Part I — Business Architecture

Appendix C — Business Process Model Details

Introduction

Appendix C contains the MITA Framework Release 2.0 artifacts of the Business Process Model (BPM). Business processes have been identified for common Medicaid agency operations corresponding to the 8 MITA Business Areas. In some cases the business process form is not complete, as indicated by the "To Be Developed" notation. All business processes are considered to be a work in progress. Collaboration between States, vendors, and CMS is needed to refine and improve all processes. Next steps include mapping business processes to the Conceptual Data Model, reviewing and refining the details contained in the forms, and adding new processes identified by States. The Conceptual and Logical Data Models are intended to consolidate Federal/CMS requirements and a consensus of additional State requirements.

Business processes are often a consolidation of several similar processes. For example, *Enroll Provider* is presented as a single process accommodating any kind of provider. This is because the processing steps are similar for all provider types even though the specific data requirements and business rules are different from type to type. This consolidation allows us to keep the BPM at a manageable size.

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 data for subsequent processing are *not* included in the BPM. They belong to a special category of business and technical services.

Appendix D contains the companion Business Capabilities. It is intended that every business process have its set of corresponding business capabilities. Business processes are meant to be used in conjunction with the business capabilities.

How to Read the Business Process Forms

The table below shows the format of the business process form. The Title and Tier number of the business process link it to the Business Areas shown in the next section.

CM3 Inquire Contractor Information

Tier 3: Inquire Contractor Information		
Item	**Details**	**Links**
Description	Overview of the business process	Connects this business process to others
Trigger Event	The action or scheduled time that initiates the process; identifies the Trigger data set. When the Conceptual Data Model is available, the Trigger data groupings should be inserted in this section.	
Result	The output(s) of the process; identifies the Result data set. When the Conceptual Data Model is available, the Result data groupings should be inserted in this section	
Business Process Steps	Enumeration of the major steps	
Shared Data	Identifies external data needed to perform the processing steps. When the Conceptual Data Model is available, the Shared data groupings should be inserted in this section	
Predecessor	Preceding business processes; i.e., the Result of a Previous business process can be the Trigger for the next one	
Successor	A business process that receives input from the result of another business process	
Constraints	States may have different approaches to the business process that need to be recognized	
Failures	Rules that specify when a business process must terminate prematurely	
Performance Measures	Type of measurement that can be used to determine the performance of this business process. The form only shows they *type* of measure to consider. Actual measures are needed in the business capabilities associated with the business process. In some of the business processes, examples of measures are supplied	

The table below list the business areas and corresponding business processes contained in the forms in Appendix C. There are 78 business processes in the BPM at this time, 7 of which require more definition.

Business Area	Business Process
Member Management (ME)	ME Determine Eligibility
	ME Disenroll Member
	ME Enroll Member
	ME Inquire Member Eligibility
	ME Manage Applicant and Member Communication
	ME Manage Member Grievance and Appeal
	ME Manage Member Information
	ME Perform Population and Member Outreach
Provider Management (PM)	PM Disenroll Provider
	PM Enroll Provider
	PM Inquire Provider Information
	PM Manage Provider Communication
	PM Manage Provider Grievance and Appeal
	PM Manage Provider Information
	PM Perform Provider Outreach
Contractor Management (CO)	CO1 Award Health Services Contract
	CO1 Close out Health Services Contract
	CO1 Manage Health Services Contracting
	CO2 Award Administrative Contract
	CO2 Close-out Administrative Contract
	CO2 Manage Administrative Contract
	CO3 Manage Contractor Information
	CO4 Manage Contractor Communication
	CO4 Perform Potential Contractor Outreach
	CO4 Support Contractor Grievance and Appeal
	CO3 Inquire Contractor Information
Operations Management (OM)	OM1 Authorize Referral
	OM1 Authorize Service
	OM1 Authorize Treatment Plan
	OM2 Apply Claim Attachment
	OM2 Apply Mass Adjustment
	OM2 Audit Claim-Encounter
	OM2 Edit Claims-Encounter Process [DELETE process]
	OM2 Price Claim - Value Encounter
	OM3 Prepare COB
	OM3 Prepare EOB

Business Area	Business Process
	OM3 Prepare Home and Community Based Services Payment
	OM3 Prepare Premium EFT-check
	OM3 Prepare Provider EFT-check
	OM3 Prepare Remittance Advice-Encounter Report
	OM4 Prepare Capitation Premium Payment
	OM4 Prepare Health Insurance Premium Payment
	OM4 Prepare Medicare Premium Payments [singular]
	OM5 Inquire Payment Status
	OM5 Manage Payment Information
	OM6 Calculate Spend-Down Amount
	OM6 Prepare Member Premium Invoice
	OM7 Manage Drug Rebate
	OM7 Manage Estate Recovery
	OM7 Manage Recoupment
	OM7 Manage Settlement
	OM7 Manage TPL Recovery
Program Management (PG)	PG1 Designate Approved Service Drug Formulary
	PG1 Develop and Maintain Benefit Package
	PG1 Manage Rate Setting
	PG2 Develop Agency Goals and Objectives
	PG2 Develop and Maintain Program Policy
	PG2 Maintain State Plan
	PG3 Formulate Budget
	PG3 Manage FFP for MMIS
	PG3 Manage F-MAP
	PG3 Manage State Funds
	PG4 Manage 1099s
	PG6 Generate Financial and Program Analysis Report
	PG6 Maintain Benefits-Reference Information
	PG6 Manage Program Information
Business Relationship Management (BR)	BR Establish Business Relationship
	BR Manage Business Relationship Communications
	BR Manage Business Relationship
	BR Terminate Business Relationship

Business Area	Business Process
Program Integrity Management (PI)	PI Identify Candidate Case
	PI Manage Case
Care Management (CM)	CM Establish Case v23 — Move to CM Care Management
	CM Manage Case
	CM Manage Medicaid Population Health
	CM Manage Registry

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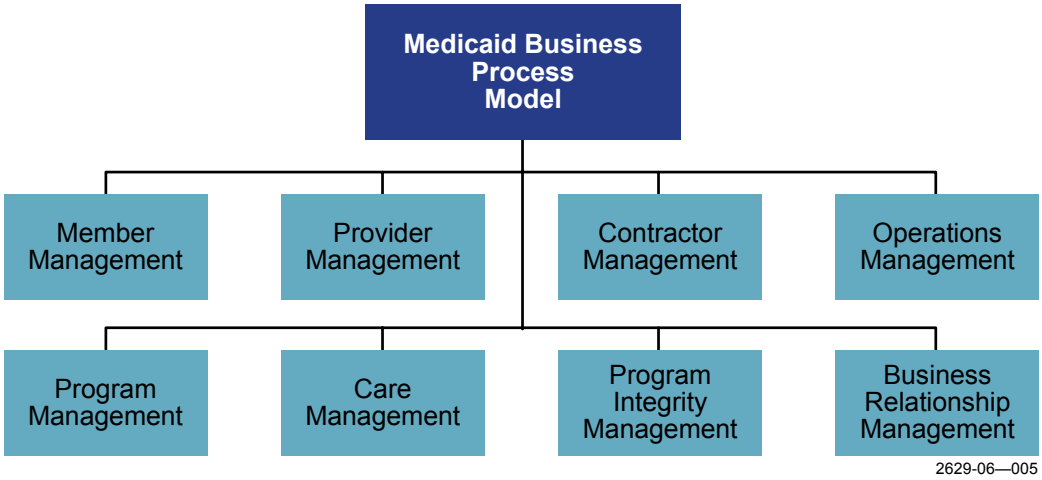
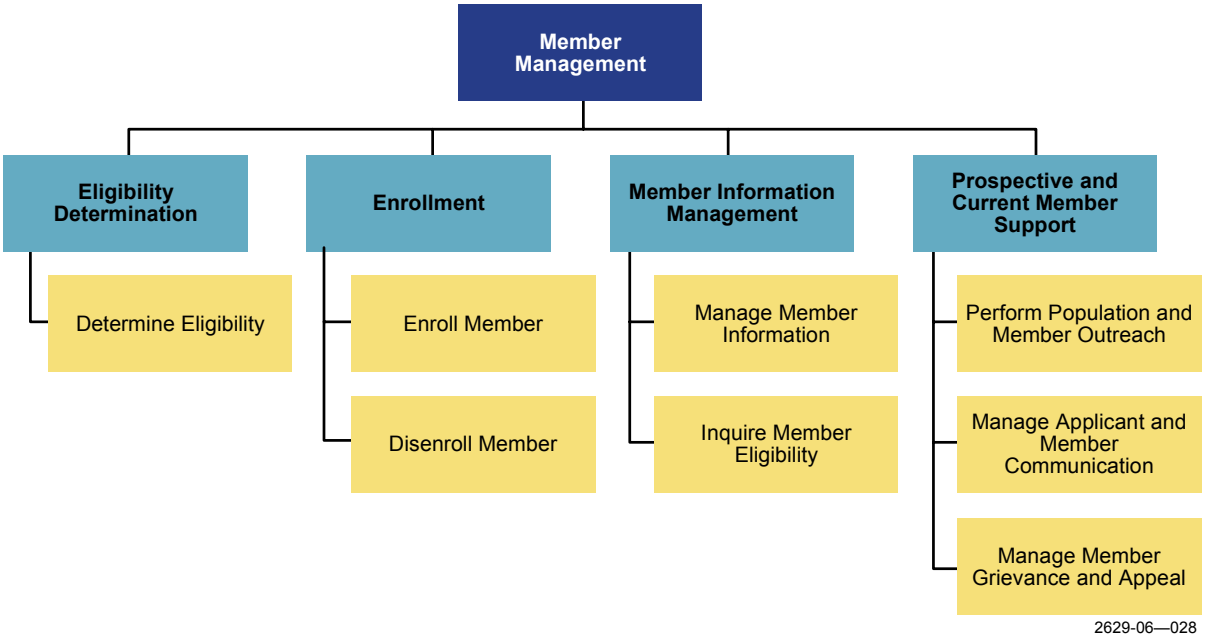
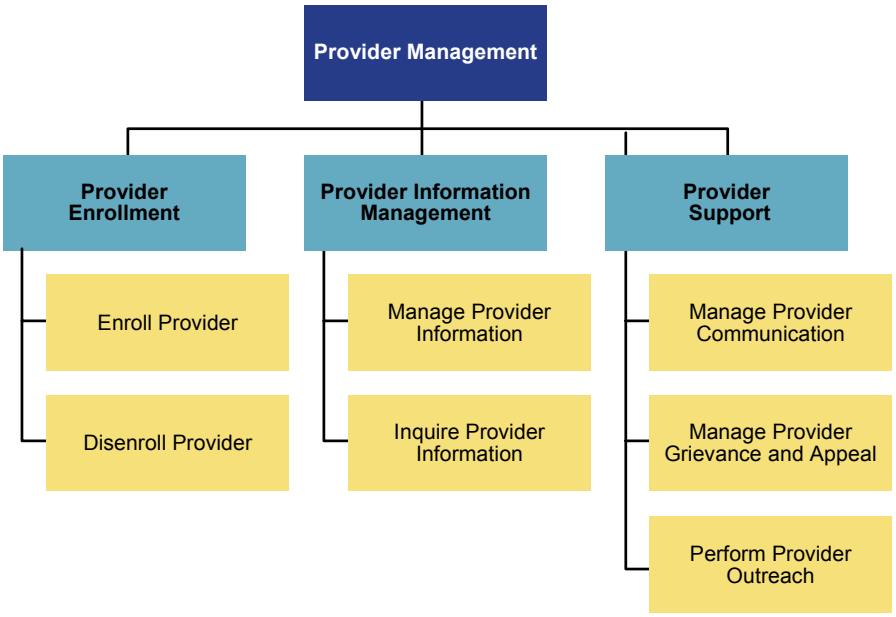
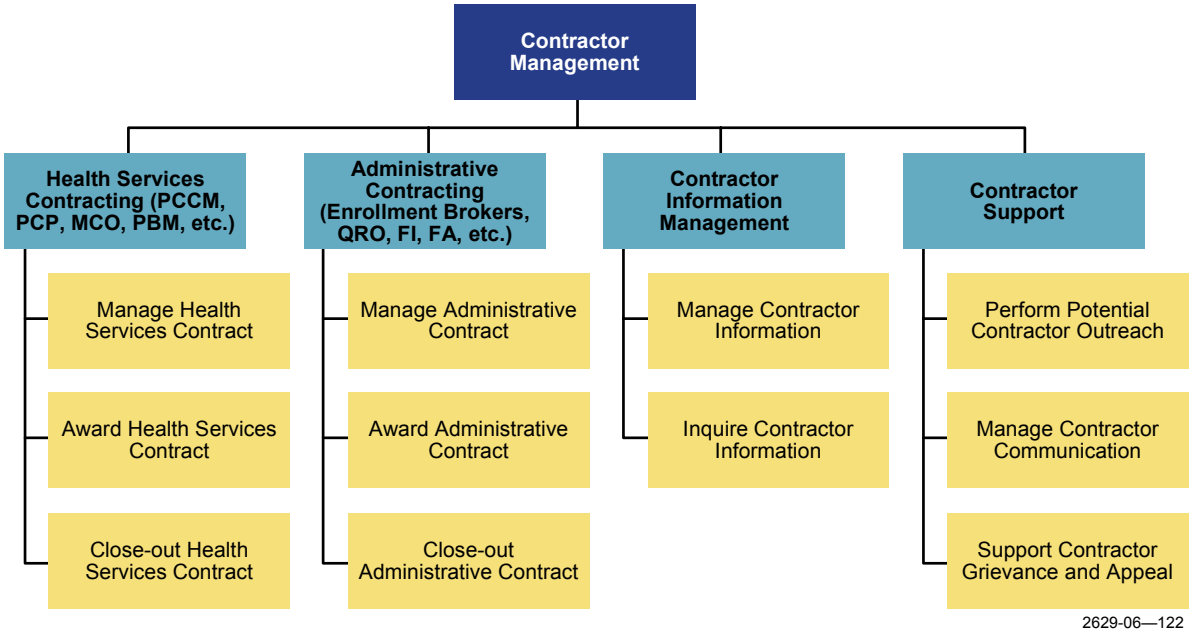
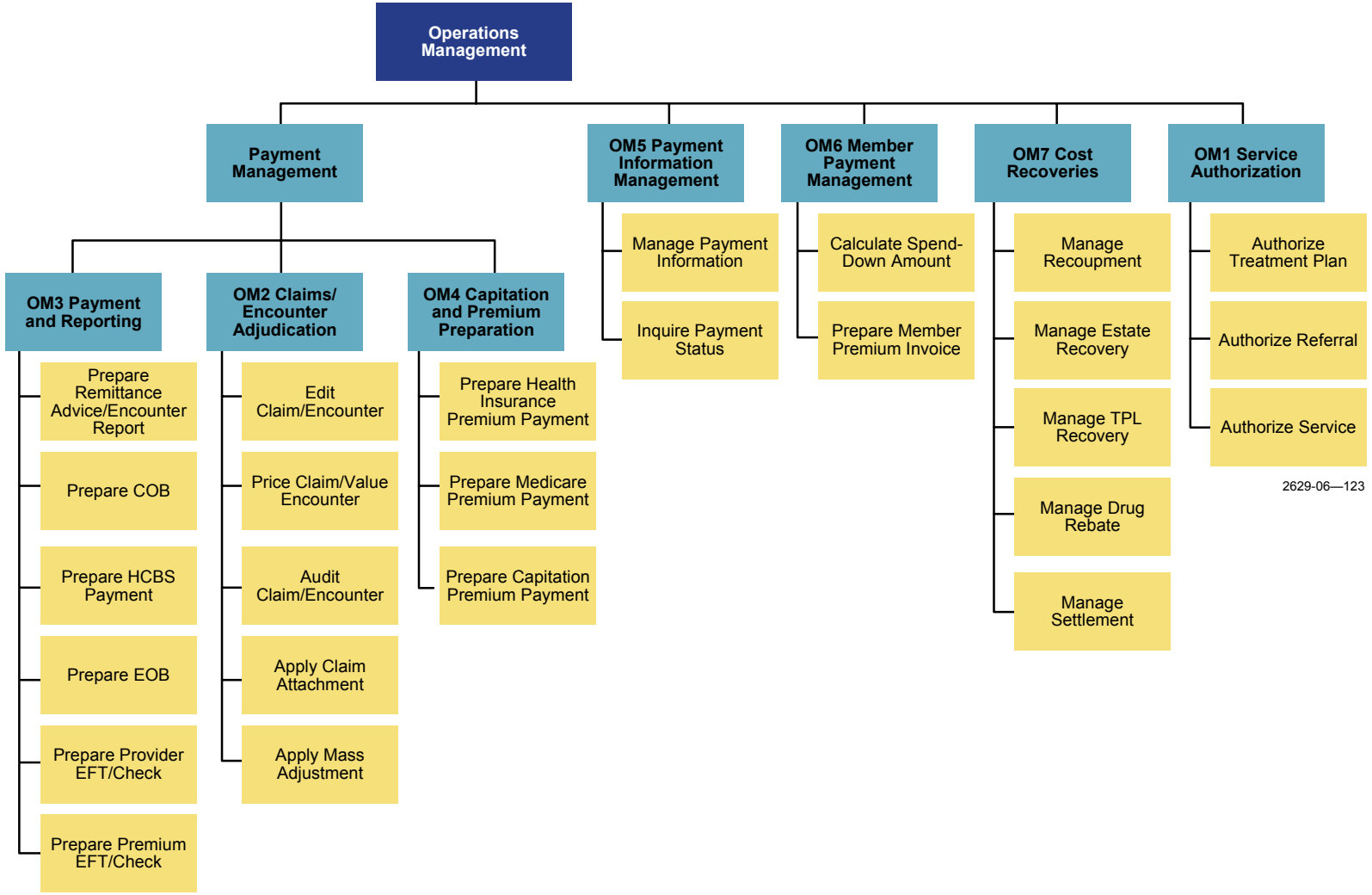
Business Process Model Business Areas

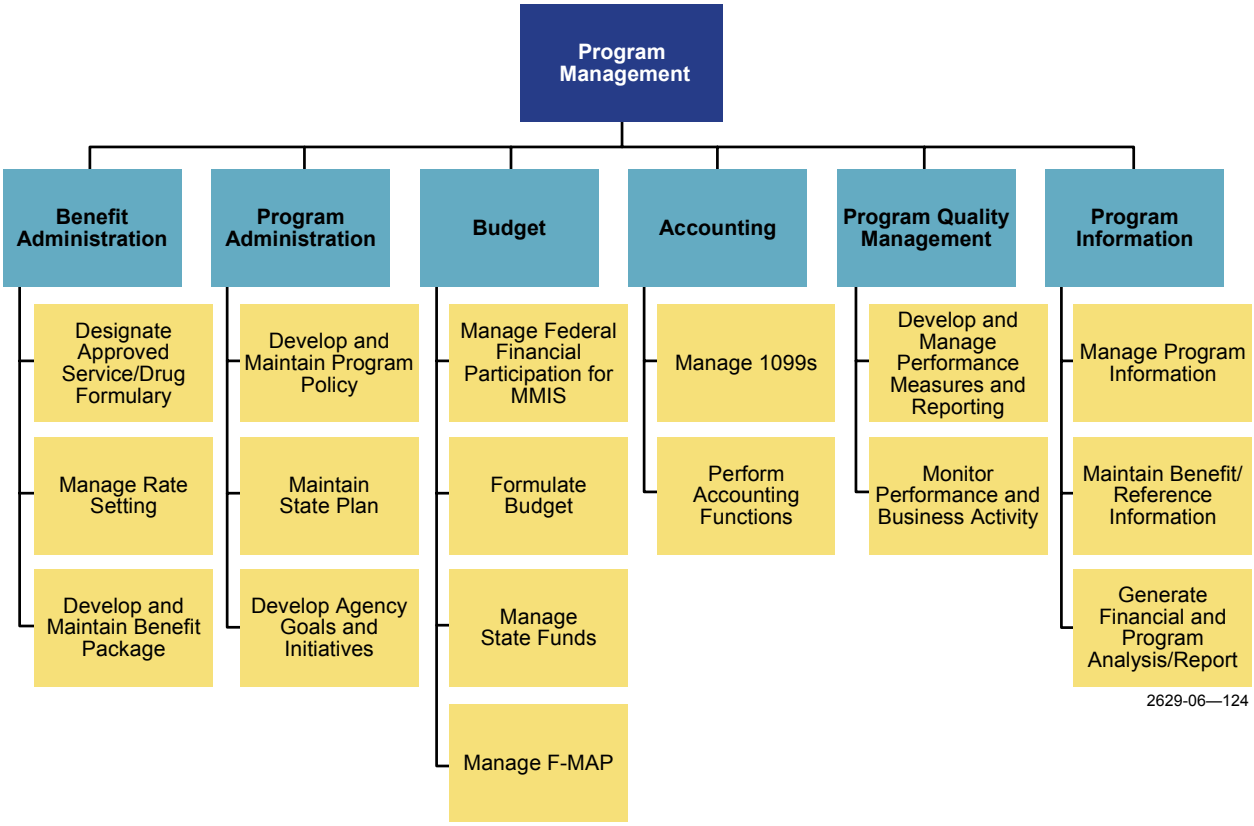

Medicaid Business Process Model
Member Management
Provider Management
Contractor Management
Operations Management
Program Management
Care Management
Program Integrity Management
Business Relationship Management
2629-06—005

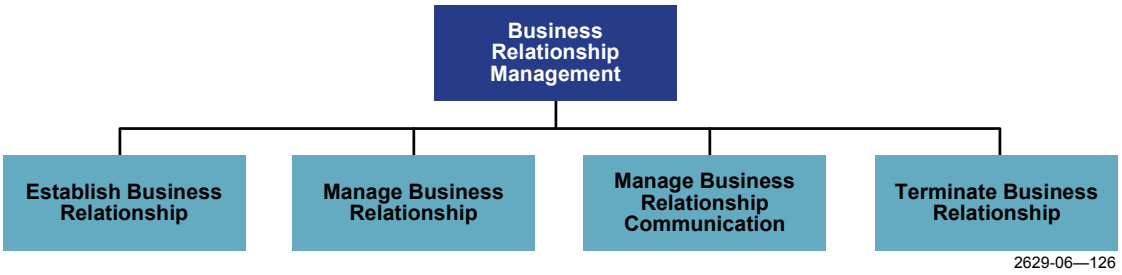

Member Management
Eligibility Determination
Enrollment
Member Information Management
Prospective and Current Member Support
Determine Eligibility
Enroll Member
Disenroll Member
Manage Member Information
Inquire Member Eligibility
Perform Population and Member Outreach
Manage Applicant and Member Communication
Manage Member Grievance and Appeal
2629-06—028

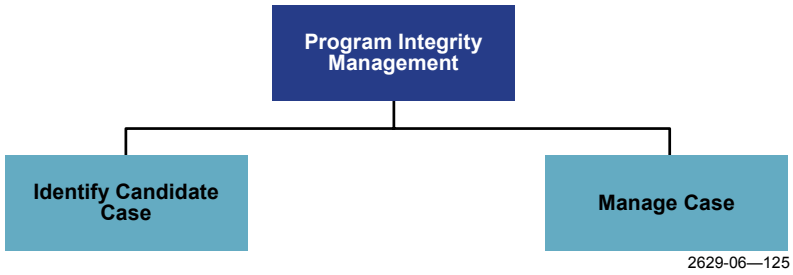

Provider Management
Provider Enrollment
Provider Information Management
Provider Support
Enroll Provider
Disenroll Provider
Manage Provider Information
Inquire Provider Information
Manage Provider Communication
Manage Provider Grievance and Appeal
Perform Provider Outreach
2629-06—121

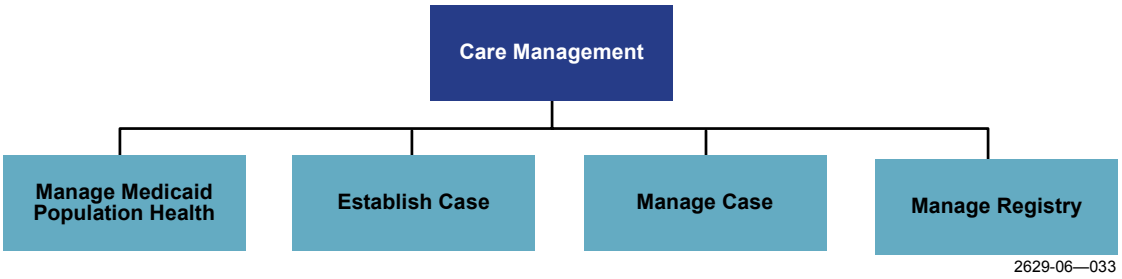

Contractor Management
Health Services Contracting (PCCM, PCP, MCO, PBM, etc.)
Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.)
Contractor Information Management
Contractor Support
Manage Health Services Contract
Award Health Services Contract
Close-out Health Services Contract
Manage Administrative Contract
Award Administrative Contract
Close-out Administrative Contract
Manage Contractor Information
Inquire Contractor Information
Perform Potential Contractor Outreach
Manage Contractor Communication
Support Contractor Grievance and Appeal
2629-06—122


Operations Management
Payment Management
OM5 Payment Information Management
OM6 Member Payment Management
OM7 Cost Recoveries
OM1 Service Authorization
OM3 Payment and Reporting
OM2 Claims/ Encounter Adjudication
OM4 Capitation and Premium Preparation
Manage Payment Information
Inquire Payment Status
Calculate Spend-Down Amount
Prepare Member Premium Invoice
Manage Recoupment
Manage Estate Recovery
Manage TPL Recovery
Manage Drug Rebate
Manage Settlement
Authorize Treatment Plan
Authorize Referral
Authorize Service
Prepare Remittance Advice/Encounter Report
Prepare COB
Prepare HCBS Payment
Prepare EOB
Prepare Provider EFT/Check
Prepare Premium EFT/Check
Edit Claim/Encounter
Price Claim/Value Encounter
Audit Claim/Encounter
Apply Claim Attachment
Apply Mass Adjustment
Prepare Health Insurance Premium Payment
Prepare Medicare Premium Payment
Prepare Capitation Premium Payment
2629-06—123


Program Management
Benefit Administration
Program Administration
Budget
Accounting
Program Quality Management
Program Information
Designate Approved Service/Drug Formulary
Manage Rate Setting
Develop and Maintain Benefit Package
Develop and Maintain Program Policy
Maintain State Plan
Develop Agency Goals and Initiatives
Manage Federal Financial Participation for MMIS
Formulate Budget
Manage State Funds
Manage F-MAP
Manage 1099s
Perform Accounting Functions
Develop and Manage Performance Measures and Reporting
Monitor Performance and Business Activity
Manage Program Information
Maintain Benefit/ Reference Information
Generate Financial and Program Analysis/Report
2629-06—124


Business Relationship Management
Establish Business Relationship
Manage Business Relationship
Manage Business Relationship Communication
Terminate Business Relationship
2629-06—126


Program Integrity Management
Identify Candidate Case
Manage Case
2629-06—125


Care Management
Manage Medicaid Population Health
Establish Case
Manage Case
Manage Registry
2629-06—033

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Member Management

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Description	The ***Determine Eligibility*** business process receives eligibility application data set from the ***Receive Inbound Transaction*** process; checks for status (e.g., new, resubmission, duplicate), establishes type of eligible (e.g., children and parents, disabled, elderly, or other); screens for required fields, edits required fields, verifies applicant information with external entities, assigns an ID, establishes eligibility categories and hierarchy, associates with benefit packages, and produces notifications. See Attachment A for details associated with specific groups of eligibility, i.e., Children and Parents, Disabled, Elderly. **NOTE:** A majority of states accept the designation of eligibility from other agencies (SSI, TANF, SCHIP, other), in which case this business process will not be used by the Medicaid agency for those individuals. In these situations, Medicaid receives and stores the member information sent from other sources in the Member Registry. This may require conversion of the data. However, this process will be used by the other states which require the TANF, disabled, elderly applicant to apply for Medicaid, and where the Medicaid agency determines eligibility for state-only programs.	Business Process Model location: Tier 1: Member Management Tier 2: Eligibility Determination
Trigger Event	1. Interaction-based Trigger Event: a. Original eligibility application data set b. Resubmitted eligibility application data set c. Eligibility application cancellation data set 2. User specified Trigger Event (date): Time for redetermination a. Spend down calculation or data b. Also for cost share	Links to other processes: Receive Inbound Transaction
Result	1. Eligibility application status set to: accepted, denied, or pended for research/additional information 2. Eligibility is determined as approved, denied or pended for additional information or review (clarify between step 1 and step 2) 3. Member eligibility record completed and sent to ***Manage Member Information*** process to be loaded into Member Registry.	Links to other processes: Manage Member Information Manage Applicant and Member Communication

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Result (Cont'd)	4. Member notification prepared and data set sent to the ***Manage Applicant and Member Communication*** process 5. Tracking information regarding the interchange as need for the ***Determine Eligibility*** process, measuring performance and business activity monitoring. 6. Feed into Enroll Member for Managed Care	
Business Process Steps	1. Start: Receive eligibility application data set (cover all trigger events i.e., time events) 2. Verify status of application (new, resubmit, duplicate, redetermination) 3. Validate syntax and semantic requirements associated with children and families eligibility application. Business rules identify fatal and non-fatal errors and associated error messages. 4. Validate completeness and required fields — business rules identify mandated fields and apply edits 5. Meet with applicant or member head of household as scheduled by the ***Manage Applicant and Member Communication*** process. Review member application and additional information provided by member in determination process, which entails completing the following steps as appropriate. 6. Verify applicant name, date of birth, gender, Social Security Number, and other required demographic elements — Validate applicant information with sources, e.g., Vital Statistics file, SSA 7. Verify Income Eligibility — Apply income standard (dollar amount) and methodology (rules for what is counted); verify applicant documentation (e.g., bank statements) with financial institutions. 8. For Spend Down applicants, verify that qualifying medical care expenditures amount has been met 9. Verify Resource Eligibility — Apply resource standard (dollar amount) and methodology (rules for which assets are counted and how they count); verify applicant documentation 10. Verify Immigrant Status — Determine which immigrant classification the individual belongs to (if applicable); verify documentation	Business rules vary by state

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	11. Verify Residency — Check documentation proving residency in the state ([Note, if institutionalized in another state, eligibility stays with state of residency: [verify State policy on the]) 12. Verify Other Coverage — Validate information supplied by applicant; verify with other coverage sources not referenced by applicant 13. For Elderly Applicants, verify the following: a. Determine Transfer of Resources — Determine if a transfer has occurred and compute the number of months before Medicaid benefits can begin based on the value of the transferred resources b. Verify Institutional vs. Non-Institutional Status — Institutionalization or community care status calls for different eligibility rules c. Determine if Spousal Impoverishment Applies — If one spouse remains in the community and the other is institutionalized, the community spouse's resources and income may be disregarded 14. For Other Elderly, determine eligibility for QMB, SLMB 15. For Disabled Applicants, Verify Disability — Determine that applicant meets disability qualifications, e.g., demonstrates HIV diagnosis or other conditions: blind, quadriplegia, mental illness or retardation, Down's syndrome, and other debilitating conditions 16. For Pregnant Women, Verify Pregnancy 17. Apply Composite Eligibility Determination Rules — Summation of all rules determines if applicant is eligible or not, and if eligible, for which category of eligibility 18. Determine Other Eligibility Categories — Identify other eligibility categories for which applicant may be eligible and determine hierarchy of applicability in the case of multiple eligibilities; this includes eligibility for other programs, e.g., Disability, Veterans Administration, Indian Health Service 19. Assign I.D.	Add assign eligibility date.

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	20. Assign Eligibility Category(ies) [some children in family may not be eligible for Medicaid, e.g., too old to qualify for income level] 21. Associate Benefit Packages [Need State-specific rules on which eligible categories map to which benefit packages and services ; do benefit packages include Manage Care? Which are optional?] 22. Load eligibility information into Member Registry 23. End: Request that the ***Manage Applicant and Member Communication*** process generate notifications	
Shared Data	Member Registry and custodial information; school, special schools tuition) Eligibility Categories and Hierarchy Table Benefit Plans and Associated Services Table TANF eligibility SSI eligibility SSP eligibility Spend down amount data store Veterans Administration Indian Health Service INS Other Insurers and type of coverage Bank account balances Employer records Fraud case file Vital Statistics Aging or Elderly Services	These are internal and external data stores
Predecessor	1. Receive Inbound Transaction process receives paper and electronic applications and generates application data sets 2. ***Manage Applicant and Member Communication*** process schedules the face to face or phone interview, receives an application, or receives a referral: logs in request and prepares a package of eligibility information which is sent to the Determine Eligibility Process. Spend down, presumptive eligibility (pregnancy), user present data to case worker?, Newborns – automatically eligible is mom is eligible	Receive Inbound Transaction; Manage Applicant & Member Communication
Successor	1. Notify Applicant, Member being redetermined or Guardian 2. Update Member Registry	Manage Applicant & Member Communication

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Constraints	A majority of Medicaid agencies accept the eligibility determination of the SSA for the SSI population. Many states delegate TANF eligibility to a sister agency. Some Medicaid agencies choose to perform the eligibility determination function themselves. States are responsible for non-SSI-linked eligibility. States differ in the rules applied to eligibility determination and the order in which the rules are applied. In all cases, determining disability status is time consuming.	Business rules differ by state
Failures	A member eligibility application may fail at the following steps: 1. Duplicate or cancelled application 2. Applicant or Member fails to keep scheduled appointment or provide additional information as requested 3. Required fields missing or not correct 4 Does not meet basic qualifications, e.g., disability status 5. Fails income eligibility 6. Fails resource eligibility 7. Fails immigrant qualifications 8. Fails residency 9. Verification with internal sources Note that the Determinate Eligibility Process does not fail because the applicant is found ineligible, only because conditions are such that the process cannot be successfully completed.	Failure notifications
Performance Measures	Examples of Measures 1. Time to complete eligibility determination process = ___ days 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less	

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ME Enroll Member

Tier 3: Enroll Member [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Description	The ***Enroll Member*** business process receives eligibility data from the Determine Eligibility process, determines additional qualifications for enrollment in programs for which the member may be eligible (e.g., managed care, HIPP, waiver), loads the enrollment outcome data into the Member and Contractor Registries, and produces notifications to the member and the contractor. Either the Agency or enrollment brokers may perform some or all of the steps in this process. See Attachment A for details associated with specific groups of eligibility, i.e., managed care, HIPP, waiver. **NOTE:** There is a separate business process for Disenroll Member.	Business Process Model location: Member Management
Trigger Event	1. Enrollment application data set that may accompany initial or redetermination of eligibility 2. Enrollment application data set submitted subsequent to being determined eligible in response to Open Enrollment period for MCO, change in demographics, e.g., residence, because important provider no longer contracts with current program/MCO, or because of change in health status, e.g., the member applies for ADAP or Maternity Case Management.	Links to other processes: Determine Eligibility
Result	1. Member is enrolled in specific programs 2. ***Perform Applicant/Member Communication*** process prepares member notification data set 3. ***Manage Contractor Communication*** prepares health service contractor notification data set 4. ***Outbound Transaction*** process notifies member by paper/phone/fax/email, or health services contractor via paper/phone/fax or 834 5. ***Manage Member Information*** loads member enrollment data loaded into Member Registry 6. Notification to other eligibility systems	Links to other processes: 1. Manage Applicant & Member Communication 2. Manage Member Information 3. Manage Contractor Communica-tions 4. Send Outbound Transactions

ME Enroll Member

Tier 3: Enroll Member [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receive member eligibility data and enrollment application from the ***Determine Eligibility*** process. 2. Verify demographic data required for the enrollment in specific programs, e.g., age, diagnosis, disability 3. Verify that residence is appropriate for the enrollment 4. Offer choice where appropriate (e.g., MCO, PCP) 5. Generate request that enrollment information be loaded by the ***Manage Member Information*** process into Member Registry 6. Notify other eligibility systems 7. Check for duplicate member 8. End: Request that member and contractor be notified	Business rules vary by state
Shared Data	1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Registry: Contracted service areas, MCO provider network and other provider data 4. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence 5. GIS data	
Predecessor	***Determine Eligibility*** process approves applicant as eligible for one or more program and benefit packages.	
Successor	1. ***Manage Applicant and Member Communication*** 2. ***Manage Contractor Communication*** 3. ***Outbound Transaction*** 4. ***Manage Member Information*** 5. ***Manage Provider Communication***	
Constraints	State may have different programs and different enrollment criteria, or may use enrollment brokers for some or all of the process steps. States may require non-HIPAA covered contractors to use the 834 Enrollment Transaction or may rely on state-specific formats for contractor notification	Business rules differ by state

ME Enroll Member

Tier 3: Enroll Member [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Failures	A member may fail to enroll in a specific program for the following reasons: 1. Duplicate enrollment application — Disregard second application 2. Required fields missing or not correct — Request additional or corrected information from Member or ***Determine Eligibility*** process [**NOTE:** These fields are those required for enrollment in the special program, not for Medicaid eligibility.] 3. Does not meet basic qualifications, e.g., disability status, diagnosis — Notify member about denial and about other programs in which they may enroll if appropriate 4. Fails residency requirements — Notify member of other programs for which they are qualified based on residence 5. Enrollment information is not loaded into Member and Contractor Registries 6. Notification fails to reach member or contractor	Failure notifications
Performance Measures	1. Time to complete process: successful applicant is enrolled within __ days 2. Accuracy of decisions 3. Consistency of decisions and disposition 4. Error rate is __% or less	

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ME Disenroll Member

Tier 3: Disenroll Member		
Item	**Details**	**Links**
Description	The ***Disenroll Member*** business process is responsible for managing the termination of a member's enrollment in a program, including: ■ Processing of eligibility terminations and requests for e.g., disenrollment – Submitted by the member, a program provider or contractor – Disenrollment based on member's death; failure to meet enrollment criteria, such as a change in health or financial status, or change of residency outside of service area – As requested by another Business Area, e.g., Prepare Member Payment Invoice process for continued failure to pay premiums or Program Integrity for fraud and abuse – Mass Disenrollment due to termination of program provider or contractor ■ Validation that the termination meets state rules ■ Requesting that the Manage Member Information process load new and changed disenrollment information ■ Prompting the Manage Member Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including – The Capitation and Premium and Member Payment Management Areas business processes about changed Member Registry information for payment preparation – The appropriate communications and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural rights Enrollment brokers may perform some of the steps in this process	Business Process Model location: Member Management

ME Disenroll Member

Tier 3: Disenroll Member		
Item	**Details**	**Links**
Trigger Event	1. State-transition based: Receipt of disenrollment request data set from the Determine Eligibility process a. In conjunction with a redetermination of eligibility for Medicaid in which the member is found to be no longer eligible b. As a result of a denial of eligibility for a program in addition to Medicaid based on health status, e.g., the member applies for ADAP, Home and Community Based Services, or Maternity Case Management 2. Interaction Trigger Event: Receipt of a disenrollment request from a. A Member to change MCO, PCCM, or waiver provider, which are forwarded by the Perform Applicant and Member Communication process: (1) During an Open Enrollment period (2) As permitted by state rules, e.g., (a) Due to change in residence (b) Because an important provider no longer contracts with current program/MCO (c) The contract with the member's MCO is terminated (d) As a result of successfully appealing auto-assignment (e) The member has issues with the MCO, PCCM, or waiver provider that may impact quality of care b. A program 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, which are forwarded by the Manage Provider and Manage Contractor Communications	Links to other processes: 1. Determine Eligibility 2. Perform Applicant & Member Communication 3. Manage Provider Communication 4. Manage Contractor Communica-tions

ME Disenroll Member

Tier 3: Disenroll Member		
Item	**Details**	**Links**
Result	1. Member is either or both a. Disenrolled from specific programs or from specific program contractors or providers b. Offered enrollment in alternative programs or with alternative contractors where the member meets program criteria 2. Member Registry is updated, disenrollment data required for operations is made available, and alerts are broadcast to subscribing processes such as Care Management the Capitation and Premium Preparation and Member Payment Management Areas business processes, the Perform Applicant and Member Outreach, and the Communications processes 3. Member and program contractor or provider is notified about disenrollment results 4. Capitation or premium payments reflect the change in enrollment	Links to other processes: 1. Perform Applicant & Member Communication 2. Manage Member Information 3. Manage Contractor Communication 4. Manage Provider Communication 5. Care Management, Establish Case 6. Capitation and Premium Payment Area business processes
Business Process Steps	1. Start: Receive member eligibility termination data and disenrollment requests from the Determine Eligibility, the Perform Applicant and Member Communication, the Manage Provider Communication or the Manage Contractor Communications processes 2. Assign unique identifier for tracking 3. Track processing status of eligibility termination and disenrollment requests (e.g., new, resubmission, duplicate) and validating application meets state submission rules, e.g., syntax/semantic conformance [If resubmit, message will contain only updated data and some steps below may be skipped; if duplicate, process terminates and result messages are produced – see Failures.] Other communications may be requests to cancel application, and to deactivate or reactivate enrollment 4. Verify demographic data does not meet specific program enrollment requirements as specified in the Benefit Repository, e.g., age, diagnosis, disability 5. Verify that residence is not appropriate for the enrollment	Business rules vary by state

ME Disenroll Member

Tier 3: Disenroll Member		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	6. Produce disenrollment record data set and request that the Manage Member Information process load disenrollment record into Member Registry 7. Alert the Manage Applicant and Member Communication, Manage Provider Communication, and Manage Contractor Communication that new or updated disenrollment information has been loaded into the Member Registry and request that these processes prepare notifications to the affected parties. This will likely include notification of appeal rights 8. Alerts Perform Applicant and Member Outreach process to provide outreach and education materials needed by members who have been disenrolled in accordance with rules 9. End: Alert the appropriate Operations Management Area processes, e.g., the Capitation and Premium Payment Area to prepare enrollment payment reflecting deletions; and the Prepare Member Premium Invoice business process to cease billing member for premiums	
Shared Data	1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Registry: Contracted service areas, MCO provider network and other provider data 4. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence	
Predecessor	■ Determine Eligibility ■ Manage Applicant and Member Communication ■ Manage Contractor Communication ■ Manage Provider Communication	
Successor	■ Manage Member Information ■ Manage Applicant and Member Communication ■ Manage Contractor Communications ■ Manage Provider Communication ■ Capitation and Premium Payment Area business processes	
Constraints	State may have different programs and enrollment change or termination criteria, or may use enrollment brokers for some or all of the process steps.	Business rules differ by state

ME Disenroll Member

Tier 3: Disenroll Member		
Item	**Details**	**Links**
Failures	A member eligibility application may fail at the following steps: 1. Duplicate disenrollment requests — Disregard second request 2. Required fields missing or not correct — Request additional or corrected information from Member or Determine Eligibility process 3. Denial of Member request for disenrollment from one program, provider or contractor due to changes 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 4. Denial of program, provider, or contractor request to disenroll the member due to, e.g., changed residence, health status or compliance issues because the request does not meet state rules 5. Member successfully appeals disenrollment 6. Disenrollment information is not loaded into Member Registry 7. Successor processes do not receive or respond according to rules about disenrollment notification 8. Notification fails to reach member or program provider or contractor	Failure notifications
Performance Measures	1. Time to complete process: successful applicant is enrolled within __ days 2. Accuracy of decisions 3. Consistency of decisions and disposition 4. Error rate is __% or less	

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ME Manage Member Information

Tier 3: Manage Member Information		
Item	**Details**	**Links**
Description	The ***Manage Member Information*** business process is responsible for managing all operational aspects of the Member Registry, which is the source of comprehensive information about applicants and members, and their interactions with the state Medicaid. The Member Registry is the Medicaid enterprise "source of truth" for member demographic, financial, socio-economic, and health status information. A member's registry record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a member may receive a customized set of services. In addition, the Member Registry stores records about and tracks the processing of eligibility applications and determinations, program enrollment and disenrollment; the member's covered services, and all communications, e.g., outreach and EOBs, and interactions related to any grievance/appeal. The Member Registry may store records or pointers to records for services requested and services provided; care management; utilization and program integrity reviews; and member payment and spend-down information. Business processes that generate applicant or member information send requests to the Member Registry to add, delete, or change this information in registry records. The Member Registry validates data upload requests, applies instructions, and tracks activity. The Member Registry provides access to member records to applications and users via batch record transfers, e.g., for Medicare Crossover claims processing, responses to queries, e.g., for eligibility verification and Operations Management Area, and "publish and subscribe" services for business processes that track member eligibility, e.g., Care Management and Perform Applicant and Member Outreach. Among the business processes that will interface with the Member Registry are: ■ The Determine Eligibility process, which checks the Member Registry for status (e.g., new, resubmission, duplicate) and sends completed member eligibility record to be loaded into Member Registry. ■ The Enroll and Disenroll Member processes, which send and retrieve member information relating to these processes, such as member's ability to access providers, and plan and provider preferences	Business Process Model location: Business Area: Member Management Tier 1: Member Information Management

ME Manage Member Information

Tier 3: Manage Member Information		
Item	**Details**	**Links**
Description (Cont'd)	■ The Perform Applicant and Member, Manage Provider, and Manage Contractor Communications processes, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring these communication processes to prepare notifications ■ The Perform Applicant and Member Outreach, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring provision of outreach and education to the affected applicant or member ■ The Perform Applicant and Member Communication process, which schedules the face to face or phone interview, receives an application, or receives a referral: logs in request and prepares a package of eligibility information which is sent to the Determine Eligibility Process ■ All Operations Management business processes, e.g., Manage Member Payment, Edit Claim/Encounter, and Authorize Service ■ The Maintain Benefit/Reference Information process, which is the Member Registry's source of benefit package information ■ The Manage Program Information business process, which consolidates key enterprise data for use in reporting, analysis and decision support ■ Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Member Registry for member information ■ Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Member Registry	

ME Manage Member Information

Tier 3: Manage Member Information		
Item	**Details**	**Links**
Trigger Event	■ State transition trigger event: Receipt of request to add, delete, change Member information or pointers to member information records from – Member Management Business Area processes: Determine Eligibility, Enroll and Disenroll Member, Perform Applicant and Member Outreach, Manage Applicant and Member Communication, or Manage Applicant and Member Grievance and Appeal – The Maintain Benefit/Reference Information process, which is the Member Registry's source of benefit package information that may be changed during the member's enrollment span – Operations Management Business Area processes: Manage Payment Information (e.g., claims/encounters, COB, TPL, cost recoveries, HIPP, and service authorization), Calculate Spend-down, or Process Member Premium Invoice – Care and Program Integrity Management Manage Repository processes ■ Interaction-based Trigger Event: Receipt of a query about data in one or more applicant or member records from enterprise business processes, or from authorized external parties, e.g., for verification of member information. ■ Environmental Trigger Event: Scheduled transmission of member information records or pointers to member information on a periodic or real time basis to the Capitation and Premium Payment Area processes for payment preparation, and the Manage Program Information business process	Links to other processes: All Member Business Processes plus: Calculate Spend-down Process Member Premium Invoice Capitation and Premium Payment Area Business Processes Care Management Establish Case Program Integrity Identify and Establish Care and Manage Repositories

ME Manage Member Information

Tier 3: Manage Member Information		
Item	**Details**	**Links**
Result	The Member Registry is loaded with new or updated member information for the purposes of: 1. Responding to queries from authorized users and applications 2. Supplying all Member Management Area business processes with applicant or member information as needed to, e.g., detect duplicate applications; schedule redetermination; conduct open enrollment processing; perform member outreach and communication functions, etc. 3. Supplying all Operations Management Area business processes with applicant or member information needed to, e.g., edit claims and encounters, process member payment invoices, prepare EOB, conduct cost recoveries, etc. 4. Sending records or pointers to the Manage Program Information business process	
Business Process Steps	1. Start: Receives data from Member Management Area and relevant Operations Management business processes 2. Loads data into the Member Registry, building new records and updating, merging, unmerging, or deleting previous records as appropriate 3. Provides access to records as required by Member Management Area business processes workflow 4. Provides access to records as requested by other authorized business processes and users 5. Provides data to the Manage Program Information business process on a real time or periodic basis in update or snapshot mode 6. End: Archive data in accordance with state and federal record retention requirements	Each state will specify its data requirements and rules for each step
Shared Data	Data needed to record information about the following: Member demographic, financial, socio-economic, and health status data; information related to requests for and determinations of eligibility, appointment scheduling, eligibility verification, and communications concerning outreach and education, programs, eligibility, enrollment, services, access, etc.; services requested and services provided; member payment and spend-down information; as well as interactions related to any grievance/appeal	

ME Manage Member Information

Tier 3: Manage Member Information		
Item	**Details**	**Links**
Predecessor	Inbound Transaction Processing for eligibility and enrollment applications, communications, scheduling requests Member Management business processes supplying data to the Member Registry, including Determine Eligibility, Enroll and Disenroll Member, Perform Applicant and Member Outreach, Manage Applicant and Member Communication, and Manage Applicant and Member Grievance and Appeal. Operations Management business processes supplying data to the Member Registry including Calculate Spend-down, and Process Member Premium Invoice business processes.	
Successor	Outbound Transaction Processing for eligibility and enrollment applications, communications, scheduling requests Member Management business processes accessing data in the Member Registry, including Determine Eligibility, Enroll and Disenroll Member, Perform Applicant and Member Outreach, Manage Applicant and Member Communication, and Manage Applicant and Member Grievance and Appeal Operations Management Area business processes, including Edit and Audit Claims and Encounters business processes; Prepare Health Insurance Premium, Medicare Premium and Capitation Payment business processes; Process Member Premium Invoice, prepare EOB, and Calculate Spend-down business processes; and all Cost Recovery business processes Care Management Establish and Manage Case business processes Manage Program Information business process Program Integrity Identify and Establish Case business processes may need to access member data from the Member Registry rather than from the Program Information Repository	
Constraints	State specific work flows will determine which processes load and access the Member Registry and by which interactions and messages (e.g., query/response, batch uploads, publish and subscribe, etc.); and the data content and structure of registry records	
Failures	Member Registry fails to load or update appropriately; or fails to make registry data available or available in correct format.	Results messages: Error Messages or Null Query Response

ME Manage Member Information

Tier 3: Manage Member Information		
Item	**Details**	**Links**
Performance Measures	1. Time to verify eligibility and generate response data set: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Response Accuracy = ___% 3. Error rate = __% or less	

ME Inquire Member Eligibility

Tier 3: Inquire Member Eligibility [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Description	The ***Inquire Member Eligibility*** business process receives requests for eligibility verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the ***Send Outbound Transaction*** process, which generates the outbound Eligibility Verification Response Transaction. This transaction will, at minimum, indicate whether the member is eligible for some health benefit plan coverage under Medicaid, in accordance with HIPAA. This transaction may include more detailed information about the Medicaid programs, specific benefits and services, and the provider(s) from which the member may received covered services. **NOTE:** This process does not include Member requests for eligibility verification. Member initiated requests are handled by the ***Manage Applicant and Member Communication*** process.	Business Process Model location: Tier 1: Member Management Tier 2: Member Information Management
Trigger Event	Interaction-based Trigger Event: Receipt of Eligibility Verification Request data set from ***Receive Inbound Transaction*** process.	Receive Inbound Transaction
Result	1. Eligibility Verification Response data set routed to ***Send Outbound Transaction*** process. Data set may include information such as eligibility start/end dates, programs the member is enrolled in, the providers that may render services, and covered benefits and services. 2. Tracking information regarding the interchange as need for the ***Inquire Member Eligibility*** process, measuring performance and business activity monitoring.	Send Outbound Transaction
Business Process Steps	1. Start: Receipt of Eligibility Verification Request data set from Receive Inbound Transaction process. 2. Determine Request status as initial or duplicate using rules to determine if the requester is “fishing”. 3. Verify authorization of the requester to receive requested eligibility information 4. Query Member Registry for requested information 5. Process Response 6. Log Response 7. End: Prepare response data set for the ***Send Outbound Transaction*** process **NOTE:** Security and Privacy verifications are handled by the Inbound, Outbound Transaction processes.	Links Receive Inbound Transaction Manage Member Information Send Outbound Transaction

ME Inquire Member Eligibility

Tier 3: Inquire Member Eligibility [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Shared Data	1. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. 2. Data sets received and sent based on the HIPAA X12 270/271 and NCPDP Telecommunications Guide v 5.1 and Batch Guide v 1.0.	
Predecessor	***Receive Inbound Transaction*** process	
Successor	***Send Outbound Transaction*** process	
Constraints	Eligibility verification request can ask for verification at the categorical, program, provider, or benefit level per X12 270 depending on trading partner agreements. For example, some trading partner agreements may support only a minimal response concerning eligibility status for general health benefit plan coverage (categorical level) as required by HIPAA.	
Failures	1. Process unable to process Eligibility Inquiry Request 2. Requester not authorized to 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 benefit plan coverage. **NOTE:** Responses that a member is not eligible or is not active are not failures to process the request.	Failure notifications such as the X12 824 or 271
Performance Measures	1. Time to verify eligibility and generate response data set: e.g., Real Time response = within __ seconds, Batch Response = within __ hours of receipt of Trigger data set 2. Response Accuracy = ___% 3. Error rate = __% or less	

ME Perform Population and Member Outreach

Tier 3: Perform Population and Member Outreach [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Description	The ***Perform Population and Member Outreach*** business process originates internally within the Agency for purposes such as: ■ Notifying prospective applicants and current members about new benefit packages and population health initiatives ■ New initiatives from Program Administration ■ Indicators of underserved populations from the ***Monitor Performance and Business Activity*** process (Program Management). It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the State Children's Health Insurance Program (SCHIP). Outreach information is developed for targeted populations that have been identified by analyzing member data. Outreach communications and information packages are distributed accordingly through various mediums via the ***Send Outbound Transaction*** and the ***Manage Business Relationship Communication*** process. All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the ***Monitor Performance and Business Activity*** process. **NOTE:** The ***Perform Population and Member Outreach*** process targets both prospective and current Member *populations* for distribution of information about programs, policies, and health issues. Inquires from applicants, prospective and current members are handled by the ***Manage Applicant and Member Communication*** process by providing assistance and responses to *individuals*, i.e., bi-directional communication.	Business Process Model location: Tier 1: Member Management Tier 2: Member Support

ME Perform Population and Member Outreach

Tier 3: Perform Population and Member Outreach [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Trigger Event	State-transition based Trigger Events: ■ Implementation of population health initiatives such as ESPDT and enrollment campaigns for SCHIP. ■ Scheduled communications related to current programs such as open enrollment ■ Changes to existing plans or benefit packages ■ Call center volumes exceed a threshold on a particular issue ■ New program policies and procedures. ■ Changes to existing policies and procedures. ■ Critical need in a specific target population. ■ Identification of new and currently served populations in need of services or access. ■ Other healthcare or Federal mandates (e.g., Privacy notice)	Care Management; Benefit Administration, Program Administration; Program Quality Management
Result	Outreach communications, such as mailings brochures, web pages, email, kiosk, and radio, billboard, and TV advertisements; are produced and distributed to targeted populations or individuals.	Send Outbound Transaction; Manage Business Relationship Communications
Business Process Steps	1. Start: Target population is identified and defined by analyzing member service data, performance measures, feedback from community, and policy directives 2. Receive request for outreach materials or communications 3. Approve ore deny (or modify) decisions to develop outreach communications 4. Determine development approach (internal and external or both) outreach materials, approaches, success measures 5. Approval of outreach materials 6. Distribute outreach materials or communications Send outreach communications to be distributed through various mediums supported by the ***Send Outbound Transaction*** process, or the ***Manage Business Relationship Communications*** process (to be distributed to target populations by community resource and advocacy groups, providers, and other entities that work with the target population) 7. Outreach communications production and distribution are tracked and materials archived [Steps may differ in a State-wide managed care setting.]	

ME Perform Population and Member Outreach

Tier 3: Perform Population and Member Outreach [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Shared Data	1. Care Management population health data 2. Program Quality Management quality measure data, e.g., CAPHS and HEDIS measures 3. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 4. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 5. Contractor Registry: Contracted service areas, MCO provider network and other provider data 6. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence 7. Claims history	Member, Provider, Contractor Registries, Benefit Repository, Program Information
Predecessor	Care Management, Benefit Administration, Program Administration, or Program Quality Management processes result in need to perform outreach to prospective members.	Care Management; Benefit Administration; Program Quality Management
Successor	1. ***Send Outbound Transaction*** and/or ***Manage Business Relationship Communication*** processes distribute communications to the target population 2. ***Monitor Performance and Business Activity Process*** measures Outreach efficacy	Send Outbound Transaction; Manage Business Relationship Communications
Constraints	Communications and information packages must address the needs of the target population. Materials must be linguistically and culturally appropriate, legally compliant, appropriate to the targeted group, meet financial guidelines (re: cost to produce and distribute). Other constraints may be agency priority, availability of resources, and accuracy of member contact information.	State specific business rules
Failures	1. Inability to provide linguistically, culturally, or competency appropriate information 2. Communication barriers such as lack of internet or phone access; failure to access needed or requested information 3. Delivery failures due to erroneous contact information or lack of contact information for mobile communities such as migrant workers or the homeless population	Failure Notice

ME Perform Population and Member Outreach

Tier 3: Perform Population and Member Outreach [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Performance Measures	Examples of Measures – 1. Time to complete process of developing outreach materials from receipt of request to completion of distribution = __ days 2. Accuracy of outreach materials = __% 3. Successful delivery rate to targeted individuals = ___%	

ME Manage Applicant and Member Communication

Tier 3: Manage Applicant and Member Communication [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Description	The ***Manage Applicant and Member Communication*** business process receives requests for information, appointments and assistance from prospective and current members' communications such as inquiries related to eligibility, redetermination, benefits, providers; health plans and programs, and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and produced for distribution via ***Send Outbound Transaction*** process. **NOTE:** Inquires from applicants, prospective and current members are handled by the ***Manage Applicant and Member Communication*** process by providing assistance and responses to *individuals*, i.e., bi-directional communication. Also included are scheduled communications such as Member ID cards, redetermination notifications, or formal program notifications such as the dispositions of grievances and appeals. The *Perform Applicant and Member Outreach* process targets both prospective and current Member *populations* for distribution of information about programs, policies, and health issues.	Business Process Model location: Member Management Tier 1: Member Support
Trigger Event	■ Interaction-based Trigger Events: – Inquiry from current or prospective member. – Request to send information packages such as eligibility applications and health plan open enrollment forms. – Request to schedule an appointment to determine eligibility. – Request for assistance, such as a request to change PCCM, health plan, or lock-in provider. – Requests from other processes to develop and produce communications for members such as notifications from the ***Determine Eligibility*** process such as requests for additional information, new eligible information packages, or determination decisions. ■ User-based Trigger Events: – Scheduled time to send information, e.g., within 24 hours of new member enrollment; redetermination notification, and monthly communications such as enrollment cards. – Follow-up on requests from grievances	Receive Inbound Transaction; Determine Eligibility; Manage Applicant and Member Communication

ME Manage Applicant and Member Communication

Tier 3: Manage Applicant and Member Communication [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Result	1. Member receives appropriate assistance, communications, appointment and/or information packages. 2. Tracking information regarding the interchange as needed for the ***Manage Applicant and Member Communication*** process and the ***Monitor Performance and Business Activity*** process to ensure that applicants and members receive the information they need 3. Tracking information from requests from members	Send Outbound Transaction
Business Process Steps	1. Start: Receive request for communication from ***Receive Inbound Transaction*** process or from other processes such as ***Determine Eligibility*** or ***Manage Member Grievance and Appeal*** to prepare communications 2. Log and track communications request and response processing data 3. Research/develop communication that is linguistically, culturally, and competency appropriate 4. Prepare/package communication 5. Perform Review or Quality Check communication 6. End: Send member communications and information packages to be distributed by the ***Send Outbound Transaction*** process. [**NOTE:** May simply route inbound messages to other processes without creating outbound.]	
Shared Data	1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Registry: Contracted service areas, MCO provider network and other provider data 4. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence 5. Claims History	Member, Provider, Contractor Registries, Benefit Repository, Program Information
Predecessor	1. ***Receive Inbound Transaction*** 2. ***Determine Eligibility*** 3. ***Manage Member Grievance and Appeal*** 4. ***Manage Population & Member Outreach***	Receive Inbound Transaction; Determine Eligibility; Manage Member Grievance and Appeal

ME Manage Applicant and Member Communication

Tier 3: Manage Applicant and Member Communication [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Successor	***Send Outbound Transaction*** process	Send Outbound Transactions
Constraints	Communications requested will vary depending on programs supported by the agency, e.g., managed care, waiver, PCCM and lock-in programs require provider assignment which members may request to change. If eligibility is determined outside the agency, then this process may not be requested to send applications or schedule eligibility determination appointments.	State specific business rules
Failures	1. Inability to provide linguistically, culturally, or competency appropriate information 2. Communication barriers such as lack of internet or phone access; failure to access needed or requested information 3. Delivery failures due to erroneous contact information or lack of contact information for mobile communities such as migrant workers or the homeless population. 4. Member does not respond to communication	Failure Notice
Performance Measures	Examples of Measures – 1. Time to complete process of developing communications: By phone __ minutes; by email ___ hours; by mail __days 2. Accuracy of communications = __% 3. Successful delivery rate to targeted individuals = ___%	

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ME Manage Member Grievance and Appeal

Tier 3: Manage Member Grievance and Appeal [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Description	The ***Manage Member Grievance and Appeal*** business process handles applicant or member (or their advocate's) appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the ***Manage Applicant and Member Communication*** process via the ***Receive Inbound Transaction*** process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the applicant or member and stored in the applicant or member information file. The applicant or member is formally notified of the decision via the ***Send Outbound Transaction*** Process. This process supports the ***Program Quality Management*** Business Area by providing data 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 data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. In some states, if the applicant or member does not agree with the Agency's disposition, a second appeal can be filed requesting a review of the disposition. If the health status or medical need of the applicant or member is urgent, the appeal may be expedited. **NOTE:** States may define "grievance" and "appeal" differently, perhaps because of state laws. States must enforce the Balance Budget Act requirements for grievance and appeals processes in their MCO contracts at 42 CFR Part 438.400. They may adopt these for non-MCO programs.	Business Process Model location: Tier 1: Member Management; Tier 2: Member Support
Trigger Event	Receipt of grievance or appeal of adverse decision data set from ***Receive Inbound Transaction*** process.	Receive Inbound Transaction
Result	Final disposition of grievance or appeal sent to the applicant or member via the ***Send Outbound Transaction*** process.	Send Outbound Transaction
Business Process Steps	1. Start: Receive grievance or appeal via ***Receive Inbound Transaction*** Process 2. Situational: Request additional documentation 3. Determine status as initial, second, or expedited.	

ME Manage Member Grievance and Appeal

Tier 3: Manage Member Grievance and Appeal [△ NMEH-Reviewed]		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	4. Triage to appropriate personnel for review. 5. Schedule hearing within required time. 6. Conduct hearing within required time. 7. Determine disposition. 8. End: Request that the ***Manage Applicant and Member Communication*** process prepare a formal disposition to be sent to the applicant or member via ***Send Outbound Transaction*** process.	
Shared Data	1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Registry: Contracted service areas, MCO provider network and other provider data 4. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence	
Predecessor	Receipt of appeal data set from ***Receive Inbound Transaction*** process.	Receive Inbound Transaction
Successor	Formally notify applicant or member via ***Send Outbound Transaction*** process.	Send Outbound Transaction
Constraints	In addition to general rights of Medicaid and Medicare beneficiaries under federal law, state policy and state law constrain the legal issues about which applicants and members may file grievances and appeals, provide additional rights, e.g., for second or expedited appeal, and set time limits for disposing of the appeal.	
Failures	1. Applicant or member withdraws grievance/appeal 2. Grievances and appeals fail to be processed according to federal or state law.	
Performance Measures	Examples of Measures – 1. Time to complete process: normal grievance/appeal = __days; second appeal =__days; expedited appeal = __hours 2. Accuracy of decisions = __% 3. Consistency of decisions and disposition = __%	

Provider Management

PM Enroll Provider

Tier 3: Enroll Provider		
Item	**Details**	**Links**
Description	The ***Enroll Provider*** business process is responsible for managing providers' enrollment in programs, including ■ Receipt of enrollment application data set from the Manage Provider Communication process ■ Processing of applications, including status tracking (e.g., new, resubmission, duplicate) and validating application meets state submission rules, e.g., syntax/semantic conformance ■ Validation that the enrollment meets state rules by – Performing primary source verification of verifies provider credentials and sanction status with external entities, including: • Education and training/Board certification • License to practice • DEA/CDS Certificates • Medicare/Medicaid sanctions • Disciplinary/sanctions against licensure • Malpractice claims history • NPDB and HIPDB disciplinary actions/sanctions – Verifying or applying for NPI enumeration with the NPPES – Verifying SSN or EIN and other business information ■ Determine contracting parameters, e.g., provider taxonomy, type, category of service for which the provider can bill ■ Establish payment rates and funding sources, taking into consideration service area, incentives or discounts ■ Negotiate contracts ■ Supporting receipt and verification of program contractor's provider enrollment roster information, e.g., from MCO and HCBS organizations ■ Requesting that the Manage Provider Information process load initial and changed enrollment information, including providers contracted with program contractors into the Provider Registry	Business Process Model location: Business Area: Provider Management; Tier 2: Provider Enrollment

PM Enroll Provider

Tier 3: Enroll Provider		
Item	**Details**	**Links**
Description (Cont'd)	■ Prompting the Manage Provider Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including: – The Capitation and Premium Payment Area – The Prepare Provider EFT/Check process – The appropriate communications and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural rights ■ Perform scheduled user requested: – Credentialing reverification – Sanction monitoring – Payment rate negotiations – Performance evaluation External contractors such as quality assurance and credentialing verification services may perform some of these steps	
Trigger Event	State-transition Trigger Events: Receipt of the following from either the provider or external contractor via the Receive Inbound Transaction process or from the Manage Provider Communication process: ■ Enrollment application data set containing Provider Name, Provider Address, Provider Affiliation, Provider SSN or EIN, Provider Type, Specialty, Taxonomy, Allowed Services, Provider Credentials or Licenses, etc. ■ Resubmitted enrollment application data set ■ Modification or cancellation of an application data set ■ Additional information in support of an enrollment application Environmental Trigger Event: Receipt of scheduled prompt of user request to ■ Reverify credentials ■ Monitor sanctions ■ Assist in program integrity review ■ Renegotiate payment rates ■ Reevaluate enrollment based on, e.g., performance measures	Links to other processes: Receive Inbound Transaction Manage Provider Communication Benefit Administration Area processes Program Quality Management Area processes Program Integrity Area processes

PM Enroll Provider

Tier 3: Enroll Provider		
Item	**Details**	**Links**
Result	1. Provider is either enrolled, re-enrolled, or denied enrollment 2. The Provider Registry is updated, enrollment data required for operations is made available, and alerts are broadcast to subscribing processes such as the Capitation and Premium Payment Area business processes, and the Prepare Provider EFT/Check, the Perform Provider Outreach and Education, and the Communications processes 3. The Provider is notified about enrollment results 4. Operations Management Area processes reflect changes	Links to other processes: Manage Provider Information Manage Provider Communication
Business Process Steps	1. Start: Receive enrollment application and other pertinent enrollment communication data set, or prompt for re-verification of currently enrolled provider 2. Validate application syntax/semantic conformance. [If validation fails, process terminates – see Failures.] 3. Determine submission status by querying the Provider Registry. Application status may be initial, resubmitted with modification, or duplicate. [If resubmit, message will contain only updated data and some steps below may be skipped; if duplicate, process terminates and result messages are produced – see Failures.] Other communications may be requests to cancel application, and to deactivate or reactivate enrollment. 4. Re-verification requires accessing provider enrollment record from the Provider Registry and completing steps as appropriate 5. Determine applicant type/provider taxonomy: e.g., Primary, Rendering, Pay To, Billing, Other 6. Verify information in the enrollment application or record with internal and external sources, including a. Enumerators, including NPI, SSN, EIN, internal enumerators. If lacking, facilitate enumeration b. Sanction status, e.g., HIPDB, NPDB, Boards, criminal background checks; and provider performance profiles c. Credentials, e.g., licensure, specialty boards, and school, affiliations Verify with external entities by sending inquiry data sets via Send Outbound Transaction and evaluating response data sets received from the Receive Inbound Transaction process. Verify with internal sources via services, interfaces, or manually	Each state will specify its data requirements and rules for each step

PM Enroll Provider

Tier 3: Enroll Provider		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	7. 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, client enrollment levels, panel size, and any contractor specific benefit packages and procedures 8. Assign any identifiers used internally 9. 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 10. Request that the Manage Provider Communication process negotiate contract and send enrollment determination notifications 11. Request that the Perform Provider Outreach and Education process send relevant state policy information 12. End: Produce enrollment record data set for loading into the Provider Registry and request that the Manage Provider Information process load the information	
Shared Data	1. Provider Registry data: e.g., NPI, provider demographics, provider taxonomy 2. NPI and provider demographics exchanged with the National Plan and Provider Enumeration System (NPPES) 3. Provider sanction data from: a. 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 Repository d. NPDB Repository 4. Tax identifiers: EIN, SSN, TIN from applicant and verified with tax identifier verification sources 5. Multiple office locations, pay to addresses, business associates and key contract personnel 6. MCO and program contracted provider information including demographics, enumerations, business, and credentialing verification	

PM Enroll Provider

Tier 3: Enroll Provider		
Item	**Details**	**Links**
Predecessor	■ The Receive Inbound Transaction authenticates submitter, verifies application format, may translate, may scan, logs in request, and produces the enrollment application message which is sent to the Enroll Provider process. ■ The Manage Provider Communication process may send inquiries about the enrollment process or prompts to re-verify provider ■ The Monitor Performance and Business Activity process may send prompts to reevaluate provider enrollment ■ The Program Integrity Area processes may request enrollment review activities	Receive Inbound Transaction, Manage Provider Communication, Monitor Performance and Business Activity
Successor	1. Manage Provider Communication process 2. Monitor Performance and Business Activity process 3. Manage Provider Information process 4. Operations Management Area business processes 5. Send Outbound Transaction process 6. Receive Inbound Transaction process	Manage Provider Communication, Manage Provider Information, Send Outbound Transaction, Receive Inbound Transaction
Constraints	The Provider application and enrollment process must 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 logic will apply to each of these different types.	Business logic differences for type
Failures	Process Failure: Enrollment application processing terminates or suspends due to: 1. Duplicate or cancelled applications 2. Failure to validate application edits 3. Requires additional information to process application 4. The Manage Provider Communication and Perform Provider Outreach and Education processes fail to send, e.g., notification of application processing issues, enrollment decision outcomes, and procedural rights, or materials about state polices related to provider enrollment	Result messages

PM Enroll Provider

Tier 3: Enroll Provider		
Item	**Details**	**Links**
Failures (Cont'd)	Alternate Process Path: Enrollment process results in a denial or delay of an enrollment requests for reasons such as: 1. Provider fails to meet state enrollment requirements 2. Provider fails enumeration or credentialing verification 3. Provider cannot be enumerated through NPPES or state assigned enumerator 4. Lack of applicable rates 5. Inability to negotiate rates or contract This process requests that the Manage Provider Communication process prepare application rejection or failure notifications, or requests for additional information data sets for generation and transmission by the Send Outbound Transaction process	
Performance Measures	1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	
Provider Enrollment Variations		
Type	**Subtypes**	**Data**
Institutional Provider	The Institutional Provider application must 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)	Type of Facility, Bed Size, Taxonomy, Type of Institutional Services, Ownership, Tax Code, DRG or other payment type
Professional Provider	The Professional Provider application must accommodate a range of professional provider types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, Other), 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). Enumerate a Group Health Practice separately from the individual physicians associated with it.	Provider Type, Affiliation, Location
Pharmacy	The Pharmacy application must 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). The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist.	Type, ownership, location, unit dose, mail order, DUR compliance

PM Enroll Provider

Tier 3: Enroll Provider		
Item	**Details**	**Links**
A-Typical	The A-typical provider application must 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). The NPI enumeration will not provide ID numbers for A-typical providers at this time.	Type of service provider, allowed services, invoicing method

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PM Disenroll Provider

Tier 3: Disenroll Provider		
Item	**Details**	**Links**
Description	The ***Disenroll Provider*** business process is responsible for managing providers' enrollment in programs, including: ■ Processing of disenrollment – Requested by the provider – Requested by another Business Area, e.g., the Manage Provider Communication, Monitor Performance and Business Activities, and Program Integrity Manage Case processes – Due to receipt of information about a provider's death, retirement, or disability from the Manage Provider Communication process – Based on failure in the Enroll Provider process, e.g., Provider fails to meet state enrollment requirements • Provider fails enumeration or credentialing verification • Provider cannot be enumerated through NPPES or state assigned enumerator • Lack of applicable rates • Inability to negotiate rates or contract ■ Tracking of disenrollment requests and records, including assigning identifiers and monitoring status (e.g., new, resubmission, duplicate) ■ Validation that the disenrollment meets state rules and substantiating basis for disenrollment, e.g., checking death records ■ Requesting that the Manage Provider Information process load initial and changed disenrollment information into the Provider Registry ■ Prompting the Manage Provider Communication process to prepare disenrollment notifications and instructions for closing out provider contracts for generation and transmission by the Send Outbound Transaction process ■ Prompting the Manage Provider Information process to provide timely and accurate notification or to make disenrollment data required for operations available to all parties and affiliated business processes, including – The Capitation and Premium Payment Area – The Prepare Provider EFT/Check process	Business Process Model location: Business Area: Provider Management; Tier 2: Provider Enrollment

PM Disenroll Provider

Tier 3: Disenroll Provider		
Item	**Details**	**Links**
Description (Cont'd)	■ Prompting Manage Applicant and Member Communication process to notify and reassign, where necessary, members who are on the provider's patient panel, e.g., PCCM, Lock-in, HCBS and other waiver program, and FFS ■ Prompting Perform Applicant and Member Outreach to provide appropriate outreach and educational material to displaced members	
Trigger Event	State-transition Trigger Event: ■ Receipt of information relating to failed enrollment applications from the Enroll Provider process Interaction based Trigger Event: ■ Receipt of a disenrollment request or a modification of or cancellation of a request either directly, from the Manage Provider Communication process, or from another Business Area, e.g., Monitor Performance and Business Activity or Program Integrity Manage Case processes	Links to other processes: Receive Inbound Transaction Enroll Provider Manage Provider Communication Program Quality Management Area Program Integrity Area
Result	1. Provider is disenrolled 2. The Provider Registry is updated, disenrollment data required for operations is made available, and alerts are broadcast to subscribing processes such as the Monitor Performance and Business Activity, Care Management Area, Program Integrity Area, Capitation and Premium Payment Area, and the Prepare Provider EFT/Check, and the Communications processes 3. The Provider and/or affected parties are notified by the Communications processes about the disenrollment, e.g., in the case of fraud and abuse, Medicare/Medicaid Sanction, NPDB, HIPDB, and state licensing boards; and members on the provider's patient panel, who may be reassigned if appropriate 4. Provider contract is terminated and closed out 5. Operations Management Area reflect changes	Links to other processes: Manage Provider Information Manage Provider Communication Operations Management Area
Business Process Steps	1. Start: Receive disenrollment request or relevant information 2. Assign unique identifier for tracking 3. Validate application syntax/semantic conformance	Each state will specify its data requirements and rules for each step

PM Disenroll Provider

Tier 3: Disenroll Provider		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	4. Determine disenrollment request or information processing status by querying the Provider Registry; status may be initial, resubmitted with modification, or duplicate [If resubmit, message will contain only updated data and some steps below may be skipped; if duplicate, process terminates and result messages are produced – see Failures.] Other communications may be requests to cancel application, and to deactivate or reactivate enrollment. 5. Verify the disenrollment information 6. Validate that the disenrollment request meets state rules 7. Produce disenrollment record data set and request that the Manage Provider Information process load disenrollment record into the Provider Registry 8. Request that the Manage Provider Communication prepare disenrollment notification for the Outbound Transaction process to generate and send to the provider including notification of appeal rights 9. Request that the Perform Provider Outreach and Education process send relevant state policy information 10. End: Alert the Operations and Program Management Area that new or updated disenrollment information has been loaded into the Provider Registry	
Shared Data	1. Provider Registry data: e.g., NPI, provider demographics, provider taxonomy 2. NPI and provider demographics exchanged with the National Plan and Provider Enumeration System (NPPES) 3. Provider sanction data from: a. 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 Repository d. NPDB Repository 4. Tax identifiers: EIN, SSN, TIN from applicant and verified with tax identifier verification sources	

PM Disenroll Provider

Tier 3: Disenroll Provider		
Item	**Details**	**Links**
Predecessor	■ The Receive Inbound Transaction authenticates submitter, verifies application format, may translate, may scan, logs in request, and produces the disenrollment request or disenrollment information message which is sent to the Enroll Provider process ■ The Manage Provider Communication process may send requests, inquiries or information about disenrollment ■ The Monitor Performance and Business Activity process may send requests to terminate provider enrollment ■ The Program Integrity Area may request enrollment review activities	Receive Inbound Transaction, Manage Provider Communication, Monitor Performance and Business Activity
Successor	1. Manage Provider Communication process 2. Monitor Performance and Business Activity process 3. Manage Provider Information process 4. Program Integrity Area 5. Operations Management Area 6. Send Outbound Transaction process 7. Receive Inbound Transaction process	Manage Provider Communication, Manage Provider Information, Send Outbound Transaction, Receive Inbound Transaction
Constraints	The Provider disenrollment process must 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 logic will apply to each of these different types.	Business logic differences for type
Failures	Process Failure: Enrollment application processing terminates or suspends due to: 1. Duplicate or cancelled disenrollment requests 2. Failure to validate requests 3. Failure to verify information that is grounds for disenrollment 4. Disenrollment fails to meet state rules 5. Provider successfully appeals disenrollment 6. Requires additional information to process disenrollment	Result messages

PM Disenroll Provider

Tier 3: Disenroll Provider		
Item	**Details**	**Links**
Failures (Cont'd)	7. The Manage Provider Communication and Perform Provider Outreach and Education processes fail to send, e.g., notification of disenrollment outcomes, including either the approval or the dismissal of request, or a successful provider appeal; procedural rights; or materials about state polices related to provider enrollment Alternate Process Path: Provider continues to be enrolled because the information upon which disenrollment would be based proves untrue, e.g., provider is not deceased; or the disenrollment request does not meet state rules	
Performance Measures	1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	

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PM Manage Provider Information

Tier 3: Manage Provider Information		
Item	**Details**	**Links**
Description	The ***Manage Provider Information*** business process is responsible for managing all operational aspects of the Provider Registry, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the state Medicaid. The Provider Registry is the Medicaid enterprise "source of truth" for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The Registry includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services. In addition, the Provider Registry stores 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 Registry 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 Registry to add, delete, or change this information in registry records. The Provider Registry validates data upload requests, applies instructions, and tracks activity. The Provider Registry provides access to member records to applications and users via batch record transfers, responses to queries, and "publish and subscribe" services. Among the business processes that will interface with the Provider Registry are ■ The Enroll and Disenroll Provider processes, which send and retrieve provider information relating to these processes such as application, credentialing and enumeration review status ■ The Provider Support processes, such as Manage Provider Communication ■ All Operations Management business processes, e.g., Edit Claim/Encounter, Apply Mass Adjustment, Authorize Service, and Prepare Provider EFT/Check ■ The Maintain Benefit/Reference Information process, which is the Provider Registry's source of benefit package information	Business Process Model location: Business Area: Tier 1: Provider Management; Tier 2: Provider Information Maintenance

PM Manage Provider Information

Tier 3: Manage Provider Information		
Item	**Details**	**Links**
Description (Cont'd)	■ Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Provider Registry for provider information ■ Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Provider Registry	
Trigger Event	1. State transition trigger event: Receipt of request to add, delete, change Provider information or pointers to provider information records from a. Provider Management Business Area processes: Enroll and Disenroll Provider, Perform Provider Outreach and Education, Manage Applicant and Member Communication, or Manage Applicant and Member Grievance and Appeal b. The Maintain Benefit/Reference Information process, which is the Provider Registry's source of benefit package information that may be changed during the provider's contract c. Operations Management Business Area processes: Manage Payment Information (e.g., claims/encounters, COB, TPL, cost recoveries, HIPP, and service authorization) d. Care and Program Integrity Management Manage Repository processes 2. Interaction-based Trigger Event: Receipt of a query about data in one or more prospective or contracted provider records from enterprise business processes, or from authorized external parties, e.g., for verification of provider information. 3. Environmental Trigger Event: Scheduled transmission of provider information records or pointers to provider information on a periodic or real time basis to the Manage Program Information business process	
Result	The Provider Registry is loaded with new or updated provider information for the purposes of: 1. Responding to queries from authorized users and applications	

PM Manage Provider Information

Tier 3: Manage Provider Information		
Item	**Details**	**Links**
Result (Cont'd)	2. Supplying all Provider Management Area business processes with prospective or contracted provider information as needed to, e.g., detect duplicate applications; schedule recertification, performance and contract review; perform provider outreach and communication functions, etc. 3. Supplying all Operations Management Area business processes with contracted provider information needed to, e.g., edit claims and encounters, prepare remittance advice/encounter report and provider EFT/check, etc. 4. Sending records or pointers to the Manage Program Information business process	
Business Process Steps	1. Start: Receives data from Provider Management Area and relevant Operations Management business processes 2. Loads data into the Provider Registry, building new records and updating, merging, unmerging, or deleting previous records as appropriate 3. Provides access to records as required by Provider Management Area business processes workflow 4. Provides access to records as requested by other authorized business processes and users 5. Provides data to the Manage Program Information business process on a real time or periodic basis in update or snapshot mode 6. End: Archive data in accordance with state and federal record retention requirements	Each state will specify its data requirements and rules for each step
Shared Data	Data needed to record information about the following: Provider demographic; business identifier, contact, and address; credentialing, enumeration, performance profiles; payment processing, and tax information contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services.	
Predecessor	Inbound Transaction processing of provider enrollment applications, communications, scheduling requests, etc. Provider Management Area business processes supplying data to the Provider Registry, including Enroll and Disenroll Provider, Provider Outreach and Education, Manage Provider Communication, and Manage Provider Grievance and Appeal. Operations Management business processes supplying data to the Provider Registry including Prepare Remittance Advice/Encounter Report and Provider EFT/Check business processes.	

PM Manage Provider Information

Tier 3: Manage Provider Information		
Item	**Details**	**Links**
Successor	Outbound Transaction Processing for provider enrollment applications, communications, scheduling requests, etc. Provider Management business processes accessing data in the Provider Registry, including Enroll and Disenroll Provider, Perform Provider Outreach and Education, Manage Provider Communication, and Manage Provider Grievance and Appeal. Operations Management Area business processes, including Edit and Audit Claims and Encounters business processes; Prepare Capitation Payment (PCCM); Service Authorization, and all Cost Recovery business processes. Manage Program Information business process The following processes may need to access provider data from the Member Registry rather than from the Program Information Repository: ■ Care Management Establish and Manage Case business processes ■ Program Integrity Identify and Establish Case business processes	
Constraints	State specific work flows will determine which processes load and access the Provider Registry and by which interactions and messages (e.g., query/response, batch uploads, publish and subscribe, etc.); and the data content and structure of registry records	
Failures	Provider Registry fails to load or update appropriately; or fails to make registry data available or available in correct format.	
Performance Measures	1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ days 2. Accuracy of decisions = ___% 3. Consistency of decisions. 4. Error rate = __% or less.	

PM Inquire Provider Information

Tier 3: Inquire Provider Information		
Item	**Details**	**Links**
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 data set for the ***Send Outbound Transaction*** process.	Business Area: Provider Management; Tier 2: Provider Information Management
Trigger Event	**Interaction-based Trigger Event:** Receipt of provider enrollment verification request data set from ***Receive Inbound Transaction*** process.	Receive Inbound Transaction
Result	1. Provider enrollment verification response data set routed to ***Send Outbound Transaction*** process. Data set may include information such as enrollment start/end dates, provider type and specific specialties. 2. Tracking information regarding the interchange as needed for the ***Inquire Provider Information*** process for measuring performance and business activity monitoring.	Send Outbound Transaction
Business Process Steps	1. Start: Receipt of provider verification information data set from ***Receive Inbound Transaction*** Process. 2. Determine Request status as initial or duplicate. 3. Verify authorization of the requester to receive requested information. 4. Query Provider Registry for requested information 5. Process Response 6. Log Response 7. End: Prepare response data set for the ***Send Outbound Transaction*** process	
Shared Data	Provider Registry	
Predecessor	***Receive Inbound Transaction*** process	
Successor	***Send Outbound Transaction*** process	
Constraints	States determine what information can be shared and who can access requested information.	
Failures	1. Process unable to process the provider information verification request. 2. Requester not authorized to receive requested information.	
Performance Measures	1. Time to verify provider information and generate response data set: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Response Accuracy = ___% 3. Error rate = __% or less	

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PM Manage Provider Communication

Tier 3: Manage Provider Communication		
Item	**Details**	**Links**
Description	The ***Manage Provider Communication*** business process receives requests for information, provider publications, and assistance from prospective and current providers' communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via ***Send Outbound Transaction*** process. Note: Inquires from prospective and current providers are handled by the ***Manage Provider Communication*** process 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*** process targets both prospective and current provider *populations* for distribution of information about programs, policies, and health care issues.	Business Area: Tier 1: Provider Management; Tier 2: Provider Support
Trigger Event	**Interaction-based Trigger Event:** 1. Inquiry from current or prospective provider. 2. Request to send information packages such as provider enrollment applications and/or billing instructions. 3. Request for assistance, such as a request for training or change in provider information. 4. Requests from other processes to develop and produce communications for providers such as notifications from the ***Enroll Provider*** process such as requests for additional information, new provider information packages. **Temporal Trigger Event:** Scheduled time to send information, e.g., within 24 hours of new provider enrollment; notification of pending expired provider eligibility, and monthly communications such as provider newsletters or other agency communications.	
Result	1. Provider receives appropriate assistance, communications, and/or information packages. 2. Tracking information regarding the interchange as needed for the ***Manage Provider Communication*** process to ensure prospective and current providers receive the information they need.	Send Outbound Transaction

PM Manage Provider Communication

Tier 3: Manage Provider Communication		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receive request for communication from ***Receive Inbound Transaction*** process or from other processes such as ***Manage Provider Grievance and Appeal*** to prepare communications 2. Log and track communications request and response processing data 3. Research/develop communication that is linguistically, culturally, and competency appropriate 4. Prepare/package communication. 5. End: Send provider communications and information packages to be distributed by the ***Send Outbound Transaction*** process.	
Shared Data	1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Contractor Registry: Contracted service areas, MCO provider network and other provider data 3. Provider Registry: Provider data, such as type, location, availability.	
Predecessor	1. ***Receive Inbound Transaction*** 2. ***Enroll Provider*** 3. *Manage Provider Grievances and Appeals*	Links to processes: 1. ***Receive Inbound Transaction*** 2. ***Enroll Provider*** 3. ***Manage Provider Grievances and Appeals***
Successor	***Send Outbound Transaction*** process	Send Outbound Transactions
Constraints	Communications requested will vary by state, depending on programs supported and type of provider requesting information.	
Failures	1. Inability to provide linguistically, culturally, or competency appropriate information 2. Communication barriers such as lack of Internet or failure to access needed or requested information 3. Delivery failures due to erroneous contact information or lack of contact information.	

PM Manage Provider Communication

Tier 3: Manage Provider Communication		
Item	**Details**	**Links**
Performance Measures	Examples of Measures – 1. Time to complete process of developing communications: By phone __ minutes; by email ___ hours; by mail __days 2. Accuracy of communications = __% 3. Successful delivery rate to targeted providers = ___%	

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PM Manage Provider Grievance and Appeal

Tier 3: Manage Provider Grievance and Appeal		
Item	**Details**	**Links**
Description	The ***Manage Provider Grievance and Appeal*** business process handles provider* appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the ***Manage Provider Communication*** process via the ***Receive Inbound Transaction*** process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the ***Send Outbound Transaction*** Process. This process supports the ***Program Quality Management*** Business Area by providing data 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 data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. **NOTE:** States may define "grievance" and "appeal" differently, depending on state laws. *This 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 an application for enrollment is denied.	Business Area: Provider Management; Tier 2: Provider Support
Trigger Event	Receipt of grievance or appeal of adverse decision data set from ***Receive Inbound Transaction*** process.	Receive Inbound Transaction
Result	Final disposition of grievance or appeal sent to the applicant or member via the ***Send Outbound Transaction*** process.	Send Outbound Transaction
Business Process Steps	1. Start: Receive grievance or appeal via ***Receive Inbound Transaction*** Process 2. Situational: Request additional documentation 3. Determine status as initial, second, or expedited. 4. Triage to appropriate personnel for review. 5. Perform research and analysis 6. Schedule hearing within required time.	

PM Manage Provider Grievance and Appeal

Tier 3: Manage Provider Grievance and Appeal		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	7. Conduct hearing within required time. 8. Determine disposition. 9. End: Request that the ***Manage Applicant and Member Communication*** process prepare a formal disposition to be sent to the provider via ***Send Outbound Transaction*** process. **NOTE:** Some of the above steps may be iterative and a grievance or appeals case may take many months to finalize.	
Shared Data	1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Contractor Registry: Contracted service areas, MCO provider network and other provider data 3. Provider Registry: Provider data, such as type, location, availability. 4. Grievance and Appeal Case File Repository	
Predecessor	Receipt of appeal data set from ***Receive Inbound Transaction*** process.	Receive Inbound Transaction
Successor	Formally notify applicant or member via ***Send Outbound Transaction*** process.	Send Outbound Transaction
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.	
Failures	N/A	
Performance Measures	Examples of Measures – 1. Time to complete process: normal grievance/appeal = __days; second appeal =__days; expedited appeal =__hours 2. Accuracy of decisions = __% 3. Consistency of decisions and disposition = __%	

PM Perform Provider Outreach

Tier 3: Perform Provider Outreach		
Item	**Details**	**Links**
Description	The ***Perform Provider Outreach*** business process originates internally within the Agency in response to multiple activities, e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical break throughs, changes in the Medicaid program policies and procedures. For Prospective Providers not currently enrolled, provider outreach information is developed for targeted providers that have been identified by analyzing program data (for example, not enough dentists to serve a population, new immigrants need language-compatible providers). For Providers currently enrolled, 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. Outreach communications and information packages are distributed accordingly through various mediums via the ***Send Outbound Transaction***. All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the ***Monitor Performance and Business Activity*** process.	Business Area: Provider Management; Tier 2: Provider Support
Trigger Event	**State-transition based Triggers Event:** 1. Executive management decision to fill gaps in health care service coverage 2. Introduction of new programs requiring new types of service 3. Changes to existing policies and procedures 4. Critical need in a specific target population 5. Identification of new populations in need of service, e.g., new immigrant communities	
Result	Outreach communications, such as mailings brochures, web pages, email, and radio, billboard, and TV advertisements; are produced and distributed to targeted providers.	Send Outbound Transaction
Business Process Steps	1. Start: Target population is identified and defined by analyzing data, performance measures, feedback from community, and policy directives 2. Receive requests or make decisions to develop Outreach communications 3. Send outreach communications to be distributed through various mediums supported by the ***Send Outbound Transaction*** process using various mediums. 4. End: Outreach communications production and distribution are tracked and materials archived.	

PM Perform Provider Outreach

Tier 3: Perform Provider Outreach		
Item	**Details**	**Links**
Shared Data	1. Care Management population health data 2. Program Quality Management quality measure data 3. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 4. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 5. Contractor Registry: Contracted service areas, MCO provider network and other provider data 6. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence	
Predecessor	***Care Management***, ***Benefit Administration***, ***Program Administration***, or ***Program Quality Management*** processes result in an identified need to perform outreach to providers.	
Successor	***Send Outbound Transaction*** processes distribute communications to the targeted provider audience. ***Monitor Performance and Business Activity*** Process measures Outreach efficacy	
Constraints	Information must address the variations of the target population. Language requirements must be met.	
Failures	N/A	
Performance Measures	Examples of Measures – 1. Time to complete process of developing outreach materials = __ days 2. Accuracy of outreach materials = __% 3. Successful delivery rate to targeted individuals = ___%	

Contractor Management

CM1 Manage Health Services Contract

Tier 3: Manage Health Services Contracting		
Item	**Details**	**Links**
Description	The ***Manage Health Services Contract*** business process gathers requirements, develops a Request for Proposals, requests and receives approvals for the RFP, and solicits responses. Health care services include: medical care services, pharmacy benefits, dental benefits, mental health benefits, primary care services, and health care services outsourced to health insurance programs.	Business Process Model location: Tier 1: Contractor Management Tier 2: Health Services Contracting
Trigger Event	Temporal Trigger Event: A Scheduled date for reprocurement of health care service contact Interaction-based Trigger Event: Request by Executive Management to reprocure	
Result	1. Advance Planning Document 2. Request for Proposal	
Business Process Steps	1. Start: Receive directive to procure health care services 2. Gather requirements for health care services 3. Determine if Advance Planning Document (APD) is required a. Produce APD b. Receive approval for APD 4. Develop Request for Proposal (RFP)for the health care services 5. Receive internal (state) and federal approvals for RFP 6. Advertise RFP 7. End: Issue RFP	
Shared Data	Previous RFP Operational data stores Strategic IT Plan Enterprise Architecture	
Predecessor	Determine Need for Health Care Contract	
Successor	Award Health Care Contract	
Constraints	Each state decides what types of health care contracts need to be procured. States engage in a wide range of health care contracts. All states are governed by statutes that provide the legal framework for procurements. Each state's statutes are different from all other states.	Business process steps differ from state to state
Failures	1. The reprocurement is challenged	
Performance Measures	Time to complete process Accuracy of decisions Consistency of decisions and disposition	

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CM1 Award Health Services Contract

Tier 3: Award Health Services Contract		
Item	**Details**	**Links**
Description	The ***Award Health Services Contract*** business process receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, notifies parties.	Business Process Model location: Tier 1: Contractor Management Tier 2: Health Services Contracting
Trigger Event	Interaction-Based Trigger Event: Receives contractor proposals	
Result	1. Contractor award status data (e.g., award, deny, need more information) 2. Data to communicate with contractor 3. Data to update Contractor Registry	Links to other Business Processes: Manage Contractor Information Manage Contractor Communications
Business Process Steps	1. Start: Receive proposal data 2. Validate completeness and required fields – business logic identifies mandated fields and applies edits for the Type of Contractor. 3. Verify contractor with external entities – business logic sends message to one or more external entities to verify information in the application, e.g., corporate status. 4. Validate contractor network, resources, and other requirements 5. Assign ID 6. Assign rates or other form of payment 7. Negotiate contract: collect additional information required to complete a contract 8. End: Produce result status (award, deny, continue negotiations)	Links to other (future) Business Processes: Assign Contractor ID Negotiate Contractor Contract Assign Rates Each State will specify its data requirements and rules for each step in the Business Logic flow.
Shared Data	Contractor Master Registry Other per Type of Contractor	
Predecessor	The predecessor business process, Receive Inbound Transaction (i.e., Proposal), authenticates, verifies format, may translate, may scan, logs in request, and produces the enrollment application message which is sent to the Enroll Contractor business process.	Receive Inbound Transaction
Successor	1. Manage Contractor Communications 2. Manage Contractor Information	Manage Contractor Communications Manage Contractor Information

CM1 Award Health Services Contract

Tier 3: Award Health Services Contract		
Item	**Details**	**Links**
Constraints	The Contractor application must accommodate the full range of contractor types.	Business logic differences for type
Failures	A contractor proposal may fail at the following steps: 1. Required fields 2. Verification with one or more external entities 3. Verification with internal sources 4. No established rates 5. Cannot complete contract	Result messages
Performance Measures	1. Time to complete process 2. Accuracy of decisions 3. Consistency of decisions and disposition	

CM1 Award Health Services Contract

Tier 3: Award Health Services Contract		
Contractor Enrollment Variations		
Type	**Subtypes**	**Data**
Institutional Contractor	The Institutional Contractor application must accommodate a range of institutional contractor types (e.g., Inpatient, Nursing Home, Day Care), different types of applicants (e.g., the Primary Contractor, Billing Agent, Pay-To Entity), and care settings (e.g., Outpatient, Emergency Room, Assisted Living)	Type of Facility, Bed Size, Taxonomy, Type of Institutional Services, Ownership, Tax Code, DRG or other payment type
Professional Contractor	The Professional Contractor application must accommodate a range of professional contractor types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, Other), different types of applicants (e.g., the Primary Contractor, Billing Agent, Pay-To Entity), and care settings (e.g., solo office practice, group practice, Rural Health Clinic). Enumerate a Group Health Practice separately from the individual physicians associated with it.	Contractor Type, Affiliation, Location
Pharmacy	The Pharmacy application must accommodate a range of types (e.g., major chain with hundreds of stores, community pharmacy), different types of applicants (e.g., the Primary Contractor, Billing Agent, Pay-To Entity), and care settings (e.g., retail store, outpatient facility, nursing home). The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist.	Type, ownership, location, unit dose, mail order, DUR compliance

CM1 Award Health Services Contract

Tier 3: Award Health Services Contract		
Contractor Enrollment Variations		
Type	**Subtypes**	**Data**
A-Typical	The A-typical contractor application must accommodate a range of types of programs (e.g., Waiver, assistance in the home), different kinds of service contractors (e.g., family care-taker, taxi cab, plumber, carpenter, meals on wheels), different types of relationships (e.g., the Primary Contractor, Billing Agent, Pay-To Entity), and care settings (e.g., in the home, day care center). The NPI enumeration will not provide ID numbers for A-typical contractors at this time.	Type of service contractor, allowed services, invoicing method

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CM1 Close-out Health Services Contract

Tier 3: Close-out Health Services Contract		
Item	**Details**	**Links**
Description	The ***Close-out Health Care Services Contract*** business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.	Business Process Model location: Tier 1: Contractor Management Tier 2: Health Services Contracting
Trigger Event	Interaction-based Trigger event: Receive instruction to terminate contract	
Result	Close-out of contract	Links to other E2E threads: Update Contractor Registry Notify Contractor
Business Process Steps	Start: Receive instruction to terminate contract Identify all requirements for termination of contract Monitor closure activities End: Officially terminate contract	
Shared Data	Contractor Registry	
Predecessor	Request to terminate contract	
Successor	1. Manage Contractor Communications 2. Manage Contractor Information	Manage Contractor Communications Manage Contractor Information
Constraints	Each state has its requirements for contract termination.	Business logic differences for type
Failures	N/A	Result messages
Performance Measures	Time to complete process Accuracy of decisions Consistency of decisions Error rate	

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CM2 Manage Administrative Contract

Tier 1: Manage Administrative Contract		
Item	**Details**	**Links**
Description	The ***Monitor Administrative Contract*** business process receives the contract award data set, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the contract throughout its duration.	Business Process Model location: Tier 1: Business Area: Contractor Management Tier 2: Administrative Contracting
Trigger Event	Interaction-based Trigger Event: Receive Administrative Services Contractor data.	
Result	1. Contractor enrollment status data (e.g., enroll, deny, need more information) 2. Data to communicate with contractor 3. Data to update Contractor Registry	
Business Process Steps	1. Start: Receive contract award data set from the ***Receive Inbound Transaction*** process 2. Implement contract 3. Update contract with amendments (if any) 4. End: Monitor terms of the contract throughout its duration	
Shared Data	Contractor Database	
Predecessor	The predecessor business process, Receive Inbound Transaction (i.e., Enrollment Application), authenticates, verifies format, may translate, may scan, logs in request, and produces the enrollment application message which is sent to the Enroll Contractor business process.	E2E thread: Receive Inbound Transaction
Successor	1. Manage Contractor Communications 2. Manage Contractor Information	E2E threads: Manage Contractor Communications Manage Contractor Information
Constraints	Business rules and/or policies may differ by state.	
Failures	N/A	Result messages
Performance Measures	1. Time to complete process 2. Accuracy of decisions 3. Consistency of decisions and disposition	

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CM2 Award Administrative Contract

Tier 3: Award Administrative Contract		
Item	**Details**	**Links**
Description	The ***Award Administrative Contract*** business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses. Administrative services include: fiscal agent, managed care enrollment broker, professional services review, authorization for services, fraud detection, third party recovery, and many other outsourced services.	Business Process Model location: Tier 1: Business Area: Contractor Management Tier 2: Administrative Contracting
Trigger Event	**Temporal Trigger Event:** A scheduled date for reprocurement of administrative service contact **Interaction Based Trigger Event:** Receipt of an executive decision to reprocure.	
Result	1. Advance Planning Document 2. Request for Proposal 3. Contract	
Business Process Steps	1. Start: Receive directive to procure administrative services 2. Gather requirements for administrative services 3. Determine if Advance Planning Document (APD) is required a. Produce APD b. Receive approval for APD 4. Develop Request for Proposal (RFP) for the administrative services 5. Receive internal (state) and federal approvals for RFP 6. Advertise RFP 7. End: Issue RFP	
Shared Data	Previous RFP Operational data stores Strategic IT Plan Enterprise Architecture	
Predecessor	Determine Need for Administrative Contract	
Successor	Award Administrative Contract	
Constraints	Each state decides what types of administrative contracts need to be procured. States engage in a wide range of administrative contracts. All states are governed by statutes that provide the legal framework for procurements. Each state's statutes are different from all other states.	Business process steps differ from state to state
Failures	N/A	

CM2 Award Administrative Contract

Tier 3: Award Administrative Contract		
Item	**Details**	**Links**
Performance Measures	Time to complete process of procuring an Administrative Contract = __ days Accuracy of RFP = ___%	
Rules Differ by Contractor Type		
Type		
Fiscal Agent		
MCO Enrollment Broker		
Professional Services Review		
SURS Case Review		
Fraud Detection		
Third Party Recovery		
Provider Relations		
Other		

CM2 Close-out Administrative Contract

Tier 1: Close-out Administrative Contract		
Item	**Details**	**Links**
Description	The ***Close-out Administrative Contract*** business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.	Business Process Model location: Tier 1: Business Area: Contractor Management Tier 2: Administrative Contracting
Trigger Event	Interaction-based Trigger Event: Instruction to terminate contract	
Result	Close-out of contract	Links to other E2E threads: Update Contractor Registry Notify Contractor
Business Process Steps	1. Start: Receive instruction to terminate contract 2. Identify all requirements for termination of contract 3. Monitor closure activities 4. End: Officially terminate contract	
Shared Data	Contractor Database	
Predecessor	Request to terminate contract	
Successor	***Manage Contractor Communications*** ***Manage Contractor Information***	E2E threads: Manage Contractor Communications Manage Contractor Information
Constraints	Requirements and business policies for contract termination may differ by state.	Business logic differences for type
Failures	N/A	Result messages
Performance Measures	Time to complete process. Accuracy with which rules are applied Consistency with which rules are applied	

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CM3 Manage Contractor Information

Tier 3: Manage Contractor Information		
Item	**Details**	**Links**
Description	The ***Manage Contractor Information*** business process receives a request for addition, deletion, or change to the Contractor Registry; validates the request, applies the instruction, and tracks the activity.	Business Area: Tier 1: Contractor Management; Tier 2: Contractor Information Management
Trigger Event	Request to add, delete, change contractor data repository information.	
Result	Modified contractor data repository Tracking information	
Business Process Steps	1. Start: Receive request to apply transaction 2. Validate request 3. Apply transaction to contractor data store 4. End: Report on action taken	
Shared Data	Receive request to update contractor data repository	
Predecessor	Report on action taken	
Successor	Contractor data repository	
Constraints	Data requirements and data structures for the contractor data store differ from state to state.	
Failures	1. Contractor information not found 2. Inability to respond to a request	
Performance Measures	1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	

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CM3 Inquire Contractor Information

Tier 3: Inquire Contractor Information		
Item	**Details**	**Links**
Description	The ***Inquire Contractor Information*** business process receives requests for contract verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the ***Send Outbound Transaction*** process.	
Trigger Event	**Interaction-based Trigger Event:** Receipt of contract verification request data set from ***Receive Inbound Transaction*** process.	
Result	1. Contract verification response data set routed to ***Send Outbound Transaction*** process. Data set may include information such as contract start/end dates, Contractor type and specific specialties. 2. Tracking information regarding the interchange as needed for the ***Inquire Contractor Information*** process for measuring performance and business activity monitoring.	
Business Process Steps	1. Start: Receipt of Contract verification information data set from ***Receive Inbound Transaction*** Process. 2. Determine Request status as initial or duplicate. 3. Verify authorization of the requester to receive requested information. 4. Query Contractor Registry for requested information 5. Process Response 6. Log Response 7. End: Prepare response data set for the ***Send Outbound Transaction*** process	
Shared Data	Contractor Registry	
Predecessor	***Receive Inbound Transaction*** process	
Successor	***Send Outbound Transaction*** process	
Constraints	States determine what information can be shared and who can access requested information.	
Failures	1. Process unable to process the Contractor information verification request. 2. Requester not authorized to receive requested information.	
Performance Measures	1. Time to verify Contractor information and generate response data set: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Response Accuracy = ___% 3. Error rate = __% or less	

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CM4 Perform Potential Contractor Outreach

Tier 2: Perform Potential Contractor Outreach		
Item	**Details**	**Links**
Description	The ***Perform Potential Contractor Outreach*** business process originates initially within the Agency in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures. For Prospective Contractors not currently enrolled, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs. For Contractors currently enrolled, information may relate to public health alerts, public service announcements, and other objectives. Contractor outreach communications are distributed through various mediums via the ***Send Outbound Transaction***. All contractor outreach communications are produced, distributed, tracked, and archived by the agency according to state archive rules. Outreach efficacy is measured by the ***Monitor Performance and Business Activity*** process.	Business Area: Tier 1: Contractor Management; Tier 2: Contractor Support
Trigger Event	State-transition based Trigger Events: Executive Management decision to: ■ Fill gaps in health care service coverage ■ Introduce new programs requiring new types of service ■ Changes to existing policies and procedures ■ Critical need in a specific target population ■ Identification of new populations in need of service, e.g., new immigrant communities	
Result	Outreach communications, such as mailing brochures, web pages, email, radio, billboard, and TV advertisements; are produced and distributed to targeted contractors.	
Business Process Steps	1. Start: Contractor population is identified and defined by analyzing data, performance measures, feedback from community, and policy directives 2. Receive requests to make decisions to develop outreach communications 3. Send outreach communications to be distributed through various mediums supported by the ***Send Outbound Transaction*** process using various mediums 4. End: Outreach communications production and distribution are tracked and materials archived	

CM4 Perform Potential Contractor Outreach

Tier 2: Perform Potential Contractor Outreach		
Item	**Details**	**Links**
Shared Data	1. Care Management population health data 2. Program Quality Management quality measure data 3. Benefit Repository 4. Member Registry 5. Contractor Registry 6. Provider Registry	
Predecessor	Care Management, Benefit Administration, Program Administration, or Program Quality Management processes result in an identified need to perform outreach to contractors.	
Successor	1. ***Send Outbound Transaction*** processes distribute communications to the targeted contractor audience. 2. ***Monitor Performance and Business Activity*** process measures outreach efficacy.	
Constraints	Information must address the variations of the target population.	
Failures	N/A	
Performance Measures	Examples of Measures – 1. Time to complete process of developing outreach materials = __days 2. Accuracy of outreach materials = __% 3. Successful delivery rate to targeted individuals = __%	

CM4 Manage Contractor Communication

Tier 3: Manage Contractor Communication		
Item	**Details**	**Links**
Description	The ***Manage Contractor Communication*** business process receives requests for information, appointments and assistance from contractor such as inquiries related to changes in Medicaid program policies and procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed and produced for distribution via the ***Send Outbound Transaction*** process. **NOTE:** Inquiries from prospective and current contractors are handled by the ***Manage Contractor Communication*** process by providing assistance and responses to individual entities, i.e., bi-directional communication. The ***Perform Contractor Outreach*** process targets both prospective and current contractor populations for distribution of information regarding programs, policies and other issues.	Business Area: Tier 1: Contractor Management; Tier 2: Contractor Support
Trigger Event	**Interaction-based Trigger Events:** 1. Inquiry from current and prospective contractor. 2. Request to send information 3. Request for assistance 4. Requests from other processes to develop and produce communications **Temporal Trigger Events:** Scheduled time to send information, e.g., within 24 hours of new or amended contract signing; periodic communications, or agency request to send information.	
Result	1. Contractor receives appropriate assistance, communications and/or information packages from ***Receive Inbound Transaction*** process 2. Tracking information regarding the interchange a needed for the ***Manage Contractor Communication*** process to ensure prospective and current contractors receive the information they need.	
Business Process Steps	1. Start: Receive request for information from ***Receive Inbound Transaction*** processor from other processes such as ***Manage Contractor Grievances and Appeals*** to prepare communications 2. Log and track communications request and response processing data 3. Research/develop communication	

CM4 Manage Contractor Communication

Tier 3: Manage Contractor Communication		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	4. Prepare/package communication 5. End: Send contractor communications and information packages to be distributed by the ***Send Outbound Transaction*** process.	
Shared Data	Contractor Registry Benefit Repository	
Predecessor	1. ***Receive Inbound Transaction*** 2. ***Manage Contractor Grievances and Appeals***	
Successor	***Send Outbound Transaction*** process	
Constraints	Communications will vary by state, by type of contractor, and by type of communication	
Failures	1. Inability to access data 2. Inability to respond to the type of inquiry	
Performance Measures	Examples of Measures – 1. Time to complete process of developing communications: By phone __ minutes; by email __hours; by mail __ days 2. Accuracy of communications = __% 3. Successful delivery rate to targeted providers = __%	

CM4 Support Contractor Grievance and Appeal

Tier 2: Support Contractor Grievance and Appeal		
Item	**Details**	**Links**
Description	The ***Support Contractor Grievance and Appeal*** business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the ***Manage Contractor Communications*** process via the ***Receive Inbound Transaction*** process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented and relevant documents are distributed to the contractor information file. The contractor is formally notified of the decision via the ***Send Outbound Transaction*** process. This process supports the ***Program Quality Management*** business area by providing data 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 data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. **NOTE:** States may define "grievance" and "appeal" differently, perhaps because of state laws. *This process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor can file a grievance or appeal for example when an application is denied.	Business Area: Tier 1: Contractor Management; Tier 2: Contractor Support
Trigger Event	Receipt of grievance or appeal of adverse decision data set from ***Receive Inbound Transaction*** process.	
Result	Final disposition of grievance or appeal sent to the contractor via the ***Send Outbound Transaction*** process.	
Business Process Steps	1. Start: Receive grievance or appeal via ***Receive Inbound Transaction*** Process 2. Situational: Request additional documentation 3. Determine status as initial, second, or expedited. 4. Triage to appropriate personnel for review. 5. Perform research and analysis 6. Schedule hearing within required time.	

CM4 Support Contractor Grievance and Appeal

Tier 2: Support Contractor Grievance and Appeal		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	7. Conduct hearing within required time. 8. Determine disposition. 9. End: Request that the ***Manage Contractor Communication*** process prepare a formal disposition to be sent to the contractor via ***Send Outbound Transaction*** process. **NOTE:** Some of the above steps may be iterative and a grievance or appeals case may take many months to finalize.	
Shared Data	1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Contractor Registry: Contracted service areas, MCO provider network and other provider data 3. Provider Registry: Provider data, such as type, location, availability. 4. Grievance and Appeal Case File Repository	
Predecessor	Receipt of appeal data set from ***Receive Inbound Transaction*** process.	
Successor	Formally notify applicant or member via ***Send Outbound Transaction*** process.	
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.	
Failures	N/A	
Performance Measures	Examples of Measures – 1. Time to complete process: normal grievance/appeal = __days; second appeal = __ days; expedited appeal = __hours. 2. Accuracy of decisions = __% 3. Consistency of decisions and disposition = __%	

Operations Management

OM1 Authorize Treatment Plan

Tier 3: Authorize Treatment Plan		
Item	**Details**	**Links**
Description	The ***Authorize Treatment Plan*** business process encompasses both a pre-approved and post-approved treatment plan. The Authorize Treatment Plan is primarily used in care management settings where the care management team assesses the client's needs, decides on a course of treatment, and completes the Treatment Plan. A Treatment Plan prior-authorizes the named providers and services. The individual providers are pre-approved for the service and do not have to submit their own Service Request. It typically covers many services and spans a length of time. A service request is more limited and focuses on a specific visits, services, or products. The pre-approved treatment plan is a care management function and begins with receiving an authorize treatment plan request data set from either an EDI, Paper/Fax, or phone Inbound Transaction Process, evaluating based on urgency and type of service/taxonomy (speech, physical therapy, home health), validating key data, and ensuring that requested plan of treatment is appropriate and medically necessary. After reviewing; approves, modifies, pends or denies the request and sends the appropriate response data set for the outbound transaction or paper/fax notifications or correspondence from the ***Manage Provider Communication*** process or sending a 277 Request for Additional Information to the provider. A post-approved treatment plan is an audit function that reviews pended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.	Business Process Model location: Operations Management: Tier 2: Service Review **NOTE:** There are three types of Service Authorization: Authorize Treatment Plan, Authorize Referral, and Authorize Service
Trigger Event	**Interaction-based Trigger Event:** An authorize treatment plan request data set is received from the ***Receive Inbound Transaction*** Process. **State Transition Treatment Plan Authorization Trigger Event:** Receipt of data set containing plan of treatment information.	
Result	An Authorize treatment plan data set is sent to the: 1. ***Send Outbound Transaction*** process for generation into an outbound transaction. 2. ***Maintain Benefits/Repository*** process for access during the claim adjudication process. 3. ***Manage Provider Communication*** process to inform the member and the various providers that the plan of treatment has been approved 4. ***Care Management*** process so that the treatment plan and services rendered can be monitored.	Links to: 1. Manage Provider Communication 2. Care Management

OM1 Authorize Treatment Plan

Tier 3: Authorize Treatment Plan		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receive data set from ***Receive Inbound Transaction*** Process 2. Assign a tracking number 3. Prioritize authorize plan of treatment request 4. Validate member eligibility 5. Validate requesting and servicing providers 6. Validate service coverage and plan of treatment requirements 7. Validate diagnosis code 8. Validate procedure code 9. Check for medical appropriateness 10. Check against currently authorized treatment plans for duplicates 11. Validate completeness of supporting documentation 12. Deny based on insufficient/erroneous data or treatment plan identifying services not medically necessary and send via ***Manage Provider Communication*** 13. Pend the plan of treatment request based on need for additional information – send request for additional information data set to ***Send Outbound Transaction*** Process for generation of paper/phone/fax correspondence or an X12 277 Request for Additional Information Transaction 14. Approve plan of treatment request (this includes approved with modifications and send approval response data set to ***Send Outbound Transaction*** Process for generation of paper/phone/fax correspondence or EDI transaction. 15. End: Load review results into ***Maintain Benefits/Reference*** repository for access during adjudication audit process.	Links to: 1. Receive Inbound Transaction 2. Provider Registry 3. Member Registry 4. Program Information Repository
Shared Data	1. Provider Registry – Provider ID Number 2. Member Registry – Eligibility 3. Benefit Package Data 4. Service Data 5. Reference Repository- carries diagnosis and procedure code data 6. Correspondence Data	
Predecessor	This business process is preceded by the ***Receive Inbound Transaction*** Process.	

OM1 Authorize Treatment Plan

Tier 3: Authorize Treatment Plan		
Item	**Details**	**Links**
Successor	1. Downstream business processes related to claims adjudication processes e.g., ***Audit Claim/Encounter*** process 2. ***Manage Provider Communication*** 3. ***Maintain Benefits/Reference Repository***	
Constraints	The Authorize Treatment Plan Request data set must conform to the format and content in accordance with state specific reporting requirements, such as states' HIPAA companion guides.	Business rules differ by state
Failures	N/A	Result messages
Performance Measures	1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours. 2. Accuracy with which service authorizations are approved 3. Consistency of decisions in approving or denying service authorizations 4. Error rate = __% or less.	

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OM1 Authorize Service

Tier 3: Authorize Service		
Item	**Details**	**Links**
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, surgeries, tests, drugs, durable medical equipment, and institutional days of stay. It is primarily used in a fee-for-service setting. The pre-approved is a care management function and begins with receiving a referral request data set from an EDI, Paper/Fax, phone, or 278 Health Care Services Review Inbound Transaction Process. Requests are evaluated based on urgency and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state), validating key data, and ensuring that requested referral is appropriate and medically necessary. After review, a referral is approved, modified, denied or pended for additional information. The appropriate response data set for the outbound 278 Response Transaction, 277 Request for additional information or paper/fax notifications/correspondence is sent to the provider using the ***Send Outbound Transaction*** through ***Manage Provider Communication***. A post-approved referral is an editing/auditing function that requires review of referral information after the referral has been made. A review may consist of: verifying referral documentation to ensure a referral for services was appropriate and medically necessary; validating provider type and specialty information to ensure a referral is in line with agency policies and procedures. Post-approved validation typically occurs in the ***Edit Claims/Encounter*** or ***Audit Claims/Encounter*** 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, Inpatient, Out-of-State Services, and Emergencies.	Business Process Model location: Operations Management: Tier 2: Service Review **NOTE:** There are three types of Service Authorization: Authorize Treatment Plan, Authorize Referral, and Authorize Service
Trigger Event	**Interaction-based Trigger Event:** A service authorization request data set is received from the ***Receive Inbound Transaction*** Process. **State Transition Service Authorization Trigger Event:** Receipt of data set containing referral information.	

OM1 Authorize Service

Tier 3: Authorize Service		
Item	**Details**	**Links**
Result	An Authorize Service data set is sent to the: 1. ***Send Outbound Transaction*** process for generation into an outbound transaction 2. ***Maintain Benefits/Repository*** process for access during the claim adjudication process. 3. ***Manage Provider Communication*** 4. ***Care Management***	Links to: Manage Provider Communication Care Management
Business Process Steps	1. Start: Receive data set from ***Receive Inbound Transaction*** Process 2. Assign a tracking number 3. Prioritize Service Authorization Request 4. Validate member eligibility 5. Validate requesting and servicing providers 6. Validate service coverage and referral requirements 7. Validate diagnosis code 8. Validate procedure code 9. Check for medical appropriateness 10. Check against current referrals for duplicates 11. Validate completeness of supporting documentation 12. Deny based on insufficient/erroneous data or referral for service not medically necessary and send via ***Manage Provider Communication*** 13. Pend the referral request based on need for additional information – send request for additional information data set to ***Send Outbound Transaction*** Process for generation of paper/phone/fax correspondence or an X12 277 Request for Additional Information Transaction 14. Approve referral request (this includes approved with modifications and send approval response data set to ***Send Outbound Transaction*** Process for generation of paper/phone/fax correspondence or an X12 278 Service Review Response 15. End: Load review results into Benefits/Reference repository for access during adjudication processes.	
Shared Data	1. Provider Registry – Provider ID Number 2. Member Registry – Eligibility 3. Benefit Package Data 4. Service Data 5. Reference Repository- carries diagnosis and procedure code data 6. Correspondence Data	
Predecessor	This business process is preceded by the ***Receive Inbound Transaction*** Process.	

OM1 Authorize Service

Tier 3: Authorize Service		
Item	**Details**	**Links**
Successor	1. Downstream business processes related to claims adjudication processes e.g., ***Audit Claim/Encounter*** process 2. ***Manage Provider Communication*** 3. ***Maintain Benefits/Reference Repository***	
Constraints	The Authorize Service Request data set must conform to the format and content in accordance with state specific reporting requirements, such as states' HIPAA companion guides.	Business rules differ by state
Failures	N/A	Result messages
Performance Measures	1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours. 2. Accuracy with which service authorizations are approved 3. Consistency of decisions in approving or denying service authorizations 4. Error rate = __% or less.	

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OM1 Authorize Referral

Tier 3: Authorize Referral		
Item	**Details**	**Links**
Description	The Authorize Referral business process is used when referrals between providers must be approved for payment. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. Referral authorization usually occurs in certain provider network and managed care settings. Authorize referrals closely follows the details of Authorize Service and may not require a separate business process definition.	**NOTE:** There are three types of Service Authorization: Authorize Treatment Plan, Authorize Referral, and Authorize Service
Trigger Event		
Result		
Business Process Steps		
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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OM2 Edit Claim/Encounter

Tier 4: Edit Claim/Encounter		
Item	**Details**	**Links**
Description	The ***Edit Claim/Encounter*** E2E business process receives an original or an adjustment claim/encounter data set from the ***Receive Inbound Transaction*** process and ■ Determines its submission status ■ Validates edits, service coverage, TPL, coding ■ Populates the data set with pricing information Sends validated data sets to ***Audit Claim/Encounter*** process and data sets that fail audit to the ***Prepare Remittance Advice/Encounter Report*** process All claim/encounter types must go through most of the steps within the ***Edit Claim/Encounter*** process with some variance of business rules and data. See Constraints. **NOTE:** This E2E is part of a suite that includes: ***Edit Claim/Encounter***, ***Audit Claim/Encounter***, ***Price Claim/Value Encounter***, ***Apply Claim Attachment***, ***Price Claim/Value Encounter***, and ***Prepare Remittance Advice/Encounter*** processes. **NOTE:** The ***Edit Claim/Encounter*** process does not apply to: ■ Point of Sale, which requires that Edit, Audit, and other processes be integrated, or ■ Direct Data Entry, On-line adjudication, or Web-enabled submissions that require field-by-field accept/reject and pre-populate fields with valid data.	Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Claim/Encounter Adjudication
Trigger Event	State-transition Trigger Event: A claim/encounter data set (received from the ***Receive Inbound Transaction*** process. Includes both paper and EDI).	Links to previous E2E threads: Receive Inbound Transaction process
Result	1. Validated claim/encounter data set (sent to the ***Audit Claim/Encounter*** process) 2. Resolved suspended claim/encounter data set (If favorable, sent to the ***Audit Claim/Encounter*** process. If unfavorable, sent with Edit error report to the ***Prepare Remittance Advice/Encounter Report*** process)	Links to other E2E threads: Audit Claim/Encounter Prepare Remittance Advice/Encounter Report Send Outbound Transaction processes

OM2 Edit Claim/Encounter

Tier 4: Edit Claim/Encounter		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receive claim/encounter data set from the ***Inbound Transaction*** process 2. Determines its status as initial, adjustment to a processed claim/encounter (based on the resubmit flag with a previously assigned ICN), 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) 3. Validate that claim/encounter submission meets filing deadlines based on service dates. 4. Validate provider information in edited fields, e.g., provider taxonomy, NPI, enrollment status, approved to bill for this service 5. Validate member information in edited fields, e.g., Member's eligibility status on the date of service, apply Third party resources to the claim/encounter 6. Validate that service is covered by member's benefit package and apply appropriate rules. For example: a. Dental services may not be covered under an adult member benefit package so deny the claim b. A service is covered but the member is enrolled in another health plan that is primary so flag as COB so that claim will be denied (check that encounter was denied for this reason), and, under payer-to-payer model, a COB claim is sent to the primary payer. c. A service is covered and the member has another payer that is primary; however the service is required to be paid by Medicaid regardless, so flag as pay-and-chase in order that the provider will be paid and a pay-and-chase COB claim will be sent to the primary payer 7. Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status 8. Validate Correct Coding; apply DRG or APC Groupers; and bundle or unbundle codes. 9. Populate claim data set with state allowed payment amount 10. End: Send accepted claim/encounter data set to ***Audit Claim/Encounter*** process	

OM2 Edit Claim/Encounter

Tier 4: Edit Claim/Encounter		
Item	**Details**	**Links**
Shared Data	1. Provider Registry data: e.g., NPI, provider demographics, provider taxonomy 2. Member Registry data: e.g., member identifier, member demographic data, third party resources 3. Benefit Repository: e.g., covered services, units, life-time limits 4. Reference Repository: e.g., correct coding, valid code set versions, claims filing deadlines 5. Payment History Data Store: e.g., claim/encounter data set with same Patient Account Number 6. Payment History Repository: ICN of original claim/encounter being adjusted by subsequent claim/encounter adjustment submission	
Predecessor	1. ***Receive Inbound Paper/Phone/Fax*** process (if non-EDI claim/encounter) 2. ***Receive Inbound EDI*** process (if EDI claim/encounter)	Receive Inbound Transaction process
Successor	1. ***Audit Claim/Encounter*** process (if the claim/encounter data set is validated by the ***Edit Claim/Encounter*** process) 2. ***Prepare Remittance Advice/Encounter Report*** process (If the claim/encounter data set is rejected) 3. ***Apply Attachment*** process (if the claim data set is suspended with a request for additional information) 4. ***Prepare COB*** process (if third party resources identified)	Audit Claim/ Encounter, Apply Attachment, Prepare Remittance Advice/Encounter Report processes
Constraints	All claim/encounter types must go through most of the steps within the ***Edit Claim/Encounter*** process with some variance of business rules and data. Types include Institutional, Professional, Dental, Pharmacy, and Waiver claims/encounters; Medicare Crossover and Medicare Part D pharmacy claims, COB claims received from payers secondary to Medicaid, e.g., for IHS eligibles; TPL cost avoidance claims and “anticipated” pay-and-chase claims (those required to be paid because of service type). Editing variances include edits on services that may be billed by claim/encounter type and by provider taxonomy code; edits on service line codes; pricing; and the additional information that may be required. Editing of encounters may differ from claims because they are typically not priced, and the encounter format and coding rules may be set by managed care contracts and structured to meet MSIS reporting requirements.	

OM2 Edit Claim/Encounter

Tier 4: Edit Claim/Encounter		
Item	**Details**	**Links**
Constraints (Cont'd)	An adjustment to a claim/encounter is an exception use case to this E2E thread that follows the same process path except that it requires a link to the previously submitted and processed claim/encounter in order to reverse the original claim payment or encounter acceptance, and association of the original to the adjustment in the Payment History Repository.	
Failures	The ***Edit Claim/Encounter*** process contains a series of potential points of failure. The claim or encounter could fail any edit. Business rules define when one or more edit failures will result in suspending or denying the claim. **Edit Failures:** Claim/encounter data set has fatal edit error. For Example: 1. Duplicate claim/encounter data set is in production 2. Claim/encounter is filed after claim filing deadline 3. Claim/encounter data set has invalid member, provider, or coverage information 4. Service is not covered because not in benefit package, not provided in an approved facility or by an approved provider type 5. Service is not appropriate based on member demographics Edit Failure Result: Rejected claim/encounter data set and Edit error report are sent to the ***Prepare Remittance Advice/Encounter Report*** process **Suspended Claim/Encounter Failures:** Claim/encounter data set has missing or incorrect data that does not constitute a fatal edit error Result: Suspended claim/encounter data set and either: 1. Conduct Internal review to find missing or correct data 2. Request that the ***Outbound Transaction*** process send the submitter a notification of the Edit failure needing correction using, e.g., an Unsolicited 277 Claim Status Report transaction 3. Request that the ***Outbound Transaction*** process send the submitter a request for additional information using, e.g., the 277 Request for Additional Information transaction	Failure Notifications: Paper Remittance Advice; 835; Encounter Report to MCO; Unsolicited 277; 275 Request for Additional Information

OM2 Edit Claim/Encounter

Tier 4: Edit Claim/Encounter		
Item	**Details**	**Links**
Failures (Cont'd)	Suspended until the claim/encounter data set either: 1. Validated to pass the edit in question by internal review 2. Validated to pass the edit based on corrected information submitted in response to an error notification 3. Validated to pass the edit based on additional information submitted in response to a request, such as the 277 Request for Additional Information. Note that this request is generated as a data set by the ***Apply Attachment***, which will review the response to validate that the additional information submitted is sufficient to pass the edit. Suspended claim/encounter data sets that are resolved favorably are sent to the ***Audit Claims/Encounter*** process Suspended claims/encounters that are resubmitted as corrections are processed as if original Suspended claim/encounter data sets that are not resolved favorably are sent to the ***Prepare Remittance Advice/Encounter Report*** process with an Edit error report. These include failure because the additional information requested for a suspended claim/encounter is not received or is inadequate or fails to satisfy the edit. **TPL Failures** 1. Cost Avoidance TPL identified. Result: Rejected claim data set and Edit error report are sent to the ***Prepare Remittance Advice/Encounter Report*** and ***Prepare COB*** processes. Rejected Encounter data set is flagged because MCO should perform TPL 2. Prospective Pay and Chase TPL identified. Result: Claim data set is sent to the ***Audit Claim/Encounter*** and ***Prepare COB*** processes, Rejected Encounter data set is flagged because MCO should perform TPL	
Performance Measures	1. Time to complete Edit process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions on suspended claims/encounters = ___% 4. Error rate = __% or less	

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OM2 Price Claim/Value Encounter

Tier 4: Price Claim/Value Encounter		
Item	**Details**	**Links**
Description	The ***Price Claim/Value Encounter*** business process begins with receiving a claim/encounter data set from the ***Audit Claim/Encounter*** Process, applying pricing algorithms, calculates managed care and PCCM premiums, decrements service review authorizations, calculates and applies member contributions, and provider advances, deducts liens and recoupments. This process is also responsible for ensuring that all adjudication events are documented in the Payment History Repository from the ***Manage Payment History*** process and are accessible to all Business Areas. All Claim Types must go through most of the processes and sub-processes but with different logic. **NOTE:** An adjustment to a claim is an exception use case to this process that follows the same process path except it requires a link to the previously submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the Payment History Repository.	Business Process Model location:
Trigger Event	State-transition Trigger Event = The Trigger Event for the ***Price Claim/Value Encounter*** process begins with receipt of a data set from the ***Audit Claim/Encounter*** process. Temporal Trigger Event = Adjudication/Payment cycles are usually set at scheduled intervals, e.g., weekly, bi-weekly, or monthly.	Links to other E2E threads: Claim/Encounter Adjudication Process
Result	An edited and audited claims data set will be priced according to state specific business rules and 1. Loaded, along with any attachments to the ***Manage Payment History*** process 2. Sent to the ***Prepare Check/EFT/Encounter Report*** process	Links to other E2E threads: Manage Payment History Repository; Prepare Check/ EFT/Encounter Report Process
Business Process Steps	1. Start: Receive audited claim data set from the ***Audit Claim/Encounter*** process. 2. Apply pricing algorithm,% of charges, and reductions due to program etc to price loaded by Edit Process 3. Apply pricing algorithm to allowed amount such as percentage of charges or reductions due to state-only program	

OM2 Price Claim/Value Encounter

Tier 4: Price Claim/Value Encounter		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	4. Price Diagnosis Related Grouping(s) (DRGs) or Ambulatory Patient Classification(s) (APCs) based on contracted rates 5. Decrement service authorization units or total dollar coverage amount 6. Calculate and apply member contributions such as co-pays or spend-down 7. Calculate and apply provider advances, 8. Deducts liens and recoupments 9. End: Send to the a. ***Prepare Check/EFT/Encounter Report*** process for payment b. ***Prepare Remittance Advice/Encounter Reports*** process c. ***Manage Payment History*** process for loading.	
Shared Data	1. Provider Registry – query/response 2. Member Registry – query/response 3. Benefit/Reference Repository	
Predecessor	***Audit Claim/Encounter*** process.	
Successor	***Prepare Check/EFT/Encounter Report*** ***Prepare Remittance Advice/Encounter Reports*** and ***Manage Payment History*** processes.	
Constraints	The ***Price Claim/Value Encounter*** process must conform to state specific business rules and pricing algorithms.	
Failures	N/A	
Performance Measures	1. Time to complete the process: e.g., Real Time response = within __seconds, Batch Response = within __ hours 2. Accuracy with which the pricing algorithms are applied = __% 3. Consistency with which the pricing algorithms are applied = __% 4. Error rate = __% or less.	

OM2 Audit Claim/Encounter

Tier 4: Audit Claim/Encounter		
Item	**Details**	**Links**
Description	The ***Audit Claim/Encounter*** E2E business process receives a validated original or adjustment claim data set from the ***Edit Claim/Encounter*** process and Checks Payment History Repository for duplicate processed claims/encounters and life time limits Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity a Suspends data sets that fail audits for internal review, corrections, or additional information Sends successfully audited data sets to the ***Price Claim/Value Encounter*** process All claim/encounter types must go through most of the steps within the ***Audit Claim/Encounter*** process with some variance of business rules and data. See Constraints. **NOTE:** This E2E is part of a suite that includes: ***Edit Claim/Encounter***, ***Audit Claim/Encounter***, ***Price Claim/Value Encounter***, ***Apply Claim Attachment***, ***Price Claim/Value Encounter***, and ***Prepare Remittance Advice/Encounter*** processes.	Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Claim/Encounter Adjudication
Trigger Event	State-transition Trigger Event: A claim/encounter data set (received from ***Edit Claims/Encounter*** process.)	Links to previous E2E threads: Edit Process
Result	1. Successfully Audited claim/encounter data set (sent to the ***Price Claim/Value Encounter*** process) 2. Rejected claim/encounter data set and Audit error report (sent to the ***Prepare Remittance Advice/Encounter Report*** process) 3. Resolved suspended claim/encounter data set (If favorable, sent to the ***Price Claim/Value Encounter*** process. If unfavorable, sent with Audit error report to the ***Prepare Remittance Advice/Encounter Report*** process)	Links to other E2E threads: Price Claim/Value Encounter Prepare Remittance Advice/Encounter Report Send Outbound Transaction processes
Business Process Steps	1. Start: Receive claim/encounter data set from the ***Edit Claim/Encounter*** process 2. Check Payment History Repository for duplicate processed claims/encounters using search key data such as ICN, date of service, provider and member demographics, service, and diagnosis codes	

OM2 Audit Claim/Encounter

Tier 4: Audit Claim/Encounter		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	3. Check Payment History Repository for Life Time Limits for services, cost and units 4. For Claims: Verify Authorized Service (prior authorization) Number to ensure available units; validate relation to claim and appropriateness of service. For Encounters: Verify the appropriateness of the service authorization against the MCO contract, e.g., overly stringent service authorization requirement for EPSDT or maternity services that might indicate underutilization practices 5. Check Clinical Appropriateness of the services provided based on clinical, case and disease management protocols 6. Perform Prospective Payment Integrity Check 7. End: Send successfully audited claim/encounter data set to the ***Price Claim/Value Encounter*** process	
Shared Data	1. Provider Registry data: Used in performing prospective program Integrity e.g., HIPDB and Medicare/Medicaid sanctions 2. Member Registry data: e.g., member health status data for checking medical appropriateness of services 3. Benefit Repository: e.g., procedures requiring service authorization, units and funding limits for authorized services, life-time limit rules by benefit package 4. Payment History Repository: search key data such as ICN, date of service, provider and member demographics, service, and diagnosis codes	
Predecessor	***Edit Claim/Encounter*** process	Edit Claim/ Encounter process
Successor	1. ***Price Claim/Value Encounter*** process (if the claim/encounter data set successfully passes the ***Audit Claim/Encounter*** process) 2. ***Prepare Remittance Advice/Encounter Report*** process (If the claim/encounter data set is rejected) 3. ***Apply Attachment*** process (if the claim data set is suspended with a request for additional information)	Price Claim/Value Encounter, Apply Attachment, Prepare Remittance Advice/Encounter Report processes

OM2 Audit Claim/Encounter

Tier 4: Audit Claim/Encounter		
Item	**Details**	**Links**
Constraints	All claim/encounter types must go through most of the steps within the ***Audit Claim/Encounter*** process with some variance of business rules and data. Types include Institutional, Professional, Dental, Pharmacy, and Waiver claims/encounters; Medicare Crossover and Medicare Part D pharmacy claims, COB claims received from payers secondary to Medicaid, e.g., for IHS eligibles; TPL cost avoidance claims and "anticipated" pay-and-chase claims (those required to be paid because of service type). Auditing variances include audits on services	
Failures	The following steps can result in failure: Audit Failures: Claim/encounter data set has fatal audit error. For Example: 1. Duplicate Claims 2. Lack of Service Authorization 3. Invalidate relation to claim and appropriateness of service 4. Medically inappropriate claim/encounter services (based on clinical, case and disease management protocols) 5. Failed Prospective Payment Integrity Check, e.g., the provider is sanctioned by HIPDB, Medicare or Medicaid or the ***Monitor Performance and Business Activity*** process detects utilization outliers and alerts the ***Audit Claims/Encounter*** process. Suspended Claim/Encounter Failures: Claim/encounter data set has missing or incorrect data that does not constitute a fatal audit error Result: Suspended claim/encounter data set and either: 1. Conduct Internal review to find missing or correct data 2. Request that the ***Outbound Transaction*** process send the submitter a notification of the Audit failure needing correction using, e.g., an Unsolicited 277 Claim Status Report transaction 3. Request that the ***Outbound Transaction*** process send the submitter a request for additional information using, e.g., the 277 Request for Additional Information transaction	Failure Notifications: Paper Remittance Advice; 835; Encounter Report to MCO; Unsolicited 277; 275 Request for Additional Information

OM2 Audit Claim/Encounter

Tier 4: Audit Claim/Encounter		
Item	**Details**	**Links**
Failures (Cont'd)	Suspended until the claim/encounter data set either: 1. Validated to pass the audit in question by internal review 2. Validated to pass the audit based on corrected information submitted in response to an error notification 3. Validated to pass the audit based on additional information submitted in response to a request, such as the 277 Request for Additional Information. Note that this request is generated as a data set by the ***Apply Attachment***, which will review the response to validate that the additional information submitted is sufficient to pass the audit. Suspended claim/encounter data sets that are resolved favorably are sent to the ***Price Claims/Value Encounter*** process Suspended claims/encounters that are resubmitted as corrections are processed as if original Suspended claim/encounter data sets that are not resolved favorably are sent to the ***Prepare Remittance Advice/Encounter Report*** process with an Audit error report. These include failure because the additional information requested for a suspended claim/encounter is not received or is inadequate or fails to satisfy the audit.	
Performance Measures	1. Time to complete Audit process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Accuracy with which audits are applied = ___% 3. Consistency of decisions on suspended claims/encounters = ___% 4. Error rate = __% or less	

OM2 Apply Claim Attachment

Tier 4: Apply Claim Attachment		
Item	**Details**	**Links**
Description	This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) from the ***Edit Claim/Encounter*** or ***Audit Claim/Encounter*** process or has been sent by the provider (unsolicited) from the ***Receive Inbound Transaction*** process, linking it with a trace number to associated claim, stapling to a claim or pending the attachment data set for a predetermined time period set by edit and/or audit process rules, validating application level edits, determining if the data set provides the additional information necessary to adjudicate the claim, and if yes, moving the attachment with claim to the next adjudication process; if no, move to payment processing as a denied claim or trigger a request for additional information, and purging an attachment data set after a predetermined time period set by edit or audit process rules if no claim is found. **NOTE:** If no claim is found, the attachment data set is pended for a predetermined time period in accordance with state specific business rules. After this time period, the attachment data set is purged.	Business Process Model location: Tier 2: Payment Management Tier 3: Claim Encounter Adjudication
Trigger Event	Interaction-based Trigger Event: Receipt of attachment data set from the ***Receive Inbound Transaction*** process for either a solicited or unsolicited attachment transaction, e.g., the X12 275/HL7 Claims Attachment Transaction.	Links to previous E2E threads: Inbound Transaction Processing
Result	A validated attachment data set (from either a solicited X12 277 Request for Additional Information or unsolicited X12 275 Additional Information to Support a Health Care Claim/Encounter data set sent by the provider) from the ***Receive Inbound Transaction*** process that can be accepted and associated with a claim, or rejected, pended awaiting the receipt of a claim, or purged after a predetermined time. A solicited or unsolicited attachment that passes the Edit Process rules will move to the Audit Process. A solicited or unsolicited attachment that passes the Audit Process rules will move to the Pricing Process. An attachment that fails either will move to Payment Processing as a denied claim or trigger another request via e.g., an X12 277 Request for Additional Information.	Links to subsequent E2E threads: Adjudication Edit, Audit & Pricing

OM2 Apply Claim Attachment

Tier 4: Apply Claim Attachment		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receive attachment data set derived from attachment transaction such as the X12 275/HL7 Claims Attachment from the ***Receive Inbound Transaction*** Process 2. Link with trace number to associated claim when claim is found 3. When claim is found, validate application level edits such as provider, member, and benefit information, and association with previous submissions 4. Electronically staple to associated claim 5. Determine whether the attachment supplies the additional information as required by state business rules 6. If "yes" then move attachment along with claim to next ***Edit/Audit Adjudication*** Process, or ***Price Claim*** process, depending on where the information is being used. 7. If "no", then: a. Send request for additional information X12 277 through the ***Send Outbound Transaction*** (in which case steps 1 through 5 are repeated) or b. Deny the claim 8. End: An attachment data set that completes the edit/audit validation rules with either move to : a. ***Send Outbound Transaction*** as a paid or denied claim or b. ***Send Outbound Transaction*** X12 277 Request for Additional Information.	
Shared Data	1. Transaction Repository 2. Provider Registry 3. Member Registry 4. Benefit/Reference File	
Predecessor	***Receive Inbound Transaction***	
Successor	1. If attachment data meets the ***Edit/Audit Claim*** process then move to ***Price Claim*** process. 2. If the attachment information fails to meet the Edit or Audit rules, then either a. Request for additional information via an X12If the attachment information and move to ***Send Outbound Transaction*** Process b. Deny and move to ***Prepare Remittance Advice/Encounter Report*** process	

OM2 Apply Claim Attachment

Tier 4: Apply Claim Attachment		
Item	**Details**	**Links**
Constraints	The attachment data set must conform to the format and content in accordance with state specific reporting requirements, such as states' HIPAA companion guides and be submitted with valid data content that is required based on several criterion e.g., type of claim, type of service, provider type and member demographic. The attachment must be consistent with the associated original claim per state rules, and must also contain the correct data for this process to execute.	
Failures	N/A	
Performance Measures	Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours Accuracy with which attachments rules are applied or associated = __% Number of attachments = __% of total claims. (Processing a higher percentage of claims attachments may indicate that a state is able to utilize more clinical data when determining whether a claim meets state payment rules). Error rate of correctly re-associating attachment data = __% or less.	

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OM2 Apply Mass Adjustment

Tier 4: Apply Mass Adjustment		
Item	**Details**	**Links**
Description	The ***Apply Mass Adjustment*** business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with HCPCS, CPT, Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the claims by claim/bill type or HCPCS, CPT, Revenue Code(s), or member ID that were paid incorrectly during a specified date range, applying a predetermined set or sets of parameters that will reverse the paid claims and repay correctly. This business process often affects multiple providers as well as multiple claims. **NOTE:** This should not be confused with the claim adjustment adjudication process. A mass adjustment involves many claims within a range of dates submitted by multiple providers.	Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Claims and Encounter Adjudication
Trigger Event	**Interaction-based Trigger Event** Receipt or notification of retroactive rate or program changes from the ***Receive Inbound Transaction*** process.	Links to previous business processes: Receive Inbound Transaction Process
Result	The results of the ***Apply Mass Adjustment*** process are a validated mass adjustment data set (stream) that can be applied to claims.	Links to other E2E threads:
Business Process Steps	1. Start: Receipt or notification of retroactive rate, program changes or retroactive changes in member eligibility. 2. Identify the parameters necessary to locate claims 3. Enter parameters into system 4. Apply the predetermined set of parameters that will reverse the paid claims 5. Produce mass adjustment request report 6. Review the mass adjustment report for validity and accuracy 7. Produce the requested mass adjustment data set 8. End: Release mass adjustment for final payment and recoupments and send to the ***Send Outbound Transaction***	
Shared Data	Provider Registry Member Registry Transaction History File	These can be internal or external data stores.
Predecessor	***Receive Inbound Transaction*** process.	

OM2 Apply Mass Adjustment

Tier 4: Apply Mass Adjustment		
Item	**Details**	**Links**
Successor	***Edit, Audit, Price Claims/Encounters*** ***Prepare Claims/Encounters RA Data Set*** ***Manage Payment History***	
Constraints	The mass adjustment must correctly identify claims to be adjusted. Processes may vary by state.	
Failures	N/A	
Performance Measures	1. Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours 2. Accuracy with which edit, audit and pricing rules are applied = ___% 3. Error rate = ___% or less.	

OM3 Prepare Remittance Advice/Encounter Report

Tier 4: Prepare Remittance Advice/Encounter Report		
Item	**Details**	**Links**
Description	The ***Prepare Remittance Advice/Encounter Report*** business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the pricing, audit and edit processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the ***Send Outbound Transaction*** process for generation into an outbound transaction. The resulting data set is also sent to ***Manage Payment History*** for loading. **NOTE:** This process does not include sending the remittance advice/encounter EDI Transaction.	Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Payment Reporting
Trigger Event	State-transition Trigger Event: Receipt of the claims/encounter data sets from the ***Edit Claims/Encounters***, ***Audit Claims/Encounters***, and ***Price Claim/Value Encounter*** processes	Links to other processes: Price Claim/Encounter
Result	Remittance advice or encounter report data set is sent to the 1. ***Send Outbound Transaction*** Process for generation into an outbound transaction 2. ***Manage Payment History*** for loading 3. ***Manage Provider Information*** for loading	Links to other processes: Send Outbound Transaction Process Manage Payment History Manage Provider Information
Business Process Steps	1. Start: Receive data sets resulting from the pricing, audit and edit processes 2. Perform required data 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/encounter, such as bundling or unbundling of services 3. Format the results into required output data set 4. End: a. Send data set to the ***Send Outbound Transaction*** for generation into an outbound transaction b. Send data set to ***Manage Payment History*** for loading c. Send total reimbursement amount to the ***Manage Provider Information*** process to load in provider record for tax purposes	
Shared Data	***Price Claim/Value Encounter*** process	

OM3 Prepare Remittance Advice/Encounter Report

Tier 4: Prepare Remittance Advice/Encounter Report		
Item	**Details**	**Links**
Predecessor	***Send Outbound Transaction*** process	
Successor	1. Remittance Advice and Encounter Reporting Business Rules 2. Data sets output from the edit, audit and pricing processes	
Constraints	Remittance Advice/Encounter Reports must conform to the format and content in accordance with state specific reporting requirements, such as states' HIPAA companion guides and MSIS reporting requirements, which may differ based on situational fields that are determined by state policy.	
Failures	N/A	
Performance Measures	1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Accuracy with which remittance advice/encounter report rules are applied = ___% 3. Error rate = __% or less	

OM3 Prepare COB

Tier 4: Prepare COB		
Item	**Details**	**Links**
Description	The ***Prepare COB*** business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries. The ***Prepare COB*** business process begins with the completion of the ***Price Claim/Value Encounter*** process. Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria such as error codes and associated disposition, service codes, program codes, third party liability information available from both the original claim and/or eligibility files. This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, formatting of claims data into the outbound EDI data set, validating that the outbound EDI transaction is in the correct format and forwarding to the ***Send Outbound Transaction***.	Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Payment & Payment Reporting
Trigger Event	State-transition Trigger Event — Receipt of the claims data sets from the ***Price Claim/Value Encounter*** process.	
Result	Prepared COB data set is sent to the: 1. ***Send Outbound Transaction*** process for generation into an outbound transaction 2. Manage Payment History for loading	Links to other processes: 1. Send Outbound Transaction Process.
Business Process Steps	1. Start: Receive claims data from ***Price Claim/Value Encounter*** process. 2. Flag claim data sets to be moved to COB file for coordination of benefit activities. 3. Move flagged claims to COB file. 4. Generate the outbound transaction data set 5. Retrieve data stored from the original transaction. 6. Format the data into the required output data set 7. Send to a. ***Send Outbound Transaction*** process b. ***Manage Payment History*** for loading	
Shared Data	Member Registry Provider Registry Payment History Repository Trading Partner Data Base	
Predecessor	***Price Claim/Value Encounter*** process	
Successor	***Send Outbound Transaction*** process	

OM3 Prepare COB

Tier 4: Prepare COB		
Item	**Details**	**Links**
Constraints	***Prepare COB*** outbound transactions must adhere to state specific laws, regulations and requirements. These rules may differ by state.	
Failures	N/A	Failure Notifications
Performance Measures	1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less	

OM3 Prepare Home and Community-Based Services Payment

Tier 4: Prepare Home and Community-Based Services Payment		
Item	**Details**	**Links**
Description	Many home and community based services are not part of the traditional Medicaid benefit package. Services tend to be client specific and often are arranged through a plan of care. Services for Home & Community Based waivers are often rendered by a-typical providers and may or may not be authorized or adjudicated in the same manner as other health care providers. The ***Prepare Home and Community-Based Services Payment*** business process describes the preparation of the payment report data set. These will be sent on paper or electronically to providers and used to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the ***Send Outbound Transaction*** process for generation into an outbound transaction. The resulting data set is also sent to ***Manage Payment History*** process for loading into the Payment History Repository. The reimbursement amount is sent to the ***Manage Provider Information*** process for loading into the Provider Registry for purposes of accounting and taxes. **NOTE:** This process does not include sending the home & community based provider payment data set transaction.	Business Process Model Location: Operations Management Tier 2: Payment Management Tier 3: Payment Reporting
Trigger Event	State Transition Trigger Event: Receipt of the claims/encounter data sets from the ***Edit Claims/Encounters***, ***Audit Claims/Encounters***, and ***Price Claim/Value Encounter*** processes.	
Result	1. A pre-processed HCBS data set is sent to the ***Send Outbound Transaction*** for generation into an outbound transaction 2. ***Manage Payment History*** for loading. 3. ***Manage Provider Information*** for loading.	

OM3 Prepare Home and Community-Based Services Payment

Tier 4: Prepare Home and Community-Based Services Payment		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receive data sets resulting from the edit, audit, and pricing processes. 2. Perform required data 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/encounter, such as bundling or unbundling of services 3. Format the results into the required output data set 4. End: a. Send data set to ***Send Outbound Transaction*** for generation into an outbound transaction b. Send data set to ***Manage Payment History*** for loading c. Send total reimbursement amount to the ***Manage Provider Information*** process to load in provider record for tax purposes	
Shared Data	Provider Registry/Repository Member Registry/Repository Reference/Benefit Repository Payment History Repository Prior Authorization Repository Other Payer Repository	These are internal and external data stores
Predecessor	***Price Claim/Value Encounter*** process	
Successor	***Send Outbound Transaction*** process	
Constraints	The prepare home & community based services payment data set must conform to the format and content with state specific requirements which may differ by state.	
Failures	N/A	
Performance Measures	1. Time to complete the process: e.g., Real Time response = within __seconds, Batch Response = within __ hours 2. Accuracy with which the edit/audit/price claim rules are applied = __% 3. Consistency of decisions and disposition = __% 4. Error rate = __% or less	

OM3 Prepare EOB

Tier 4: Prepare EOB		
Item	**Details**	**Links**
Description	The ***Prepare EOB*** business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the explanation of benefits (EOBs), and processing returned EOBs to determine if the services claimed by a provider were received by the client. The EOBs or letters must be provided to the clients within 45 days of payment of claims. This process includes identifying sample data using random sampling methodology, retrieving the sample data set, preparing the Explanation of Benefits (EOBs) and/or notification letters, formatting the data into the required data set, which is sent to the ***Send Outbound Transaction*** for generation. The resulting data set is also sent to ***Manage Applicant and Member Communication***. **NOTE:** This process does not include the handling of returned data nor does it include sending the EOB Sample Data Set.	Business Process Model Location: Operations Management Tier 2: Payment Management Tier 3: Payment and Reporting
Trigger Event	**Temporal Trigger Event:** The EOB sample data sets are scheduled on a pre-determined timetable.	
Result	The EOB data set is sent to the client via the ***Send Outbound Transaction***.	
Business Process Steps	1. Start: Identify sample selection using random sampling methodology 2. Retrieve sample selection data. 3. Prepare the Explanation of Benefits and/or notification letters. 4. Format data into the required data set 5. End: a. Send data to the ***Send Outbound Transaction*** for generation b. Send data to ***Manage Applicant and Member Communication*** for tracking purposes.	
Shared Data	Member Registry Payment History	
Predecessor	This business process represents the point of entry.	
Successor	***Send Outbound Transaction*** ***Manage Applicant and Member Communication***	
Constraints	The policies and business rules for preparing the EOB sample data set differ by state	
Failures	N/A	

OM3 Prepare EOB

Tier 4: Prepare EOB		
Item	**Details**	**Links**
Performance Measures	1. Time to complete process: e.g., Real Time response = within __seconds, Batch Responses = within __ days 2. Accuracy of decisions = __% 3. Consistency of decisions and disposition = __% 4. Error rate = __% or less.	

OM3 Prepare Provider EFT/Check

Tier 4: Prepare Provider EFT/Check		
Item	**Details**	**Links**
Description	The ***Prepare Provider EFT/Check*** business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including: ■ Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, HCBS provider claims, and MCO encounters based on inputs such as the priced claim, including any TPL, crossover or member payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and taxes, performance incentives, recoupments, garnishments, and liens per data in the Provider Registry, Agency Accounting and Budget Area rules, including the ***Manage 1099*** process ■ Payroll processing, e.g., for HCBS providers, includes withholding payments for payroll, federal and state taxes, as well as union dues ■ Dispersement of payment from appropriate funding sources per Agency Accounting and Budget Area rules ■ Associating the EFT with a X12 835 electronic remittance advice transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the remittance advice within the banking system may not be HIPAA covered entities] ■ Routing the payment per the Provider Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction ■ Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history ■ Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate, e.g., Pharmacy POS	Business Process Model location: Operations Management Payment Management Payment and Reporting
Trigger Event	State-transition Trigger Event: Receipt of payment data from the Price Claim/Value Encounter process	Links to other processes: Price Claim/Value Encounter process
Result	Provider receives reimbursement, either by EFT or Check	Links to other processes:

OM3 Prepare Provider EFT/Check

Tier 4: Prepare Provider EFT/Check		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receipt of payment data from the Price Claim/Value Encounter process 2. Apply automated or user defined payment calculation rules such as deducting tax per rates in provider files, performance incentives, deduction of garnishments and liens, etc. by accessing data from provider files and generating data to be sent to the Perform Accounting Function process 3. For payroll processing, perform tax withholds and generate data for accounting 4. Disperse funds as specified by the Agency Accounting and Budget Area rules 5. Route payments as specified by the "pay to" instruction in the provider record 6. End: Update the Payment Information Repository, the Perform Accounting Function, and State Financial Management business processes with pending and paid claims transaction accounting detail	Each state will specify its data requirements and rules for each step
Shared Data	Priced claims data, provider demographic, tax, "pay to" instructions, routing instructions, liens, garnishments, adjustments, incentives; accounting rules, rates, funding sources	
Predecessor	Accounting and Budget Area, Manage Provider Information, Price Claim/Value Encounter; Monitor Performance and Business Activity processes	
Successor	Accounting and Budget Area, Manage Payment Information	
Constraints	States will apply different tax and accounting rules to this process; some will not do payroll processing or have performance incentives; some may associate EFTs with remittance advice transactions	
Failures	Calculation of payment and application of payment adjustments may lack accurate information or be performed inaccurately	Result messages
Performance Measures	1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	

OM3 Prepare Premium EFT/Check

Tier 4: Prepare Premium EFT/Check		
Item	**Details**	**Links**
Description	The ***Prepare Premium Capitation EFT/Check*** business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including ■ Calculation of – HIPP premium based on members' premium payment data in the Contractor Registry – Medicare premium based on dual eligible members' Medicare premium payment data in the Member Registry – PCCM management fee based on PCCM contract data re: difference reimbursement arrangements in the Contractor Registry – MCO premium payments based on MCO contract data re: different reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package in the Contractor Registry – Stop-loss claims payments for MCOs in the Contractor Registry ■ Application of automated or user defined adjustments based on contract, e.g., adjustments or performance incentives ■ Dispersement of premium, PCCM fee, or stop loss payment from appropriate funding sources per Agency Accounting and Budget Area rules ■ Associate the MCO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the Premium Payment within the banking system may not be HIPAA covered entities] ■ Routing the payment per the Contractor Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction ■ Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid premium, fees, and stop loss claims transaction accounting details, tying all transactions back to a specific contractual payment obligation and its history	Business Process Model location: Tier 1: Operations Management Tier 2: Payment Management Tier 3: Capitation and Premium Preparation

OM3 Prepare Premium EFT/Check

Tier 4: Prepare Premium EFT/Check		
Item	**Details**	**Links**
Description (Cont'd)	Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate	
Trigger Event	State-transition Trigger Event: Receipt of premium, fee or stop loss claim payment data from the Health Insurance Premium Payment, Prepare Medicare Premium Payment or Prepare Capitation Payment processes	Links to other processes: Health Insurance Premium Payment, Prepare Medicare Premium Payment or Prepare Capitation Payment processes
Result	Contractors receive reimbursement, either by EFT or Check	Links to other processes:
Business Process Steps	1. Start: Receipt of premium payment data from the Prepare Health Insurance Premium Payment, Prepare Medicare Premium Payment or Prepare Capitation Payment processes 2. Apply automated or user defined payment calculation rules such as risk adjustment and stop loss claims (based on contract, care management, and member data), retrospective enrollment (based on member eligibility data), performance incentives (based on Monitor Performance and Business Activity process data) 3. Disperse funds as specified by the Agency Accounting and Budget Area rules 4. Route payments as specified by the "pay to" instruction in the contractor or provider record 5. End: Update the Payment Information Repository, the Perform Accounting Function, and State Financial Management business processes with pending and paid premium, PCCM fee, or stop-loss transaction accounting detail	Each state will specify its data requirements and rules for each step
Shared Data	Premium, PCCM fee or stop-loss data, provider or contractor demographic, tax, "pay to" instructions, routing instructions, liens, garnishments, adjustments, incentives; accounting rules, rates, funding sources	
Predecessor	Accounting and Budget Area, and the Manage Provider and Contractor Information, Health Insurance Premium Payment, Prepare Medicare Premium Payment or Prepare Capitation Payment, and Monitor Performance and Business Activity processes	
Successor	Accounting and Budget Area, Manage Payment Information	

OM3 Prepare Premium EFT/Check

Tier 4: Prepare Premium EFT/Check		
Item	**Details**	**Links**
Constraints	States will apply different tax and accounting rules to this process; some will not have MCO premium, 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 accurate information or be performed inaccurately	Result messages
Performance Measures	1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	

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OM4 Prepare Health Insurance Premium Payment

Tier 4: Prepare Health Insurance Premium Payment		
Item	**Details**	**Links**
Description	Medicaid agencies are required to pay the private health insurance premiums for members who may have private health insurance benefits through their employers and because of devastating illness are no longer employable and become Medicaid eligible. It can also include children who are Medicaid eligible but also have private health insurance provided by a parent(s). In these circumstances, a cost effective determination is made and a premium is prepared and sent to the member's private health insurance company rather than enrolling them into a Medicaid managed health care plan or pay fee for service claims as submitted by providers. The ***Process Health Insurance Premium Payments*** business process begins by receiving eligibility information via referrals from Home and Community Services Offices, schools, community services organizations, or phone calls directly from members; checking for internal eligibility status as well as eligibility with other payers, editing required fields, producing a report, and notifying members. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. The formatted premium payment data set is sent to the ***Send Outbound Transaction*** for generation into an outbound transaction. The resulting data set is also sent *to* ***Manage Payment History*** for loading and ***Maintain Member Information*** for updating. **NOTE:** This process does not include sending the health insurance premium payment data set.	Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Capitation and Premium Payment
Trigger Event	**Temporal Trigger Event:** The insurance premium payments are scheduled on a pre-determined timetable, usually monthly.	
Result	The health insurance premium payments data set is sent to the ***Send Outbound Transaction*** for generation into an outbound transaction and to ***Manage Payment History*** for loading and ***Maintain Member Information*** for updating.	Links to other business processes: Send Outbound Transaction Manage Payment History Maintain Member Information

OM4 Prepare Health Insurance Premium Payment

Tier 4: Prepare Health Insurance Premium Payment		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receive referral information 2. Check internal and external eligibility information 3. Edit eligibility information 4. Produce a report identifying individuals where paying premiums would be cost effective 5. Produce Member notifications 6. Format the payment report/list 7. End: a. Send data set to the ***Send Outbound Transaction*** for generation into an outbound transaction b. Send data to ***Manage Payment History*** for loading c. Send data to ***Maintain Member Information*** for updating.	
Shared Data	Member Registry Payment History	These are internal and external data stores
Predecessor	***Receive Inbound Transaction***	
Successor	***Send Outbound Transaction***	
Constraints	Health Insurance Premium Payments must adhere to state specific laws, regulations and requirements. These rules will differ by state.	
Failures	N/A	Result messages
Performance Measures	1. Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours 2. Accuracy with which rules are applied =___% 3. Error rate =___% or less	

OM4 Prepare Medicare Premium Payment

Tier 4: Prepare Medicare Premium Payment		
Item	**Details**	**Links**
Description	State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process State Medicaid agencies, the Social Security Administration (SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance. The ***Prepare Medicare Premium Payments*** business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member registry, generating buy-in files for CMS for verification, formatting the premium payment data into the required output data set, which is sent to the ***Send Outbound Transaction***. The resulting data set is also sent *to* ***Manage Payment History*** and ***Manage Member Information*** for loading. **NOTE:** This process does not include sending the Medicare premium payments EDI transaction.	Business Process Model Location: Operations Management Tier 2: Payment Management Tier 3: Capitation and Premium Processing
Trigger Event	**State-transition Trigger Event:** The receipt of Medicare eligibility data from the ***Receive Medicare Dual Eligible Data*** process. **Temporal Trigger Event:** The receipt of Medicare eligibility data may be at scheduled intervals stipulated by Trading Partner Agreement.	Links to other processes: Inbound EDI Transactions
Result	Pre-processed data set is sent to the 1. ***Send Outbound Transaction*** process for generation into an outbound transaction 2. ***Manage Payment History*** for loading 3. ***Manage Member Information*** for loading.	Links to other processes: 1. Send Outbound Transaction 2. Manage Payment History 3. Manage Member Information

OM4 Prepare Medicare Premium Payment

Tier 4: Prepare Medicare Premium Payment		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receive State Data Exchange (SDX) and Beneficiary Data Exchange (BENDEX) eligibility files from the ***Receive Medicare Dual Eligible*** business process. 2. Perform a matching process against the Medicaid member registry. 3. Generate two-part buy-in file, one for Medicare Part A and one Medicare Part B 4. Send buy-in file to CMS 5. Receive CMS responses to the buy-in file 6. Process CMS responses to the buy-in file, assessing the file for accuracy and completeness 7. Post buy-in changes to the MMIS member information 8. Produce buy-in reports reflecting potential Medicare eligibles including any additions or deletions to existing eligibility registry as well as other problems 9. Send reports reflecting potential Medicare eligibles, unmatched, and other problems to the Buy-in Administration 10. Research unmatched and problems items to determine appropriate eligibility 11. Update and correct final Medicare buy-in file 12. Verify whether co-insurance and deductible payments are required in addition to the premiums 13. Produce notification to member 14. Format the payment data set 15. End: Send data set to the: a. ***Send Outbound EDI*** for generation into b. ***Send Medicare Premium Payment*** c. ***Manage Payment History*** for loading d. ***Manage Applicant and Member Communication***	
Shared Data	Member Registry Medicare Dual Eligible data	These are internal and external data stores
Predecessor	***Receive Medicare Dual Eligible***	
Successor	***Send Outbound Transaction***	
Constraints	The ***Prepare Medicare Premium Payments*** business process must adhere to the State policies and business rules that may differ by state.	
Failures	N/A	

OM4 Prepare Medicare Premium Payment

Tier 4: Prepare Medicare Premium Payment		
Item	**Details**	**Links**
Performance Measures	1. Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours 2. Accuracy with which rules are applied =___% 3. Consistency with which rules are applied=___% 4. Error rate =___% or less.	

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OM4 Prepare Capitation Premium Payment

Tier 4: Prepare Capitation Premium Payment		
Item	**Details**	**Links**
Description	The ***Prepare Capitation Premium Payment*** business process includes premiums for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the ***Maintain Member Information***, retrieving the rate data associated with the plan from the ***Manage Provider Information***, formatting the payment data into the required data set, which is sent to the ***Send Outbound Transaction*** for generation into an outbound transaction. The resulting data set is also sent to ***Manage Payment History*** for loading and ***Manage Provider Information*** for updating. **NOTE:** This process does not include sending the capitation payment data set.	Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Capitation and Premium Processing
Trigger Event	**Temporal Trigger Event:** The preparing capitation payment data set is scheduled on a pre-determined timetable, usually monthly.	
Result	The prepared capitation payment data set is sent to the ***Send Outbound Transaction*** for generation into an outbound transaction and to ***Manage Payment History*** for loading and to ***Manage Provider Information*** for updating.	
Business Process Steps	1. Start: Timetable for scheduled payment 2. Retrieve enrollment 3. Retrieve benefit transaction data 4. Retrieve rate data associated with the contracted plan, PCCM or other capitation program 5. Run algorithms for determining specific capitated rates for individual enrollees. 6. Concatenate rate totals if sending summary premium payment (**NOTE:** This step is may not be applicable.) 7. Format the data into the required data set 8. End: a. Send data set to the ***Send Outbound Transaction*** for generation into an outbound transaction b. Send data to ***Manage Payment History*** for loading c. Send data to ***Manage Provider Information*** for updating	
Shared Data	Member Registry Provider (Health Plan) Registry Payment History	May be maintained internally or externally

OM4 Prepare Capitation Premium Payment

Tier 4: Prepare Capitation Premium Payment		
Item	**Details**	**Links**
Predecessor	Member is enrolled into a Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs	
Successor	***Send Outbound Transaction***	
Constraints	Preparation of the capitation payment data set must adhere to state specific requirements. These rules will differ by state.	
Failures	N/A	
Performance Measures	1. Time to complete process: e.g., Real Time response = within __seconds, Batch Response = within __ hours 2. Accuracy with which rules are applied = __% 3. Error rate = __% or less	

OM5 Manage Payment Information

Tier 3: Manage Payment Information		
Item	**Details**	**Links**
Description	The ***Manage Payment Information*** business process is responsible for managing all the operational aspects of the Payment Information Repository, which is the source of comprehensive information about payments made to and by the state Medicaid agency for healthcare services. The Payment Information Repository exchanges data with Operations Management business processes that generate payment information at various points in their workflow. These processes send requests to the Payment Information Repository to add, delete, or change data in payment records. The Payment Information Repository validates data upload requests, applies instructions, and tracks activity. In addition to Operations Management business processes, the Payment Information Repository provides access to payment records to other Business Area applications and users, such as the Manage Program, Member, Contractor, and Provider Information processes, via record transfers, response to queries, and "publish and subscribe" services.	Business Process Model location: Tier 1: Operations Management Tier 2: Payment Information Management
Trigger Event	1. State transition trigger event: Receipt of request to add, delete, change Payment information from a. Operations Management Business Area processes: Manage Payment Information (e.g., claims/encounters, COB, TPL, cost recoveries, HIPP, and service authorization), Calculate Spend-down, or Process Member Premium Invoice b. Care and Program Integrity Management Manage Repository processes 2. Interaction-based Trigger Event: Receipt of a query about data in one or more payment records from enterprise business processes, or from authorized external parties, e.g., for payment status verification. 3. Environmental Trigger Event: Scheduled transmission of data in payment information records or pointers to payment information on a periodic or real time basis to the Manage Program Information business process. Rule based transmission of payment information data or pointers to public health for bio-surveillance and to Program Integrity Identify Case process.	Links to other processes: All Operations Management business processes plus: Program Management, Care Management, and Program Integrity Management

OM5 Manage Payment Information

Tier 3: Manage Payment Information		
Item	**Details**	**Links**
Result	The Payment Information Repository is loaded with new or updated payment information for the purposes of: 1. Responding to queries from authorized users and applications 2. Supplying all other Operations Management Area business processes with payment information as needed to, e.g., detect duplicate claims or encounters; to check lifetime, yearly, or prior authorized service limitations etc. 3. Supplies all Business Area processes with payment information needed to e.g., manage communications, perform outreach and education, manage contracts, etc. 4. Sends records or pointers to the Manage Program Information business process	Links to other processes: All Operations Management Area business processes Program Management Business Area Manage Program Information business process
Business Process Steps	1. Start: Receives data from Operations Management Area business processes 2. Loads data into the Payment Information Repository, building new records and updating, merging, unmerging, or deleting previous records as appropriate 3. Provides access to records as required by Payment Management Area business processes workflow 4. Provides access to records as requested by authorized business processes and users, e.g., the Verify Payment Status process and Program Integrity Identify Case process 5. Provides data to the Manage Program Information business process on a real time or periodic basis in update or snapshot mode 6. End: Archive data in accordance with state and federal record retention requirements	Each state will specify its data requirements and rules for each step
Shared Data	■ Claims and encounter adjudication log, edit and audit exceptions, claim attachment, and claims limitations data from the Claims/Encounter Adjudication business process e.g., each claim's disposition in the current adjudication cycle to afford a complete audit trail of the claim's processing path from time of receipt to adjudication ■ Premium and capitation request processing log, exceptions, and payment data from the Capitation and Premium Preparation Business Area ■ Claims and HCBS payment, encounter reporting, COB claims, data, and EFT/check preparation and transmittal data from the Payment and Reporting Business Area	
Predecessor	Any Operations Management business process required to store processing or output data	

OM5 Manage Payment Information

Tier 3: Manage Payment Information		
Item	**Details**	**Links**
Successor	All Operations Management Area processes when workflow requires retrieval of payment information; other enterprise processes needing to retrieve payment information directly rather than through the Manage Program Information business process; Manage Program Information business process	
Constraints	Managing the payment information business rules will differ by state.	Business rules differ by state
Failures	Inability or failure to load initial records or update data in existing records in the Payment Information Repository.	
Performance Measures	1. Time to complete the process = within __ hours. 2. Accuracy with which updates are applied 3. Consistency with which updates are applied 4. Error rate = __%	

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OM5 Inquire Payment Status

Tier 3: Inquire Payment Status		
Item	**Details**	**Links**
Description	The ***Inquire Payment Status*** business process begins with receiving a 276 Claim Status Inquiry or via paper, phone, fax or AVR request for the current status of a specified claim(s), calling the payment history data store and/or repository, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response, and sending claim status response data set via the ***Send Outbound Transaction*** process.	Business Process Model location: Operations Management; Tier 1: Payment Management; Tier 2: Payment Information Management
Trigger Event	Interaction-based Trigger Event: Receipt of the X12 276 Claim Status Inquiry data set from the ***Receive Inbound Transaction*** process.	
Result	The payment status request data set is sent to the ***Send Outbound Transaction*** process.	
Business Process Steps	1. Start: Receives 276 claim status inquiry (similar claim status information can be requested via paper, phone, fax and AVR) 2. Retrieves the payment status information from ***Manage Payment History*** (run-time environment) and payment history data repository (persistent data) to obtain required requested data elements (e.g., recipient birth date, recipient gender, recipient last name, recipient first name, member ID, trace number, total claim charge amount, claim service date, ICN number, bill type identifier, medical record number, claim account number) 3. Captures the required claim status responses data 4. Formats the data into the 277 Claim Status Response 5. End: Sends the response data set to the ***Send Outbound Transaction*** process	Business rules vary by state
Shared Data	***Manage Payment History***	These are internal and external data stores
Predecessor	***Receive Inbound Transaction***	
Successor	***Send Outbound Transaction***	
Constraints	Payment Status Inquiry and Response must conform to the format and content in accordance with state specific requirements, such as states' HIPAA companion guides which may differ based on situational fields that are determined by state policy.	Business rules differ by state
Failures	N/A	

OM5 Inquire Payment Status

Tier 3: Inquire Payment Status		
Item	**Details**	**Links**
Performance Measures	1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Accuracy with which payment status rules are applied = __% 3. Consistency with which payment status rules are applied = __% 4. Error rate = __% or less.	

OM6 Calculate Spend-Down Amount

Tier 3: Calculate Spend-Down Amount		
Item	**Details**	**Links**
Description	A person that is not eligible for medical coverage when they have income and/or resources above the benefit package or program standards may become eligible for coverage through a process called "spend-down" (see Determine Eligibility). The ***Calculate Spend-Down Amount*** business process describes the process by which spend-down amounts are tracked and a client's responsibility is met through the submission of medical claims. Excess resources are automatically accounted for during the claims processing process resulting in a change of eligibility status once spend-down has been met which allows for Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels, but may also occur in other situations. The ***Calculate Spend-Down Amount*** business process begins with the receipt of member eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the member is assigned to a benefit package or program that requires a predetermined amount the member must be financially responsible for prior to Medicaid payment for any medical services. **NOTE:** The 'Calculate Spend-down Amount' today is primarily a manual process in the Eligibility Determination, Member Payment Management and Maintain Payment History threads. At Level 3 these processes have almost eliminated any use of manual intervention.	Business Process Model location: Operations Management Tier 2: Member Payment Management
Trigger Event	**State-transition Trigger Event** = member data set.	
Result	***Maintain Member Information***	
Business Process Steps	1. Start: Receive member eligibility data, including spend-down amount 2. Perform a matching process to identify the appropriate member file 3. Load eligibility data	

OM6 Calculate Spend-Down Amount

Tier 3: Calculate Spend-Down Amount		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	4. Receive claim information 5. Monitor and subtract medical claim amounts from spend-down to insure member responsibility is met. Once spend-down is met 6. Change eligibility status to active 7. End: Send notification that spend-down has been met via the ***Send Outbound Transaction*** process to ***Manage Applicant and Member Communication*** and to ***Maintain Member Information*** for loading.	
Shared Data	Member Registry Payment History Data	These may be stored internally or externally
Predecessor	Determine Member Eligibility	Eligibility Determination
Successor	Send notification to member that spend-down has been met through ***Manage Applicant and Member Communication*** and update ***Maintain Member Information***	Member Information Management
Constraints	The calculate spend-down must conform to the state specific policies which may differ by state.	Business rules differ by state
Failures	N/A	
Performance Measures	1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within__ hours 2. Accuracy with which rules are applied 3. Consistency of decisions and disposition = __% 4. Error rate = __% or less	

OM6 Prepare Member Premium Invoice

Tier 3: Prepare Member Premium Invoice		
Item	**Details**	**Links**
Description	Due to tightening budgets and an ever-increasing population that is covered under the Medicaid umbrella, States began client/member cost-sharing through the collection of premiums for medical coverage. The premium amounts are based 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 process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium invoices which will be sent to the ***Send Outbound Transaction*** process for generation into an outbound transaction. The resulting data set is also sent to ***Maintain Member Information*** process for updating. **NOTE:** This process does not include sending the member premium invoice EDI transaction.	Business Process Model location: Tier 1: Operations Management: Tier 2: Member Payment Management
Trigger Event	**Temporal Trigger Event:** This trigger event is a monthly timetable for scheduled invoicing.	
Result	A pre-processed member premium invoice data set is sent to the ***Send Outbound Transaction***	Operations Support Send Outbound Transactions
Business Process Steps	1. Start: Monthly timetable for scheduled invoicing 2. Retrieve member premium data 3. Perform required data manipulation 4. Format the results into required output data set 5. Produce member invoice data 6. End: Send data set to the a. ***Send Outbound Transaction*** for generation into an outbound transaction b. Send data to ***Maintain Member Information***	
Shared Data	1. Member Registry	These are internal and external data stores
Predecessor	N/A	
Successor	***Perform Accounting Function***	
Constraints	The Prepare Member Premium process must conform to the state specific requirements.	Business rules differ by state
Failures	N/A	

OM6 Prepare Member Premium Invoice

Tier 3: Prepare Member Premium Invoice		
Item	**Details**	**Links**
Performance Measures	1. Time to complete process: e.g., Real Time response = within __seconds, Batch Responses = within __ days 2. Accuracy of decisions = __% 3. Consistency of decisions and disposition = __% 4. Error rate = __% or less.	

OM7 Manage Recoupment

Tier 3: Manage Recoupment		
Item	**Details**	**Links**
Description	The ***Manage Recoupment*** business process describes the process of managing provider recoupment. Provider recoupment are initiated by the discovery of an overpayment as the result of a provider utilization review audit, receipt of a claims adjustment request, for situations where monies are owed to the agency due to fraud/abuse, and the involvement of a third party payer. The E2E business thread begins with discovering the overpayment, retrieving claims payment data from the ***Manage Claims History***, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results from the ***Manage Provider Communication***, applying refund in the system from the ***Perform Accounting Functions***, and monitoring payment history until the repayment is satisfied. Recoupments can be collected via check sent by the provider or credited against future payments for services.	Business Process Model location: Tier 1: Operations Management Tier 2: Cost Recoveries
Trigger Event	Interaction-based Trigger Event. This trigger event is the result of a Provider submitting a request for claim adjustment from the ***Claims/Encounter Adjudication***. State-transition Trigger Event. This trigger event is the result of a provider utilization review audit and/or for fraud/abuse from the ***Identify, Establish, or Manage Case***.	Fraud Detection; Inbound EDI Process; Inbound Paper/Phone/Fax Process
Result	Receivables data is sent to ***Perform Accounting Functions*** and ***Manage Payment History***.	Perform Accounting Functions; Manage Payment History
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 data 3. Initiate recoupment request 4. Notify provider of amount owed and agreed upon method of repayment 5. Apply refund in the system 6. End: Monitor payment history until repayment is satisfied	
Shared Data	Payment History Repository Provider Registry	These are internal and external data stores

OM7 Manage Recoupment

Tier 3: Manage Recoupment		
Item	**Details**	**Links**
Predecessor	***Inbound EDI Transaction*** Process ***Inbound Paper/Phone/Fax*** Process ***Identify Case, Establish Case, Monitor Case***	Inbound EDI Transaction Process Inbound Paper/Phone/Fax Transaction Process; Program Integrity Identify Case
Successor	***Perform Accounting Functions*** ***Manage Payment History***	Perform Accounting Functions; Maintain and Manage Payment History
Constraints	Policies and procedures differ by state Integration of the MMIS with state accounting systems can greatly impact the ability of the state to track receivables established by the recoupment.	Business rules differ by state
Failures	N/A	
Performance Measures	1. Time to complete provider recoupment process: e.g., Real Time response = within ___seconds, Batch Response = within ___hours 2. Accuracy with which recoupments are applied = ___ % 3. Consistency of decisions on suspended claims/encounters = ___% 4. Error rate = ___% or less.	

OM7 Manage Estate Recovery

Tier 3: Manage Estate Recovery		
Item	**Details**	**Links**
Description	Estate recovery is a process whereby States are required to recover certain Medicaid benefits correctly paid on behalf of an individual. This is done by the filing of liens against a deceased member'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, ICF/MR, or other medical institution. The ***Manage Estate Recovery*** business process begins by receiving estate recovery data from multiple sources (e.g., date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), generating correspondence data set (e.g., demand of notice to probate court via ***Send Outbound Transaction*** process, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the ***Manage Applicant and Member Communication*** process, opening formal estate recovery case based on estate ownership and value of property, determining value of estate lien, files petition for lien, files estate claim of lien, conducts case follow-up, sending data set to ***Perform Accounting Functions***, releasing the estate lien when recovery is completed, updating Member Registry, and sending to ***Manage Payment History*** for loading. **NOTE:** This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.	Business Process Model location: Tier 1: Operations Management; Tier 2: Cost Recoveries
Trigger Event	State-transition Trigger Event: Receipt of estate recovery data from ***Receive Inbound Transaction*** process, paper, phone, or fax.	Links to other E2E threads: Receive Inbound Transaction.
Result	Manage Estate Recover y data is sent to 1. ***Perform Accounting Functions*** process 2. ***Maintain Member Information*** process 3. ***Manage Payment History*** for loading.	Links to other E2E threads: Manage Payment History Perform Accounting Functions Maintain Member Information

OM7 Manage Estate Recovery

Tier 3: Manage Estate Recovery		
Item	**Details**	**Links**
Business Process Steps	1. Start: Estate recovery referral data is received via several different sources (e.g., date of death match, probate petition notices, eligibility case worker, nursing homes) 2. Demand notice data is sent to Member Correspondence (e.g., onto probate court) 3. Estate recovery Questionnaire data is sent to ***Manage Applicant and Member Correspondence*** (e.g., onto deceased representative) 4. Estate recovery Case is opened 5. Value of estate lien is determined by analyzing all Medicaid claims from age 55 forward (e.g., all paid claims equals lien amount) 6. Estate recovery proceedings data generated (e.g., lien petition, notice of pendency action) and sent to the ***Send Outbound Transaction*** process 7. Upon court approval, estate claim of lien is filed 8. Case follow-up occurs (every 30 to 90 days) 9. Estate recovery payment receipt data is sent to the ***Perform Accounting Functions*** process and ***Maintain Member Information*** process. 10. End: Estate recovery case file is closed and archived upon receipt of full payment and ***Manage Payment History*** for loading.	
Shared Data	Member Registry Payment History Repository	These are internal and external data stores
Predecessor	***Receive Inbound Transaction*** process	
Successor	***Send Outbound Transaction*** process	
Constraints	The Manage Estate Recovery process must be in accordance with state specific policy.	Business rules differ by state
Failures	N/A	
Performance Measures	1. Time to complete the process __. 2. Accuracy with which rules are applied = __% 3. Consistency with which rules are applied = __% 4. Error rate = __% or less 5. Total $ amount received through estate recoveries.	

OM7 Manage TPL Recovery

Tier 3: Manage TPL Recovery		
Item	**Details**	**Links**
Description	The ***Manage TPL Recoveries*** business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, Attorney's, SUR, Fraud and Abuse units, providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from ***Manage Payment History***, creating post-payment recovery files, sending notification data to other payer or provider from the ***Manage Provider Communication*** process, receiving payment from provider or third party payer, sending receivable data to ***Perform Accounting Function***, and updating payment history ***Manage Payment History***. **NOTE:** States are generally required to cost avoid claims unless they have a waiver approved by CMS which allows them to use the pay and chase method.	Business Process Model location: Tier 1: Operations Management; Tier 2: Cost Recoveries
Trigger Event	Interaction-based Trigger Event: Receipt of third party liability data from outside sources, and internal and external eligibility data matches from ***Verify Member Eligibility***.	Links to other E2E threads: Operations Support Tier 1: Transaction Processing
Result	TPL recovery data is sent to the: 1. ***Perform Accounting Function*** process 2. ***Manage Payment History*** process	Links to other E2E threads: Maintain Payment History Perform Accounting Functions
Business Process Steps	1. Start: Receive third party liability data 2. Identify the provider or TPL carrier 3. Locate recoverable claims 4. Create post-payment recovery files 5. Send notification to provider or other payer 6. Receive payment from provider or third party payer 7. End: a. Send receivables data to the ***Perform Accounting Functions***. b. Send data set to ***Manage Payment History***	

OM7 Manage TPL Recovery

Tier 3: Manage TPL Recovery		
Item	**Details**	**Links**
Shared Data	Member Registry Provider Registry Carrier Data Other Agency Data – DMV, Veterans Administration Indian Health Service INS Fraud case file	
Predecessor	Receipt of third party liability data from outside sources and/or internal or external data matches from ***Verify Member Eligibility***.	
Successor	Maintain Payment History Perform Accounting Functions	Manage/Maintain Payment History Perform Accounting Functions
Constraints	States differ in the rules applied to TPL recoveries. Capabilities related to data matches vary and some states utilize recovery services contractors. Integration of state eligibility information systems with the MMIS also has significant impact on their ability to cost avoid versus cost recover.	Business rules differ by state
Failures	N/A	
Performance Measures	Time to complete process Consistency with which rules are applied. Accuracy with which rules are applied. Total dollars recovered	

OM7 Manage Drug Rebate

Tier 3: Manage Drug Rebate		
Item	**Details**	**Links**
Description	The ***Manage Drug Rebate*** business process describes the process of managing drug rebate that will be collected from manufacturers. The process begins with receiving quarterly drug rebate data from CMS and includes receiving quarterly drug rebate data from CMS, comparing it to quarterly payment history data, identifying drug data matches based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the drug manufacturer via the ***Send Outbound Transaction*** Process sending to ***Perform Accounting Functions***.	Business Process Model location: Tier 1: Operations Management; Tier 2: Cost Recoveries
Trigger Event	Temporal Trigger Event = Receipt of the CMS quarterly drug rebate data set from the ***Receive Inbound Transaction*** process.	Links to other E2E threads: Receive Inbound Transaction data set
Result	Drug rebate invoice data set is sent to the 1. ***Send Outbound Transaction*** process for generation into an outbound transaction. 2. Drug rebate receivables data is sent to the ***Perform Accounting Functions*** process 3. ***Manage Payment History*** process for loading	Links to other E2E threads: 1. Manage Payment History 2. Perform Accounting Functions 3. Send Outbound Transaction
Business Process Steps	1. Start: The State receives a quarterly file from CMS containing the rebate factors by manufacturer, drug code, and volume 2. The file is compared to the corresponding claims history extract for the same quarter. 3. Drug claims matching the manufacturer and drug codes on the CMS files are selected. 4. Drug claims selected for invoice processing are sorted by manufacturer and drug code.	Business rules vary by state

OM7 Manage Drug Rebate

Tier 3: Manage Drug Rebate		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	5. The rebate factor and volume indicators are applied to calculate a rebate total per manufacturer. 6. The invoice data is generated 7. End: Invoice data set is sent to the a. ***Send Outbound Transactions*** process where it is sent to the manufacturer b. ***Perform Accounting Functions*** to prepare for rebate payment from manufacturer c. ***Manage Payment History*** process for loading	
Shared Data	CMS Unit Rebate Amount (URA) Data Payment History Drug Code Data Manufacturer Data	These are internal and external data stores
Predecessor	***Receive Inbound Transaction*** process	
Successor	***Send Outbound Transaction*** process Prepare Accounting Functions process ***Manage Payment History*** process	E2E threads:
Constraints	The Manage Drug Rebate process must be in accordance with state specific drug formulary, business rules and reporting requirements which may differ by State.	Business rules differ by state
Failures	N/A	
Performance Measures	1. Time to complete the process. 2. Accuracy with which the Drug Rebate rules are applied = __% 3. Consistency with which the Drug Rebate rules are applied = __% 4. Amount of drug rebate received quarterly 5. Error rate = __% or less.	

OM7 Manage Settlement

Tier 3: Manage Settlement		
Item	**Details**	**Links**
Description	The ***Manage Settlement*** business process begins with requesting annual claims summary data from ***Manage Payment History***, 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 data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates, sending the cost settlement data set via the ***Send Outbound Transaction*** process to ***Manage Provider Communication***, ***Manage Payment History***, ***Manage Rate Setting*** and sending receivables data to ***Perform Accounting Functions***, and tracking settlement payments.	Business Process Model location: Tier 1: Operations Management; Tier 2: Cost Recoveries
Trigger Event	State-transition Trigger Event: Receipt of provider costs from claims history repository and receipt of Medicare Cost Report. Temporal or Rule-based Trigger Event: Prompt for annual provider cost review.	Links to other E2E threads:
Result	1. Data set with determination of cost settlement data as calculated, reviewed and modified is sent via the ***Send Outbound Transaction*** to ***Manage Provider Communication*** and ***Perform Accounting Functions***.	Provider Support: Prepare Outgoing Information
Business Process Steps	1. Start: Request annual claims summary data 2. Review provider costs 3. Establish a basis for cost settlements or compliance reviews 4. Receive audited Medicare Cost Report from intermediaries from ***Receive Inbound Transaction*** 5. Receive provider cost settlement data from ***Receive Inbound Transaction***. 6. Capture the necessary provider cost settlement data 7. Calculate the final annual cost settlement based on the Medicare Cost Report and prorating for Medicaid services 8. Establish interim reimbursement rates	

OM7 Manage Settlement

Tier 3: Manage Settlement		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	9. Generate cost settlement data identifying the amount of overpayment or underpayment and the reimbursement rates to be considered for the next year 10. Verify the data is correct 11. Produce notifications to providers 12. Send claims summary data via the ***Send Outbound Transaction*** to ***Manage Provider Communication***, to ***Perform Accounting Functions***, to ***Manage Payment History***, and to ***Manage Rate Setting***. 13. End: Track cost settlement data until receivable or payable is satisfied.	
Shared Data	Payment History Repository Provider Registry	These are internal and external data stores
Predecessor	Receipt of provider cost reports and Medicare Cost Report	E2E thread:
Successor	1. ***Manage Provider Communication*** 2. ***Perform Accounting Functions*** 3. ***Manage Payment History*** 4. ***Manage Rate Setting***	E2E threads:
Constraints	Cost Settlement data must conform to state specific reporting requirements and MSIS reporting requirements.	Business rules differ by state
Failures	N/A	
Performance Measures	Time to complete the process. Consistency with which rules are applied Accuracy with which rules are applied Amount of overpayment Amount of underpayment	

Program Management

PG1 Designate Approved Service/Drug Formulary

Tier 3: Designate Approved Service/Drug Formulary		
Item	**Details**	**Links**
Description	The ***Designate Approved Services/Drug Formulary*** business process begins with a review of new and/or modified service codes or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package. Service, supply and drug codes are reviewed by a team of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the 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 must be met. Review includes the identification of any changes or additions needed to regulations, policies, and 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. **NOTE:** This does not include implementation of ***Approved Service/Formulary***.	Business Process Model location: Tier 1: Program Management Tier 2: Benefit Administration
Trigger Event	**State transition based Trigger Event:** Receipt of Benefit Package information from ***Develop and Maintain Benefit Package***. **Temporal Trigger Event:** Annual, Bi-annual, Quarterly or other review of newly established or modified services codes and National Drug Codes as published by maintainers of medical codes.	

PG1 Designate Approved Service/Drug Formulary

Tier 3: Designate Approved Service/Drug Formulary		
Item	**Details**	**Links**
Result	1. Approved services and drug formularies are established and defined. 2. Service/NDC codes are approved or denied for inclusion or exclusion in one or more Medicaid Benefit plan. 3. ***Maintain Benefits/Reference Repository*** loads approved services and drug formulary registry. 4. ***Maintain State Plan*** process updates state plan. 5. ***Manage Applicant and Member Communication*** prepares member notification data set 6. ***Manage Provider Communication*** prepares provider notification data set 7. ***Manage Benefit and Reference Information*** 8. ***Manage Rate Setting*** establishes rates for approved services and drug formularies.	Links to other processes: 1. ***Maintain Benefits/ Reference Repository*** 2. ***Maintain State Plan*** 3. ***Manage Applicant and Member Communication*** 4. ***Manage Provider Communication*** 5. ***Maintain Benefit and Reference Information*** 6. ***Manage Rate Setting***
Business Process Steps	1. Start: Receive new codes 2. Review new coding or changed coding to determine impact to coverage requirements based on current benefit programs. 3. Approve addition or elimination of services or NDC from service/drug formulary. 4. Determine coverage policies. 5. Review and identify changes to State Plan 6. Review and identify changes to regulations. 7. Recommend changes to system tables 8. Produce notification for vendors, providers, and impacted members 9. End: Send notification via the ***Send Outbound Transaction*** to a. ***Manage Applicant and Member Communication*** b. ***Manage Provider Communication*** c. ***Maintain State Plan***	
Shared Data	Drug Formulary Table Service Code Table Benefit Plans and Associated Service Tables Provider Data Program Data	

PG1 Designate Approved Service/Drug Formulary

Tier 3: Designate Approved Service/Drug Formulary		
Item	**Details**	**Links**
Predecessor	Receive Inbound Transaction Develop and Maintain Benefit Packages	
Successor	1. ***Maintain State Plan*** 2. ***Manage Applicant and Member Communication*** 3. ***Manage Provider Communication*** 4. ***Maintain Benefit and Reference Information*** 5. ***Manage Rate Setting*** 6. ***Send Outbound Transaction***	
Constraints	Most service/drug formularies are established at the state level, policies and procedures may differ from state to state.	
Failures	N/A	Failure Notifications
Performance Measures	1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less	

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PG1 Manage Rate Setting

Tier 3: Manage Rate Setting		
Item	**Details**	**Links**
Description	The Established Rate Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program.	Tier 1: Project Management Tier 2: Benefit Administration
Trigger Event	Scheduled date for new or changed rate, receipt of new/changed rates, or official request for rate update.	
Result	New Rate, with effective date and date span, or "no action" if rate is rejected.	
Business Process Steps	1. START. Receive notification of rate. 2. Change or request for rate change. 3. Request data to verify rate change or research and analyze rate. 4. Validate rate or establish rate. 5. Optional: Perform "what if" impact analysis. 6. END. Create rate update.	
Shared Data	Any information regarding the service or product association with the rate; history of the rate; selected data for impact analysis.	
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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PG1 Develop & Maintain Benefit Package

Tier 3: Develop & Maintain Benefit Package		
Item	**Details**	**Links**
Description	The ***Develop & Maintain Benefit Package*** business process begins with receipt of coverage requirements and recommendations through new or revised: Federal statutes and/or regulations, State law, organizational policies, requests from external parties such as quality review organizations or changes resulting from court decisions. Benefit package requirements are mandated through regulations or other legal channels and must be implemented. Implementation of benefit package recommendations is optional and these requests must be approved, denied or modified. Benefit package requirements and approved recommendations are reviewed for impacts to state plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including: ■ Determination of scope of coverage ■ Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc. ■ Identification of impacted members and trading partners.	Business Process Model location: Tier 1: Program Management Tier 2: Benefit Administration
Trigger Event	**State transition based Trigger Events:** New or changed Federal/State legislation, regulations, or policies. Material changes to State law or organization policy/regulations. Court decisions. **User based Trigger Event:** Annual/bi-annual quality-of-care review.	
Result	1. New benefit package requests approved, denied, or modified. **NOTE:** This result is only applicable to optional requests. 2. New/modified benefit packages defined 3. Updates to ***Maintain State Plan*** 4. ***Manage Applicant & Member Communication***, ***Manage Provider Communication*** — notifications sent to impacted business partners, trading partners and/or clients 5. Implementation of new or modified benefits.	

PG1 Develop & Maintain Benefit Package

Tier 3: Develop & Maintain Benefit Package		
Item	**Details**	**Links**
Business Process Steps	1. Start: Receipt of coverage requirements and/or recommendations identifying new or modified benefits. 2. Analysis of request for feasibility of implementation. 3. Approve, Deny, or modify request. (**NOTE** This step is only applicable to optional requests). 4. Define coverage requirements including: scope of coverage and eligibility criteria. 5. Amend state plan if necessary. 6. Implementation of new/modified benefit package including system modifications and updating of applicable benefit and service tables. 7. End: Notify impacted parties via ***Manage Applicant & Member Communication*** and ***Manage Provider Communication***.	
Shared Data	Benefit Plans and Associated Service Tables. Provider Data Program Data Member Data	Data can be maintained internally or externally.
Predecessor	Receipt of new legislation or benefit change request via ***Receive Inbound Transaction***	Receipt of new legislation or change request.
Successor	1. ***Maintain State Plan*** 2. ***Manage Applicant and Member Communication*** 3. ***Manage Provider Communication*** 4. ***Maintain Benefit and Reference Information*** 5. ***Designate Approved Services/Drug Formulary***	
Constraints	Many benefit plans are defined at the state level where policies and procedures will differ by state.	
Failures	N/A	Failure Notifications
Performance Measures	1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% Error rate = __% or less	

PG2 Develop and Maintain Program Policy

Tier 3: Develop and Maintain Program Policy		
Item	**Details**	**Links**
Description	The ***Develop and Program Administrative Policy*** Business Process responds to requests or needs for change in the agency's programs, benefits, or rules, based on federal or state statutes and regulations; governing board or commission directives; QIO findings; federal or state audits; agency decisions; and consumer pressure.	Tier 1: Project Management Tier 2: Program Administration
Trigger Event	Scheduled date for review of policy. Scheduled date to implement new policy or change.	
Result	New or changed policy. New or changed business rules.	
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. 6. Revise policy. 7. Determine effective date and date span for policy. 8. Optional: Develops training plan for new policy. 9. Develops implementation plan for policy. 10. END. Disseminate policy.	
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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PG2 Maintain State Plan

Tier 3: Maintain State Plan		
Item	**Details**	**Links**
Description	The ***Maintain State Plan*** business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.	Tier 1: Program Management Tier 2: Program Administration
Trigger Event	Scheduled, periodic date prompt to review and update state plan, unscheduled notification to review and update state plan.	
Result	Modification to state plan.	
Business Process Steps	1. START. Receive prompt or notification to review and update state plan. 2. Review current state plan documentation. 3. Analyze requirements for change to state plan. 4. Research information associated with the change. 5. Analyze impact of the change. 6. Develop state plan modification. 7. Disseminate state plan modification for review and comment. 8. Refine state plan modification. 9. END. Publish state plan modification.	
Shared Data	Current state plan, information about affected area, "What if" models	
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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PG2 Develop Agency Goals and Initiatives

Tier 3: Develop Agency Goals and Initiatives		
Item	**Details**	**Links**
Description	The ***Develop Agency Goals and Initiatives*** business process periodically assess current mission statement, goals, and objectives to determine if changes are called for. Changes to goals and objectives could be warranted under a new administration or in response to changes in demographics or public opinion; or in response to natural disasters such as Katrina.	Tier 1: Program Management Tier 2: Program Administration
Trigger Event	Receipt of notice that a reviewing of current goals and objectives is warranted.	
Result	New statement of goals and objectives.	
Business Process Steps	1. START. Receive notice that a review of current goals and objectives is warranted. 2. Request. 3. Review. 4. Convene Stakeholders. 5. Develop consensus on changes. 6. END. Publish new statement of goals and objectives.	
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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PG3 Manage FFP for MMIS

Tier 3: Manage FFP for MMIS		
Item	**Details**	**Links**
Description	The Federal government allows funding for the design, development, maintenance and operation of a federally certified MMIS. The ***Manage Federal Financial Participation*** business process oversees reporting and monitoring of Advanced Planning Documents and other program documents necessary to secure and maintain federal financial participation. These are the types of functions within this business area but this does not appear to be a stand-alone process.	Business Process Model location: Tier 1:Program Management Tier 2: Budget
Trigger Event	Trigger event may include the decision to add a new program. Temporal Trigger Event which is a date or time such as a quarterly statement of expenditures.	
Result	State receives maximum Federal Financial Participation available for all eligible clients, systems, and administration of the MMIS.	1. ***Manage State Funds***
Business Process Steps	1. Start: Generate reports, e.g., CMS 64 2. Review generated reports for accuracy and deficiencies. 3. Monitor expenditures 4. Analyze potential program additions, modification, or deletions for fiscal impact 5. Finalize report 6. End: Send report via the ***Send Outbound Transaction*** process	
Shared Data	***Member Registry*** ***Provider Registry*** ***Accounting Tables*** ***Payment History Repository***	May be maintained internally or externally
Predecessor	Determination to add or modify a new program An established reporting time period or deadline	
Successor	Send reporting information via the ***Send Outbound Transaction*** process.	
Constraints	Manage FFP must conform to state specific reporting requirements.	
Failures	N/A	Failure Notifications
Performance Measures	1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less	

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PG3 Formulate Budget

Tier 1: Formulate Budget		
Item	**Details**	**Links**
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, and periodically produces a new budget.	Tier 1: Project Management Tier 2: Budget
Trigger Event	Specific date for budget review or external forces requiring a review, e.g., notice of revenue shortfall and/or unforeseen rise in costs.	
Result	New budget.	
Business Process Steps	1. START. Receive notice of date or other trigger event. 2. Review current budget. 3. Request information regarding cost and revenue trends, demographics, utilization, and outcomes. 4. Research national and global factors affecting revenue, costs, and benefits. 5. Convene stakeholders to consider alternatives. 6. Model various budget scenarios. 7. Build new budget. 8. Review and approve new budget. 9. END. Publish new budget.	
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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PG3 Manage State Funds

Tier 3: Manage State Funds		
Item	**Details**	**Links**
Description	The ***Manage State Funds*** business process oversees Medicaid state funds and ensures accuracy in reporting of funding sources. Funding sources for Medicaid services may come from a variety of sources and often State funds are spread across administrations. The ***Manage State Funds*** monitors state funds through ongoing tracking and reporting of expenditures. These are the types of functions that may occur within this business area, but this does not appear to be a stand-alone process.	Business Process Model location: Tier 1: Program Management Tier 1: Budget
Trigger Event	State-transition Trigger Event: Request from legislature or new budget approved. Temporal Trigger Event: Established time frame for generating quarterly reports.	List business area or process that is source of trigger
Result	State is able to fund all programs without budget shortfalls.	List business area or process that is affected by the completion of the process
Business Process Steps	1. Start: Establish state and federal budget categories 2. Establish reporting requirements 3. Define report content 4. Define report frequency 5. Define report media 6. Generate report 7. End: Review reports for accuracy	
Shared Data	Member Registry Provider Registry Accounting Tables State Financial Management Applications Payment History Repository	May be maintained internally or externally
Predecessor	***Receive Inbound Transaction*** in the form of a request.	List Predecessor Processes
Successor	Sending report information via the ***Send Outbound Transaction***.	List Successor Processes
Constraints		
Failures	N/A	Failure Notifications

PG3 Manage State Funds

Tier 3: Manage State Funds		
Item	**Details**	**Links**
Performance Measures	1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less	

PG3 Manage F-MAP

Tier 3: Manage F-MAP		
Item	**Details**	**Links**
Description	The ***Manage F-MAP*** business process periodically assesses current F-MAP for benefits and administrative services to determine compliance with federal regulations and state objectives.	Tier 1: Program Management Tier 2: Budget
Trigger Event	Notification of need for review or receipt of an audit finding or enquiry.	
Result	Directive to revise FFP calculations; new FFP algorithms.	
Business Process Steps	1. START. Receive notification of need, audit finding, or inquiry. 2. Review notification, audit finding, or inquiry. 3. Request information supporting F-MAP, FFP. 4. Review and analyze information. 5. Review applicable laws. 6. Propose change in approach to calculating F-MAP, FFP. 7. Submit change for review and approval. 8. Develop guidelines for change. 9. Develop specific algorithms. 10. Develop implementation plan. 11. END. Publish new FFP rules.	
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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PG4 Manage 1099s

Tier 3: Manage 1099s		
Item	**Details**	**Links**
Description	The ***Manage 1099s*** business process describes the process by which 1099s are handled including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number. The ***Manage 1099s*** process receives payment and/or recoupment data from the ***Price Claim/Value Encounter*** Process or from the ***Manage Settlements*** process. The ***Manage 1099s*** process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies via the ***Send Outbound Transaction*** process. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.	Business Process Model location: Tier 1: Program Management Tier 2: Accounting
Trigger Event	**Interaction Based Trigger Event:** Request from a provider. **State-transition Trigger Event:** Receipt of data set from ***Price Claim/Value Encounter*** or ***Manage Settlements*** indicating payments and/or recoupments. **Temporal Trigger Event:** End of the calendar year.	
Result	Updated and/or corrected 1099 forms sent to providers via the ***Send Outbound Transaction*** process.	1. ***Send Outbound Transaction*** process.
Business Process Steps	Preparation/Maintenance 1. Start: Receive claim/encounter payment and adjustment information from ***Price Claim/Value Encounter*** or ***Manage Settlements*** process. 2. Match tax ID or SS#. 3. Update cumulative totals applying all payments and recoupments including those resulting from cost settlements and manual checks. 4. Prepare 1099 at close of calendar year. 5. Send 1099 to providers prior to January 31 6. End: Submit 1099 data to Internal Revenue Service (IRS)	

PG4 Manage 1099s

Tier 3: Manage 1099s		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	Additional Requests 1. Start: Receive request for additional 1099s 2. Verify identity of requesting entity 3. Re-generate requested 1099 4. End: Send 1099 to requesting entity Corrections 1. Start: Receive notification of error. 2. Verify identity of provider 3. Research error or update request. 4. If no error found, End: Notify provider of findings 5. If error found 6. Correct system tables 7. Prepare corrected or updated1099 8. Send corrected 1099 to affected parties. 9. End: Submit corrected 1099 data to Internal Revenue Service (IRS).	
Shared Data	***Price Claim/Value Encounter*** process. ***Manage Settlements*** process	List Predecessor Processes
Predecessor	***Send Outbound Transaction*** ***Manage Provider Communication***	List Successor Processes
Successor	Provider Registry	
Constraints	N/A	
Failures	N/A	Failure Notifications
Performance Measures	1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% Error rate = __% or less	

PG4 Perform Accounting Functions

Tier 3: Perform Accounting Functions		
Item	**Details**	**Links**
Description	To Be Developed. Currently States use a variety of solutions including outsourcing to another Department or use of a COTS package.	
Trigger Event		
Result		
Business Process Steps		
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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PG5 Develop and Manage Performance Measures and Reporting

Tier 3: Develop and Manage Performance Measures and Reporting		
Item	**Details**	**Links**
Description	To Be Developed.	
Trigger Event		
Result		
Business Process Steps		
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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PG5 Monitor Performance and Business Activity

Tier 3: Monitor Performance and Business Activity		
Item	**Details**	**Links**
Description	To Be Developed.	
Trigger Event		
Result		
Business Process Steps		
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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PG6 Manage Program Information

Tier 3: Manage Program Information		
Item	**Details**	**Links**
Description	The Manage Program Information business process is responsible for managing all the operational aspects of the Program Information Repository, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The Program Information Repository receives requests to add, delete, or change data in program records. The Repository validates data upload requests, applies instructions, and tracks activity. The Program Information Repository provides access to payment records to other Business Area applications and users, especially those in Program Management and Program Integrity Management, via batch record transfers, response to queries, and "publish and subscribe" services.	Business Process Model location: Tier 1: Program Management Tier 2: Program Information
Trigger Event	State-transition Trigger Event: Program Information Repository receives data to be loaded as initial records or updates to data in existing records from any Business Area 1. State transition trigger event: Receipt of request to add, delete, change Program information from Member, Provider, and Contractor Registries, and the Payment, Care and Program Integrity Management Repositories 2. Interaction-based Trigger Event: Receipt of a query about data in one or more program records from enterprise business processes, or from authorized external parties, e.g., a legislator requests outcome measures for a particular program. 3. Environmental Trigger Event: Scheduled transmission of program information records or pointers to program information on a periodic or real time basis to authorized external parties, e.g., CMS MSIS.	Links to other processes: All Manage Information business processes; all other Program Management business processes

PG6 Manage Program Information

Tier 3: Manage Program Information		
Item	**Details**	**Links**
Result	The Program Information Repository is loaded with new or updated data from all Business Areas and made available to all Business Area processes as required for analysis, reporting, and decision reporting; including: 1. Responding to queries from authorized users and applications 2. Supplying all other Program Management Area business processes with program information as needed to, e.g., develop benefit packages and drug formularies, set rates, analyze and project budgets, perform accounting functions, manage FFP, measure quality, outcomes and performance; and develop policies and strategic initiatives, etc. 3. Supplies all Business Area processes with program information needed to e.g., manage communications, manage business relationships, perform outreach and education, manage contracts, etc. 4. Sends records or pointers to external parties for reporting, e.g., CMS MSIS and public health for population health studies	Links to other processes: All business processes
Business Process Steps	1. Start: Load initial data from enterprise information registries or repositories 2. Loads data into the Program Information Repository, building new records and updating, merging, unmerging, or deleting previous records as appropriate 3. Process the records so that the data is available as required, e.g., to an operational data store, a data mart, or a data warehouse 4. Provide reporting, analysis and decision support capabilities 5. Manage versioning issues 6. Provides access to records as requested by authorized business processes and users, e.g., Manage Business Relationships and Program Integrity Identify Case processes 7. End: Archive data in accordance with state and federal record retention requirements	Each state will specify its data requirements and rules for each step
Shared Data	Member, provider, contractor, payment, operations, program, program integrity, business relationship and care management information	
Predecessor	Manage Member, Provider, Contractor, Business Relationship, Operations, Program, Program Integrity and Care Management information	
Successor	All business processes requiring access to program information.	

PG6 Manage Program Information

Tier 3: Manage Program Information		
Item	**Details**	**Links**
Constraints	Policies and procedures will differ by state, especially those relating to data standards, record keeping, and privacy.	
Failures	Inability or failure to load initial records or update data in existing records in the Program Information Repository	
Performance Measures	1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	

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PG6 Maintain Benefits/Reference Information

Tier 3: Maintain Benefits/Reference Information		
Item	**Details**	**Links**
Description	The ***Maintain Benefits/Reference Information*** process is triggered by any addition or adjustment that is referenced or used during the ***Edit Claim/Encounter***, ***Audit Claim/Encounter*** *or* ***Price Claim/Encounter***. It can also be triggered by the addition of a new program or the change to an existing program due to the passage of new state or federal legislation, or budgetary changes. The process includes adding new HCPCS, CPT and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the ***Manage Prospective & Current Member Communication***, updating/adding provider information from the ***Manage Provider Information***, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the ***Receive Inbound Transaction***.	Business Process Model Location: Tier 1: Program Management Tier 2: Program Information
Trigger Event	Interaction-based Trigger Event: The maintain benefits/reference repository is triggered by the ***Receive Inbound Transaction***.	
Result	Payment of claims during ***Edit Claim/Encounter***, ***Audit Claim/Encounter*** or ***Price Claim Encounter***.	Links to other E2E threads: Edit Claims/Encounter; Audit Claims/ Encounter; Price Claims/Encounter
Business Process Steps	1. Start: Add new codes and rates 2. Update rates 3. Update/add member benefits 4. Update/add provider information 5. Update/add drug formulary information 6. End: Update/add program under which services are available.	
Shared Data	Rate data Member benefits data Provider data Program data	May be maintained internally or externally
Predecessor	***Receive Inbound Transaction***.	
Successor	***Edit Claim/Encounter***, ***Audit Claim/Encounter*** *or* ***Price Claim Encounter***	
Constraints	The Benefits/Reference Repository must be maintained according to state specific policies and procedures that may differ by state.	

PG6 Maintain Benefits/Reference Information

Tier 3: Maintain Benefits/Reference Information		
Item	**Details**	**Links**
Failures	N/A	
Performance Measures	1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ days 2. Accuracy of decisions = ___% 3. Consistency of decisions. 4. Error rate = __% or less.	

PG6 Generate Financial & Program Analysis/Report

Tier 3: Generate Financial & Program Analysis/Report		
Item	**Details**	**Links**
Description	It is essential for Medicaid agencies to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the benefits and programs that are established 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 & Program Analysis/Report*** process begins with a request for information or a time table for scheduled correspondence. The process includes defining the required reports format, content, frequency and media, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy),retrieving data from multiple sources, e.g., ***Manage Payment History***; ***Maintain Member Information***; ***Manage Provider Information***; and ***Maintain Benefits/Reference Repository***; compiling the retrieved data, compiling the data, and formatting into the required data set, which is sent to the ***Send Outbound Transaction*** for generation into an outbound transaction. **NOTE:** This process does not include maintaining the benefits, reference, or program information. Maintenance of the benefits and reference information is covered under a separate business process.	Business Process Model location Tier 1: Program Management Tier 2: Program Information
Trigger Event	**Interaction based Trigger Events:** This trigger event is the request that financial and/or reporting information be produced. **Temporal Trigger Event:** The trigger event for this business process could also be based on a pre-determined time-table for scheduled report generation	
Result	The financial and program analysis report is sent to the ***Send Outbound Transaction***.	

PG6 Generate Financial & Program Analysis/Report

Tier 3: Generate Financial & Program Analysis/Report		
Item	**Details**	**Links**
Business Process Steps	1. Start: Define required report(s) format, content, frequency, and media for the reports 2. Define state and federal budget categories of service, eligibility codes, provider type and specialty codes (taxonomy codes), accounting codes and other codes necessary to produce the reports 3. Retrieve data from multiple sources, e.g., claims payment history data, member eligibility data, provider data, and program and benefit data 4. Compile the data into the defined format 5. Format the data 6. End: a. end data set to the ***Send Outbound Transaction*** for generation into an outbound transaction.	
Shared Data	Member Registry Provider Registry Benefits/Reference Repository Payment History	
Predecessor	Request for financial and/or reporting data/information be produced using data from ***Manage Payment History***; ***Maintain Member Information***; ***Manage Provider Information***; and ***Maintain Benefits/Reference Repository***.	
Successor	***Send Outbound Transaction***.	
Constraints	The generation of financial and program analysis reports must adhere to state specific laws, regulations, and requirements. These rules will differ by state.	
Failures	N/A	
Performance Measures	1. = ___% Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Accuracy of decisions 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less	

Business Relationship Management

BR Establish Business Relationship

Tier 2: Establish Business Relationship		
Item	**Details**	**Links**
Description	The ***Establish Business Relationship*** business process encompasses activities undertaken by the State Medicaid agency to enter into business partner relationships with other stakeholders. These include Memoranda of Understanding (MOUs) with other agencies, electronic data interchange agreements with providers, managed care organizations, and others, and CMS, other Federal agencies, and Regional Health Information Organizations (RHIOs).	Business Process Model location: Tier 1: Business Relationship Management
Trigger Event	Receive data content of agreement submitted by other party	Links to other processes: Receive Agreement Document from Other Party
Result	Produce data content for response to other party	Links to other processes: Send Response to Other Party
Business Process Steps	1. Receive data content of agreement with other party 2. Validate information submitted 3. Verify authentication protocol 4. Verify security protocol 5. Verify privacy requirements 6. Verify data exchange requirements 7. Verify business rules	Each State will specify its data requirements and rules for each step
Shared Data	1. Standard agreement template 2. Business rules for type of agreement 3. Data from previous agreement for same party 4 Comparable information on other agreements	
Predecessor	Receive Agreement Document	
Successor	Send Response to Other Party	
Constraints		
Failures	Contents of agreement submitted from other party are incomplete, inaccurate.	Result messages
Performance Measures	1. Time to complete business process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	

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BR Manage Business Relationship

Tier 2: Manage Business Relationship		
Item	**Details**	**Links**
Description	The ***Manage Business Relationship*** business process maintains the agreement between the State Medicaid agency and the other party. This includes routine changes to required information such as authorized signers, addresses, coverage, and data exchange standards.	Business Process Model location: Tier 1: Business Relationship Management
Trigger Event	Receive agreement updates and new data	Links to other processes: Establish Business Relationship
Result	Produce changes to agreement	Links to other processes: Update Agreement
Business Process Steps	1. Receive agreement updates and new data 2. Validate update and new data 3. Prepare update and new data	Each State will specify its data requirements and rules for each step
Shared Data	1. Standard agreement template 2. Business rules for type of agreement 3. Data from previous agreement for same party	
Predecessor	Establish Business Relationship	
Successor	Update Agreement	
Constraints	Updates cover the gamut of all required fields in the agreement and depend on the type of agreement and business rules associated with the agreement.	
Failures	1. Update or new data does not comply with standards 2. Update or new data does not comply with business rules	Result messages
Performance Measures	1. Time to complete business process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	

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BR Manage Business Relationship Communication

Tier 2: Manage Business Relationship Communication		
Item	**Details**	**Links**
Description	The ***Manage Business Relationship Communication*** business process produces routine and ad hoc communications between the business partners.	Business Process Model location: Tier 1: Business Relationship Management
Trigger Event	Time to send communication Receive request for communication	Links to other processes: Receive Request for Communication
Result	Produce communication	Links to other processes: Send Communication
Business Process Steps	1. Receive time alert or request 2. Determine content of communication 3. Prepare content of communication	Each State will specify its data requirements and rules for each step
Shared Data	1. Content for communication	Stored data for communication
Predecessor	Receive Request for Communication	
Successor	Send Communication	
Constraints	State Medicaid agencies and their business partners agree on the content of the communications. Content depends on the business relationship. Content is standards-based.	
Failures	1. Data is not available for the communication 2. Cannot authenticate receiver of communication	Result messages
Performance Measures	1. Time to complete business process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	

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BR Terminate Business Relationship

Tier 2: Terminate Business Relationship		
Item	**Details**	**Links**
Description	The ***Terminate Business Relationship*** business process cancels the agreement between the State Medicaid agency and the business partner.	Business Process Model location: Business Relationship Management
Trigger Event	Receive request for terminate agreement	Links to other processes: Receive Request for Termination of Agreement
Result	Produce response to other party	Links to other processes: Send Response
Business Process Steps	1. Receive request 2. Verify data in request 3. Verify authority to terminate 4. Prepare termination response	Each State will specify its data requirements and rules for each step
Shared Data	1. Content for response	Stored data for communication
Predecessor	Receive Request for Termination	
Successor	Send Response to Other Party	
Constraints	State Medicaid agencies and their business partners agree on the content of the termination message. Content depends on the business relationship. Content is standards-based.	
Failures	1. Termination is inconsistent with business rules 2. Cannot authenticate receiver of communication	Result messages
Performance Measures	1. Time to complete business process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less	

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Program Integrity Management

PI Identify Candidate Case

Tier 2: Identify Candidate Case		
Item	**Details**	**Links**
Description	The ***Identify Candidate Case*** business process uses State-specific criteria and rules to identify target populations (e.g., providers, contractors, or beneficiaries), establishes patterns or parameters of acceptable/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. Candidate cases may be identified for: ■ Provider utilization review ■ Contractor ■ Beneficiary utilization review ■ Potential fraud ■ Drug utilization review ■ Quality review Each type of case is driven by different State criteria and rules, different relationships, and different data.	Business Process Model location: Tier 1: Program Integrity Management
Trigger Event	1. Scheduled time to scan for candidate cases 2. Request to examine a specific group or individual 3. An alert triggered by other events	
Result	1. List of candidate cases 2. Record of criteria for targeted population, data selection, parameters used	
Business Process Steps	1. Identify target population — Define characteristics of the population in which the search will focus: types of provider, location, types of services, patient characteristics, medical conditions 2. Identify data requirements — Specify time period, data elements, data relationships to include in the search 3. Identify rules to apply to the data — Select or create rules including specified norms, statistical deviations, types of patterns, Boolean logic, ratios, percentages 4. Apply rules to target population data — Execute rules and record results	
Shared Data	Member, provider, and service history data stores Rules database	
Predecessor	Maintain schedule for case identification Receive special request for review Receive warning to investigate	
Successor	Research candidate case	
Constraints	States and programs within states establish different criteria for their investigations. Rules change along with the experience of the state, changes in benefits, new provider types	

PI Identify Candidate Case

Tier 2: Identify Candidate Case		
Item	**Details**	**Links**
Failures	N/A	
Performance Measures		

PI Manage Case

Tier 2: Manage Case		
Item	**Details**	**Links**
Description	The Manage Case business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, or beneficiary from the Medicaid program; or the case may be terminated or suspended. Individual State policy determines what evidence is needed to support different types of cases: ■ Provider utilization review ■ Provider compliance review ■ Contractor utilization review ■ Contractor compliance review ■ Beneficiary utilization review ■ Investigation of potential fraud ■ Drug utilization review ■ Quality review ■ Performance review Each type of case is driven by different criteria and rules, different relationships, and different data. Each type of case calls for different types of external investigation.	Business Process Model location: Tier 1: Program Integrity Management
Trigger Event	1. Scheduled time to perform case management 2. Receipt of information requiring case management 3. Special request to perform case management	
Result	1. Record of documentation 2. Disposition of case	
Business Process Steps	1. Assign case manager — A case manager is assigned and authorized to manage a case and request additional information 2. Establish case — The case file is opened, a schedule is added, and a reporting framework is established 3. Review case — Examine information associated with the case; request more historical information as needed 4. Notify affected parties — Correspond with providers, beneficiaries, agents, guardians, attorneys, et al to notify them regarding the investigation, their rights, and the right of the Medicaid agency to request documentation	

PI Manage Case

Tier 2: Manage Case		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	5. Conduct inquiries and investigations — Depending on the type of case, different external inquiries will need to be conducted, e.g., a. View medical records b. Interview patient c. Validate credentials 6. Document evidence — Evidence is documented in the case file 7. Determine action — Based on evidence gathered, a determination is made to close the case 8. Determine disposition — When research and analysis are completed, the case disposition is reported, e.g., cancel case, claim damages, identify corrective action, terminate membership in Medicaid program	
Shared Data	Member, provider, and service history data stores Rules data base Medical records	
Predecessor	Research Candidate Case	
Successor	Prepare Outgoing Information Support Grievance and Appeals	
Constraints	States and programs within states establish different criteria for their investigations. Rules change along with the experience of the state, changes in benefits, new provider and beneficiary types	
Failures	N/A	
Performance Measures		

Care Management

CO Manage Medicaid Population Health

Tier 2: Manage Medicaid Population Health		
Item	**Details**	**Links**
Description	This business process designs and implements strategies to improve general population health by targeting individuals by cultural or diagnostic or other demographic indicators. The input to this process are census, vital statistics, immigration, and other data sources. The outputs are educational materials, communications, and other media. To Be Developed.	
Trigger Event		
Result		
Business Process Steps		
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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CO Establish Case

Tier 2: Establish Case		
Item	**Details**	**Links**
Description	The ***Establish Case*** business process uses criteria and rules to identify target member populations for specific programs, assign a care manager, assess client's needs, select program, establish treatment plan, identify and confirm providers, and prepare information for communication. Cases may be established for: ■ Medicaid Waiver program case management – Home and Community-Based Services – Other ■ Disease management ■ Catastrophic cases ■ EPSDT ■ Population management Each case type is driven by different criteria and rules, different relationships, and different data.	Business Process Model location: Care Management
Trigger Event	1. Scheduled time to scan for new cases 2. Request to look into a specific member case 3. An alert triggered by other events	
Result	1. List of members associated with cases and programs 2. Needs assessment 3. Treatment Plan 4. Associated Providers List 5. Case file data 6. Communications data for providers, clients	
Business Process Steps	1. Identify new cases — Apply criteria for the care management program, e.g., patient characteristics, medical conditions, location, age 2. Identify data requirements — Specify time period, data elements, data relationships to include in the search 3. Identify new cases — Apply rules to data and identify new cases; create case folder for each 4. Assess needs — Apply needs template to individual case and record results 5. Select program — Based on needs, determined which program(s) are appropriate for the client	

CO Establish Case

Tier 2: Establish Case		
Item	**Details**	**Links**
Business Process Steps (Cont'd)	6. Establish treatment plan — Based on needs, established treatment (care) plan which identifies the services the client needs to receive, the types of providers, the care setting, frequency, and expected results 7. Identify and confirm providers — Based on the treatment plan, select providers to deliver the services, contact and confirm availability, record decisions 8. Prepare communications to the clients and providers — Prepare content of case file for communications with clients and providers, and on-going management of the case	
Shared Data	Member, provider, and service history data stores Assessment protocol Treatment Plan protocol Table of available providers	
Predecessor	Maintain schedule for new case identification Receive special request for case analysis Receive alert to investigate	
Successor	Monitor Case	
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. EPSDT case management is not required, but states may chose to have it to strengthen preventive measures.	
Failures	N/A	
Performance Measures		

CO Manage Case

Tier 2: Manage Case		
Item	**Details**	**Links**
Description	To Be Developed.	
Trigger Event		
Result		
Business Process Steps		
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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CO Manage Registry

Tier 2: Manage Registry		
Item	**Details**	**Links**
Description	This business process operates a registry (e.g., immunizations, cancer), receives continuous updates, responds to inquiries, and provides access to authorized parties. To Be Developed.	
Trigger Event		
Result		
Business Process Steps		
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

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