesses external factors affecting the program. • Assesses agency initiatives and plans. • Models different budget scenarios. • Periodically produces a new budget.
Trigger Event	Environment-based Trigger Events: • Periodic timetable (e.g., annual) is due for budget review. • Receive review request from external forces (e.g., notice of revenue shortfall or overage and/or unforeseen rise in costs).
Result	• New or revised budget. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START**: Receive notice or other trigger event to prepare the Office of Governor budget transmittal for Legislative approval. 2. Review current budget including cost and revenue trends, Centers for Medicare & Medicaid Services (CMS) notification of federal grant award, demographics, utilization, and other information. 3. Research factors (e.g., national, legislative, and global) that affect the State Medicaid Agency (SMA) revenue, costs, major initiatives, and benefits. 4. Develop and send Office of Governor budget transmittal. 5. Testify before state legislature and/or convene stakeholders to consider alternatives. 6. Model or modify budget transmittal based on legislative or Office of Governor directives. 7. Legislature publishes finalized budget. 8. **END**: Enter approved budget into state accounting system and other expenditure accounting systems.
Shared Data	Financial data store including budget information Business Activity data store including performance information Plan data store including plan information Health Benefit data store including benefit information

FM Fiscal Management	
Formulate Budget	
Item	**Details**
Predecessor	***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Performance Measures***
Successor	***Manage Budget Information*** ***Manage Health Plan Information*** ***Manage Health Benefit Information***
Constraints	The SMA will follow federal and state requirements for budget management. Economic conditions shift, making less revenue available to fund the approved and planned budget.
Failures	• Failure to receive all levels of required approval (that could result in continued use of previously approved budget).
Performance Measures	• Time to complete process = within __ days • Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Accuracy of budget projections measured against reality = ___%

Manage Budget Information

FM Fiscal Management	
Manage Budget Information	
Item	**Details**
Description	The ***Manage Budget Information*** business process is responsible for auditing all planned expenses and revenues of the State Medicaid Agency (SMA). Activities in this business process comply with Cash Management Act, Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP).
Trigger Event	Environment-based Trigger Events: • Receive request to review budget information (e.g., funding requirements, funding sources).
Result	• Modified budget information. • Tracking information as needed for measuring performance and business activity monitoring.

FM Fiscal Management	
Manage Budget Information	
Item	**Details**
Business Process Steps	1. **START:** Receive request to review or modify approved budget. 2. Review policies and procedures for planning and budgeting to determine if budget meets state and federal requirements. 3. Review long-term goals and objectives plans. 4. Review budget to determine accurate and timely information. 5. Review budget performance monitoring information. 6. Review budget revisions to determine their justification and the SMA makes in a timely manner. 7. Prepare budget modification request to Office of Governor based on state budget policies. 8. Receive approval from Office of Governor to modify budget. 9. **END:** Modify budget information as necessary.
Shared Data	Financial data store including accounts payable, accounts receivable, and budget information
Predecessor	***Formulate Budget*** ***Manage Fund*** ***Manage Health Plan Information*** ***Manage Health Benefit Information***
Successor	***Generate Financial Report*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Data***
Constraints	The SMA will follow federal and state requirements for budget management. Economic conditions shift, making less revenue available to fund the approved and planned budget.
Failures	• This business process has no failure modes that prevent the process from going to completion.
Performance Measures	• Time to complete process = within __ days • Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Manage Fund

FM Fiscal Management	
Manage Fund	
Item	**Details**
Description	The ***Manage Fund*** business process oversees Medicaid funds, ensures accuracy in their allocation and the reporting of funding sources. Funding for Medicaid services may come from a variety of sources, and often, state funds span across state agency administrations, e.g., Mental Health, Aging, Substance Abuse, physical health, as well as state counties and local jurisdictions. The ***Manage Fund*** business process monitors funds through ongoing tracking and reporting of expenditures and corrects any improperly accounted expenditure. It also deals with projected and actual over and under fund allocations. Manage Federal Medical Assistance Percentages (FMAP) The Manage FMAP activity periodically reviews and modifies, as appropriate, FMAP and Enhanced Federal Medical Assistance Percentages (enhanced FMAP) rate used. (See 42 CFR 433.10). The U.S. Department of Health & Human Services (HHS) notifies the state of the FMAP and (enhanced FMAP) that HHS will use in determining the amount of federal matching for state medical assistance (Medicaid), Children's Health Insurance Program (CHIP), and Recovery Audit Contractor (RAC) expenditures for a specified federal fiscal year. The State Medicaid Agency (SMA) reviews and approves the FMAP rates for application in enterprise accounting. Manage Federal Financial Participation (FFP) The Manage FFP business activity includes the creation and management of business rules for assigning claims, service payments, and recoveries (including RAC recoveries) to the appropriate FMAP, and the application of administrative costs to the state accounting system. It also includes the oversight of reporting and monitoring Advance Planning Documents or other program documents necessary to secure and maintain FFP. Draw and Report FFP The Draw and Report FFP business activity assures that the SMA properly draws federal funds and reports to Centers for Medicare & Medicaid Services (CMS). The SMA is responsible for assuring that the correct FFP rate applies to all expenditures in determining the amount of federal funds to draw. When CMS has approved a Medicaid State Plan, it makes quarterly grant awards to the SMA to cover the federal share of expenditures for services, training, and administration. The grant award authorizes the SMA to draw federal funds as needed in accordance with the Cash Management Improvement Act (CMIA) to pay the federal share of disbursements. The SMA receives FFP in expenditures for the CHIP program.
Trigger Event	Environment-based Trigger Events: • A request from the legislature, or a new budget approved. • Periodic timetable (e.g., weekly, monthly, quarterly, annual, 3-year plan, 5-year plan) is due for generating required reports. • Receive new match rates or rate modifications from HHS. • Receive notification to apply FMAP rate to service expenditures or recoveries.

FM Fiscal Management	
Manage Fund	
Item	**Details**
	• Periodic timetable (e.g., quarterly) is due for a statement of expenditures. • Continuous oversight of expenditures for an FFP. • The SMA adds a new health plan or health benefit. • Periodic timetable is due for an audit.

Result	• Tracking and trending of all program expenditures and management of them within budget constraints.
	• Produces updated FMAP.
	• Service expenditure and recovery information with applied FMAP rate.
	• Calculation of FFP available for all eligible members, systems, and administration of the State Medicaid Enterprise.
	• Content prepared for the following reports:
	  o CHIP Program Budget Report (CMS-21B)
	  o Medicaid Program Budget Report (CMS-37)
	  o Quarterly CHIP Statement of Expenditures (CMS-21)
	  o Quarterly Expense Report (CMS-64)
	NOTE: The ***Generate Financial Report*** business process generates and sends the CMS report.
	• Tracking information as needed for measuring performance and business activity monitoring.

Business Process Steps	<u>Manage Fund</u> 1. **START:** Establish state appropriation for federal and state funds. 2. Allocate funds to direct and indirect budget categories. 3. Establish reporting requirements. 4. Define report content, frequency, and media. 5. Prepare the information. 6. Compare fund usage with categories, flag funds improperly used. 7. Trend rate of usage of funds versus amounts available, flag-computed shortfalls. 8. Generate defined reports. 9. Review reports for accuracy. 10. Distribute reports. 11. **END:** Review trends and improper use of funds, and manage funds as needed to deal with shortfalls and over allocations. <u>Manage FMAP</u>

FM Fiscal Management	
Manage Fund	
Item	**Details**
	1. **START:** Receive notification of FMAP rates or rate modifications. 2. Review and analyze notification. 3. Verify accuracy of rates in notification. 4. Notify HHS of any disagreement. 5. Resolve any disagreement with HHS. 6. **END:** Publish/load approved rates. <u>Manage FFP</u> 1. Prepare information necessary to create the reports (e.g., CMS-21, CMS-37 and CMS-64). 2. Generate reports. 3. Review generated reports for accuracy and deficiencies. 4. Monitor expenditures, cost, budget, and so forth. 5. Analyze potential program additions, modifications, or deletions for fiscal impact. 6. Modify and update impacted reports and budget. 7. Finalize report. 8. **END:** Send report via the **Send Outbound Transaction.** <u>Draw and Report FFP</u> 1. **START:** Submit Form CMS–37 and Form CMS–21B through the Medicaid Budget and Expenditure System/CHIP Budget and Expenditure System (MBES/CBES). 2. Review the quarterly grant request. 3. Receive the grant award from CMS regardless of whether there are open issues with CMS. The Payment Management System (PMS) deposits funds into the Medicaid account based upon the CMS 37 estimates. 4. Determine the federal share of current expenditures taking into consideration receipts (e.g. estate recovery, recoupments of incorrect billings) and draw federal funds in accordance with the terms of the CMIA. 5. At end of each quarter, complete cash management reconciliation using the PMS 272 report. 6. Submit Form CMS–64 and Form CMS–21 to MBES/CBES. 7. CMS may increase or decrease the grant request amount already deposited according to the resolution of issues process. The SMA sends supporting documentation to the CMS Regional Office for use in its quarterly review to support State Medicaid Enterprise numbers and to address deferrals,

FM Fiscal Management	
Manage Fund	
Item	**Details**
	disallowances, supplemental payment. 8. The SMA cooperates with CMS reviews of program and administration expenditures and implements corrective action if CMS Financial Management Review (FMR) or Office of Inspector General reviews reveal any federal requirement compliance problems. 9. Arrange for annual Single Audit for the Comprehensive Annual Financial Report conducted by a state-contracted Certified Public Accountant (CPA) firm in accordance with the provisions of OMB Circular A-133. 10. **END:** Follow-up and corrective action(s) on audit findings includes the preparation of a summary schedule of prior audit findings and submission of a Corrective Action Plan (CAP).
Shared Data	Financial data store including budget, accounts receivable, and accounts payable information Plan data store including health plan information Health Benefit data store including benefit package and benefits information State Financial Management Applications Reference data store including code sets information
Predecessor	**Receive Inbound Transaction** ***Manage Health Plan Information*** ***Manage Health Benefit Information***
Successor	**Send Outbound Transaction** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Information***
Constraints	State legislative or agency policies augment the information. FMAP applies to Medicaid expenditures for services under the Medicaid State Plan with the exception of the following: family planning services, services provided through Indian Health Service facilities, services provided to members eligible under the optional Breast and Cervical Cancer program, and Medicare Part B premiums for Qualified Individuals. Manage FFP will conform to state-specific and CMS FFP assignment requirements.
Failures	• The SMA lacks money for budget or is short of revenue. • Natural disaster strikes impacting budget management. • System failure prevents new rates from loading or rates are loaded incorrectly. • The SMA encounters errors in FMAP rate or assignment of rate to individual services.

FM Fiscal Management	
Manage Fund	
Item	**Details**
	• The SMA is unable to balance reports. • The SMA is unable to access all information required for reporting. • There are discrepancies in information invalidate FFP calculations.
Performance Measures	• Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours • Accuracy of decisions = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Generate Financial Report

FM Fiscal Management	
Generate Financial Report	
Item	**Details**
Description	It is essential for the State Medicaid Agency (SMA) to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the established benefits and programs are meeting the needs of the member population and are performing according to the intent of the legislative laws or federal reporting requirements. The ***Generate Financial Report*** business process begins with a request for information or a timetable for scheduled correspondence. The business process includes: • Defining the report attributes (e.g., format, content, frequency, media, and retention). • Defining the state and federal budget categories of service, eligibility codes, provider types, and specialties (taxonomy). • Extracting required financial information from source data stores. • Transforming information to meet business and technical needs of target destination. • Applying necessary encryption algorithms for security. • Sending alert with information to the target destination. **NOTE:** This business process does not include maintaining the benefits, reference, or program information. Maintenance of the health plan, health benefits, and reference information is in separate business processes.
Trigger Event	Environment-based Trigger Events: • Request to generate on-demand report on financial and/or program information.

FM Fiscal Management	
Generate Financial Report	
Item	**Details**
	• Periodic timetable (e.g., daily, weekly, quarterly) is due for financial reporting.

Result	• The on-demand or scheduled generation of a financial report.
	• The financial and program analysis report set sent to the **Send Outbound Transaction**.
	• Generation of Centers for Medicare & Medicaid Services (CMS) specific reports such as the following:
	  o CHIP Program Budget Report (CMS-21B)
	  o Medicaid Program Budget Report (CMS-37)
	  o Quarterly CHIP Statement of Expenditures (CMS-21)
	  o Quarterly Expense Report (CMS-64)
	• Tracking information as needed for measuring performance and business activity monitoring.

Business Process Steps	1. **START:** Receive request for generation of financial report. 2. Agency logs the request. 3. Define required report(s) format, content, frequency, media for the reports, and its retention period. 4. Define data elements necessary to produce the report (e.g., state and federal budget categories of service, eligibility codes, taxonomy codes). 5. Extract required information from source data stores. 6. If applicable, transform information to meet business and technical needs of target destination. 7. If applicable, apply necessary encryption algorithms for security. 8. Agency logs the response. 9. If applicable, send the report to the **Send Outbound Transaction** for delivery to target destination. 10. **END:** Review financial report for analysis or distribution.
Shared Data	Financial data store including accounts receivable, accounts payable, Recovery Audit Contractor (RAC) recoveries, and budget information Claims data store including payment information Member data store including demographics information Provider data store including provider network information Reference data store including code set information
Predecessor	***Manage Budget Information*** ***Manage Accounts Receivable Information***

FM Fiscal Management	
Generate Financial Report	
Item	**Details**
	Manage Accounts Payable Information
Successor	**Send Outbound Transaction** ***Manage Data***
Constraints	The generation of financial and program analysis reports will adhere to state-specific or federal laws, regulations, and requirements. These rules will differ by state.
Failures	• Information is unavailable to generate the report.
Performance Measures	• Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy of decisions • Consistency of decisions and disposition = ___% • Error rate = __% or less

MEMBER MANAGEMENT

NOTE: *Due to the regulation rule-making efforts underway at CMS, the MITA Framework 3.0 does not include the Member Management business processes or business capability matrices. CMS will update the MITA Framework 3.0 with appropriate information from the final rules in a future release.*

OPERATIONS MANAGEMENT

Generate Remittance Advice

OM Payment and Reporting	
Generate Remittance Advice	
Item	**Details**
Description	The ***Generate Remittance Advice*** business process describes the activity of preparing remittance advice/encounter Electronic Data Interchange (EDI) transactions that providers use to reconcile their accounts receivables. This business process begins with receipt of information resulting from the ***Process Claim*** business process, performing required manipulation according to business rules and formatting the results into the required output information that process sends to **Send Outbound Transaction**.
Trigger Event	Interaction-based Trigger Events: • Receive the claims information from the ***Process Claim*** business process.
Result	• Alert to send to provider Accredited Standards Committee (ASC) X12 835 Health Care Claim Payment/Advice transaction. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive claims information from the ***Process Claim*** business process. 2. Perform required information manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, e.g., bundling or unbundling of services. 3. Generate remittance advice transaction. 4. Send alert to send to provider ASC X12 835 Health Care Claim Payment/Remittance Advice transactions. 5. **END:** If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA).
Shared Data	Provider data store including provider network and contract information Claims data store including payment information
Predecessor	***Process Claim***
Successor	**Send Outbound Transaction** ***Manage Data***
Constraints	Remittance Advice-Encounter Reports conforms to the format and content in accordance with federal and state-specific reporting requirements, e.g., using HIPAA Transaction Standard Companion Guide that may differ based on situational fields determined by state policy.

OM Payment and Reporting	
Generate Remittance Advice	
Item	**Details**
Failures	• Unresolved conflicts in the reported details in the remittance advice.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which remittance advice/encounter report rules are applied = ___% • Error rate = __% or less

Inquire Payment Status

OM Payment and Reporting	
Inquire Payment Status	
Item	**Details**
Description	The ***Inquire Payment Status*** business process begins with receiving an Accredited Standards Committee (ASC) X12 276 Health Care Claim Status Request transaction or a request for information received through other means such as email, paper, telephone, facsimile, web, or Automated Voice Response (AVR). The business process handles the request for the status of a specified claim(s), retrieves information from the claims payment history, and generates the response information. In addition, the business process formats the information into the ASC X12 277 Health Care Information Status Notification transaction, or other mechanism for responding, via the media used to communicate the inquiry, and sends claim status response via the **Send Outbound Transaction**.
Trigger Event	Interaction-based Trigger Events: • Receive status request via ASC X12 276 Health Care Claim Status Request transaction. Environment-based Trigger Events: • Receive status request via email, mail, mobile device, facsimile, telephone, or web.
Result	• Requester received claims status information. • If applicable, response sent via ASC X12 277 Health Care Information Status Notification transactions to requester. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Tracking information as needed for measuring performance and business activity monitoring.

OM Payment and Reporting	
Inquire Payment Status	
Item	**Details**
Business Process Steps	1. **START:** Receive claim status request. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process ends. 2. Agency logs claim status request. 3. Validate requester has authorization to receive requested information. 4. Inquire the payment status information to obtain required requested data elements (e.g., member birth date, member last and first name, member ID, claim service date, internal control number, medical record number). 5. Generate claim status response. 6. If applicable, provide claim status response via ASC X12 277 Health Care Information Status Notification transactions to requester. 7. **END:** If applicable, receive alert from submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA).
Shared Data	Claim data store including payment information
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Process Encounter*** ***Generate Remittance Advice*** ***Apply Mass Adjustment***
Successor	**Send Outbound Transaction**
Constraints	Payment Status Inquiry and Response will conform to the format and content in accordance with federal and state-specific requirements, e.g., using HIPAA Transaction Standard Companion Guide that may differ based on situational fields determined by state policy.
Failures	• The State Medicaid Agency (SMA) does not receive the claim Payment Status Inquiry submission.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which payment status rules are applied = __% • Consistency with which payment status rules are applied = __%

OM Payment and Reporting	
Inquire Payment Status	
Item	**Details**
	• Error rate = __% or less

Prepare Provider Payment

OM Payment and Reporting	
Prepare Provider Payment	
Item	**Details**
Description	The ***Prepare Provider Payment*** business process is responsible for the preparation of the payment report information. Reports sent via email, mail, or Electronic Data Interchange (EDI) to providers and used to reconcile their accounts receivable. Many Home and Community-Based Services (HCBS) are not part of the traditional Medicaid health plan. Services tend to be member specific and often arranged through a plan of care. Atypical providers who render services for HCBS waivers may not have authorization, or may not adjudicate in the same manner as other health care providers. This business process begins with receipt of HCBS information from the ***Process Claim*** business process or capitation information from ***Process Encounter*** business process, performing required manipulation according to business rules, and formatting the results into the required information. The capitation payment activity includes a per-member-per-month payment for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This business process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement (TPA) and includes retrieving enrollment and benefit transaction information from the Member data store, retrieving the rate information associated with the plan from the Provider or Contractor data store, and formatting the payment into the required information.
Trigger Event	Interaction-based Trigger Events: • Alert from ***Process Claim*** business process to prepare HCBS payment. • Alert from ***Process Encounter*** business process to prepare capitation payment. Environment-based Trigger Events: • Periodic timetable (e.g., monthly) is due for capitation payment.
Result	• Generated Provider's payment report. • Alert to send HCBS payment information to member. • Alert to send capitation payment information to member. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	<u>HCBS Payment</u> 1. **START:** Receive alert from ***Process Claim*** business process. 2. Perform required information manipulation according to business rules,

OM Payment and Reporting	
Prepare Provider Payment	
Item	**Details**
	including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, such as bundling or unbundling of services. 3. Calculate payment amount. 4. Generate payment report. 5. **END:** Send alert to submit HCBS payment information to member. <u>Capitation Payment</u> 1. **START:** Periodic timetable is due for capitation payment. 2. Perform required information manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, such as bundling or unbundling of services. 3. Calculate payment amount. 4. Generate payment report. 5. **END:** Send alert to submit capitation payment information to member.
Shared Data	Claims data store including payment information Reference data store including code set, drug formulary, and service code formulary information Care management data store including prior authorization information Member data store including demographics and third-party insurance information Provider data store including provider network and contract information Contractor data store including provider network and contract information Financial data store including accounts payable information
Predecessor	***Process Claim*** ***Process Encounter***
Successor	**Send Outbound Transaction** ***Manage Contractor Payment***
Constraints	The ***Prepare Provider Payment*** business process will adhere to the federal and state policies and business rules that may differ by state.
Failures	• No alerts received from ***Process Claim*** or ***Process Encounter*** business processes.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which rules are applied =___% • Consistency with which rules are applied=___%

OM Payment and Reporting	
Prepare Provider Payment	
Item	**Details**
	• Error rate =___% or less

Process Claim

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Process Claim	
Item	**Details**

Description	The ***Process Claim*** business process receives original or adjusted claim (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction, assigns an internal control number, and
	• Determines its submission status, and based on that:
	  o Performs Claims Edits:
	  ✓ Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction.
	  ✓ Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding.
	  o Performs Claims Audits:
	  ✓ Verify against historical information.
	  ✓ Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity.
	  o Suspends claim that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules.
	  o Applies National Correct Coding Initiative (NCCI) Edits.
	  o Applies Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC), as appropriate.
	  o Prices Claims:
	  ✓ Calculate state allowed amount.
	  ✓ Calculate paid amount.
	NOTE: All fee-for-services claim types will go through most of the business process steps but with different business rules associated with the different claim types. Both Centers for Medicaid & Medicaid Services (CMS) and state policy determine business rules for claims edits, audits, and pricing methodologies. State business rules define whether the State Medicaid Agency (SMA) pays, suspends, flags for information, or denies a claim. State business rules define whether an edit is fatal or non-fatal as well. *See Constraints*.
	NOTE: An adjustment to a claim is on an exception use case to this business process that follows the same process path except it requires a link to the previously

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Process Claim	
Item	**Details**
	submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the payment information. **NOTE:** This business process is part of a suite including ***Calculate Spend-down Amount, Submit Electronic Attachment***, and ***Generate Remittance Advice*** business processes.
Trigger Event	Interaction-based Trigger Events: • Receive claim via Accredited Standards Committee (ASC) X12 837 Health Care Claim fee-for-services claims transactions. • Receive Retail Pharmacy Claim Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). Environment-based Trigger Events: • Receive a scanned or direct-data-entered paper claim. • Periodic (e.g., daily, weekly) adjudication/payment cycles is due.
Result	• The SMA adjudicates a claim. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to send to submitter via ASC X12 277 Health Care Information Status Notification for requesting additional information. • If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to ***Generate Remittance Advice*** business process with payment and/or error report information. • Alert sent to ***Prepare Provider Payment*** business process for payment. • If applicable, alert sent to send to ***Manage TPL Recovery*** business process for third-party insurance. • Alert sent to ***Manage Accounts Receivable Information*** business process with payment information. • Alert sent to ***Manage Accounts Payable Information*** business process with HCBS payment information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive claim submission or claim adjustment information. 2. Perform Fatal Edits:

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Process Claim	
Item	**Details**
	a. If electronic claim submission, perform ASC X12N edits for valid syntax and format, identifiers and codes, dates, and other information required for the transaction according to the agreed-upon levels 1-7 stated in the Trading Partner Agreement. i. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. b. Validate that claim submission meets filing deadlines based on service dates. c. If applicable, reject claim for electronic or paper claim fatal validation errors and send alert to ***Generate Remittance Advice*** business process with error report information. **END:** Business process stops. 3. Perform Non-Fatal Edits: a. Determine claim status as initial, adjustment to a processed claim, or a duplicate submission that is already in the adjudication process, but not yet completed and loaded into payment history (using a unique Patient Account Number). i. If applicable, associate the claim adjustment to the original claim submission. b. Validate provider information (e.g., provider taxonomy, National Provider Identification (NPI), enrollment status, approved to bill for this service). c. Validate member information (e.g., Member's eligibility status on the date of service, apply third-party resources to the claim). i. If applicable, alert sent to ***Manage TPL Recovery*** business process for third-party insurance. d. Validate member's health benefit covers the service and apply appropriate rules. For example: i. Because adult member benefit package does not cover dental services, deny the claim. ii. Member is in another health plan that is their primary insurance, and the Medicaid covers the same service. Designate the claim for the Coordination of Benefits (COB) and deny the claim. Under a payer-to-payer business model, the primary payer receives the COB claim. e. Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status. f. If provider submits service authorization, referral or treatment plan number, verify the number, member, provider, service, and date(s) of service. g. If state-defined business rules identify certain edits that cause a claim to suspend, and a claim fails for one or more of them, go to Alternate

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Process Claim	
Item	**Details**
	Path: Suspended Claim below. 4. Perform Audits: a. Check payment history for duplicate processed claim using search key information such as in-house claim number, date of service, provider and member demographics, service, and diagnosis codes. b. If provider did not submit service authorization, referral or treatment plan, and one exists on file, validate number, member, provider, service, and date(s) of service against claims history. c. Check Clinical Appropriateness of the services provided based on clinical, case, and disease management protocols. d. Perform Prospective Payment Integrity Check. e. If state-defined business rules identify certain audits that cause a claim to suspend, and a claim fails for one or more of them, go to Alternate Path: Suspended Claim below. 5. Validate National Correct Coding Initiative (NCCI) (bundle/unbundle codes). 6. If applicable, apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules, as appropriate. 7. Perform Pricing: a. Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC). 8. Check for presence of Coordination of Benefits (COB) claim information. a. If COB is present: i. Set status to Deny claim. iii. Flag and move claim to COB file. iv. Send alert to ***Send Outbound Process*** with claim adjudication information and claim. 9. Send alert to ***Generate Remittance Advice*** business process with payment information. 10. Send alert to ***Manage Accounts Receivable Information*** business process with payment information. 11. Send alert to ***Manage Accounts Payable Information*** business process with payment information. 12. **END:** Send alert to ***Prepare Provider Payment*** business process for payment. Alternate Path: Suspended Claim 1. **START:** Claim has an assigned suspended status. 2. Conduct Internal review a. If applicable, reviewer requests further information as an alert sent to

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Process Claim	
Item	**Details**
	requestor via ASC X12 277 Health Care Information Status Notification. i. If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). ii. Internal review makes a determination to resolve the edit or audit in question. iii. **END:** Business process stops. 3. Provider submits corrected information in response to an error notification. a. The claim passes the edit or audit based on additional information submitted in response to a request, such as the ASC X12 277 Health Care Information Status Notification. **NOTE:** The ***Submit Electronic Attachment*** business process generates this request and reviews the response to validate that the additional information submitted is sufficient to pass the edit or audit. 4. If there is a favorably resolved suspended claim: a. Send alert to ***Generate Remittance Advice*** business process with adjudicated claim information. b. Go to step 7 of the ***Process Claim*** business process. c. **END:** Business process stops. 5. If provider submits a corrected claim, process it as if it is an original claim. a. Go to step 2 of the ***Process Claim*** business process. b. **END:** Business process stops. 6. If there is an unfavorably resolved suspended claim, send alert to ***Generate Remittance Advice*** business process with error report information. These include failures because the additional information requested for a suspended claim is not present, is inadequate or fails to satisfy the edit or audit. 7. **END:** The SMA resolves the suspended claim. <u>Alternate Path: Third Party Liability Failures</u> 1. **START:** The SMA identifies a third-party resource. 2. If a Cost Avoidance for third-party liability exists, reject claim for edit errors. 3. Send alert to ***Manage TPL Recovery*** business process for third-party insurance recovery. 4. **END:** Send alert to ***Generate Remittance Advice*** business process with Edit Error Report information.
Shared Data	EDI Translator data store including ASC X12 Implementation Guide Validation Edits for Levels 1 through 7 Claim data store including payment, in-house claim number,

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Process Claim	
Item	**Details**
	and Patient Account Number information Provider data store including performing prospective program integrity (e.g., Healthcare Integrity and Protection Data Bank (HIPDB)) and Medicare/Medicaid sanctions information, provider network, and contract information Member data store including demographics, third-party insurance information, and member-specific pricing Plan data store including health benefit information (e.g., covered services, units, life-time limits, units and funding limits for authorized services, and benefit package-specific rates) Reference data store including filing deadlines, code set, drug formulary, and service code formulary. Additional information includes Diagnosis Related Group (DRG), Ambulatory Payment Classification (APC), and National Correct Coding Initiative (NCCI) information Authorization data store including authorization and treatment plan information Rate setting data store including applicable rates Claims data store including adjudication and payment history information Financial data store including accounts receivable and accounts payable information
Predecessor	**Receive Inbound Transaction** ***Submit Electronic Attachment***
Successor	**Send Outbound Transaction** ***Calculate Spend-down Amount*** ***Generate Remittance Advice*** ***Prepare Provider Payment*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Disbursement*** ***Manage TPL Recovery*** ***Submit Electronic Attachment*** ***Manage Data*** ***Manage Performance Measures***

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Process Claim	
Item	**Details**
Constraints	All claim types will go through most of the steps within the ***Process Claim*** business process main flow with some variance of business rules and information. Types of claim variances include: Institutional, Professional, Dental, Pharmacy, and Waiver claims, Medicare Crossover and Medicare Part D pharmacy claims, coordination of benefits claims received from payers secondary to Medicaid (e.g., for IHS eligibles), and TPL cost-avoided claims. The business rules will conform to federal and state-specific rules and pricing algorithms. Editing, auditing, and pricing variances could exist on services billed by claim type, provider taxonomy code, service line codes, and the process may require additional information. An adjustment to a claim follows the same business process path except that it requires a link to the previously submitted and processed claim in order to reverse the original claim payment, and associate the original to the adjustment.
Failures	The ***Process Claim*** business process contains a series of potential points of failure. The claim could fail any edit or audit. Business rules define whether one or more edit or audit failures will result in suspending or denying the claim. Fatal Edit Failures: Claim information has fatal edit error. For example: • Claim submitted without all the required information. • Provider files claim after claim filing deadline. Other Edit Failures: Claim information has other errors. For example: • The SMA does not cover the service because not in health benefit, not provided in an approved facility or by an approved provider type. • Service is not appropriate based on member demographics. • Member has TPL coverage.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hour • Accuracy with which edits, audits and pricing algorithms are applied and paid amount is calculated = ___% • Consistency of decisions on suspended claims = ___% • Error rate = __% or less

Process Encounter

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Process Encounter	
Item	**Details**

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Process Encounter	
Item	**Details**

Description	The ***Process Encounter*** business process receives original or adjusted encounter (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction and determines its submission status, and based on that:
	• Performs Encounter Edits:
	  o Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction.
	  o Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding.
	• Performs Encounter Audits:
	  o Verify against historical information.
	  o Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity.
	• Suspends encounter that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules.
	  o Apply National Correct Coding Initiative (NCCI) Edits.
	  o Apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC), as appropriate.
	  o Prices Encounters:
	  ✓ Calculate state allowed amount.
	  ✓ Calculate paid amount.
	  ✓ Set paid amount to zero dollars.
	NOTE: All encounters will go through most of the business process steps but with different business rules associated with the different encounter claim types. Both Centers for Medicare & Medicaid Services (CMS) and state policy determine business rules for encounter edits, audits, and pricing methodologies. State business rules define whether an encounter goes to a to-be-paid status, suspends, flags for information, or denies. State business rules define whether an edit is fatal or non-fatal as well. *See Constraints*.
	NOTE: An adjustment to an encounter is on an exception use case to this business process that follows the same process path except it requires a link to the previously submitted processed encounter in order to reverse the original encounter and associate the original and replacement encounter in the calculation information.
	NOTE: This business process is part of a suite including ***Calculate Spend-down Amount, Submit Electronic Attachment***, and ***Generate Financial Report*** business processes.

Trigger Event	Interaction-based Trigger Events: • Receive encounter via Accredited Standards Committee (ASC) X12 837 Health

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Process Encounter	
Item	**Details**
	Care Claim encounter transactions. • Receive Retail Pharmacy Encounter Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). Environment-based Trigger Events: • Periodic timetable (e.g., daily, weekly) is due for adjudication and payment cycles.
Result	• The State Medicaid Agency (SMA) adjudicates an encounter. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to send to submitter via ASC X12 277 Health Care Information Status Notification for requesting additional information. • If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Prepare Provider Payment*** business process for capitation payment. • If applicable, alert sent to ***Generate Financial Report*** business process with payment and/or error report information. • If applicable, alert sent to send to ***Manage TPL Recovery*** business process for third-party insurance. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive encounter submission or encounter adjustment information. 2. Perform Fatal Edits: a. If electronic encounter submission, perform ASC X12N edits for valid syntax and format, identifiers and codes, dates, and other information required for the transaction according to the agreed-upon levels 1-7 stated in the Trading Partner Agreement. i. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. b. Validate that encounter submission meets filing deadlines based on service dates. c. If applicable, reject encounter for electronic fatal validation errors and send alert to ***Generate Financial Report*** business process with error

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Process Encounter	
Item	**Details**
	report information. **END:** Business process stops. 3. Perform Non-Fatal Edits: a. Determine encounter status as initial, adjustment to a processed encounter, or a duplicate submission that is already in the adjudication process but not yet completed and loaded into encounter payment history (using a unique Patient Account Number). i. If applicable, associate encounter adjustment to original encounter submission. b. Validate provider information (e.g., provider taxonomy, NPI, enrollment status, approved to bill for this service). c. Validate member information (e.g., demographics, eligibility status on the date of service). d. Validate the SMA covers service in member's health benefit and apply appropriate rules. For example: i. Adult member benefit package does not cover dental services so deny the encounter. e. Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status. f. If provider submits service authorization, referral or treatment plan number, verify the number, member, provider, service, and date(s) of service. g. If state defined business rules identify certain edits that cause an encounter to suspend, and an encounter fails for one or more of them, send alert to ***Generate Financial Report*** business process with error report information. **END:** Business process stops. 4. Perform Audits: a. Check encounter history for duplicate processed encounter using search key information such as in-house encounter number, date of service, provider and member demographics, service, and diagnosis codes. b. If provider did not submit service authorization, referral or treatment plan, and one exists on file, validate number, member, provider, service, and date(s) of service against claims history. c. Check Clinical Appropriateness of the services provided based on clinical, case, and disease management protocols. d. Perform Prospective Payment Integrity Check. e. If state defined business rules identify certain audits that cause an encounter to suspend, and an encounter fails for one or more of them, send alert to ***Generate Financial Report*** business process with error report information. **END:** Business process stops.

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Process Encounter	
Item	**Details**
	5. Validate National Correct Coding Initiative (NCCI) (bundle/unbundle codes). 6. If applicable, apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules. 7. Perform Pricing (Shadow-Pricing): a. Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC). b. Calculates to-be-paid amount by deducting: i. Contributions provided by Member. ii. Provider advances, liens, and recoupments. 8. Send alert to ***Prepare Provider Payment*** business process for payment. 9. **END:** Send alert to ***Generate Financial Report*** business process with payment information. <u>Alternate Path: Suspended Encounter</u> 1. **START:** Provider submits corrected information in response to an error notification. 2. Process it as if it is an original encounter. a. Go to step 2 of the ***Process Encounter*** business process. 3. **END:** Business process stops.
Shared Data	EDI Translator data store including ASC X12 Implementation Guide Validation Edits for Levels 1 through 7 encounter data store including payment, in-house encounter number, and Patient Account Number information Provider data store including performing prospective program Integrity (e.g., HIPDB) and Medicare/Medicaid sanctions information, provider network, and contract information Member data store including demographics, eligibility, enrollment, and member-specific pricing Plan data store including health benefit information (e.g., covered services, units, life-time limits, units and funding limits for authorized services, and benefit package-specific rates) Reference data store including filing deadlines, code set, drug formulary, and service code formulary. Additional information includes Diagnosis Related Group (DRG), Ambulatory Payment Classification (APC), and National Correct Coding Initiative (NCCI) information Authorization data store including authorization and treatment plan information Rate setting data store including applicable rates Encounter data store including adjudication and encounter payment history information

OM Claims Adjudication	
Process Encounter	
Item	**Details**
	Financial data store including accounts receivable and accounts payable information
Predecessor	**Receive Inbound Transaction** ***Submit Electronic Attachment***
Successor	**Send Outbound Transaction** ***Calculate Spend-down Amount*** ***Generate Financial Report*** ***Submit Electronic Attachment*** ***Manage Data***
Constraints	All encounter claim types will go through most of the steps within the ***Process Encounter*** business process main flow with some variance of business rules and information. Types of counter variances include: Institutional, Professional, Dental, Pharmacy, and Waiver encounters; Medicare Crossover and Medicare Part D pharmacy encounters; and Coordination of Benefits (COB) encounters received from payers secondary to Medicaid (e.g., for IHS eligibles). The business rules will conform to federal and state-specific rules and pricing algorithms. Editing, auditing, and pricing variances could exist on services billed by encounter claim type, provider taxonomy code, service line codes, and the process may require additional information. An adjustment to an encounter follows the same business process path except that it requires a link to the previously submitted and processed encounter in order to reverse the original encounter and associate the original to the adjustment.
Failures	The ***Process Encounter*** business process contains a series of potential points of failure. The encounter could fail any edit or audit. Business rules define whether one or more edit or audit failures will result in suspending or denying the encounter. Fatal Edit Failures: Encounter information has fatal edit error. For example: • Encounter submitted without all the required information. • Encounter submitted after encounter filing deadline. Other Edit Failures: Encounter information has other errors. For example: • The SMA does not cover the service because it is not in the health benefit, or is not in an approved facility or performed by an approved provider type. • Service is not appropriate based on member demographics.
Performance Measures	• Time to complete ***Process Encounter*** business process: e.g., Real Time response = within __ seconds, Batch Response = within __ hour • Accuracy with which edits, audits, and pricing algorithms are applied and to-be-paid and paid amount is calculated = ___% • Consistency of decisions on suspended encounters = ___%

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Process Encounter	
Item	**Details**
	• Error rate = __% or less

Manage Data

OM Payment and Reporting	
Manage Data	
Item	**Details**
Description	The ***Manage Data*** business process is responsible for the preparation of the data sets and delivery to federal agencies (e.g., Centers for Medicare & Medicaid Services (CMS), Social Security Administration (SSA).) Information exchange may include extraction of Medicaid and CHIP Business Information and Solutions (MACBIS) information needs (i.e., fee-for-services, managed care, eligibility and provider information). The ***Manage Data*** business process includes activity to extract the information, transform to the required format, encrypt for security, and load the electronic file to the target destination. The uses for the information include: • Research and evaluation of health care activities. • Staff can forecast the utilization and expenditures for a program. • Staff can analyze policy alternatives. • State and federal agencies can respond to congressional inquiries. • Matches to other health related databases.
Trigger Event	Environment-based Trigger Events: • Periodic (e.g., quarterly) timetable for information is due. • Receive request for information.
Result	• Information message sent to target destination. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive time event or request to initiate ***Manage Data*** business process. 2. Extract required information from source data stores. 3. Transform information to meet business and technical needs of target destination. 4. Apply necessary encryption algorithms for security. 5. **END:** Send message with information to the target destination.

OM Payment and Reporting	
Manage Data	
Item	**Details**
Shared Data	Claims data store including claims, encounters, adjudication, and historical information Care management data store including treatment plan, outcomes, and authorization information Plan data store including Medicaid State Plan, health plan, health benefits, reference, performance measures, and benchmarks information Compliance Incident data store including anomalies and adverse action information Member data store including demographics, eligibility determination, enrollment, grievance and appeals, communication, and outreach information Provider data store including provider network, eligibility determination, enrollment, grievance and appeals, communication, and outreach information Contractor data store including provider network, enrollment, grievance and appeals, communication, and outreach information Financial data store including accounts payable and accounts receivable information
Predecessor	**NOTE:** Many MITA Framework business processes collect data for extraction of information and send to target destination. The following are the business processes that manage primary data stores. ***Manage Case Information*** ***Manage Contractor Information*** ***Manage Member Information*** ***Manage Provider Information*** ***Manage Budget Information*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Information*** ***Generate Financial Report*** ***Process Claim*** ***Process Encounter*** ***Generate Remittance Advice*** ***Manage Compliance Incident Information*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Performance Measures*** ***Manage Reference Information***
Successor	**Send Outbound Transaction**

OM Payment and Reporting	
Manage Data	
Item	**Details**
Constraints	The ***Manage Data*** business process will adhere to the federal requirements for submission of information to federal agency.
Failures	• Requested information is not available for extraction. • Transformation does not meet the federal requirements for submission. • Information message does not meet the target destination submission requirements.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which the State Medicaid Agency (SMA) applies rules =___% • Consistency with which the SMA applies rules =___% • Error rate =___% or less

Calculate Spend-Down Amount

OM Claims Adjudication	
Calculate Spend-Down Amount	
Item	**Details**
Description	A person that is not eligible for medical coverage when they have income above the health plan standards may become eligible for coverage through a process called spend-down (see ***Determine Member Eligibility*** business process). The ***Calculate Spend-Down Amount*** business process is responsible for tracking spend-down amounts and determining if a member meets its responsibility through the submission of medical claims. The ***Process Claim*** business process automatically accounts for the spend-down amount during adjudication. Once the member has met the spend-down obligation, a modification of eligibility status allows Medicaid payments to begin and/or resume. This typically occurs in situations where a member has a chronic condition and is consistently above the resource levels, but it may also occur in other situations. The ***Calculate Spend-Down Amount*** business process begins with the receipt of member's health plan information from ***Enroll Member*** business process that requires a predetermined amount the member will be financially responsible for prior to Medicaid payment for any medical services.
Trigger Event	Interaction-based Trigger Events: • Receive health plan information from ***Enroll Member*** business process.
Result	• Member has met spend-down obligation. • Alert sent to ***Manage Member Information*** with spend-down information. • Sent notification that Member has met spend-down obligation to member via ***Manage Applicant and Member Communication*** business process.

OM Claims Adjudication	
Calculate Spend-Down Amount	
Item	**Details**
	• Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive health plan information from ***Enroll Member*** business process 2. Determine spend-down obligation amount. 3. Receive claim including payment information. 4. Subtract medical claim amounts from member's spend-down until they meet their responsibility. 5. Send alert to ***Manage Member Information*** with spend-down information. 6. **END:** Send notification that member has met spend-down obligation via ***Manage Applicant and Member Communication*** business process.
Shared Data	Member data store with demographics and spend-down information Claims data store with payment information
Predecessor	***Enroll Member*** ***Process Claim***
Successor	***Manage Applicant and Member Communication*** ***Maintain Member Information***
Constraints	The calculate spend-down will conform to the state-specific policies that may differ by state.
Failures	• No health plan information from ***Enroll Member***.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within__ hours • Accuracy with which rules are applied • Consistency of decisions and disposition = __% • Error rate = __% or less

Submit Electronic Attachment

OM Claims Adjudication	
Submit Electronic Attachment	
Item	**Details**
Description	The ***Submit Electronic Attachment*** business process begins with receiving attachment information that either a payer requests (solicited) or a provider submits (unsolicited). The solicited attachment information can be in response to requests for more information from the following business processes for example: ***Process***

OM Claims Adjudication	
Submit Electronic Attachment	
Item	**Details**
	Claim, Process Encounter, ***Authorize Service***, ***Authorize Treatment Plan***, and ***Manage Estate Recovery***. The business process links attachment information to the associated applicable transaction (e.g., claim, prior authorization, treatment plan) or suspends for a predetermined time set by state specific business rules, after which the business process purges information. The business process validates the successfully associated attachment information using application-level edits, determining whether the information provides the additional information necessary to adjudicate (i.e., approve, suspend or deny) the transaction.
Trigger Event	Interaction-based Trigger Event: • Receive claim via Accredited Standards Committee (ASC) X12 837 Health Care Claim transaction. • Receive Retail Pharmacy Claim Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). • Receive ASC X12 277 Health Care Information Status Notification requesting additional information. • Receive ASC X12 278 Health Care Servicer Review Information transaction. Environment-based Trigger Event: • Periodic timetable to associate suspended attachment information with subsequently received transactions.
Result	• The State Medicaid Agency (SMA) accepts and associates attachment information with the appropriate transaction (e.g., claim, prior authorization, treatment plan, etc.). • If applicable, the SMA rejects attachment information as invalid. • If applicable, the SMA suspends attachment information awaiting the receipt of a matching transaction. • If applicable, the SMA purges attachment after duration of predetermined time. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive attachment information. 2. Validate attachment provides all required information. 3. Associate attachment information with applicable transaction. 4. Validate application level edits such as provider, member, and benefit information, and association with transaction. 5. Determine whether the attachment supplies the additional information as required by state business rules. 6. If applicable, reject attachment information as invalid. **END:** Business process stops.

OM Claims Adjudication	
Submit Electronic Attachment	
Item	**Details**
	7. If applicable, suspend attachment information awaiting the receipt of a matching transaction. **END:** Business process stops. 8. If applicable, purge attachment after duration of predetermined time. **END**: Business process stops. 9. **END:** The SMA accepts and associates attachment information with the appropriate transaction.
Shared Data	Claims data store with transaction information Provider data store with provider network information Member data store with demographic information Care Management data store with authorization information Financial data store including accounts receivable information
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Process Encounter*** ***Authorize Service*** ***Authorize Treatment Plan*** ***Authorize Referral*** ***Manage Estate Recovery***
Successor	**Send Outbound Transaction** ***Process Claim*** ***Process Encounter*** ***Authorize Service*** ***Authorize Treatment Plan*** ***Authorize Referral*** ***Manage Estate Recovery***
Constraints	The attachment information will conform to the format and content in accordance with national standards and state-specific rule-reporting requirements, e.g., using HIPAA Transaction Standard Companion Guide, and contain valid required information content based on several criterion (e.g., type of claim, type of service, provider type, and member demographic). The attachment will be consistent with the associated original transaction per state rules, and will contain the correct information for this business process to execute.
Failures	• Quality of the image too bad to render as usable. • Cannot locate applicable transaction (i.e., claim, prior authorization).

OM Claims Adjudication	
Submit Electronic Attachment	
Item	**Details**
	• Attachment is missing required information.
Performance Measures	• Time to complete the process: Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which the SMA applies and associates attachments rules = __% • Number of attachments = __% of total claims. (Processing a higher percentage of claims attachments may indicate that a state is able to utilize more clinical information when determining whether a claim meets state payment rules) • Error rate of correctly re-associating attachment information = __% or less

Apply Mass Adjustment

OM Claims Adjudication	
Apply Mass Adjustment	
Item	**Details**
Description	The ***Apply Mass Adjustment*** business process begins with the receipt or notification of retroactive modifications. These changes may consist of modified rates associated with Healthcare Common Procedure Coding System (HCPCS), Claim Payment/Advice Transaction (CPT), Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the payment transactions such as claims or capitation payment by identifiers (e.g., claim/bill type, HCPCS, CPT, Revenue Code(s), or member identification) that the State Medicaid Agency (SMA) paid incorrectly during a specified date range. The business process applies a predetermined set or sets of parameters that may reverse or amend the paid or denied transactions and repay correctly. **NOTE:** Do not confuse this process with the claim adjustment within the adjudication process. A mass adjustment may involve many previous payments based on a specific date or date range affecting single or multiple providers, members, or other payees. Likewise, mass adjustments historically refer to large-scale modifications in payments as opposed to disenrollment of a group of members from a Managed Care Organization (MCO).
Trigger Event	Environment-based Trigger Event: • Receive a mass adjustment notification of retroactive rate or program modifications. • Correction of system errors resulting in incorrect payment amounts. • Identification of incorrectly denied claims
Result	• Validated mass adjustment information applied to previous payment records. • If applicable, alert sent to notify member via ***Manage Applicant and Member Communication*** business process of relevant modifications. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of relevant modifications. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of relevant modifications. • If applicable, alert sent to send to provider Accredited Standards Committee (ASC) X12 835 Health Care Claim Payment/Advice transactions. • If applicable, alert sent to ***Manage Accounts Receivable Information*** business process of relevant modifications. • If applicable, alert sent to ***Manage Accounts Payable Information*** business process of relevant modifications. • Tracking information as needed for measuring performance and business activity monitoring.

OM Claims Adjudication	
Apply Mass Adjustment	
Item	**Details**
Business Process Steps	1. **START:** Receipt or notification of incorrect payments or denials, based on retroactive rate modifications, program modifications, retroactive modifications in member eligibility, or system errors. 2. Identify the parameters necessary to locate claim records. 3. Enter parameters (i.e., corrected information). 4. Apply the predetermined set of parameters that reverse the incorrect payments or denials. 5. If applicable, produce mass adjustment request report. 6. Review the mass adjustment report for validity and accuracy. 7. If applicable, send alert to notify member via ***Manage Applicant and Member Communication*** business process of relevant modifications to their cost share. 8. If applicable, send alert to notify provider via ***Manage Provider Communication*** business process of relevant modifications. 9. If applicable, send alert to send to provider ASC X12 835 Health Care Claim Payment/Advice transactions. 10. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of relevant modifications. 11. If applicable, send alert to ***Manage Accounts Receivable Information*** business process of relevant modifications. 12. If applicable, send alert to ***Manage Accounts Payable Information*** business process of relevant modifications. 13. **END:** Apply mass adjustment to previous payments.
Shared Data	Claims data store with transaction information Provider data store with provider network and contract information Contractor data store with provider network and contract information Member data store with demographic information Plan data store including policy information Health Benefit data store including benefit program and benefit information Financial data store including accounts receivable and accounts payable information
Predecessor	***Manage Provider Recoupment*** ***Manage Cost Settlement***
Successor	***Manage Provider Communication*** ***Manage Contractor Communication*** ***Manage Applicant and Member Communication***

OM Claims Adjudication	
Apply Mass Adjustment	
Item	**Details**
	Process Claim ***Process Encounter*** ***Generate Remittance Advice*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Information***
Constraints	The mass adjustment will correctly identify payments for adjustments. Processes may vary by state.
Failures	• Cannot locate all claims, capitation payments, or denials specified for adjustment.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which edit, audit, and pricing rules are applied = ___% • Error rate = ___% or less

PERFORMANCE MANAGEMENT

Identify Utilization Anomalies

PE Compliance Management	
Identify Utilization Anomalies	
Item	**Details**
Description	The ***Identify Utilization Anomalies*** business process uses criteria and rules to identify target groups (e.g., providers, contractors, trading partners or members) and establishes patterns or parameters of acceptable and unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Internal and external referrals, business intelligence analysis (i.e., historical, current, and predictive views of business operations), and scheduled or on-demand reporting may identify a compliance incident. Identification of utilization anomalies include evaluation of: • Provider utilization review • Provider compliance review • Contractor utilization review (includes managed care organizations) • Contractor compliance review • Member utilization review • Investigation of potential fraud or abuse review • Drug utilization review • Quality review (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures) • Performance review (e.g., Key Performance Indicator (KPI)) • Erroneous payment • Contract review • Audit Review • Other evaluation of information Different criteria and rules, relationships, and information define each type of compliance incident and require different types of external investigation.
Trigger Event	Interaction-based Trigger Events: • Receive alert sent from business process that has outliers from established benchmarks. Environment-based Trigger Events: • Periodic timetable is due to scan for compliance incidents. • Request to examine a specific group, individual, or other entity.
Result	• Identification of utilization anomalies. • If applicable, alert sent to notify member via ***Manage Applicant and Member***

PE Compliance Management	
Identify Utilization Anomalies	
Item	**Details**
	Communication business process with anomaly information. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process with anomaly information. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process with anomaly information. • If applicable, alert sent to ***Establish Compliance Incident*** business process for further investigation and monitoring. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request or reach scheduled timetable review. 2. Review performance measures and benchmark targets. 3. Define characteristics of the target group in which the analysis will focus: types of provider, location, types of services, member characteristics, medical conditions. 4. Identify information requirements, both selection parameters and reporting parameters to include items such as time period(s), data elements, data relationships. 5. Identify rules to apply to the information — Select or create rules including specified norms, statistical deviations, types of patterns, Boolean logic, ratios, percentages. 6. Apply rules to targeted group information. 7. Record the results. 8. If applicable, send alert to notify member via ***Manage Applicant and Member Communication*** business process with anomaly information. 9. If applicable, send alert to notify provider via ***Manage Provider Communication*** business process with anomaly information. 10. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process with anomaly information. 11. **END:** If applicable, send alert to the ***Establish Compliance Incident*** business process for further investigation and monitoring.
Shared Data	Member data store including demographics, eligibility, enrollment, and grievance information Provider data store including provider network, contract, and grievance information Contractor data store including provider network, and contract information Care Management data store including member health status, clinical data, and treatment outcome information Claims data store including payment information Financial data store including accounts receivable and accounts payable information

PE Compliance Management	
Identify Utilization Anomalies	
Item	**Details**
	Business Activity data store including performance information Compliance Management data store including compliance incident information
Predecessor	***Manage Performance Measures***
Successor	***Establish Compliance Incident*** ***Manage Business Relationship Communication*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication***
Constraints	States and programs within States establish different criteria for their investigations. Rules change along with the experience of the state, health care industry best practices, modifications in benefits, or with the addition of new provider types.
Failures	• Staff is unable to identify target population because of insufficient information.
Performance Measures	• Time to complete the process = within __ hours, ___ minutes • Compliance Incident resulting in corrective action, settlement, or collection = __%

Establish Compliance Incident

PE Compliance Management	
Establish Compliance Incident	
Item	**Details**
Description	The ***Establish Compliance Incident*** business process is responsible registration of a case for incident tracking of utilization anomalies. It establishes an incident file, generates incident identification, assigns an incident manager, links to related cases, and collects related documentation.
Trigger Event	Incident-based Trigger Events: • Receive alert to establish incident tracking from ***Identify Utilization Anomalies*** business process. • Receive alert to establish incident tracking from ***Manage Member Grievance and Appeal*** business process. • Receive alert to establish incident tracking from ***Manage Provider Grievance and Appeal*** business process. • Receive alert to establish incident tracking from ***Manage Contractor Grievance and Appeal*** business process. Environment-based Trigger Events:

PE Compliance Management	
Establish Compliance Incident	
Item	**Details**
	• Request to initiate incident tracking for business partner, member, provider, contractor or other entity. • Request to initiate incident from communication (e.g., mail, telephone, facsimile or web). • Receive requests for suppression of information or corrective action from federal and state law enforcement. • Receive compliance investigation information from Centers for Medicare & Medicaid Services (CMS). • Receive compliance investigation information from Medicaid Fraud Control Unit (MFCU). • Receive compliance investigation information from Office of Inspector General (OIG). • Receive self-disclosure of actual or potential violations from provider.
Result	• Initiation of a compliance incident. • Alert sent to ***Manage Compliance Incident Information*** business process for incident monitoring. • If applicable, notification sent to state or federal law enforcement agencies of possible criminal investigation. • If applicable, notification sent to CMS of compliance investigation. • If applicable, notification sent to MFCU of compliance investigation. • If applicable, notification sent to OIG of compliance investigation. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Request to establish incident tracking. 2. Establish incident case with required information. 3. Generate incident identification. 4. Assign and authorize an incident manager to manage an incident and request additional information. 5. Identify and link related incidents to this one. 6. Collect relevant documentation. 7. If applicable, send notification to state or federal law enforcement agencies of possible criminal investigation. 8. If applicable, send notification to CMS of compliance investigation. 9. If applicable, send notification to MFCU of compliance investigation. 10. If applicable, send notification to OIG of compliance investigation.

PE Compliance Management	
Establish Compliance Incident	
Item	**Details**
	11. **END:** Send alert to ***Manage Compliance Incident Information*** business process for incident monitoring.
Shared Data	Member data store including demographics, eligibility, enrollment, and grievance information Provider data store including provider network, contract, and grievance information Contractor data store including provider network, and contract grievance information Claims data store including payment information Financial data store including accounts receivable and accounts payable information Business Activity data store including performance information Compliance Management data store including compliance incident information
Predecessor	***Identify Utilization Anomalies*** ***Manage Member Information*** ***Manage Provider Information*** ***Manage Contractor Information***
Successor	***Manage Compliance Incident Information***
Constraints	States and programs within States establish different criteria for their investigations. Rules change along with the experience of the state, health care best practices, modifications in benefits, and with the addition of new provider and member types.
Failures	• No incident tracking requests made. • Lack of required information to establish an incident.
Performance Measures	• Time to complete the process = e.g., ___ days, ___ hours or ___ minutes • Accuracy with which rules are applied = __% • Consistency with which rules are applied = __% • Error rate = __% or less

Manage Compliance Incident Information

PE Compliance Management	
Manage Compliance Incident Information	
Item	**Details**
Description	The ***Manage Compliance Incident Information*** business process is responsible for the monitoring of incidents of utilization anomalies. Activities include referring (e.g., escalation) incident to another incident manager or agency, modifications to

PE Compliance Management	
Manage Compliance Incident Information	
Item	**Details**
	incident information, journaling activities, and disposition of incident.
Trigger Event	Interaction-based Trigger Events: • Receive alert from ***Establish Compliance Incident*** business process of new incident. Environment-based Trigger Events: • Staff periodically reviews incident. • Staff modifies incident information due to follow-up activities. • Receive requests for suppression of information or corrective action from federal and state law enforcement. • Receive compliance investigation information from Centers for Medicare & Medicaid Services (CMS). • Receive compliance investigation information from Medicaid Fraud Control Unit (MFCU). • Receive compliance investigation information from Office of Inspector General (OIG). • Receive self-disclosure of actual or potential violations from provider.
Result	• Monitored incident and tracked. • Determination of disposition and closure of incident. • If applicable, alert sent to notify member via ***Manage Applicant and Member Communication*** business process of incident tracking information. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of incident tracking information. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of incident tracking information. • If applicable, alert sent to ***Determine Adverse Action Incident*** business process for further investigation. • If applicable, notification sent to state or federal law enforcement agencies of possible criminal investigation. • If applicable, notification sent to CMS for compliance investigation. • If applicable, notification sent to MFCU of compliance investigation. • If applicable, notification sent to OIG of compliance investigation. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive established incident. 2. Review incident information for determination of action.

PE Compliance Management	
Manage Compliance Incident Information	
Item	**Details**
	3. Review allegations. 4. If applicable, refer or escalate incident to responsible individual, department or state or federal agency. 5. Determine action to take (e.g., journal entry, appointment scheduling, research, communication). 6. Perform appropriate action. 7. If applicable, send alert to notify member via ***Manage Applicant and Member Communication*** business process of incident tracking information. 8. If applicable, send alert to notify provider via ***Manage Provider Communication*** business process of incident tracking information. 9. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of incident tracking information. 10. Determine disposition of incident. 11. If applicable, send notification to state or federal law enforcement agencies of possible criminal investigation. 12. If applicable, send notification to CMS for compliance investigation. 13. If applicable, send notification to MFCU of compliance investigation. 14. If applicable, send notification to OIG of compliance investigation. 15. If applicable, send alert to ***Determine Adverse Action Incident*** business process for further investigation. 16. **END:** Close incident.
Shared Data	Member data store including demographics, eligibility, enrollment, and grievance information Provider data store including provider network, contract, and grievance information Contractor data store including provider network, and contract information Claims data store including payment information Financial data store including accounts receivable and accounts payable information Business Activity data store including performance information Compliance Management data store including compliance incident information
Predecessor	***Establish Compliance Incident*** ***Maintain State Plan***
Successor	***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication***

PE Compliance Management	
Manage Compliance Incident Information	
Item	**Details**
	Determine Adverse Action Incident ***Manage Data***
Constraints	States and programs within States establish different criteria for their investigations. Rules change along with the experience of the state, health care best practices, modifications in benefits, and with the addition of new provider and member types.
Failures	• This business process has no failure modes that prevent the process from completion.
Performance Measures	• Time to complete the process = e.g., ___ days, ___ hours or ___ minutes • Accuracy with which rules are applied = __% • Consistency with which rules are applied = __% • Error rate = __% or less

Determine Adverse Action Incident

PE Compliance Management	
Determine Adverse Action Incident	
Item	**Details**
Description	The ***Determine Adverse Action Incident*** business process receives an incident from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, corrective action, removal of a provider, contractor, trading partner or member from the Medicaid Program, or the State Medicaid Agency (SMA) may terminate or suspend the case. Individual state policy determines what evidence is necessary to support different types of cases: • Provider utilization review • Provider compliance review • Contractor utilization review (includes managed care organizations) • Contractor compliance review • Member utilization review • Investigation of potential fraud or abuse review • Drug utilization review • Quality review (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures) • Performance review (e.g., Key Performance Indicator (KPI))

PE Compliance Management	
Determine Adverse Action Incident	
Item	**Details**
	• Contract review • Erroneous payment review • Audit Review • Other evaluation of information Different criteria and rules, relationships, and information define each type of adverse action incident and require different types of external investigation.
Trigger Event	Interaction-based Trigger Events: • Receive alert from ***Manage Compliance Incident Information*** business process for further investigation. Environment-based Trigger Events: • Request to investigate adverse action incident. • Receive requests for suppression of information or corrective action from federal and state law enforcement. • Receive compliance investigation information from Centers for Medicare & Medicaid Services (CMS). • Receive compliance investigation information from Medicaid Fraud Control Unit (MFCU). • Receive compliance investigation information from Office of Inspector General (OIG). • Receive self-disclosure of actual or potential violations from provider.
Result	• Monitored adverse action incident and tracked activities. • Determination of disposition and closure of incident. • If applicable, alert sent to notify member via ***Manage Applicant and Member Communication*** business process of incident tracking information. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of incident tracking information. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of incident tracking information. • If applicable, alert sent to ***Disenroll Member*** business process to remove member from services. • If applicable, alert sent to ***Disenroll Provider*** business process to remove provider from services. • If applicable, alert sent to ***Terminate Provider*** business process to cease activities with provider. • If applicable, alert sent to ***Close Out Contract*** business process to cease activities with contractor.

PE Compliance Management	
Determine Adverse Action Incident	
Item	**Details**
	• If applicable, notification sent to state or federal law enforcement agencies of possible criminal investigation. • If applicable, notification sent to CMS for compliance investigation. • If applicable, notification sent to MFCU of compliance investigation. • If applicable, notification sent to OIG of compliance investigation. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request to investigate adverse action incident. 2. Assign and authorize an adverse action incident manager to manage an incident and request additional information. 3. Establish adverse action incident case with required information. 4. Examine information associated with the case, and request more historical information as needed. 5. Determine action to take (e.g., journal entry, appointment scheduling, research, communication). 6. Perform appropriate action. 7. Correspond with providers, members, agents, guardians, attorneys, and others to notify them regarding the investigation, their rights, and the right of the SMA to request documentation. 8. If applicable, send alert to notify member via ***Manage Applicant and Member Communication*** business process of incident tracking information. 9. If applicable, send alert to notify provider via ***Manage Provider Communication*** business process of incident tracking information. 10. If applicable, send sent to notify contractor via ***Manage Contractor Communication*** business process of incident tracking information. 11. Conduct inquiries and investigations. Depending on the type of case, the SMA may need to conduct different external inquiries (e.g., view medical records, interview members, validate credentials). 12. Document evidence as required. 13. When research and analysis are complete, report the case disposition (e.g., cancel incident, claim damages, identify corrective action, suspend or terminate participation in Medicaid Program). 14. If applicable, send alert to ***Disenroll Member*** business process to remove member from services. 15. If applicable, send alert to ***Disenroll Provider*** business process to remove provider from services. 16. If applicable, send alert to ***Terminate Provider*** business process to cease activities with provider.

PE Compliance Management	
Determine Adverse Action Incident	
Item	**Details**
	17. If applicable, send alert to ***Close Out Contract*** business process to cease activities with contractor. 18. If applicable, send notification to state or federal law enforcement agencies of possible criminal investigation. 19. If applicable, send notification to CMS for compliance investigation. 20. If applicable, send notification to MFCU of compliance investigation. 21. If applicable, send notification to OIG of compliance investigation. 22. **END:** Close adverse action incident.
Shared Data	Member data store including demographics, eligibility, enrollment, and grievance information Provider data store including provider network, contract, and grievance information Contractor data store including provider network, and contract information Claims data store including payment information Financial data store including accounts receivable and accounts payable information Business Activity data store including performance information Compliance Management data store including compliance incident information
Predecessor	***Establish Compliance Incident***
Successor	***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Disenroll Member*** ***Disenroll Provider*** ***Terminate Provider*** ***Close Out Contract***
Constraints	States and programs within States establish different criteria for their investigations. Rules change along with the experience of the state, health care best practices, modifications in benefits, and with the addition of new provider and member types.
Failures	• No request to investigate adverse action incident received. • Ceased incident without reaching disposition.
Performance Measures	• Time lag between request for documents and receipt = __ Days, __ Hours • Time to bring a case to closure = __ Months, __ Weeks • Number of cases that the agency is able to close within designated time period = ___

PE Compliance Management	
Determine Adverse Action Incident	
Item	**Details**
	• Percent cases closed without grievance or appeal = ___%

Prepare REOMB

PE Compliance Management	
Prepare REOMB	
Item	**Details**
Description	The ***Prepare REOMB*** business process is responsible for the creation of Recipient Explanation of Medicaid Benefits (REOMB) for detecting payment problems. The State Medicaid Agency (SMA) sends the REOMB to randomly selected members of Medicaid services. It gives information on the Medicaid services paid on behalf of the member. The communication includes the provider's name, the date(s) of services, and the payment amount(s). Instructions on the communication tell the member what to do if the provider did not actually perform any of the listed services billed directly to him/her by the provider. **NOTE:** This business process does not include the handling of returned information.
Trigger Event	Environment-based Trigger Events: • Periodic timetable is due for generation of the REOMB sample information.
Result	• Member receives REOMB. • Alert sent with REOMB notification to member via ***Manage Applicant and Member Communication*** business process with REOMB information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Timetable for scheduled REOMB generation. 2. Identify member selection using random sampling methodology. 3. Review sample selection information. 4. Prepare REOMB for each select member. 5. **END:** Send alert to member via ***Manage Applicant and Member Communication*** business process with REOMB information.
Shared Data	Member data store including demographics information Claims data store including payment information
Predecessor	None
Successor	***Manage Applicant and Member Communication***
Constraints	The policies and business rules for preparing the REOMB sample information differ by state. The SMA will provide the REOMB or letters to the members within 45 days of payment of claims.

PE Compliance Management	
Prepare REOMB	
Item	**Details**
Failures	• This business process has no failure modes that prevent the process from going to completion.
Performance Measures	• Time to complete process: e.g., Batch Responses = within __ hours • Error rate = __% or less

PLAN MANAGEMENT

Develop Agency Goals and Objectives

PL Plan Administration	
Develop Agency Goals and Objectives	
Item	**Details**
Description	The ***Develop Agency Goals and Objectives*** business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary. Goals and objectives may warrant change for example, under a new administration, in response to changes in demographics, public opinion or medical industry trends, or in response to regional or national disasters.
Trigger Event	Environment-based Trigger Events: • Periodic timetable (e.g., annual) is due for review of goals and objectives. • Periodic timetable (e.g., annual) is due to implement new goals or objectives. • Ad hoc request for goals or objectives updates.
Result	• The State Medicaid Agency (SMA) defines new or modified statement of goals or objectives. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START.** Receive notice that the SMA requires a review of current goals and objectives or the review interval is due. 2. Review existing goals, objectives, and priorities. 3. Review information such as current performance measurements, industry successes, budget, and other States/programs successes. 4. Convene Stakeholders. 5. Develop consensus on changes and priorities. 6. **END**. Publish new or revised statement of goals and objectives, including performance measurements and priorities.
Shared Data	Plan data store including Medicaid State Plan, health plan, health benefits, performance measures, and benchmarks information Business Activity data store including performance information (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures)
Predecessor	***Manage Performance Measures***
Successor	***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Maintain Program Policy*** ***Maintain State Plan***

PL Plan Administration	
Develop Agency Goals and Objectives	
Item	**Details**
	Manage Performance Measures
Constraints	Economic conditions shift, making less revenue available to fund the approved and planned budget. The State Medicaid Agency will comply with federal and state regulations.
Failures	• Stakeholders are unable to reach consensus on the SMA goals and objectives.
Performance Measures	• Time to complete the process = within __ days, ___ weeks • Achievement of goals and objectives linked to policy implementation

Maintain Program Policy

PL Plan Administration	
Maintain Program Policy	
Item	**Details**
Description	The ***Maintain Program Policy*** Business Process responds to requests or needs for change in the enterprise's programs, benefits, or business rules, based on factors such as federal or state regulations, governing board or commission directives, Quality Improvement Organization's findings, federal or state audits, enterprise decisions, or consumer pressure.
Trigger Event	Environment-based Trigger Events: • Periodic timetable (e.g., annual) is due for review of program policy. • Periodic timetable (e.g., annual) is due to implement new program policy or modification. • Ad hoc request for program policy updates.
Result	• The State Medicaid Agency (SMA) defines new or modified statement of program policy. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START**: Receive request to add, delete, or change policy. 2. Request information to analyze policy. 3. Assess impact of policy on budget, stakeholders, and other benefits. 4. Formulate and publish policy. 5. Hold public hearings.

PL Plan Administration	
Maintain Program Policy	
Item	**Details**
	6. Revise policy. 7. Seek all federal and state administrative and regulatory approvals. 8. If applicable, assess impact of requested revisions. 9. Determine effective date and date span for policy in coordination with other enterprise considerations. 10. If applicable, develop training plan for new policy. 11. Develop implementation plan for policy. 12. **END**: Disseminate policy.
Shared Data	Plan data store including Medicaid State Plan, health plan, health benefits, performance measures, and benchmarks information Business Activity data store including performance information (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures)
Predecessor	***Develop Agency Goals and Objectives*** ***Manage Performance Measures*** ***Maintain State Plan***
Successor	***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Maintain State Plan*** ***Manage Performance Measures*** ***Establish Business Relationship***
Constraints	Economic conditions shift, making less revenue available to fund the approved and planned budget. The SMA will comply with federal and state regulations.
Failures	• Cost/benefit analysis does not support proposed policy. • Inability to obtain necessary approvals.
Performance Measures	• Time to complete the process = within __ days, ___ weeks • Achievement of goals and objectives linked to policy implementation

Maintain State Plan

PL Plan Administration	
Maintain State Plan	
Item	**Details**
Description	The ***Maintain State Plan*** business process responds to the scheduled and unscheduled prompts to update and revise the Medicaid State Plan. The Medicaid State Plan is the officially recognized statement describing the nature and scope of the State Medicaid program as required under Section 1902 of the Social Security Act.
Trigger Event	Environment-based Trigger Events: • Periodic timetable (e.g., annual) is due for review of Medicaid State Plan. • Periodic timetable (e.g., annual) is due to implement new policy or modification. • Ad hoc request for Medicaid State Plan updates.
Result	• The State Medicaid Agency (SMA) defines new or modified Medicaid State Plan. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive prompt or notification to review and update Medicaid State Plan. 2. Review relevant current Medicaid State Plan documentation. 3. Analyze requirements for change to Medicaid State Plan. 4. Research information associated with the change. 5. Analyze impact of the change and determine whether to move forward with modification based on results of analysis: a. If no modifications to Medicaid State Plan are necessary, **END:** Business process stops. b. If necessary, request a waiver for submission in accordance with procedures from appropriate authorities. 6. Develop Medicaid State Plan modification. 7. Disseminate Medicaid State Plan modification for review, comment and approval by internal and external stakeholders. 8. Refine Medicaid State Plan modification based on feedback. 9. Conduct Medicaid State Plan Amendment (SPA) review process with CMS. 10. **END:** Publish Medicaid State Plan Amendment.
Shared Data	Plan data store including Medicaid State Plan, health plan, health benefits, performance measures, and benchmarks information Business Activity data store including performance information

PL Plan Administration	
Maintain State Plan	
Item	**Details**
Predecessor	***Develop Agency Goals and Objectives*** ***Maintain Program Policy*** ***Manage Performance Measures*** ***Manage Budget Information***
Successor	***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Performance Measures*** ***Manage Applicant and Member Communication*** ***Perform Population and Member Outreach*** ***Manage Provider Communication*** ***Perform Provider Outreach*** ***Manage Contractor Communication*** ***Perform Contractor Outreach*** ***Manage Business Relationship Communication*** ***Manage Compliance Incident Information*** ***Formulate Budget*** ***Manage Data*** ***Establish Business Relationship***
Constraints	Economic conditions shift, making less revenue available to fund the approved and planned budget. The SMA will comply with federal and state regulations.
Failures	• The SMA is unable to receive approval of Medicaid State Plan from internal or external stakeholders.
Performance Measures	• Time to complete the process = within __ days, ___ weeks • Achievement of goals and objectives linked to policy implementation

Manage Health Plan Information

PL Health Plan Administration	
Manage Health Plan Information	
Item	**Details**
Description	The ***Manage Health Plan Information*** business process includes evaluation of federal or state regulations, legislative and judicial mandates, federal or state audits governing board or commission directives, Quality Improvement Organization's findings, enterprise decisions, and consumer pressure to develop or enhance enterprise business rules, benefit plans and services available to members. The State Medicaid Agency (SMA) collaboratively develops Health Plan service offerings with input and review by other agencies and stakeholders. This business process ensures the organization is on track with the goals and objectives of the SMA and is in concert with statewide goals.
Trigger Event	Environment-based Trigger Events: • Periodic timetable (e.g., annual) is due for review of policy. • Periodic timetable (e.g., annual) is due to implement new policy or modification. • Ad hoc request for program policy updates.
Result	• The SMA defines new or modified policy. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Notification of legal or administrative mandates that have potential impact to Health Plan policy. 2. Analyze legal or administrative mandates and determine whether to create, revise, or terminate Health Plan policy. 3. Assess impact of policy on budget, stakeholders, and other benefits. 4. Create, revise, or terminate Health Plan policy and publish new, revised Health Plan policy, or notification of intent to terminate existing Health Plan policy. 5. Hold public hearings regarding Health Plan policy. 6. Revise Health Plan policy as necessary. 7. Submit Health Plan policy to federal and state administrative and regulatory agencies for approval. 8. Assess impact of requested revisions, if applicable. 9. Determine effective date and duration for Health Plan policy in coordination with other enterprise considerations. 10. Develop training plan for new, revised or discontinued Health Plan policy. 11. Develop implementation or transition plan for new, revised, or discontinued Health Plan policy. 12. Implement Health Plan policy. 13. **END:** Send Health Plan policy to Health Insurance Marketplace (HIX) for

PL Health Plan Administration	
Manage Health Plan Information	
Item	**Details**
	certification.
Shared Data	Financial data store including budget information Member data store including demographic information Contractor data store including provider network information Provider data store including provider network information Plan data store including policy information Health Benefit data store including benefit program and benefit information Reference data store including code set information Authorization data store including authorization and treatment plan information Business Activity data store including performance information (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures)
Predecessor	***Develop Agency Goals and Objectives*** ***Maintain Program Policy*** ***Maintain State Plan*** ***Manage Health Benefit Information*** ***Manage Performance Measures*** ***Formulate Budget*** ***Manage Budget Information***
Successor	***Manage Health Benefit Information*** ***Manage Reference Information*** ***Manage Rate Setting*** ***Manage Performance Measures*** ***Manage Applicant and Member Communication*** ***Perform Population and Member Outreach*** ***Manage Provider Communication*** ***Perform Provider Outreach*** ***Manage Contractor Communication*** ***Perform Contractor Outreach*** ***Manage Business Relationship Communication*** ***Establish Compliance Incident***

PL Health Plan Administration	
Manage Health Plan Information	
Item	**Details**
	Manage Compliance Incident Information ***Formulate Budget*** ***Manage Data***
Constraints	Economic conditions shift, making less revenue available to fund the approved and planned budget. The SMA will comply with federal and state regulations.
Failures	• Cost/benefit analysis does not support proposed policy. • Inability to obtain necessary approvals.
Performance Measures	• Time to complete the process = within __ days, ___ weeks • Achievement of goals and objectives linked to policy implementation

Manage Performance Measures

PL Health Plan Management	
Manage Performance Measures	
Item	**Details**
Description	The ***Manage Performance Measures*** business process involves the design, implementation, and maintenance of mechanisms and measures the State Medicaid Agency (SMA) uses to monitor the business activities and performance of the State Medicaid Enterprise's business processes and programs. This includes the steps involved in defining the criteria by which the SMA measures activities and programs (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures). This business process develops the reports and other mechanisms that it uses to track activity and effectiveness at all levels of monitoring. Business Intelligence analysis (i.e., historical, current and predictive views of business operations) occurs within this process. Examples of performance measures and associated reports may be things such as: *Goal*: The SMA makes prompt and accurate payments to providers. *Measurement:* Pay or deny 95% of all clean claims within 30 days of receipt. *Mechanism:* The SMA generates weekly report on claims processing timelines. *Goal*: Accurately and efficiently, draw and report funds in accordance with the federal Cash Management Improvement Act (CMIA) and general cash management principles and timeframes to maximize non-general fund recovery. *Measurement:* Draw 98% of funds with the minimum time allowed under CMIA. *Mechanism*: The SMA generates monthly report on funds drawn.

PL Health Plan Management	
Manage Performance Measures	
Item	**Details**
	Goal: Improve health care outcomes for Medicaid members. *Measurement:* Reduce emergency room visits by ten percent by assigning a primary care case manager. *Mechanism:* The SMA generates monthly report comparing emergency room usage by member for the period prior to and after Primary Care Case Managers (PCCM) assignment.
Trigger Event	Environment-based Trigger Events: • Receive request to revise or develop new performance measures and/or reporting. • Notification of a periodic review of measures and/or reporting is due. • Receive notification for executing a periodic monitoring activity. • Receive notice describing an incident requiring monitoring.
Result	• Update to the criteria, mechanisms, and/or reports utilized to monitor performance measures. • Produce reporting related to the incident analysis or periodic monitoring results. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request or reach scheduled review time. 2. Review existing performance measures and reports. 3. Revise, delete or add to existing measures and reports. 4. Produce updated definition of performance measures. 5. Monitor business activity against established performance measures. 6. Assess resulting information with business intelligence methods (i.e., historical, current and predictive views of business operations). 7. Produce reporting. 8. **END:** Disseminate information to designated members (e.g., individuals or business processes).
Shared Data	Business Activity data store including performance information (e.g., CAPHS and HEDIS measures)
Predecessor	**NOTE:** Any MITA business process could be a predecessor to any performance monitoring activity depending on the performance measures. ***Develop Agency Goals and Objectives*** ***Maintain Program Policy*** ***Maintain State Plan*** ***Manage Health Plan Information***

PL Health Plan Management	
Manage Performance Measures	
Item	**Details**
	Identify Utilization Anomalies ***Manage Compliance Incident Information***
Successor	**Send Outbound Information** ***Manage Health Plan Information*** ***Formulate Budget*** ***Establish Compliance Incident*** ***Manage Data*** ***Develop Agency Goals and Objectives*** ***Maintain Program Policy*** ***Maintain State Plan***
Constraints	The SMA will comply with federal and state regulations. Business intelligence tools have different abilities depending on the tool utilized and technical configuration.
Failures	• Inability to access relevant information.
Performance Measures	• Time to complete the process = within __ hours, ___ minutes • Accuracy with which State Medicaid Enterprise applies updates • Consistency with which State Medicaid Enterprise applies updates • Error rate = __% • Effectiveness of performance measures • Ease of implementation of performance measures

Manage Health Benefit Information

PL Health Benefit Administration	
Manage Health Benefit Information	
Item	**Details**
Description	The ***Manage Health Benefit Information*** business process includes the activities for development and implementation of health benefit packages to accommodate service delivery to targeted member populations. The health benefit package accommodates information to support current and future health benefit packages for members eligible for programs administered by the State Medicaid Agency (SMA). The SMA determines benefit terms and limitations, and applicable periods for services defined within a health benefit package.

PL Health Benefit Administration	
Manage Health Benefit Information	
Item	**Details**
	Health benefit package administration involves the ability to determine, define and coordinate and modify the following parameters within the SMA, as the Medicaid Enterprise policies, funding and business decisions dictate: • Multiple health benefit package definitions targeted to specific populations. • Service categories to define available covered service. • Federal and state regulations define service limitations to restrict utilization. • Customization of edits and audits relative to SMA policy. • Utilization tracking of limited services at the member level. • Generation of state and federal reporting requirements.
Trigger Event	State transition-based Trigger Events: • Receive information to load as initial records or updates to existing records from any Business Area. Interaction-based Trigger Events: • Receive inquiry for health benefit information from enterprise business processes. • Receive an inquiry from authorized external parties (e.g., a legislator requests outcome measures for a particular program). Environmental Trigger Events: • Periodic or near real-time transmission of program information to authorized external parties or systems, (e.g., Centers for Medicare & Medicaid Services (CMS) or Medicaid Statistical Information System (MSIS)).
Result	All Business Areas load new or updated information and have access to the Health Benefit Information data store to use for analysis, reporting, and decision reporting including: • Response to inquiries from authorized requestors and/or applications. • Provision to all other Health Plan Management business processes with program information as needed (i.e., to develop benefit packages and drug formularies, set rates, analyze and project budgets, perform accounting functions, manage federal financial participation (FFP), measure quality, outcomes and performance, and develop policies and strategic initiatives, etc.). • Provision to all MITA business processes with program information needed (e.g., to manage communications, manage business relationships, perform outreach and education, and manage contracts). • Delivery of information to external parties or systems for reporting (e.g., CMS Medicaid Statistical Information System (MSIS) and public health for population health studies). • Delivery of modification to health benefits to Health Insurance Marketplace (HIX)

PL Health Benefit Administration	
Manage Health Benefit Information	
Item	**Details**
	for certification. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** The modification of health plan policy determines the health plan benefit packages that require definition or modifications to comply with the policy. 2. Create and modify health plan benefit packages that support definition of services available for various SMA programs. 3. Define the effective date and duration of the health plan benefit packages. 4. Define the health plan benefit package coverage narrative. 5. Define services specific to unique health plan benefit packages. 6. Specify limitations at both the service and monetary levels relative to health plan benefit packages and service categories. 7. Define any applicable member monetary constraints that include co-pay, co-insurance, deductible, and share of cost amounts, limits, and lifetime maximums. 8. **END:** Send health plan benefit services to Health Insurance Marketplace (HIX) for certification.
Shared Data	Business Activity data store including performance information (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures) Plan data store including policy and health benefit information Health Benefit data store including benefit package and benefits information Provider data store including provider network and contract information Contractor data store including provider network and contract information Member data store including applicant or member demographics, enrollment, financial, social, functional and clinical information Claims data store including payment history
Predecessor	***Develop Agency Goals and Objectives*** ***Maintain Program Policy*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Rate Setting*** ***Manage Reference Information***

PL Health Benefit Administration	
Manage Health Benefit Information	
Item	**Details**
Successor	***Manage Health Plan Information*** ***Manage Reference Information*** ***Manage Data***
Constraints	Policies and procedures will differ by state, especially those relating to information standards, record keeping, and privacy.
Failures	• Inability or failure to load initial records, properly analyze, update, or locate existing records in the Business Activity data store.
Performance Measures	• Time to store information = within __ minutes • Time to access information = within __ minutes • Error rate = __% or less

Manage Reference Information

PL Health Benefit Administration	
Manage Reference Information	
Item	**Details**
Description	The ***Manage Reference Information*** business process is responsible for all operations aspects for the creation, modification, and deletions of reference code information. The ***Process Claim*** business process additions or adjustments trigger this business process. Additional triggers for ***Manage Reference Information*** business process include the addition of a new health plan or benefit, or the modification to an existing program due to the passage of new state or federal legislation, or budgetary modifications. The business process includes revising code information (e.g., Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), National Drug Code (NDC)), and/or revenue codes. Business process also adds rates associated with those codes and updates existing rates. The business process updates and adds information from the ***Manage Member Information*** and ***Manage Provider Information*** business processes as well as drug formulary, health plan and health benefit information. <u>Designate Approved Services and Drug Formulary</u> The Designate Approved Services and Drug Formulary activity is responsible for review of new and/or modified service codes (e.g., HCPCS, International Classification of Diseases (ICD) or NDC) for possible inclusion in various Medicaid Benefit programs. The State Medicaid Agency (SMA) may include or exclude certain services and drugs in each benefit package. Internal or external team(s) of medical, policy, and rates staff review service, supply, and drug codes to determine fiscal impacts and medical appropriateness for the

PL Health Benefit Administration	
Manage Reference Information	
Item	**Details**
	inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that the SMA will meet. Review includes the identification of any modifications or additions needed for regulations, policies, and or Medicaid State Plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.
Trigger Event	Interaction-based Trigger Events: • Receive new or modification of reference information from ***Process Claim*** business process. • Receive new or modification of health plan information from ***Manage Health Plan Information*** business process. • Receive new or modification of health benefits information from ***Manage Health Benefit Information*** business process. Environment-based Trigger Events: • Addition or modification to health plan or health benefit as directed by state or federal legislation or budgetary modifications. • Receive revised reference code set by industry standards organization. • Annual, bi-annual, quarterly or other review of newly established or modified service codes and National Drug Codes as published by maintainers of medical codes.
Result	• Addition or modification of reference code set elements. • Alert sent to notify provider and contractor of reference code addition or modification. • Approved services and drug formularies established and defined. • The SMA approved or denied service codes and NDC codes for inclusion or exclusion in one or more Medicaid Health Plan. • Alert sent to notify impacted member of approved services and drug formulary. • Alert sent to ***Manage Rate Setting*** business process to establish rates for approved services and drug formulas. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive addition or modification of reference information. 2. Review addition or modification to determine impact to coverage requirements based on current benefit programs. 3. Add or update codes or rates, including pre- and post-verification for accuracy. 4. Add or update member benefits, including pre- and post-verification for

PL Health Benefit Administration	
Manage Reference Information	
Item	**Details**
	accuracy. 5. Add or update drug formulary information, including pre- and post-verification for accuracy. 6. Add or update program under which services are available. 7. **END:** Send alert to notify provider and contractor of reference code addition or modification. <u>Designate Approved Services and Drug Formulary</u> 1. **START:** Receive addition or modification of codes information. 2. Review new or modified coding to determine impact to coverage requirements based on current benefit programs. 3. Approve addition or elimination of services or NDC. 4. Determine coverage policies. 5. Review and identify modifications to Medicaid State Plan. 6. Review and identify modifications to regulations. 7. Recommend modifications to the State Medicaid Enterprise. 8. **END:** Send alert to notify provider, contractor, and impacted member of approved services and drug formulary.
Shared Data	Reference data store including code set, drug formulary, and service code formulary information Member data store including health benefits information Provider data store including provider network information Contractor data store including provider network information Health Benefit data store including benefit and rate information
Predecessor	**Receive Inbound Transaction** ***Manage Rate Setting*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Process Claim*** ***Process Encounter***
Successor	***Process Claim*** ***Process Encounter*** ***Manage Rate Setting*** ***Manage Provider Communication***

PL Health Benefit Administration	
Manage Reference Information	
Item	**Details**
	Manage Contractor Communication ***Manage Applicant and Member Communication*** ***Manage Data***
Constraints	The SMA will maintain the Reference data store according to federal and state-specific policies and procedures, and comply with any code authority requirements. The SMA establishes service and drug formularies. Policies and procedures may differ from state to state.
Failures	• The review does not take place prior to the effective date of the codes.
Performance Measures	• Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ days • Accuracy of decisions = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Manage Rate Setting

PL Health Benefit Administration	
Manage Rate Setting	
Item	**Details**
Description	The ***Manage Rate Setting*** business process responds to requests to add or modify rates for any service or product covered by the Medicaid Program.
Trigger Event	Environment-based Trigger Events: • Receive official request for rate setting addition or modification. • Periodic timetable is due for rate addition or modification. • Receive the addition or modification of rate information.
Result	• The State Medicaid Agency (SMA) defines new rate with effective date and date span. • The SMA rejects rate request. • Alert sent to notify provider and contractor of rate modification. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START**. Receive notification of request for addition or modification of rate. 2. Research and analyze rate, which may include request information to determine initial or updated rate.

PL Health Benefit Administration	
Manage Rate Setting	
Item	**Details**
	3. Validate rate requested or establish rate. 4. Optional: Perform What-if scenarios analysis. 5. Create rate update or deny the request. 6. **END:** Send alert to notify provider and contractor of rate addition or modification.
Shared Data	Business Activity data store including performance measures Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS))information Plan data store including policy information Health Benefit data store including benefit package and benefit information Claims data store including payment information Provider data store including provider network and Contract information Contractor data store including provider network information
Predecessor	***Manage Health Plan Information***
Successor	***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Manage Reference Information***
Constraints	The SMA will conform to mandates from the legislature or court. For a new service, procedure or product, information may not exist to assist in establishing a rate.
Failures	• The SMA does not have enough information to validate rate or perform What-if scenario analysis delaying or interrupting the process. • Process includes possible denial of rate setting request.
Performance Measures	• Time to establish/update rate or reject rate request = __ hours or days • Accuracy: The process produces acceptable results __ % of the time • Efficiency: Combination of staff plus automated processes results in utilization of __ FTEs per occurrence of this process

PROVIDER MANAGEMENT

Manage Provider Information

PM Provider Information Management	
Manage Provider Information	
Item	**Details**
Description	The ***Manage Provider Information*** business process is responsible for managing all operational aspects of the Provider data store, which is the source of comprehensive information about prospective and contracted providers and their interactions with the State Medicaid Agency (SMA). The Provider data store is the SMA Source of Record (SOR) for provider demographic, business, credentialing, enumeration, performance profiles, payment processing, and tax information. The data store includes contractual terms (e.g., the services the provider is to provide) related performance measures, and the reimbursement rates for those services. In addition, the Provider data store contains records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification, and all communications with or about the provider, including provider verification requests and responses, and interactions related to any grievance/appeal. The Provider data store may store records or pointers to records for services requested and services provided, performance, utilization, and program integrity reviews, and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member data store to add, delete, or modify information. The Provider data store validates information upload requests, applies instructions, and tracks activity. The Provider data store provides access to provider records to applications and staff via batch record transfers, responses to queries, and subscription services.
Trigger Event	Environment-based Trigger Events: • Receive request to create, inquire, delete, or modify provider information from authorized individuals via email, mail, facsimile, telephone or web. • Receive request to verify provider information from authorized external parties.
Result	• The SMA creates, inquires on, modifies or deletes provider information. • Alert sent to notify Health Insurance Marketplace (HIX) of provider network modification information. • Alert sent to notify insurance affordability program (i.e., Medicare, CHIP and Basic Health Program) of provider network modification. • Alert sent to ***Manage Provider Communication*** to notify provider of relevant modifications. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request from authorized individuals or agencies to create, inquire, delete or modify provider information. 2. Agency logs request for provider information. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields.

PM Provider Information Management	
Manage Provider Information	
Item	**Details**
	4. Validate the authorization by requestor to acquire provider information. 5. Find appropriate provider. 6. Create, inquire, delete or modify relevant provider information. 7. Send alert to notify Health Insurance Marketplace (HIX) of provider network modification. 8. Send alert to notify insurance affordability program of provider network modification. 9. Send alert to ***Manage Provider Communication*** to notify provider of relevant modifications 10. **END:** The SMA creates, inquires on, deletes, or modifies provider information.
Shared Data	Provider data store including provider network, contract, demographics, application, eligibility, enrollment, grievance, appeals and communications information Financial data store including payment information Plan data store including policy information Health Benefit data store including benefit program and benefit information Claims data store including claim status and claims payment information Care Management data store including case management, health record, and clinical data information Business Activity data store including performance information
Predecessor	**Receive Inbound Transaction** ***Determine Provider Eligibility*** ***Enroll Provider*** ***Disenroll Provider*** ***Terminate Provider*** ***Perform Provider Outreach*** ***Manage Provider Communication*** ***Manage Provider Grievance and Appeal*** ***Establish Compliance Incident*** ***Determine Adverse Action Incident***
Successor	**Send Outbound Transaction** ***Determine Provider Eligibility*** ***Enroll Provider*** ***Disenroll Provider*** ***Terminate Provider***

PM Provider Information Management	
Manage Provider Information	
Item	**Details**
	Perform Provider Outreach ***Manage Provider Communication*** ***Manage Provider Grievance and Appeal*** ***Manage Provider Recoupment*** ***Manage Contractor Payment*** ***Manage Capitation Payment*** ***Establish Compliance Incident*** ***Manage Data***
Constraints	State-specific workflows determine which processes load and access the Provider data store and by which interactions and messages (e.g., query/response, batch uploads, publish and subscribe, etc.), the information content and how they will structure data store records, as well as determine how to validate the incoming information prior to updating the Provider data store. Archive information in accordance with state and federal record retention requirements.
Failures	• Requestor has no authorization to the provider information. • Unable to find requested Provider. • Provider information is not available for inquiry.
Performance Measures	• Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ days • Accuracy of decisions = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Terminate Provider

PM Provider Information Management	
Terminate Provider	
Item	**Details**
Description	The ***Terminate Provider*** business process is responsible for the termination of provider agreement to participate in the Medicaid Program. The basis for termination can be: • Centers for Medicare & Medicaid Services (CMS) and the State Medicaid Agency (SMA) terminate a provider agreement if an individual provider: ○ Is not in substantial compliance with the requirements of participation, regardless of whether immediate jeopardy is present; or

PM Provider Information Management	
Terminate Provider	
Item	**Details**
	○ Provider does not meet the eligibility criteria for continuation of payment as set forth in 42 CFR 488.412(a)(1). • CMS and the state may terminate a facility's provider agreement if a facility: ○ Is not in substantial compliance with the requirements of participation, regardless of whether immediate jeopardy is present; or ○ Facility fails to submit an acceptable Corrective Action Plan (CAP) within the timeframe specified by CMS or the SMA. • CMS and the SMA terminate a facility's provider agreement if a facility: ○ Fails to relinquish control to the temporary manager, if CMS or the SMA imposes that remedy; or ○ Facility does not meet the eligibility criteria for continuation of payment as set forth in 42 CFR 488.412(a)(1). The effect of termination of the provider agreement ends: (1) payment to the facility, and (2) any alternative remedy.
Trigger Event	Interaction-based Trigger Events: • Receive alert from ***Determine Adverse Action Incident*** business process to cease activities with provider. Environment-based Trigger Events: • Receive request to terminate provider. • Receive notification of termination of provider from insurance affordability program.
Result	• Removal of provider or contractor from participation in Medicaid Program. • Alert sent to notify provider via ***Manage Provider Communication*** business process of termination proceedings. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of termination proceedings. • If applicable, alert sent to notify public via ***Perform Population and Member Outreach*** business process of termination proceedings. • Alert sent to notify business partners via ***Manage Business Relationship Communication*** business process of provider termination. • Alert sent to notify Health Insurance Marketplace (HIX) of provider termination information. • Alert sent to notify insurance affordability program of provider termination information. • Tracking information as needed for measuring performance and business activity monitoring.

PM Provider Information Management	
Terminate Provider	
Item	**Details**
Business Process Steps	1. **START:** Receive request to terminate provider. 2. Review determination of noncompliance and investigation materials. 3. Send alert to notify provider via ***Manage Provider Communication*** business process of termination proceedings. 4. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of termination proceedings. 5. If applicable, send alert to notify public via ***Perform Population and Member Outreach*** business process of termination proceedings. 6. Conduct communications and investigations within required timeframes. 7. If provider had implemented systems and processes to ensure that the likelihood of further violation is remote, and there is adequate evidence that the provider is in compliance with the requirements, the SMA rescinds the termination action and puts the provider back into compliance. 8. If provider has not implemented systems and processes to avoid further violations, terminate the provider. 9. Send alert to notify business partners via ***Manage Business Relationship Communication*** of provider termination. 10. Send alert to notify Health Insurance Marketplace (HIX) of provider termination information. 11. Send alert to notify insurance affordability program of provider termination information. 12. **END:** Remove provider or contractor from participation in Medicaid Program.
Shared Data	Provider data store including provider network and contract information Business Activity data store including performance information Compliance Management data store including compliance incident information Insurance Affordability Program data store including eligibility and enrollment information
Predecessor	***Determine Adverse Action Incident***
Successor	***Manage Provider Communication*** ***Manage Contractor Communication*** ***Perform Population and Member Outreach*** ***Manage Business Relationship Communication***
Constraints	Before terminating a provider agreement, CMS and the SMA will notify the facility and the public: (1) At least two (2) calendar days before the effective date of termination for a

PM Provider Information Management	
Terminate Provider	
Item	**Details**
	facility with immediate jeopardy deficiencies; and (2) At least 15 calendar days before the effective date of termination for a facility with non-immediate jeopardy deficiencies that constitute noncompliance.
Failures	• Unable to find requested Provider. • Provider information is not available for inquiry.
Performance Measures	• Time to complete termination process = within __ days • Consistency of decisions and disposition = ___% • Error rate = __% or less

Manage Provider Communication

PM Provider Support	
Manage Provider Communication	
Item	**Details**
Description	The ***Manage Provider Communication*** business process receives requests for information, provides publications, and assistance from prospective and current providers' communications (e.g., inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements). The State Medicaid Agency (SMA) may communicate information using a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). This business process includes the log, research, development, approval and delivery of routine or ad hoc messages. **NOTE:** ***Manage Provider Communication*** business process handles inquiry from prospective and current providers by providing assistance and responses to *individual entities* (i.e., bi-directional communication). Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The ***Perform Provider Outreach*** business process targets both prospective and current provider *populations* for distribution of information about programs, policies, and health care issues.
Trigger Event	Interaction-based Trigger Events: • Receive requests from other business processes to develop and produce communications for providers such as notifications from ***Enroll Provider*** business process. • Receive inquiries originating from customer help desk through ***Manage Provider Information*** business process. Environment-based Trigger Events: • Receive inquiry from current or prospective provider.

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Manage Provider Communication	
Item	**Details**
	• Receive request to send information packages such as provider enrollment applications and/or billing instructions. • Receive request for assistance, such as a request for training or modify in provider information. • Periodic timetable (e.g. hours, monthly, and quarterly) is due to send information. For example, SMA sends communications within 24 hours of new provider enrollment or periodic publications such as newsletters.
Result	• Current or prospective provider receives appropriate assistance, communications, appointment, and/or information packages. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for communication. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information is authentic. 4. Agency logs request for communication. 5. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web, or EDI. 6. Determine performance measures. 7. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 8. Review and approve communication. 9. Generate communication in agreed upon format. 10. Agency logs communication message. 11. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate).
Shared Data	Provider data store including provider network, contract, and grievance information Plan data store including policy information Health Benefit data store including benefit package and benefit information Ancillary Communication Tracking Systems: Customer Relationship Management (CRM), Help Desk Log, Protected Health Information (PHI) disclosure log, etc.
Predecessor	**Receive Inbound Transaction** ***Determine Provider Eligibility*** ***Enroll Provider***

PM Provider Support	
Manage Provider Communication	
Item	**Details**
	Disenroll Provider ***Terminate Provider*** ***Manage Provider Grievance and Appeal*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information***
Successor	**Send Outbound Transaction** ***Manage Provider Information*** ***Manage Performance Measures***
Constraints	Communications requested will vary by state, depending on programs supported and type of provider requesting information. Provider may have communication barriers such as lack of internet or phone access. Provider is unable to access required or requested information.
Failures	• SMA is unable to provide linguistically, culturally, or competency appropriate information. • Delivery failures due to erroneous contact information or lack of contact information.
Performance Measures	• Time to complete response: By phone __ minutes; by email ___ hours; by mail __days • Accuracy of communications = __% • Communications successfully delivered = __%

Manage Provider Grievance and Appeal

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Manage Provider Grievance and Appeal	
Item	**Details**
Description	The ***Manage Provider Grievance and Appeal*** business process handles provider* appeals of adverse decisions or communications of a grievance. The ***Manage Provider Communication*** business process initiates a grievance or appeal from a provider. The State Medicaid Agency (SMA) logs and tracks the grievance or appeal, triages it, and sends it to appropriate reviewers. Staff researches or requests additional information. The SMA may schedule a hearing, conduct actions in accordance with legal requirements, and make a ruling based upon the evidence presented. Staff documents and distributes results of the hearings, and adds relevant documents to the provider's information. SMA formally notifies provider of

PM Provider Support	
Manage Provider Grievance and Appeal	
Item	**Details**
	the decision. This business process supports the ***Manage Performance Measures*** business process by providing information about the types of grievances and appeals it handles, grievance and appeals issues, parties that file or are the target of the grievances and appeals, and the dispositions. The SMA uses information to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. Based on the appeal business process, if a provider wins an appeal that affects or clarifies a Medicaid State Plan, health plan, or health benefit, this process sends that information to ***Maintain State Plan, Manage Health Plan Information*** or ***Manage Health Benefit Information*** business processes to modify the relevant policy or procedure. Disposition could result in legislative change requirements that the SMA will communicate to lawmakers. **NOTE:** States may define grievance and appeal differently, depending on state laws. States may involve multiple agencies in the ***Manage Provider Grievance and Appeal*** business process. *This business process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when SMA denies an application for enrollment.
Trigger Event	Interaction-based Trigger Events: • Receive grievance or appeal of adverse decision alert from ***Manage Provider Information***.
Result	• Alert sent to notify provider of final disposition of grievance or appeal. • If applicable, alert sent to ***Establish Compliance Incident*** business process for further investigation. • If applicable, alert sent to ***Maintain State Plan*** business process to modify the relevant policy or procedure. • If applicable, alert sent to ***Manage Health Plan Information*** business process to modify the relevant policy or procedure. • If applicable, alert sent to ***Manage Health Benefit Information*** business process to modify the relevant policy or procedure. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive grievance or appeal. 2. Agency logs grievance or appeal. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields. 4. Validate that the provided information is authentic. 5. If appropriate, request additional documentation.

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Manage Provider Grievance and Appeal	
Item	**Details**
	6. Determine status as initial, second, or expedited or other status as designated by the state. 7. Triage to appropriate personnel for review. 8. Perform research and analysis. 9. If appropriate, schedule hearing within required time. 10. If appropriate, conduct hearing within required time. 11. Determine disposition. 12. If applicable, send alert to ***Establish Compliance Incident*** business process for further investigation. 13. If applicable, alert sent to ***Maintain State Plan*** business process to modify the relevant policy or procedure. 14. If applicable, alert sent to ***Manage Health Plan Information*** business process to modify the relevant policy or procedure. 15. If applicable, alert sent to ***Manage Health Benefit Information*** business process to modify the relevant policy or procedure. 16. **END:** Send alert to notify provider of disposition determination. **NOTE:** Some of the above steps may be iterative and a grievance or appeals case may take many months to finalize.
Shared Data	Provider data store including eligibility, enrollment and provider network information Claims data store including claims and premium Information Grievance and Appeal data store including case history and Recovery Audit Contractor (RAC) adverse determination information Adverse Action data store including case history information
Predecessor	***Manage Provider Information***
Successor	***Manage Provider Communication*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Performance Measures*** ***Establish Compliance Incident***
Constraints	States may have different requirements for evidence and the process for conducting the grievance and appeals cases. They may have different rules for assigning outcome status and state specific consequences. The State Medicaid Agency will conform to state and federal regulations.
Failures	• Grievance and Appeal supporting documentation is incomplete.

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Manage Provider Grievance and Appeal	
Item	**Details**
	• SMA cannot schedule or conduct hearing in the required period. • Final disposition was a result of summary judgment due to lack of timeliness within the process. • Provider withdraws grievance or appeal.
Performance Measures	• Time to complete process: normal grievance/appeal = __days; second appeal =__days; expedited appeal =__hours • Accuracy of decisions = __% • Consistency of decisions and disposition = __% • Error rate = __% or less

Perform Provider Outreach

PM Provider Support	
Perform Provider Outreach	
Item	**Details**
Description	The ***Perform Provider Outreach*** business process originates internally within the State Medicaid Agency (SMA) in response to multiple activities (e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, modifications in the Medicaid Program policies and procedures). SMA may develop prospective Provider outreach information, also referred to as Provider Recruiting information, for targeted providers identified by analyzing program information (for example, not enough dentists to serve a population, new immigrants need language-compatible providers). Enrolled Provider outreach information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives. The State Medicaid Agency develops outreach information for target populations identified by analyzing member information. The State Medicaid Agency may communicate information in a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). The State Medicaid Agency produces, distributes, tracks and archives all contractor outreach communications according to state rules. The ***Manage Performance Measures*** business process defines benchmarks and measures outreach efficacy. **NOTE:** The ***Perform Provider Outreach*** business process targets both prospective and current provider *populations* for distribution of information about programs, policies, and health issues. ***Manage Provider Communication*** business process handles inquiry from applicants, prospective and current providers by providing assistance and responses to *individuals* (i.e., bi-directional communication).
Trigger Event	State transition Trigger Events:

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Perform Provider Outreach	
Item	**Details**

	• Alert received from ***Manage Health Plan Information*** business process of addition or modification.
	• Alert received from ***Manage Health Benefit Information*** business process of addition or modification.
	Environment-based Trigger Events:
	• Executive Management decision to:
	  o Fill gaps in health care service and administrative coverage.
	  o Solicit updated/new administrative and technical functions.
	  o Introduce new programs requiring new types of health or administrative service.
	  o Change existing policies and procedures.
	  o Identify critical need for a specific target population.
	  o Identify new populations in need of service (e.g., new immigrant communities).

Result	• Agency produces outreach communications (e.g., mailing brochures, web pages, email, kiosk, and radio, billboard, and TV advertisements) and distributes to targeted providers. Agency may also conduct face-to-face meetings. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for outreach materials or communication. 2. Target population is identified and defined by analyzing information, performance measures, feedback from community, and policy directives. 3. Approve, deny, or modify decisions to develop outreach communications. 4. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web or EDI. 5. Determine performance measures. 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate)
Shared Data	Provider data store including provider network, application and enrollment information

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Perform Provider Outreach	
Item	**Details**
	Plan data store including policy information Health Benefits data store including benefit package and benefit information Performance Measures data store including agency's objectives Care Management data store including population health and treatment plan information Business activity data store including performance information Compliance Management data store including compliance incident information
Predecessor	***Manage Performance Measures*** ***Identify Utilization Anomalies*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information***
Successor	**Send Outbound Transaction** ***Manage Provider Communication***
Constraints	Communications and information packages will address the needs of the targeted population. Materials will be linguistically and culturally appropriate, legally compliant, appropriate to the targeted group, and meet financial guidelines (re: cost to produce and distribute). Other constraints may be agency priority, availability of resources, and accuracy of contractor contact information. Provider may have communication barriers such as lack of Internet or phone access. Provider is unable to access needed or requested information.
Failures	• Unable to identify target population based on desired criteria. • Management denies permission for outreach activity. • Cancel health plan or health benefit. • Delivery failures due to erroneous contact information.
Performance Measures	• Time to complete process of developing outreach materials = __ days • Accuracy of outreach materials = __% • Successful delivery rate to targeted individuals = ___% • Effectiveness of the communication – Outreach results in achieving specified goals (e.g., recruitment of new providers from targeted population)