

**Core MMIS**  
**Business Process Validation**  
**Draft**

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**Version 3.0**



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## 1.0 Introduction

Leveraging Federal Financial Participation (FFP), AHS is embarking on a series of projects to enhance the technological support for the State's Medicaid operations. The solutions will include a modern Medicaid Management Information System (MMIS) as well as targeted solutions required to support the State's Medicaid Operations. The solutions will include software and may include ongoing services for claims processing, provider management, data provisioning, and data analysis.

The acquisition will occur in three components as follows:

- Care Management (CM) Solution – Focusing on Care Management that can be leveraged by multiple programs, starting with Vermont Chronic Care Initiative (VCCI), high risk pregnancy, pediatric palliative care and DDS.
- Pharmacy Benefits Management (PBM) – The solution will be responsible for the pharmacy benefits provided by the State of Vermont (i.e. Medicaid, Pharmacy Programs and General Assistance Emergency Medication Program).
- Core MMIS – The core claims processing, financial management, provider management, data analytics and other functionality that supports the Medicaid program

This project is focusing on the replacement and enhancement of the current MMIS with a new Core MMIS. This document outlines the MITA processes to be included in the new Core MMIS and highlights any major characteristics of these processes that are unique to AHS. The MITA processes have been grouped into 5 work streams to reflect AHS' business environment.

## 2.0 Data Analytics

Vermont has defined Data Analytics as one of the key components of the MMIS to be procured. There are seven business processes that have been defined by the CMS Medicaid Information Technology Architecture (MITA) v3.0. These business processes span different MITA business process areas including Operations Management (OM), Performance Management (PE), and Provider Management (PM).

The business processes in this document provide a description of the processes Vermont wishes to be performed with the new MMIS and the associated services the vendor will support. These processes provide context to the Core MMIS functional requirements.

### 2.1 OM28 Manage Data

#### 2.1.1 Description

The **Manage Data** business process is responsible for the preparation of the data sets and delivery to federal agencies (e.g., Centers for Medicare & Medicaid Services (CMS), Social Security Administration (SSA)) and other entities (e.g. Vermont's APCD, VCCI and other State needs). Information exchange may include extraction of Medicaid and CHIP Business Information and Solutions (MACBIS) information needs (i.e., fee-for-services, managed care, eligibility and provider information). MACBIS extracts in the future will be in the format and structure defined by T-MSIS (Transformed Medicaid Statistical Information System).

The **Manage Data** business process includes activity to extract the information, transform to the required format, encrypt for security, and load the electronic file to the target destination.

The uses for the information include:

- Research and evaluation of health care activities.
- Staff can forecast the utilization and expenditures for a program.
- Staff can analyze policy alternatives.
- State and federal agencies can respond to congressional inquiries.
- Matches to other health related databases.

##### 2.1.1.1 Additional Information

VT will need both specific extracts/reports and a platform to allow agency users to access data and create extracts/reports. It will need a mechanism to integrate and present Medicaid enterprise data in order to support analytics across the agency needs (e.g. an integrated Data Warehouse). This is critical to be able to perform analyses across MMIS data and data from other sources; e.g. MSR, TEDS, DOH public health systems and Clinical details from all types of Providers (including laboratories) possibly via VITL.

VT will perform formal governance of the data within the MMIS and any integrated data solution for analytics. There is an ongoing project to address redundancy of data from stakeholders. The State is seeking to enable providers to only make a single submission for any data being submitted to AHS.

### 2.1.2 Business Process Steps

1. START: Receive time event or request to initiate **Manage Data** business process.
2. Extract required information from source data stores.
3. Transform information, integrate and perform analyses to meet business and technical needs of target destination.
4. Apply necessary encryption algorithms for security.
5. Apply necessary masking for privacy
6. END: Send message with information to the target destination.

## 2.2 PE01 Identify Utilization Anomalies

### 2.2.1 Description

The **Identify Utilization Anomalies** business process uses criteria and rules to identify target groups (e.g., providers, contractors, trading partners or members) and establishes patterns or parameters of acceptable and unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate utilization of program benefits potentially indicative of either improved practices that could be adopted more widely or problems that need corrective action. Internal and external referrals, business intelligence analysis (i.e., historical, current and predictive views of business operations), and scheduled or on-demand reporting may identify a compliance incident.

Identification of utilization anomalies include evaluation of:

- Provider utilization review
- Provider compliance review
- Contractor utilization review (includes managed care organizations)
- Contractor compliance review
- Member utilization review
- Investigation of potential fraud or abuse review
- Drug utilization review
- Quality review (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Healthcare Effectiveness Data and Information Set (HEDIS) measures)
- Performance review (e.g., key performance indicators (KPI))
- Erroneous payment
- Contract review
- Audit Review
- Peer Groups Comparisons
- Outlier Reports, high rejection rates etc.
- Other evaluation of information

Different criteria and rules, relationships, and information define each type of compliance incident and require different types of external investigation

### **2.2.1.1 Additional Information**

When anomalies are repeatedly identified, VT is seeking the ability to provide prospective edit during claims processing.

### **2.2.2 Business Process Steps**

1. START: Receive request or reach scheduled timetable review.
2. Review performance measures and benchmark targets.
3. Define characteristics of the target group in which the analysis will focus: types of provider, location, types of services, member characteristics, and medical conditions.
4. Identify information requirements, both selection parameters and reporting parameters to include items such as time period(s), data elements, and data relationships.
5. Identify rules to apply to the information, both proactively and retrospectively — Select or create rules and algorithms including specified norms, statistical deviations, types of patterns, Boolean logic, ratios, percentages using peer group assessments
6. Apply rules and algorithms to targeted group information.
7. Record the results.
8. If applicable, send alert to notify member via **Manage Applicant and Member Communication** business process with anomaly information.
9. If applicable, send alert to notify provider via **Manage Provider Communication** business process with anomaly information.
10. If applicable, send alert to notify contractor via **Manage Contractor Communication** business process with anomaly information.
11. END: If applicable, send alert to the **Establish Compliance Incident** business process for further investigation and monitoring.

## **2.3 PE02 Establish Compliance Incident**

### **2.3.1 Description**

The **Establish Compliance Incident** business process is responsible registration of a case for incident tracking of utilization anomalies. It establishes an incident file, generates incident identification, assigns an incident manager, links to related cases, and collects related documentation.

#### **2.3.1.1 Additional Information**

The case tracking described in this and the next three processes can extend to any compliance case tracking needed in response to utilization anomalies.

VT is seeking a solution for which the case tracking includes:

- Program Integrity case tracking
- Tracking providers who are out of compliance with performance measures

VT has determined that it is important that the Program Integrity system (consisting of dashboard functionality, statistical and financial reporting, workload assignment and ad hoc reporting tightly integrated with Program Integrity case tracking) be an industry best-practice system from and supported by a leading Program Integrity contractor. Both the selected System and Contractor must have a proven track record in the specialist Program Integrity industry.

Compliance incidents and associated cases must only be accessed by authorized users. This will be addressed by the NFRs (Non-Functional Requirements) for role-based Identity and Access Management and the level of granularity of database security.

The specific targets (e.g. inclusive of any state regulatory authorities) for escalation, notifications and alerts should be highly configurable based on defined rules that are easily changeable by Program Integrity system administrators or other authorized staff.

The system to support the Establish Compliance Incidents process area must include:

- Case triage and prioritization software or processes
- Templates for and the ability to create and administer surveys of both providers and members for more consistent communication

### **2.3.2 Business Process Steps**

1. START: Request to establish incident tracking.
2. Establish incident case with required information.
3. Generate incident identification.
4. Assign and authorize an incident manager to manage an incident and request additional information.
5. Identify and link related incidents to this one.
6. Collect relevant documentation (both paper and electronic).
7. If applicable, send notification to state or federal law enforcement agencies of possible criminal investigation.
8. If applicable, send notification to CMS of compliance investigation.
9. If applicable, send notification to MFRAU (Medicaid Fraud and Residential Abuse Unit in the VT Office of the Attorney General) of compliance investigation.
10. If applicable, send notification to OIG (Federal HHS Office of Inspector General) of compliance investigation.
11. If applicable, send notification to other State, Regulative and/or Credentialing authorities.
12. END: Send alert to **Manage Compliance Incident Information** business process for incident monitoring.

## **2.4 PE03 Manage Compliance Incident Information**

### **2.4.1 Description**

The **Manage Compliance Incident Information** business process is responsible for the monitoring of incidents of utilization anomalies. Activities include referring (e.g., escalation) incident to another

incident manager or agency, modifications to incident information, journaling activities, and disposition of incident.

#### **2.4.1.1 Additional Information**

The specific thresholds for escalation, notifications and alerts should be highly configurable.

#### **2.4.2 Business Process Steps**

1. START: Receive established incident.
2. Review incident information for determination of action.
3. Review allegations.
4. If applicable, refer or escalate incident to responsible individual, department or state or federal agency.
5. Determine action to take (e.g., journal entry, appointment scheduling, research, communication).
6. Perform appropriate action.
7. If applicable, send alert to notify member via **Manage Applicant and Member Communication** business process of incident tracking information.
8. If applicable, send alert to notify provider via **Manage Provider Communication** business process of incident tracking information.
9. If applicable, send alert to notify contractor via **Manage Contractor Communication** business process of incident tracking information.
10. Determine disposition of incident.
11. If applicable, send notification to state or federal law enforcement agencies of possible criminal investigation.
12. If applicable, send notification to CMS for compliance investigation.
13. If applicable, send notification to MFRAU of compliance investigation.
14. If applicable, send notification to OIG of compliance investigation.
15. If applicable, send notification to other State, Regulative and/or Credentialing authorities.
16. If applicable, send alert to **Determine Adverse Action Incident** business process for further investigation.
17. END: Close incident.

### **2.5 PE04 Determine Adverse Action Incident**

#### **2.5.1 Description**

The **Determine Adverse Action Incident** business process receives an incident from an investigative unit with the direction to pursue the case to closure. The case may result in civil, criminal or administrative changes, corrective action, removal of a provider, contractor, trading partner or member from the Medicaid Program, or AHS may terminate or suspend the case.

Individual state policy determines what evidence is necessary to support different types of cases:

- Provider utilization review
- Provider compliance review
- Contractor utilization review (includes managed care organizations)
- Contractor compliance review
- Member utilization review
- Investigation of potential fraud or abuse review
- Drug utilization review
- Quality review (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Healthcare Effectiveness Data and Information Set (HEDIS) measures)
- Performance review (e.g., key performance indicators (KPI))
- Contract review
- Erroneous payment review
- Audit Review
- Other evaluation of information

### **2.5.1.1 Additional Information**

Most civil and criminal changes are through the Attorney General (AG)'s office and out of scope.

Some VT State standards are more stringent than federal standards.

Notifications and alerts should be highly configurable.

### **2.5.2 Business Process Steps**

1. START: Receive request to investigate adverse action incident.
2. Assign and authorize an adverse action incident manager to manage an incident and request additional information.
3. Establish adverse action incident case with required information.
4. Examine information associated with the case, and request more historical information as needed.
5. Determine action to be taken (e.g., journal entry, appointment scheduling, research, communication).
6. Coordinate action plan with the Fiscal Agent. (e.g., payment suspension, payment withholds, provider on review).
7. Perform appropriate action.
8. Correspond with providers, members, agents, guardians, attorneys, and others to notify them regarding the investigation, their rights, and the right of the AHS to request documentation.
9. If applicable, send alert to notify member via **Manage Applicant and Member Communication** business process of incident tracking information.
10. If applicable, send alert to notify provider via **Manage Provider Communication** business process of incident tracking information.
11. If applicable, send alert to notify contractor via **Manage Contractor Communication** business process of incident tracking information.

12. Conduct inquiries and investigations. Depending on the type of case, AHS may need to conduct different external inquiries (e.g., view medical records, interview members, validate credentials).
13. Document evidence as required.
14. When research and analysis are complete, report the case disposition (e.g., cancel incident, claim damages, identify corrective action, suspend or terminate participation in Medicaid Program).
15. If applicable, send alert to **Disenroll Member** business process to remove member from services.
16. If applicable, send alert to **Disenroll Provider** business process to remove provider from services.
17. If applicable, send alert to **Terminate Provider** business process to cease activities with provider.
18. If applicable, send alert to **Close Out Contract** business process to cease activities with contractor.
19. If applicable, send notification to state or federal law enforcement agencies of possible criminal investigation.
20. If applicable, send notification to CMS for compliance investigation.
21. If applicable, send notification to MFRAU of compliance investigation.
22. If applicable, send notification to OIG of compliance investigation.
23. If applicable, send notification to other State, Regulative and/or Credentialing authorities.
24. END: Close adverse action incident.

## 2.6 PE05 Explanation of Benefits (EOB)

### 2.6.1 Description

The **Explanation of Benefits** business process is responsible for the creation of Explanation of Medicaid Benefits (EOB) for detecting payment problems. AHS sends both targeted and random EOB's to selected members, providers and contractors. It gives information on the Medicaid services paid on behalf of the member. The communication may include the provider's name, member's name, the date(s) of services, service performed, payment amount(s), etc. Instructions on the communication tell the member/provider what to do if the service was not performed/ordered or if any additional concerns are identified.

NOTE: This business process does not include the handling of returned information.

#### 2.6.1.1 Additional Information

VT is seeking an easy to understand EOBs that can be usefully shared with much higher proportions of the member base (target to reach 100%).

The communication to members, providers and contractors must be configurable to ensure useful feedback is obtained.

## 2.6.2 Business Process Steps

1. START: Request received or timetable for scheduled EOB generation.
2. Identify target sample for EOB (some random and others targeted based on analysis).
3. Review sample selection information.
4. Prepare EOB for each selected member, provider and/or contractor
5. If applicable, send alert to member via **Manage Applicant and Member Communication** business process with EOB query information.
6. If applicable, send alert to notify provider via **Manage Provider Communication** business process with EOB query information.
7. END: If applicable, send alert to notify contractor via **Manage Contractor Communication** business process with EOB query information.

## 3.0 Financial Management

Vermont has defined Financial Management as one of the key components of the MMIS to be procured. There are sixteen business processes that have been defined by the CMS Medicaid Information Technology Architecture (MITA) v3.0. These business processes are contained within the MITA Financial Management business process area, and contain all of the processes within that area except Manage TPL Recovery, Manage Estate Recovery (both part of the Operations Management business area) and Manage Contractor Payment (part of the Contractor Management capability)

The business processes in this document provide a description of the processes Vermont wishes to be performed with the new MMIS and the associated services the vendor will support. These processes provide context to the Core MMIS functional requirements.

### 3.1 FM01 Manage Provider Recoupment

#### 3.1.1 Description

The **Manage Provider Recoupment** business process manages the determination and recovery of overpayments to providers. Provider recoupment is initiated upon the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where provider owes monies due to fraud or abuse.

The business thread begins with discovering the overpayment, then retrieving claims payment information, initiating the recoupment, or adjudicating a claims adjustment, and notifying the provider of audit results via the **Manage Provider Communication** business process, applying recoupments in the system via the **Manage Accounts Receivable** Information business process, and monitoring payment history until the provider satisfies the repayment.

##### 3.1.1.1 Additional Information

Recoupments are collected in most forms in Vermont, including via cash, check, EFT, etc., however AHS prefers that providers are credited against future payments for services if recoupment can be realized within 30 days.

Some Departments pay providers based on a six-month prospective budget and then reconcile against the Monthly Service Report (MSR) data submitted external to the MMIS. Recoupments for any overpayment are then calculated. This process needs to be automated.

Recoupments are tracked in the MMIS and associated to the appropriate claim. This will ensure that the appropriate amount is tracked to the **Manage 1099** process

#### 3.1.2 Business Process Steps

1. Fiscal Agent, MMIS or AHS discovers overpayment. This may be caused by (not inclusive):
  - a. Routine adjustment notification
  - b. Provider utilization review finding
  - c. Fraud and abuse case finding or outcome

- d. Communication with a third-party payer.
2. Fiscal Agent retrieves claims payment information.
3. Fiscal Agent Initiates recoupment.
4. MMIS sends alert to notify provider of recoupment (e.g., amount owed).
5. AHS discusses and agrees upon the method and timing of repayment or recoupment.
6. If applicable, MMIS sends alert to **Apply Mass Adjustment** business process for retroactive modifications.
7. MMIS sends alert to monitor recoupment activities to **Manage Accounts Receivable Information** business process.

## 3.2 FM04 Manage Drug Rebate

### 3.2.1 Description

Rebate functions are performed by the PBM, but the information must be communicated to [the MMIS for streamlined reporting](#).

## 3.3 FM05 Manage Cost Settlement

### 3.3.1 Description

The Manage Cost Settlement business process begins with the submission of the provider's annual Medicare Cost Report to Medicaid.

Staff makes inquiries for paid, denied and adjusted claims information in the Claims data store. The business process includes:

- Reviewing provider costs and establishing a basis for cost settlements or compliance reviews.
- Receiving audited Medicare Cost Report from intermediaries.
- Capturing the necessary provider cost settlement information.
- Calculating the final annual cost settlement based on the Medicare Cost Report.
- Generating the information for notification to the provider.
- Verifying the information is correct.
- Producing the notifications to providers.
- Establishing interim reimbursement rates.

#### 3.3.1.1 *Additional Information*

Vermont may make some cost settlements through the Apply Mass Adjustment business process (DMH Level 1 payments, Medicaid eligible residential treatment services though DCF).

Programs that are known to have cost settlements include (subject to review):

- Federally Qualified Health Centers (FQHCs)
- Department of Mental Health Level 1 Inpatient
- Juvenile Rehabilitation

### 3.3.2 Business Process Steps

1. The Fiscal Agent receives Medicare Cost Report from provider.
2. The Fiscal Agent requests annual claims detail information.
3. The Fiscal Agent reviews provider costs.
4. The Fiscal Agent establishes a basis for cost settlements or compliance reviews.
5. The MMIS receives audited Medicare Cost Report from intermediaries from **Receive Inbound Transaction**.
6. The MMIS receives provider cost settlement information from **Receive Inbound Transaction**.
7. The MMIS captures the necessary provider cost settlement information.
8. The MMIS calculates the final annual cost settlement based on the Medicare Cost Report and prorates for Medicaid services.
9. The Fiscal Agent establishes interim reimbursement rates.
10. The Fiscal Agent generates cost settlement information identifying the amount of overpayment or underpayment
11. AHS identifies the reimbursement rates AHS would consider for the next year.
12. AHS verifies that all information is correct.
13. The MMIS sends alert to notify providers of cost settlements summary information.
14. The MMIS sends cost settlement summary information to providers via **Send Outbound Transaction**.
15. The MMIS sends alert to monitor payment activities to **Manage Accounts Receivable Information** business process.
16. The MMIS sends alert to conduct retroactive modifications to **Apply Mass Adjustment** business process.
17. AHS sends alert of interim reimbursement rates to **Manage Rate Setting** business process.

## 3.4 FM06 Manage Accounts Receivable Information

### 3.4.1 Description

The Manage Accounts Receivable Information business process is responsible for all operational aspects of collecting money owed. At a minimum, activities in this business process comply with CFR 45, Cash Management Improvement Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP), in addition to any of those currently in place within the State.

Activities included in this business process include at least the following:

- Periodic reconciliations between the State Medicaid Enterprise and the accounting system of record for Vermont, Vision.
- Assign account coding to transactions processed in State Medicaid Enterprise.
- Process Accounts Receivable invoicing (estate recovery, co-pay, drug rebate, recoupment, third-party liability (TPL) recovery, SB6 match payments, provider taxes and member premiums).
- Manage cash receipting process.

- Manage payment-offset process to collect receivables.
- Respond to inquiries concerning Accounts Receivable.

The MMIS, with support by the FA, will provide the capability to manage non-Medicaid Accounts Receivable as decided by the State.

### 3.4.2 Business Process Steps

1. The Fiscal Agent receives initial Accounts Receivable information and generates an associated invoice to establish the receivable amount and demographic information for the debt owner.
  - a. This step may be completed within the MMIS and Fiscal Agent, or may be received from a business trading partner, such as a sister department within AHS.
2. The Fiscal Agent records Accounts Receivable payments to the account balance.
3. MMIS adjusts balance for additional Accounts Receivable amounts. An adjustment may increase or decrease the balance.
  - a. The adjustments include settlements, liens, levies and/or judgments against the Accounts Receivable.
  - b. Adjustments may be received from (not inclusive):
    - i. Other business processes including (but not limited to):
      1. **Manage Provider Recoupment**
      2. **Manage TPL Recovery**
      3. **Manage Estate Recovery**
      4. **Manage Drug Rebate**
      5. **Manage Cost Settlement;**
    - ii. Other State or Federal agencies
    - iii. Other payment methods and/or purposes, including, but not limited to:
      1. Provider taxes
      2. SB6 match payments
    - c. Adjustments are considered refunds of expenditures, not revenues.
  4. MMIS produces month-end Accounts Receivable balance and statement. This includes invoices to the debt owner and summary information for financial reports.
  5. MMIS produces aging report of Accounts Receivable due.
  6. MMIS updates the State accounting System of Record, Vision.
  7. MMIS sends alert to collect payment to **Manage Accounts Receivable Collection/Refund** business process.
  8. MMIS sends response to requested function.

## 3.5 FM07 Manage Accounts Receivable Collection/Refund

### 3.5.1 Description

The Manage Accounts Receivable Collection/Refund business process is responsible for all operations aspects of the collection of payment owed to Vermont AHS. At a minimum, activities in this business process comply with CFR 45, Cash Management Improvement Act (CMIA), Governmental Accounting

Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP), in addition to any of those currently in place within the State.

### **3.5.1.1 Additional Information**

Additional Accounts Receivable types that are specific to Vermont include, but are not limited to:

- Provider Taxes
- Success Beyond Six (SB6) Payments

### **3.5.2 Business Process Steps**

1. Fiscal Agent receives payment (e.g., cash, check, credit/debit, electronic funds transfer).
2. Fiscal Agent records the payer and payment amount information.
3. MMIS creates payment receipt notice. Whether a receipt is generated should be based on at least:
  - a. Established payer preferences within the system
  - b. Program or payment type configuration
  - c. Manual overrides by the system user
4. If applicable, MMIS notifies payer of payment receipt (e.g., email, mail, electronic funds transfer). Whether a notification is generated should be based on at least:
  - a. Established payer preferences within the system
  - b. Program or payment type configuration
  - c. Manual overrides by the system user
5. MMIS applies payment to Accounts Receivable in system.
6. MMIS prepares a file to be automatically uploaded into the Vision system including relevant coding for recognizing the receipt in the State's accounting system.

## **3.6 FM08 Prepare Member Premium Invoice**

### **3.6.1 Description**

Vermont AHS formulates the premium amounts on factors such as family size, income, age, and benefit plan during eligibility determination and enrollment.

The **Prepare Member Premium Invoice** business process begins with a configurable timetable (currently monthly) for scheduled invoicing. The business process includes:

- Retrieving member premium information.
- Performing required information manipulation according to business rules.
- Formatting the results into required output information.
- Sending member premium invoice alert to the **Manage Applicant and Member Communication** business process.

NOTE: This business process does not include sending the member premium invoice electronic data interchange (EDI) transaction.

### **3.6.2 Business Process Steps**

1. Alert is triggered based on periodic, configurable timetable for scheduled invoicing.
2. MMIS retrieves member premium information.
3. MMIS adjusts member premium information based on established criteria.
4. MMIS formats the results into required output information.
5. MMIS produces member invoice information.
6. MMIS sends alert to generate invoice via **Manage Applicant and Member Communication** business process.

## **3.7 FM10 Manage Member Financial Participation**

### **3.7.1 Description**

**The Manage Member Premium Payment** business process is responsible for all operations aspects of preparing member premium payments. This includes premiums for Medicare, also known as Medicare Buy-in, and other health insurance. The business process begins with the alert from Medicare or other insurer requesting a premium payment, or from an applicant or a referral on behalf of the applicant.

Vermont assists low-income Medicare members in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a process referred to as buy-in. Under the buy-in process AHS, the Social Security Administration (SSA) and U.S. Department of Health & Human Services (HHS) has entered into a contract where AHS pays the Medicare member a share of premium costs, and, in some instances, deductibles, and co-insurance.

An exchange of eligibility information between Medicare and AHS initiates Medicare premium payments. The State Fiscal Agent receives eligibility information from Medicare, performs a matching process against the AHS member data store located in the MMIS, generates buy-in files to Centers for Medicare & Medicaid Services (CMS) for verification, receives premium payment information and generates payments to CMS. AHS stakeholders are involved in the process to verify, authorize and manage exceptions. NOTE: This business process does not include sending the premium payments as an electronic data interchange (EDI) transaction.

#### **3.7.1.1 Additional Information**

Vermont is pursuing a Dual Eligible Demonstration Program. This process will be revised to incorporate changes based on the implementation of that program.

Each sub-process (e.g. Medicare buy-in) should have the ability to be processed for a single member, the full Medicaid population, or a selected subset of the Medicaid population.

### **3.7.2 Business Process Steps**

1. Alert is triggered to determine if AHS should pay a member's premium. Alerts may be triggered by:
  - a. Receipt of a Medicare eligibility file(s)
2. Fiscal Agent prepares Medicaid Premium Payment for Medicare.

- a. The Fiscal Agent receives a State Data Exchange (SDX), Enrollment Data Base (EDB) file, and/or the SSA Beneficiary Data Exchange (BENDEX) eligibility files from the Receive Inbound Transaction.
  - b. The MMIS performs a member matching and verification process against the member data store within the MMIS.
  - c. The MMIS generates a buy-in file, containing both Medicare Part A and Medicare Part B members (includes all requests for action including discrepancies from previous month).
  - d. The Fiscal Agent sends the buy-in file to CMS.
  - e. The Fiscal Agent receives CMS responses to the buy-in file (i.e., the billing file for both Medicare Part A and Part B) including eligibles, responses to errors, and Medicare buy-in file information.
  - f. The Fiscal Agent processes CMS responses to the submitted buy-in file and assess the file for accuracy and completeness.
  - g. The MMIS posts buy-in modifications to the member data store.
  - h. The MMIS produces buy-in reports reflecting potential Medicare eligibles including any additions or deletions to existing Member data store as well as other discrepancies.
  - i. The Fiscal Agent researches unmatched and discrepancies to determine appropriate eligibility.
  - j. The MMIS creates problem discrepancy form(s) reflecting potential Medicare eligibles, unmatched, and discrepancies, and update final Medicare buy-in file.
1. Fiscal Agent confirms member remains eligible for coverage under the alternative insurance coverage on a monthly basis.
  2. MMIS sends alert to conduct premium payment to **Manage Accounts Payment Information** business process.
  3. MMIS sends alert to notify member of premium payment.
    - a. Alerts are configurable by at least:
      - i. Program
      - ii. Payment type
      - iii. Member configuration
  4. MMIS sends alert to notify Medicare of member premium payment.
    - a. Alerts are configurable by at least:
      - i. Program
      - ii. Payment type
      - iii. Member configuration

## 3.8 FM11 Manage Capitation Payment

### 3.8.1 Description

The **Manage Capitation Payment** business process includes the activities to prepare Primary Care Case Management (PCCM) or Managed Care Organization (MCO) capitation payments. Vermont offers members the option of enrolling in a PCCM product that requires the selection of a Primary Care

Physician (PCP). The PCP receives a Per-Member-Per-Month (PMPM) capitation payment amount for all members.

The provider payment schedule defines the PCCM capitation rates, typically actuary-based, generated on an age and gender rating or a flat rate. The **Manage Capitation Payment** business process interrogates the member, provider, and member assignment and contract capitation information, and creates the information extract necessary to generate the capitation payment. The extract information includes any processing rules and options including retroactive adjustments to member assignments that affect the capitation payment amount to the provider.

### **3.8.1.1 Additional Information**

Vermont currently employs a 1115 Global Commitment waiver that provides PMPM funding, through DVHA, to other governmental entities including VDH, AOE, DAIL, DCF and DMH via Inter-Governmental Agreements to provide care to certain populations in innovative care models. Examples of investments that the State has made under this waiver include:

- School health services
- Blueprint for Health
- Vermont Information Technology Leaders (VITL)
- Tobacco Cessation
- Women, Infant, & Children (WIC)
- Non-traditional Mental Health Services
- HIV Drug Coverage

The MMIS will support these models with calculation of the payment structure, management of the payment, allocation of multiple funds, and any reconciliation of funding and service details (as available) after payment.

In addition, AHS currently pays a number of provider types via a capitated payment, including Community Rehabilitation and Treatment (CRT) providers and non-emergency transportation providers.

Some capitated payments are reconciled by various methods, including

- Calculated based on a look-back of configurable length to determine how many eligible members received a service during the period. Currently look-back lengths are between 100 days and multiple years.
- Cost reconciled based on actual services provided

Timing of payments is configurable based on program, including, but not limited to, daily, weekly, monthly, quarterly and annually.

### **3.8.2 Business Process Steps**

1. Timed event triggered on daily, weekly or monthly basis to initiate **Manage Capitation Payment** business process to invoke capitation information extract.

2. MMIS sends alert to **Manage Account Payment** Information business process to generate capitation payments.

## 3.9 FM12 Manage Incentive Payment

### 3.9.1 Description

The **Manage Incentive Payment** business process accommodates administration of various incentive compensations to payers, providers, and members.

Federal or state policy defines the programs, which are typically short duration and limited in scope. The policy defines specific periods, qualification criteria, and certification or verification requirements.

The **Manage Incentive Payment** business process follows the **Manage Program Policy** that manages program administrative rules, whether Federal or State, and concludes with paying the payer, provider, or member.

#### 3.9.1.1 Additional Information

Examples of incentive programs include:

- IFS Bundled Rate Program which increases rates if providers meet a target caseload
- EHR Incentive Program which pays certain providers if they meaningfully use Electronic Health Record applications
- 340B Program Incentive Payments
- Good Health Screening for members

### 3.9.2 Business Process Steps

1. AHS receives addition or modification of incentive program based on federal or state policy.
2. AHS disseminates Federal or State policy regarding incentive program.
3. If applicable, payer, provider, or member applies for incentive.
4. MMIS, AHS or Fiscal Agent determines if payer, provider, or member is eligible for incentive program.
5. Payer, provider, or member performs activities defined in incentive program policy.
6. If applicable, payer, provider, or member submits artifacts required for compliance.
7. If applicable, payer, provider, or member requests payment.
8. AHS or Fiscal Agent determines appropriate payment based on policy guidelines.
9. MMIS sends alert to **Manage Account Payment** Information business process to generate payment to payer, provider, or member.

## 3.10 FM13 Manage Accounts Payable Information

### 3.10.1 Description

The Manage Accounts Payable Information business process is responsible for all operational aspects of money AHS pays. Activities in this business process comply with, at a minimum, CFR 45, Cash

Management Act, Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP), and others currently in use by the State.

Activities included in this process may be:

- Periodic reconciliations between the State Medicaid Enterprise and the system that performs State accounting functions, Vision.
- Assignment of account coding to transactions processed in the State Medicaid Enterprise, including interfacing with the State's accounting system - Vision.
- Processing Accounts Payable invoices created at any AHS Department.
- Processing Accounts Payable invoices created in Accounting System (gross adjustments or other service payments not processed through the State Medicaid Enterprise, and administrative payables).
- Loading Accounts Payable information (warrant number, date, etc.) into the State Medicaid Enterprise and the State's accounting system - Vision
- Managing canceled/voided/stale dated warrants.
- Disbursing federal administrative costs reimbursements to other entities.
- Responding to inquiries concerning accounting activities.

#### **3.10.1.1 Additional Information**

There are several current processes that will be automated with a new MMIS and / or performed by the Fiscal Agent. Some of these processes include:

- Medicaid payments made to Foster Parents are currently managed and issued through the Department of Children and Families SSMIS and reconciled to MMIS.
- TPL Accounts Payable are determined and then manually entered into the MMIS. The expected TPL functionality should perform this function with verification by AHS workers.
- DMH provides a manual list of providers and amounts to pay and these are entered into the MMIS.

Vermont utilizes Financial Pends as a means to temporarily create an Accounts Payable to providers to manage appropriation limitations within the budget cycle, compliant with the timely payment standards. The use of Financial Pends is automated based on funding available, or manual, and the length of the Accounts Payable for each pen created is configurable to a date or length of time.

#### **3.10.2 Business Process Steps**

1. Fiscal Agent and/or the MMIS receive request and information to make payment.
2. Fiscal Agent and the MMIS confirm all appropriate payment authorizations have been received. Payment authorizations are configurable by at least:
  - a. Program
  - b. Payment type
3. MMIS performs requested function.
4. MMIS produces report.
5. MMIS produces financial transaction.

6. MMIS updates financial information.
7. MMIS send alert to make payment to **Manage Accounts Payment Disbursement** business process.
8. If applicable, MMIS sends alert to **Establish Compliance Incident** business process for continued failure to make obligated payments.
9. MMIS sends response to requested function.

### 3.11 FM14 Manage Accounts Payable Disbursement

#### 3.11.1 Description

The **Manage Accounts Payable Disbursement** business process is responsible for managing the generation of electronic and paper-based reimbursement instruments (check and EFT) and may include:

- Calculation of payment amounts for fee-for-service claims, pharmacy point-of-sale, and home and community-based services (HCBS) based on:
  - Priced claim, including any third-party liability (TPL), and crossover or member payment adjustments.
  - Retroactive rate adjustments.
  - Adjustments for previous incorrect payments, taxes, performance incentives, recoupments, garnishments, and liens based on information in the Provider data store, as well as state accounting and budget rules.
  - Application of automated or user-defined adjustments based on contract (e.g., adjustments or performance incentives).
- Disbursement of the entirety of all payment from appropriate funding sources per Vermont and AHS accounting and budget rules including, but not limited to:
  - Health Insurance Premium Payment Program (HIPP) premium.
  - Medicare premium.
  - Primary Care Case Managers (PCCM) fee.
  - Stop-loss payment.
  - PCCM management fee.
- If applicable, association of the electronic funds transfer (EFT) with an ANSI X12 835 Health Care Claim Payment/Advice or ANSI X12 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction.
- Routing of the payment per the provider or contractor data store payment instructions for EFT or check generation and mailing.
- Alert sent to the Manage Accounts Payment Information business process with updated suspended and paid claims transaction accounting details.
- Alert sent to the Manage Accounts Payment Information business process with updated suspended and paid premium, fees, and stop-loss claims transaction accounting details.

The process must support differing frequency of payments under the federal Cash Management Improvement Act (CMIA), including real-time payments where appropriate (e.g., Pharmacy Point-of-Sale).

### 3.11.2 Business Process Steps

1. MMIS receives request for payment based on a transactional request, is triggered at a specified time (e.g. weekly), or is generated as a batch processing,
2. MMIS prepares provider payment:
  - a. Receive payment information from the **Process Claim** or **Process Encounter** business processes.
  - b. Apply automated or user-defined payment calculation rules (e.g., deducting tax per rates in provider files, garnishments, and liens) by accessing information from provider files and send alert to the **Manage Accounts Payable** Information business process.
3. MMIS prepares premium payment:
  - a. Receive premium payment information from the **Prepare Member Premium Payment** or **Prepare Provider Payment** business processes.
  - b. Apply automated or user-defined payment calculation rules such as risk adjustment and stop-loss claims, retrospective enrollment, and performance incentives.
4. MMIS disperse funds as specified by the Vermont and AHS accounting and budget business rules.
5. MMIS routes payments as specified by the provider or contractor pay-to instruction or based on information submitted in the standard claim transactions.

## 3.12 FM15 Manage 1099

### 3.12.1 Description

The **Manage 1099** business process describes how AHS handles IRS 1099 forms including preparation, maintenance and corrections. Any payment or adjustment in payment made to a single Social Security Number (SSN) or federal Tax ID Number (TIN) impacts the business process.

The **Manage 1099** business process receives payment and/or recoupment information from the **Process Claim** business process or from the **Manage Accounts Payment Information** business process.

The **Manage 1099** business process may also receive requests for additional copies of a specific IRS 1099 form or receive notification of an error or a needed correction. The business process provides additional requested copies via the **Manage Provider Communication** or **Manage Contractor Communication** business process. Staff researches error notifications and requests for corrections for validity and generate a corrected 1099 or a brief explanation of findings.

#### 3.12.1.1 Additional Information

Currently, workarounds exist to manage 1099's that are impacted by TPL recoveries. The MMIS will track these recoveries to the claim level to ensure an accurate 1099.

1099 solution being required for HIPP payments in instances where the State is reimbursing individuals for employer deductions for individual's share of their premium with appropriate handling of pre-tax and post-tax contributions. Business Process Steps

Preparation/Maintenance

1. The Fiscal Agent receives claim payment and adjustment information from **Process Claim** or **Manage Accounts Payment Information** business process.
2. The Fiscal Agent matches TIN or SSN.
3. The Fiscal Agent updates cumulative totals by applying all payments and relevant recoupments, including those from cost settlements and manual checks.
  - a. Prepare report of those not getting a 1099.
  - b. Produce master report of 1099s.
  - c. Review all 1099 reports for accuracy.
4. The Fiscal Agent prepares the 1099's at close of calendar year.
5. The Fiscal Agent sends the 1099's, preferably electronically, to appropriate providers and contractors prior to January 31.
6. The Fiscal Agent submits 1099 information to Internal Revenue Service (IRS).

#### Alternate Path - Additional Requests

1. The Fiscal Agent receives request for additional 1099(s).
2. The Fiscal Agent logs request.
3. The Fiscal Agent verifies identity of requesting entity.
4. The Fiscal Agent re-generates requested 1099(s).
5. The Fiscal Agent sends 1099 to requesting entity.
6. The Fiscal Agent logs 1099(s) sent.

#### Alternate Path - Corrections

1. The Fiscal Agent receives notification of error.
2. The Fiscal Agent logs request.
3. The Fiscal Agent verifies identity of requesting entity.
4. The Fiscal Agent researches error or update request.
5. If no error found, END: The Fiscal Agent sends alert to notify requesting entity of findings.
6. If error found valid, the Fiscal Agent makes necessary modifications.
7. The Fiscal Agent prepares corrected or updated 1099.
8. The Fiscal Agent logs 1099 sent.
9. The Fiscal Agent sends corrected 1099 to affected parties.
10. The Fiscal Agent submits corrected 1099 information to Internal Revenue Service (IRS).

### **3.13 FM16 Formulate Budget**

#### **3.13.1 Description**

The overall process, performed in part by AHS and the Fiscal Agent and supported by MMIS capabilities:

- Examines the current budget revenue stream and trends, and expenditures.
- Assesses external factors affecting the program.
- Assesses agency initiatives and plans.
- Models different budget scenarios.
- Periodically produces a new budget.

### **3.13.1.1 Additional Information**

The Formulate Budget business is jointly performed by AHS and the Fiscal Agent with support by MMIS budgeting tools. The Fiscal Agent is expected to prepare information and generate reports, as well as assist the State with analyzing Federal mandates, and the State policy decisions of these mandates, as well as general support for AHS in this process. AHS will be responsible for the setting direction, analyzing and documenting changes and projections, and developing the budget.

### **3.13.2 Business Process Steps**

1. AHS receives notice or other trigger event to prepare the Office of Governor budget transmittal for Legislative approval.
2. AHS reviews current budget including cost and revenue trends, Centers for Medicare & Medicaid Services (CMS) notification of federal grant award and changes in FFP and FMAP rates, demographics, utilization and other information. The MMIS will support the review by allowing users to:
  - a. Continue analyses developed the cycle before, and incorporate the most recent cycle
  - b. Compare budgeted amounts to actuals
  - c. Analyze funded initiatives according to ROI, and non-monetary targets
  - d. Assign monetary impacts based on changes, and display the annual and cumulative effects of these impacts. Ex:
    - i. Changes in rates
    - ii. Additional/removed programs or services
  - e. Analyze known trends
  - f. Discover new trends
  - g. Compare multiple budgets
  - h. Project expenditures based on actual expenditures with calculated and user-definable forecasted changes
  - i. Providing access to reports on demand, including:
    - i. Extensive use of graphics where appropriate
    - ii. Summary and detailed views of information
    - iii. Drill-down and drill-up capabilities on information
    - iv. Export capabilities in common formats
    - v. Sorting and filtering capabilities based on available provider, member, financial and other criteria
    - vi. Exception reporting
3. AHS researches factors (e.g., national, legislative, and global) that affect revenue, costs, major initiatives and benefits. The MMIS capabilities to do this include:
  - a.
  - b. "What-if" scenarios for potential impacts to the budget based on expected changes in rates, populations, utilization, programs, benefits, funding, match rates, etc.
  - c. Sensitivity analyses on potential initiatives or changes
  - d. "Sandbox" functionality that allows for experimentation that is easily reversed

- e. Reporting on the modeled budget consistent with the reporting described above
- 4. AHS develops the final budget and transmits to the Office of the Governor.
  - a. When finalized, the budgeting tool will allow AHS to “lock in” at least the following
    - i. Selected changes
    - ii. Initiatives chosen, with targets, financial measures and non-financial measures
- 5. AHS testifies before the State legislature and/or convene stakeholders to consider alternatives.
- 6. AHS models or modifies budget transmittal based on legislative or Office of Governor directives.
- 7. Legislature publishes finalized budget.
- 8. State workers enter approved budget into state accounting system, Vision and other expenditure accounting systems, including Vantage.

### **3.14 FM17 Manage Budget Information**

#### **3.14.1 Description**

The Manage Budget Information business process is responsible for auditing all planned expenses and revenues of AHS.

Activities in this business process comply with, at a minimum, CFR 45, Cash Management Act, Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP), in addition to other standards and mandates used currently.

#### **3.14.2 Business Process Steps**

1. AHS receives request to review or modify approved budget.
2. AHS reviews policies and procedures for planning and budgeting to determine if budget meets State and Federal requirements.
3. AHS reviews long-term goals and objectives plans.
4. AHS reviews budget to determine accurate and timely information.
5. AHS reviews budget performance monitoring information, including performance-based budgets on a scheduled basis.
6. AHS reviews budget revisions to determine their justification.
7. AHS prepares budget modification request to Office of Governor based on state budget policies.
8. AHS receives approval from Office of Governor to modify budget.
9. AHS modifies budget information as necessary within Vantage.

### **3.15 FM18 Manage Fund**

#### **3.15.1 Description**

The Manage Fund business process oversees Medicaid and other funds, ensures accuracy in their allocation and the reporting of funding sources. Funding for Medicaid services may come from a variety of sources, and some State funds span across State agency administrations, e.g., Department of Mental Health, Vermont Department of Health, Department of Aging and Independent Living, Agency of Education, as well as counties and local jurisdictions.

The Manage Fund monitors funds through ongoing tracking and reporting of expenditures and corrects any improperly accounted expenditure. It also deals with projected and actual over and under fund allocations.

Manage Fund business activities include:

- Manage Federal Medical Assistance Percentages (FMAP)  
The Manage FMAP activity periodically reviews and modifies, as appropriate, FMAP and Enhanced Federal Medical Assistance Percentages (enhanced FMAP) rate used. (See 42 CFR 433.10). The U.S. Department of Health & Human Services (HHS) notifies the state of the FMAP and (enhanced FMAP) that HHS will use in determining the amount of federal matching for state medical assistance (Medicaid), Children's Health Insurance Program (CHIP), and Recovery Audit Contractor (RAC) expenditures for a specified federal fiscal year. The SMA reviews and approves the FMAP rates for application in enterprise accounting.
- Manage Federal Financial Participation (FFP)  
The Manage FFP business activity includes the creation and management of business rules for assigning claims, service payments, and recoveries (including RAC recoveries) to the appropriate FMAP, and the application of administrative costs to the state accounting system. It also includes the oversight of reporting and monitoring Advance Planning Documents or other program documents necessary to secure and maintain FFP.
- Draw and Report FFP  
The Draw and Report FFP business activity assures that the SMA properly draws federal funds and reports to Centers for Medicare & Medicaid Services (CMS). The SMA is responsible for assuring that the correct FFP rate applies to all expenditures in determining the amount of federal funds to draw. When CMS has approved a State Plan, it makes quarterly grant awards to the SMA to cover the federal share of expenditures for services, training, and administration. The grant award authorizes the SMA to draw federal funds as needed in accordance with the Cash Management Improvement Act (CMIA) to pay the federal share of disbursements. The SMA receives FFP in expenditures for the CHIP program.

### **3.15.2 Business Process Steps**

#### Manage Fund

1. AHS establishes State appropriation for Federal, State, and, potentially, employer funds.
2. AHS allocates funds to direct and indirect budget categories.
3. AHS establishes reporting requirements.
  - a. Vermont reporting requirements include:
    - i. All mandated CMS reports including CMS-64 and CMS-21
    - ii. Additional reporting detail supporting the State Jumbo IAPD
4. The Fiscal Agent defines report content, frequency, and media.
5. The Fiscal Agent prepares the information.
6. The Fiscal Agent compares fund usage with categories and flags funds improperly used.

7. The Fiscal Agent analyzes trend rate of usage of funds by Medicaid Eligibility Group and Category of Service as compared to amounts available and flags computed overages / underages. The Fiscal Agent generates defined reports.
8. AHS reviews reports for accuracy.
9. AHS distribute reports.
10. AHS reviews trends and improper use of funds, and manage funds as needed to deal with shortfalls and over allocations.

#### Manage FMAP

1. AHS receives notification of FMAP rates or rate modifications.
2. AHS reviews and analyze notification.
3. AHS verifies accuracy of rates in notification.
4. AHS notifies HHS of any disagreement.
5. AHS resolves any disagreement with HHS.
6. AHS requests the Fiscal Agent to publish/load approved rates.
7. The Fiscal Agent loads the approved rates into the MMIS.

#### Manage FFP

1. AHS prepares information necessary to create the reports (e.g., CMS-21, CMS-37 and CMS-64).
2. AHS generates reports.
3. AHS reviews generated reports for accuracy and deficiencies.
4. AHS monitors expenditures, cost, budget, and so forth.
5. AHS analyzes potential program additions, modifications, or deletions for fiscal impact.
6. AHS modifies and update impacted reports and budget.
7. AHS finalize reports.
8. AHS sends report via the Send Outbound Transaction, preferably through electronic submission.

#### Draw and Report FFP

1. AHS submits Form CMS-37 and Form CMS-21B through the Medicaid Budget and Expenditure System/CHIP Budget and Expenditure System (MBES/CBES).
  - a. Reports are submitted electronically whenever possible.
2. AHS reviews the quarterly grant request.
3. AHS receives the grant award from CMS regardless of whether there are open issues with CMS. The Payment Management System (PMS) deposits funds into the Medicaid account based upon the CMS 37 estimates.
4. AHS determines the Federal share of current expenditures taking into consideration receipts (e.g. estate recovery, recoupments of incorrect billings) and draw Federal funds in accordance with the terms of the CMIA.
5. At end of each quarter, AHS completes cash management reconciliation using the PMS 272 report.
6. AHS submits Form CMS-64 and Form CMS-21 to MBES/CBES.
  - a. Reports are submitted electronically whenever possible.

7. CMS may increase or decrease the grant request amount already deposited according to the resolution of issues process.
  - a. If necessary, AHS sends supporting documentation to the CMS Regional Office for use in its quarterly review to support State Medicaid Enterprise numbers and to address deferrals, disallowances, supplemental payment.
8. AHS cooperates with CMS review of program and administration expenditures and implements corrective action if CMS Financial Management Review (FMR) or Office of Inspector General reviews reveal any Federal requirement compliance problems.
9. AHS arranges for annual Single Audit for the Comprehensive Annual Financial Report conducted by a state-contracted Certified Public Accountant (CPA) firm in accordance with the provisions of OMB Circular A-133.
10. AHS follows-up and takes corrective action(s) on audit findings includes the preparation of a summary schedule of prior audit findings and submission of a corrective action plan (CAP).

### **3.16 FM19 Generate Financial Report**

#### **3.16.1 Description**

It is essential for AHS to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the established benefits and programs are meeting the needs of the member population and are performing according to the intent of the legislative laws or federal reporting requirements.

- The Generate Financial Report business process begins with a request for information or a timetable for scheduled correspondence. The business process includes:
  - Defining the report attributes (e.g., format, content, frequency, media, and retention).
  - Defining the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy).
  - Extracting required financial information from source data stores.
  - Transforming information to meet business and technical needs of target destination.
  - Applying necessary encryption algorithms for security.
  - Sending alert with information to the target destination.
- NOTE: This business process does not include maintaining the benefits, reference, or program information. Maintenance of the health plan, health benefits and reference information is in separate business processes.

##### **3.16.1.1 Additional Information**

Reports are generated in a variety of formats that meet the needs of the user. These report types include:

- Dashboard or interactive graphical and numeric reports that provide drill-down and drill-up capabilities and links to related reporting.
- Static periodic reports.
- Parameterized reports that provide a controlled number of variables that can be changed.

- Ad hoc reporting capabilities that provide authorized users to generate queries and reports on data sets available through the MMIS, and in conjunction with other data sets that are available.

In addition, reporting capabilities will have:

- Appropriate security and role-based access to data
- Access to data at least the following levels:
  - Claim / encounter
  - Provider / service entity
  - Member
  - Funding source
  - Department
  - Time

### **3.16.2 Business Process Steps**

1. AHS receives request for generation of financial report.
2. AHS logs the request.
3. AHS defines required report(s) format, content, frequency, media for the reports and its retention period.
4. AHS defines data elements necessary to produce the report (e.g., state and federal budget categories of service, eligibility codes, taxonomy codes).
5. AHS extracts required information from source data stores.
6. If applicable, AHS transforms information to meet business and technical needs of target destination.
7. If applicable, AHS applies necessary encryption algorithms for security.
8. AHS logs the response.
9. If applicable, AHS sends the report to the Send Outbound Transaction for delivery to target destination.
10. AHS reviews financial report for analysis or distribution.

## **3.17 FMX1 Manage Clawback Payment**

### **3.17.1 Description**

AHS processes clawback payments to the Federal government for dual-eligible members. Payments are processed based on receipt of an invoice from CMS of the dual-eligible population, member matching and verification through the MMIS, and clarification of the correct population and associated costs with CMS.

### **3.17.2 Business Process Steps**

1. Alert is triggered to determine if AHS should pay a clawback payment. Alerts may be triggered by:
  - k. Receipt of a Medicare invoice
3. Fiscal Agent prepares Medicaid Clawback Payment for Medicare.

- a. The Fiscal Agent receives an eligibility file from Medicare with the invoice.
  - b. The MMIS performs a member matching and verification process against the member data store within the MMIS.
  - c. The MMIS generates a clawback file (includes all requests for action including discrepancies from previous month).
  - d. The Fiscal Agent sends the clawback file to CMS.
  - e. The Fiscal Agent receives CMS responses to the clawback file including eligibles, responses to errors, and Medicare clawback file information.
  - f. The Fiscal Agent processes CMS responses to the submitted clawback file and assess the file for accuracy and completeness.
  - g. The MMIS posts clawback modifications to the member data store.
  - h. The MMIS produces clawback reports reflecting potential Medicare eligibles including any additions or deletions to existing Member data store as well as other discrepancies.
  - i. The Fiscal Agent researches unmatched and discrepancies to determine appropriate eligibility.
  - j. The MMIS creates problem discrepancy form(s) reflecting potential Medicare eligibles, unmatched, and discrepancies, and update final Medicare clawback file.
5. MMIS sends alert to conduct clawback payment to **Manage Accounts Payment Information** business process.
  6. MMIS sends alert to notify Medicare of clawback payment.
    - a. Alerts are configurable by at least:
      - i. Program
      - ii. Payment type

## 4.0 Member Services

There are seven business processes for Member Services defined by the CMS Medicaid Information Technology Architecture (MITA). These business processes include: Member Enrollment (ME) and Eligibility and Enrollment Management (EE).

The business processes in this document provide a description of the processes Vermont wishes to be performed with the new MMIS and the associated services the vendor will support. These processes provide context to the Core MMIS functional requirements.

### 4.1 EE02 Enroll Member

#### 4.1.1 Description

The Enroll Member business process receives eligibility information from the **Determine Member Eligibility** business process via an interface to the eligibility system (ACCESS or IE). This process determines additional qualifications for enrollment in health benefits for which the member is eligible, and produces notifications for coordination of communications to the member, provider, and to the eligibility system.

The Marketplace, Agency, Vendor or enrollment brokers may perform some or all of the steps in this business process.

##### 4.1.1.1 Additional Information

Medicaid benefit eligibility and associated plan can be determined by an external process to ACCESS, and in the future the Integrated Eligibility System (e.g. Ladies First). Once eligibility is determined, this information will be entered into the IE system. Similarly, the **Enroll Member** business process will receive all eligibility determination information from ACCESS and the future IE System (once in place).

All member communications should be coordinated to minimize multiple communications (e.g. Notification to Member determined eligible for Medicaid benefits must be coordinated with their welcome package).

Vermont currently enrolls members on the 1st day of the month but requires flexibility in enrollment dates to allow differing dates for populations or programs.

#### 4.1.2 Business Process Steps

1. START: Receive eligibility determination to enroll or “un-suspend” member.
2. Associate member with appropriate health plan, if applicable, and health benefits. Member can be associated to one or more health plans.
3. If applicable, send alert to send enrollment information to contractor.
4. If applicable, send alert to send dual eligibility enrollment information to Medicare.
5. If applicable, send alert to **Manage Member Premium Payment** for premium payment arrangement.

6. END: Send notification to member with welcome package and identification cards via **Manage Applicant and Member Communication** business process.

## 4.2 EE03 Disenroll Member

### 4.2.1 Description

The **Disenroll Member** business process is responsible for the termination (or suspension) of a member's enrollment in a health plan or health benefit. An enrollment termination may occur when:

- A member is no longer eligible based on redetermination of Medicaid eligibility either on an annual basis or as a result of change reporting during the coverage year.
- Upon receipt of a notification of incarceration, AHS may decide to suspend enrollment.
- A member is no longer eligible based on change in residence. NOTE: Members who move out of state for the purposes of receiving treatment are not immediately ineligible.
- The eligibility for a program is based on health status, and the member's health status has changed.
- A member submits a disenrollment request.
- Disenrollment request from a provider or contractor due to issues with the member such as moving out of service area, fraud and abuse, disruptive behavior, non-compliance, or death.
- Member is deceased.
- Receive disenrollment request from Manage Compliance Incident Information business process for continued failure to make payments.
- Receive disenrollment request from Determine Adverse Action Incident due to fraudulent or abuse activity.
- The provider or contractor has a change of status or termination that requires a mass disenrollment of members.
- A health plan or health benefit has a change that requires a mass disenrollment of members.
- A member modifies their Manage Care Organization (MCO), Primary Care Case Manager (PCCM), or waiver provider:
  - Member changes information during Open Enrollment period.
  - As permitted by State rules, such as the following:
    - Change in member's residence.
    - A provider whom the member has chosen no longer contracts with current program or MCO.
    - Medicaid terminates the contract with the member's MCO or PCCM.
    - Member successfully appeals auto-assignment.
    - The member has issues with the MCO, PCCM, or waiver provider that may affect quality of care.

NOTE: Enrollment brokers may perform some of the steps in this business process.

#### **4.2.1.1 Additional Information**

All member communications should be coordinated to minimize multiple communications. A clear coordination process must be established between the notices that are sent out by ACCESS / the IE system and the future MMIS.

#### **4.2.2 Business Process Steps**

1. START: Receive disenrollment request.
2. Log disenrollment request including source of disenrollment and type of request.
3. Validate request meets State disenrollment rules.
4. If applicable, terminate enrollment in Medicaid health plans and/or health benefits.
5. If applicable, enroll member in alternative health plans and/or health benefits.
6. If applicable, terminate enrollment with provider or contractor.
7. If applicable, enroll member with alternative provider or contractor.
8. Send alert to **Manage Applicant and Member Communication** business process to notify member of enrollment status changes including disenrollment and procedural rights.
9. Send alert to **Perform Population and Member Outreach** business process to notify affected members with the termination of health plan, health benefit, a provider or a contractor.
10. If applicable, send alert to **Manage Member Premium Payment** to stop premium payment arrangement.
11. If applicable, send alert to **Manage Case Information** to discontinue care management. Once this information is shared with the Member, Care Management must inform the specific Member's program what has been communicated to the Member in relation to their disenrollment/suspension.
12. Send alert to send disenrollment information to relevant programs, Departments and Agencies.
13. END

### **4.3 EE04 Inquire Member Eligibility**

#### **4.3.1 Description**

The **Inquire Member Eligibility** business process receives requests for eligibility verification from Health Insurance Marketplace (HIX), authorized providers, programs or business associates; performs the inquiry; and prepares the Eligibility, Coverage or Benefit Information response. The response information includes but is not limited to benefit status, explanation of benefits, coverage, effective dates, case notes, and amount for co-insurance, co-pays, deductibles, exclusions and limitations. The information may include details about the Medicaid health plans, health benefits, and the provider(s) from which the member may receive covered services.

NOTE: This business process does not include Member requests for eligibility verification. Member initiated requests are handled by the **Manage Member Information** business process.

### 4.3.2 Business Process Steps

1. START: Receive eligibility verification request via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 inquiry transaction using CAQH CORE Rules. This request may contain multiple 270 transactions.
2. Log eligibility verification request.
3. Validate requester's authorization to receive requested information based on their role. This authorization may vary based on requestor type (i.e. Provider, State program lead, authorized non-providers, etc.) or on the plan to which the member is enrolled (e.g. substance abuse treatment).
4. Find requested member's eligibility information.
5. SMA logs response.
6. If applicable, send response to AVRS (automated voice response system) with eligibility information.
7. END: Send response to requestor via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules. If the original request encompassed multiple 270 transactions, the response transaction should encompass the multiple 271 transactions.

## 4.4 ME01 Manage Member Information

### 4.4.1 Description (from Manage Member Information in MITA 2.0)

The **Manage Member Information** business process is responsible for managing all operational aspects of the Member, 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**.

#### **4.4.1.1 Additional Information**

The Vermont Member Registry is external to the MMIS. The MMIS will access the Member Registry through an interface with the State’s Enterprise Master Person Index interface, a component of the Health Services Enterprise (HSE) Platform.

Changes to Member information must be auditable and traceable.

#### **4.4.2 Business Process Steps (from Manage Member Information in MITA 2.0)**

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

### **4.5 ME02 Manage Applicant and Member Communication**

#### **4.5.1 Description (from Manage Applicant and Member Communication in MITA 2.0)**

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 including ad hoc communication(s) by benefit/program are handled by the **Manage Applicant and Member Communication** process by providing assistance and responses to individuals, i.e., bidirectional 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.

#### 4.5.1.1 **Additional Information**

Member communications can occur through multiple push/pull channels, including:

- Push channels - Mail, email, and automated phone notifications
- Pull channels - Member portal for Members to setup account and access member-specific information, including claims status information

In addition, Member communications may be sent to one or more alternate contacts (authorized representatives) in addition to or in alternative to the member.

#### 4.5.2 **Business Process Steps (from Manage Member Information in MITA 2.0)**

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, including required timeframe for communication.
3. Research/develop communication that is linguistically, culturally, and competency appropriate
4. Prepare/package communication. Bundle relevant communication and coordinate content based on State business rules.
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.]

### 4.6 **ME03 Perform Population and Member Outreach**

#### 4.6.1 **Description (from Perform Population and Member Outreach in MITA 2.0)**

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 plans 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. Inquiries from applicants, prospective and current members including ad hoc communication(s) by benefit/program are handled by the **Manage Applicant and Member Communication** process by providing assistance and responses to individuals, i.e., bidirectional communication.

#### **4.6.1.1 Additional Information**

Outreach communications must include the ability to conduct population surveys. Target population could include not only current and prospective members but also past participants.

#### **4.6.2 Business Process Steps (from Manage Member Information in MITA 2.0)**

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 or 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. Alert **Manage Member Information** if communication is undeliverable or misdirected.
8. Outreach communications production and distribution are tracked and materials archived.
9. Efficacy measures are recorded for outreach activity.

### **4.7 ME08 Manage Member Grievance and Appeal**

#### **4.7.1 Description (from Manage Member Grievance and Appeal in MITA 2.0)**

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.

#### **4.7.1.1 Additional Information**

Every AHS Department manages a Grievance and Appeals process, with program-specific rules, policies and procedures. In addition, there is a Fair Hearings process with the Attorney General's Office which can occur sequentially or concurrently with the process at the Departments.

#### **4.7.2 Business Process Steps (from Manage Member Information in MITA 2.0)**

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. Schedule hearing within required time.
6. Conduct hearing within required time.
7. Determine disposition within required time.
8. Log disposition
9. If applicable, alert **Manage Member Information** in order to modify information based on disposition.
10. 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.

## 5.0 Operations Management

There are eighteen business processes for Operations Management defined by the CMS Medicaid Information Technology Architecture (MITA). These business processes include: Operations Management (OM), Care Management (CM) – which are not addressed in the CM Solution procurement, Financial Management (FM) processes related to third party liability, and Plan Management (PL).

The business processes in this document provide a description of the processes Vermont wishes to be performed with the new MMIS and the associated services the vendor will support. These processes provide context to the Core MMIS functional requirements.

### 5.1 OM04 Submit Electronic Attachment

#### 5.1.1 Description

The **Submit Electronic Attachment** business process begins with receiving attachment information that either a payer requests (solicited) or a provider submits (unsolicited). The solicited attachment information can be in response to requests for more information from the following business processes for example: **Authorize Service**, **Authorize Treatment Plan**, and **Manage Estate Recovery**.

The business process links attachment information to the associated applicable transaction (e.g. prior authorization, treatment plan). The business process validates the successfully associated attachment information using application-level edits, determining whether the information provides the additional information necessary to adjudicate (i.e., approve, suspend or deny) the transaction.

##### 5.1.1.1 Additional Information

The payer or provider should be able to submit paper attachments (which will be scanned) or attach electronic documents (via the web or through an interface). When a claim or encounter is submitted through the web front-end/portal the system should perform validations (wherever possible) to confirm the appropriate attachment is included prior to accepting the claim.

If a claim/encounter requires an attachment and it is not submitted with the claim/encounter the claim/encounter will be denied – they will not be suspended waiting for attachments to be received and the process below does not apply.

To streamline the processing, AHS' goal is to minimize the paper attachments received and scanned in favor of electronic attachments. As such, the system should allow parties to submit a variety of attachments electronically. All electronic attachments will be automatically processed by the MMIS system and the Fiscal Agent will process any paper attachments received.

#### 5.1.2 Business Process Steps

1. START: Fiscal Agent or MMIS receives attachment information.
2. Fiscal Agent or MMIS validates that the attachment provides all required information.

3. Fiscal Agent or MMIS associates attachment information with applicable transaction (If applicable, submitter should provide document number or other identifying information of the transaction to which the attachment needs to be associated).
4. Fiscal Agent or MMIS validates application level edits such as provider, member, and benefit information, and association with transaction.
5. Fiscal Agent or MMIS determines whether the attachment supplies the additional information as required by Vermont's business rules.
6. If applicable, the Fiscal Agent rejects attachment information as invalid and communicates to the submitter. END: Business process stops.
7. If applicable, the Fiscal Agent or the MMIS suspends attachment information awaiting the receipt of a matching transaction. END: Business process stops.
8. If applicable, the Fiscal Agent or the MMIS purges the attachment after duration of predetermined time. END: Business process stops.
9. END: Accept and associates attachment information with the appropriate transaction.

#### **5.1.2.1 *Alternate Business Process Path: Self Service Submittal***

1. START: Payer or provider logs into the MMIS system.
2. Payer or provider validates the attachment provides all required information.
3. Payer or provider associates attachment with the applicable transaction.
4. Go to Step 4 of the primary business process.

## **5.2 OM05 Apply Mass Adjustment**

### **5.2.1 Description**

The **Apply Mass Adjustment** business process begins with the receipt or notification of retroactive modifications. These changes may consist of modified rates associated with HCPCS, CPT, Revenue Codes, or program modifications/conversions that affect payment or reporting.

The **Apply Mass Adjustment** business process includes identifying the payment transactions such as claims or capitation payment by identifiers (e.g., claim/bill type, HCPCS, CPT, Revenue Code(s), or member identification) that need to be adjusted and a specified date range.

Mass adjustments could also be due to a retroactive role change which would allow a denied claim to be paid as an edit/audit was changed/removed.

#### **5.2.1.1 *Additional Information***

The State frequently pays correctly based on the system information on the adjudication date, but needs to make retroactive adjustments. The business process applies a predetermined set or sets of parameters that may reverse or amend the paid transaction and repay correctly.

The State may want to notify impacted parties (e.g. providers, members, contractors) beforehand as the change may result in claims being denied as a result of the adjustment.

The State needs the ability to perform a vulnerability review before making the changes so they can assess the impact.

The MMIS must track the changes to each claim. This should include tracking whether the claim allowed and paid amount is the original claim, adjusted or mass adjusted.

If the original claim was manually forced through audits and then the claim was mass adjusted, the MMIS needs to track that the claim passed the original audits and allow it to be bypassed during the adjustment.

No previously adjudicated claim can be re-submitted as a new claim. The provider must be able to reopen, change and resubmit a claim, keeping the same claim number (for example, providers must be able to correct an internally denied claim). Audit trail information about the history of any changes to claim must be maintained. The version of the claim should be evident in the ICN.

### 5.2.2 Business Process Steps

1. START: AHS determines a mass adjustment is required based on retroactive rate modifications, program modifications, retroactive modifications in member's eligibility or system errors.
2. Fiscal Agent or AHS identifies the parameters necessary to locate payment records (e.g. provider type, procedure code, procedure).
3. Fiscal Agent or AHS enters parameters (i.e. updated information).
4. Fiscal Agent or AHS applies a pre-defined set of rules to identify the claims which may be modified based on this change.
5. A pre-finalized adjustment report is created to assess impact. AHS provides approval to make the change.
6. Fiscal Agent or AHS applies the predetermined set of parameters that adjusts the payments.
7. MMIS, if applicable, produces mass adjustment request report.
8. Fiscal Agent or AHS reviews the mass adjustment report for validity and accuracy.
9. MMIS, if applicable, automatically sends an alert to notify member (via **Manage Applicant and Member Communication** process) of relevant modifications.
10. MMIS, if applicable, automatically sends alert to notify providers (via **Manage Provider Communication** process) of relevant modifications.
11. MMIS, if applicable, automatically sends an alert to send providers an ANSI X12 835 Health Care Claim Payment/Advice transactions.
12. MMIS, if applicable, automatically sends an alert to notify contractors (via **Manage Contractor Communication** process) of relevant modifications.
13. MMIS, if applicable, sends alert to **Manage Accounts Receivable Information** of relevant modifications.
14. MMIS, if applicable, sends alert to **Manage Accounts Payable Information** of relevant modifications.
15. END: Apply mass adjustment to previous payments.

## 5.3 OM07 Process Claims

### 5.3.1 Description

The **Process Claims** business process receives the original or adjusted claim (e.g., institutional, professional, dental and waiver) information via web, electronic data interchange (EDI) transaction or paper.

All claim types must go through most of the business process steps but with different logic associated with the different claim types. Both the Center for Medicaid & Medicaid Services (CMS) and state policy determine business rules for claims edits, audits, and pricing methodologies. Vermont specific business rules define whether to pay, suspend or deny a claim.

Processing an adjustment to a claim is an exception process that follows the same process path. It requires a link to the previously processed claim in order to reverse the original claim payment and associate the original and adjusted claim's payment information.

#### 5.3.1.1 Additional Information

The State supports associating a funding source with the claim line item based on a hierarchical relationship. The MMIS must be able to determine the funding split for submitted claims based on business rules. For example:

- Federal/state split for Medicare eligible members
- Split between funding sources
- Split based on plan covered services
- Split based on multiple plan coverage

Vermont policy includes multiple match rates within a single service stream. For example, Affordable Care Act pays 100% for changes between 2009 rate and current rate.

Vermont does not edit the face of the claim: the submitter must resubmit an adjusted claim.

Claims data must be made available to run predictive analysis to indicate the need for follow-up intervention (e.g. real-time, daily, weekly etc.).

Vermont needs the ability to enter comments throughout the adjudication process capturing the reason/rationale for the decision made to support the auditing process.

The system must have the ability to process bundled claims based on a variety of payment methodologies. The system must be able to process bundled claims to a service detail level.

Pharmacy claims will be adjudicated by the PBM system and be paid through the MMIS system. The MMIS system must support a two way interface with PBM solution to support, at a minimum, claims to be submitted by the PBM system and status/historical information be provided to the PBM solution.

### 5.3.2 Business Process Steps

1. START: MMIS or Fiscal Agent receives claim submission or claim adjustment information. Processing of electronic submittals will be automated and paper submittals will be received by the Fiscal Agent who will scan the documents and input the required data into the system
2. MMIS Perform Fatal Edits:
  - a. If electronic claim submission, perform X12 edits for valid syntax and format, identifiers and codes, dates, and other information required for the transaction according to the agreed-upon levels 1-7 stated in the Trading Partner Agreement.
    - i. If applicable, MMIS send alert to submitter via ANSI X12 TAI Interchange Acknowledgement or 997 Functional Acknowledgement with Fatal Edit failure(s) needing correction.
    - ii. END: Business process stops.
  - b. MMIS validates that claim submission meets filing deadlines based on service dates.
  - c. If applicable, MMIS rejects electronic or paper claim for fatal validation errors and send alert to **Generate Remittance Advice** business process with error report information.
  - d. END: Business process stops.
3. Perform Non-Fatal Edits:
  - a. MMIS determines claim status as initial submittal, adjustment to a processed claim (based on the resubmit flag with a previously assigned in-house claim number), or a duplicate submission that is already in the adjudication process, but not yet completed and loaded into payment history (using a unique Patient Account Number).
    - i. If applicable, associate the claim adjustment to the original claim submission.
  - b. MMIS validates provider information (e.g., provider taxonomy, NPI, enrollment status, approved to bill for this service).
  - c. MMIS validates member information (e.g., member's eligibility status on the date of service, apply third-party resources to the claim).
    - i. If applicable, go to alternate path **Third Party Liability Failures**.
  - d. MMIS validates member's health benefits cover the service and applies appropriate rules. For example:
    - i. Member has another health plan as their primary insurance and the State covers the same service. Designate the claim for the Coordination of Benefits (COB) and processes claims according to COB business rules.
    - ii. Pay and Chase – Based on certain factors (e.g. codes or court orders) the State of Vermont processes and pays the claims independent of the member's additional insurance and pursues re-imburement after the fact.
  - e. MMIS validates appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status.
  - f. If state-defined business rules identify certain edits that cause a claim to be suspended, and a claim fails for one or more of them, go to **Alternate Path: Suspended Claim** below.

4. Perform Audits:
  - a. MMIS checks payment history for duplicate processed claim using search key information such as in-house claim number, date of service, provider and member demographics, service, and diagnosis codes.
  - b. MMIS verifies Authorized Service (prior authorization) Number to ensure available units, and validate relationship to claim and appropriateness of service.
  - c. MMIS checks Clinical Appropriateness of the services provided based on clinical, case and disease management protocols (i.e. Care Management).
  - d. MMIS performs Prospective Payment Integrity Check.
  - e. If applicable, MMIS determines if claim amount exceeds member's allocation, provider's payment budget with accrued claims to date.
  - f. If State-defined business rules identify certain audits that cause a claim to suspend, and a claim fails for one or more of them, go to Alternate Path: **Suspended Claim** below.
5. MMIS validates National Correct Coding Initiative (NCCI) (bundle/unbundle codes) and/or other codes (e.g. MUE, medically unlikely events).
6. If applicable, MMIS applies Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules, as appropriate.
7. MMIS performs Pricing (based on effective date):
  - a. Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC, patient share).
  - b. Calculates paid amount by deducting:
    - i. Contributions provided by the member.
    - ii. Provider advances and recoupment.
8. MMIS checks for presence of coordination of benefits (COB) claim information.
  - a. if system identifies the member has insurance and no COB attachment is included::
    - i. Set status to Deny
    - ii. Flag and move claim to COB file.
    - iii. Send alert to Send Outbound Process with claim adjudication information and claim.
  - b. If COB is included on the claim and the system does not indicate the member has additional coverage
    - i. Suspend the claim to be researched
8. If at any point during processing the claim is denied, the provider will re-submits the claim which will follow the original process.
  - a. Go to step 2 of the **Process Claim** business process.
  - b. END: Business process stops.
9. MMIS sends alert to **Generate Remittance Advice** business process with payment information.
9. MMIS sends alert to **Manage Accounts Receivable Information** business process with payment information.
10. MMIS sends alert to **Manage Accounts Payable Information** business process with payment information.
11. END: MMIS send alert to **Prepare Provider Payment** business process for payment.

### **5.3.2.1 *Alternate Business Process Path: Suspended Claim***

1. START: Claim has an assigned suspended status.
2. AHS conducts Internal review
  - a. If applicable, reviewer requests further information.
  - b. If applicable, send alert to submitter via ANSI X12 277 Health Care Information Status Notification.
  - c. Internal review (including clinical review as required) makes a determination to pass the edit in question. If applicable, the Fiscal Agent may redirect a suspended detail or claim to another entity to review, utilizing the MMIS to facilitate the redirection or assignment of the claim for another review to evaluate.
3. Provider submits additional information or resubmits claim with corrected information in response to an error notification.
  - a. The claim passes the edit or audit based on additional information submitted in response to a request, such as the ANSI X12 277 Health Care Information Status Notification. NOTE: The **Submit Electronic Attachment** business process generates this request and reviews the response to validate that the additional information submitted is sufficient to pass the edit or audit.
4. If there is a favorably resolved suspended claim (e.g. weekly bill vs. monthly claim)
  - a. Go to step 7 of the **Process Claim** business process. END: Business process stops.
5. If there is an unfavorably resolved suspended claim, the claim is denied and MMIS sends an alert to **Generate Remittance Advice** business process with error report information. These include failures because the additional information requested for a suspended claim is not present, is inadequate or fails to satisfy the edit or audit.
6. END: All suspended claims are processed - either denied or paid.

### **5.3.2.2 *Alternate Business Process Path: Third Party Liability Failures***

1. START: A third-party resource is identified.
2. Analyze and research COB and EOB information. If it is correct, process TPL information.
3. If a cost-avoidance for third party liability exists and an explanation of benefits (EOB) from the primary insurer is not attached to the claim, the claim should be denied for COB edit. If the EOB is attached to the claim, the claim should be processed accordingly. TPL may not be available for all services covered by Agency of Human Services programs, the new MMIS must be able to differentiate Medicaid-only services from services covered by other programs and services covered by other health insurance entities.
4. Send alert to **Manage TPL Recovery** business process for recovery of funds from third-party insurance carrier.
5. END: Send alert to **Generate Remittance Advice** business process with Edit Error Report information.

## 5.4 OM14 Generate Remittance Advice

### 5.4.1 Description

The **Generate Remittance Advice** business process describes the activity of preparing remittance advice/encounter electronic data interchange (EDI) transactions that providers use to reconcile their accounts receivables. This business process begins with receipt of information resulting from the **Process Claim** business processes, performing required manipulation according to business rules and formatting the results into the required output information which sends to **Send Outbound Transaction** process.

#### 5.4.1.1 Additional Information

Remittance Advice information must be made available to the **Manage Provider Communications** process to support electronic and human language communications.

In certain cases, Remittance Advice information must be sent to multiple people based on provider enrollment information. Remittance Advice information must be clear and readable, where possible it should include English descriptions (e.g. include “Provider not on file” not just the error code “001”) and can be loaded/extracted into end-user tools.

The Remittance Advice should include flags and provide the edits/audits that cause a claim to be denied.

The State also needs the ability to produce a Remittance Advice Form even when no payment is made.

### 5.4.2 Business Process Steps

1. START: MMIS receives claims information from the **Process Claim** business processes.
2. MMIS performs required information manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim (e.g., bundling or unbundling of services), to captures comments as to reason for adjudication decision making for auditing purposes.
3. MMIS generates remittance advice transaction.
4. END: MMIS sends alert to send to provider ANSI X12 835 Health Care Claim Payment/Advice transactions.

## 5.5 OM18 Inquire Payment Status

### 5.5.1 Description

The **Inquire Payment Status** business process begins with receiving a 276 Health Care Claim Status Request transaction or a request for information received through other means such as email, paper, telephone, facsimile, web, or automated voice response (AVR).

The business process handles the request for the status of a specified claim(s), retrieves information from the claims payment history, and generates the response information. In addition, the business process formats the information into the ANSI X12 277 Health Care Information Status Notification

transaction, or other mechanism for responding, via the media used to communicate the inquiry, and sends claim status response via the Send Outbound Transaction.

#### **5.5.1.1 Additional Information**

All medical related communications must be HIPAA compliant.

Vermont must be able to associate comments/notes with a claim to capture communications with requestor.

Participants must be able to submit requests and receive status information via fax, phone or via the web/portal front end.

#### **5.5.2 Business Process Steps**

1. START: Fiscal Agent or MMIS receives claim status request.
2. Fiscal Agent or MMIS logs/creates a claim status request.
3. MMIS validates requester has authorization to receive requested information.
4. MMIS reviews the payment status information to obtain required requested data elements (e.g., member's birth date, member's last and first name, member's ID, claim service date, ICN number, medical record number).
5. MMIS generates claim status response.
6. Fiscal Agent or AHS, if applicable, sends response via X12 277 Health Care Information Status Notification transactions to requester.
7. END: Fiscal Agent or AHS provides claim status response to requestor.

### **5.6 OM20 Calculate Spend-Down Amount**

#### **5.6.1 Description**

An individual who is categorically eligible for Medicaid but has income above the Medicaid standards may become eligible for Medicaid coverage through a spend-down of income. Eligibility is determined and the spend-down amount is calculated during the eligibility determination process by the Integrated Eligibility solution (currently ACCESS).

The eligibility status and spend-down amount are passed to the MMIS and all tracking of expenses to the spend-down amount will be performed by the MMIS during claims processing. Health expenses that are appropriate to the spend-down amount that are not submitted via other MMIS processes must be able to be submitted by the Member via the Member portal including receipt imaging and verified by State workers, or entered by State workers.

### **5.6.1.1 Additional Information**

The spend-down balance must reflect all eligible payments made by Members, including payments to pharmacies managed and tracked by the PBM, and payments for any qualified medical expense

### **5.6.2 Business Process Steps**

1. START: The applicant is determined to be an eligible Member with a spend-down amount. Integrated Eligibility system establishes an amount (the spend-down amount/spend-down obligation) for which each Member is responsible in order to receive payment for Medicaid services.
2. Upon receipt of a claim for payment from a Provider for Medicaid-eligible services for a Member with a spend-down amount, **OM07 Process Claims** calculates the State payment amount by reducing the payment by the remaining balance of the Member's spend-down amount.
3. If the original state payment amount exceeds the spend-down balance, the MMIS processes payment to the Provider for the excess.

END -If the spend-down balance exceeds the original state payment amount, the MMIS processes the claim with a \$0 payment to the Provider and reduces the Member's spend-down balance by the original State payment amount.

### **5.6.2.1 Alternate Business Process Path: Member Documents Spend-down**

1. START: The Member has a spend-down balance
2. The Member incurs out-of-pocket costs for qualifying medical expenses and provides AHS with appropriate documentation of the expenditure through the following methods including, but not limited to:
  - a. Uploading images of receipts and/or appropriate documentation of the expense through the Member portal
  - b. Submission of receipts and/or appropriate documentation of the expense to a State worker who then images and/or enters the information into the MMIS
3. The expense is verified by a State worker as a valid expense
4. END: Upon receipt and acceptance of documentation for a qualifying medical expense, the MMIS reduces the Member's spend-down balance by the expense amount.

## **5.7 OM27 Prepare Provider Payment**

### **5.7.1 Description**

The **Prepare Provider Payment** business process is responsible for the preparation of the payment report information. The reports are sent via email, mail, or electronic data interchange (EDI) to providers and used to reconcile their accounts receivable.

Home and Community-Based Services (HCBS) are not part of the traditional Medicaid benefit. Home and Community-Based Services are provided, authorized and arranged as an addition to traditional Medicaid benefits through an individual's plan of care.

This business process begins with receipt of information performing required manipulation according to business rules, and formatting the results into the required information.

This business process begins with a timetable for scheduled correspondence and includes retrieving enrollment and benefit transaction information, retrieving the rate information associated with the member's individual plan, and formatting the payment into the required structure

#### **5.7.1.1 Additional Information**

The assumption is that there will be a payment processing engine which supports:

- Making payments based on information contained on a claim
- Making ongoing payments based on information related to member/provider information (e.g. capitation payments)
- Making payments (ongoing or one-off) based on other related information (e.g. ACOs, promotional incentive payments, performance measures and performance payments)

Vermont needs the ability to hold payments (until outstanding balances are paid) and/or offset outstanding balance (including taxes, Medicare etc.) before making payments. This includes any funds captured through the recoupment process.

The State of Vermont manages, tracks and provides payment for a variety of programs based on different capitated rates and capitated rate methodology. The capitation payment may be configured per day, per month, or other period, depending on the program requirements and varying program rate methodologies. It must, however be able to be reported/tracked based on the amount, duration and scope of individual services included in the bundled payment package

Vermont needs the ability to suppress a check based on the Provider (e.g. AOE or school provider). These providers get a Remittance Advice but the check/payment is suppressed as other organizations process the payment.

Vermont needs the ability to group together payments based on provider, service and other criteria (specific to ACO).

Vermont also supports additional payment types including (but not limited to):

1. ACO
2. Pay for Performance
3. Incentive payments to dentists
4. Graduate Medical Education Payments
5. BluePrint

6. Primary Care
7. Temporary financial relief for nursing homes
8. Cash advances
9. Per-member per month payments
10. Manual Payouts

### **5.7.2 Business Process Steps**

1. START: MMIS receives alert from **Process Claim** business process (e.g. HCBS payments) or an alert that a timetable has passed and a payment is due (e.g. capitation payment).
2. MMIS performs required information manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, such as bundling or unbundling of services.
3. MMIS calculates payment amount.
4. MMIS generates payment report.
5. END: MMIS sends alert to submit payment information to provider.

## **5.8 OM29 Process Encounters**

### **5.8.1 Description**

The **Process Encounter** business process receives original encounter (e.g., institutional, professional, dental, and HCHS) information via paper, web or electronic data interchange (EDI) transaction and determines its submission status, and based on that:

All encounters must go through most of the business process steps but with different logic associated with the different encounter claim types. Both the Center for Medicare & Medicaid Services (CMS) and state policy determine business rules for encounter edits, audits, and pricing methodologies. Vermont specific business rules define whether an encounter goes to a to-be-paid status, suspends or denies an encounter.

Processing an adjustment to an encounter is an exception process that follows the same process path. It requires a link to the previously processed encounter in order to reverse the original encounter and associate the original and adjusted encounter.

#### **5.8.1.1 Additional Information**

The State of Vermont pays providers for the encounter but needs to capture the costs at the line item level.

COB must be supported on bundled payments.

Vermont needs the ability to enter comments throughout the adjudication process capturing the reason/rationale for the decision make to support the auditing process.

The system must have the ability to process bundled claims based on a variety of payment methodologies. The system must be able to process bundled claims to a service detail level.

### 5.8.2 Business Process Steps

1. START: MMIS or Fiscal Agent receives encounter submission or encounter adjustment information. Processing of electronic submittals will be automated and paper submittals will be received by the Fiscal Agent who will scan the documents and input the required data into the system
2. MMIS perform Fatal Edits:
  - a. If electronic encounter submission, perform X12 edits for valid syntax and format, identifiers and codes, dates, and other information required for the transaction according to the agreed-upon levels 1-7 stated in the Trading Partner Agreement.
    - i. If applicable, MMIS sends alert to send to submitter via ANSI X12 TAI Interchange Acknowledgement or 997 Functional Acknowledgement with Fatal Edit failure(s) needing correction.
    - ii. END: Business process stops.
  - b. MMIS validates that encounter submission meets filing deadlines based on service dates.
  - c. If applicable, MMIS rejects encounter for electronic or paper claim for fatal validation errors and send alert to **Generate Financial Report** business process with error report information.
  - d. END: Business process stops.
3. Perform Non-Fatal Edits:
  - a. MMIS determines encounter status as initial submittal, adjustment to a processed encounter (based on the resubmit flag with a previously assigned in-house encounter number), or a duplicate submission that is already in the adjudication process but not yet completed and loaded into encounter payment history (using a unique Patient Account Number).
    - i. If applicable, associate encounter adjustment to original encounter submission.
  - b. MMIS validates provider information (e.g., provider taxonomy, NPI, enrollment status, approved to bill for this service).
  - c. MMIS validates member information (e.g., demographics, eligibility status on the date of service).
    - i. MMIS validates service is covered by member's health benefits and apply appropriate rules. For example: This member's home and community based services package includes only home, work and crisis supports and excludes community supports
  - d.
  - e. MMIS validates appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status.

- f. If state defined business rules identify certain edits that cause an encounter to be suspended, and an encounter fails for one or more of them, send alert to Generate Financial Report business process with error report information. END: Business process stops.
4. Perform Audits:
  - a. MMIS checks encounter history for duplicate processed encounter using search key information such as in-house encounter number, date of service, provider and member demographics, service, and diagnosis codes.
  - b. MMIS verifies Authorized Service (prior authorization) Number to ensure available units; validate relation to encounter and appropriateness of service.
  - c. MMIS checks Clinical Appropriateness of the services provided based on clinical, case and disease management protocols (i.e. Care Management).
  - d. MMIS performs Prospective Payment Integrity Check.
  - e. If State defined business rules identify certain audits that cause an encounter to suspend, and an encounter fails for one or more of them, send alert to **Generate Financial Report** business process with error report information.
  - f. END: Business process stops.
5. MMIS validates National Correct Coding Initiative (NCCI) (bundle/unbundle codes).
6. If applicable, MMIS and Fiscal Agent apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules.
7. MMIS performs Pricing (Shadow-Pricing):
  - a. Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC).
  - b. Calculates to-be-paid amount by deducting:
    - i. Contributions provided by the member.
    - ii. Provider advances and recoupments.
8. Send alert to **Prepare Provider Payment** business process for payment.
9. END: Send alert to **Generate Financial Report** business process with payment information.

#### **5.8.2.1 Alternate Business Process Path: Suspended Encounter**

1. START: Provider re-submits information (corrected) in response to an error notification.
2. Process it as if it is an original encounter.
  - a. Go to step 2 of the **Process Encounter** business process.
3. END: Business process stops.

## **5.9 CM07 Authorize Referral**

### **5.9.1 Description**

The **Authorize Referral** business process is responsible for referrals between providers that the State of Vermont processes, based on state policy. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment.

Vermont uses this business process primarily for Primary Care Case Management programs where additional approval controls deemed necessary but also uses the process to approve members for Care Management.

The **Authorize Referral** business process may encompass both a pre-approved and post-approved referral request, especially in the case where the member required immediate services.

This business process may include, but is not limited to, referrals for specific types and numbers of visits, procedures, surgeries, tests, drugs, durable medical equipment, therapies, and institutional days of stay.

Vermont evaluates requests based on urgency, state priority requirements and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state). It validates key information, and ensures that the referral is appropriate and medically necessary. After review, staff approves, modifies, suspends for additional information or denies the request. This business process sends an alert to **Manage Case Information** business process.

A post-approved referral request is an editing/auditing function that requires review of information after the referral is complete. A review may consist of verifying documentation to ensure that the referral was appropriate, and medically and or functionally necessary, and validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the **Process Claim** or **Process Encounter** business processes.

NOTE: MITA contains three (3) different authorization business processes:

- Authorize Service – the standard process of prior authorization of services.
- Authorize Treatment Plan – the approval of a treatment plan prepared by a care management team in a care management setting.
- Authorize Referral – specifically the approval of a referral to another provider, requested by a primary care physician.

#### **5.9.1.1 Additional Information**

The State of Vermont requires prior approval referrals in certain scenarios and captures other referrals even if they are not required. For example, some out-of-network, durable goods, some pharmaceuticals, etc. referrals require prior approval.

The MMIS needs to track the relationship between the member and the authorized provider. This could include a combination of services.

Vermont would like the new MMIS solution to support receiving referrals via paper, electronic (e.g. integrate with EHR systems) or having the provider enter the information through a web interface.

If prior authorization is not required, the steps outlined above may be processed in a different order.

In addition to the typical referrals, the State of Vermont also supports the following referrals:

- Home and community based service providers designated to serve identified members based upon specific program rules (e.g. address of member, initial choice/election of provider by member).
- For times when the member chooses a new provider, the system needs the capacity to enable providers to refer to new providers (e.g. from one DA to another, or one case management agency to another).

### **5.9.2 Business Process Steps**

1. START: MMIS or Fiscal Agent receives referral notification from authorized provider.
2. MMIS validates information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields.
3. MMIS validates that the provided information is authentic.
4. END: If no authorization is required for referral, END.
5. MMIS assigns a tracking number.
6. MMIS prioritizes Referral Authorization Request.
7. MMIS verifies member program eligibility for services authorized or requested in the referral request
8. MMIS validates the following:
  - Member eligibility– for social service model, this entails assessing member’s health, functional, and socio-economic status
  - Eligibility for requesting and referral providers
  - Service coverage and referral requirements
  - Diagnosis code
  - Procedure code/or procedure groupings
7. MMIS checks for record of medical or functional necessity and appropriateness.
8. MMIS checks against current referral authorizations for duplicates.
9. MMIS validates completeness of supporting documentation.
10. MMIS denies based on insufficient/erroneous information for referral. Go to step 14.
11. MMIS suspends the referral request based on need for additional information – send request for additional information, suspend request and wait for additional information.
12. MMIS approves referral request (this includes approved with modifications).
13. MMIS sends alert to send referral authorization to requestor via ANSI X12 278 Health Care Services Review Request and Response transaction.
14. MMIS tracks approval of referral to be used by the claims processing engine and care management system.
15. END: MMIS sends alert to notify member, referring provider and referred-to provider of authorization determination.

### **5.9.2.1 Alternate Path – Post Approval**

For the authorization of some services, Vermont will use the post approval rather than the pre-approval business process. The post approval business process will cover all steps listed above but may execute in a different order.

## **5.10 CM08 Authorize Service**

### **5.10.1 Description**

The **Authorize Service** business process encompasses both a pre-approved and post-approved service request. It is variable based on amount, duration and scope of myriad of services. This business process focuses on specific types and amount, duration and scope of visits, procedures, surgeries, tests, drugs, therapies, durable medical equipment and home and community based services.

Pre-approval of a service request is a care management function and begins when a care manager receives a service request by mail, facsimile, telephone, or ANSI X12 278 Health Care Services Review Information request transaction. The care manager evaluates requests based on State of Vermont's rules for prioritization such as urgency and type of service/taxonomy (e.g., durable medical equipment, speech, physical therapy, dental, and out-of-network), validates key information, and ensures that requested service is appropriate and medically necessary.

After reviewing the service request, AHS staff approves, modifies, denies or suspends the service request for additional information. Vermont sends the appropriate response information for the outbound ANSI X12 278 Health Care Services Review Response transaction to the provider using the Send Outbound Transaction.

A post-approved service request is an editing/auditing function that requires review of information after the service is complete.

- A review may consist of verifying documentation to ensure that the services were appropriate and medically necessary, and validating provider type and specialty information to ensure alignment with agency policies and procedures.

NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including, but not limited to, Medical, Dental, Drugs, out-of-state transportation and lodging and Agency programs, .

NOTE: MITA contains three (3) different authorization business processes:

- Authorize Referral – specifically the approval of a referral to another provider, requested by a primary care physician.
- Authorize Service – the standard process of prior authorization of services.
- Authorize Treatment Plan – the approval of a treatment plan prepared by a care management team in a care management setting.

### **5.10.1.1 Additional Information**

Vermont supports receiving service authorization requests via paper, electronic (e.g. integrate with EHR systems) or having the providers enter the information. This includes supporting clinical documentation to determine medical appropriateness and medical necessity of services.

Vermont requires a two way interface with providers.

The MMIS must require the provider only enter the service authorization request once; so this business process must be linked to care management and claims processing.

### **5.10.2 Business Process Steps**

1. START: MMIS or Fiscal Agent receives service authorization request from authorized provider.
2. MMIS or Fiscal Agents validates information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields.
3. MMIS or Fiscal Agent validates that the provided information is authentic.
4. MMIS assigns a tracking number.
5. MMIS prioritizes Service Authorization Request.
6. MMIS verifies member program eligibility for services authorized or requested in the referral request.
7. MMIS validates the following:
  - a. Member eligibility – for social service model, this entails assessing member’s health, functional, and socio-economic status
  - b. Requesting and servicing providers
  - c. Service coverage and referral requirements
  - d. Diagnosis code
  - e. Procedure code/or procedure groupings
7. AHS checks for medical or functional necessity and appropriateness.
8. MMIS checks against current service authorizations for duplicates.
9. AHS validates completeness of supporting documentation.
10. AHS denies based on insufficient/erroneous information or authorization for service not medically necessary. Go to step 13.
11. AHS suspends the authorization request based on need for additional information. Go to step 13.
12. AHS approves service authorization request (this includes approved with modifications).
13. MMIS sends alert to send service authorization to requestor via ANSI X12 278 Health Care Services Review Request and Response transaction.
14. END: MMIS sends alert to notify member and requesting provider of service authorization determination within state-defined timeframes.

### **5.10.2.1 Alternate Path – Post Approval**

For the authorization of some services, Vermont will use the post approval rather than the pre-approval business process. The post approval business process will cover all steps listed above but they may execute in a different order.

## **5.11 CM09 Authorize Treatment Plan**

### **5.11.1 Description**

The **Authorize Treatment Plan** business process encompasses both a pre-approved and post-approved plan across traditional Medicaid services as well as home and community based service programs. Vermont uses the Authorize Treatment Plans primarily in many care coordination setting where the care management team assesses the client’s needs, decides on the appropriate array of services and completes the treatment plan. However, AHS may choose to use this process for other treatment plans, including those being managed by DMH and DAIL.

A treatment plan authorizes the named providers or provider types to provide services or a category of services. Vermont sometimes pre-approves individual providers for these service or category of services so they do not have to always submit individual service requests.

A treatment plan typically covers many services and spans a length of time.

- In contrast, the State of Vermont sometimes limits an individual service request, primarily associated with fee-for-services payment, to focus on a specific visit, services, or products (e.g., a single specialist office visit, approval for a specific test or particular piece of Durable Medical Equipment (DME)).

The pre-approved treatment plan generally begins with the receipt of an authorize treatment plan request from the care management team or a service coordinator. The request is evaluated based on program rules (for example urgency, state priority requirements, and type of service/taxonomy (speech, physical therapy, home health, behavioral, social). The request validates key information (for example, program eligibility, funding availability, rate methodology), and ensures that requested plan of treatment is appropriate and medically or behaviorally necessary. After reviewing, the plan may require approval by a local provider and routing to the authorizing State agency for review and approval. A provider agency or state staff approves, modifies, suspends for additional information or denies the request. Business process sends an alert to **Manage Case Information** business process.

A post-approved treatment plan is an audit function that reviews suspended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.

Vermont takes a broad interpretation of a “Treatment Plan” to include services and/or coverage for any individual.

NOTE: MITA contains three (3) different authorization business processes:

- Authorize Referral – specifically the approval of a referral to another provider, requested by a primary care physician.
- Authorize Service – the standard process of prior authorization of services.
- Authorize Treatment Plan – the approval of a treatment plan prepared by a care management team in a care management setting.

### 5.11.2 Business Process Steps

1. START: MMIS or AHS receives a request for Treatment Plan authorization for authorized provider or care manager.
2. MMIS validates information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields.
3. MMIS validates that the provided information is authentic.
4. MMIS assigns a tracking identifier.
5. MMIS prioritizes authorize treatment plan request.
6. MMIS validates the following:
  - a. Member eligibility
  - b. Eligibility for requesting and servicing providers
  - c. Service coverage and plan of treatment requirements
  - d. Diagnosis code
  - e. Procedure codes/or procedure groupings
7. MMIS and AHS check for medical, social, and behavioral appropriateness.
8. MMIS checks against currently authorized treatment plans and service requests for duplication.
9. MMIS coordinates services (check for duplicates) across programs and systems.
10. MMIS and AHS validate completeness of supporting documentation.
11. AHS denies based on insufficient/erroneous information or treatment plan identifying services not medically, socially and/or behaviorally necessary. Go to step 14.
12. AHS suspends the treatment plan request based on the need for additional information. Send a request for additional information. Go to step 14.
13. AHS approves plan of treatment request (this includes approved with modifications) and send approval response information to requesting parties.
14. MMIS sends alert to send treatment plan authorization. The system must be able to accommodate sending notifications to a variety of parties (e.g. requestor) through multiple mechanisms (e.g. via ANSI X12 278 Health Care Services Review Request and Response transaction). This must also notify service providers that services have been approved (e.g. transportation needs to know the member is approved to receive the service but does not need to know the details of the treatment plan).
15. END: MMIS sends an alert to notify member, care manager, and provider of authorization determination.

## 5.12 FM02 Manage TPL Recovery

### 5.12.1 Description

The **Manage TPL Recovery** business process begins by receiving third-party liability (TPL) information from various sources such as external and internal information matches, tips, referrals, attorneys, compliance management incident, Medicaid Fraud Control Unit (MFCU), providers and insurance companies. The business process includes:

- Identifying the provider or TPL carrier, locates recoverable claims.
- Working the case and collecting all relevant information.
- Providing COB information to the Integrated Eligibility system.
- Creating post-payment recovery documents (e.g. claims)
- Closing the case once the funds have been recovered or it has been determined there is no third party liability.
- Adjusting the historical files to reflect the results of the third party collection.
- Sends notification to the provider through the **Manage Provider Communication** business process or directly to third party who are not provider (e.g. automobile insurance companies).

#### 5.12.1.1 Additional Information

Potential TPL can be identified by the Fiscal Agent, the State, the member, or another third party. If this occurs the MMIS will generate claims to recover the costs of services paid by Vermont Medicaid and the claims will be tendered to the primary insurance company.

There are three primary types of TPL Recovery in Vermont:

- Retroactive Health Insurance Recovery – The member has health insurance about which Vermont was not aware when the claim was processed. If this occurs a claim is automatically generated and sent to the primary insurer for recovery.
- Pay and Chase – Certain procedure codes are automatically paid (e.g. Well Child Visits, EPSDT) and then the fees are recovered.
- Casualty Recovery – Vermont identifies these through multiple channels (e.g. Fiscal Agent Questionnaire, attorneys, insurance companies). For certain diagnosis/injury codes, Vermont sends out claims letters to assess whether funds can be recovered (e.g. automobile accident).

During the TPL Recovery process:

- Claims/recoveries must be flagged so they are not reported on 1099s
- Receivables must be set up
- Claims must be tracked through the process (in process of being recovered, partially recovered or fully recovered).

The MMIS needs to contain all information regarding the TPL including claims, recovery, lien (if required), notice of claim to individual's representative. All of these should be associated in a similar fashion to a member.

All additional insurance information identified during the process will be captured so it can be leveraged when processing future claims.

Vermont is seeking to tie recoveries to the original claims paid and, therefore, the fund from which the service was paid.

MMIS needs to have the ability to identify members with potential third party liability, through claims and then interface with the primary insurer to exchange TPL data and to submit claims to the primary insurer for services paid by Vermont Medicaid as primary.

### **TPL Sub-Process – Estate Recovery**

**Manage Estate Recovery** is a business process that requires States to recover certain Medicaid benefits correctly paid on behalf of an individual, by claiming funds against a deceased member's or deceased spouse's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid.

The **Manage Estate Recovery** business process begins by receiving estate recovery information from multiple sources (e.g., State of Vermont Tax Department, deceased Member's family member, tips from caseworkers and reports of death from nursing homes).

The MMIS system must generate correspondence (e.g., demand of notice to probate court via Send Outbound Transaction, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the **Manage Applicant and Member Communication** business process.

NOTE: This is not to be confused with settlements that are recoveries for certain Medicaid benefits correctly paid on behalf of an individual because of a legal ruling or award involving accidents.

Vermont complies with all Federal Regulations regarding Estate Recovery.

Vermont can only place claims against Estates opened in Probate Court. Presently Vermont receive a notice from the Tax Department of all Estates opened in Probate, or receive notice from the Executor/Executrix or and Attorney.

Vermont tracks the creation and financial activity of special needs trusts and annuities. Trusts and annuities are identified in the Medicaid eligibility process when an applicant is required to disclose income and assets to determine program eligibility. Trust and annuity balances are tracked on a yearly basis by the Coordination of Benefits Unit. Upon the Medicaid member's demise the remaining proceeds in the trust or annuity revert to the State of Vermont Medicaid program.

To the extent feasible, Vermont is seeking to tie recoveries to the original claims paid and, therefore, the fund from which the service was paid.

### **TPL Sub-Process – HIPP**

In addition, AHS has a Health Insurance Premium Payment (HIPP) process within the TPL team. AHS will pay the health insurance premiums for members who have health insurance benefits, if the insurance is determined to be cost effective. In these circumstances, a premium is prepared and sent to an external organization on the member's behalf (or to the member themselves) who serve as the member's primary insurance in addition to the Medicaid coverage.

HIPP initiates with an application for Medicaid where the applicant indicates they have third-party health coverage or by receiving eligibility information via referrals from Home and Community-Based Services (HCBS) offices, schools, community services organizations, or phone calls directly from members. The business process checks for internal eligibility status as well as eligibility with other payers, producing a report identifying individuals where paying premiums would be cost effective, and notifying members via **Manage Applicant and Member Communication**. AHS workers currently manage this process, but AHS is seeking opportunities to simplify and automate this process.

#### **TPL Sub-Process – VPHARM**

The TPL team also supports the VPHARM process. This process ensures appropriate Medicare D Plan payments are made. Every year the Medicare D Plan's offerings and costs change. This process analyzes plan enrollment to calculate the appropriate plan payment.

#### **5.12.2 Business Process Steps**

1. START: Fiscal Agent or AHS receives third-party liability information.
2. AHS identifies the provider or TPL carrier.
3. AHS locates recoverable claims.
4. AHS researches/works the case and collects required information.
5. MMIS and/or AHS, as appropriate, provides COB information to the Integrated Eligibility system which creates the file.
6. MMIS adjust historical files to reflect the results of the third party collection.
7. MMIS creates post-payment recovery documents (e.g. claims).
8. Send alert to notify provider or other payer of recovery request.
9. AHS closes the case once the funds have been recovered or it has been determined there is no third party liability.
10. Sends notification to the provider through the Manage Provider Communication business process or directly to third party who are not provider (e.g. automobile insurance companies).
11. END: Send alert to monitor recoupment activities to **Manage Accounts Receivable Information** business process.

Note: the AHS resources perform this task but the MMIS will be the repository for all information regarding the case. In some instances (e.g. Pay & Chase) the responsibilities are shared between AHS and The Fiscal Agent.

#### **5.12.2.1 Additional TPL Process – Estate Recovery**

1. START: Receive estate recovery referral information via several different sources (e.g., vital statistics and SSA date of death match, probate petition notices, eligibility caseworker, and nursing homes).
2. AHS review the deceased medical history and assess whether to open a case based on specific business rules (e.g. long term care, age).
3. AHS opens an estate recovery case.
4. AHS sends demand notice information to member correspondence (e.g., onto probate court).
5. AHS sends alert to notify deceased representative to complete estate recovery questionnaire.
6. AHS determines value of the claim by analyzing all Medicaid claims from age 55 forward (e.g., all paid claims equals claim amount).
7. If applicable, member may file an undue hardship waiver based on state regulations. If the SoV grants hardship, staff defers or closes the case.
8. AHS generate estate recovery proceedings information (e.g., file estate claim with probate court, estate recovery claim letters sent to Executor, Attorney, Special Administrator with copy to Probate Court) and send via Send Outbound Transaction.
8. AHS performs case follow-up at a predefined frequency (up to every 6 months)
9. MMIS sends an alert to monitor recovery activities to **Manage Accounts Receivable Information** business process.
10. MMIS sends an alert to **Manage Member Information** business process, updating Member data store.
11. END: Upon receipt of maximum possible payment, send letter of Discharge to Probate Court, Attorney, and Executor via Send Outbound Transaction. Close and archive estate recovery case.

#### **5.12.2.2 Additional TPL Process – HIPP Processing**

1. AHS receives information that it may be cost effective to include a Member in the HIPP program (automatically from MMIS, from case workers, policy holders and/or members covered by health insurance or JINC list).
2. AHS prepares HIPP information:
  - a. MMIS gathers known eligibility information.
  - b. AHS worker checks internal and external eligibility information and adds additional information as prompted by the MMIS, or as needed.
    - i. Information from the paperwork filled out by the employer
    - ii. Insurance information
    - iii. Cost of insurance per month and deductible
    - iv. Who is covered
    - v. If Plan is active
  - c. The MMIS runs a cost-effective test to determine potential cost effectiveness by using information such as policy coverage, past usage and by making a determination of future need.
  - d. The AHS worker selects to accept the System analysis, or override the suggestion

- i. All changes will contain a full audit trail and allow notes (with attribution) when doing so
- 3. If it is not cost effective the AHS worker collects EOBs and information regarding upcoming medical costs (e.g. upcoming surgeries) to see if this is still not cost effective
- 4. If not cost effective: END Process
- 5. If effective – AHS worker enters information into the MMIS System to support HIPP including:
  - a. Carrier code
  - b. Effected person
  - c. Recipient of payments
  - d. Premium re-imbusement amount
- 6. MMIS send an approval letter to client with start date of reimbursement and amount of reimbursement
- 7. MMIS sends alert to conduct ongoing premium payment to Manage Accounts Payment Information business process.
- 8. (ongoing) Fiscal Agent makes payment (via EFT or paper) to recipient (note: payment could be to a variety of recipients such as the member or their insurance company).
- 9. (ongoing) MMIS verifies the member’s Medicaid eligibility and verifies other insurance is still active before issuing payment END:

**5.12.2.3 Additional TPL Process – VPHARM Processing**

- 1. AHS determines the Medicare D yearly cost based on the benchmark set by CMS
  - a. Medicare D plan offerings and cost differ from year to year
- 2. AHS determines eligibility and adds/updates Medicare D plan information
  - a. Due to changing yearly this would need to be updateable
- 3. MMIS System identifies members who are eligible for Medicare D plan and analyzes premiums received monthly and calculates Medicare D payment amounts due from AHS to the member
- 4. MMIS sends an alert to FM14 Manage Accounts Payable Disbursement to process payments
- 5. MMIS analyzes Medicare D payments and identifies any recoupment opportunities based on new Medicare D information from CMS.
- 6. MMIS sends an alert to FM07 Manage Accounts Receivable Collection/Refund to collect any payments made in error (this could be a different carrier than the member’s current carrier and could be up to 1 years worth of historical premiums).
- 7. END:

**5.13 PL04 Manage Health Plan Information**

**5.13.1 Description**

The **Manage Health Plan Information** business process includes evaluation of federal or state regulations, legislative and judicial mandates, federal or state audits governing board or commission directives, Quality Improvement Organization’s findings, enterprise decisions, and consumer pressure to develop or enhance enterprise business rules, benefit plans and services available to members.

Vermont collaboratively develops Health Plan service offerings with input from a multitude of stakeholders.

#### **5.13.1.1 Additional Information**

Vermont expects the Fiscal Agent to monitor Federal and State policies and ensure the MMIS is compliant (e.g. update the rules engine as part of ongoing maintenance). In addition, Vermont expects the Fiscal Agent to communicate when changes to the MMIS are required.

Vermont will perform impact analysis on any proposed policy/regulation change, with the Fiscal Agent providing input with respect to the impact on the system.

The Fiscal Agent is responsible for implementing the policy decided by the State of Vermont.

#### **5.13.2 Business Process Steps**

1. START: AHS receives notification of legal or administrative mandates that have potential impact on Health Plan policy.
2. AHS analyzes legal or administrative mandates and determine whether to create, revise, or terminate Health Plan policy.
3. AHS assesses impact of policy on budget, stakeholders, and other benefits and communicates, reviews, adjusts policies in alignment with State of Vermont statutes.
4. Fiscal Agent assesses impact of requested revisions, if applicable, as needed.
5. AHS determines effective date and duration for Health Plan policy. Fiscal Agent develops training plan for new, revised or discontinued Health Plan policy and presents to AHS for approval.
6. Fiscal Agent develops implementation or transition plan for new, revised, or discontinued Health Plan policy and presents to AHS for approval.
7. Fiscal Agent and AHS implement and tests Health Plan policy.
8. END: AHS sends Health Plan policy to Health Insurance Exchange (HIX) for certification.

### **5.14 PL05 Manage Performance Measures**

#### **5.14.1 Description**

The **Manage Performance Measures** business process involves the design, implementation, and maintenance of mechanisms and measures Vermont uses to monitor the business activities and performance of Vermont's Medicaid Enterprise's business processes and programs.

This includes the steps involved in defining the criteria by which Vermont measures activities and programs (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Healthcare Effectiveness Data and Information Set (HEDIS) measures). This business process develops the reports and other mechanisms that are used to track activity and effectiveness at all levels of monitoring.

Business Intelligence analysis (i.e., historical, current and predictive views of business operations) occurs within this process.

Examples of performance measures and associated reports may be things such as:

- Goal: Vermont makes prompt and accurate payments to providers. Measurement: Pay or deny 95% of all clean claims within 30 days of receipt. Mechanism: Vermont generates weekly report on claims processing timelines.
- Goal: Accurately and efficiently, draw and report funds in accordance with the federal Cash Management Improvement Act (CMIA) and general cash management principles and timeframes to maximize non-general fund recovery. Measurement: Draw 98% of funds with the minimum time allowed under CMIA. Mechanism: Vermont generates monthly report on funds drawn.
- Goal: Improve health care outcomes for Medicaid members. Measurement: Reduce emergency room visits by ten percent by assigning a primary care case manager. Mechanism: Vermont generates monthly report comparing emergency room usage by member for the period prior to and after Primary Care Case Managers (PCCM) assignment.
- Goal: Promote the health, well-being, and safety of individuals, families, and our communities. Indicator: Cholesterol Management for Patients with Cardiovascular Conditions. Performance measure: Rate of LDL-C Screening for those enrolled in the Community Rehabilitation and Treatment (CRT) Program in Addison County, Vermont.

#### **5.14.1.1 Additional Information**

Vermont's performance against the pre-defined measures will be reviewed at a regular interval (likely in alignment with the review of the Fiscal Agent's performance against SLAs).

The performance measures will include performance against operational SLRs (e.g. how quickly a claim is paid), Outcomes (e.g. effectiveness of the program) and include all core CMS measures (e.g. HEDIS, CAPS, PQIs, Medicaid child/adult core measures, meaningful use, NQF, etc.)

Before the MMIS goes live the system will be configured to report performance against the Performance Measures. Over time the performance measures will be refined and/or updated. The performance measures (and reports capturing performance against these measures) will be reviewed at a periodic basis and the MMIS must allow for easy updating/modifying as needed.

Staff must be able to access the performance management data through standard or ad-hoc reporting capabilities. Additionally, Vermont requires the ability to extract information from the MMIS to be used in other applications for analysis and for State and Federal reporting purposes.

#### **5.14.2 Business Process Steps**

1. START: AHS receives request or reach scheduled review time
2. MMIS monitors business activity against established performance measures.
3. MMIS produces reports.
4. AHS assesses resulting information with business intelligence methods (i.e., historical, current and predictive views of business operations).

5. END: AHS disseminate information to appropriate stakeholders (e.g., individuals or business processes).

## **5.15 PL06 Manage Health Benefit Information**

### **5.15.1 Description**

The **Manage Health Benefit Information** business process includes the activities for development and implementation of health plans to accommodate service delivery to targeted member populations.

The health plan accommodates information to support current and future health plans for members eligible for programs administered by AHS. Vermont determines benefit terms and limitations, and applicable periods for services defined within a health plan.

Health plan administration involves the ability to determine, define, coordinate and modify parameters as policies, funding and business decisions dictate. This includes, but is not limited to:

- Health plans targeted to specific populations.
- Service categories defining available covered service.
- Federal and state regulations defining service limitations.
- Customization of edits and audits relative to policy.
- Utilization tracking of limited services at the member level.

#### **5.15.1.1 Additional Information**

Vermont supports a member being covered by multiple plans.

The health plans must be associated with a funding source; funding source may vary based on services being provided within a health plan.

There may be a monetary cap or visit limit on a set of services. In addition, once the cap is reached another funding source might pay for the services depending on the budgeting cycle.

### **5.15.2 Business Process Steps**

1. START: AHS identifies that the modification of health plan policy results in the need for health plans definition or modifications to comply with the policy.
2. AHS creates and/or modifies health plans to comply with the policy.
3. AHS defines/modifies the effective date and duration of the health plans.
4. AHS defines/modifies the health plan coverage narrative.
5. AHS defines/modifies services specific to unique health plans.
6. If applicable, AHS specifies limitations at both the service and monetary levels.
7. AHS defines/modifies applicable member's cost sharing obligations e.g. co-pay, co-insurance, deductible, and share of cost amounts, limits.
8. END: AHS sends health plan services to Health Insurance Exchange (HIX) for certification.

## 5.16 PL07 Manage Reference Information

### 5.16.1 Description

The **Manage Reference Information** business process is responsible for all operations aspects for the creation, modification, and deletions of reference code information.

The **Process Claim** business process additions or adjustments trigger this business process. Additional triggers for **Manage Reference Information** include the addition of a new health plan or benefit, or the modification to an existing program due to the passage of new state or federal legislation, or budgetary modifications.

The business process includes revising diagnosis and procedure code information (e.g., Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), National Drug Code (NDC), ICD0 and ICD10 diagnosis and surgical procedure codes), and/or revenue codes.

Business process also adds rates associated with those codes and updates existing rates.

The business process updates and adds information from the **Manage Member Information** and **Manage Provider Information** business process as well as drug formulary, health plan and health benefit information.

#### 5.16.1.1 Additional Information

The MMIS must track the changes to codes including who changed the code, who approved the change, and the reason and justification for the change to provide an audit trail.

The MMIS must support versioning and/or effective date so old claims can be processed using the old version.

### 5.16.2 Business Process Steps

1. START: Fiscal Agent receives addition or modification to reference information.
2. Fiscal Agent and AHS review addition or modification to determine impact to coverage requirements based on current benefit plans. Confirm the codes don't already exist. Perform impact analysis to confirm the changes made will align with business rules.
3. Fiscal Agent tests the additions or updates to the codes and member benefits. This includes evaluating any current edits or audits and the impact of the changes to the reference information. If needed, the Fiscal Agent updates the existing edit/audit logic and re-tests.
4. AHS reviews the testing results and provides approval to proceed.
5. Fiscal Agent adds or updates codes or rates, member benefits and programs under which services are available.
6. Fiscal Agent performs a post-implementation validation.
7. END: MMIS sends alert to notify provider and contractor (and other stakeholders) of reference code addition or modification.

## 5.17 PL08 Manage Rate Setting

### 5.17.1 Description

The **Manage Rate Setting** business process responds to requests to add or modify rates for any service or product covered by the Medicaid Program.

#### 5.17.1.1 Additional Information

In addition to fee-for-service and bundled rates, this process must be flexible and accommodate alternative payment methodologies, including (but not limited to):

- Performance-based payments
- Outcome based
- Volume driven
- Shared savings
- Quality incentives

Vermont also needs to track and manage different rates including (but not limited to):

- “Incident to” Billing (services or supplies furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness)
- Also have cases where certain provider types might have a different payment. Ex. Physician’s Assistant might pay at 90%

The MMIS must track the changes to rates including who changed the rate, who approved the rate change, the reason and justification to provide an audit trail.

The MMIS must support versioning and/or effective date so old claims can be processed using the old rate (based on Date of Service on claim).

### 5.17.2 Business Process Steps

1. START: AHS receives notification of request for addition or modification of rate.
2. AHS researches and analyzes rate, which may include requesting additional information to determine initial or updated rate.
3. AHS validates rate requested or establish rate.
4. Perform what-if scenario analysis
5. Fiscal Agent tests the rate changes and gets approval from AHS to proceed.
6. Fiscal Agent updates the system with the new rates.
7. END: MMIS sends alert to providers of rate or code changes

## 6.0 Provider Management

There are eight business processes for Provider Management defined by the CMS Medicaid Information Technology Architecture (MITA). These business processes include: Eligibility and Enrollment Management (EE) and Provider Management (PM).

The business processes in this document provide a description of the processes Vermont wishes to be performed with the new MMIS and the associated services the vendor will support. These processes provide context to the Core MMIS functional requirements.

### 6.1 EE05 Determinate Provider Eligibility

#### 6.1.1 Description

The **Determine Provider Eligibility** business process collects an application from a Provider, or collects revalidation information from an existing Provider. The business process verifies the format and meaning of the information, checks status tracking (e.g., initial, modification, duplicate, cancelation), requests additional information when necessary, determines screening level (i.e., limited, moderate or high), verifies applicant information with external entities, collects application fees and notifies Provider of enrollment eligibility determination (e.g., accepted, denied, or suspended). **Determine Provider Eligibility** sends eligibility determination alert signals to subscribing business processes **Enroll Provider** and **Manage Provider Communications**. **Determine Provider Eligibility** sends alert signal to **Manage Accounts Receivable Collection/Refund** business process to collect application fee.

The **Determine Provider Eligibility** business process works in conjunction with Medicare and the processing of dual eligibles. Medicare agency conducts provider screening activities, application fee collection and revalidation for those providers who are dual eligible. **Determine Provider Eligibility** business process is responsible for the provider screening activities, application fee collection and revalidation for only Medicaid providers.

NOTE: External contractors such as quality assurance and credentialing verification services may perform some of these steps.

##### 6.1.1.1 Additional Information

All Provider screening and enrollment activity must be done in accordance with [42 CFR 455 Subpart E](#).

When a need is identified for a specific provider type or geography, outreach to un-enrolled, potentially eligible providers should occur.

Prior to submitting an application, a potential provider should be able to query and learn about fee schedules, paid HCPC codes, etc.

The following table provides an example of the types of providers that are captured in the MMIS.

**Table 1. Provider Enrollment Variations**

Type	Subtype	Information
<b>Institutional Provider</b>	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).	National Provider Identification (NPI), entity type, taxonomy, type of facility, bed size, equipment, type of institutional services, ownership, trading partner information, billing and payment information, tax code, Diagnosis Related Group (DRG) or other payment type
<b>Individual Provider</b>	The Individual Billing Provider application must accommodate a range of professional billing Provider types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other).	NPI, entity type, taxonomy, affiliation, location, trading partner information, billing and payment information
<b>Individual Rendering Provider</b>	The Individual Rendering Provider application must accommodate a range of professional rendering Provider types (e.g. Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other) Enumerate a group health practice separately from the individual physicians associated with it.	NPI, entity type, taxonomy, affiliation, location, equipment
<b>Pharmacy</b>	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). NOTE: The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist.	NPI, entity type, ownership, location, unit dose, mail order, Drug Enforcement Administration (DEA) information, Drug Utilization Review (DUR) compliance, trading partner information, billing and payment information

Type	Subtype	Information
<b>Atypical</b>	The atypical 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, foster care provider, taxi cab, plumber, carpenter, meals on wheels), different types of relationships (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., in the home, day care center). NOTE: The NPI enumeration does not provide ID numbers for atypical Providers at this time.	Provider ID, Social Security Number (SSN), specialty, type of service Provider, allowed services, invoicing method
<b>Suppliers</b>	The Durable Medical Equipment (DME) suppliers and manufacturers supply or manufacturers application must accommodate a range of durable medical equipment, prosthetics, orthotics, supplies (DME Ops) types.	NPI, entity type, Employee ID (EIN), DME license, supplies, trading partner information, billing and payment information, ownership
<b>Medical Transportation</b>	The Medical Transportation Provider application must accommodate a range of transportation modes that include Air, Ambulance, Law, Pedestrian, Private or Public Transport. It should accommodate different types of vehicles, aircraft, licensing, and inspection information.	EIN, entity type, license type and number, inspection, vehicle, aircraft and/or ambulance information

### 6.1.2 Business Process Steps

1. START: The Provider completes and submits an application or existing Provider submits new or updated application, via online, fax, or mail for revalidation.
2. If applicable, Provider identifies Office of the National Coordinator (ONC) Authorized Testing and Certification Body (ATCB) certification for electronic health record incentive.
3. Provider identifies if they are currently participating in Medicare and their participation is verified using the PECOS system. If yes, skip to step 14.
4. If applicable, Provider selects application fee payment option including designation of hardship or exclusions from payment.
5. If applicable, Provider provides appropriate payment information.
6. Receive enrollment application and other pertinent enrollment communication information.
7. Validate application information for completeness and accuracy.
  - a. END: If validation fails, produce result messages and business process stops
8. If necessary, request missing information from requestor. Go step 14.

9. Determine submission status by querying the Provider data store. Application status may be initial, resubmitted with modification, or duplicate.
  - a. If resubmitted application, message contains only updated information and process may skip irrelevant steps below.
  - b. END: If duplicate application, produce result messages and stop business process
  - c. Other communications may be requests to cancel application, and to deactivate or reactivate eligibility.
10. Determine applicant type/Provider taxonomy (e.g., primary, rendering, pay to, billing, or other).
11. Determine designated categorical risk (e.g., limited, moderate, or high) based on provider/supplier's category.
12. Assess categorical risk to determine appropriate required screening level.
  - a. Limited Risk may include:
    - i. Verification of any provider/supplier-specific requirements established by Medicare
    - ii. License verifications (may include licensure checks across state)
    - iii. Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an OIG exclusion; taxpayer identification number; tax delinquency; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)
  - b. Moderate Risk may include:
    - i. Inclusion of Limited Risk screening
    - ii. Unscheduled or Unannounced Site Visits. AHS will provide a checklist for site visits, specifying the items that must be verified.
  - c. High Risk may include:
    - i. Inclusion of Moderate Risk screening
    - ii. Criminal Background Check
    - iii. Fingerprinting
13. Conduct screening based on required screening level with automated transactions except where manual verification is necessary.
14. Confirm Department-level, program-specific eligibility, where required.
15. Determine Provider eligibility (e.g., accepted, denied, or suspended) based on federal and state rules.
16. Determine if there are enrollment caps due to moratoriums issued. If yes, skip to step 19.
17. If Medicaid accepts application, send alert to **Enroll Provider** business process to assign contracting parameters, establish payment rates, and other activities for eligible requestor.
18. Alert sent to **Manage Accounts Receivable Collection/Refund** business process to collect application fee.
19. If Medicaid denies the enrollment application for existing Provider, send alert to **Disenroll Provider** business process to remove provider from services.
20. If applicable, send alert to notify Medicare of both dual eligible and regular Medicaid providers information.

21. END: Send enrollment eligibility determination to **Manage Provider Communications** to send relevant information to requestor.

#### **6.1.2.1 Alternate Business Process Path**

**Determine Provider Eligibility** business process results in a denial or suspension of an enrollment eligibility request for reasons such as:

- Requestor fails to meet screening requirements.
- Requestor fails to meet state enrollment requirements.
- National Plan and Provider Enumeration System (NPPES) or any other national enumeration systems cannot enumerate Health Care Provider.

## **6.2 EE06 Enroll Provider**

### **6.2.1 Description**

The Enroll Provider business process is responsible for enrolling providers into Medicaid that includes:

- Determination of contracting parameters (e.g., Provider taxonomy, type, category of service that the Provider can bill, enrollment of Providers for Medicare crossover claiming only, etc).
- Establishment of payment rates and funding sources, taking into consideration service area, incentives or discounts.
- Alert sent to **Manage Contract** business process to negotiate contracts.
- Supporting receipt and verification of program contractor's Provider enrollment roster information (e.g., from Managed Care Organization (MCO) and home and community-based services (HCBS)).
- Alert sent to **Manage Provider Information** business process to load initial and modified enrollment information, including Providers contracted with program contractors into the Provider data store.
- Alert sent to **Manage Provider Information** business process to provide timely and accurate notification, or to make enrollment information required for operations available to all parties and affiliated business processes, including:
  - Alert sent to **Prepare Provider Payment** business process for capitation and premium payments.
  - To prepare Provider electronic funds transfer (EFT) or check with the **Manage Accounts Payable Disbursement** business process.
  - The appropriate communications and outreach processes for follow-up with the affected parties, including informing parties of their procedural rights.
- Periodic review is due or receipt of request to:
  - Negotiate payment rates.
  - Notify Provider of enrollment determination.

**Enroll Provider** supports receipt and verification of program contractor’s Provider enrollment roster information (e.g., name, identification, contract information, type, specialty and services) from Managed Care Organization (MCO) and home and community-based services (HCBS) organizations.

### 6.2.2 Business Process Steps

1. START: Determine contracting parameters (e.g., Provider taxonomy, categories of service for which the Provider can bill), eligible Provider types, payment types, contract terms and maximums, client enrollment levels, panel size, and any contractor specific plans and procedures.
2. Assign any identifiers used internally.
3. Determine if there are enrollment limits due to moratoriums issued. If yes, skip to step 9.
4. If applicable, assign to programs and determine rates: Includes identifying type of rate (e.g., negotiated, Medicare, percent of charges, case management fee, other via look-ups in the reference and benefit repositories).
5. If applicable, send alert to **Manage Contractor Payment** for payment arrangement.
6. Send alert to **Perform Provider Outreach** to send relevant state policy information, based on Provider Type.
7. If applicable, send alert to **Manage Contract** business process to negotiate contract.
8. If applicable, send alert to notify contractor via **Manage Contractor Communication** business process of enrollment determination.
9. If applicable, provide response to request for Provider enrollment roster information.
10. If applicable, send alert to notify Health Insurance Exchange (HIX) of provider enrollment information.
11. Send alert to notify all AHS Departments of enrollment status.
12. END: Send alert to notify provider via **Manage Provider Communication** business process of enrollment determination.

## 6.3 EE07 Disenroll Provider

### 6.3.1 Description

The **Disenroll Provider** business process is responsible for managing disenrollment in the Medicaid Program. This business process covers the activity of disenrollment including the tracking of disenrollment requests and validation that the disenrollment meets state’s rules. Medicaid sends notifications to affected parties (e.g., provider, contractor, business partners) as well as alerts to other business processes to discontinue business activities.

### 6.3.2 Business Process Steps

1. START: Receive disenrollment request or relevant information.
2. Validate authenticity of the requestor to have authorization to request disenrollment.
3. Determine disenrollment request or information processing status by querying the Provider data store; status may be initial, resubmitted with modification, or duplicate

- a. If resubmitted, message contains only updated information and process may skip irrelevant steps below.
  - b. If duplicate, produce result messages and stop business process (see Failures).
4. Verify the disenrollment information.
5. Determine if Provider needs to be disenrolled or suspended.
6. If suspended, send alert to Claims Adjudication to notify of suspension. All Medicaid payment suspensions from a particular Medicaid program or from a new admissions outside of Medicaid must be tracked.
7. Validate that the disenrollment request meets state rules.
8. Remove provider or contractor from Medicaid participation.
9. Send alert to notify Medicare/Medicaid Sanction, National Practitioner Data Bank (NPDB), Healthcare Integrity Protection Data Bank (HIPDB), and state licensing boards via **Manage Business Relationship Communication** business process of disenrollment information.
8. If applicable, send alert to **Manage Contractor Payment** to stop payment arrangement.
9. If applicable, send alert to **Close Out Contract** business process with disenrollment information.
10. If applicable, send alert to **Apply Mass Adjustments** business process to associate members with alternate provider or contractor.
11. Send alert to notify provider via Manage Provider Communication business process of disenrollment information.
12. If applicable, send alert to notify contractor via **Manage Contractor Communication** business process of disenrollment.
13. Send alert to notify other insurance affordability programs of the disenrollment from Medicaid.
14. Send alert to notify Health Insurance Exchange (HIX) of provider disenrollment information.
15. Send alert to notify all AHS Departments of enrollment status.
16. END: Agency removes Provider or contractor from participation in Medicaid services.

## 6.4 EE08 Inquire Provider Information

### 6.4.1 Description

The **Inquire Provider Information** business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry, and prepares the response information for the Send Outbound Transaction.

#### 6.4.1.1 Additional Information

There should be access to Provider information across AHS Departments.

Providers will have access to their information via multiple channels including: Provider Portal and Automated Voice Recognition (AVR) access.

### 6.4.2 Business Process Steps

1. START: Receive provider enrollment verification information from Receive Inbound Transaction.
2. Agency logs enrollment verification request.

3. Validate requestor's authorization to receive requested information.
4. Find requested provider's enrollment verification information.
5. Agency logs response.
6. If applicable, send eligibility inquiry response via Automated Voice Response System (AVRS).
7. END: Send response to requestor via Send Outbound Transaction.

## 6.5 PM01 Manage Provider Information

### 6.5.1 Description

The **Manage Provider Information** business process is responsible for managing all operational aspects of the Provider data store, which is the source of comprehensive information about prospective and contracted providers and their interactions with the Agency. The Provider data store is the Agency's source of record for provider demographic, business, credentialing, enumeration, performance profiles, payment processing, and tax information. The data store includes contractual terms (e.g., the services the provider is to provide) related performance measures, and the reimbursement rates for those services.

In addition, the Provider data store contains records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification, and all communications with or about the provider, including provider verification requests and responses, and interactions related to any grievance/appeal. The Provider data store may store records or pointers to records for services requested and services provided, performance, utilization, and program integrity reviews, and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member data store to add, delete, or modify information. The Provider data store validates information upload requests, applies instructions, and tracks activity. The Provider data store provides access to provider records to applications and staff via batch record transfers, responses to queries, and subscription services.

### 6.5.2 Business Process Steps

1. START: Receive request from interface, individual or agency to create, inquire, delete or modify provider information.
2. Validate that requestor is authorized to create, inquire, delete or modify the specific provider information.
3. Log request for provider information.
4. Validate information submitted is correct and complete.
5. Find requested provider.
6. Create, inquire, delete or modify relevant provider information.
7. Create audit trail of all additions, deletions, and modifications.
8. Determine applicable updates to external Provider data stores.
9. If applicable, send alert to notify Health Insurance Exchange (HIX) of provider network modification.
10. Send alert to **Manage Provider Communication** to notify provider of relevant modifications

11. END: System creates, inquires on, deletes, or modifies provider information.

## **6.6 PM02 Manage Provider Communication**

### **6.6.1 Description**

The **Manage Provider Communication** business process receives requests for information, provides publications, and assistance from prospective and current providers' communications (e.g., inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements). The Agency may communicate information using a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or electronic data interchange (EDI). This business process includes the log, research, development, approval and delivery of routine or ad hoc messages.

**NOTE: Manage Provider Communication** business process handles inquiry from prospective and current providers by providing assistance and responses to individual entities (i.e., bi-directional communication). Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The **Perform Provider Outreach** business process targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues.

#### **6.6.1.1 Additional Information**

This business process also includes the ability to create targeted communications, based on State-provided criteria (i.e. Geography, provider type, etc.).

When communication includes certain types of documents or notifications (i.e. policy or rate changes) the process should require acknowledgement of receipt.

### **6.6.2 Business Process Steps**

1. START: Receive request for communication.
2. Validate information submitted is correct and complete.
3. Authenticate the provided information.
4. Log request for communication.
5. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web, or EDI.)
6. Determine performance measures.
7. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format.
8. Review and approve communication.
9. Generate communication in agreed upon format.
10. If applicable, require acknowledge receipt from receiver.
11. END: Log communication message.

## 6.7 PM03 Perform Provider Outreach

### 6.7.1 Description

The **Perform Provider Outreach** business process originates internally within AHS and its Departments in response to multiple activities (e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, modifications in the Medicaid Program policies and procedures). Departments will develop prospective Provider outreach information, also referred to as Provider Recruiting information, for targeted providers identified by analyzing program information (for example, not enough dentists to serve a population, new immigrants need language-compatible providers).

Enrolled Provider outreach information may relate to modifications to billing practices, new or modified health care policies and procedures, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives.

The AHS Department develops outreach information for target populations identified by analyzing member information and may communicate information in a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). The State Medicaid Agency produces, distributes, tracks and archives all contractor outreach communications according to State rules. The **Manage Performance Measures** business process defines benchmarks and measures outreach efficacy.

**NOTE:** The **Perform Provider Outreach** business process targets both prospective and current provider *populations* for distribution of information about programs, policies, and health issues. **Manage Provider Communication** business process handles inquiry from applicants, prospective and current providers by providing assistance and responses to *individuals* (i.e., bi-directional communication).

### 6.7.2 Business Process Steps

1. START: Receive request for outreach materials or communication.
2. Determine if outreach is to be directed at potential or enrolled Providers, based on the nature of the initiating request.
3. Specific target population is identified and defined by analyzing information, performance measures, feedback from community, and policy directives.
4. Approve, deny, or modify decisions to develop outreach communications and the target population identified.
5. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web or EDI).
6. Determine performance measures.
7. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format.
8. Review and approve communication.
9. Generate communication in agreed upon format.

10. Log communication message.
11. END: Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate)

## 6.8 PM07 Manage Provider Grievance and Appeal

### 6.8.1 Description

The **Manage Provider Grievance and Appeal** business process handles provider (both current and prospective providers) appeals of adverse decisions or communications of a grievance. The **Manage Provider Communication** business process initiates a grievance or appeal from a provider. AHS (or the Fiscal Agent on behalf of AHS) logs and tracks the grievance or appeal, triages it, and sends it to appropriate reviewers. Staff researches or requests additional information. AHS (or the Fiscal Agent on behalf of AHS) may schedule a hearing, conduct actions in accordance with legal requirements, and make a ruling based upon the evidence presented. Staff documents and distributes results of the hearings, and adds relevant documents to the provider's information. The provider must be formally notified of the decision...

This business process supports the **Manage Performance Measures** business process by providing information about the types of grievances and appeals it handles, grievance and appeals issues, parties that file or are the target of the grievances and appeals, and the dispositions. AHS (or the Fiscal Agent on behalf of AHS) uses information to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.

Based on the appeal business process, if a provider wins an appeal that affects or clarifies a Medicaid State Plan, health plan, or health benefit, this process sends that information to **Maintain State Plan, Manage Health Plan Information** or **Manage Health Benefit Information** business processes to modify the relevant policy or procedure. Disposition could result in legislative change requirements that AHS must communicate to lawmakers.

#### 6.8.1.1 Additional Information

This process is used for both enrolled and prospective providers. The appropriate personnel noted in Step 7 (Triage) could be anyone across the Agency.

VT is seeking a system that automates the Provider Grievance and Appeal tracking process separate from the PI tracking database.

### 6.8.2 Business Process Steps

1. START: Receive grievance or appeal.
2. Agency logs grievance or appeal.
3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields.
4. Validate that the provided information is authentic.

5. If appropriate, request additional documentation.
6. Determine status as initial, second, or expedited or other status as designated by the state.
7. Triage to appropriate personnel for review.
8. Perform research and analysis.
9. If appropriate, schedule hearing within required time.
10. If appropriate, conduct hearing within required time.
11. Determine disposition.
12. If applicable, send alert to **Establish Compliance Incident** for further investigation.
13. If applicable, alert sent to **Maintain State Plan** to modify the relevant policy or procedure.
14. If applicable, alert sent to **Manage Health Plan Information** to modify the relevant policy or procedure.
15. If applicable, alert sent to **Manage Health Benefit Information** to modify the relevant policy or procedure.
16. END: Send alert to notify provider of disposition determination.

NOTE: Some of the above steps may be iterative and a grievance or appeals case may take many months to finalize.

## 6.9 PM08 Terminate Provider

### 6.9.1 Description

The **Terminate Provider** business process is responsible for the termination of a provider agreement to participate in the Medicaid Program. The basis for termination can be:

- Centers for Medicare & Medicaid Services (CMS) and AHS terminate a provider agreement if an individual provider:
  - Is not in substantial compliance with the requirements of participation, regardless of whether immediate jeopardy is present; or
  - Provider does not meet the eligibility criteria for continuation of payment as set forth in 42 CFR 488.412(a)(1).
- Centers for Medicare & Medicaid Services (CMS) and AHS may terminate a facility's provider agreement if a facility:
  - Is not in substantial compliance with the requirements of participation, regardless of whether immediate jeopardy is present; or
  - Facility fails to submit an acceptable corrective action plan (CAP) within the timeframe specified by CMS or the Agency.
- CMS and the AHS may terminate a facility's provider agreement if a facility:
  - Fails to relinquish control to the temporary manager, if that remedy is imposed by CMS or the Agency; or
  - Facility does not meet the eligibility criteria for continuation of payment as set forth in 42 CFR 488.412(a)(1).

The effect of termination of the provider agreement ends:

- (1) payment to the facility, and
- (2) any alternative remedy.

Note: Disenrolling a provider is done at the request of a provider. Terminating a provider is initiated by the State. State may also choose not to reenroll.

### **6.9.2 Business Process Steps**

1. START: Receive request to terminate provider.
2. Review determination of noncompliance and investigation materials.
3. If applicable, suspend payments to provider pending review of noncompliance and investigation materials.
4. Send alert to notify provider via **Manage Provider Communication** business process of suspension.
5. If applicable, send alert to notify contractor via **Manage Contractor Communication** business process of termination proceedings.
6. If applicable, send alert to notify public via **Perform Population and Member Outreach** business process of termination proceedings.
7. Conduct communications and investigations within required timeframes.
8. If provider had implemented systems and processes to ensure that the likelihood of further violation is remote, and there is adequate evidence that the provider is in compliance with the requirements, SMA rescinds the termination action and puts the provider back into compliance.
9. If provider has not implemented systems and processes to avoid further violations, terminate the provider.
10. Send alert to notify provider via **Manage Provider Communication** business process of termination proceedings.
11. Send alert to notify business partners via **Manage Business Relationship Communication** of provider termination.
12. Send alert to notify Health Insurance Exchange (HIX) of provider termination information.
13. Send alert to notify CMS of provider termination information.
14. END: Remove provider or contractor from participation in Medicaid Program.