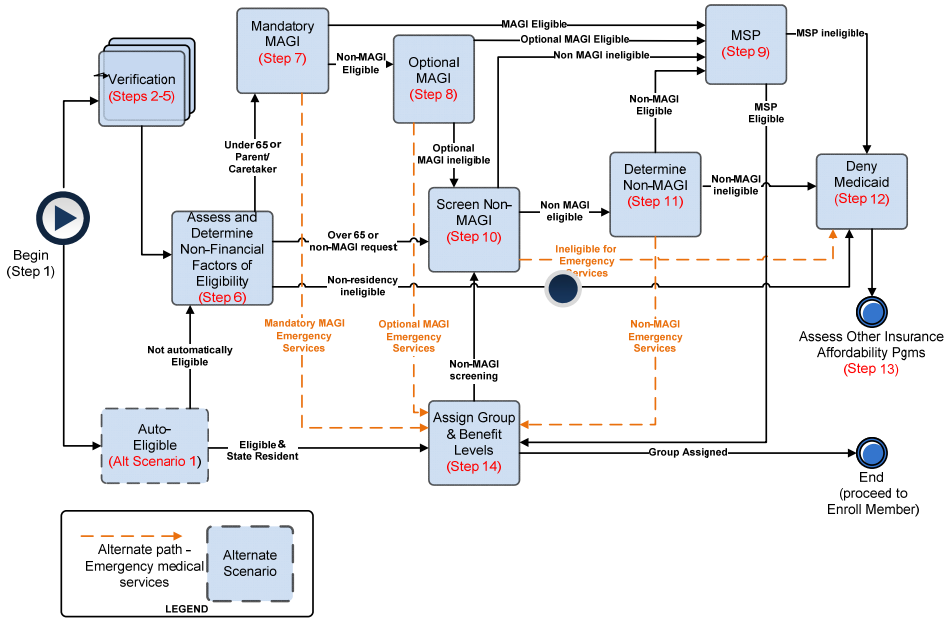
Member Enrollment

Determine Member Eligibility

EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**
Description	The ***Determine Member Eligibility*** business process is responsible for the operational aspects of determining if an applicant is eligible for Medicaid or potentially eligible for other insurance affordability programs (e.g., Advance Premium Tax Credits through the Health Insurance Marketplace (HIX) commonly referred to as the Marketplace. Children's Health Insurance Program [CHIP], and/or Basic Health Program [BHP]). An applicant submits an application or a member updates account information via online, in person, over the phone, by mail, or by other commonly available electronic means. The business process checks for status (e.g., new, resubmission, redetermination, duplicate, or referral from the Health Insurance Marketplace or other agencies administering insurance affordability programs) and verifies applicant information in accordance with the policies established. The business process determines eligibility based on modified adjusted gross income (MAGI) or on a basis other than MAGI methods including group/category (e.g., parents/caretaker relatives, pregnant women, children under 19 year of age). The business process also assigns a Medicaid ID, associates the benefit packages, and produces notifications for coordinated communications. When required, the State Medicaid Agency (SMA) submits applicant or member eligibility information and/or eligibility determination to other agencies administering insurance affordability programs and CMS information systems. This business process could be a Shared Eligibility Service between the Medicaid Agency, the Health Insurance Marketplace, and other State-based insurance affordability programs such as CHIP or BHP. **NOTE: Applications and Accounts:** An individual seeking eligibility for enrollment in an insurance affordability program completes and submits an application on-line, in person, over the phone, by mail, or paper application for verification and eligibility determination. Accepted application data is managed in an "electronic account" (as defined in 42 CFR 435.4) by the receiving program to enable access to this information during the verification and eligibility determination processes, as well as after the conclusion of the process to support change reporting and for other purposes.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receipt of referral of Medicaid applicant from the Health Insurance Marketplace, CHIP or BHP. • Receipt of individuals based on Auto-Eligibility, such as Deemed Newborns, SSI/1634, Title IV-E Foster Care, Adoptions and Guardianship. Environment-based Trigger Events to include but not limited to: • Receive application via online, in person, over the phone, by mail, or other commonly available electronic means. • Periodic timetable (e.g., annual) for existing member who is due for redetermination

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

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

Verifications

NOTE: Conduct steps 2, 3, and 4 simultaneously or in any order in accordance with State's established verification plan (42 CFR 435.945(j)). Financial Information will be verified if financial assistance is requested and the information is provided. Verify asset information if applicant has requested to be evaluated for Medicaid eligibility based on a non-MAGI group that requires an asset test.

Verify Non-Financial Requirements

2. Verify the following non-financial requirements for eligibility determination. CMS expects the State to use Federal or local electronic data sources as available. The State may also rely on self-attestation for all eligibility criteria other than citizenship and satisfactory immigration status, as described in Section H of the preamble of the Medicaid Final Eligibility Rule. Resolve discrepancies by identifying non-financial factors that do not meet verification based on data matches or self-attestation and request additional information as necessary.
    a. Verify State residency.
    b. Verify the SSN.
    c. Verify citizenship or satisfactory immigration status.
    d. If applicable, verify whether individual is an American Indian/Alaska Native, in accordance with established procedure. **Note**: American Indian/Alaska Native status is not a condition of eligibility for Medicaid.
    e. If applicable, verify individual incarceration status. **Note:** Incarceration status is not a condition of eligibility for Medicaid.
    f. Pregnancy. **Note**: The Agency must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation.
    g. Age, date of birth and household size. **Note**: The Agency may accept self-attestation of date of birth and the individuals that comprise an individual's household or may verify through other reasonable verification procedures.
    h. Other non-financial factors (e.g., full-time student status, categorical eligibility as a parent or other caretaker relative as defined in 42 CFR 435.4).

Verify Other Health Coverage

3. Verify enrollment in other health coverage, including Medicare, other public programs, as well as private coverage. **Note:** Enrollment in private health coverage is not a barrier to Medicaid eligibility except as an optional targeted low-income child or as a woman needing treatment for breast or cervical cancer. Medicare recipients are exempted from certain eligibility groups, while Medicare coverage is required for certain other eligibility groups.

Verify Financial Information

4. Verify financial information (42 CFR 435.948) provided by the applicant or member,

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

including:

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

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

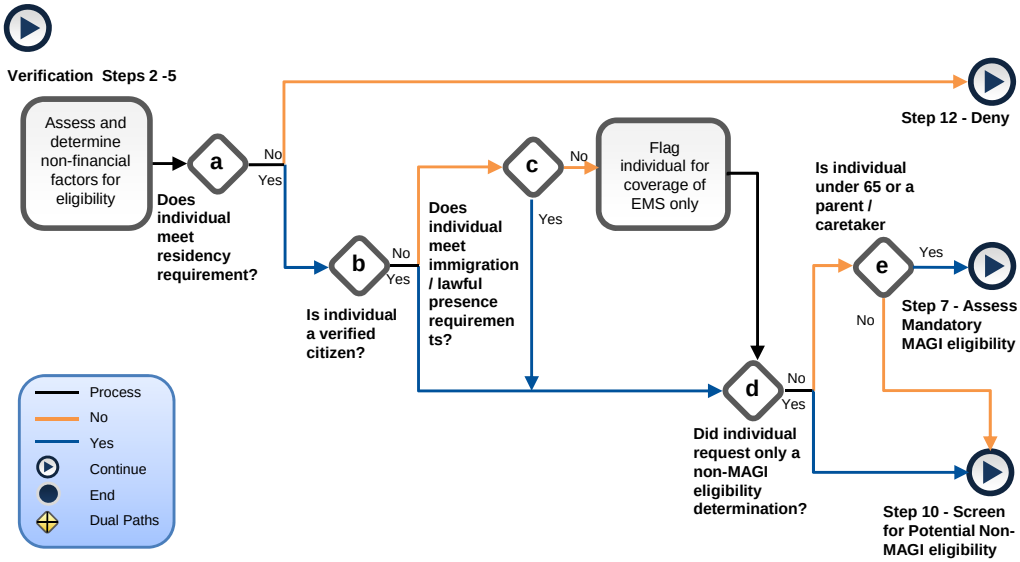
Verify Asset Information

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

Determine Individual Medicaid Eligibility

Assess and Determine Individual Non-Financial Factors of Eligibility

Step 6 - Assess Non-Financial Factors



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

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

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

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

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

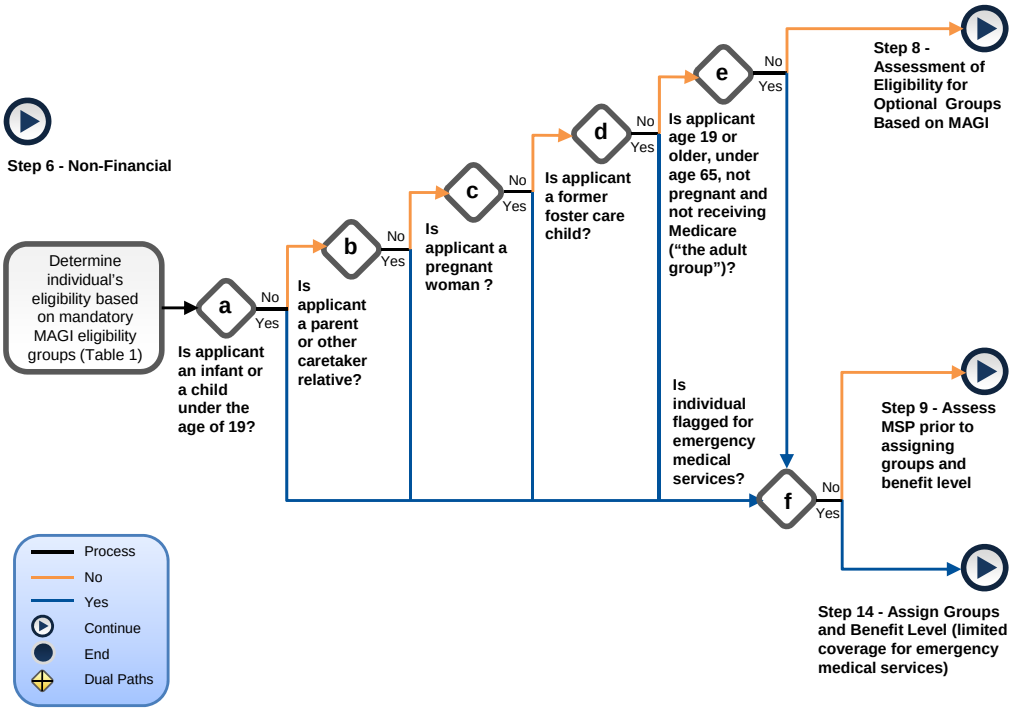
EE Member Enrollment	
Determine Member Eligibility	
Item	**Details**

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

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

Assess and Determine Eligibility for Mandatory MAGI Eligibility Groups

Step 7 - Mandatory MAGI



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

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

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

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

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

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

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

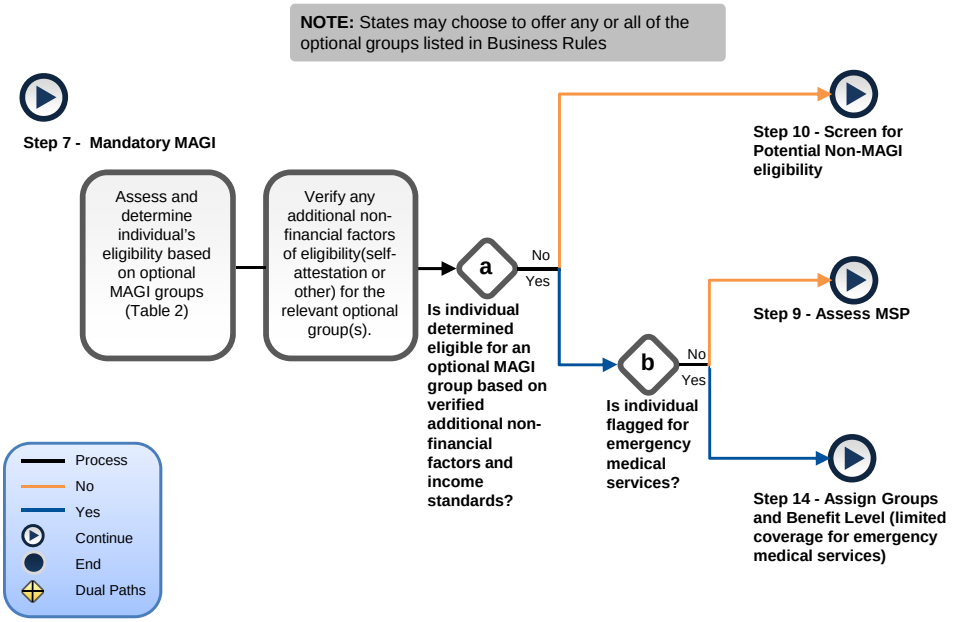
pregnant, is not receiving Medicare (42 CFR 435.119) and is therefore eligible as part of "the adult group". If yes, go to 7f , if not, go to Step 8 to assess individual for optional MAGI groups.

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

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

Assess and Determine Eligibility for Optional Eligibility Groups Based on MAGI

Step 8 - Optional MAGI



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

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

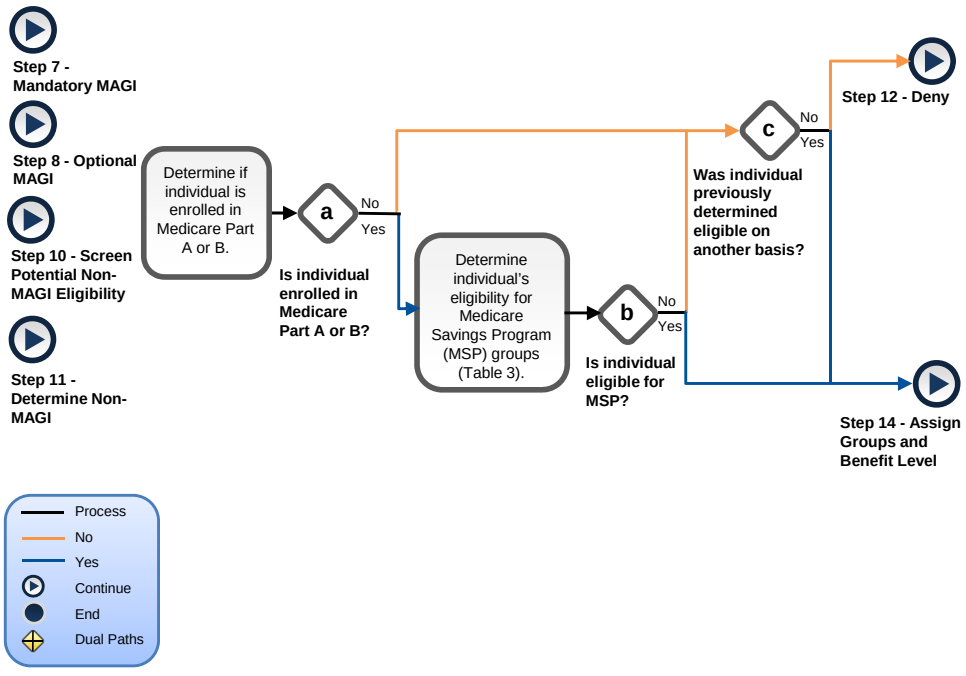
a. If an individual meets non-financial factors and income standards for an optional MAGI group, go to Step 8b. If not, go to Step 10 to screen for potential non-MAGI eligibility.

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

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

Assess and Determine Medicare Savings Program (MSP) eligibility

Step 9 - Assess and Determine MSP



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

9. Prior to approving or denying Medicaid eligibility, assess and determine if individual is eligible for a Medicare Savings Program. **Note:** See Medicare Savings Program Groups Table 3.

    a. Determine if individual is enrolled in Medicare Part A or B. If enrolled in Medicare Part A or B, go to Step 9b. If not, go to Step 9c.

    b. Determine if individual is eligible for a Medicare Savings Program Group. If the individual is eligible based on MSP criteria, go to Step 14 to assign groups and benefit level. If not, go Step 9c.

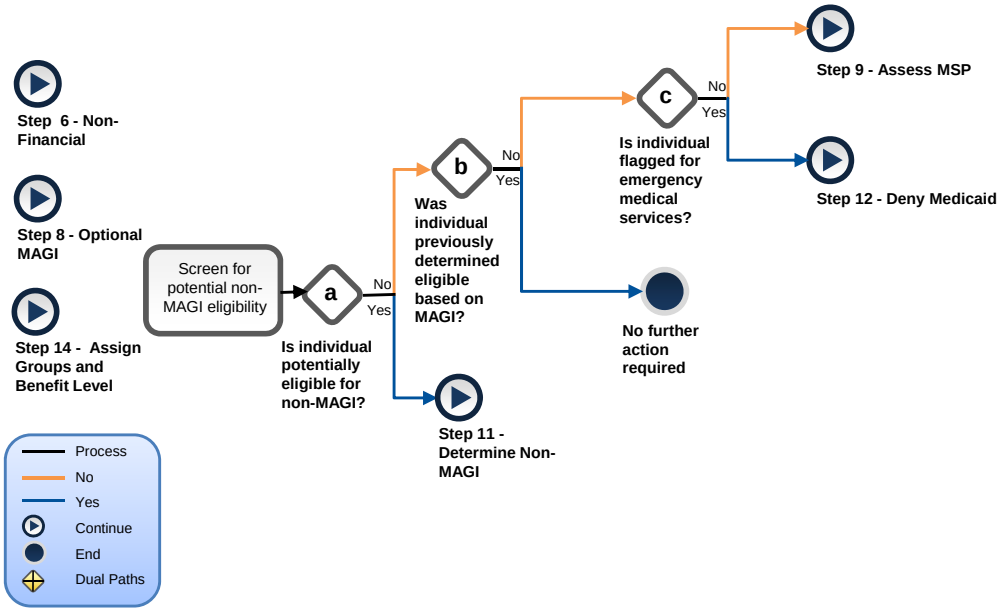
    c. If individual was previously determined eligible on another basis, go to Step 14 to assign groups and benefit level. If not, go to Step 12 to deny Medicaid.

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

Screen for Potential non-MAGI eligibility

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

Step 10 - Screen Potential Non-MAGI Eligibility



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

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

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

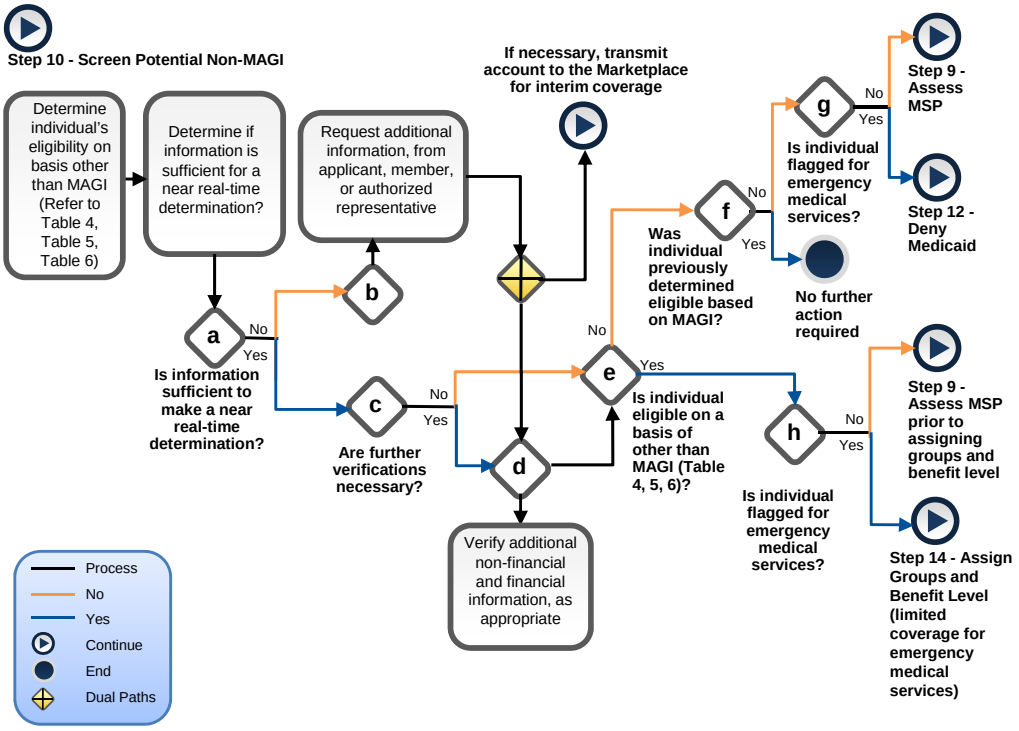
    c. If individual is flagged for emergency medical services only, go to Step 12 to deny Medicaid. If not go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility

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

Determine Eligibility on Basis Other than MAGI

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

Step 11 - Determine Eligibility on Basis Other than MAGI



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

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

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

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

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

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

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

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

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

Savings Program (MSP) eligibility.

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

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

Table 4:	Non MAGI Optional Groups
42 CFR 435.213	Optional Individuals with Breast / Cervical Cancer 21-64 (No Income Test)
42 CFR 435.222	Optional Reasonable Classifications of Children <21 (No Income Test)
42 CFR 435.227	Optional State Adoption Assistance Children <21 (No Income Test)
42 CFR 435.226	Optional Chafee Independent Foster Care Adolescents <21 (No Income Test)
See Table 5	Aged, Blind or Disabled
42 CFR 435.236	Special Income – Level Group
42 CFR 435.217	Individual eligible for Home and Community based services using institutional rules
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XXII), 1915(i)	Individual eligible for Home and Community based services (150% FPL)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XXII), 1915(i)	Individual eligible for Home and Community based services Special Income Level

Table 5:	ABD Groups
42 CFR 435.210	Individuals Eligible for but not Receiving Cash
42 CFR 435.211	Individuals Eligible for Cash except for Institutionalization
42 CFR 435.212	Individuals in HMOs Guaranteed Eligibility
Social Security Act, Sec. 1934	Individuals participating in a PACE program under Institutional Rules
Social Security Act, Sec. 1902(a)(10)(A)(ii)(VII), 1905(o)	Individuals Receiving Hospice Care

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

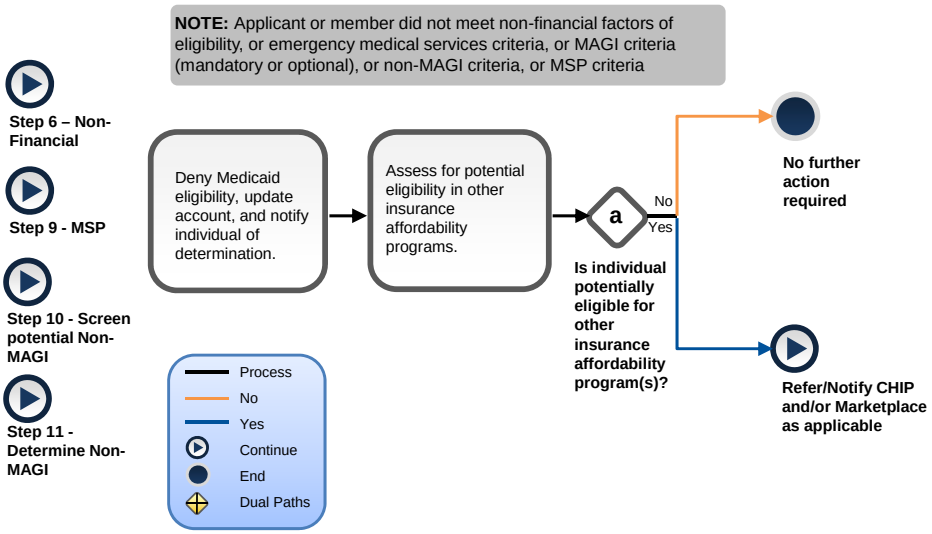
42 CFR 435.232	Optional State Supplemental Recipients - 1634 States, and SSI Criteria States with 1616 Agreements
42 CFR 435.234	Optional State Supplemental Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements
Social Security Act, Sec. 1902(e)(3)	Qualified Disabled Children under 19 (TEFRA Kids)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(X), 1902(m)(1)	Poverty Level Aged or Disabled
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XIII)	Work Incentives Eligibility Group (BBA)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XV)	Ticket to Work Basic Group (TWWIIA)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XVI)	Ticket to Work Medical Improvements Group (TWWIIA MI)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XIX)	Family Opportunity Act for Children with Disabilities (FOA)

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

Deny Medicaid and Assess for Other Insurance Affordability Programs

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

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



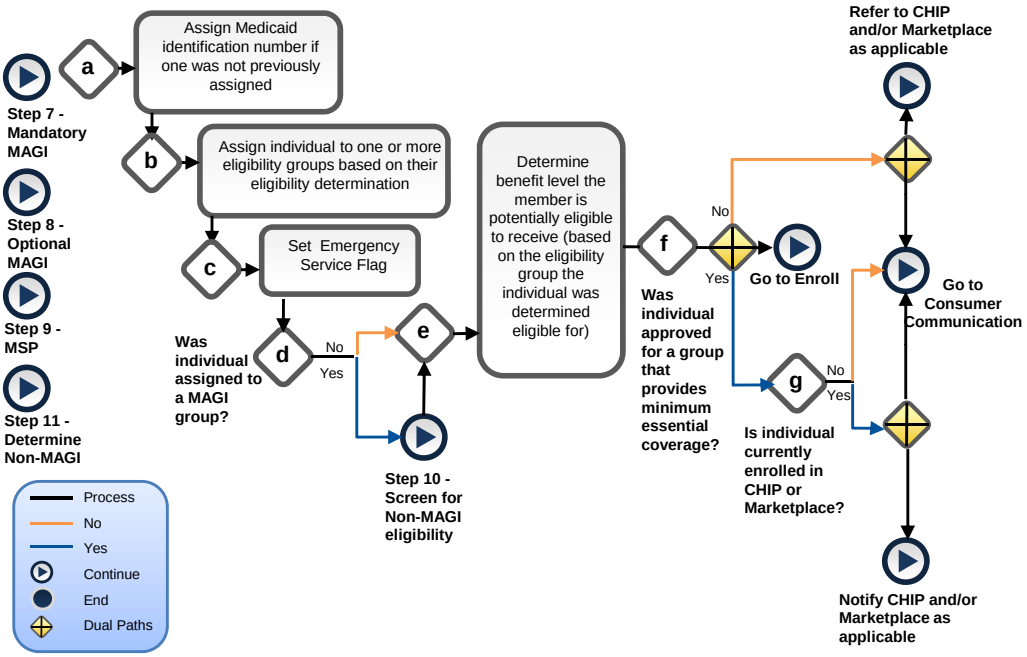
12. Deny Medicaid eligibility, update account *(ME-01 Manage Member Information*) and notify individual (*Manage Applicant and Member Communication*) of determination.
13. Assess individual for other Insurance Affordability Programs
    a. Assess for potential eligibility in other insurance affordability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

Assign Groups and Benefit Levels

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

Step 14 - Assign Group(s) and Benefit Level

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



14. Assign group and benefit levels as appropriate.

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

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

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

    c. Flag individuals determined eligibile for emergency medical services.

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

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

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

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

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

group(s); and determine if individual was approved for a group that provides minimum essential coverage. If yes, individual is approved for a group that provides minimum essential coverage, go to 14g. If no, refer to CHIP and/or Health Insurance Marketplace as applicable (Manage Member Information); and notify individual (Manage Applicant and Member Communication) of determination.

g. If individual is currently enrolled in CHIP or the Health Insurance Marketplace, notify CHIP and/or the Health Insurance Marketplace as applicable of individual's enrollment in Medicaid for potential disenrollment; and notify individual (Manage Applicant and Member Communicatio*n)* of determination. If not currently enrolled in CHIP orHealth Insurance Marketplace, notify individual of determination.

15. **END**

Alternate Scenario 1 – Auto Eligible

1. Determine if applicant or member is automatically categorically eligible without a requirement for financial eligibility (e.g., SSI recipients, IV-E children, deemed newborns). Assess if the individual is a State resident. If so, approve Medicaid eligibility and go to step 14. If not, go to step 6. **Note:** See Mandatory Auto Eligible Groups Table 7.

Table 7:	**Auto-Eligible Groups** ***(Not inclusive** of Closed Groups)*
Social Security Act, Sec. 1902(e)(4), 42 CFR 435.117	Deemed Newborns
Social Security Act, Sec. 1902(a)(10)(A)(i)(II), 42 CFR 435.120	SSI in a 1634 State
Social Security Act, Sec. 1902(a)(10)(A)(i)(I), 42 CFR 435.145	Title IV-E Foster Care, Adoption and Guardianship
Social Security Act, Sec. 1902(a)(10)(A)(i)(II), 42 CFR 435.120	Individual Receiving SSI
Social Security Act, Sec. 1902(a)(10)(A)(i)(II),1902(f), 42 CFR 435.121	Aged, Blind, and Disabled in 209(b) States
Social Security Act, Sec. 1619(b), 1902(10)(A)(i)(II), 1905(q)	Working Disabled Individuals
Social Security Act, Sec. 1634(c)	Disabled Adult Children
42 CFR 435.130	Individuals Receiving Mandatory State Supplements
42 CFR 435.135	Individuals who would be eligible for SSI/SSP but for OASDI COLA increases since April, 1977
Social Security Act, Sec. 1634(b), 42 CFR 435.137	Disabled widows and widowers ineligible for SSI due to increase in OASDI

Shared Data	Member data store including demographics and enrollment information

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

Enroll Member

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

EE Member Enrollment	
Enroll Member	
Item	**Details**
	NOTE: There is a separate business process for Disenroll Member. **NOTE: Applications and Accounts -** An individual seeking eligibility for enrollment in a qualified health plan through the Health Insurance Marketplace, advance premium tax credits, cost-sharing reductions, Medicaid, CHIP or BHP completes and submits an on-line, telephone, in-person, or paper application for verification and eligibility determination. The Health Insurance Marketplace or insurance affordability program accepts application data and manages information in an "account" by the receiving program to enable access to this information during the verification and eligibility determination processes, as well as after the conclusion of the process to support change reporting and for other purposes.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive enrollment determination from ***Determine Member Eligibility*** business process. Environment-based Trigger Events to include but not limited to: • Receive presumptive eligibility determination from provider.
Result	• Enroll eligible member in Medicaid health plans and health benefits. • Alert sent to ***Manage Applicant and Member Communication*** to send welcome package, health plan, if applicable, health benefits, and identification cards. • Alert sent to send enrollment information to contractor. • If applicable, alert sent to ***Manage Member Financial Participation*** for premium payment arrangement. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive eligibility determination to enroll member. 2. Agency associates member with elected health plan, if applicable, and health benefits. 3. Send alert to send enrollment information to contractor. 4. Send alert to send dual eligibility enrollment information to Medicare. 5. If applicable, send alert to ***Manage Member Financial Participation*** for premium payment arrangement. 6. **END:** Send notification to member with welcome package and identification cards via ***Manage Applicant and Member Communication*** business process.
Shared Data	Plan data store including policy information Health Benefit data store including benefit package and benefit information Member data store including demographics and application information

EE Member Enrollment	
Enroll Member	
Item	**Details**
	Provider data store including provider network information Contractor data store including provider network information
Predecessor	**Receive Inbound Transaction** ***Determine Member Eligibility*** ***Manage Applicant and Member Communication***
Successor	**Send Outbound Transaction** ***Manage Applicant and Member Communication*** ***Manage Member Information*** ***Manage Member Financial Participation***
Constraints	State may have different programs and different enrollment criteria, or may use enrollment brokers for some or all of the business process steps. States may require non-HIPAA covered contractors to use the ANSI X12 834 Benefit Enrollment and Maintenance transaction or may rely on State specific formats for contractor notification.
Failures	• Alert fails to reach member or contractor. • Duplicate enrollment requests, • Required field missing or not correct
Performance Measures	• Time to complete process: successful applicant is enrolled within __ days • Accuracy of enrollment = ___% • Consistency of enrollments and disposition = ___% • Error rate is __% or less

Disenroll Member

EE Member Enrollment	
Disenroll Member	
Item	**Details**
Description	The ***Disenroll Member*** business process is responsible for the termination of a member's enrollment in a health plan or health benefit. An enrollment termination may occur due to: • A member is no longer eligible based on redetermination of Medicaid eligibility either on an annual basis or as a result of change reporting during the coverage year.

EE Member Enrollment	
Disenroll Member	
Item	**Details**
	• Upon receipt of a notification of incarceration, SMA may suspend eligibility (if State policy indicates to do so). • A member is no longer eligible based on change in residence. • The denial of eligibility for a or benefit that is based on a technical factor or non-financial characteristic. • A member submits a disenrollment request. • Disenrollment request from a provider or contractor due to issues with the member such as moving out of service area, fraud and abuse, disruptive behavior, non-compliance, or death. • Member is deceased. • Receive disenrollment request from ***Manage Compliance Incident Information*** business process for continued failure to make payments. • Receive disenrollment request from ***Determine Adverse Action Incident*** due to fraudulent or abuse activity. • The provider or contactor has a change of status or termination that requires a mass disenrollment of members. • A health plan or health benefit has a change that requires a mass disenrollment of members. • A member modifies their Manage Care Organization (MCO), Primary Care Case Manager (PCCM), or waiver provider: o Member changes information during Open Enrollment period. o As permitted by State rules, such as the following: ✓ Change in member's residence. ✓ A provider whom the member has chosen no longer contracts with current program or MCO. ✓ Medicaid terminates the contract with the member's MCO or PCCM. ✓ Member successfully appeals auto-assignment. ✓ The member has issues with the MCO, PCCM, or waiver provider that may affect quality of care. **NOTE:** Enrollment brokers may perform some of the steps in this business process.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive disenrollment request from insurance affordability program. • Receive disenrollment request from ***Manage Compliance Incident Information*** business process for continued failure to make payments. • Receive disenrollment request from ***Determine Adverse Action Incident*** business process to remove member from services.

EE Member Enrollment	
Disenroll Member	
Item	**Details**
	Environment-based Trigger Events to include but not limited to: • Receive disenrollment request from member, provider or contractor. • Change in member's information that no longer meets eligibility criteria. • Member modifies their selection of provider, MCO, PCCM or waiver provider. • Provider or contractor modifies network information that alters their service offering. • Modifications in health plan or health benefit that alters service offering.
Result	• Member disenrolled from specific health plans and health benefits. • Member disenrolled from elected provider or contractor. • Alert sent to ***Manage Applicant and Member Communication*** business process to notify member of disenrollment and fair hearing/procedural rights. • Alert sent to ***Perform Population and Member Outreach*** business process to notify affected members with the termination of health plan, health benefit, a provider or a contractor. • Alert sent to send disenrollment information to insurance affordability program. • If applicable, alert sent to ***Manage Member Financial Participation*** to stop premium payment arrangement. • If applicable, alert sent to ***Manage Case Information*** to discontinue care management. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive disenrollment request. 2. Agency logs disenrollment request including source of disenrollment and type of request. 3. Validate request meets State disenrollment rules. 4. If applicable, terminate enrollment in Medicaid health plans and/or health benefits. 5. If applicable, go to ***Enroll Member*** to enroll member in alternative health plans and/or health benefits. 6. If applicable, terminate enrollment with provider or contractor. 7. If applicable, enroll member with alternative provider or contractor. 8. Send alert to ***Manage Applicant and Member Communication*** business process to notify member of disenrollment and procedural rights. 9. Send alert to ***Perform Population and Member Outreach*** business process to notify affected members with the termination of health plan, health benefit, a provider or a contractor.

EE Member Enrollment	
Disenroll Member	
Item	**Details**
	10. If applicable, send alert to ***Manage Member Financial Participation*** to stop premium payment arrangement. 11. If applicable, send alert to ***Manage Case Information*** to discontinue care management. 12. Send alert to send disenrollment information to insurance affordability program. 13. **END**
Shared Data	Member data store including demographics and eligibility information Plan data store including health policy information Health Benefit data store including benefit package and benefit information Provider data store including provider network information Contractor data store including provider network information
Predecessor	**Receive Inbound Transaction** ***Determine Member Eligibility*** ***Manage Member Information*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Provider Information*** ***Manage Contractor Information*** ***Manage Compliance Incident Information*** ***Determine Adverse Action Incident***
Successor	**Send Outbound Transaction** ***Enroll Member*** ***Manage Member Information*** ***Manage Applicant and Member Communication*** ***Manage Case Information*** ***Manage Contractor Communication*** ***Manage Member Financial Participation*** ***Manage Provider Information*** ***Manage Provider Communication*** ***Perform Population and Member Outreach***
Constraints	Programs have different termination criteria.

EE Member Enrollment	
Disenroll Member	
Item	**Details**
Failures	• Duplicate disenrollment requests — Disregard second request. • Required fields missing or not correct — Request additional or corrected information from member, provider, contractor, Health Insurance Marketplace, or insurance affordability program. • Denial of member request for disenrollment from one health plan, health benefit, provider or contractor due to modifications in circumstances, such as residence, health status, or provider access issues because the request does not meet State rules or the member is not eligible for enrollment in an alternative program. • Denial of program, provider, or contractor request to disenroll the member (e.g., modified residence, health status or compliance issues because the request does not meet State rules).
Performance Measures	• Time to complete process: member is disenrolled within __ days or __ minutes • Accuracy of decisions • Consistency of decisions and disposition = ___% • Error rate is __% or less

Inquire Member Eligibility

EE Member Enrollment	
Inquire Member Eligibility	
Item	**Details**
Description	The ***Inquire Member Eligibility*** business process receives requests for eligibility verification from Health Insurance Marketplace, authorized providers, programs or business associates; performs the inquiry; and prepares the Eligibility, Coverage or Benefit Information response. The response information includes but is not limited to benefit status, explanation of benefits, coverage, effective dates, and amount for co-insurance, co-pays, deductibles, exclusions and limitations. The information may include details about the Medicaid health plans, health benefits, and the provider(s) from which the member may receive covered services. **NOTE:** This business process does not include Member requests for eligibility verification. Member initiated requests are handled by the ***Manage Member Information and or Manage Applicant and Member Communication*** business processes.

EE Member Enrollment	
Inquire Member Eligibility	
Item	**Details**
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive eligibility inquiry from the Health Insurance Marketplace via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 Inquiry transaction using the Council for Affordable Healthcare (CAQH®) Committee on Operating Rules for Information Exchange (CORE®) Phase 1 and 2 Rules. • Receive eligibility inquiry from the provider via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 inquiry transaction using CAQH CORE Rules. • Receive eligibility inquiry from the pharmacist via National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Eligibility transaction. • Receive eligibility inquiry via Automated Voice Response System (AVRS) or other commonly available electronic means.
Result	• Response sent to Health Insurance Marketplace via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules. • Response sent to provider via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules. • If applicable, response sent to AVRS or other commonly available electronic means with eligibility information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive eligibility verification request. 2. Agency logs eligibility verification request. 3. Validate requester's authorization to receive requested information. 4. Find requested member's eligibility information. 5. Agency logs response. 6. If applicable, send response to AVRS with eligibility information. 7. **END:** Send response to requestor via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules.
Shared Data	Member data store including demographics, eligibility and enrollment information
Predecessor	**Receive Inbound Transaction**
Successor	**Send Outbound Transaction**

EE Member Enrollment	
Inquire Member Eligibility	
Item	**Details**
Constraints	Eligibility verification request can ask for verification at the categorical, health plan, provider, or health benefit level per X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 Inquiry depending on trading partner agreements. Agency must use Council for Affordable Healthcare (CAQH®) Committee on Operating Rules for Information Exchange (CORE®) Phase 1 and 2 Rules in addition to other HIPAA compliant inquiry methods.
Failures	• Unauthorized requestor cannot receive requested information at the level asked (e.g., eligibility for mental health program); however, requester may receive more general information such as verification of eligibility for health plan or health benefit coverage. **NOTE:** Responses that a member is not eligible or is not active are not failures to process the request.
Performance Measures	• Time to verify eligibility and generate response: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Response Accuracy = ___% • Error rate = __% or less • Usage of CORE certified response = ____ % of the time

Determine Provider Eligibility

EE Provider Enrollment	
Determine Provider Eligibility	
Item	**Details**
Description	The ***Determine Provider Eligibility*** business process collects enrollment application from Health Care Provider, or collects re-enrollment or revalidation information from existing Provider. The business process verifies syntax and semantic of information, checks status tracking (e.g., initial, modification, duplicate, cancelation), requests additional information when necessary, determines screening level (i.e., limited, moderate or high), verifies applicant information with external entities, collects application fees, and notifies Health Care Provider or Provider of enrollment eligibility determination (e.g., accepted, denied, or suspended). ***Determine Provider Eligibility*** business process sends enrollment determination alert signals to subscribing business processes ***Enroll Provider*** and ***Manage Provider Communication. Determine Provider Eligibility*** sends alert signal to ***Manage Accounts Receivable Funds*** business process to collect application fee.

EE Provider Enrollment	
Determine Provider Eligibility	
Item	**Details**
	The ***Determine Provider Eligibility*** business process works in conjunction with Medicare and the processing of dual eligibles. Medicare agency conducts provider screening activities, application fee collection, and revalidation for those providers who are dual eligible. ***Determine Provider Eligibility*** business process is responsible for the provider screening activities, application fee collection, and revalidation for only Medicaid providers. **NOTE:** External contractors such as quality assurance and credentialing verification services may perform some of these steps.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive the following from either a Health Care Provider or existing Provider: o Requester completes enrollment application information (e.g., Provider name, Provider address, Provider National Provider Identifier (NPI), etc.). o Requestor resubmits enrollment application information. o Requestor modifies or cancels application. o Disenrolled Provider submits re-enrollment application information. o Requestor submits additional information in support of an enrollment application. • Periodic review is due or receipt of request to: o Determine revalidation of credentials. Revalidation takes place every five (5) years except for Durable Medical Equipment Prosthetic, Orthotics & Supplies which is every three (3) years; revalidation also requires an application fee. o Monitor sanctions applied to a Provider. o Assist in program integrity review.
Result	• Agency accepts, denies, or suspends the requestor's application. • Agency notifies the requestor of enrollment eligibility (i.e., accepted, denied or suspended). • Alert sent to ***Enroll Provider*** business process to assign contracting parameters; establish payment rates and other activities for eligible requestor. • Alert sent to ***Manage Accounts Receivable Funds*** business process to collect application fee. • If applicable, alert sent to ***Disenroll Provider*** business process to remove provider from services. • Alert sent to notify provider via ***Manage Provider Communication*** business process of enrollment eligibility determination. • If applicable, alert sent to notify Medicare of both dual eligible and regular Medicaid providers information. • Tracking information as needed for measuring performance and business

EE Provider Enrollment	
Determine Provider Eligibility	
Item	**Details**
	activity monitoring.
Business Process Steps	1. **START:** Health Care Provider completes and submits an enrollment application or existing Provider submits enrollment application for revalidation. 2. Requestor identifies Office of the National Coordinator for Health Information Technology (ONC) Authorized Testing and Certification Body (ATCB) certification for electronic health record incentive. 3. Requestor identifies if they are currently participating in Medicare or Children's Health Insurance Program (CHIP). If yes, skip to step 14. 4. Requestor selects application fee payment option including designation of hardship or exclusions from payment. 5. Requestor provides appropriate payment information. 6. Receive enrollment application and other pertinent enrollment communication information. 7. Validate application syntax/semantic conformance. a. **END:** If validation fails, business process stops (see Failures). 8. If necessary, request missing information from requestor. Go step 14. 9. Determine submission status by querying the Provider data store. Application status may be initial, resubmitted with modification, or duplicate. a. If resubmitted application, message contains only updated information and process may skip irrelevant steps below. b. **END:** If duplicate application, produce result messages and stop business process (see Failures). c. Other communications may be requests to cancel application, and to deactivate or reactivate enrollment. 10. Determine applicant type/Provider taxonomy (e.g., primary, rendering, pay to, billing, or other). 11. Determine designated categorical risk (e.g., limited, moderate, or high) based on provider/supplier's category. 12. Assess categorical risk to determine appropriate required screening level. a. Limited Risk includes: i. Verification of any provider/supplier-specific requirements established by Medicare ii. License verifications (may include licensure checks across state) iii. Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an Office of the Inspector General (OIG) exclusion; taxpayer identification number; tax delinquency; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)

EE Provider Enrollment	
Determine Provider Eligibility	
Item	**Details**
	b. Moderate Risk includes: i. Inclusion of Limited Risk screening ii. Unscheduled or Unannounced Site Visits c. High Risk includes: i. Inclusion of Moderate Risk screening ii. Criminal Background Check iii. Fingerprinting 13. Conduct screening based on required screening level with automated transactions except where manual verification if necessary. 14. Determine enrollment eligibility (e.g., accepted, denied, or suspended) based on federal and state rules. 15. Determine if there are enrollment caps due to moratoriums issued. If yes, skip to step 19. 16. If Medicaid accepts enrollment application, send alert to ***Enroll Provider*** business process to assign contracting parameters, establish payment rates, and other activities for eligible requestor. 17. Alert sent to ***Manage Accounts Receivable Funds*** business process to collect application fee. 18. If Medicaid denies the enrollment application for existing Provider, send alert to ***Disenroll Provider*** business process to remove provider from services. 19. If applicable, send alert to notify Medicare of both dual eligible and regular Medicaid providers information. 20. **END:** Send enrollment eligibility determination to ***Manage Provider Communication*** business process to send relevant information to requestor. 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.
Shared Data	Centers for Medicare & Medicaid Services (CMS) Medicare Dual Eligible Provider data store Provider data store including application information (NPI, Provider demographics, Provider taxonomy) NPI and Provider demographics exchanged with the National Plan and Provider Enumeration System (NPPES) and any other national enumeration systems Provider sanction information from:

EE Provider Enrollment	
Determine Provider Eligibility	
Item	**Details**
	• The OIG or the General Accounting Office (GAO) sanction lists of individuals, vendors, and/or suppliers excluded from participation in Medicare, Medicaid, and other federally funded Sate programs from databases such as the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). • State Provider Licensing Authority • Healthcare Integrity and Protection Data Bank (HIPDB) data store • National Practitioner Databank (NPDB) • State Prescription Monitoring Program (PMP) Tax identifiers: Employer ID Number (EIN), Social Security Number (SSN), Taxpayer Identification Number (TIN) from applicant and verified with tax identifier verification sources and any other information required for Form 1099 production Disclosure information including: • Information on ownership and control • Information related to business transactions • Information on persons convicted of crimes • Disclosure by providers and State Medicaid agencies. Multiple office locations, pay to addresses, business associates, and key contract personnel CMS caps and limits moratorium information Insurance Affordability Program data store including eligibility and enrollment information
Predecessor	**Receive Inbound Transaction**
Successor	***Manage Accounts Receivable Funds*** ***Enroll Provider*** ***Disenroll Provider*** ***Manage Provider Communication***
Constraints	The Provider application process will accommodate the full range of Provider types, organizations, specialties, different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., solo office practice, group practice, rural health clinic); as well as, appropriate applications (e.g., New, Modification, Cancellation, Update). Different business rules may apply to each of these different types. Affiliations – Managed Care Organization (MCO) or subpart relationship.
Failures	Enrollment application processing terminates or suspends due to: • Duplicate or cancelled applications. • Failure to validate application edits.

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	
	• Requires additional information to process application.	
Performance Measures	• Time to complete Enrollment process = within __ days • Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less	
Provider Enrollment Variations		
Type	**Subtypes**	**Information**
Institutional Provider	The Institutional Provider application will accommodate a range of institutional Provider types (e.g., inpatient, nursing home, day care), different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., outpatient, emergency room, assisted living).	NPI, entity type, taxonomy, type of facility, bed size, equipment, type of institutional services, ownership, trading partner information, billing and payment information, tax code, Diagnosis Related Group (DRG) or other payment type
Individual Provider	The Individual Billing Provider application will accommodate a range of professional billing Provider types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other).	NPI, entity type, taxonomy, affiliation, location, trading partner information, billing and payment information
Individual Rendering Provider	The Individual Rendering Provider application will accommodate a range of professional rendering Provider types (e.g. Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other) Enumerate a group health practice separately from the individual physicians associated with it.	NPI, entity type, taxonomy, affiliation, location, equipment
Pharmacy	The Pharmacy application will accommodate a range of types (e.g., major chain with hundreds of stores, community pharmacy), different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., retail store, outpatient facility, nursing home). **NOTE:** The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist.	NPI, entity type, ownership, location, unit dose, mail order, Drug Enforcement Administration (DEA) information, Drug Utilization Review (DUR) compliance, trading partner information, billing and payment information
Atypical	The atypical Provider application will accommodate a range of types of programs (e.g., waiver, assistance in the home), different kinds of service Providers (e.g., family care-taker, taxi cab, plumber, carpenter, meals on wheels), different types of relationships (e.g., the primary Provider, billing agent, pay-to entity),	Provider ID, SSN, specialty, type of service Provider, allowed services, invoicing method

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	
	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.	
Suppliers	The DME suppliers and manufacturers supply or manufacturers application will accommodate a range of durable medical equipment, prosthetics, orthotics, supplies (DME Ops) types.	NPI, entity type, EIN, DME license, supplies, trading partner information, billing and payment information, ownership
Medical Transportation	The Medical Transportation Provider application will accommodate a range of transportation modes that include Air, Ambulance, Law, Pedestrian, Private or Public Transport. It should accommodate different types of vehicles, aircraft, licensing, and inspection information.	EIN, entity type, license type and number, inspection, vehicle, aircraft, and/or ambulance information

Enroll Provider

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

EE Provider Enrollment	
Enroll Provider	
Item	**Details**
	with the affected parties, including informing parties of their procedural rights. • Periodic review is due or receipt of request to: o Negotiate payment rates. o Notify Provider of enrollment determination. ***Enroll Provider*** business process supports receipt and verification of program contractor's Provider enrollment roster information (e.g., name, identification, contract information, type, specialty and services) from Managed Care Organization (MCO) and HCBS organizations.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive newly eligible Provider from ***Determine Provider Eligibility*** business process. • Receive newly eligibility contractor from ***Award Contract*** business process. • Receive alert from ***Manage Performance Measures*** to revalidate provider. Environment-based Trigger Events to include but not limited to: • Periodic review is due or receipt of to: o Renegotiate payment rates. o Reevaluate enrollment based criteria such as performance measures, or triggered by date such as anniversary date based on Medicaid policy to verify information based on a contractual duration (e.g. year or months). • Receive program enrollment or disenrollment information from Medicaid or CHIP. • Receive request for provider's enrollment roster information.
Result	• Enrolled, re-enrolled, suspended, or denied enrollment of provider or contractor into programs. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of enrollment determination. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of enrollment determination. • If applicable, alert sent to ***Manage Contractor Payment*** for payment arrangement. • Alert sent to ***Perform Provider Outreach*** to send relevant state policy information. • Alert sent to ***Manage Contract*** business process to negotiate contract. • If applicable, send response for Provider enrollment roster information. • Alert sent to notify Health Insurance Marketplace of provider enrollment

EE Provider Enrollment	
Enroll Provider	
Item	**Details**
	information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Determine contracting parameters (e.g., Provider taxonomy, categories of service for which the Provider can bill), eligible Provider types, payment types, contract terms and maximums, member enrollment levels, panel size, and any contractor specific benefit packages and procedures. 2. Assign any identifiers used internally. 3. Determine if there are enrollment limits due to moratoriums issued. If yes, skip to step 9. 4. Assign to programs and determine rates: Includes identifying type of rate (e.g., negotiated, Medicare, percent of charges, case management fee, other via look-ups in the reference and benefit repositories). 5. If applicable, send alert to ***Manage Contractor Payment*** business process for payment arrangement. 6. Send alert to ***Perform Provider Outreach*** business process to send relevant state policy information. 7. Send alert to ***Manage Contract*** business process to negotiate contract. 8. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of enrollment determination. 9. If applicable, provide response to request for Provider enrollment roster information. 10. Send alert to notify Health Insurance Marketplace of provider enrollment information. 11. **END:** Send alert to notify provider via ***Manage Provider Communication*** business process of enrollment determination.
Shared Data	Provider data store including: • Provider demographics • Provider network • Contract information o Type o Specialty o Enrolled Program o Jurisdiction o Payment Information • Provider taxonomy

EE Provider Enrollment	
Enroll Provider	
Item	**Details**

	• Service Location Information
	  o Category of Service
	  o Services
	  o Limitations
	  o Business Arrangement
	Contractor data store including provider network information
	Plan data store including health benefit and fees information
	Moratorium data store including Caps and Limits information
	Health Insurance Marketplace including provider enrollment information

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

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

EE Provider Enrollment		
Enroll Provider		
Item	**Details**	
Transportation	will accommodate a range of transportation modes that include Air, Ambulance, Law, Pedestrian, Private or Public Transport. It should accommodate different types of vehicles, aircraft, licensing, and inspection information.	and number, inspection, vehicle, aircraft, and/or ambulance information

Disenroll Provider

EE Provider Enrollment	
Disenroll Provider	
Item	**Details**
Description	The ***Disenroll Provider*** business process is responsible for managing disenrollment in the Medicaid Program. This business process covers the activity of disenrollment including the tracking of disenrollment requests and validation that the disenrollment meets state's rules. Medicaid sends notifications to affected parties (e.g., provider, contractor, business partners) as well as alerts to other business processes to discontinue business activities.
Trigger Event	Interaction-based Trigger Events: • Receive disenrollment from insurance affordability program. • Receive disenrollment from ***Determine Provider Eligibility*** business process within ineligible information. • Receive disenrollment from ***Manage Compliance Incident Information*** business process for continued failure to make payments. • Receive disenrollment from ***Manage Provider Information*** business process from provider request. • Receive disenrollment from ***Manage Contractor Information*** business process from contractor request. • Receive alert from ***Determine Adverse Action Incident*** business process to remove provider from services. • Receive alert from ***Close Out Contract*** business process to remove provider from services. Environment-based Trigger Events to include but not limited to: • Receive request to disenroll provider. • Receive information from Medicare/Medicaid Sanction, National Practitioner Databank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB), or state licensing boards. • Receive information about a provider's death, retirement, or disability.
Result	• Agency disenrolls Provider or contractor from participation in Medicaid Program.

EE Provider Enrollment	
Disenroll Provider	
Item	**Details**
	• Alert sent to notify provider via ***Manage Provider Communication*** business process of disenrollment information. • Alert sent to notify contractor via ***Manage Contractor Communication*** business process of disenrollment. • Alert sent to notify Medicare/Medicaid Sanction, National Practitioner Data Bank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB), and state licensing boards via ***Manage Business Relationship Communication*** business process of disenrollment information. • If applicable, alert sent to ***Manage Contractor Payment*** to stop payment arrangement. • Alert sent to ***Close Out Contract*** business process with disenrollment information. • Alert sent to ***Apply Mass Adjustment*** business process to associate members with alternate provider or contractor. • Alert sent to notify Health Insurance Marketplace of provider disenrollment information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive disenrollment request or relevant information. 2. Validate authenticity of the requestor to have authorization to request disenrollment. 3. Determine disenrollment request or information processing status by querying the Provider data store. Application status may be one of the following: initial, resubmitted with modification, or duplicate. a. If resubmitted application, message contains only updated information and process may skip irrelevant steps below. b. If duplicate application, produce result messages and stop business process (see Failures). c. Other communications may be requests to cancel application, and to deactivate or reactivate enrollment. 4. Verify the disenrollment information. 5. Validate that the disenrollment request meets state rules. 6. Remove provider or contractor from Medicaid participation. 7. Send alert to notify Medicare/Medicaid Sanction, NPDB, HIPDB, and state licensing boards via ***Manage Business Relationship Communication*** business process of disenrollment information. 8. If applicable, send alert to ***Manage Contractor Payment*** business process to stop payment arrangement. 9. Send alert to ***Close Out Contract*** business process with disenrollment

EE Provider Enrollment	
Disenroll Provider	
Item	**Details**
	information. 10. Send alert to ***Apply Mass Adjustment*** business process to associate members with alternate provider or contractor. 11. Send alert to notify provider via ***Manage Provider Communication*** business process of disenrollment information. 12. Send alert to notify contractor via ***Manage Contractor Communication*** business process of disenrollment. 13. Send alert to notify other insurance affordability programs of the disenrollment from Medicaid. 14. Send alert to notify Health Insurance Marketplace of provider disenrollment information. 15. **END:** Agency removes Provider or contractor from participation in Medicaid services.
Shared Data	Provider data store including provider network and contact information (e.g., NPI, provider demographics, provider taxonomy) NPI and provider demographics exchanged with National Plan and Provider Enumeration System (NPPES) Provider sanction information such as: a. The Office of Inspector General or the General Accounting Office (OIG/GAO) sanction lists of individuals, vendors, and/or suppliers that are excluded from participation in Medicare, Medicaid, and other federally funded state programs b. State Provider Licensing Authority c. HIPDB d. NPDB Tax identifiers: Employer ID Number (EIN), Social Security Number (SSN), Taxpayer Identification Number (TIN) from applicant and verified with tax identifier verification sources Insurance Affordability Program data store including eligibility and enrollment information
Predecessor	***Determine Provider Eligibility*** ***Manage Compliance Incident Information*** ***Manage Provider Information*** ***Manage Contractor Information*** ***Determine Adverse Action Incident*** ***Close Out Contract***

EE Provider Enrollment	
Disenroll Provider	
Item	**Details**
Successor	***Manage Provider Communication*** ***Manage Provider Information*** ***Manage Contractor Communications*** ***Manage Contractor Information*** ***Manage Business Relationship Communication*** ***Manage Contractor Payment*** ***Close Out Contract*** ***Apply Mass Adjustment***
Constraints	The Provider disenrollment process will accommodate the full range of provider types, organizations, specialties, different types of applicants (e.g., the Primary Provider, Billing Agent, Pay-To Entity), and care settings (e.g., solo office practice, group practice, Rural Health Clinic) as well as different types of application (e.g., New, Modification, Cancellation, Update). Different business rules will apply to each of these different types.
Failures	• Duplicate disenrollment requests. • Requirement for additional information to process disenrollment.
Performance Measures	• Time to complete Disenrollment process = within __ days • Accuracy with which edits are applied = ___% • Consistency of decisions and disposition = ___% • Error rate = __% or less

Inquire Provider Information

EE Provider Enrollment	
Inquire Provider Information	
Item	**Details**
Description	The ***Inquire Provider Information*** business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry, and prepares the response information for the **Send Outbound Transaction**.
Trigger Event	Interaction based Trigger Events: • Receive eligibility inquiry via Automated Voice Response System (AVRS). Environment-based Trigger Events to include but not limited to: • Receive provider enrollment verification request from **Receive Inbound Transaction**.
Result	• Provider enrollment verification response that may include information such as

EE Provider Enrollment	
Inquire Provider Information	
Item	**Details**
	enrollment start/end dates, provider type, and specific specialties provided. • If applicable, response sent with eligibility inquiry information via AVRS. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive provider enrollment verification information from **Receive Inbound Transaction**. 2. Agency logs enrollment verification request. 3. Validate requestor's authorization to receive requested information. 4. Find requested provider's enrollment verification information. 5. Agency logs response. 6. If applicable, send eligibility inquiry response via AVRS. 7. **END:** Send response to requestor via **Send Outbound Transaction**.
Shared Data	Provider data store including: • Provider demographics • Provider network • Contract information o Type o Specialty o Enrolled Program o Jurisdiction o Payment Information • Provider taxonomy • Service Location Information o Category of Service o Services o Limitations o Business Arrangement
Predecessor	**Receive Inbound Transaction**
Successor	**Send Outbound Transaction**
Constraints	States determine what information share and who can access what requested information.
Failures	• Process unable to process the provider information verification request. • Unauthorized requester cannot receive requested information.

EE Provider Enrollment	
Inquire Provider Information	
Item	**Details**
Performance Measures	• Time to verify provider information and generate response information: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Response Accuracy = ___% • Error rate = __% or less