Manage Provider Information

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Manage Provider Information	
Item	**Details**
Description	The ***Manage Provider Information*** business process is responsible for managing all operational aspects of the Provider data store, which is the source of comprehensive information about prospective and contracted providers and their interactions with the State Medicaid Agency (SMA). The Provider data store is the SMA Source of Record (SOR) for provider demographic, business, credentialing, enumeration, performance profiles, payment processing, and tax information. The data store includes contractual terms (e.g., the services the provider is to provide) related performance measures, and the reimbursement rates for those services. In addition, the Provider data store contains records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification, and all communications with or about the provider, including provider verification requests and responses, and interactions related to any grievance/appeal. The Provider data store may store records or pointers to records for services requested and services provided, performance, utilization, and program integrity reviews, and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member data store to add, delete, or modify information. The Provider data store validates information upload requests, applies instructions, and tracks activity. The Provider data store provides access to provider records to applications and staff via batch record transfers, responses to queries, and subscription services.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive request to create, inquire, delete, or modify provider information from authorized individuals via email, mail, facsimile, telephone or web. • Receive request to verify provider information from authorized external parties.
Result	• The SMA creates, inquires on, modifies or deletes provider information. • Alert sent to notify Health Insurance Marketplace of provider network modification information. • Alert sent to notify insurance affordability program (i.e., Medicare, CHIP and Basic Health Program) of provider network modification. • Alert sent to ***Manage Provider Communication*** to notify provider of relevant modifications. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request from authorized individuals or agencies to create, inquire, delete or modify provider information. 2. Agency logs request for provider information. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields.

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

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

Terminate Provider

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

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

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

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

Manage Provider Communication

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Manage Provider Communication	
Item	**Details**
Description	The ***Manage Provider Communication*** business process receives requests for information, provides publications, and assistance from prospective and current providers' communications (e.g., inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements). The State Medicaid Agency (SMA) may communicate information using a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). This business process includes the log, research, development, approval and delivery of routine or ad hoc messages. **NOTE: *Manage Provider Communication*** business process handles inquiry from prospective and current providers by providing assistance and responses to *individual entities* (i.e., bi-directional communication). Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The ***Perform Provider Outreach*** business process targets both prospective and current provider *populations* for distribution of information about programs, policies, and health care issues.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive requests from other business processes to develop and produce communications for providers such as notifications from ***Enroll Provider*** business process. • Receive inquiries originating from customer help desk through ***Manage Provider Information*** business process. Environment-based Trigger Events to include but not limited to: • Receive inquiry from current or prospective provider.

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

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

Manage Provider Grievance and Appeal

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

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	the decision. This business process supports the ***Manage Performance Measures*** business process by providing information about the types of grievances and appeals it handles, grievance and appeals issues, parties that file or are the target of the grievances and appeals, and the dispositions. The SMA uses information to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. Based on the appeal business process, if a provider wins an appeal that affects or clarifies a Medicaid State Plan, health plan, or health benefit, this process sends that information to ***Maintain State Plan, Manage Health Plan Information*** or ***Manage Health Benefit Information*** business processes to modify the relevant policy or procedure. Disposition could result in legislative change requirements that the SMA will communicate to lawmakers. **NOTE:** States may define grievance and appeal differently, depending on state laws. States may involve multiple agencies in the ***Manage Provider Grievance and Appeal*** business process. *This business process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when SMA denies an application for enrollment.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive grievance or appeal of adverse decision alert from ***Manage Provider Information***.
Result	• Alert sent to notify provider of final disposition of grievance or appeal. • If applicable, alert sent to ***Establish Compliance Incident*** business process for further investigation. • If applicable, alert sent to ***Maintain State Plan*** business process to modify the relevant policy or procedure. • If applicable, alert sent to ***Manage Health Plan Information*** business process to modify the relevant policy or procedure. • If applicable, alert sent to ***Manage Health Benefit Information*** business process to modify the relevant policy or procedure. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive grievance or appeal. 2. Agency logs grievance or appeal. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields. 4. Validate that the provided information is authentic. 5. If appropriate, request additional documentation.

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

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

Perform Provider Outreach

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

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	• Alert received from ***Manage Health Plan Information*** business process of addition or modification. • Alert received from ***Manage Health Benefit Information*** business process of addition or modification. Environment-based Trigger Events to include but not limited to: • Executive Management decision to: o Fill gaps in health care service and administrative coverage. o Solicit updated/new administrative and technical functions. o Introduce new programs requiring new types of health or administrative service. o Change existing policies and procedures. o Identify critical need for a specific target population. o Identify new populations in need of service (e.g., new immigrant communities).
Result	• Agency produces outreach communications (e.g., mailing brochures, web pages, email, kiosk, and radio, billboard, and TV advertisements) and distributes to targeted providers. Agency may also conduct face-to-face meetings. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive request for outreach materials or communication. 2. Target population is identified and defined by analyzing information, performance measures, feedback from community, and policy directives. 3. Approve, deny, or modify decisions to develop outreach communications. 4. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web or EDI. 5. Determine performance measures. 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate)
Shared Data	Provider data store including provider network, application and enrollment information

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