MMIS IV&V Project
Department of Health and Hospitals
“As-Is” Business Process Validation
February 19, 2009

1.0 Document Information

Revision #	Revision Date	Section(s) Revised	Revision Description
1.0	12/12/2008	Initial Submission	
2.0	1/9/2009	Second Submission	
3.0	1/30/2009	Third Submission	
4.0	2/13/2009	Forth Submission	
5.0	2/18/2009	Fifth Submission	
6.0	2/19/2009	Sixth Submission	

2.0 **Executive Summary**

The MAXIMUS IV&V Team began work on the LA MMIS Replacement Project in September 2008. This Project is scheduled for 36 months duration and includes four (4) key project Phases, which have clearly defined tasks and subtasks:

Phase I: Planning/Pre-Implementation

Phase II: Design and Development

Phase III: Testing and Implementation

Phase IV: Preparation for CMS certification

Initially, the MAXIMUS focus has been on Phase I activities and the project's first objectives: to prepare and develop the Solicitation for Proposal (SFP) for the MMIS Procurement for Fiscal Intermediary (FI) services and MMIS Replacement Project and the associated Implementation Advance Planning Document (IAPD). The "As Is" Business Process Validation is a key Phase I deliverable and the information and data gathered from the "As-Is" JAD sessions provide the basis for this validation.

The intent of this "As-Is" Business Process Validation has changed since the start of the project as the original approach was based upon the existence of a completed DHH prepared "As-Is" and "To-Be" MITA State Self-Assessment (SS-A). With only an "As-Is" business process model in place, the approach for the "As-Is" Gap Analysis was changed to validating the "As-Is" business process model (prepared by DHH prior to the start of the MMIS IV&V Project) and comparison to MITA business processes and required SS-A content.

In November and December 2008, MAXIMUS conducted an assessment of the current Medicaid business processes and business processes through a series of "As Is" and "To Be" Joint Application Design (JAD) sessions. The focus of the "As-Is" sessions was to review the MITA "As-Is" business process model prepared by DHH; determine the accuracy of the information provided; and refine the business process models. These additions/clarifications will be documented by MAXIMUS in the format of the final "As-Is" Business Process Validation deliverable. The Business Process Models from this document will be used as the "As-Is" MITA documentation. The Phase I, Subtask I-1.3 Gap Analysis, includes the following key elements that reflect the acceptance criteria for the Business Process Validation:

- A comparison of the DHH Prepare "As-Is" Business Process Model to MITA and identification of any discrepancies
- Business Process Models included in the deliverable appropriately reflects all input obtained during JADs and documented in the meeting notes
- Business Process Workflows accurately reflect the associated business process
- Limited grammatical or typographical errors that DO NOT affect the intent of the documentation

3.0 Deliverable Description

The Phase I "As-Is" Business Process Validation deliverable documents results of MAXIMUS IV&V Team's identification and in-depth evaluation of current business processes of the current Medicaid environment using the MITA business process areas and standards as a basis for the review. To accomplish this effort, the following tasks were completed:

- Analysis of the most current DHH prepared "AS-Is" MITA State Self-Assessment (SSA) completed by DHH
- Identification of the gaps between the environment defined in the DHH prepared business processes and the definition of those business processes resulting from the "As-Is" JADs facilitated by MAXIMUS, as approved by the DHH Project Management Team, the "As-Is" Gap Analysis includes the following components
- Overview of the Business Process Areas (Member Management, Program Management, Care Management, Provider Management, Contract Management, Business Relationship Management, Operations Management, and Program Integrity as reflected in the MAXIMUS Defined Business "As-Is" business processes
- Cross-reference of DHH defined business processes and the MAXIMUS defined "As-Is" business processes resulting from the JAD sessions
- Business process models and workflows for each of the business processes associated with each of the eight (8) MITA business process areas. The BPMs are presented in the format required for the MITA SS-A
- Discussion of any conclusions that have resulted from the MAXIMUS assessment of the business processes
- The Gap Analysis deliverable does not include an analysis of the Business Capability Matrix (BCMs) prepared by DHH for the following reasons:
- BCMs for all processes have not been provided by DHH
- DHH prepared business process models have significantly changed as a result of the MAXIMUS JAD process and are under review and refinement
- DHH prepared BCMs will be reviewed as a first step in "To-Be" JADs and refined based upon the final MAXIMUS prepared business process models. This refinement based upon the final models will be documented in the "To-Be" MITA Documentation deliverable.

4.0 **Methodology**

4.1 Creating the "As-Is" Business Process Validation

The methodology for creating the "As Is" Business Process Validation for the LA MMIS Replacement Project included the following activities:

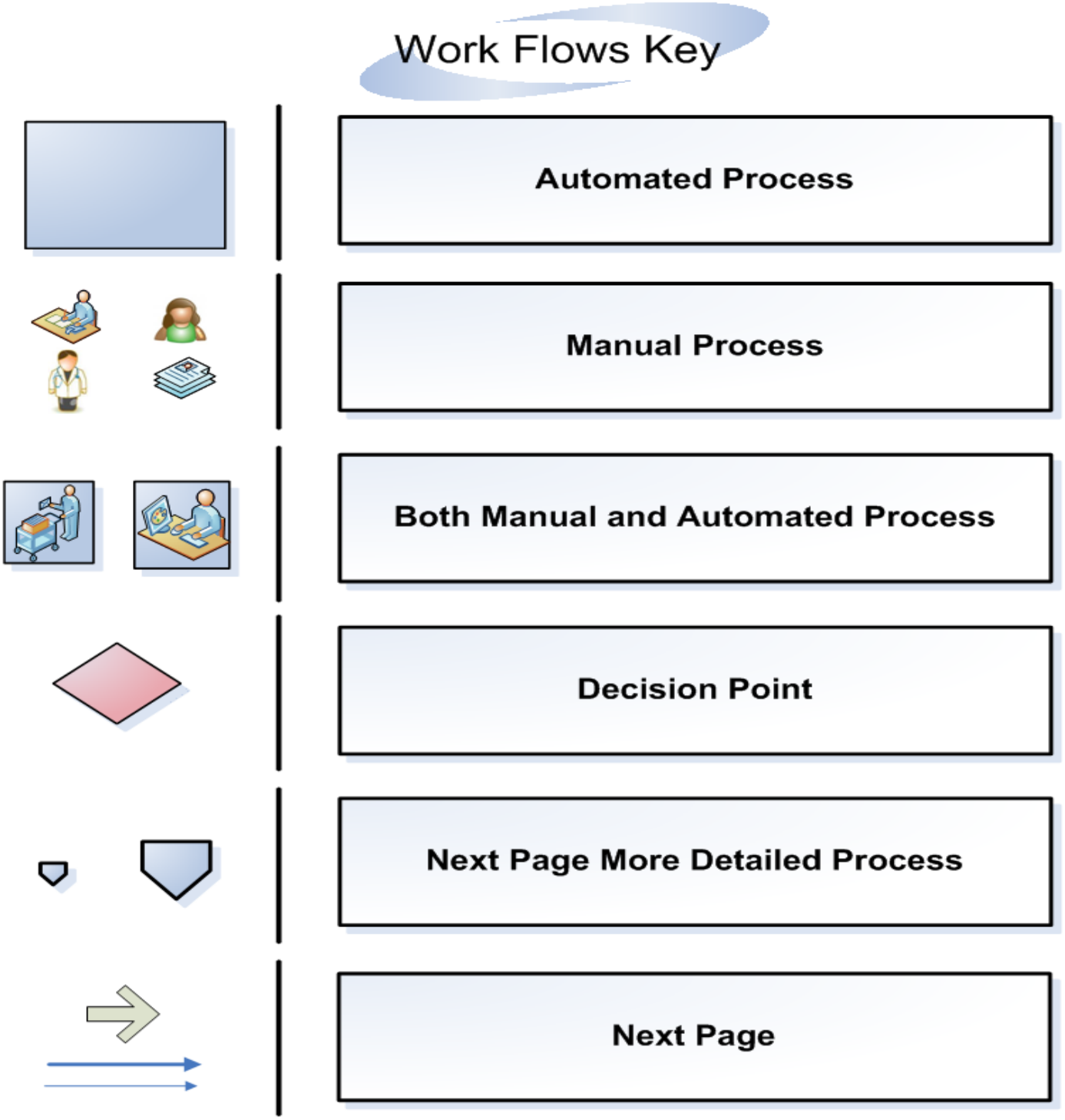
1. Review of available business and system documentation as necessary
2. Presentation by the DHH PMT of the current MMIS system and discussion of basic limitations in terms of screen design and navigation
3. Facilitation of visioning sessions with Medicaid executives to obtain input regarding problems experienced in the "As-Is" environment and visions for the future system
4. Detailed review of the results of the DHH prepared "As-Is" MITASS-A which included 148 business process associated with the eight(8) MITA business process areas
5. Facilitation of JAD sessions to validate the "As-Is" DHH prepared MITA business process models
6. Development of workflows to reflect the refined business steps for each of the business processes
7. Development of the draft "As-Is" Business Process Validation Analysis for DHH review and comment

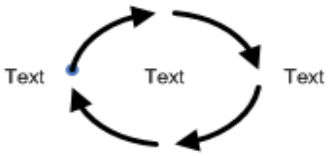
The DHH Project Management Team (PMT) has been very supportive in facilitating the scheduling of the JADs and the distribution of agendas and work materials to JAD participants. MAXIMUS appreciates the support that has been provided. The timeline for conducting the JADs and review of work products has been hectic.

Where time allowed, MAXIMUS prepared agendas and work materials for review by the JAD participants prior to the session. During the "As-Is" session, MAXIMUS facilitated a review of the business process models prepared by DHH. BPMs were updated to reflect the changes identified by JAD participants. MAXIMUS then developed workflows to mirror the business steps defined in the revised BPMs and reviewed with participants. The BPMs and workflows have undergone a number of reviews and revisions throughout the "As-Is" and "To-Be" JAD sessions.

4.2 Shapes Definitions

MAXIMUS is providing the following definitions for the major shapes used in the workflow documents.





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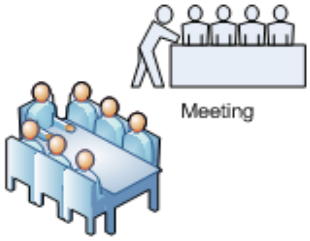


Meeting

Go to another Business Process

Submit to CMS

Verification or Quality Control

End Business Process

Purchase or Payment

Manual Receiving

5.0 Member Management Overview

The Member Management business processes are for handling Medicaid eligibility and enrollment. The DHH has several sections involved in these processes and they meet all federal requirements. These business processes are also more automated then other areas but there is still room for improvement. Better communication between the systems and easier access to information by authorized staff will make these business processes more efficient to the DHH staff and the member population of the State of Louisiana.

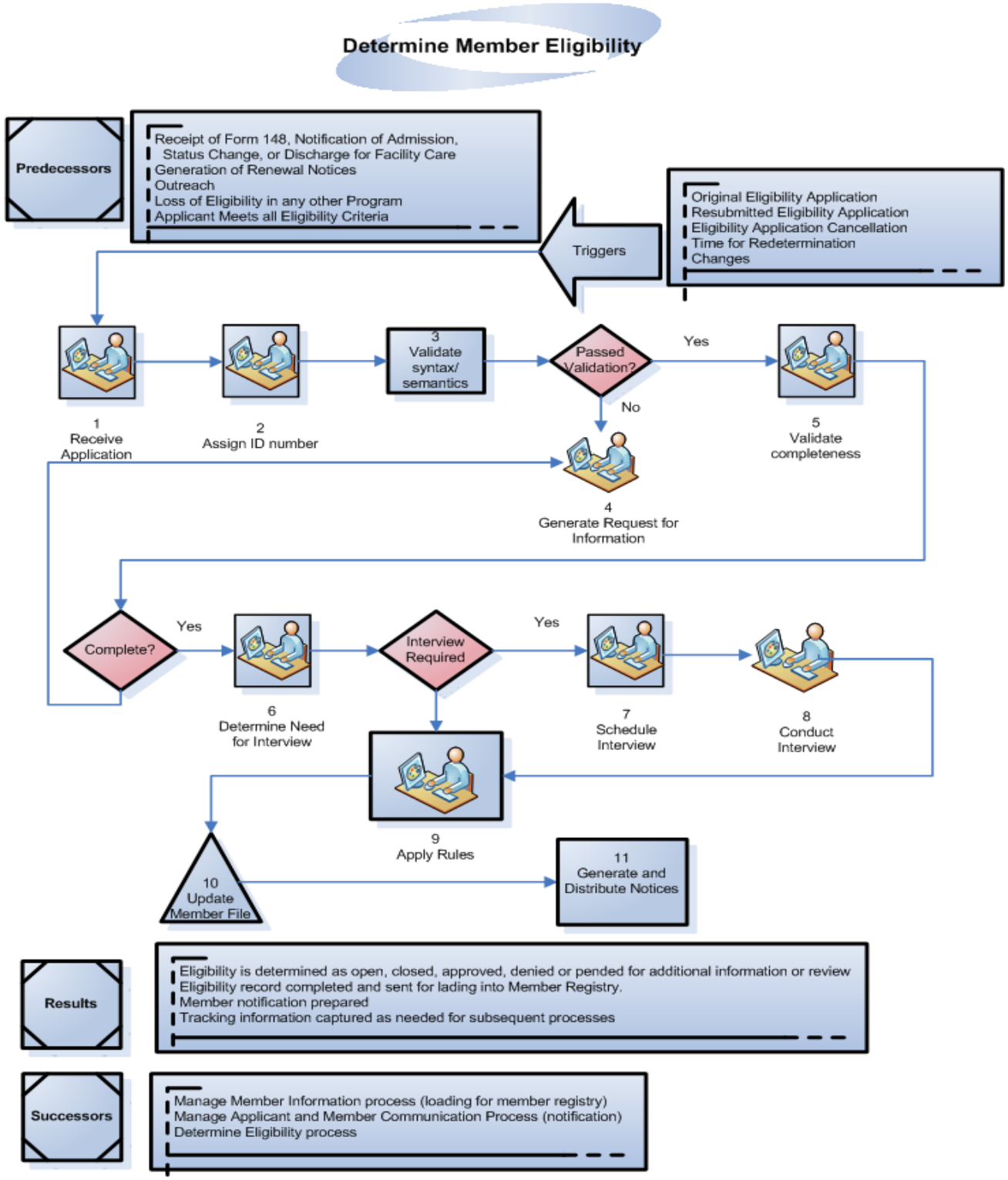
5.1 Determine Member Eligibility

5.1.1 Determine Member Eligibility Business Process Model

Item	Details
Description	The **Determine Eligibility** business process receives application by phone, fax, mail and/or internet; checks for status (e.g., new, resubmission, duplicate), establishes type of eligible (e.g., children and parents, disabled, elderly, or other); screens for required fields, edits required fields, verifies applicant information with external entities, assigns an ID, establishes eligibility categories and hierarchy, associates with benefit packages, and produces notifications and other program guidelines.
Trigger Event	1. Original eligibility application 2. Resubmitted eligibility application 3. Eligibility application cancellation 4. Time for redetermination 5. Changes
Result	1. Eligibility is determined as open, closed, approved, denied or pended for additional information or review 2. Eligibility record completed and sent for lading into Member Registry. 3. Member notification prepared 4. Tracking information captured as needed for Determine Eligibility process, measuring performance and business activity monitoring and Ad Hoc reporting for QC.
Business Process Steps	1. Receive eligibility application. 2. Assign I.D. 3. Validate syntax and semantic pass validation requirements associated with children and families eligibility application. Business rules identify fatal and non-fatal errors and associated error messages. a. If Yes, continue to Step 5 b. If No, go to Step 4 4. Generate request for information. 5. Validate completeness and required fields — business rules identify mandated fields and apply edits a. If Yes complete, continue to Step 4a b. If No, got to Step 3a 6. Determine need for interview a. If Yes, continue to Step 7 b. If No, go to Step 9 7. Schedule interview 8. Conduct interview 9. Apply Rules - Composite Eligibility Determination Rules are applied — Summation of all rules determines if applicant is eligible or not, and if eligible, for which category of eligibility

Item	Details
	10. Update Member Files 11. Generate and distribute notices
Shared Data	1. TANF eligibility 2. IUSCIS 3. Other Insurers and type of coverage 4. Bank account balances 5. Employer records 6. Vital Statistics 7. Department of Labor 8. Medical Certification 9. Medical Reports 10. Wage Verification Service 11. SSI/SS-A 12. Child Support 13. Food Stamps 14. Veterans Administration
Predecessor	1. Receive by phone, fax, mail and/or internet and/or referrals 2. Receive Form 148, Notification Of Admission, Status Change, Or Discharge For Facility Care 3. Generation of renewal notices 4. Outreach 5. Loss of eligibility in any other program 6. Applicant meets all eligibility criteria
Successor	1. Manage Member Information process (loading for member registry) 2. Manage Applicant and Member Communication Process (notification) 3. Determine Eligibility process by SSA/SSI/TANF, etc.
Constraints	4. Agency accepts the eligibility determination of the SSA for the SSI population. 5. Agency accepts TANF eligibility from DSS for Medicaid eligibility. 6. Responsible for non-SSI-linked eligibility. 7. Determining disability status is time consuming. Language barrier 8. Limited Providers
Failures	None
Performance Measures	1. Determine eligibility 98.5% standard 2. 90% or greater of eligible population enrolled in LACHIP 3. Process 98% of claims with in 30 days of receipt 4. Edit 100% of claims for TPL coverage

5.1.2 Determine Member Eligibility Workflow

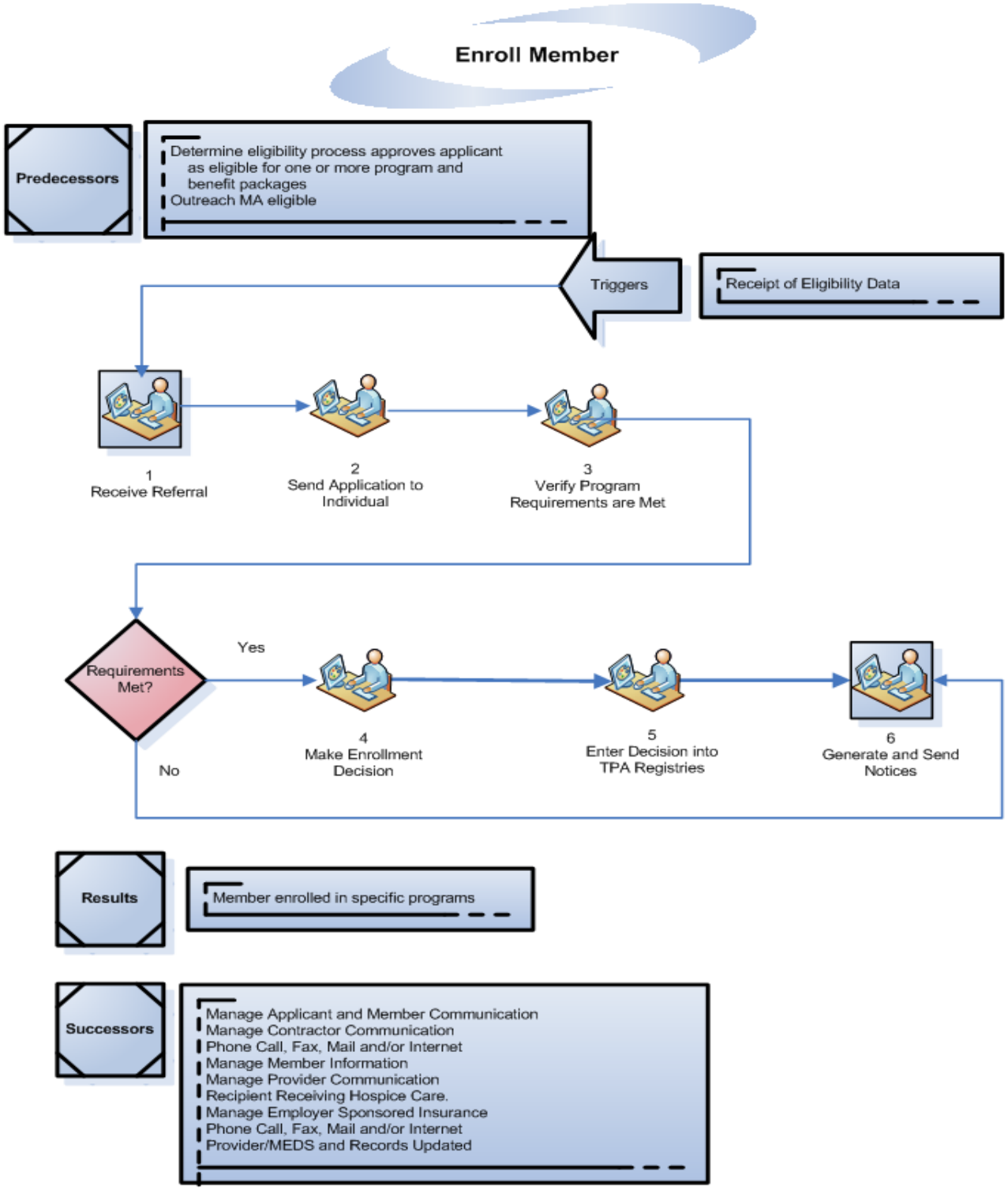


5.2 Enroll Member

5.2.1 Enroll Member Process Model

Item	Details
Description	The **Enroll Member** business process receives eligibility data from the **Determine Eligibility** process or other sources, determines additional qualifications for enrollment in programs for which the member may be eligible, loads the enrollment outcome data into the Member and Contractor (TPA) Registries, and produces notifications to the member and the contractor
Trigger Event	Receive member eligibility data and enrollment application from the Determine Eligibility process or other sources
Result	Member is enrolled in specific programs
Business Process Steps	1. Receive referral via internal/external sources in either paper or electronic: • LaHIPP – internal and external referrals • Hospice – external referrals • OGB – Office of Group Benefits referrals • FOA – Family Opportunity Act referrals • LAP – LA Affordable plan referrals • CommunityCare system generates run in MMIS on individual record 2. Send application to individual or policy holder 3. Verify program requirements are met a. If Yes, continue to Step 4 b. If No, go to Step 6 4. Make enrollment decision 5. Enter decision into TPA registries 6. Generate and send notices
Shared Data	Verify: INS, Medical Reports, Employers
Predecessor	1. Determine Eligibility process approves applicant as eligible for one or more program and benefit packages. 2. Outreach MA eligible
Successor	1. Manage Applicant and Member Communication 2. Manage Contractor Communication 3. Phone Call, Fax, Mail and/or Internet 4. Manage Member Information 5. Manage Provider Communication 6. Recipient receiving hospice care. 7. Manage Employer Sponsored Insurance 8. Phone Call, Fax, Mail and/or Internet 9. Provider/MEDS and records updated
Constraints	State and Federal Rules and Regulations
Failures	None
Performance Measures	None

5.2.2 Enroll Member Workflow



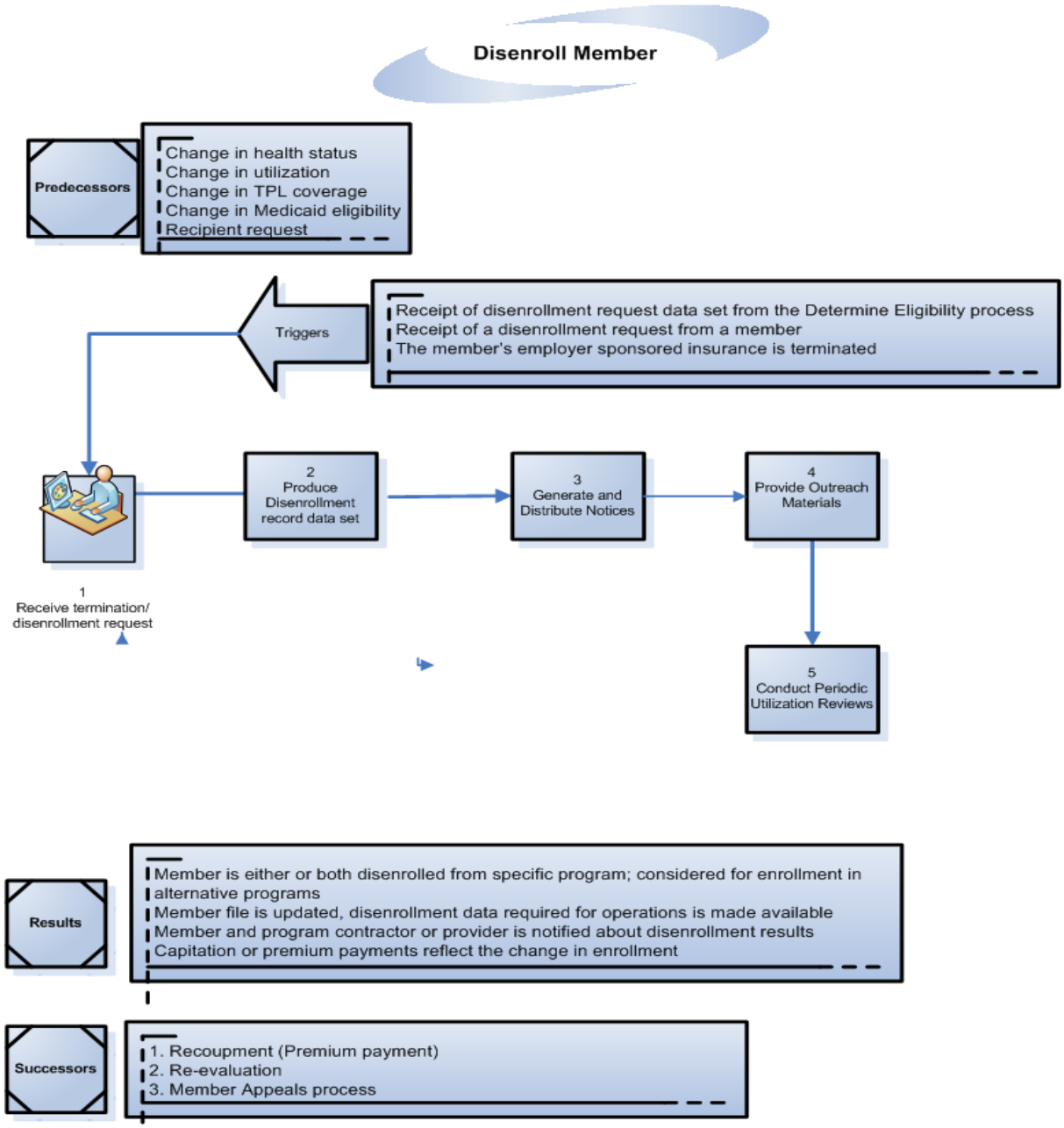
5.3 Disenroll Member

5.3.1 Disenroll Member Business Process Model

Item	Details
Description	The ***Disenroll Member*** business process is responsible for managing the termination of a member's enrollment in a program, including: 1. processing of enrollment terminations and requests submitted by the member, a program provider or contractor 2. disenrollment based on member's death 3. failure to meet enrollment criteria such as a change in health or financial status, or change of residency outside of service area
Trigger Event	1. Receipt of disenrollment request data set from the Determine Eligibility process a. In conjunction with a redetermination of eligibility for Medicaid in which the member is found to be no longer eligible b. As a result of eligibility for a program in addition to Medicaid based on health status, e.g., home and community based waivers for recipients under age 19, obtaining TPL coverage with physician benefits, etc. 2. Receipt of a disenrollment request from a member a. During an Open Enrollment period b. Due to change in residence c. Any time for Medically High Risk Exemption Request 3. The member's employer sponsored insurance is terminated
Result	1. Member is either or both a. Disenrolled from specific programs b. Considered for enrollment in alternative programs 2. Member file is updated; disenrollment data required for operations is made available. 3. Member and program contractor or provider is notified about disenrollment results 4. Capitation or premium payments reflect the change in enrollment
Business Process Steps	1. Receive member eligibility termination data and/or disenrollment requests from the Determine Eligibility. 2. Produce disenrollment record data set and request that the Manage Member Information process load disenrollment record into Member file 3. Generate and distribute decision notice which may include notification of appeal rights 4. Provide outreach and education materials needed by members who have been disenrolled in accordance with rules 5. Conduct Periodic utilization reviews
Shared Data	1. Medical documentation 2. Vital Records 3. Employer Records 4. Insurance Records
Predecessor	1. Change in health status 2. Change in utilization 3. Change in TPL coverage 4. Change in Medicaid eligibility 5. Recipient request
Successor	1. Recoupment (Premium payment) 2. Re-evaluation 3. Member Appeals process
Constraints	State and federal rules and regulations
Failures	Change in circumstances prior to completion of process

Item	Details
Performance Measures	Terms & conditions of contract

5.3.2 Disenroll Member Workflow

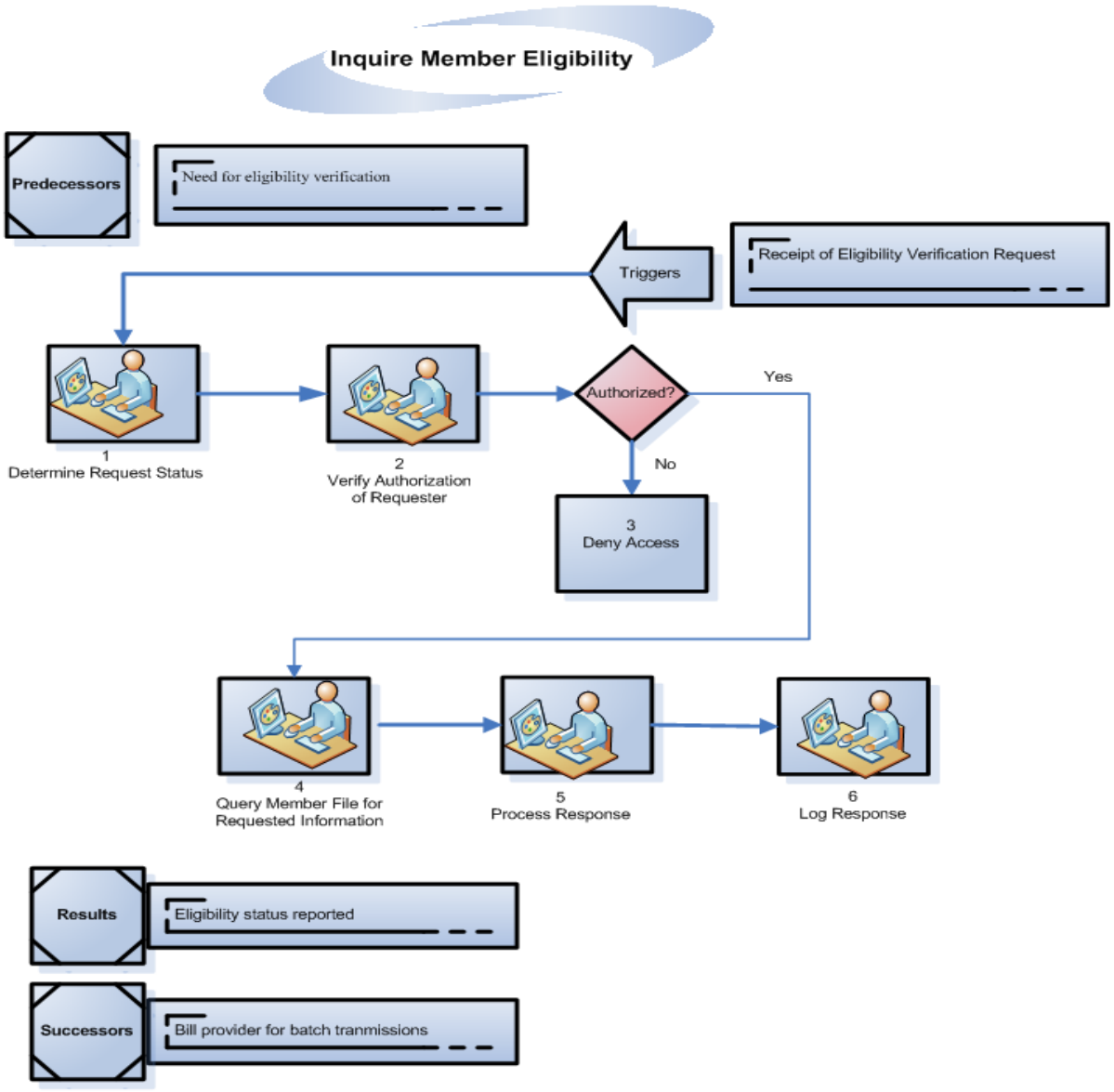


5.4 Inquire Member Eligibility

5.4.1 Inquire Member Eligibility Business Process Model

Item	Details
Description	The **Inquire Member Eligibility** business process receives requests for eligibility verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response **NOTE:** This process does not include Member requests for eligibility verification. Member initiated requests are handled by the **Manage Applicant and Member Communication** process.
Trigger Event	Receipt of Eligibility Verification Request
Result	Eligibility status reported
Business Process Steps	1. Determine Request status as initial or duplicate using rules to determine if the requester is "fishing". 2. Verify authorization of the requester to receive requested eligibility information a. If Yes, continue to Step 4 b. If No, go to Step 3 3. Deny access and End Process 4. Query Member file for requested information 5. Process Response 6. Log Response
Shared Data	None
Predecessor	Need for eligibility verification
Successor	Bill provider for batch transmissions
Constraints	Federal and state rules and regulations
Failures	1. Communication failures 2. System failures
Performance Measures	None

5.4.2 Inquire Member Eligibility Workflow

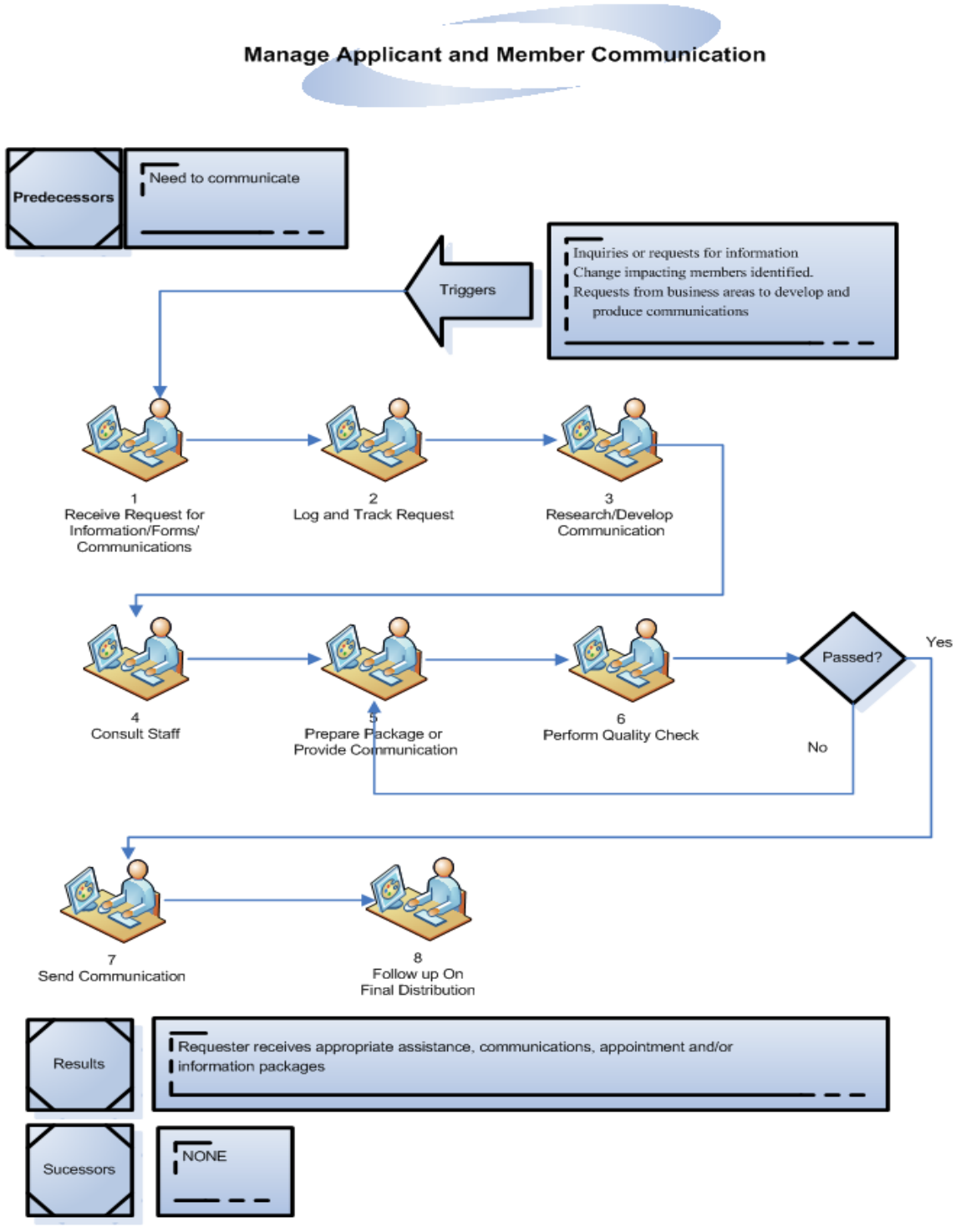


5.5 Manage Applicant and Member Communication

5.5.1 Manage Applicant and Member Communication Business Process Model

Item	Details
Description	The **Manage Applicant and Member Communication** business process receives requests for information, appointments and assistance from prospective and current members' communications such as inquiries related to eligibility, redetermination, benefits, providers; health plans and programs, and provides requested assistance and appropriate responses and information packages. Communications are researched, developed, and produced for distribution via by phone, fax, mail, and/or internet; process. Inquires from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bi-directional communication. Also included are scheduled communications such as formal program notifications such as the dispositions of grievances and appeals.
Trigger Event	Inquiries or requests for information Change impacting members identified. Requests from business areas to develop and produce communications.
Result	Requester receives appropriate assistance, communications, and appointment and/or information packages
Business Process Steps	1. Receive request for information or forms or need to communicate with member is identified. 2. Log and track communications request or needs and response 3. Research/develop communication that is linguistically, culturally, and competency appropriate 4. Consult with Agency staff in the development of the notifications 5. Prepare, package or provide communication 6. Perform Review or Quality Check communication a. If review passed, continue to step 7 b. If review not passed, return to step 5 7. Send member communications and information 8. Follow-up on final dissemination to members
Shared Data	Information from other agencies
Predecessor	Need to communicate
Successor	None
Constraints	1. State and federal rules and regulations 2. Accurate contact information for requester 3. Communication barriers
Failures	Lack of accurate contact information for requester
Performance Measures	1. Syntellect ACD Category & Agent Report 2. Time to complete process of developing communications: By phone 15 minutes; by email 24 hours; by mail 7 days 3. Accuracy of communications = 97% 4. Successful delivery rate to targeted individuals = 97% 5. Successful delivery rate

5.5.2 Manage Applicant and Member Communications Workflow



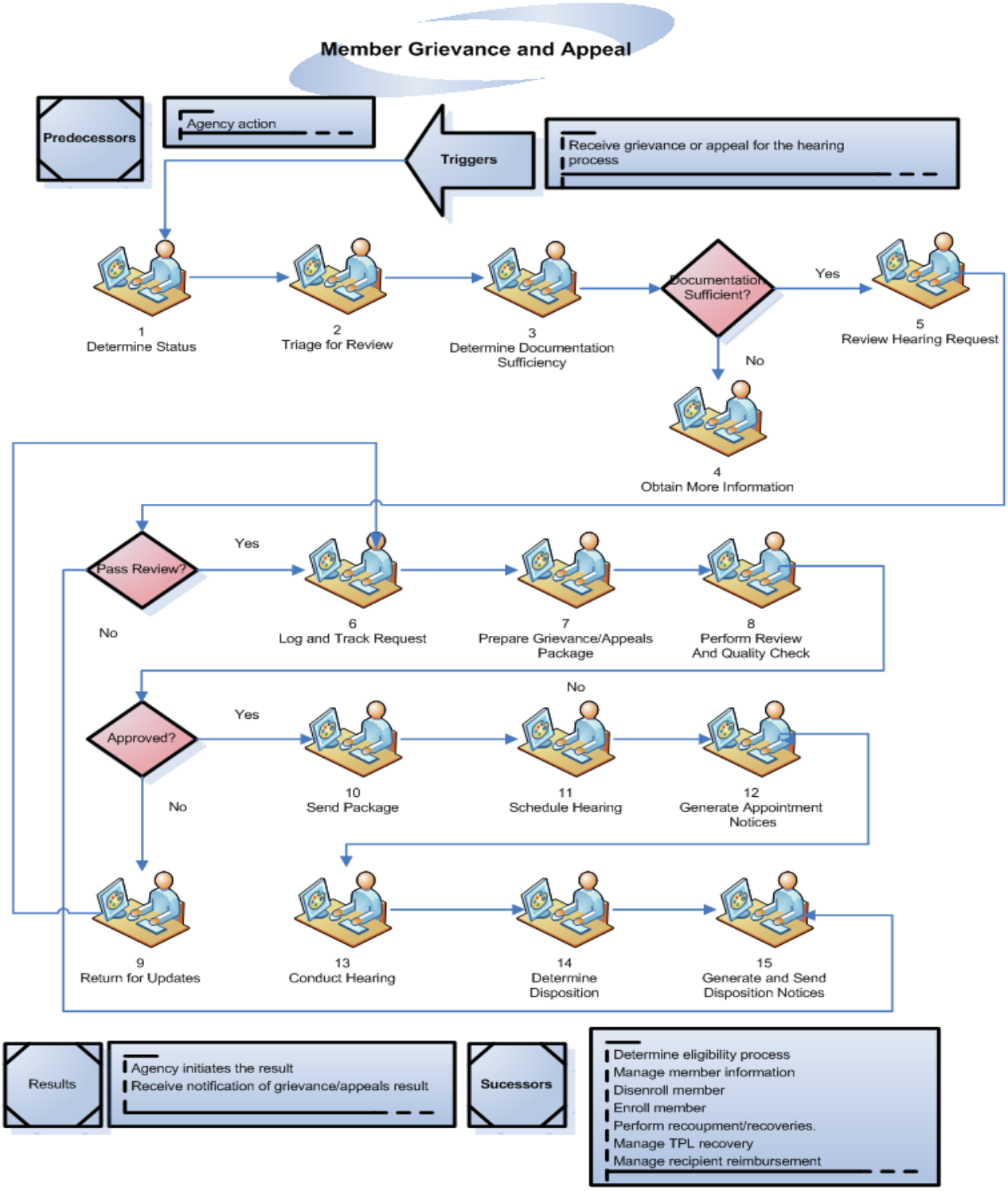
5.6 Manage Member Grievance and Appeal

5.6.1 Manage Member Grievance and Appeal Business Process Model

Item	Details
Description	The **Manage Complainant Grievance and Appeal** business process handles appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the agency. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the Provider or complainant and stored in the Provider or complainant information file. The provider or complainant is formally notified of the decision via the written mailed correspondence.
Trigger Event	Receive grievance or appeal for the hearing Process.
Result	1. Agency initiates the result (i.e., recoupment, benefits restored, etc.) 2. Complainant (or their advocate) and staff receive notification of grievance/appeals result
Business Process Steps	1. Determine status. 2. Triage to appropriate personnel for review 3. Determine documentation sufficiency - Situational a. If Yes, continue to Step 5 b. If No, go to Step 4 4. Obtain more information. Go to Step 2 5. Review hearing request to determine timeliness of request and appropriate hearing type. a. If Yes pass review, continue to Step 6 b. If No pass review, go to Step 15 6. Log and track request 7. Prepare grievance/appeals package 8. Perform Review or Quality Check communication for approval a. If Yes approved, continue to Step 10 b. If No approved, go to Step 9 9. Return for updates. Go to Step 6 10. Send grievance/appeals package 11. Schedule hearing 12. Generate and send appointment notices with date/time/place of hearing 13. Conduct hearing 14. Determine disposition 15. End: Generate and send formal disposition notification to complainant (or their advocate) and staff
Shared Data	1. Medical documentation 2. Additional documentation of verification requirements 3. Testimonies
Predecessor	Agency action
Successor	1. Determine eligibility process 2. Manage member information 3. Disenroll member 4. Enroll member 5. Perform recoupment/recoveries

Item	Details
	6. Manage TPL recovery 7. Manage recipient reimbursement(s)
Constraints	Federal and state rules and regulations.
Failures	None
Performance Measures	None

5.6.2 Manager Member Grievance and Appeal Workflow



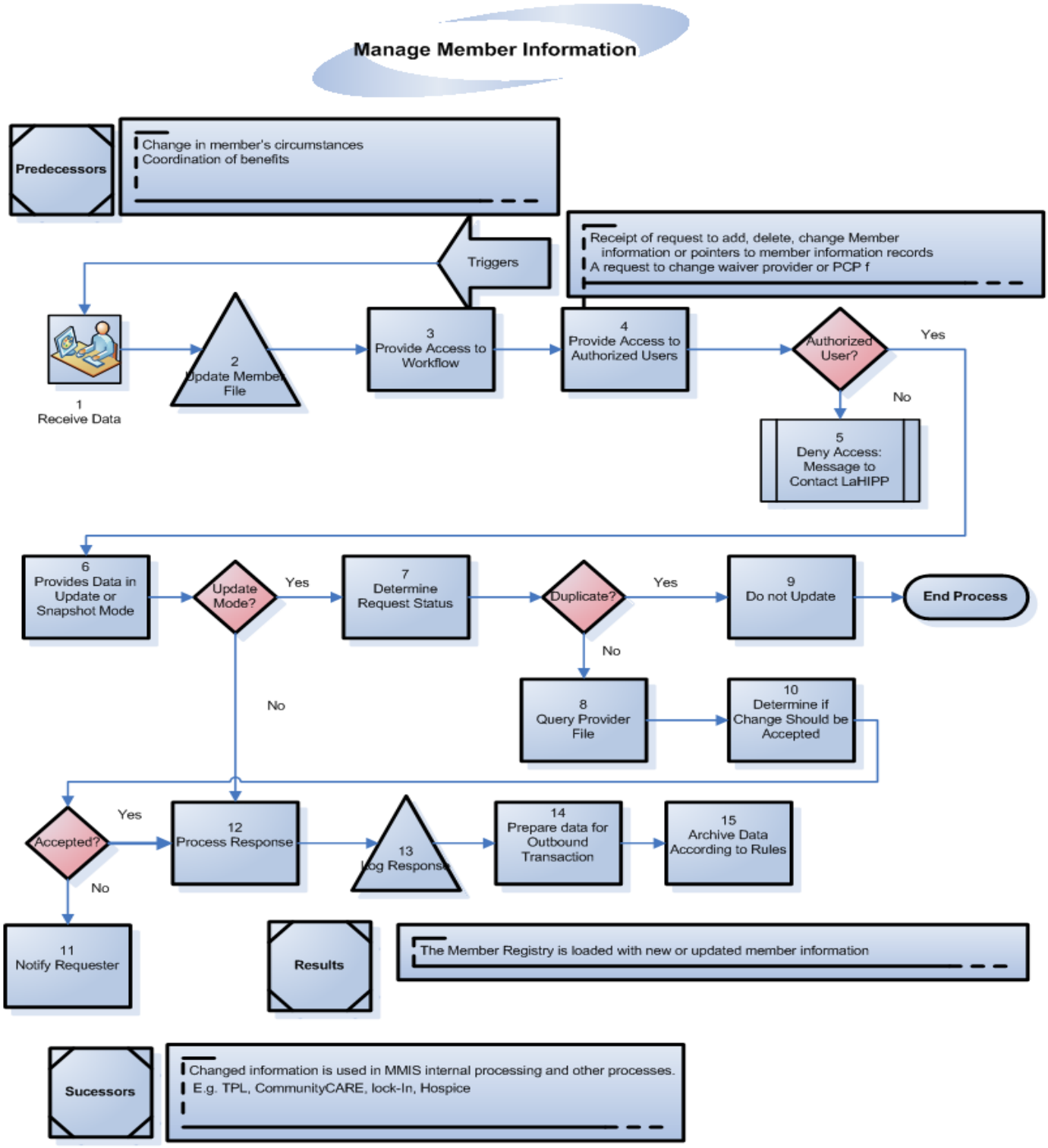
5.7 Manage Member Information

5.7.1 Manage Member Information Business Process Model

Item	Details
Description	The **Manage Member Information** business process is responsible for managing all operational aspects of the Member File, which is the source of comprehensive information about applicants and members, and their interactions with the state Medicaid. This includes Mass Disenrollment from linked provider due to termination of program provider.
Trigger Event	1. Receipt of request to add, delete, change Member information or pointers to member information records from – a. Member Management Business Area processes: b. Determine Eligibility, c. Enroll and Disenroll Member, d. Perform Applicant and Member Outreach, e. Manage Applicant and Member Communication, or f. Manage Applicant and Member Grievance and Appeal 2. A request to change waiver provider or PCP for the following reasons: a. Member has issues with the PCP, or waiver provider that may impact quality of care b. A program provider or contractor due to issues with the member such as moving out of service area, fraud and abuse, disruptive behavior, non-compliance or death, which are forwarded by the Manage Provider and Manage Contractor Communications c. A PCP for administrative or BHSF-approved "for cause" reasons
Result	The Member File is loaded with new or updated member information for the purposes of: 1. Responding to queries from authorized users and applications 2. Supplying all Member Management Area business processes with applicant or member information as needed to, e.g., detect duplicate applications; schedule redetermination; conduct open enrollment processing; perform member outreach and communication functions, etc. 3. Supplying all Operations Management Area business processes with applicant or member information needed to, e.g., edit claims and encounters, process member payment invoices, prepare EOB, conduct cost recoveries, etc. 4. Sending records or pointers to the Manage Program Information business process
Business Process Steps	1. Receives data from Member Management Area and relevant Operations Management business processes 2. Update member file - Loads data into the Member File, building new records and updating, merging, unmerging, or deleting previous records as appropriate 3. Provide access to records as required by Member Management Area business processes workflow 4. Provide access to authorized users - Provides access to records as requested by other authorized business processes and users a. If Yes authorized user, continue to Step 6 b. If No, go to Step 5 5. Deny access: message to contact LAHIPP 6. Provide data to the Manage Program Information business process on a real time or periodic basis in update or snapshot mode a. If Yes update mode, continue to Step 7 b. If No, go to Step 12 7. Determine Request status as initial or duplicate

Item	Details
	a. If Yes duplicate, End Process b. If No, continue to Step 10 8. Do not update. Stop 9. Query Provider File for requested information 10. Determine if changes should be accepted a. If Yes, continue to Step 12 b. If No, go to Step 11 11. Notify requester. Stop 12. Process Response 13. Log Response 14. Prepare response data set for the Send Outbound Transaction process 15. Archive data in accordance with state and federal record retention requirements
Shared Data	Data needed to record information about the following: Member demographic, financial, information related to requests for and determinations of eligibility, appointment scheduling, eligibility verification, education, programs, eligibility, enrollment, services, access, etc.; services requested and services provided; member payment and spend-down information; as well as interactions related to any grievance/appeal
Predecessor	Change in member's circumstances Coordination of benefits
Successor	Changed information is used in MMIS internal processing and other processes. E.g. TPL, CommunityCARE, lock-In, Hospice
Constraints	State and Federal Rules and Regulations
Failures	Member File fails to load or update appropriately; or fails to make registry data available or available in correct format. Duplicate request
Performance Measures	None

5.7.2 Manage Member Information Workflow

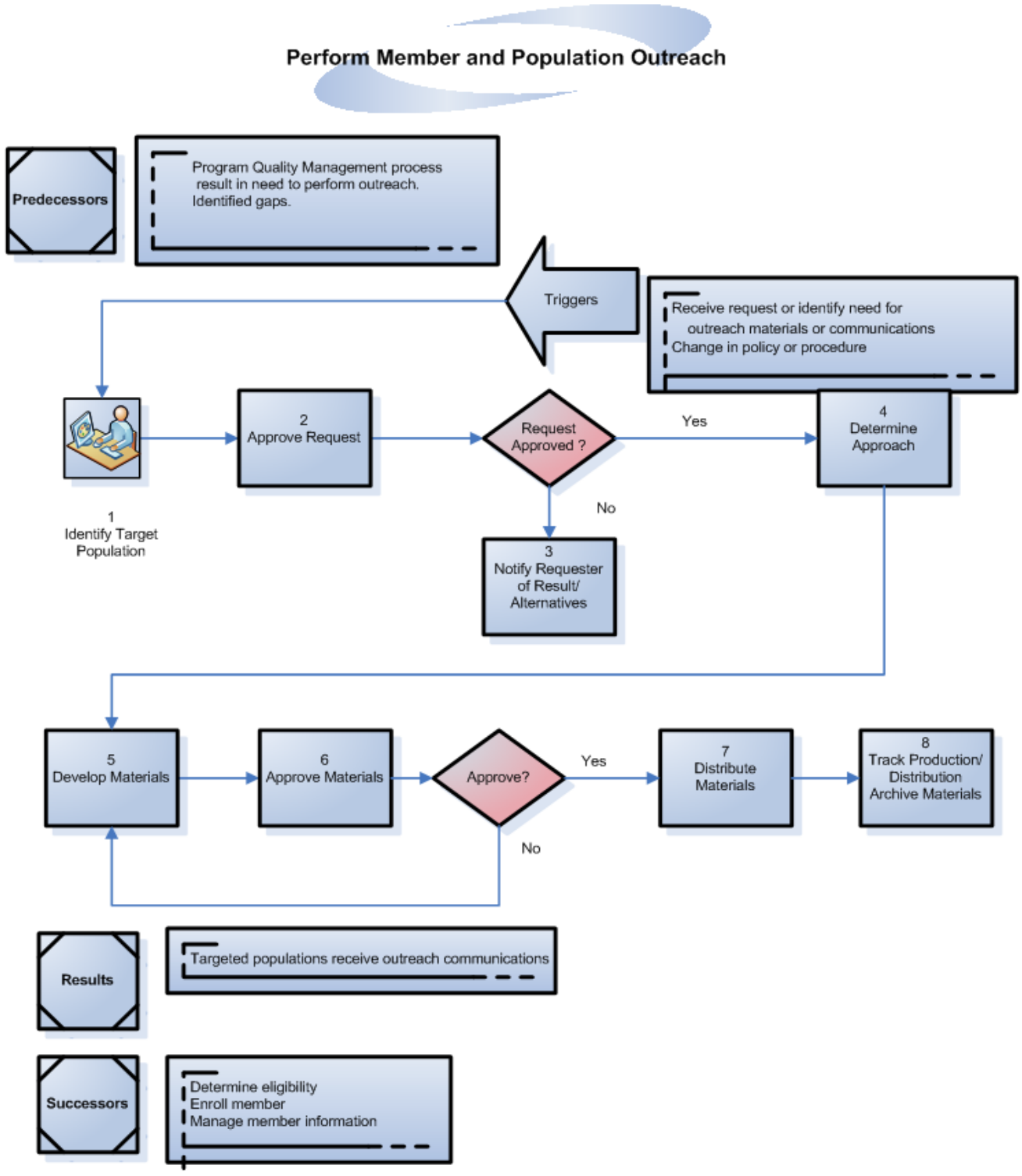


5.8 Perform Population and Member Outreach

5.8.1 Perform Population and Member Outreach Business Process Model

Item	Details
Description	The ***Perform Population and Member Outreach*** business process originates internally within the Agency for purposes such as: 1. Notifying prospective applicants and current members about new benefit packages and population health initiatives 2. New initiatives from Program Administration 3. Indicators of underserved populations It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the State Children's Health Insurance Program (SCHIP) ,"What is CommunityCARE", "Keeping Your Child Healthy", information on the use of the various DHH external websites.
Trigger Event	1. Receive request or identify need for outreach materials or communications 2. Change in policy or procedure
Result	Targeted populations receive outreach communications
Business Process Steps	1. Identify target population 2. Approve or deny (or modify) decisions to develop outreach communications a. If Yes approved, continue to Step 4 b. If No, go to Step 3 3. Notify requestor of result/alterative 4. Determine development approach (internal and external or both) outreach materials, approaches, success measures 5. Develop materials 6. Approve outreach materials a. If Yes approved, continue to Step 7 b. If No, go to Step 5 7. Distribute multi-lingual outreach materials or communications through various mediums 8. Track production/distribution of outreach communications and archive materials
Shared Data	External quality measures.
Predecessor	1. Program Quality Management process result in need to perform outreach. 2. Identified gaps.
Successor	1. Determine eligibility 2. Enroll member 3. Manage member information
Constraints	1. Accurate contact information 2. State and federal rules and regulations
Failures	1. Communication barriers such as lack of internet or phone access; failure to access needed or requested information. 2. Delivery failures due to erroneous contact information or lack of contact information. 3. Cancellations of outreach events by sponsors
Performance Measures	None

5.8.2 Perform Population and Member Outreach Workflow



6.0 Provider Management Overview

The Provider Management Business Area supports all aspects of provider enrollment both for Medicaid and Waiver providers. Providers are enrolled, disenrolled, and managed using the various business processes in this business area.

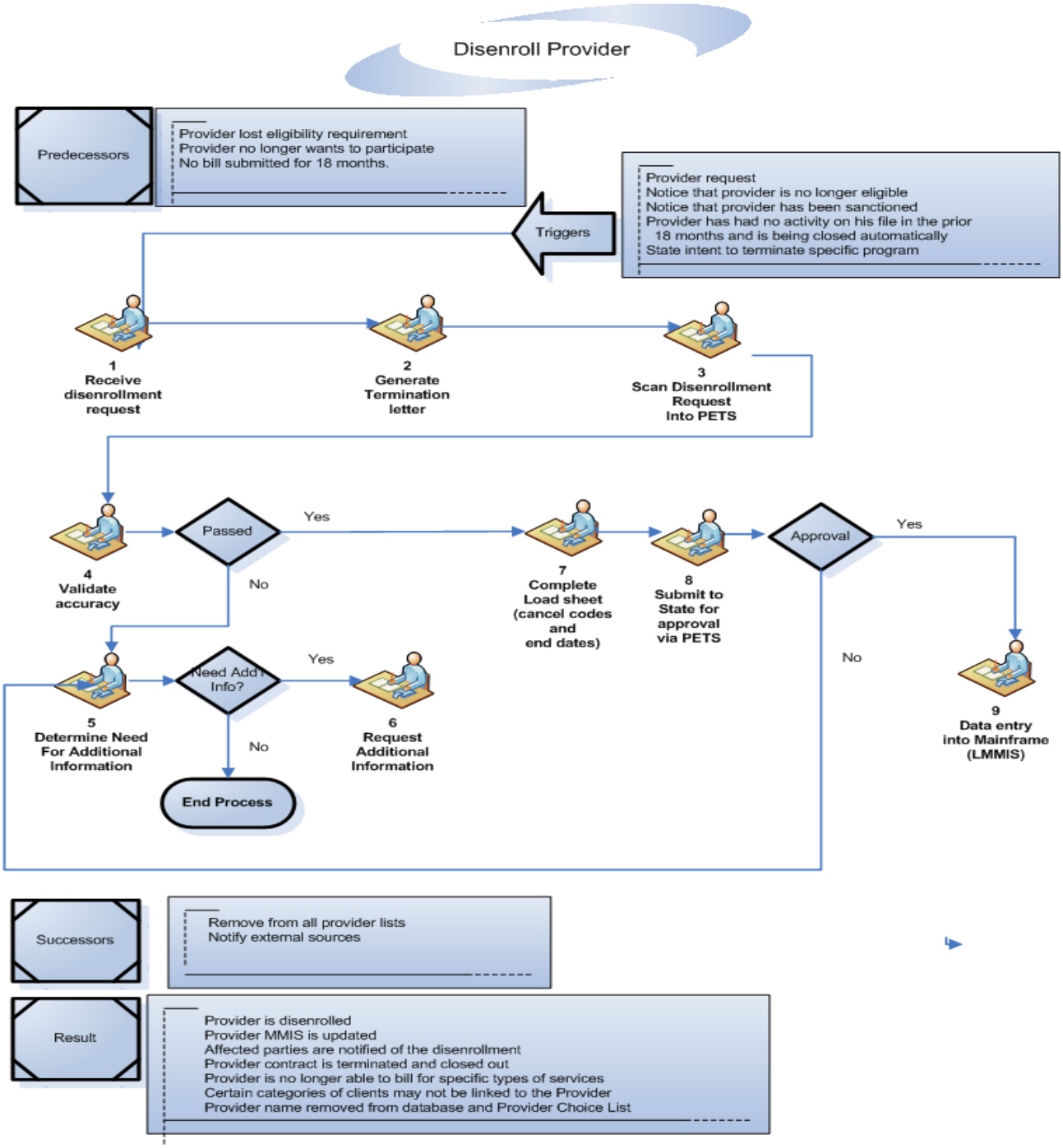
6.1 Disenroll Provider

6.1.1 Disenroll Provider Business Process Model

Item	Details
Description	The **Disenroll Provider** business process is responsible for managing providers' disenrollment from all the different programs, including: 1. Processing of disenrollment 2. Provider request to close case. 3. Provider becomes ineligible (i.e., license suspension, revocation or disciplinary action taken by Medical licensing boards or Medicare/Medicaid 4. Auto-closure (providers who have had no activity for 18 months or more). 5. Receipt of information regarding provider's death
Trigger Event	Disenrollment is triggered by receipt of: 1. Provider request. 2. Notice that provider is no longer eligible 3. Notice that provider has been sanctioned 4. Provider has had no activity on his file in the prior 18 months and is being closed automatically 5. State intent to terminate specific program
Result	1. Provider is disenrolled 2. Provider MMIS is updated 3. Affected parties are notified of the disenrollment 4. Provider contract is terminated and closed out 5. Provider is no longer able to bill for specific types of services 6. Certain categories of clients may not be linked to the Provider 7. Provider name removed from database and Provider Choice list
Business Process Steps	1. Receive disenrollment request or relevant information 2. Generate termination letter to provider 3. Scan disenrollment request or relevant information into Provider Enrollment Tracking System (PETS) 4. Validate accuracy of request/document via mail, phone, email, or even site visit a. If Yes, proceed to Step 7 b. If No, go to Step 5 5. Determine need for additional information a. If Yes, go to 6 b. If No, end process 6. Request additional information 7. Complete load sheet, which includes cancel codes and end date 8. Submit to state staff via PETS for approval. a. If Yes, proceed to Step 9 b. If No, go to Step 5 9. Submit to files maintenance for data entry to the mainframe (LMMIS)

Item	Details
Shared Data	1. Provider sanctions data. 2. Licensing Boards (in and out-of state)
Predecessor	1. Provider lost eligibility requirement 2. Provider no longer wants to participate 3. No bill submitted for 18 months
Successor	1. Removed from all provider lists 2. Notify external sources
Constraints	State and federal rules and regulations
Failures	None
Performance Measures	Percentage of Returned mail

6.1.2 Disenroll Provider Workflow



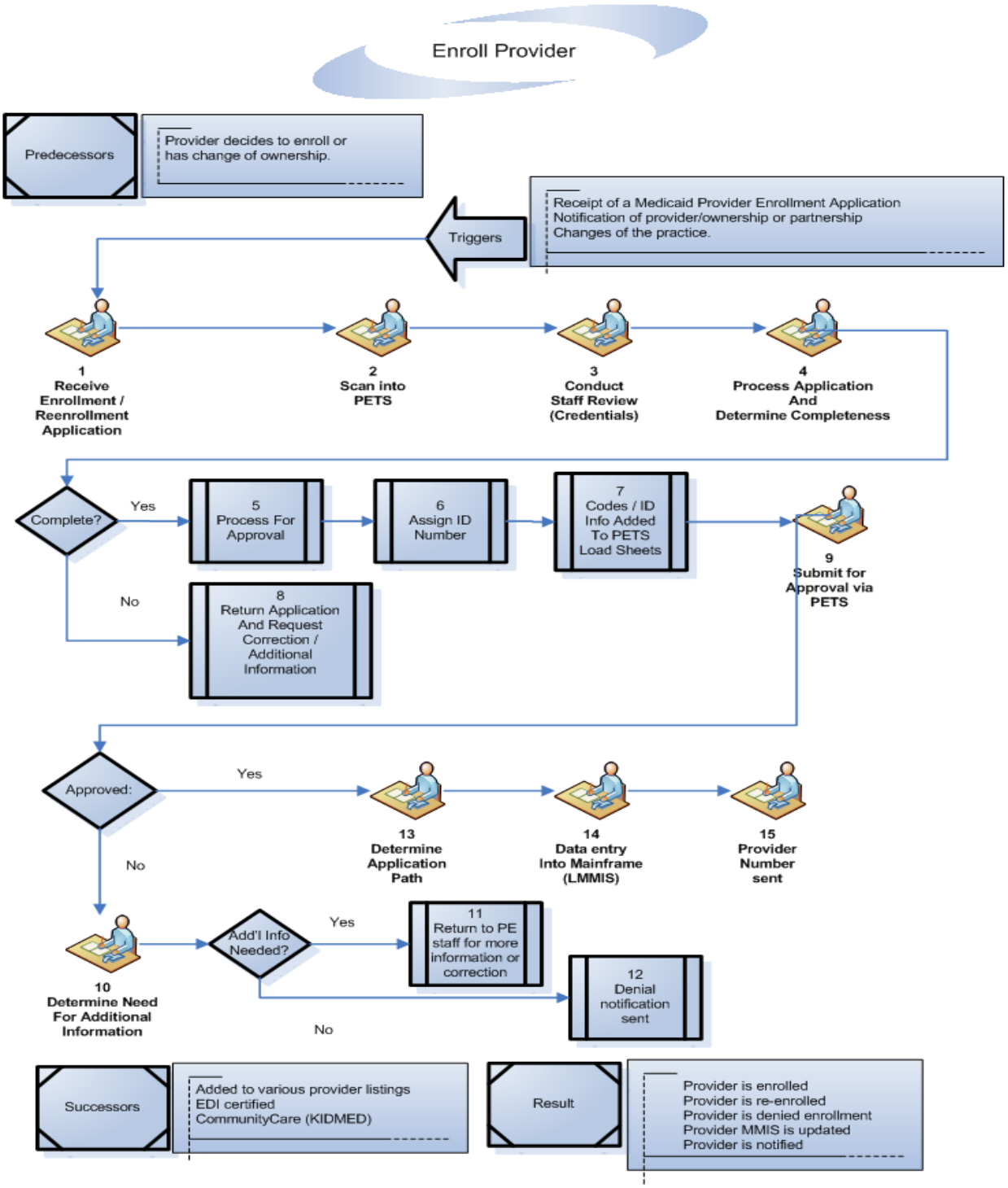
6.2 Enroll Provider

6.2.1 Enroll Provider Business Process Model

Item	Details
Description	The **Enroll Provider** business process is responsible for the enrollment of approximately 85 provider types into the Medicaid program. The enrollment of providers is contracted out to the State's Fiscal Intermediary. The contractor is required to process applications within 15 working days of receipt. Applications are reviewed for all applicable requirements of enrollment, which may vary from program to program. Applications are either enrolled as a Medicaid provider or returned for additional information. Several different business areas have specialized processes in the validation of data steps, but are similar enough to be regarded as one process.
Trigger Event	1. Receipt of a Medicaid Provider Enrollment Application 2. Notification of provider/ownership or partnership changes of the practice
Result	1. Provider is enrolled 2. Provider is re-enrolled 3. Provider is denied enrollment 4. Provider MMIS is updated 5. Provider is notified
Business Process Steps	1. Receive enrollment / reenrollment application 2. Scan application into Provider Enrollment Tracking System (PETS) 3. Conduct staff review for completeness, accuracy and to ensure that all standards of participation have been met, required documentation and verifications are included. 4. Determine completeness of application: a. If complete, proceed to Step 5 b. If application is incomplete, proceed to Step 9 5. Process application for State approval 6. Assign 7 digit ID number 7. Codes/ID Info added to PETS load sheets 8. Return application and request corrections or additional information 9. Submits application and attachments for State approval via the approval queue in PETS a. If Yes, proceed to Step 14 b. If No, go to Step 11 return to PE staff for correction or additional information and/or denial notification is sent 10. Determine need for additional information a. If Yes, go to Step 11 b. If No, go to Step 12 11. Return to PE staff for more information or correction 12. Send denial notification 13. Determine application path - provider types and specialty, and/or programs, are identified which determine the exact path of each application 14. Data entry into LMMIS - approved applications and load sheets are forwarded to Files Maintenance for data entry into the mainframe (LMMIS) 15. Provider number sent - once loaded onto mainframe (LMMIS), the provider is notified of the Provider number by computer generated letter
Shared Data	1. Provider Sanction data from OIG/EPLS 2. NPI system

Item	Details
	3. Licensing boards (in and out-of-state) 4. Multiple office locations, pay to addresses, business associates and key contract personnel
Predecessor	Provider decides to enroll or has change of ownership.
Successor	1. Added to various provider listings 2. EDI certified 3. CommunityCARE/KIDMED
Constraints	State and federal rules and regulations
Failures	None
Performance Measures	Percentage of Returned mail

6.2.2 Enroll Provider Workflow

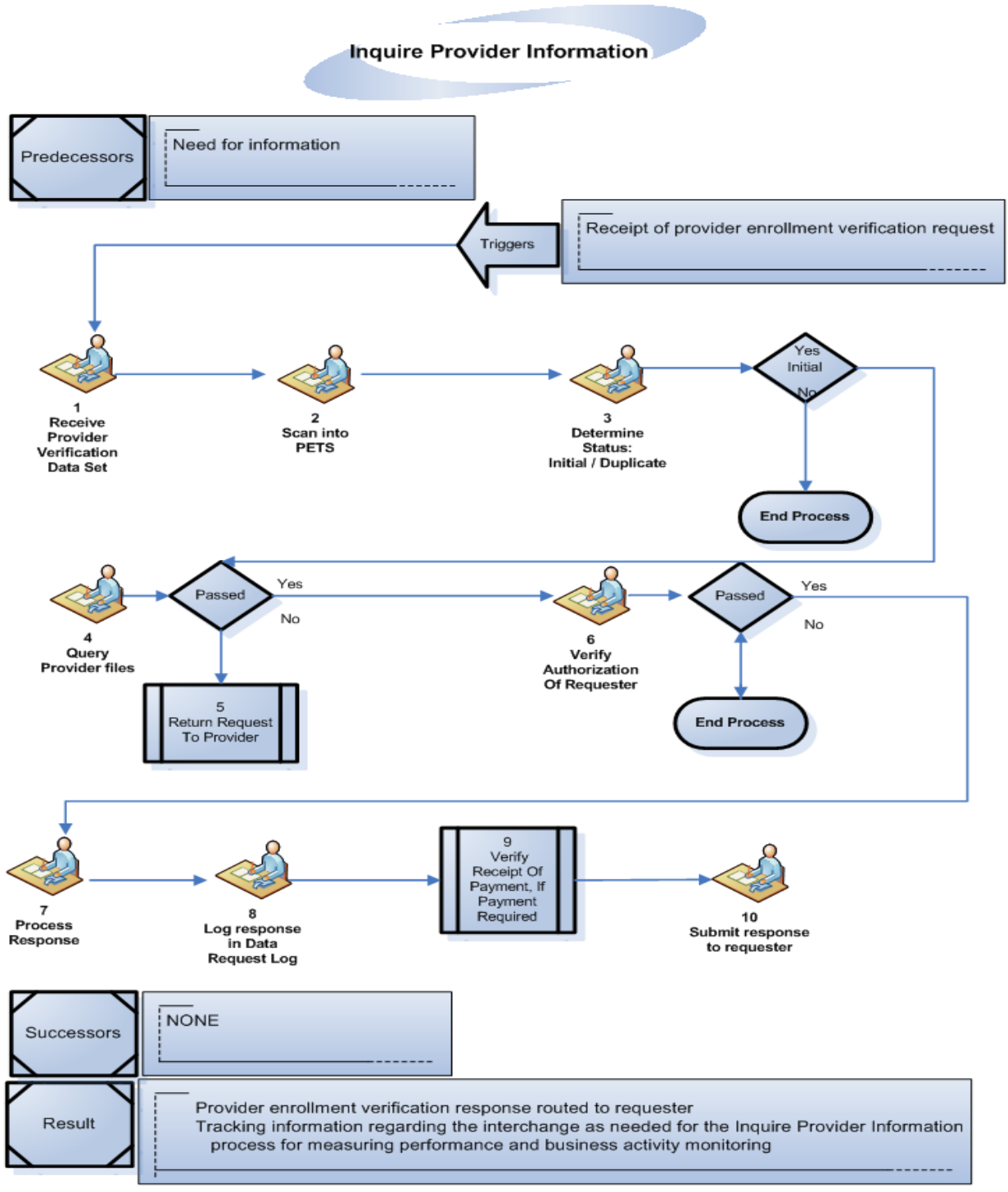


6.3 Inquire Provider Information

6.3.1 Inquire Provider Information Business Process Model

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.
Trigger Event	Receipt of provider enrollment verification request.
Result	1. Provider enrollment verification response routed to requester 2. Tracking information regarding the interchange as needed for the Inquire **Provider Information** process for measuring performance and business activity monitoring
Business Process Steps	1. Receipt of provider verification information data set 2. Scan request into PETS 3. Determine Request status as initial or duplicate. a. If initial, proceed to Step 4 b. If duplicate, process ends (no action taken) 4. Query Provider files (LMMIS) for requested information. a. If Yes passed, proceed to Step 5 b. If No, proceed to Step 5 5. Return request to Provider 6. Verify authorization of the requestor to receive requested information. a. If Yes, proceed to Step 7 b. If No, process ends (becomes an incomplete file) 7. Process Response. 8. Log Response in Data Request Log. 9. Verify receipt of payment, if payment required for data requested 10. Submit response to requester
Shared Data	None
Predecessor	Need for information
Successor	None
Constraints	State and federal rules and regulations
Failures	None
Performance Measures	None

6.3.2 Inquire Provider Information Workflow

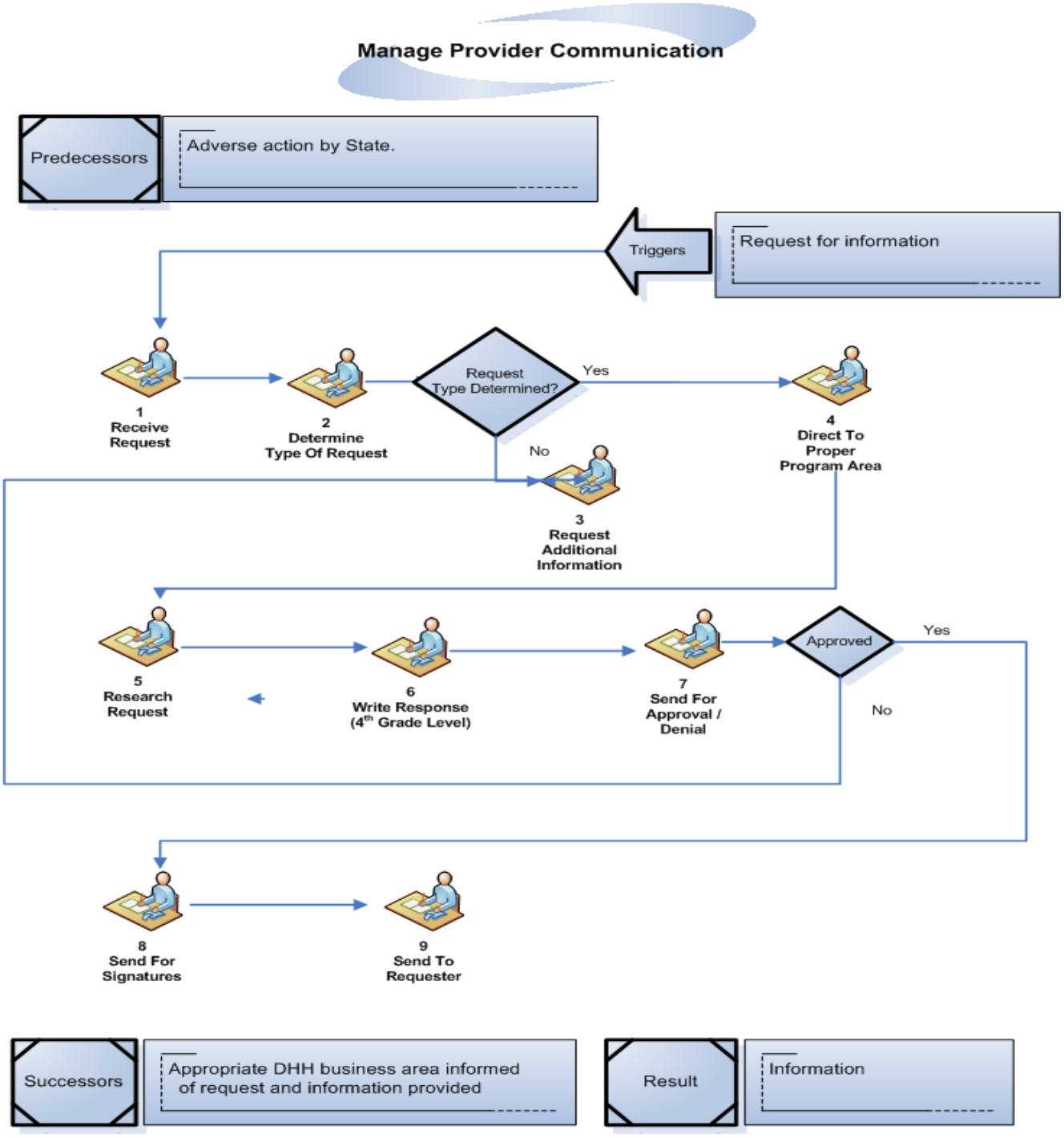


6.4 Manage Provider Communication

6.4.1 Manage Provider Communication Business Process Model

Item	Details
Description	The **Manage Provider Communication** business process is responsible for written or verbal provider specific requests for information regarding Medicaid program rules, regulations, and activities.
Trigger Event	Request for information
Result	Information
Business Process Steps	1. Receive request 2. Determine type of request – log, track and conduct review to determine type of request: a. If Yes, proceed to Step 4 b. If No, proceed to Step 3 3. Send request for additional information or end process 4. Direct to proper program area 5. Research request 6. Write response (at 4th grade level) 7. Send for approval/denial: a. If Yes, proceed to Step 8 b. If No, proceed to Step 3 8. Send for signatures 9. Send to requester
Shared Data	1. Witness 2. Evidence
Predecessor	Adverse action by State
Successor	Appropriate DHH business area informed of request and information provided
Constraints	State and federal rules and regulations
Failures	None
Performance Measures	1. Check time length of appeals process 2. Percentage of Returned mail

6.4.2 Manage Provider Communication Workflow

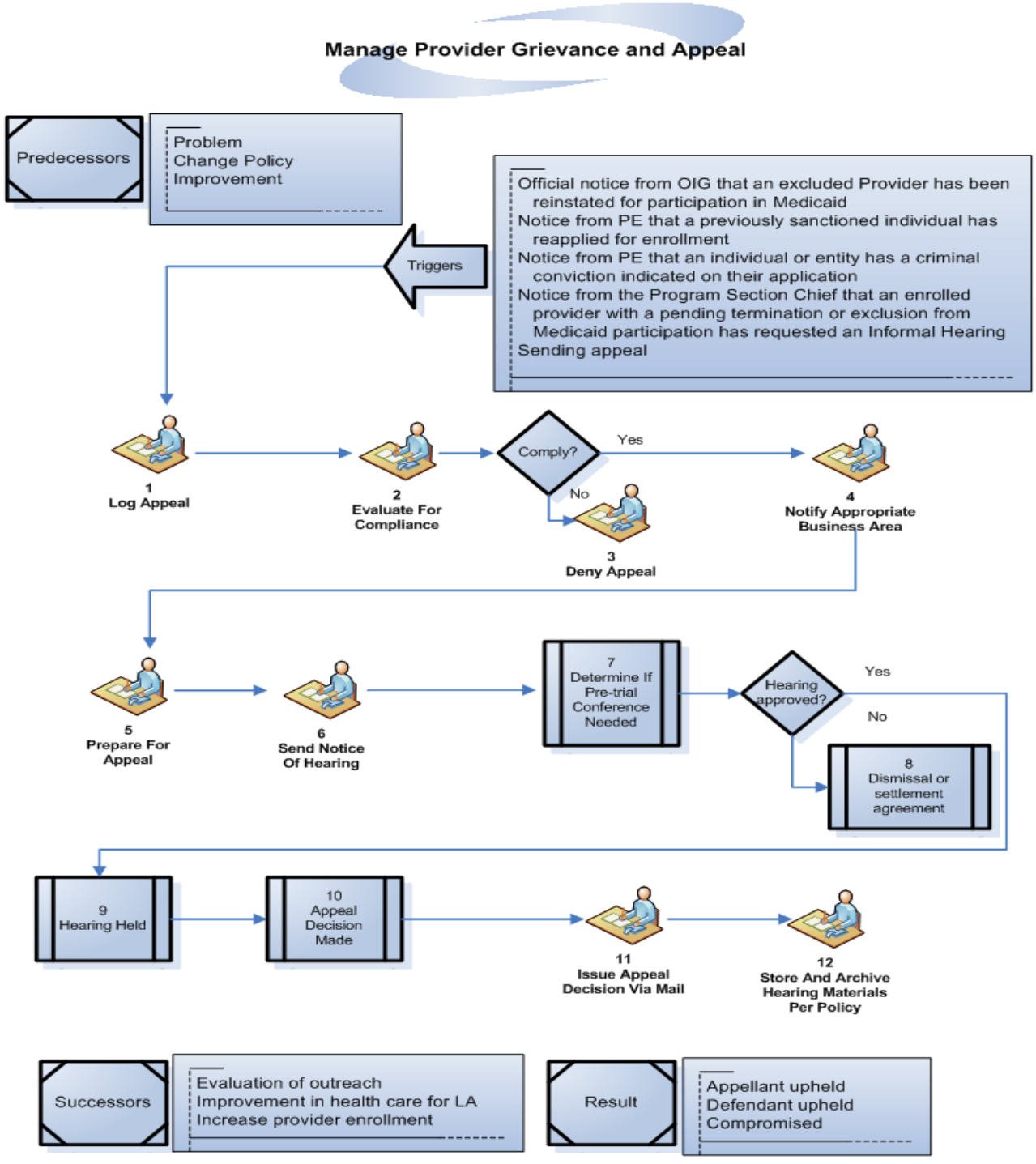


6.5 Manage Provider Grievance and Appeal

6.5.1 Manage Provider Grievance and Appeal Business Process Model

Item	Details
Description	The **Manage Provider Grievance and Appeal** business process is responsible for the result of an adverse action taken against a provider - said provider may appeal the action.
Trigger Event	An Informal Hearing is scheduled subsequent to: • Official notice from the OIG that an excluded provider has been reinstated for participation in Medicaid • Notice from PE that a previously sanctioned individual has reapplied for enrollment • Notice from PE that an individual or entity has a criminal conviction indicated on their application • Notice from the Program Section Chief that an enrolled provider with a pending termination or exclusion from Medicaid participation has requested an Informal Hearing. • Sending appeal
Result	1. Appellant upheld 2. Defendant upheld 3. Compromised
Business Process Steps	1. Log appeal 2. Evaluate for compliance - to see if appeal meets DHH appeal process rules and regulations a. If Yes, appeal complies, proceed to Step 4 b. If No, proceed to Step 3 3. Deny appeal - appeal does not comply and appeal is denied 4. Notify appropriate business area receives notice 5. Prepare for appeal 6. Send notice of hearing (date, time, location…) 7. Determine if pre-trial conference is needed. a. If Yes, hearing is approved, proceed to Step 9 b. If No, proceed to Step 8 8. Hearing is dismissed and/or a settlement agreement is made 9. Hearing is held 10. Hearing decision is made and notice issued 11. Issue Appeal decision to appropriate parties by mail 12. Store and archive Hearing materials per policy
	None
Predecessor	1. Problem 2. Change Policy 3. Improvement
Successor	1. Evaluation of outreach 2. Improvement in health care for LA 3. Increase provider enrollment
Constraints	State and federal rules and regulations
Failures	1. Funding 2. Lack of executive support
Performance Measures	1. Intended result from the outreach is achieved 2. Percentage of Returned mail

6.5.2 Manage Provider Grievance and Appeal Workflow

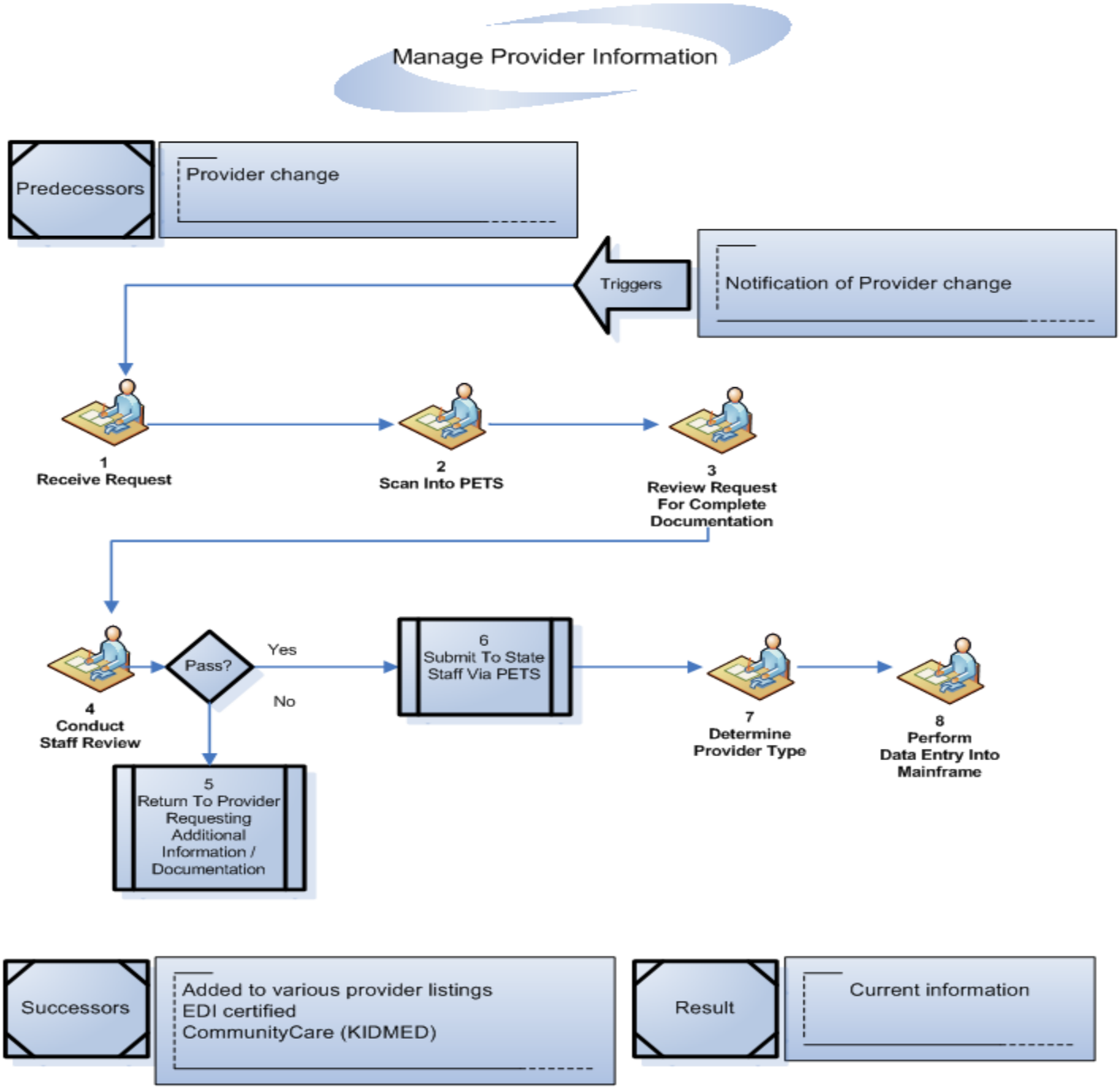


6.6 Manage Provider Information

6.6.1 Manage Provider Information Business Process Model

Item	Details
Description	The **Manage Provider Information** business process is responsible for all changes to enrolled provider information.
Trigger Event	Notification of provider change.
Result	Current information.
Business Process Steps	1. Receives request from provider or state agency staff 2. Scan documents into PETS 3. Review request to ensure appropriate documentation is included 4. Conduct Staff review: a. If Yes, documentation is complete. Proceed to Step 6 b. If No, proceed to Step 5 5. Return request to Provider for additional information/documentation (documentation is incomplete) 6. Submit to state staff for approval via PETS 7. Determine Provider type 8. Perform data entry - State staff approves load sheet and submits to Files maintenance for data entry into mainframe (LMMIS)
Shared Data	1. Licensing board 2. Sections boards
Predecessor	Provider change
Successor	1. Added to various provider listings 2. EDI certified 3. CommunityCARE/KIDMED
Constraints	State and federal rules and regulations.
Failures	None
Performance Measures	1. Annual monitoring 2. Percentage of Returned mail 3. Site visit 4. Provider monitoring

6.6.2 Manage Provider Information Workflow



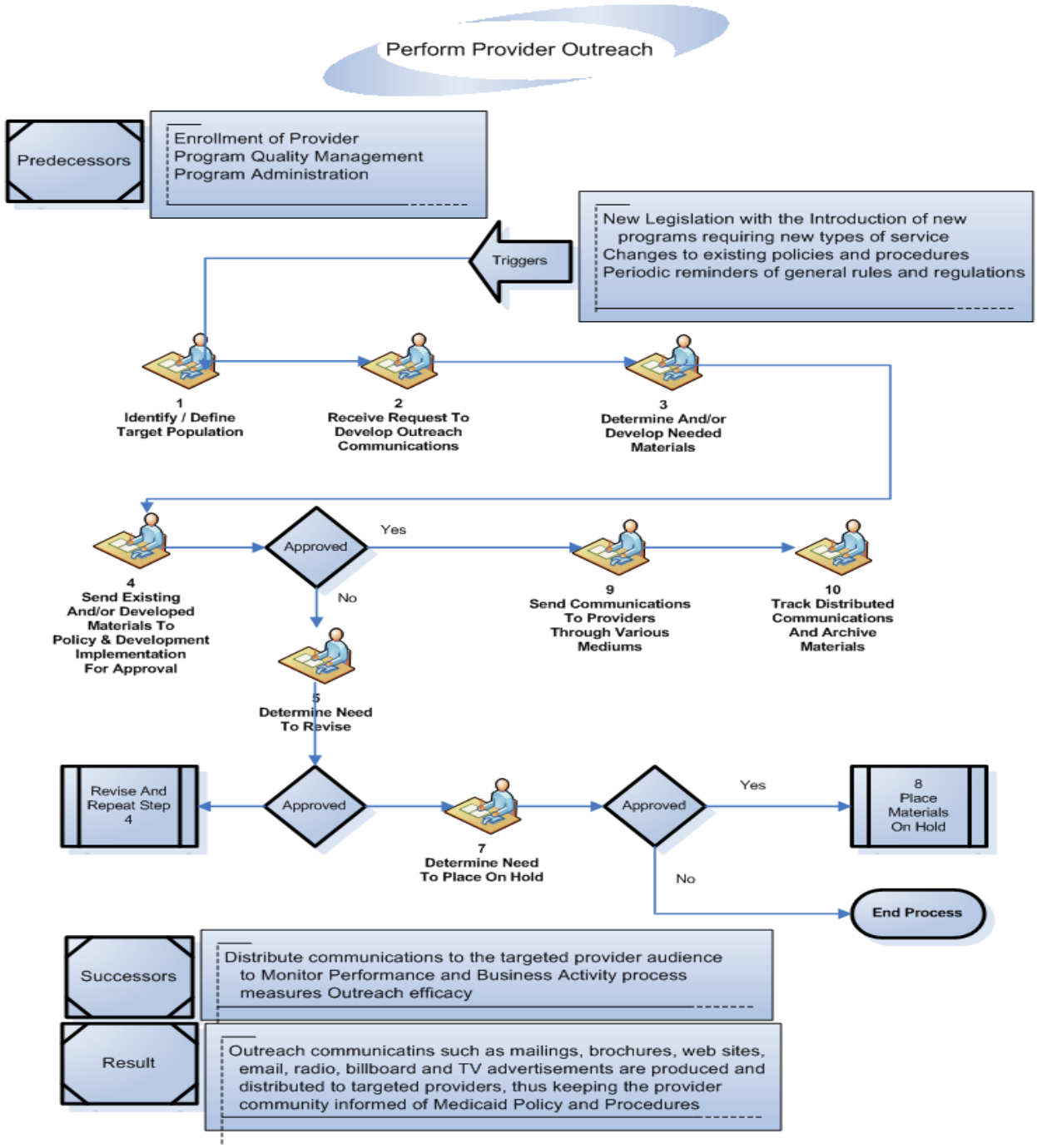
6.7 Perform Provider Outreach

6.7.1 Perform Provider Outreach Business Process Model

Item	Details
Description	The **Perform Provider Outreach** business process originates internally within the Agency in response to multiple activities e.g. provides Periodic public notification of facts to the provider community in various forms such as, Website, Remittance Advice (RA), Bi-monthly Provider Updates, and letters from the Medicaid Director.
Trigger Event	1. New Legislation with the Introduction of new programs requiring new types of service 2. Changes to existing policies and procedures 3. Periodic reminders of general rules and regulations
Result	Outreach communications, such as mailings, brochures, web sites, email, radio, billboard, and TV advertisements; are produced and distributed to targeted providers thus keeping the provider community informed of Medicaid Policy and Procedures.
Business Process Steps	1. Identify/define target population – target population is identified and defined by analyzing data, performance measures, feedback from community, and policy directives. 2. Receive request to develop Outreach communications (Request or changes received from Legislature, Medicaid Director, CMS, etc.) 3. Determine and/or develop necessary materials needed to assist the potential provider and/or existing provider to succeed in the CommunityCARE (CC) program with assisting the population in which they serve 4. Send existing information (published in the Provider Update or RA) to P & D Implementation for approval a. If Yes approved, proceed to Step 9 b. If No, proceed to Step 5 5. Determine need to revise a. If Yes, proceed to Step 6 b. If No, proceed to Step 7 6. Revise and proceed to Step 4 7. Determine need to Place on Hold a. If Yes, proceed to Step 8 b. If No, end process c. to either: make necessary revisions and repeat Step 4 8. Place materials on Hold 9. Send outreach communications to be distributed through various mediums supported by the mass mail out process to providers for CMS notices, Legislative notices, and Medicaid Director Letters. Compose language for website notification and submit to FI technical writer who prepares and submits to Webmaster. 10. Track and archive outreach communications production and distribution materials.
Shared Data	1. LAMEDICAID.com website 2. LMMIS (Provider Files)
Predecessor	1. Enrollment of Provider 2. Program Quality Management 3. Program Administration
Successor	Distribute communications to the targeted provider audience – Monitor Performance and Business Activity Process measures Outreach efficacy.

Item	Details
Constraints	1. Limited staff 2. Must address the variations of the target population
Failures	1. Untimely notification 2. Notification to the wrong population
Performance Measures	1. Accuracy of outreach materials = 100 %. 2. Successful delivery rate to targeted providers= 100%.

6.7.2 Perform Provider Outreach Workflow



7.0 Contractor Management Overview

The Contractor Management business area meets all current regulations and deals with the entire contracting process for both Health Services and Administrative contracts. All DHH sections use all or parts of these contracting business processes. During the Joint Application Design (JAD) sessions, DHH participants determined that the processes for Health Services and Administrative contracts are so similar that only one business process model (BPM) and one workflow is needed. Therefore, the business models and workflow provided in the Health Services sections also represent the Administrative contracts. No BPMs or workflows are provided under the Administrative sections. The majorities of these business processes are manual, distributed across various sections, and appear to be redundant. This business area has the potential to provide excellent opportunities for business process reengineering, automation and work effort savings. As an example, Perform Potential Contractor Outreach is not currently performed. Adding this process into this business area could show an increase in potential contractors, which could result in, improved services and/ or reduced costs.

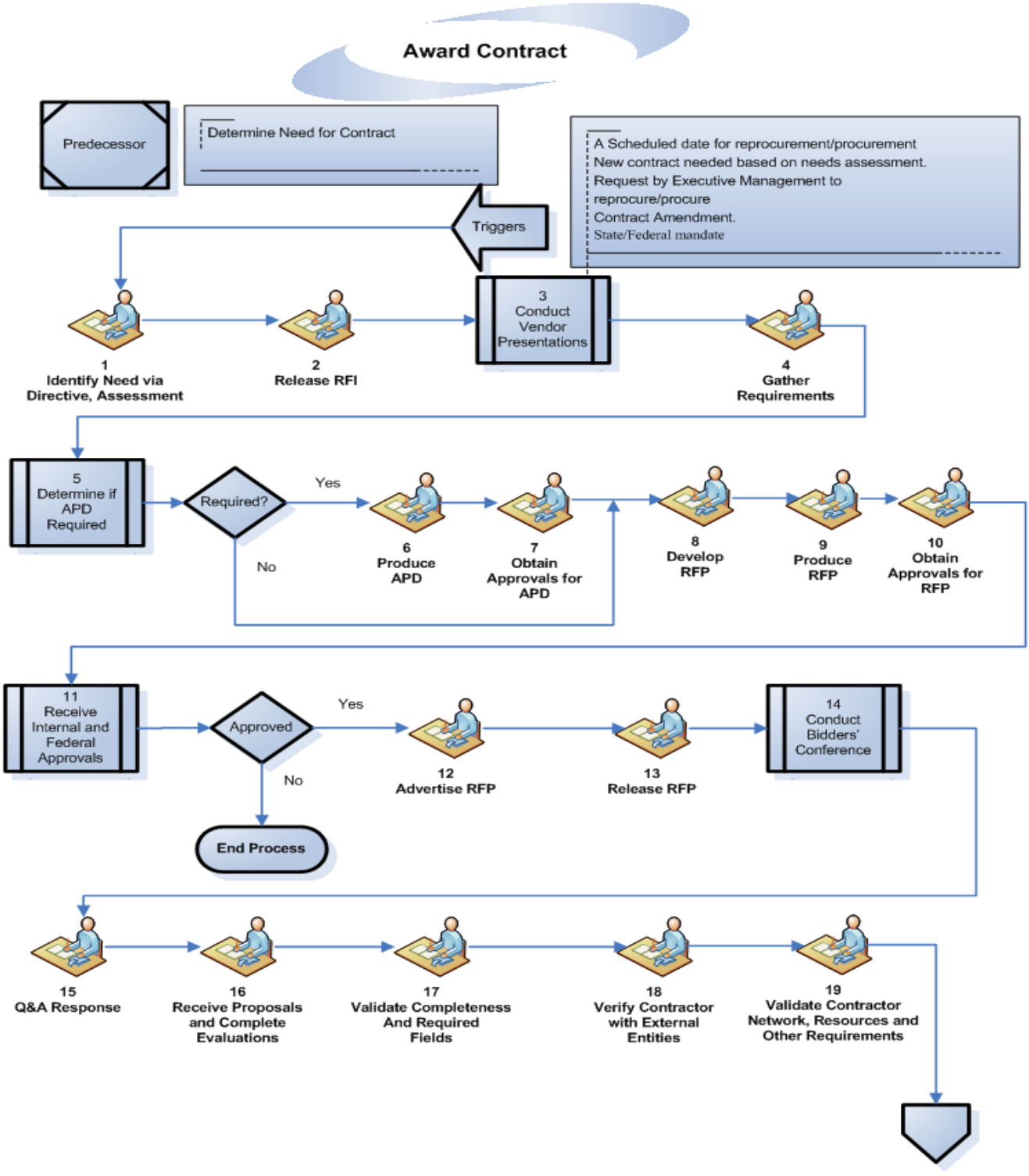
7.1 Award Contract

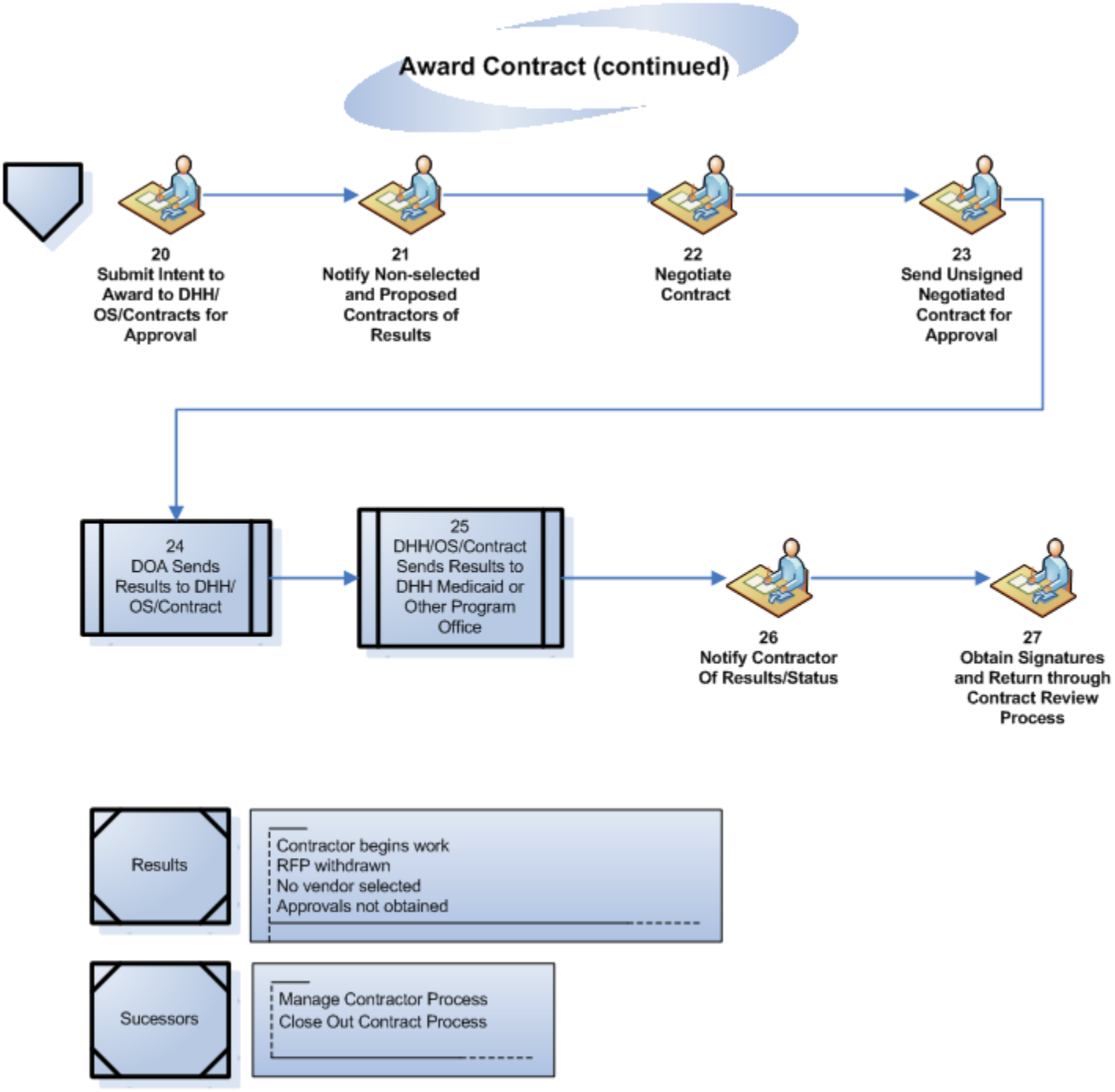
7.1.1 Award Contract Business Process Model

Item	Details
Description	The **Award Contract** business process gathers requirements, develops a Request for Proposals, requests and receives approvals for the RFP if applicable, and solicits responses. This process also receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, negotiates contract, and notifies parties.
Trigger Event	1. A Scheduled date for reprocurement/procurement 2. New contract needed based on needs assessment. Request by Executive Management to reprocure/procure 3. Contract Amendment 4. State/Federal mandate
Result	1. Contractor begins work 2. RFP withdrawn 3. No vendor selected 4. Approvals not obtained
Business Process Steps	1. Identify need via directive, assessment (e.g., performing an assessment and/or receipt of directive to procure and/or amend contract) 2. Release Request for Information (RFI) 3. Conduct Vendor presentations 4. Gather requirements. 5. Determine if Advance Planning Document (APD) is required a. If Yes, an APD is required, go to Steps 6 b. If No APD required, go to Step 8 6. Produce APD 7. Obtain approvals for APD 8. Develop Request for Proposal (RFP) and receive necessary approvals 9. Produce RFP 10. Receive approval for RFP 11. Receive internal (state) and federal approvals for RFP

Item	Details
	a. If Yes, Go to Step 12 b. If No, process ends 12. Advertise RFP Notice 13. Release RFP 14. Conduct Bidder's Conference 15. Complete Q & A response 16. Receive proposals and complete evaluations 17. Validate completeness and required fields – 18. Verify contractor with external entities – business logic sends message to one or more external entities to verify information in the application, e.g., corporate status. 19. Validate contractor network, resources, and other requirements 20. Submit Intent to Award to DHH/OS/Contract to obtain approvals 21. Notify non-selected and proposed contractor of results 22. Negotiate contract: collect additional information required to complete a contract, Assign rates or other form of installment payment. 23. Send unsigned negotiated contract for review/denial/approval (BHSF, DHH Contract Review, DOA/Contract Review) 24. DOA/Office of Contract Review sends result to DHH/OS/Contract 25. DHH/OS/Contract sends result status to DHH/Medicaid and/or other DHH Program Office. 26. Notify Contractor of result status (award, deny, continue negotiations 27. Obtain signatures and return through Contract Review process.
Shared Data	1. Preferred Offeror's List (qualified bidder's list) 2. Disqualified Vendor List 3. Strategic IT Plan
Predecessor	Determine Need for Contract
Successor	1. Manage Contractor Process 2. Close Out Contract Process
Constraints	1. State and federal laws 2. Court order
Failures	The reprocurement/procurement is challenged Withdrawn
Performance Measures	NONE

7.1.2 Award Contract Workflow



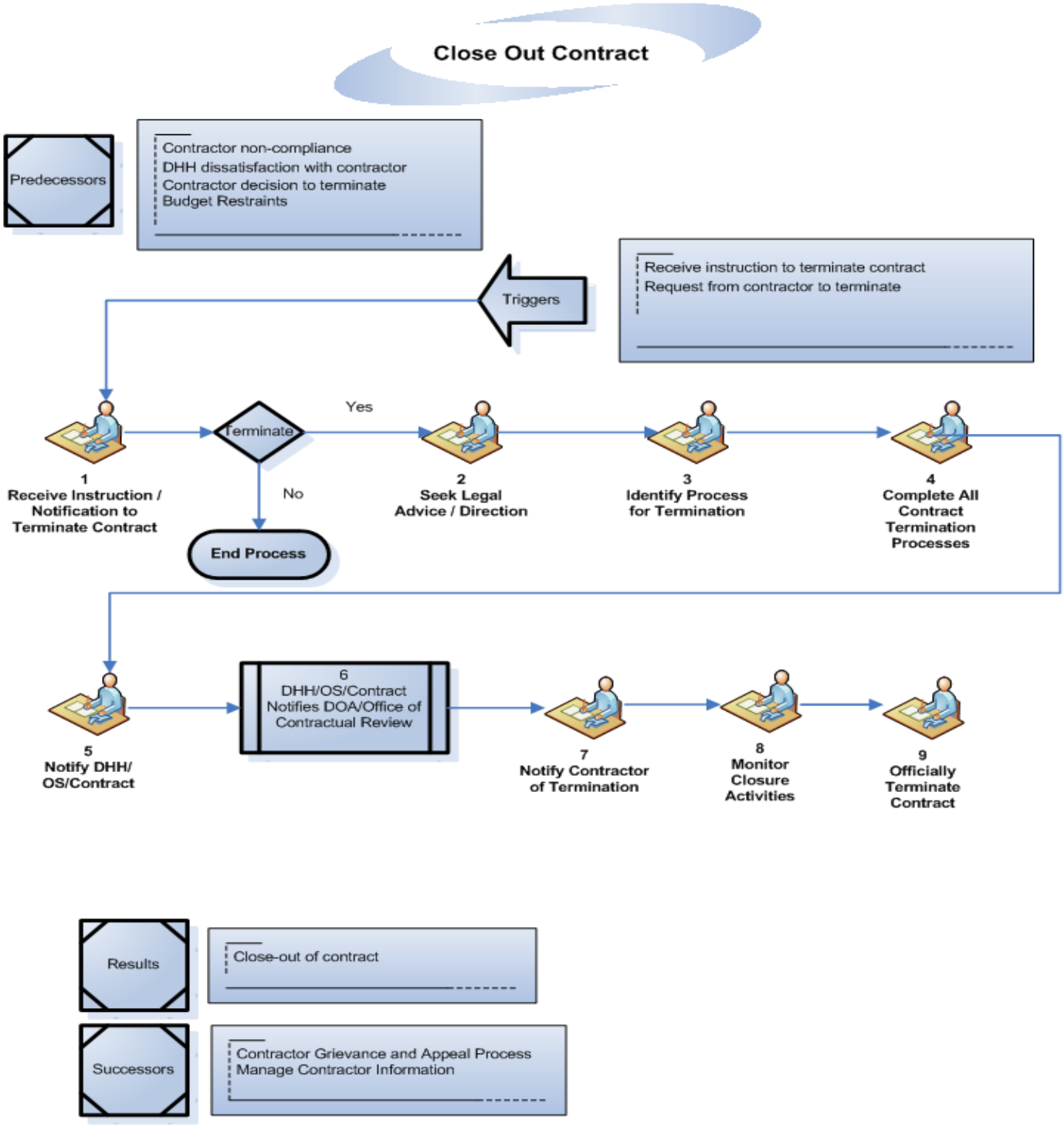

Award Contract (continued)
20
Submit Intent to Award to DHH/ OS/Contracts for Approval
21
Notify Non-selected and Proposed Contractors of Results
22
Negotiate Contract
23
Send Unsigned Negotiated Contract for Approval
24
DOA Sends Results to DHH/ OS/Contract
25
DHH/OS/Contract Sends Results to DHH Medicaid or Other Program Office
26
Notify Contractor Of Results/Status
27
Obtain Signatures and Return through Contract Review Process
Results
Contractor begins work
RFP withdrawn
No vendor selected
Approvals not obtained
Sucessors
Manage Contractor Process
Close Out Contract Process

7.2 Close Out Contract

7.2.1 Close Out Contract "As-Is" Process Model

Item	Details
Description	The **Close-out Contract** business process begins with an order to terminate a contract or a notice from the contractor that they are terminating the contract. The termination or cancellation of a contract may occur for the following, non-inclusive, reasons: 1. The need for the service no longer exists 2. Funding is not available for continued purchase of the service 3. Service costs require competitive bidding to award contract for the service 4. Non-performance of contract terms 5. Deficiencies in provision of services required by the contract 6. Contractor does not wish to continue the contract 7. Loss of licensure The closeout process ensures that the obligations of the current contract are fulfilled and the turnover to the new contractor and/or agency is completed according to contractual obligations.
Trigger Event	1. Receive instruction to terminate contract 2. Request from contractor to terminate
Result	Close-out of Contract
Business Process Steps	1. Receive instruction or notification to terminate contract a. If Yes, go to Step 2 b. If No, process ends 2. Seek Legal Advice/Direction - If no mutual agreement, provide documentation for reason to terminate for approval/denial (Director/Legal) 3. Identify process for termination of contract 4. Complete all contract termination processes 5. Notify DHH/OS/Contract by letter or memo 6. DHH/OS/Contract notifies DOA/Office of Contractual Review. 7. Notify the contractor of the termination of contract 8. Monitor closure activities 9. Officially terminate contract
Shared Data	NONE
Predecessor	1. Contractor non-compliance 2. DHH dissatisfaction with contractor 3. Contractor decision to terminate 4. Budget Restraints
Successor	1. Contractor Grievance and Appeal process 2. Manage Contractor Information
Constraints	State and Federal Rules and Regulations
Failures	Fail to obtain approvals
Performance Measures	NONE

7.2.2 Close Out Workflow

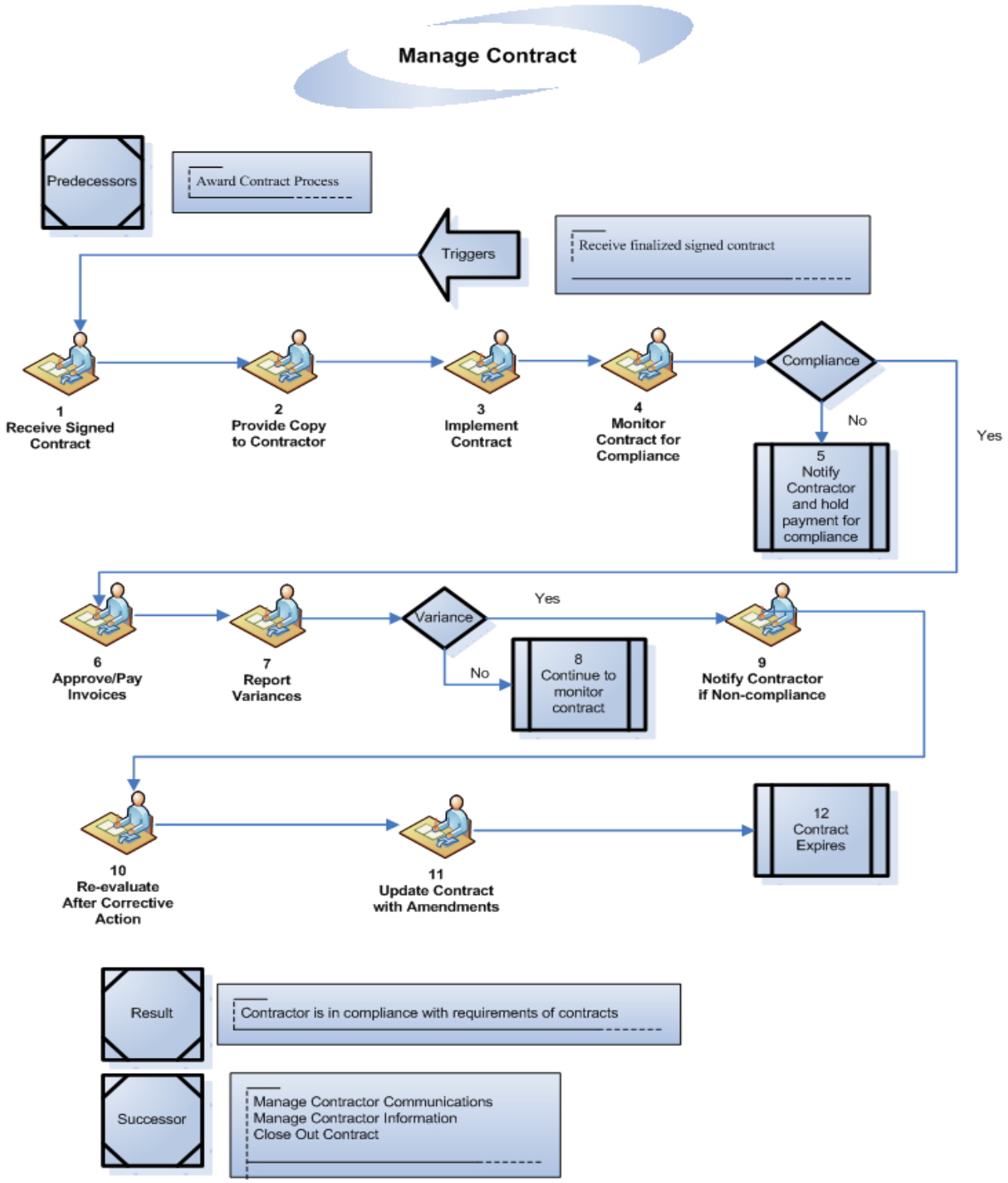


7.3 Manage Contract

7.3.1 Manage Contract Business Process Model

Item	Details
Description	The **Manage Contract** business process receives the contract award information, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the contract throughout its duration.
Trigger Event	Receive finalized signed contract.
Result	Contractor is in compliance with requirements of the contract.
Business Process Steps	1. Receive signed contract 2. Provide copy to contractor 3. Implement contract 4. Monitor the contract for compliance with requirements a. If Yes, compliance with requirements, go to Step 6 b. If No, go to Step 5 5. Notify contractor and withhold payment until compliance is achieved 6. Approve/Pay appropriate invoices 7. Report variances, if any a. If Yes, a variance is identified, go to Step 9 b. If No, go to Step 8 8. Continue to monitor the contract 9. Notify contractor of non-compliance with requirements 10. Reevaluate contractor performance following implementation of corrective actions 11. Update contract with amendments (if any) 12. Contract expires
Shared Data	Contract Variables (from Contract Financial Management System)
Predecessor	Award Contract Process
Successor	1. Manage Contractor Communications 2. Manage Contractor Information 3. Close out Contract
Constraints	State and Federal Rules and Regulations
Failures	NONE
Performance Measures	NONE

7.3.2 Manage Contract Workflow

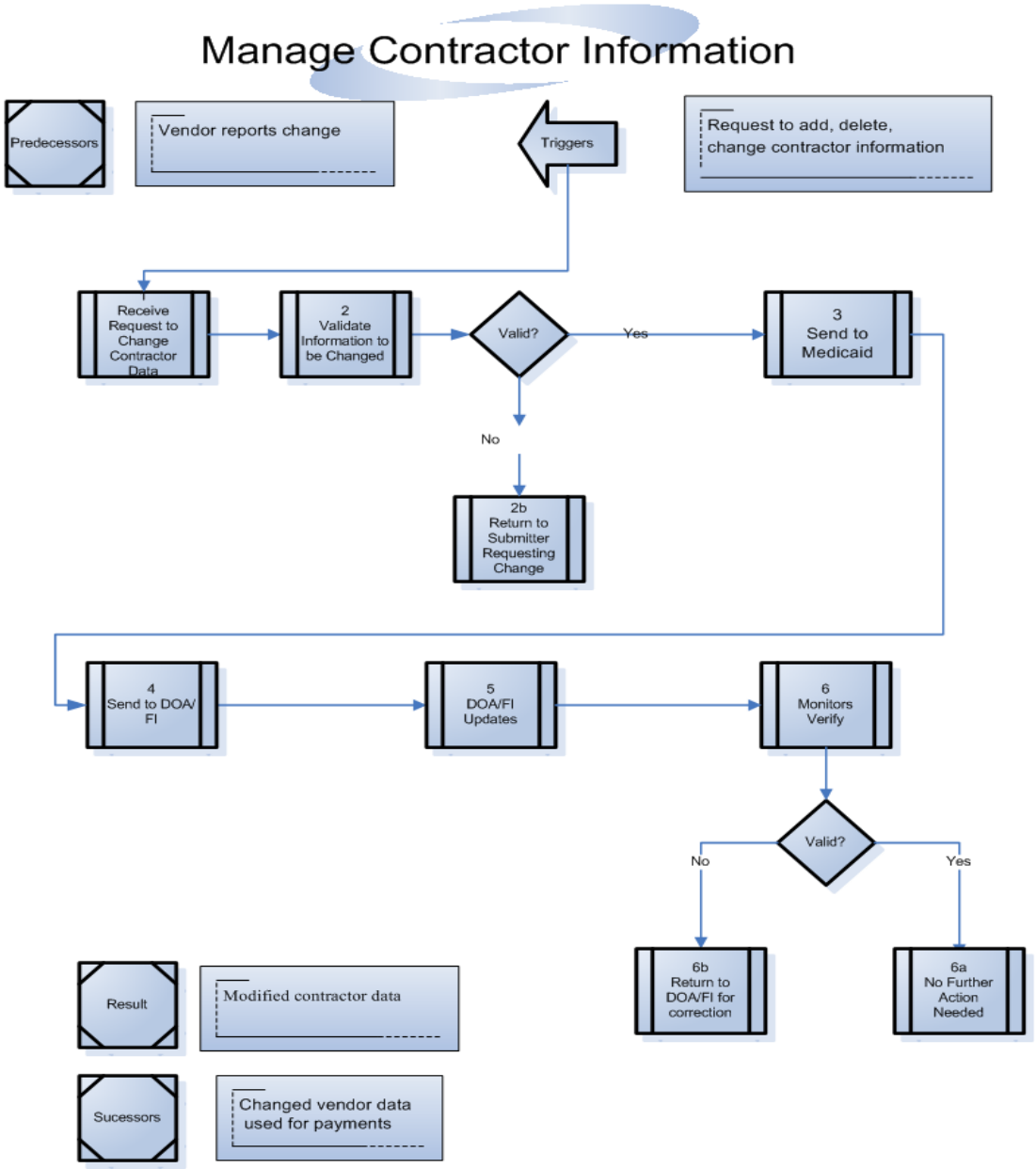


7.4 Manage Contractor Information

7.4.1 Manage Contractor Information Business Process Model

Item	Details
Description	The **Manage Contractor Information** business process receives a request for addition, deletion, or change to the Contractor Information; validates the request, applies the change, verifies changes, and monitors contract
Trigger Event	Request to add, delete, change contractor information
Result	Modified contractor data
Business Process Steps	1. Receive request to update contractor data 2. Validate information to change a. If Yes, go to Step 3 b. If No, return request to submitter for correction or additional information 3. Send to Medicaid 4. Send to DOA / FI 5. DOA/FI updates completed 6. Contract Monitors verify the contractor updates a. If Yes, no action taken b. If No, contact DOA / FI for correction or additional information
Shared Data	Receive request to update contractor data repository
Predecessor	Vendor reports change
Successor	Changed vendor data used for payments
Constraints	Change requested not in compliance with terms and conditions of contract
Failures	Change requested not in compliance with terms and conditions of contract
Performance Measures	None

7.4.2 Manage Contractor Information (Current Contractor) Workflow

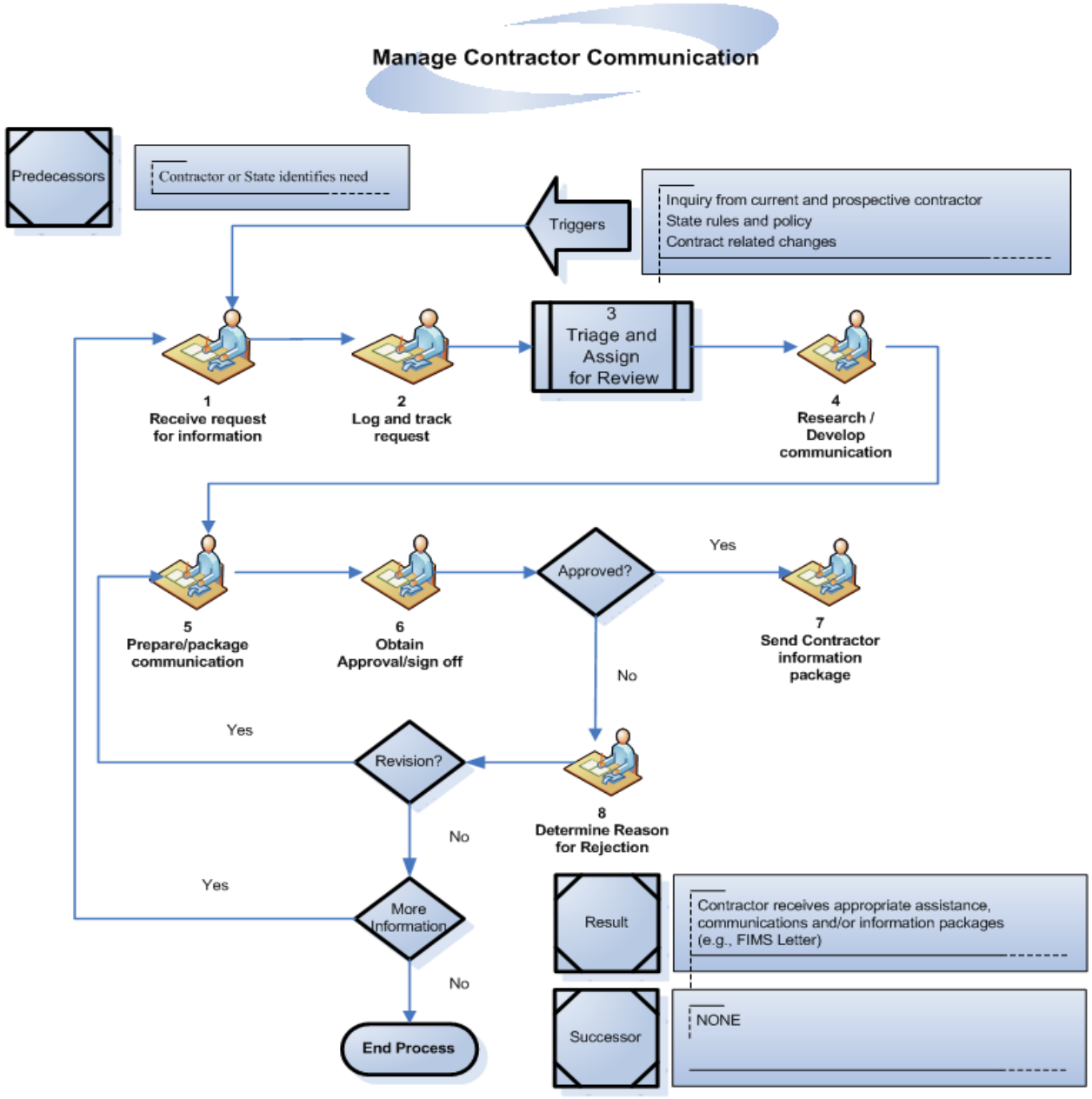


7.5 Manage Contractor Communication

7.5.1 Manage Contractor Communication Business Process Model

Item	Details
Description	The ***Manage Contractor Communication*** business process receives requests for information, appointments, and assistance from contractor such as inquiries related to changes in Medicaid program policies and procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed, and produced for distribution. **NOTE:** Inquiries from prospective and current contractors are handled by the ***Manage Contractor Communication*** process by providing assistance and responses to individual entities, i.e., bi-directional communication.
Trigger Event	1. Inquiry from current and prospective contractor 2. State rules and policy 3. Contract related changes
Result	Contractor receives appropriate assistance, communications and/or information packages
Business Process Steps	1. Receive request for information 2. Log and track communication request 3. Triage and assign to appropriate staff member 4. Research/develop communication 5. Prepare/package communication 6. Obtain Approval/signoff a. If Yes, go to Step 7 b. If No, go to Step 8 7. Send contractor communications and information packages 8. Determine Reason for Rejection a. If Revision Needed, go to Step 5 b. If more information needed from contractor, go to Step 1 c. If No, end process
Shared Data	Contract variables from CFMS (Contractor Financial Management System)
Predecessor	Contractor or State identifies need
Successor	NONE
Constraints	State and Federal rules and regulations
Failures	NONE
Performance Measures	NONE

7.5.2 Manage Contractor Communication



7.6 Perform Potential Contractor Outreach

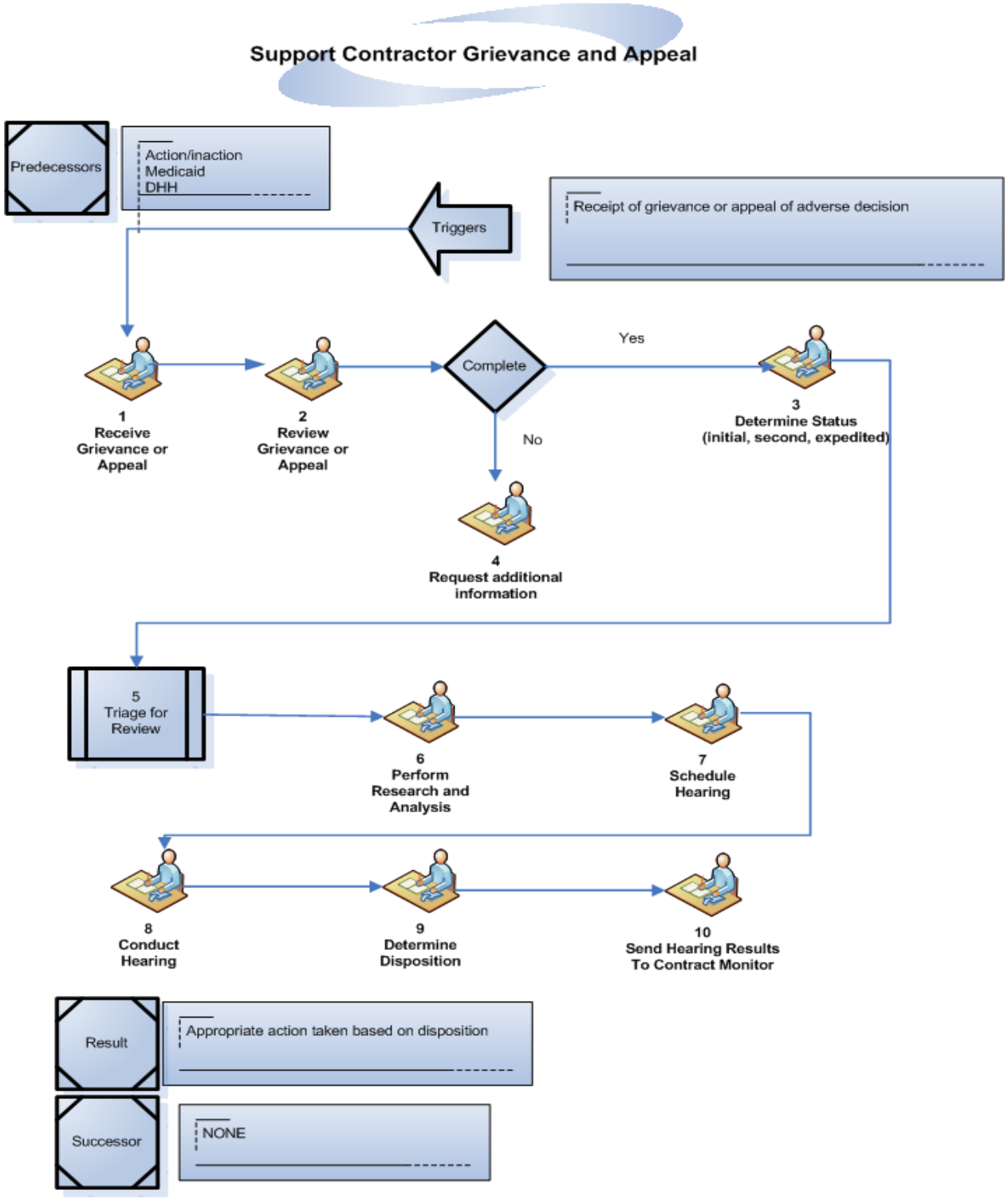
During the JAD sessions, participants determined that Louisiana DHH does NOT perform Potential Contractor Outreach at this time. Therefore an "As-Is" process model and workflow could not be developed. Since a process model and workflow could not be developed, none is presented.

7.7 Support Contractor Grievance and Appeal

7.7.1 Support Contractor Grievance and Appeal Business Process Model

Item	Details
Description	The **Support Contractor Grievance and Appeal** business process handles contractor appeals of adverse decisions or communications of a grievance A grievance or appeal is received by the agency. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented and relevant documents are distributed. The contractor result will be distributed to contract monitor.
Trigger Event	Receipt of grievance or appeal of adverse decision
Result	Appropriate action taken based on disposition
Business Process Steps	1. Receive grievance or appeal 2. Review grievance or appeal (Situational – to determine if complete) a. If Yes, documentation is complete, go to Step 3 b. If No, documentation is incomplete, go to Step 4 3. Determine status as initial, second, or expedited. 4. Request additional information 5. Triage for appropriate personnel for review. 6. Perform research and analysis 7. Schedule hearing within required time 8. Conduct hearing within required time 9. Determine disposition 10. Send hearing results to Contract Monitor **NOTE:** Some of the above steps may be repeated and a grievance or appeals case may take many months to finalize.
Shared Data	Information from appellant and/or Witnesses
Predecessor	1. Action/inaction 2. Medicaid 3. DHH
Successor	NONE
Constraints	State and Federal Rules and Regulations
Failures	Timeframes not met
Performance Measures	NONE

7.7.2 Support Contractor Grievance and Appeal Workflow

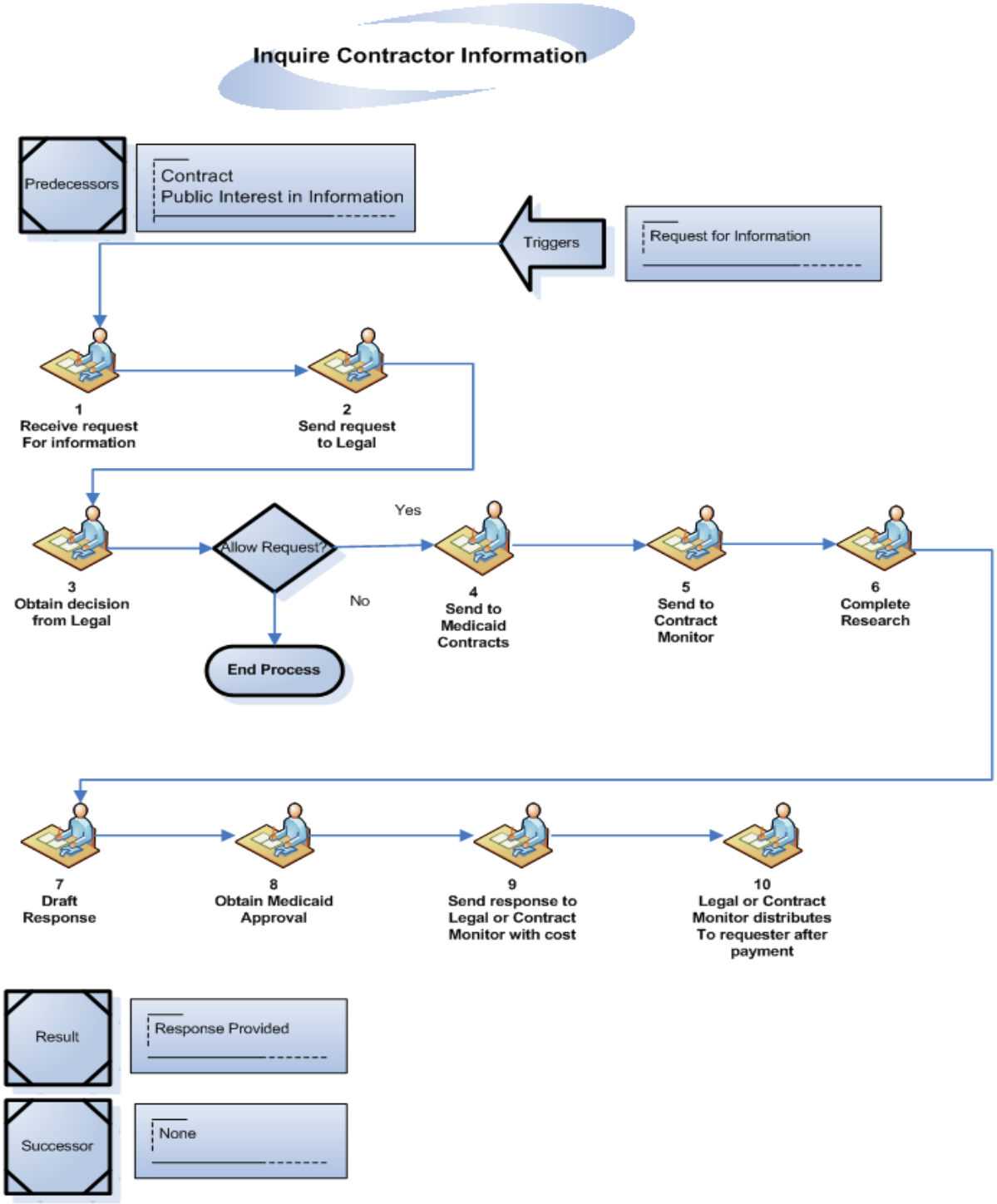


7.8 Inquire Contractor Information

7.8.1 Inquire Contractor Information Business Process Model

Item	Details
Description	The **Inquire Contractor Information** business process receives requests for contract verification from authorized providers, programs or business associates, general public; performs the inquiry; and prepares the response data via: email, web, phone, mail process.
Trigger Event	Request for Information
Result	Response Provided
Business Process Steps	1. Receive request for information 2. Send request to Legal 3. Obtain decision from Legal a. If Yes to allow request, go to Step 4 b. If No, process ends 4. Send to Medicaid contracts 5. Send to contract monitor 6. Research completed 7. Draft response 8. Obtain Medicaid Approval 9. Send response to Legal or contract monitor with cost 10. Distribute to Requestor after Payment (Legal or Contract Monitor performs)
Shared Data	NONE
Predecessor	1. Contract 2. Public interest in information
Successor	NONE
Constraints	1. Comply with HIPAA 2. Proprietary and legal requirements
Failures	Non-payment of copy fee
Performance Measures	NONE

7.8.2 Inquire Contractor Information Workflow



8.0 Operations Management Overview

The Operations Management business area is the core of the claims processing function addressed by the MMIS area. It includes 26 business functions that support the payment of providers, PACE providers, other agencies, insurers, and Medicare premiums and support the receipt of payments from other insurers, providers, and member premiums. This area starts with the claim coming into the doors of the FI, validating requests for payment and determining payable amount. Also, within the process, responding to premium payment schedules and identifying and pursuing recoveries, recoupment, and drug rebates are accomplished. The result of this process is financial reporting, remittance advice reports, and a history of claims that can stored for other processes.

8.1 Authorize Referral

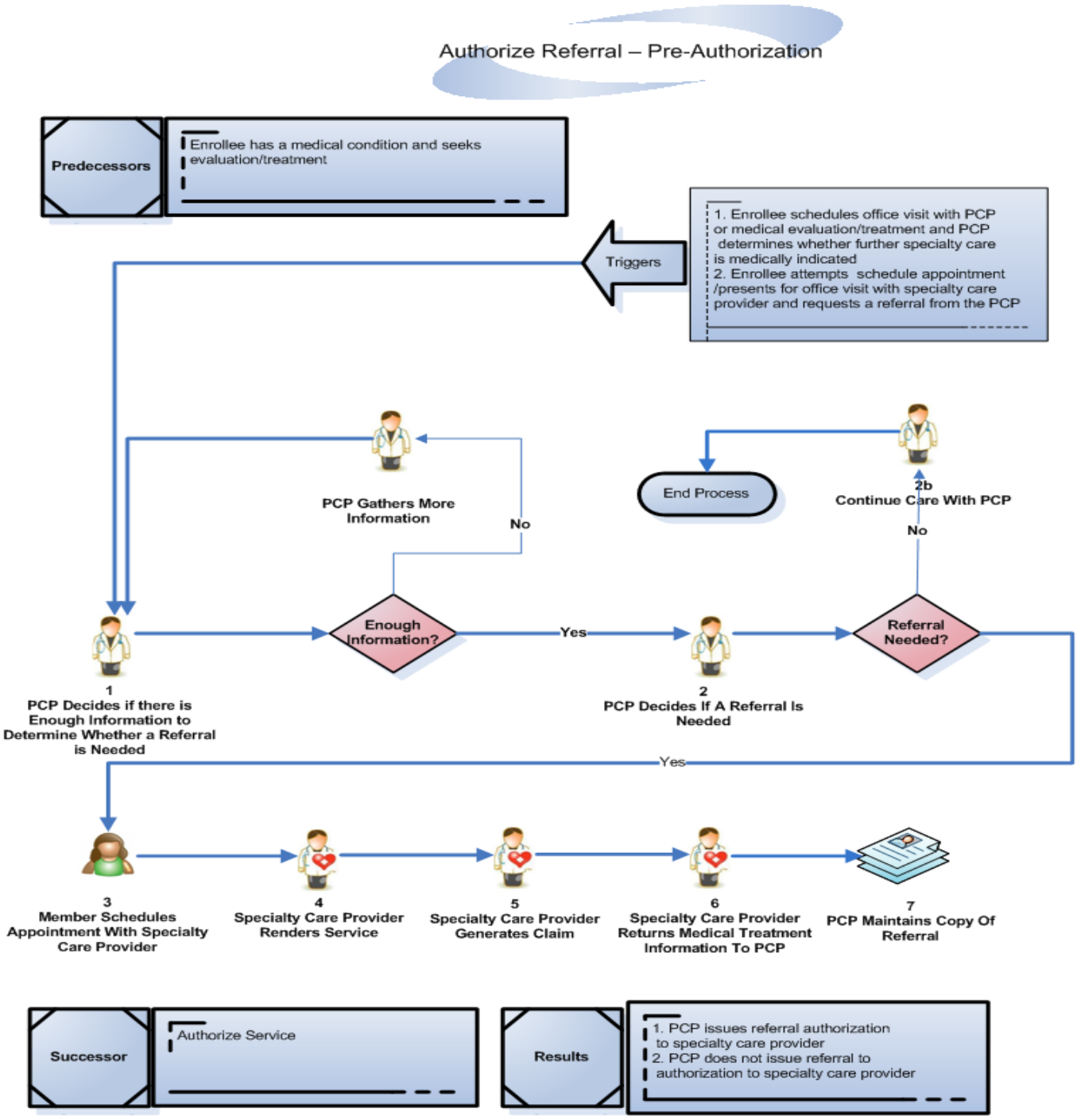
8.1.1 Authorize Referral Business Process Model

Item	Details
Description	The **Authorize Referral** business process is used when referrals between providers must be approved for payment. The CommunityCARE Primary Care Provider (PCP) is the initiator of the referral authorization for all non-exempt, non-emergency services... The **Post-Authorize Referral** business process is used when referrals between providers must be approved for payment after care is rendered in the ER. The CommunityCARE Primary Care Provider (PCP) receives requests for post-authorization of services provided to enrollees in the hospital emergency room (ER).
Trigger Event	1. (Pre) Enrollee schedules office visit with PCP for medical evaluation/treatment and PCP determines further specialty care is medically indicated. 2. (Pre) Enrollee attempts to schedule appointment/presents for office visit with a specialty care provider and requests a referral from the PCP. 3. (Post) Enrollee request treatment for a medical condition in the Emergency Room (ER)
Result	**Pre-Authorization** 1. PCP issues referral authorization to specialty care provider. 2. PCP does not issue referral authorization to specialty care provider. **Post Authorization** 1. PCP approves ER post-authorization request and hospital provider generates claim using PCP referral authorization number and forwards to FI for payment. 2. PCP denies request and hospital provider may generate a bill for services rendered and forwards to the enrollee for payment

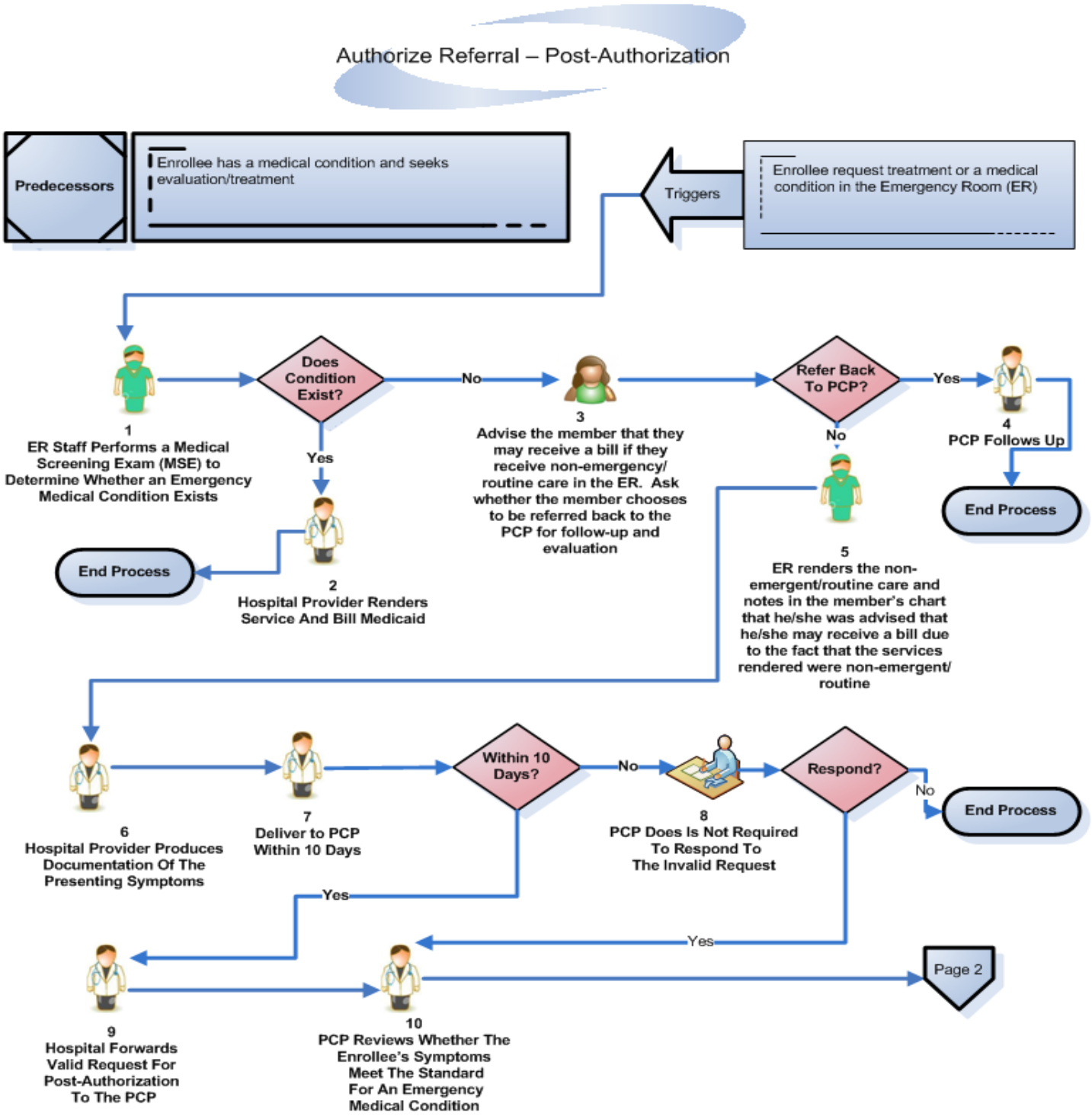
Business Process Steps	**Pre-Authorization** 1. PCP decides if there is a enough information to determine whether a referral is needed a. If Yes, proceed to Step 2 b. If No, PCP gathers more information. Proceed to Step 1 2. PCP decides if a referral is needed a. If Yes, proceed to Step 3 b. If No, Continue care with PCP, End Process 3. Member schedules appointment with specialty care provider 4. Specialty care provider renders service 5. Specialty care provider generates claim for payment using PCP referral authorization number 6. Specialty care provider returns medical treatment information to PCP 7. PCP maintains copy of referral authorization and treatment information in enrollee medical record.
Business Process Steps (cont.)	**Post-Authorization** 1. ER staff performs a medical screening exam (MSE) to determine whether an emergency medical condition exists a. If Yes, go to Step 2 b. If No, go to Step 3 2. Hospital provider renders service and bills Medicaid, End Process 3. Advise the member that they may receive a bill if they receive non-emergency/routine care in the ER. Ask whether the member chooses to be referred back to the PCP for follow-up and evaluation a. If Yes, go to Step 4 b. If No, go to Step 5 4. Refer member back to the PCP for follow-up and evaluation, End Process 5. ER renders the non-emergent/routine care and notes in the member's chart that he/she was advised that he/she might receive a bill because the services rendered were non-emergent/routine. 6. Hospital provider produces documentation of the presenting symptoms 7. Will ER deliver documentation to the PCP within 10 days? a. If Yes, go to Step 9 b. If No, go to Step 8 8. PCP is not required to respond to the invalid request. If PCP chooses to respond a. If Yes, go to Step 10 b. If No, End process 9. Hospital forwards valid request for post-authorization to the PCP 10. PCP reviews the presenting symptoms and determines whether or not the enrollee's presenting symptoms meet the "Prudent Layperson Standard" of an emergency medical condition 11. PCP responds within 10 days of receipt of post authorization from hospital a. If Yes, go to Step13 b. If No, go to Step 12 12. Perform provider communications business function, Proceed to Step 13 13. PCP determines if they need additional information from hospital provider a. If Yes, go to Step 14 b. If No go to Step 15 14. Request sent by PCP to Hospital for additional documentation of presenting symptoms. Upon receipt of additional information go to Step 13 15. PCP Validates Post-Authorization Request

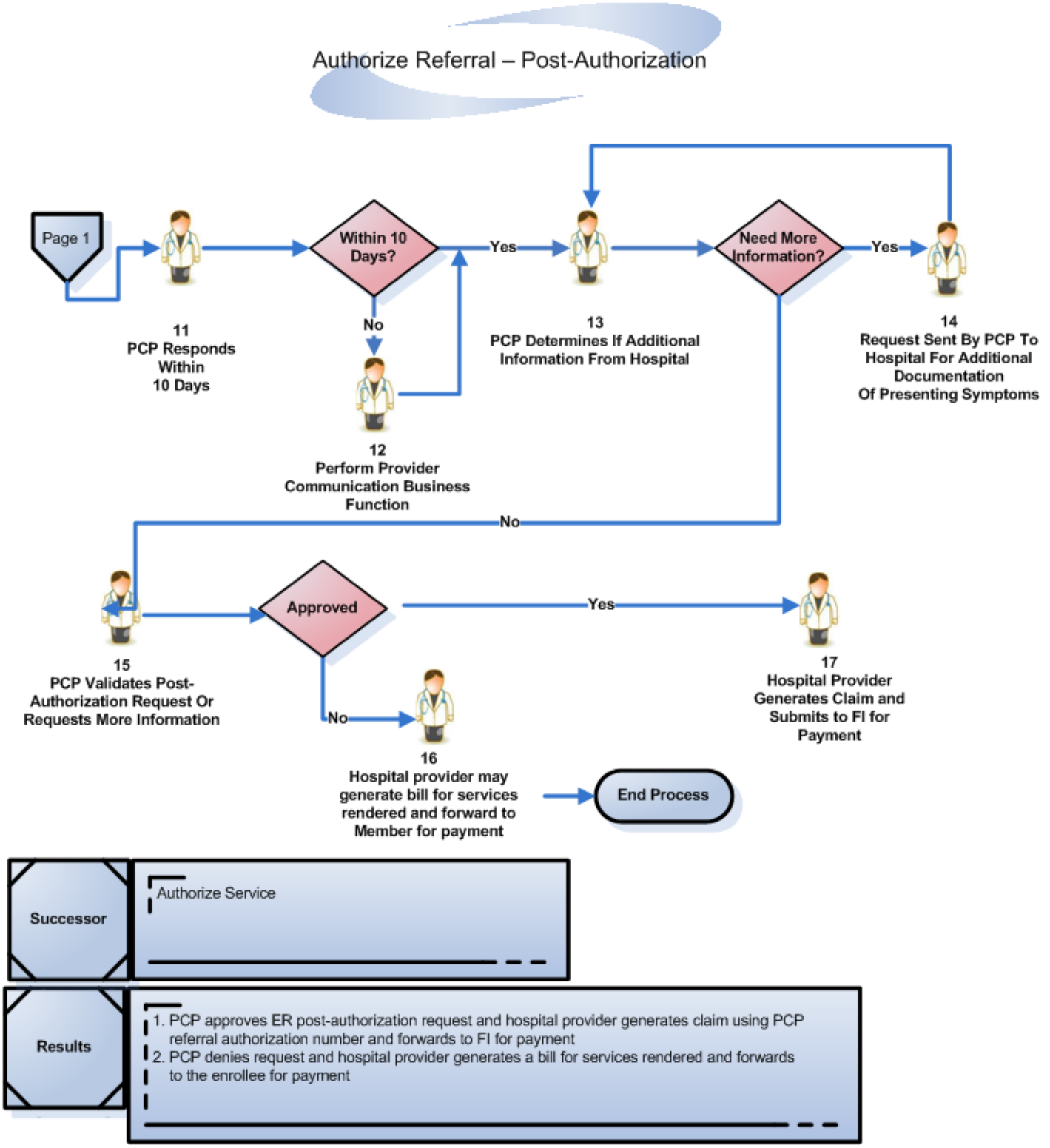
	a. If Yes, go to Step 17 b. If No, go to Step 16 16. Hospital provider may generate bill for services rendered and forward to Member for payment. End Process 17. Hospital provider generates claim using PCP referral authorization number and submits to Fiscal Intermediary for payment.
Shared Data	Medical documentation
Predecessor	Enrollee has a medical condition and seeks evaluation / treatment
Successor	Authorize Service
Constraints	PCP determines that the need exists for further specialty care, and issues referral authorization using the State's standardized form or any pre-existing format containing the required information.
Failures	Requester/Provider withdraws request
Performance Measures	None

8.1.2 Authorize Referral Workflow – Pre- Authorization



8.1.3 Authorize Referral Workflow – Post- Authorization



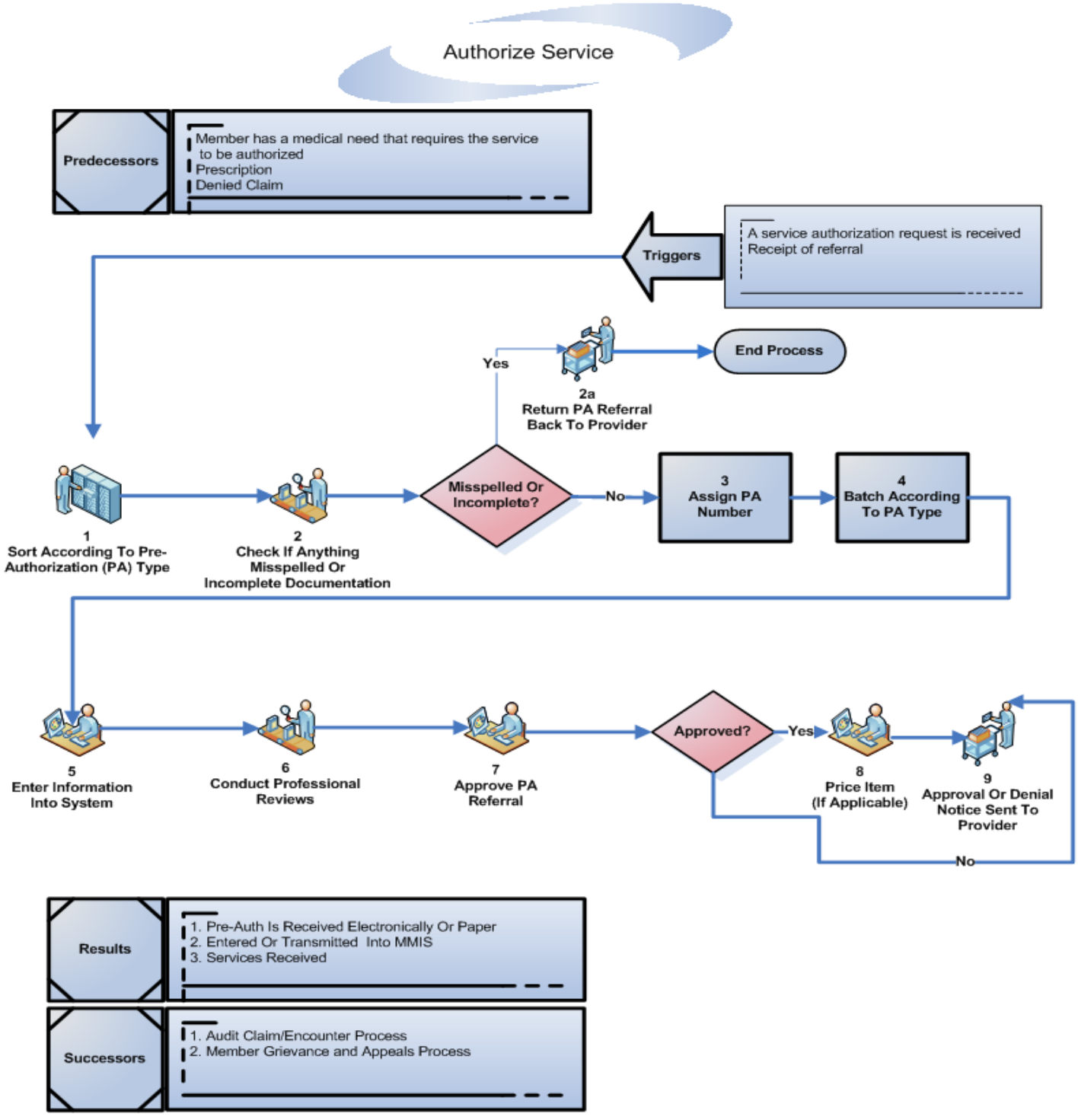

Authorize Referral – Post-Authorization
Page 1
11
PCP Responds Within 10 Days
Within 10 Days?
Yes
No
12
Perform Provider Communication Business Function
13
PCP Determines If Additional Information From Hospital
Need More Information?
Yes
14
Request Sent By PCP To Hospital For Additional Documentation Of Presenting Symptoms
No
15
PCP Validates Post-Authorization Request Or Requests More Information
Approved
Yes
17
Hospital Provider Generates Claim and Submits to FI for Payment
No
16
Hospital provider may generate bill for services rendered and forward to Member for payment
End Process
Successor
Authorize Service
Results
1. PCP approves ER post-authorization request and hospital provider generates claim using PCP referral authorization number and forwards to FI for payment
2. PCP denies request and hospital provider generates a bill for services rendered and forwards to the enrollee for payment

8.2 Authorize Service

8.2.1 Authorize Service Business Process Model

Item	Details
Description	The **Pre-Authorize Service** business process encompasses the business process includes referrals for specific types and numbers of visits, surgeries, tests, drugs, durable medical equipment, dental services and institutional days of stay. It is primarily used in a fee-for-service setting.
Trigger Event	1. A service authorization request is received 2. Receipt of referral
Result	1. Pre-Auth is received electronically or paper 2. Entered or transmitted into MMIS 3. Services received
Business Process Steps	1. Sort according to Pre-Authorized (PA) Type 2. Check to see if anything is missing or incomplete documentation from the PA a. If Yes either missing or incomplete documentation, Return PA referral back to provider b. If No, proceed to Step 3 3. Assign PA number 4. Batch according to PA Type (Rehab, DME, Home Health, etc.) 5. Enter information into system (Review Status) 6. Conduct professional reviews 7. Approve PA referral a If Yes, go to Step 8 b If No, go to Step9 8. Price item (if applicable) 9. Approval or denial notice sent to provider
Shared Data	1. Correspondence Data 2. Prescription 3. Medical Documentation
Predecessor	1. Member has a medical need that requires the service to be authorized 2. Prescription 3. Denied Claim
Successor	1. Audit Claim/Encounter process 2. Member Grievance and Appeal Process
Constraints	PA requests have a contracted turn-around limit by the PA contractor or FI
Failures	None
Performance Measures	Number of post authorizations per member; per PCP

8.2.2 Authorize Service Workflow



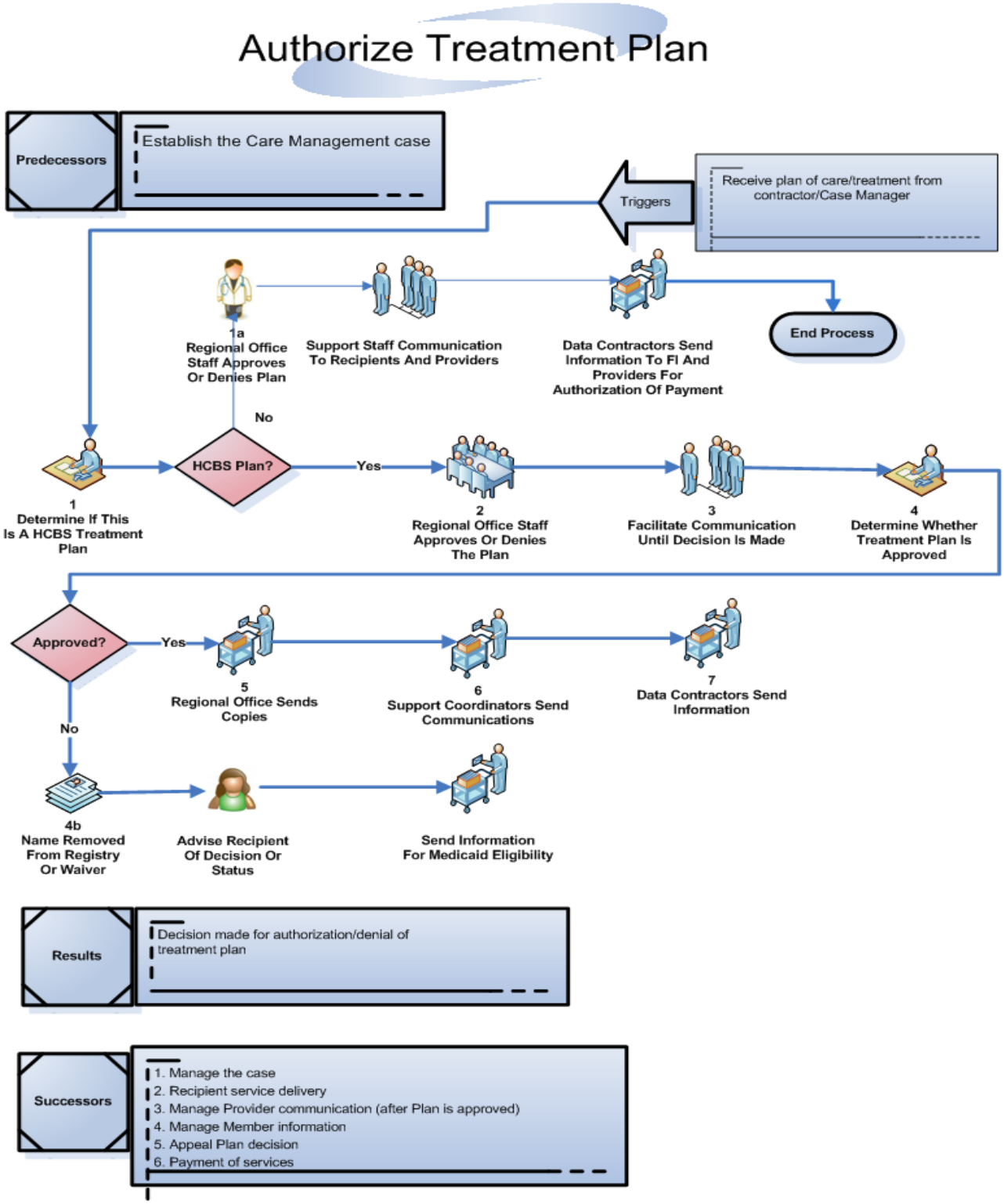
8.3 Authorize Treatment Plan

8.3.1 Authorize Treatment Plan Business Process Model

Item	Details
Description	Home Health The **Authorize Treatment Plan** is primarily used in care management settings (HCBS) where the care management team assesses the client's needs, decides on a course of treatment, and completes the Treatment Plan. A Treatment Plan prior-authorizes the named providers and services. The individual providers are pre-approved for the service and do not have to submit their own Service Request. It typically covers many services and spans a length of time. A service request is more limited and focuses on a specific visits, services, or products. Home Health Care Services provided in the home under the order of a physician that are necessary for the diagnosis and treatment of the patient's illness or injury, including: skilled nursing, physical therapy, speech-language therapy, occupational therapy, home health aide services or medical supplies , equipment and appliances suitable for use in the home (with approved Prior Authorizations
Trigger Event	Receive Plan of care/treatment from contractor/Case Manager
Result	Decision made for authorization/denial of Treatment Plan
Business Process Steps	1. Determine if this is a HCBS Treatment Plan a. If No, i. FI medical staff approves/denies plan based on medical necessity ii. Support staff communications to recipients and Providers iii. Data contractors send information to FI and providers for authorization of payments. End Process b. If Yes, proceed to Step 2 2. Regional office staff preliminary approves or denies the Plan. 3. Facilitate communication between Regional office and contractor/support coordinators until decision made. 4. Determine whether treatment plan is approved a. If Yes, proceed to Step 5 b. If No, i. Name removed from Registry or Waiver ii. Advise recipient of decision/status iii. Send information to Medicaid Eligibility. End Process 5. Regional office sends copies to contractor/support coordinators, data contractors and Medicaid Eligibility 6. Support coordinators/contractors send communications to recipients and providers 7. Data contractors send information to FI and providers for authorization for payment.
Shared Data	Medical documentation
Predecessor	Establish the Care Management case
Successor	1. Manage the case 2. Recipient service delivery 3. Manage Provider communication (after Plan is approved) 4. Manage Member information 5. Appeal Plan decision 6. Payment of services
Constraints	State and federal rules and regulations

Failures	None
Performance Measures	None

8.3.2 Authorize Treatment Plan Workflow

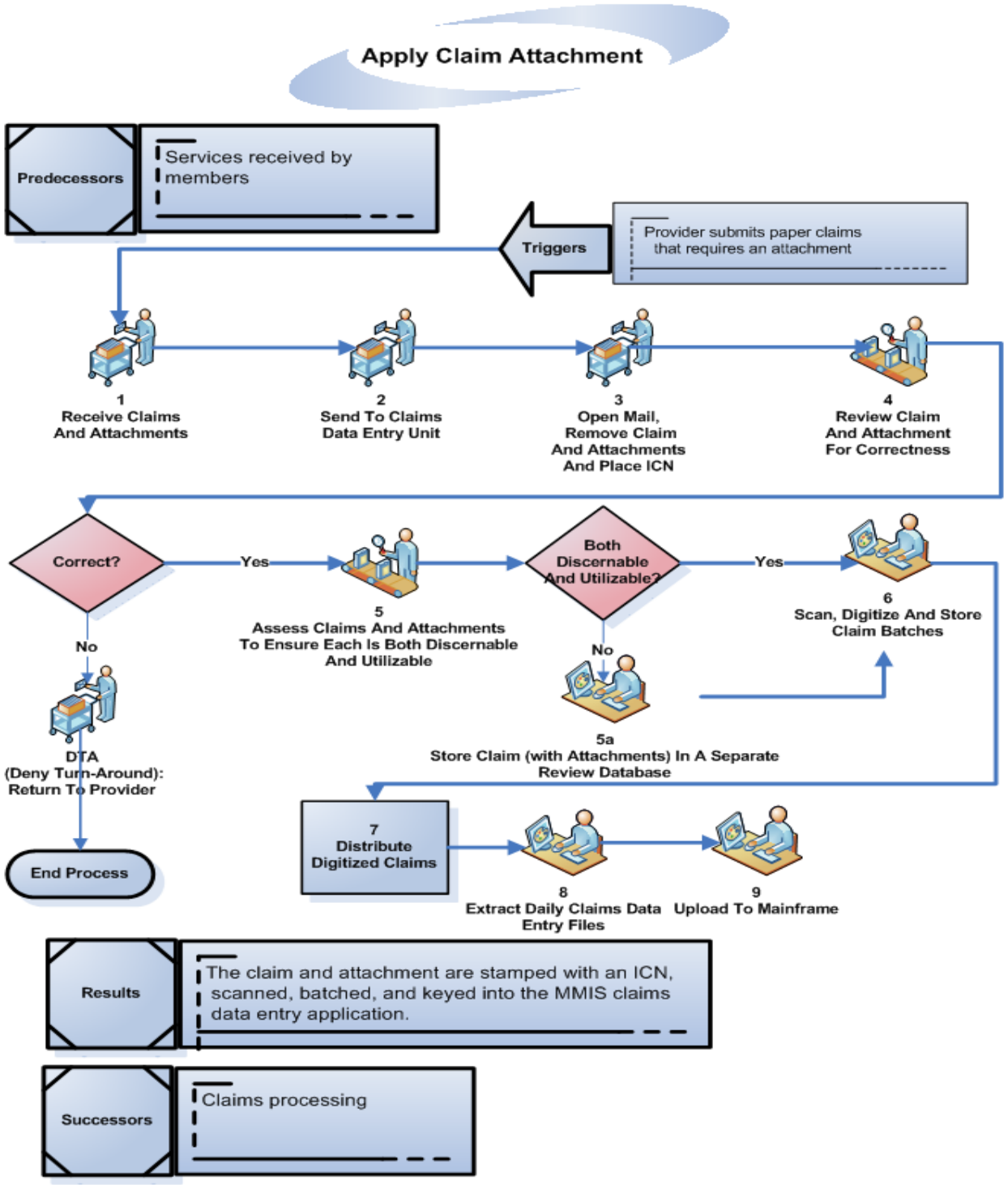


8.4 Apply Claim Attachment

8.4.1 Apply Claim Attachment Business Process Model

Item	Details
Description	The **Apply Claim Attachment** business process is used if a claim requires supporting documentation, in the form of attachments, such as TPL EOB information, then the claim must be filed with the Fiscal Intermediary (FI) as a paper document. It is the provider's responsibility to complete the paper claim form and attach the supporting documentation.
Trigger Event	Provider submits paper claim that requires an attachment
Result	The claim and attachment are stamped with an ICN, scanned, batched, and keyed into the MMIS claims data entry application.
Business Process Steps	1. Mail room clerk receives claims and attachments 2. Sends to Claims Data Entry Unit for processing 3. Claims operations technician opens mail, removes claims and attachments, and places an ICN on them 4. Claim and attachment(s) are reviewed for correctness based on DHH LMMIS standards of accuracy a. If Yes correct, proceed to Step 5 b. If No, DTA (denied turn-around) and returned to the provider. Process ends. 5. Assess each to assure the information on attachment can be discerned and utilized a. If Yes, discernable and utilizable, continue to Step 6 b. If No, the claim (with attachments) is stored in a separate review database made accessible to DHH TPL unit. Proceed to Step 6. 6. Claim batches are scanned, digitized, and stored in a computer database 7. Digitized claims are automatically distributed via the OADES application to individual data entry technicians, who are able to key-from-image. Note: The application permits the data entry technician to retrieve and review the attachment(s) associated with the claims they are keying 8. Extract daily claims data entry files 9. Upload to mainframe for Claims Processing
Shared Data	None
Predecessor	None – services received by Member
Successor	Claims processing
Constraints	State and Federal Rules and Regulations
Failures	None
Performance Measures	None

8.4.2 Apply Claim Attachment Workflow

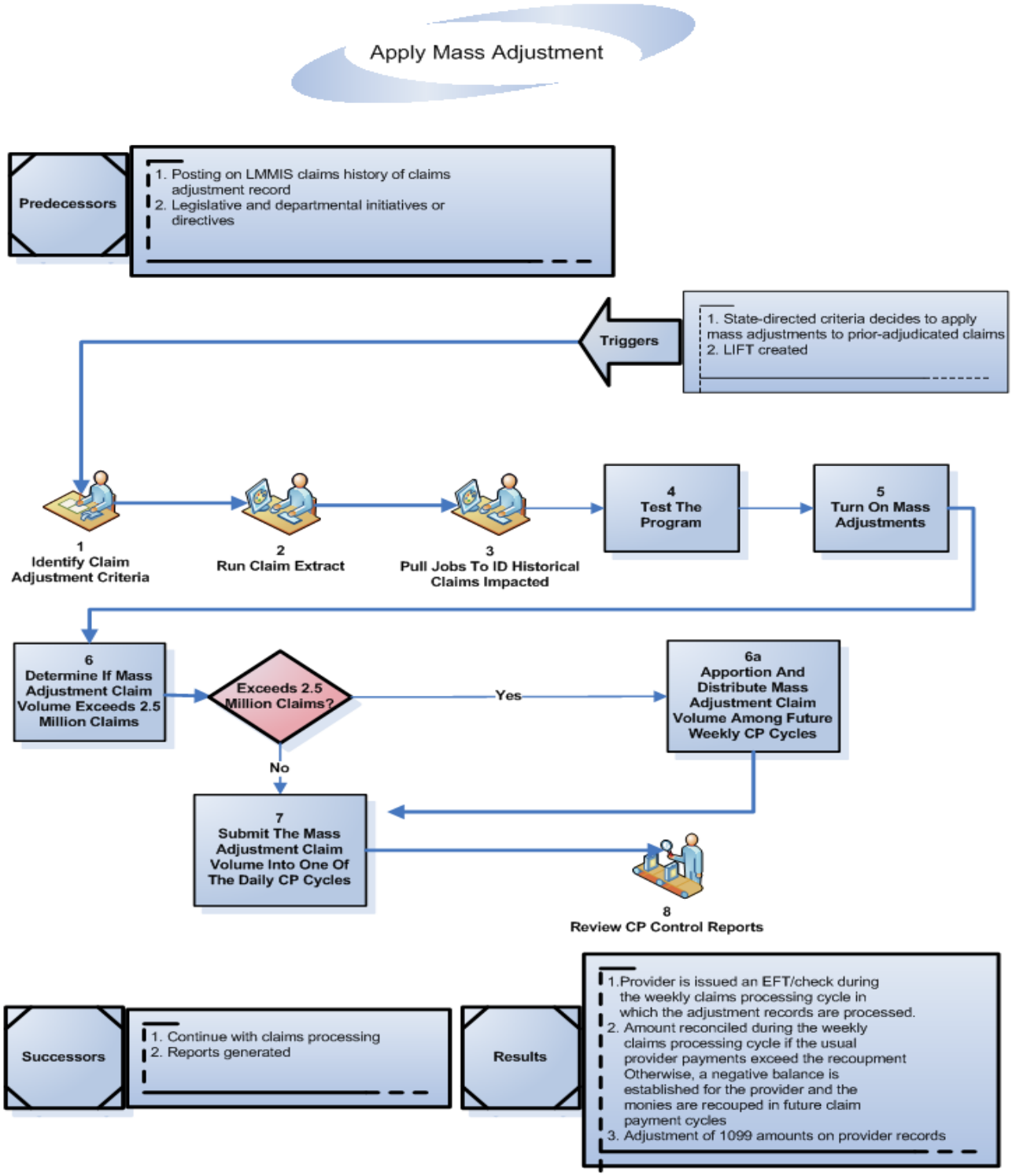


8.5 Apply Mass Adjustment

8.5.1 Apply Mass Adjustment Business Process Model

Item	Details
Description	**Apply Mass Adjustments** to claims history owing to State-specific budget and/or corrective and/or audit events.
Trigger Event	1. State-directed criteria decides to apply mass adjustments to prior-adjudicated claims 2. LIFT created
Result	1. Provider is issued an EFT/check during the weekly claims processing cycle in which the adjustment records are processed. 2. Amount reconciled during the weekly claims processing cycle if the usual provider payments exceed the recoupment. Otherwise, a negative balance is established for the provider and the monies are recouped in future claim payment cycles. 3. Adjustment of 1099 amounts on provider records
Business Process Steps	1. Identify the claim adjustment criteria: services, providers, recipients, dates; depending on the nature of the mass adjustment (corrective action, budget action, or audit action). 2. Run claim extract 3. Pull jobs to identify historical claims that are impacted systems write the program enhancement needed to apply the mass adjustment criteria to the claims extracted 4. Systems test the program 5. Systems turn-on the mass adjustments in the claims processing cycle 6. Systems determine if the mass adjustment claim volume exceed 2.5 million claims a. If Yes, exceeds, Apportion and distribute the mass adjustment claim volume among future weekly CP cycles. Proceed to Step 7 b. If No, proceed to Step 7 7. Submit the adjustment claims into one of the daily CP cycles 8. Review CP control reports to ensure correctness of the adjustments
Shared Data	None
Predecessor	1. Posting on LMMIS Claims History of claim adjustment records 2. Legislative and departmental initiatives or directives
Successor	1. Continue with claims processing 2. Reports generated
Constraints	State and Federal Rules and Regulations
Failures	Funding runs out and Mass adjustment stops
Performance Measures	None

8.5.2 Apply Mass Adjustment Workflow



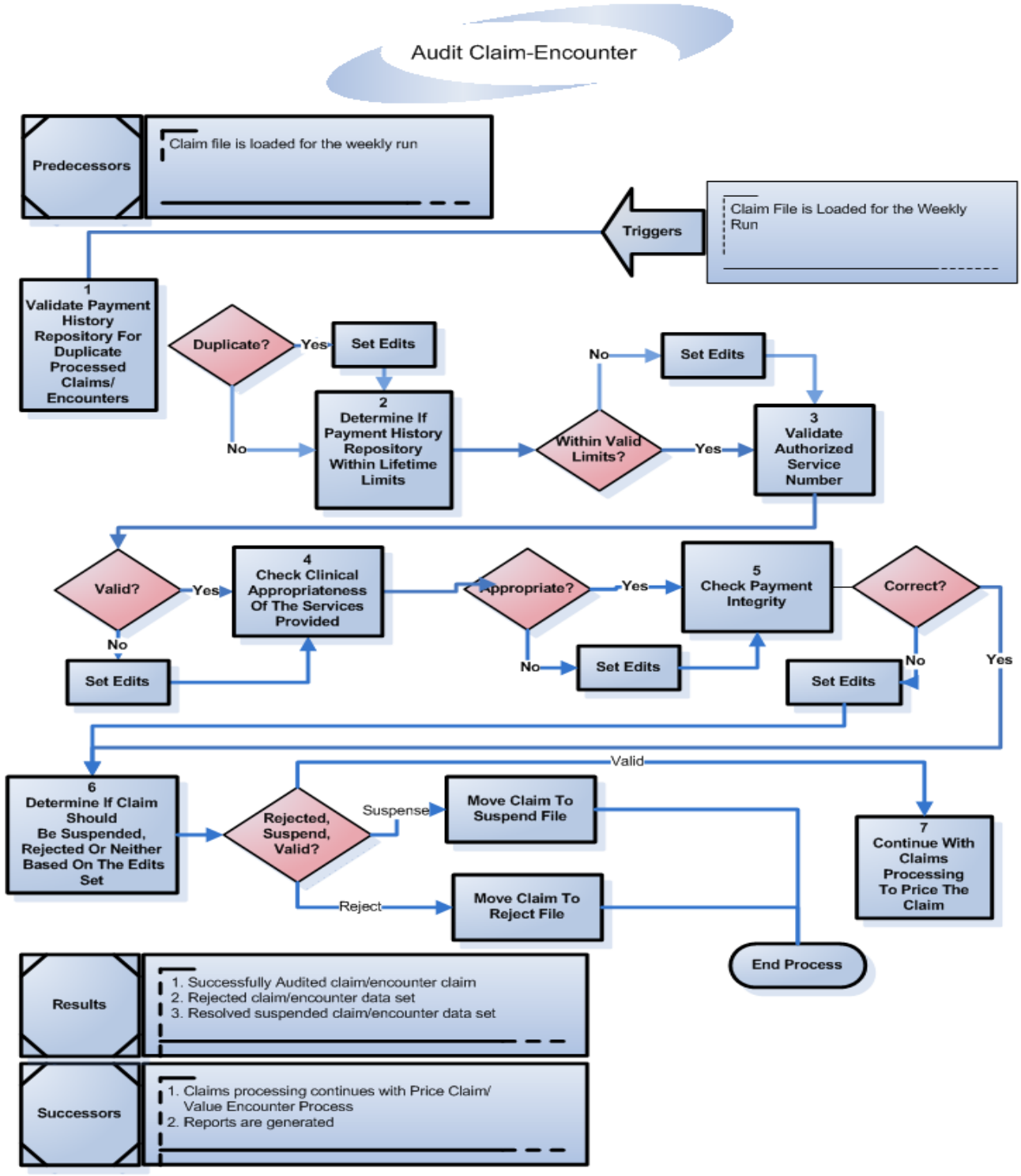
8.6 Audit Claim-Encounter

8.6.1 Audit Claim-Encounter Business Process Model

Item	Details
Description	The **Audit Claim/Encounter** (weekly edits) business process receives a validated original or adjustment claim from the **Edit Claim/Encounter** process and Checks Payment History Repository for duplicate processed claims/encounters and life time limits. Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity.
Trigger Event	Claim file is loaded for the weekly run.
Result	1. Successfully Audited claim/encounter claim 2. Rejected claim/encounter data set 3. Resolved suspended claim/encounter data set
Business Process Steps	1. Validate Payment History Repository for duplicate processed claims/encounters using search key data such as ICN, date of service, provider and member demographics, service, and diagnosis codes a. If Yes duplicate, Set Duplicate Edit flag. Proceed to step 2 b. If No, proceed to Step 2 2. Determine if Payment History Repository for services, costs, and units is within the lifetime limits a. If Yes within valid lifetime limits, proceed to Step 3 b. If No, Set Edit flags. Proceed to Step 3 3. Validate Authorized Service (prior authorization) Number to ensure available units; validate relation to claim and appropriateness of service a. If Yes, proceed to Step 4 b. If No, Set Edit flags. Proceed to Step 4 4. Check Clinical Appropriateness of the services provided based on clinical, case and disease management protocols a. If Yes appropriate, proceed to Step 5 b. If No, Set Edit flags. Proceed to Step 5 5. Check for Payment Integrity of the services provided based on clinical, case and disease management protocols a. If Yes correct, proceed to Step 6 b. If No, Set Edit flags. Proceed to Step 6 6. Determine if claim should be suspended, rejected or neither based on the edits that were set a. If Yes should be suspended, Move claim information to suspend file. Process ends b. If Yes should be rejected, Move claim information to reject file. Process ends c. If Neither, Go to Step 7 7. Continue with claims processing to price the claim
Shared Data	None
Predecessor	Claims from the Edit Claim Process
Successor	1. Claims processing continues with the Price Claim/Value Encounter process 2. Reports are generated
Constraints	None
Failures	None

Performance Measures	Time to complete Audit process: e.g., Real Time response within .05 seconds, Batch Response = within 24 hours

8.6.2 Audit Claim-Encounter Adjustment Workflow



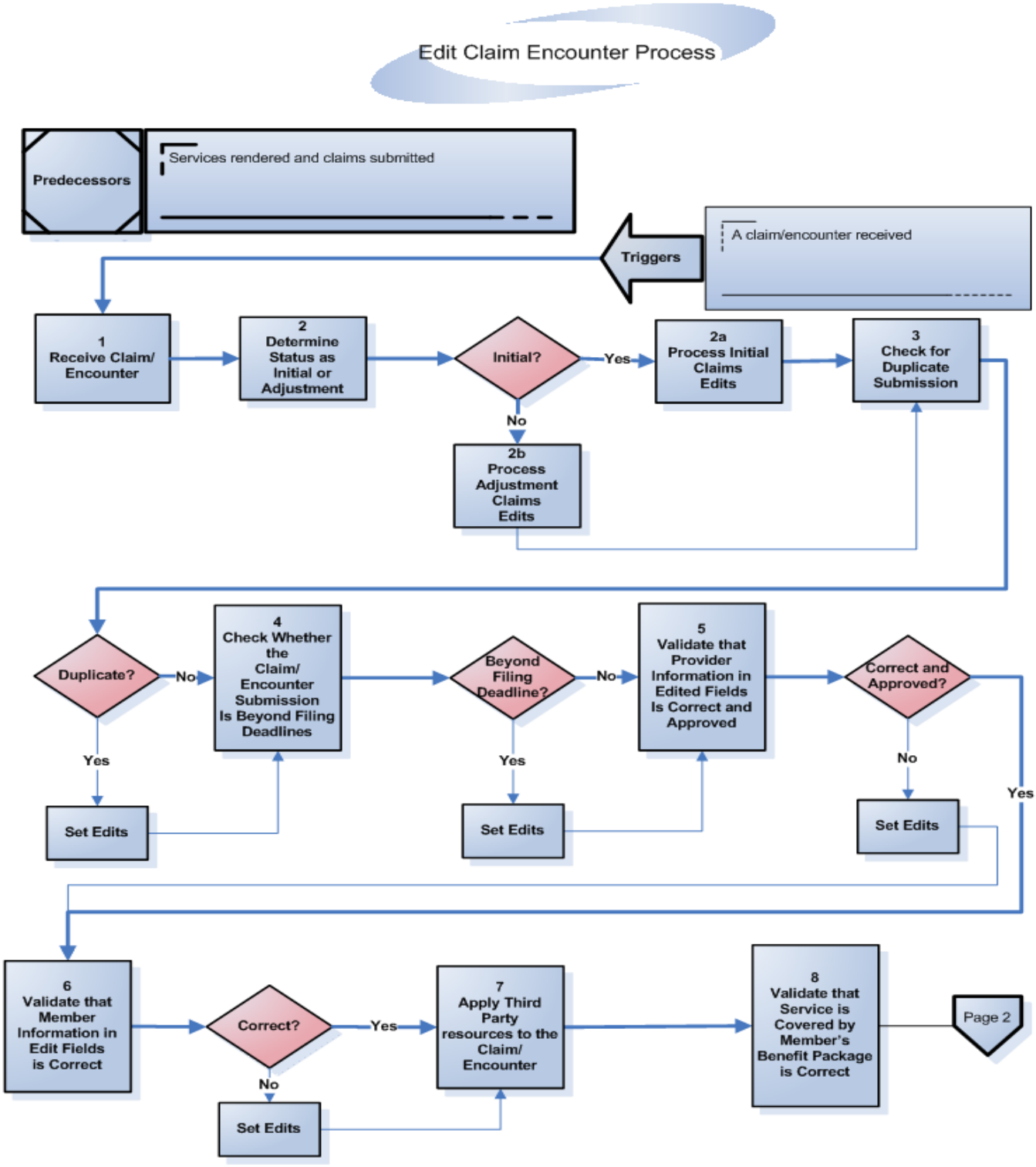
8.7 Edit Claims-Encounter Process

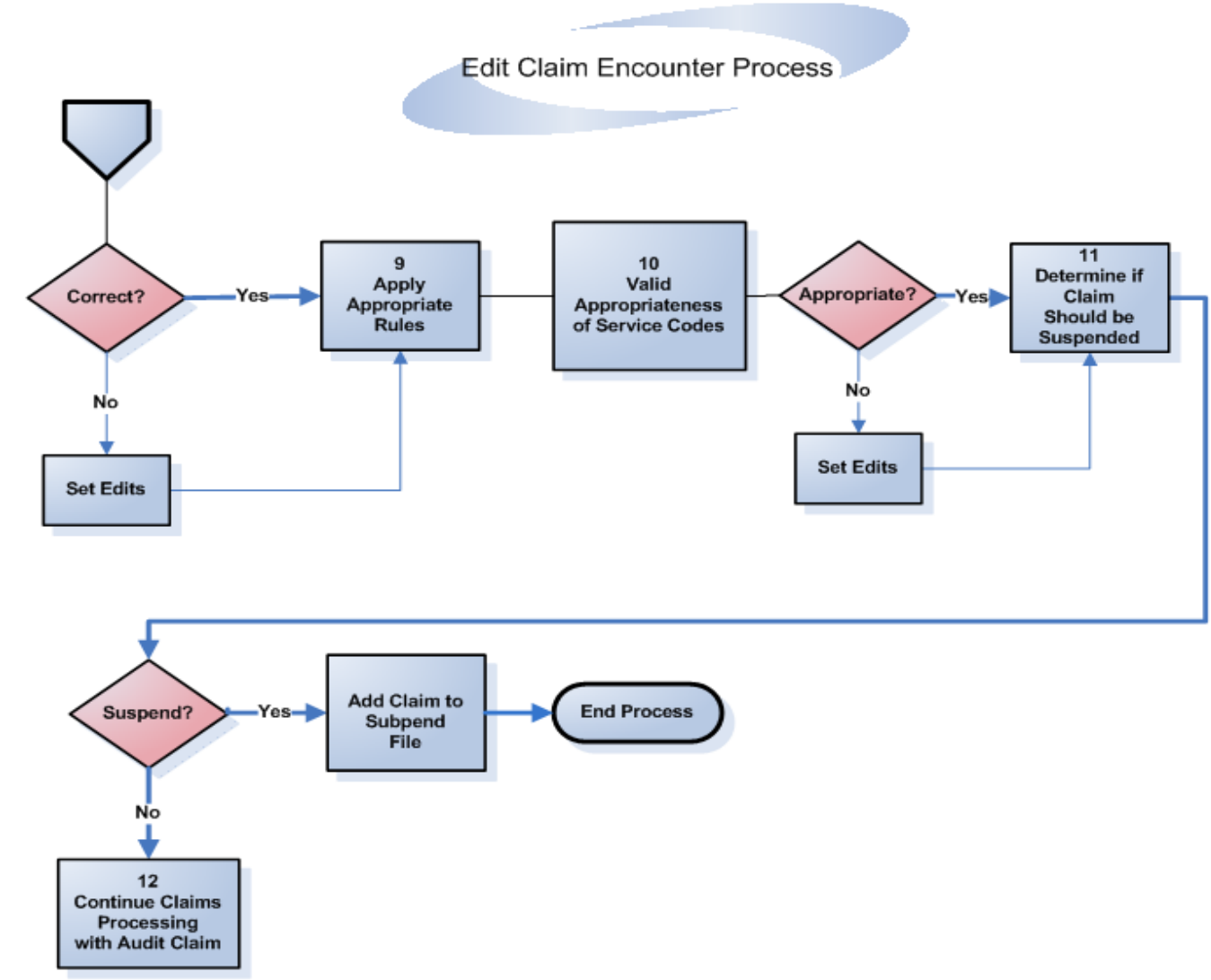
8.7.1 Edit Claims-Encounter Process Business Process Model

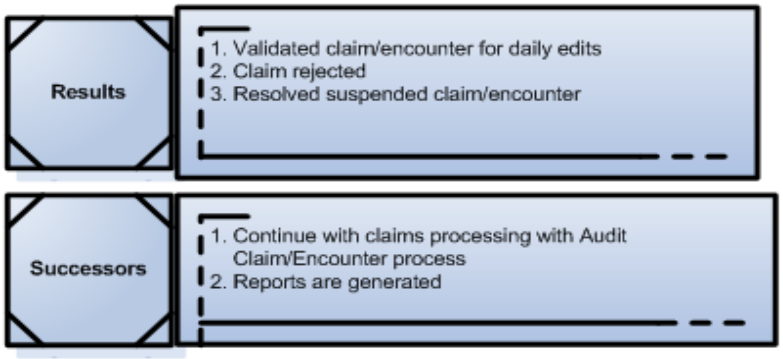
Item	Details
Description	The **Edit Claims-Encounter** business process receives an original or an adjustment claim/encounter data set. 1. Determines its submission status 2. Validates edits, service coverage, TPL, coding
Trigger Event	A claim/encounter received
Result	1. Validated claim/encounter for daily edits 2. Claim rejected 3. Resolved suspended claim/encounter
Business Process Steps	1. Receive claim/encounter 2. Determine status as initial or adjustment to a processed claim/encounter a. If Yes initial, Process initial claims edits as defined in the system and global edits. Proceed to Step 3 b. If No adjustment, Process adjustment claims edits as defined in the system global edits. Proceed to Step 3 3. Check for duplicate submission that is already in the adjudication process but not yet completed and loaded into payment history a. If Yes duplicate, Set duplicate edits. Proceed to step 4 b. If No, proceed to Step 4 4. Check whether the claim/encounter submission is beyond filing deadlines based on service dates a. If Yes beyond deadline, Set Filing deadline edits. Proceed to Step 5 b. If No deadline not met, proceed to Step 5 5. Validate that provider information in edited fields, e.g., provider taxonomy, NPI, enrollment status, is correct and approved to bill for this service a. If Yes correct and approved, proceed to Step 6 b. If Not valid, Set provider edits. Proceed to Step 6 6. Validate that member information in edited fields, e.g., Member's eligibility status on the date of service is correct a. If Yes, proceed to Step 7 b. If Not valid, Set member edits. Proceed to Step 7 7. Apply Third party resources to the claim/encounter 8. Validate that service is covered by member's benefit package is correct a. If Yes, proceed to Step 9 b. If Not valid, Set member benefit edits. Proceed to Step 9 9. Apply appropriate rules 10. Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status a. If Yes valid, proceed to Step 11 b. If Not valid, Set service code edits. Proceed to Step 11 11. Determine if claim should be suspended based on the edits that were set a. If Yes claim should be suspended, Move claim information to suspense file, Process ends.

	b. If No, proceed to Step 12 12. Continue claims processing with Audit Claim
Shared Data	Provider claims information
Predecessor	Services rendered and claim submitted
Successor	1. Continue with claims processing with Audit Claim/Encounter process 2. Reports are generated
Constraints	State and Federal Rules and Regulations
Failures	Claims Rejected
Performance Measures	Time to complete Edit process: e.g., Real Time response = within .05 seconds, Batch Response = within 24 hours.

8.7.2 Edit Claims-Encounter Process Workflow




Edit Claim Encounter Process
Correct?
Yes
No
9
Apply
Appropriate
Rules
Set Edits
10
Valid
Appropriateness
of Service Codes
Appropriate?
Yes
No
Set Edits
11
Determine if
Claim
Should be
Suspended
Suspend?
Yes
No
Add Claim to
Subpend
File
End Process
12
Continue Claims
Processing
with Audit Claim

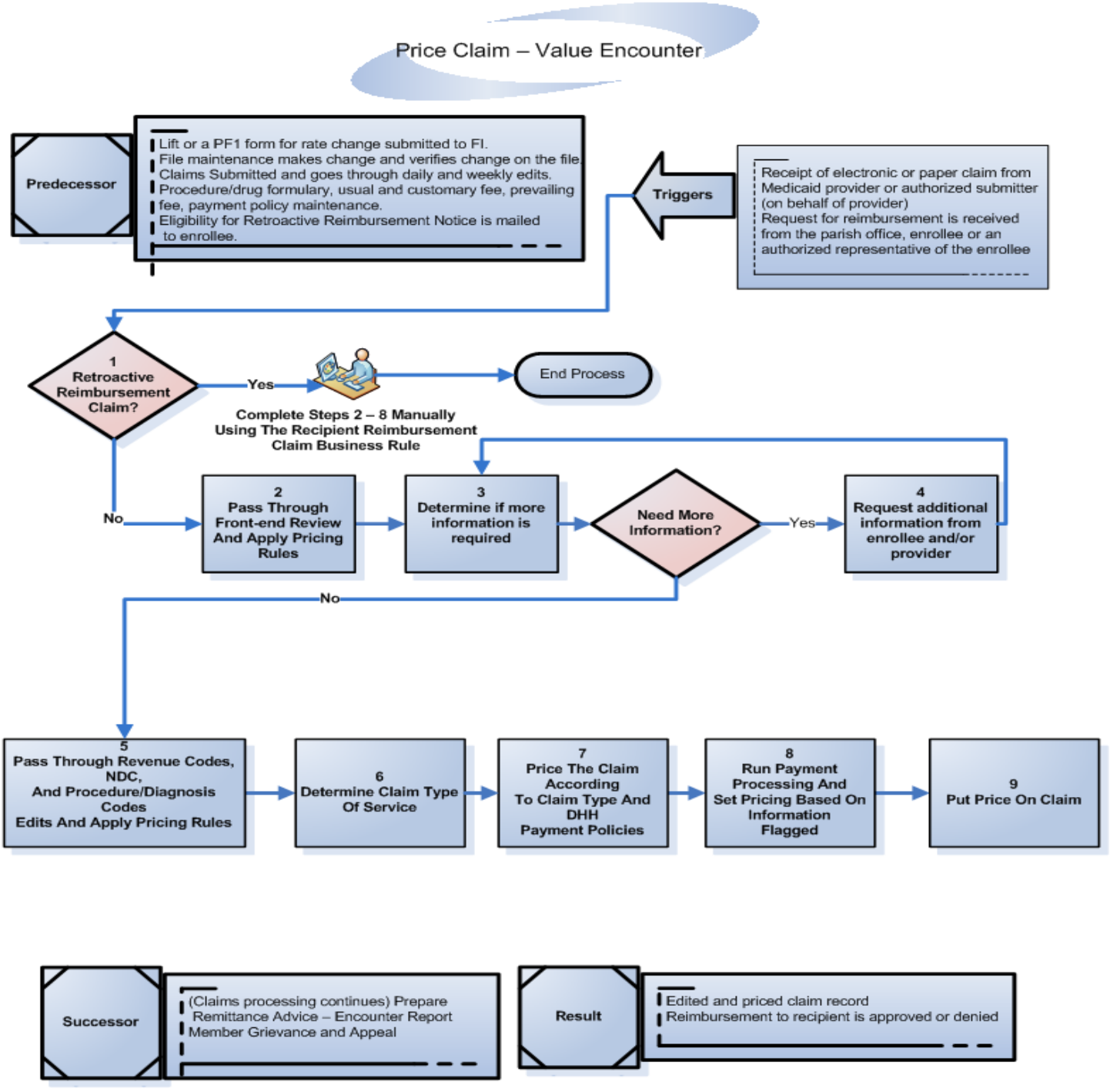

Results
1. Validated claim/encounter for daily edits
2. Claim rejected
3. Resolved suspended claim/encounter
Successors
1. Continue with claims processing with Audit Claim/Encounter process
2. Reports are generated

8.8 Price Claim – Value Encounter

8.8.1 Price Claim – Value Encounter Business Process Model

Item	Details
Description	The Price Claim – Value Encounter business process business process begins with receiving a claim/encounter data set from the Edits and Audits process, applying pricing algorithms, calculates managed care decrements service review authorizations, calculates and applies member contributions, and provider advances, deducts liens and recoupment's. This process is also responsible for ensuring that all adjudication events are documented in payment history.
Trigger Event	1. Receipt of electronic or paper claim from Medicaid provider or authorized submitter (on behalf of provider) 2. Request for reimbursement is received from the parish office, enrollee or an authorized representative of the enrollee
Result	1. Edited and priced claim record 2. Reimbursement to recipient is approved or denied
Business Process Steps	1. If Retroactive Reimbursement process a If Yes, complete Steps 2 thru 9 manually using the retroactive reimbursement business rules b If no, proceed to Step 2 2. Pass through front-end review/edits and apply pricing rules when applicable 3. Determine if more information is required a If Yes, go to Step 4 b If No, go to Step 5 4. Request additional information from enrollee and/or provider, go to step 3 5. Pass through revenue codes, NDC, and procedure/diagnosis codes edits and apply pricing rules when applicable 6. Determine claim type of service (TOS) for the non-denied claim 7. Price the claim according to claim type and DHH payment policy using procedure/drug formulary, provider usual and customary fee file, prevailing fee file (Medicare), or other payment rules, as appropriate 8. Run payment processing and set pricing based on information flagged on edit, audit, and TOS rules 9. Put price on claim
Shared Data	1. TPL Information 2. Verification of Payment 3. Medical Service Verification
Predecessor	1. Lift or a PF1 form for rate change submitted to FI. File maintenance makes change and verifies change on the file. 2. Claims Submitted and goes through daily and weekly edits. 3. Procedure/drug formulary, usual and customary fee, prevailing fee, payment policy maintenance 4. Eligibility for Retroactive Reimbursement Notice is mailed to enrollee
Successor	1. (Claims processing continues) Prepare Remittance Advice – Encounter Report 2. Member Grievance and Appeal
Constraints	1. Federal and State Rules and Regulations 2. Provider not willing to or unable (Ex. Katrina) to provide requested information
Failures	Claim is rejected
Performance Measures	None

8.8.2 Price Claim – Value Encounter Workflow

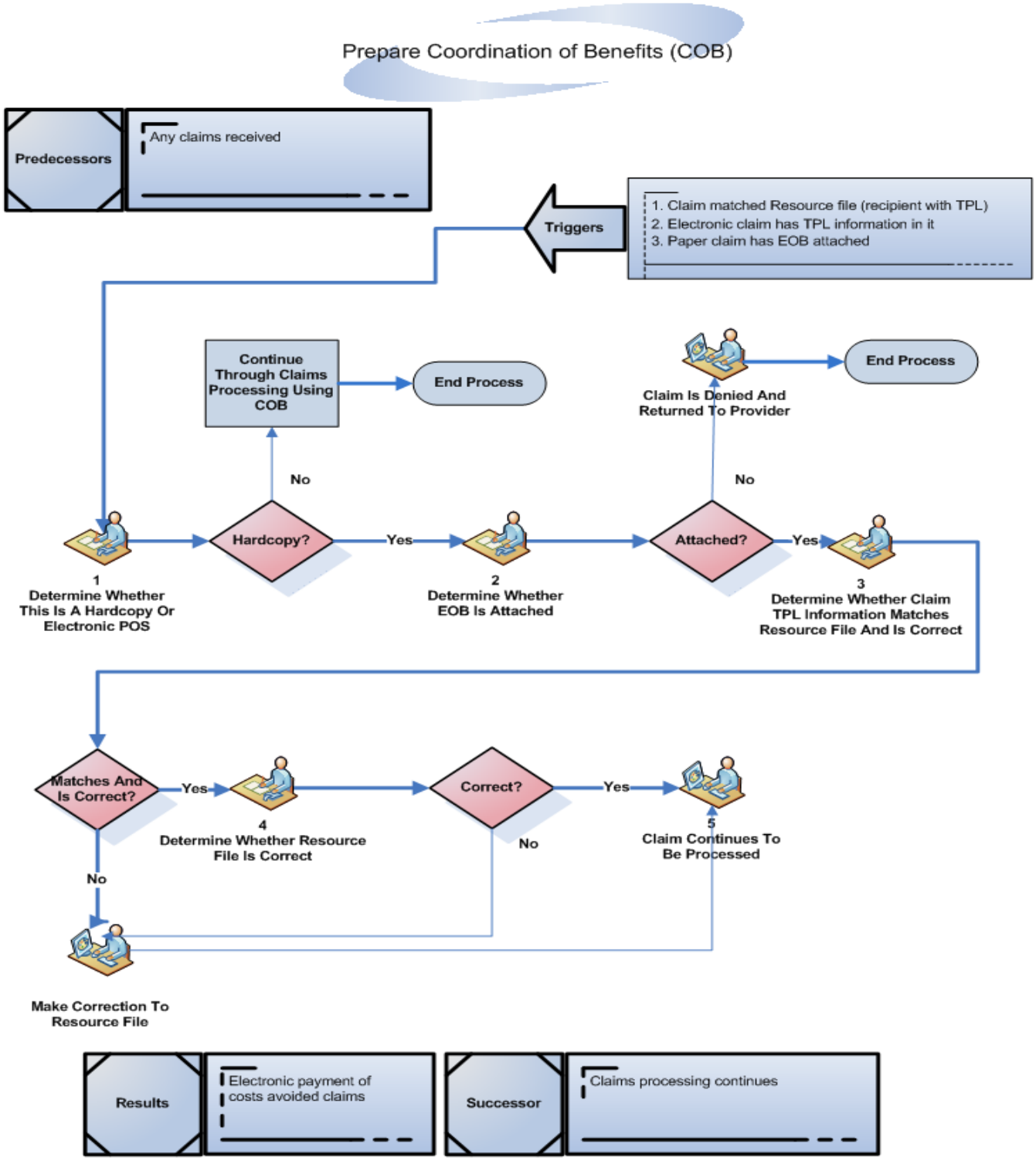


8.9 Prepare Coordination of Benefits (COB) Attachment

8.9.1 Prepare COB Business Process Model

Item	Details
Description	The **Prepare Coordination of Benefits (COB)** business process describes the process used to identify and prepare EDI and paper claim transactions that are submitted by the provider with third party liability or our Resource file indicates that TPL exists for the recipients.
Trigger Event	1. Claim matched Resource file (recipient with TPL) 2. Electronic claim has TPL information in it 3. Paper claim has EOB attached
Result	Electronic payment of cost avoided claims
Business Process Steps	1. Determine whether this is a hard Copy or Electronic and POS a. If Yes hardcopy, proceed to Step 2 b. If No electronic and POS, continue through Claims Processing using COB Information in Electronic Transaction. 2. Determine whether EOB is attached a. If Yes, proceed to Step 3 b. If No, Claim is denied and returned to provider. 3. Determine whether Claim TPL Information matches resource file and is correct a. If Yes, proceed to Step 4 b. If No, Make correction to resource file. Proceed to Step 5 4. Determine whether resource file correct a. If Yes, proceed to Step 5 b. If No, Make correction to resource file. Proceed to Step 5 5. Claim continues to be processed.
Shared Data	1. Data from carrier 2. Medicare claims data 3. TRICARE DEERS
Predecessor	Any claims received
Successor	Claims processing continues
Constraints	Federal and State rules and regulations
Failures	None
Performance Measures	None

8.9.2 Prepare COB Workflow

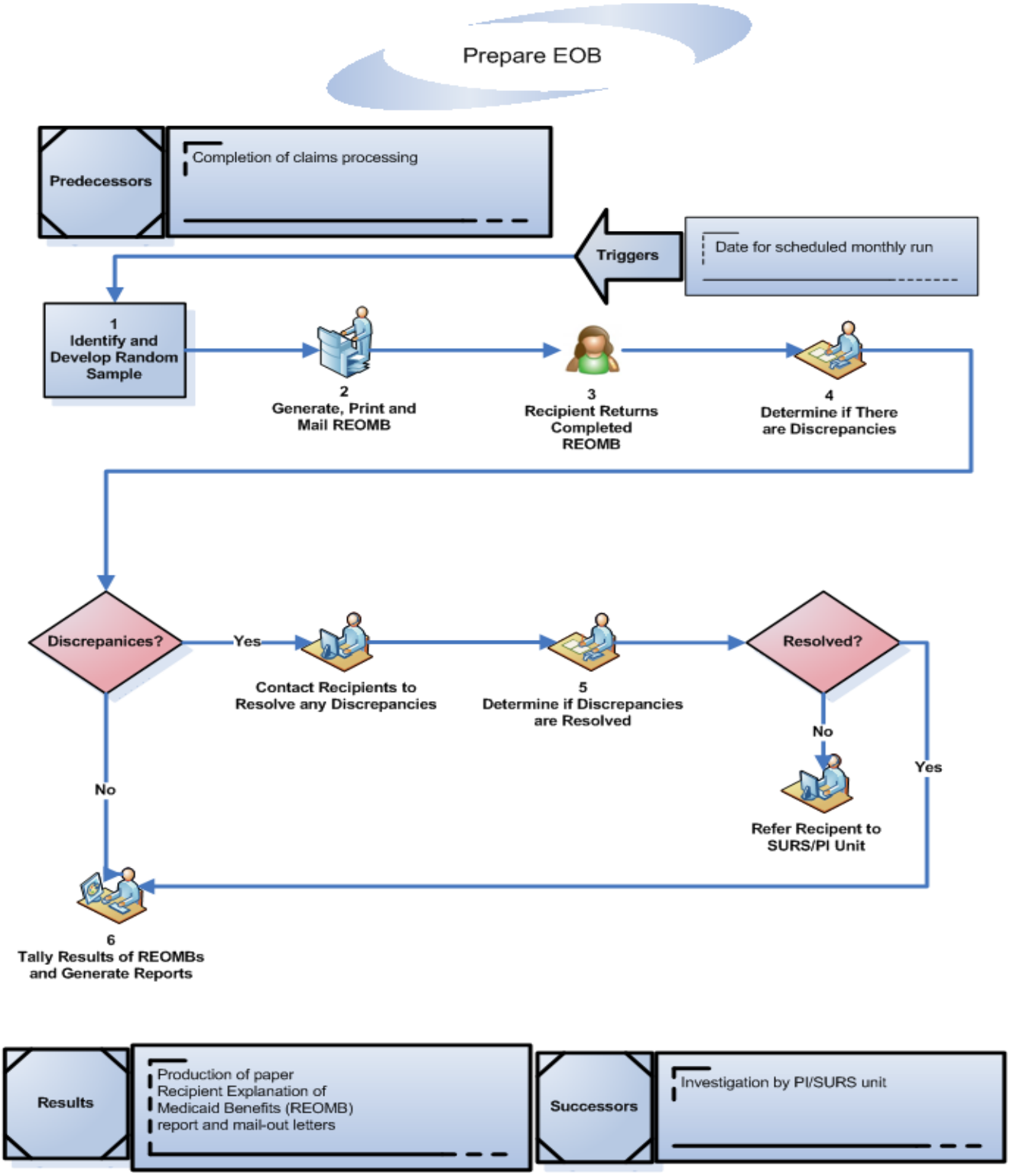


8.10 Prepare Explanation of Benefits (EOB)

8.10.1 Prepare EOB Business Process Model

Item	Details
Description	The **Prepare Explanation of Benefits** (EOB) business process includes the preparation of the explanation of benefit (EOB).
Trigger Event	Date for scheduled monthly run
Result	Production of paper REOMB report and mail-out letters (REOMB=recipient explanation of Medicaid benefit).
Business Process Steps	1. Identify/develop random sample 2. Generate, print and mail REOMB for the sampling of recipients who had one or more paid claims during the most recent processing month 3. Recipient returns completed REOMB 4. Determine if there are discrepancies a. If Yes, contact recipients to resolve any discrepancies. Proceed to Step 5 b. If No, proceed to Step 6 5. Determine if discrepancies are resolved a. If Yes, proceed to Step 6 b. If Not, Refer Recipient to SURS/PI unit. Process ends 6. Tally results of REOMBs and generate report
Shared Data	1. Medical information 2. Verification of payment for services
Predecessor	Completion of claims processing
Successor	Investigation by PI/SURS unit
Constraints	State and Federal rules and regulations
Failures	None
Performance Measures	None

8.10.2 Prepare EOB Workflow

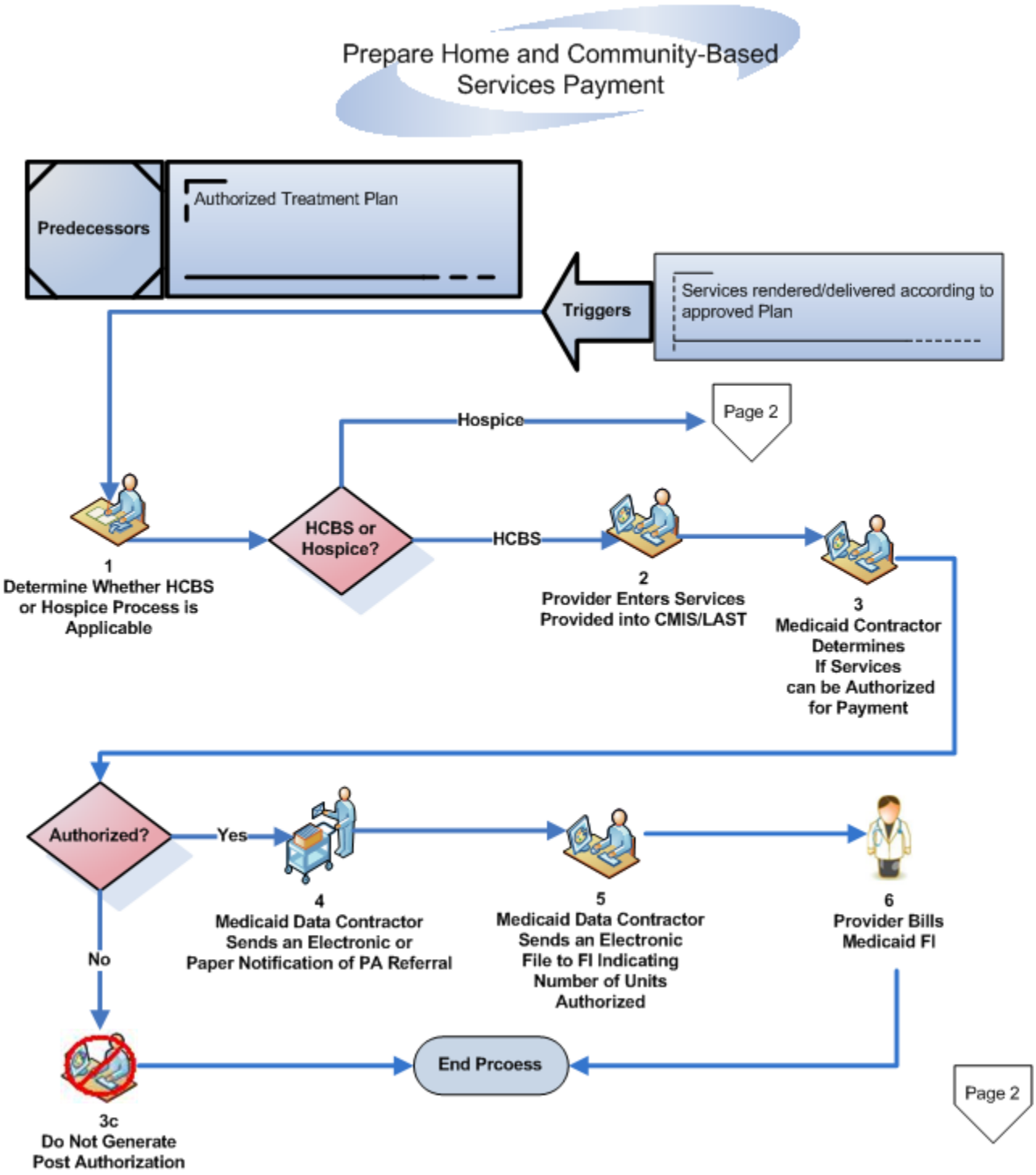


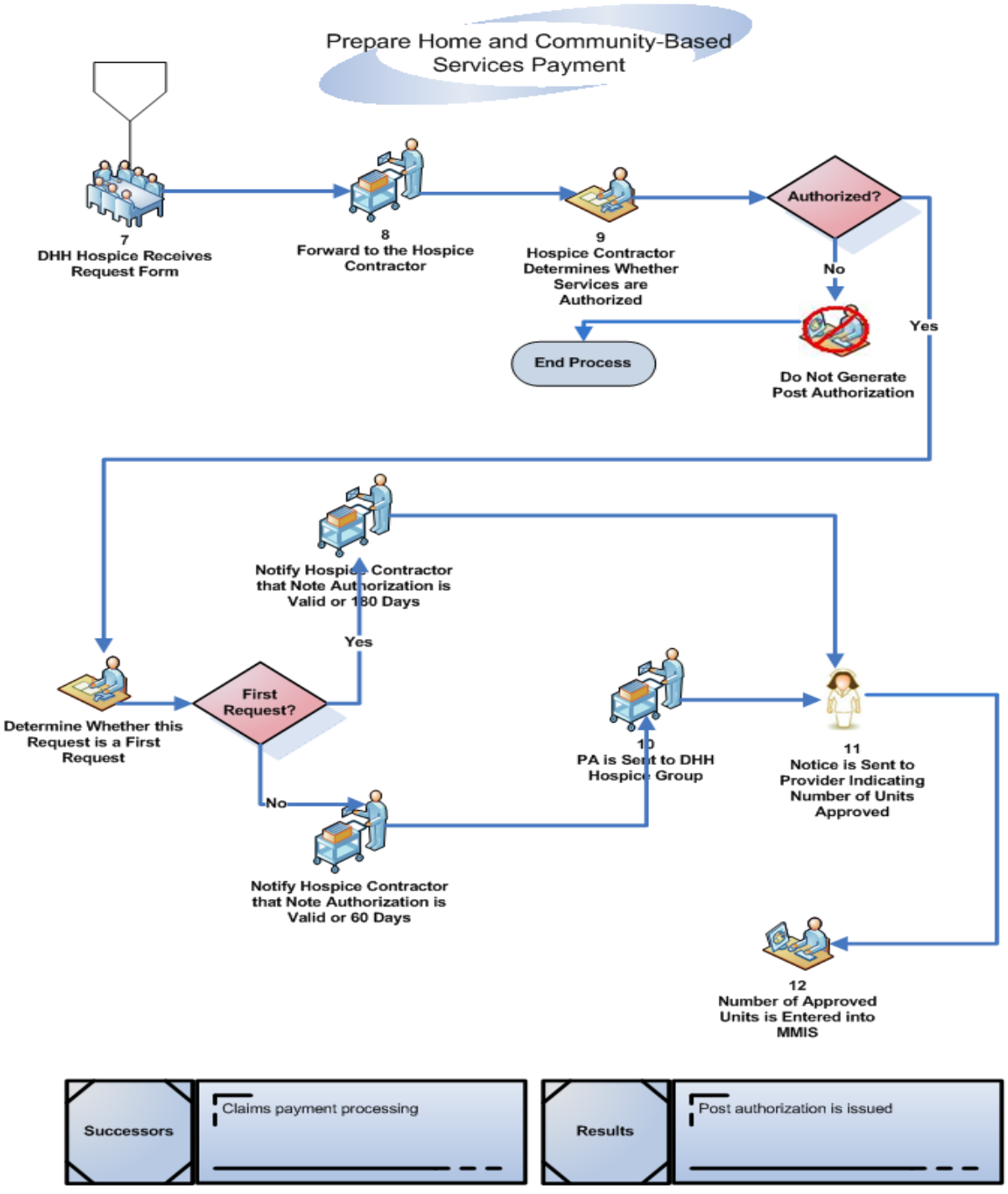
8.11 Prepare Home and Community-Based Services (HCBS) Payment

8.11.1 Prepare HCBS Payment Business Process Model

Item	Details
Description	The ***Prepare Home and Community-Based Services Payment*** business process describes the preparation of the payment authorization data. All waiver services and targeted case management services require prior authorization, which is transmitted through the Medicaid data contractor. All case management providers are required to enter data into the Case Management Information System (CMIS) and direct service providers are required to enter data into the Louisiana Service Tracking (LAST) system.
Trigger Event	Services rendered/delivered according to approved Plan
Result	Post authorization is issued
Business Process Steps	1. Determine whether the HCBS or Hospice process is applicable a. If HCBS process applicable, proceed to Step 2 b. If Hospice process applicable, proceed to Step 7 2. Provider enters services provided into CMIS/LAST 3. Medicaid data contractor determines if services can be authorized for payment based on specific programmatic business rules a. If Yes authorized, proceed to Step 4 b. If No, Do not generate post authorization. Process ends. 4. Medicaid data contractor sends an electronic or paper notification of the Pre-Authorized referral (PA) to the provider. 5. Medicaid data contractor sends an electronic file to the Fiscal Intermediary (Fl) indicating the number of units authorized. 6. Provider bills Medicaid Fl. Process ends 7. DHH hospice group receives request form 8. Forward to the Hospice contractor who determines if the services are authorized based on the rules 9. Is the request authorized? a. If Yes, determine whether this request is a first request i. If Yes, Notify Hospice contractor that note authorization is valid for 180 days, proceed to step 11 ii. If No, Notify Hospice contractor that note authorization is valid for 60 days, proceed to step 10 b. If No, do not generate post authorization. Process ends. 10. PA is sent to DHH hospice group from hospice contractor 11. Notice is sent to the provider indicating number of units approved and when the next package is due 12. Number of approved units is entered into MMIS by the DHH hospice group
Shared Data	None
Predecessor	Authorized Treatment Plan
Successor	Claims payment processing
Constraints	State and federal rules and regulations
Failures	None
Performance Measures	None

8.11.2 Prepare HCBS Payment Workflow



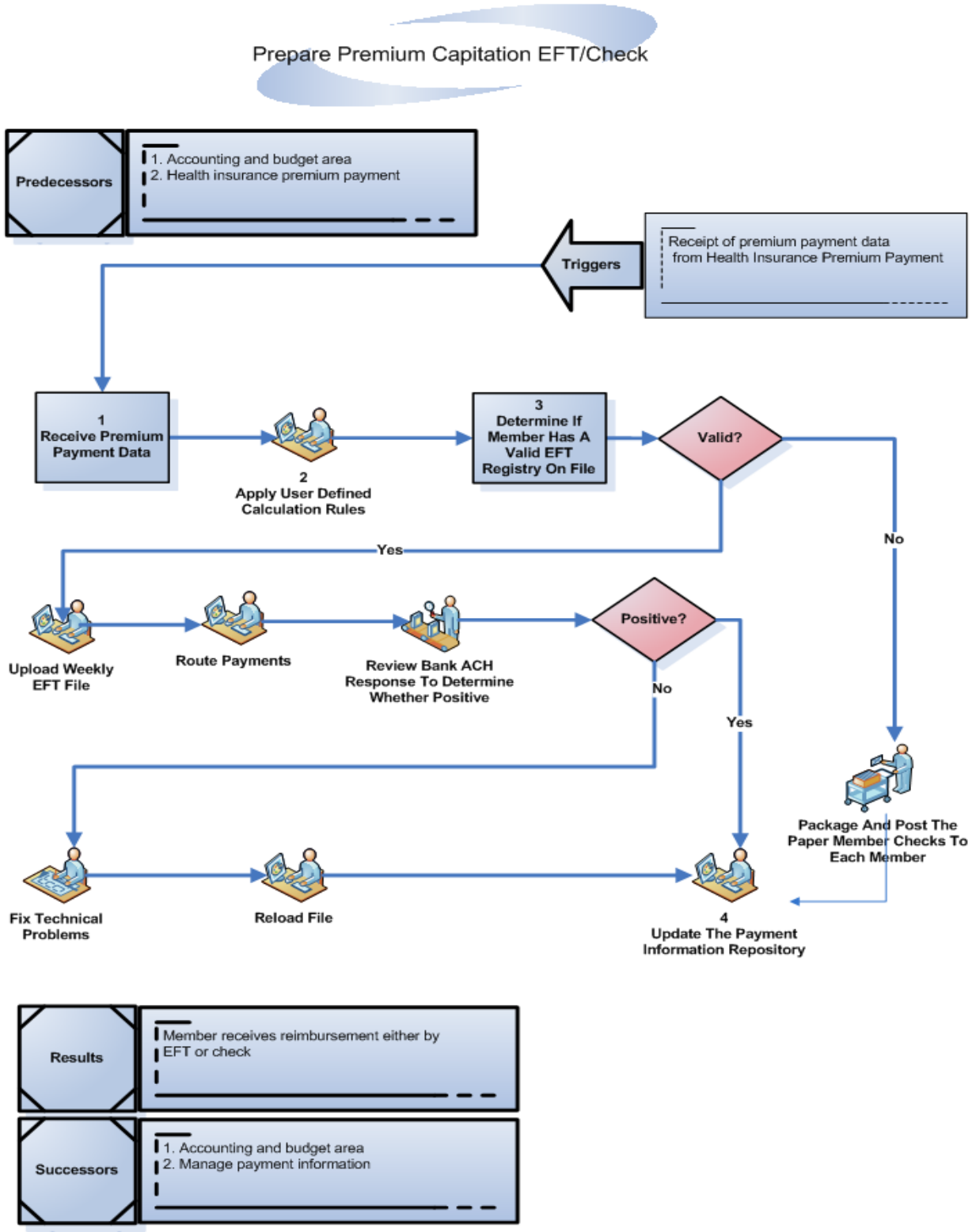

Prepare Home and Community-Based Services Payment
7
DHH Hospice Receives Request Form
8
Forward to the Hospice Contractor
9
Hospice Contractor Determines Whether Services are Authorized
Authorized?
No
Yes
End Process
Do Not Generate Post Authorization
Notify Hospice Contractor that Note Authorization is Valid or 180 Days
Yes
Determine Whether this Request is a First Request
First Request?
No
Notify Hospice Contractor that Note Authorization is Valid or 60 Days
10
PA is Sent to DHH Hospice Group
11
Notice is Sent to Provider Indicating Number of Units Approved
12
Number of Approved Units is Entered into MMIS
Successors
Claims payment processing
Results
Post authorization is issued

8.12 Prepare Premium Capitation EFT-Check

8.12.1 Prepare Premium Capitation EFT-Check Business Process Model

Item	Details
Description	The **Prepare Premium Capitation EFT-Check** business process is responsible for managing the generation of electronic and paper based reimbursement instruments including: 1. Calculation of LaHIPP premiums based on members' premium payment data in the Member Registry 2. Disbursement of premiums from appropriate funding sources per Agency Accounting and Budget Area rules 3. Routing the payment per the Member Registry payment instructions for electronic fund transfer (EFT) or check generation 4. Transferring the data set to State Fiscal Management for actual payment transaction 5. Perform updates the State Financial Management business processes with pending and paid premiums tying all transactions back to a specific payment obligation and its history.
Trigger Event	Receipt of premium payment data from Health Insurance Premium Payment
Result	Member receives reimbursement either by EFT or Check
Business Process Steps	1. Receive premium payment data from the Prepare Health Insurance Premium Payment business process 2. Apply automated or user defined calculation rules based on member eligibility data and calculate payment 3. Determine if member has a valid EFT registry on file a. If Yes, on file, i. Upload weekly EFT file on automated clearing house (ACH) via DHH bank record ii. Route payments as specified by the "pay to" instruction in the member registry. iii. Review bank ACH response to EFT upload to determine whether positive 1. If response positive, proceed to Step 4 2. If response negative, a. Fix technical problems b. Reload file. Proceed to Step 4 b. If Not on file, Package and post the paper member checks to each member. Proceed to Step 4 4. Update the Payment Information Repository, the Perform Accounting Function, and State Financial Management business process
Shared Data	1. Bank information 2. State Financial Management
Predecessor	1. Accounting and Budget Area 2. Health Insurance Premium Payment
Successor	1. Accounting and Budget Area 2. Manage Payment Information
Constraints	None
Failures	Calculation of payment and application of payment adjustments may lack accurate information or be performed inaccurately
Performance Measures	None

8.12.2 Prepare Premium Capitation EFT-Check Workflow



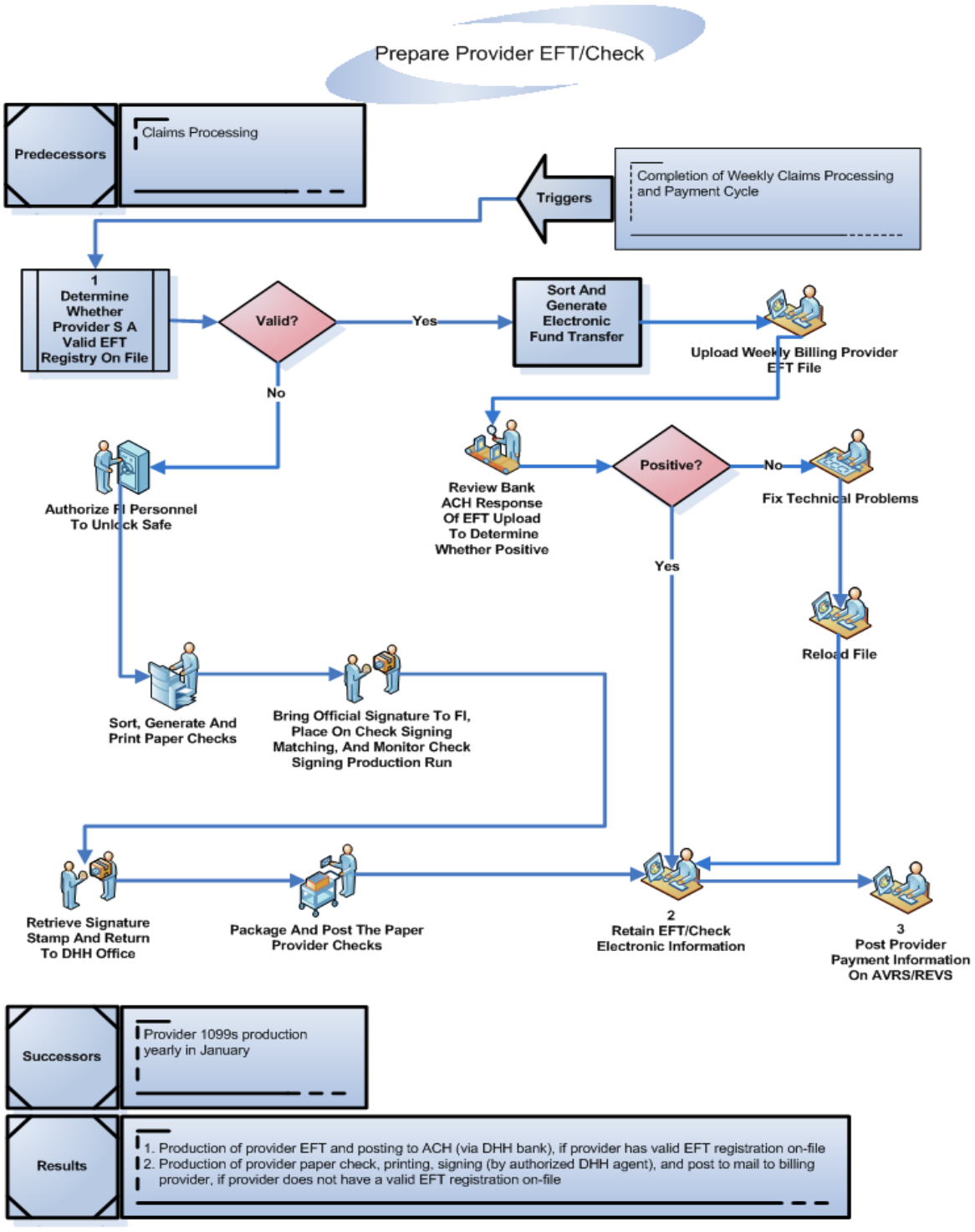
8.13 Prepare Provider EFT-Check

8.13.1 Prepare Provider EFT-Check Business Process Model

Item	Details
Description	The **Prepare Provider EFT/Check** business process model is responsible for the preparation of the provider EFT or check.
Trigger Event	Completion of weekly claims processing and payment cycle
Result	1. Production of provider EFT and posting to ACH (via DHH bank), if provider has valid EFT registration on-file 2. Production of provider paper check, printing, signing (by authorized DHH agent), and post to mail to billing provider, if provider does not have a valid EFT registration on-file
Business Process Steps	1. Determine whether provider has a valid EFT registry on file a. If Yes, EFT on registry, i. Sort and generate electronic fund transfer (EFT) transaction records based on published ACH guidelines ii. Upload weekly billing provider EFT file to automated clearinghouse via DHH bank or record iii. Review bank ACH response of EFT upload to determine if positive 1. If response is Yes, proceed to Step 2 2. If response is No, a. fix financial problem b. Reload File c. Proceed to Step 2 b. If No EFT, i. Authorize FI personnel to unlock safe to retrieve check stock appropriate for the weekly cycle. Once the appropriate check stock volume is retrieved, the safe (with the remaining unused check stock) is locked. Check stock is pre-printed with check number. ii. Sort, generate, and print paper checks. Check number that is printed on each check during this print process must coincide with pre-printed number on check stock. iii. DHH authorized agent brings the official signature stamp to FI, places it on the automated check signing matching, and monitors the check signing production run. iv. The agent retrieves the signature stamp and returns with it to DHH offices. v. Package and post the paper provider checks to each billing provider, when appropriate. Proceed to Step 2. 2. Retain EFT/check electronic information by provider and date of payment on the appropriate file archive and back-up 3. Post provider payment information on AVRS/REVS: automated voice response system / recipient eligibility verification system, to be made available for provider review each Monday morning
Shared Data	Bank ACH information
Predecessor	Claims processing
Successor	Provider 1099s production, yearly in January

Item	Details
Constraints	1. ACH Guidelines 2. Federal and State guidelines
Failures	BBS for bank ACH is unavailable to upload provider EFT transactions
Performance Measures	None

8.13.2 Prepare Provider EFT-Check Workflow

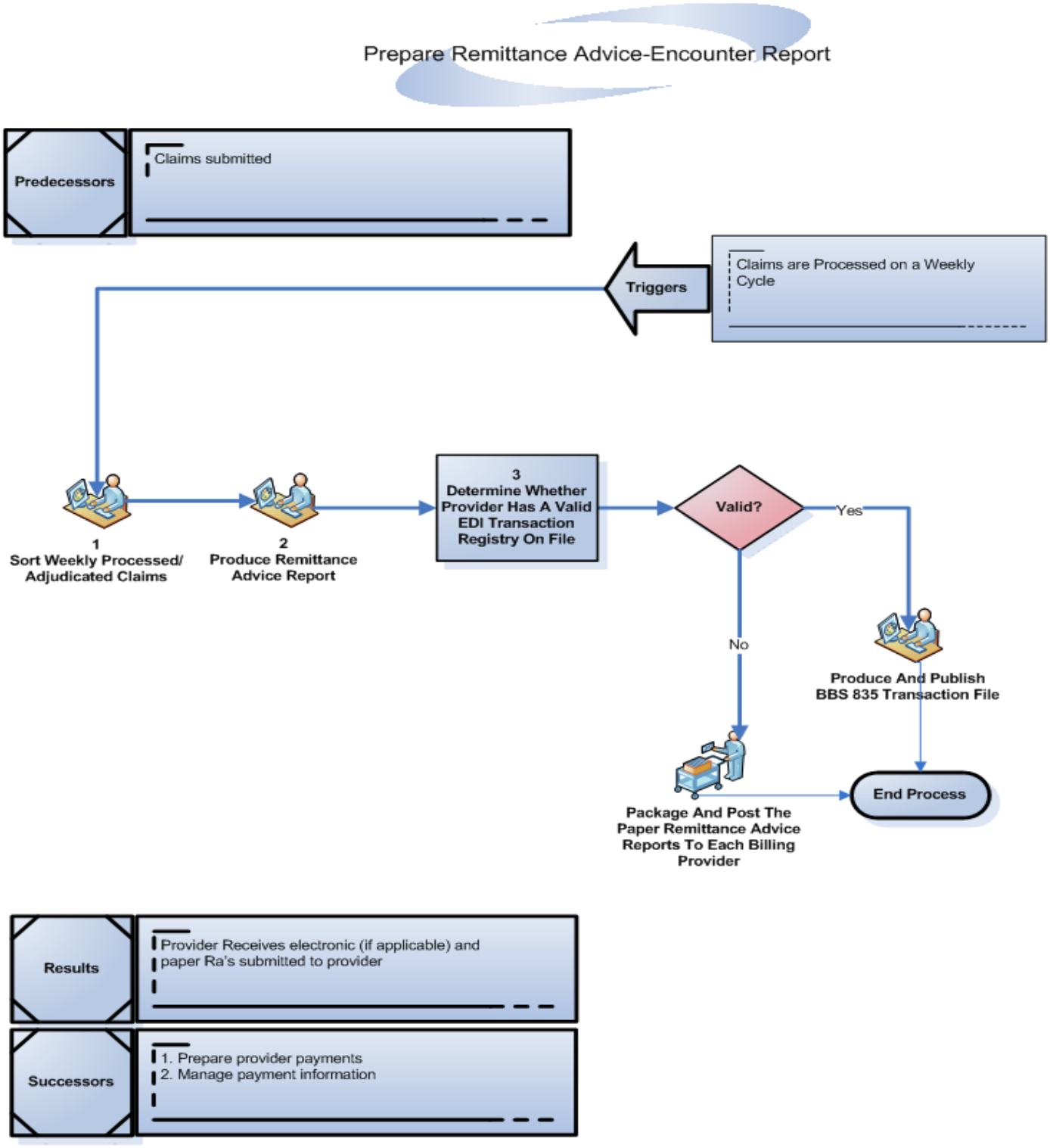


8.14 Prepare Remittance Advice-Encounter Report

8.14.1 Prepare Remittance Advice-Encounter Report Business Process Model

Item	Details
Description	The **Prepare Remittance Advice-Encounter Report** business process model is responsible for preparation of the provider remittance advice (RA) based on Louisiana Medicaid claim processing policies and rules.
Trigger Event	Claims are processed on a weekly cycle.
Result	Provider receives electronic (if applicable) and paper RA 's submitted to the provider
Business Process Steps	1. Sort weekly processed/adjudicated claims by billing provider 2. Produce remittance advice report (proprietary La Medicaid format) for each billing provider with claims processed during the weekly cycle 3. Determine if the provider has a valid EDI Transaction registry on file a. If Yes EDI on file, Produce and publish BBS 835 transaction file for authorized providers (approved by DHH). Process ends b. If No EDI registered, Package and post the paper remittance advice reports to each billing provider. Process ends
Shared Data	None
Predecessor	Claims submitted
Successor	1. Prepare Provider Payments 2. Manage Payment Information
Constraints	None
Failures	Systems problems
Performance Measures	None

8.14.2 Prepare Remittance Advice-Encounter Report Workflow

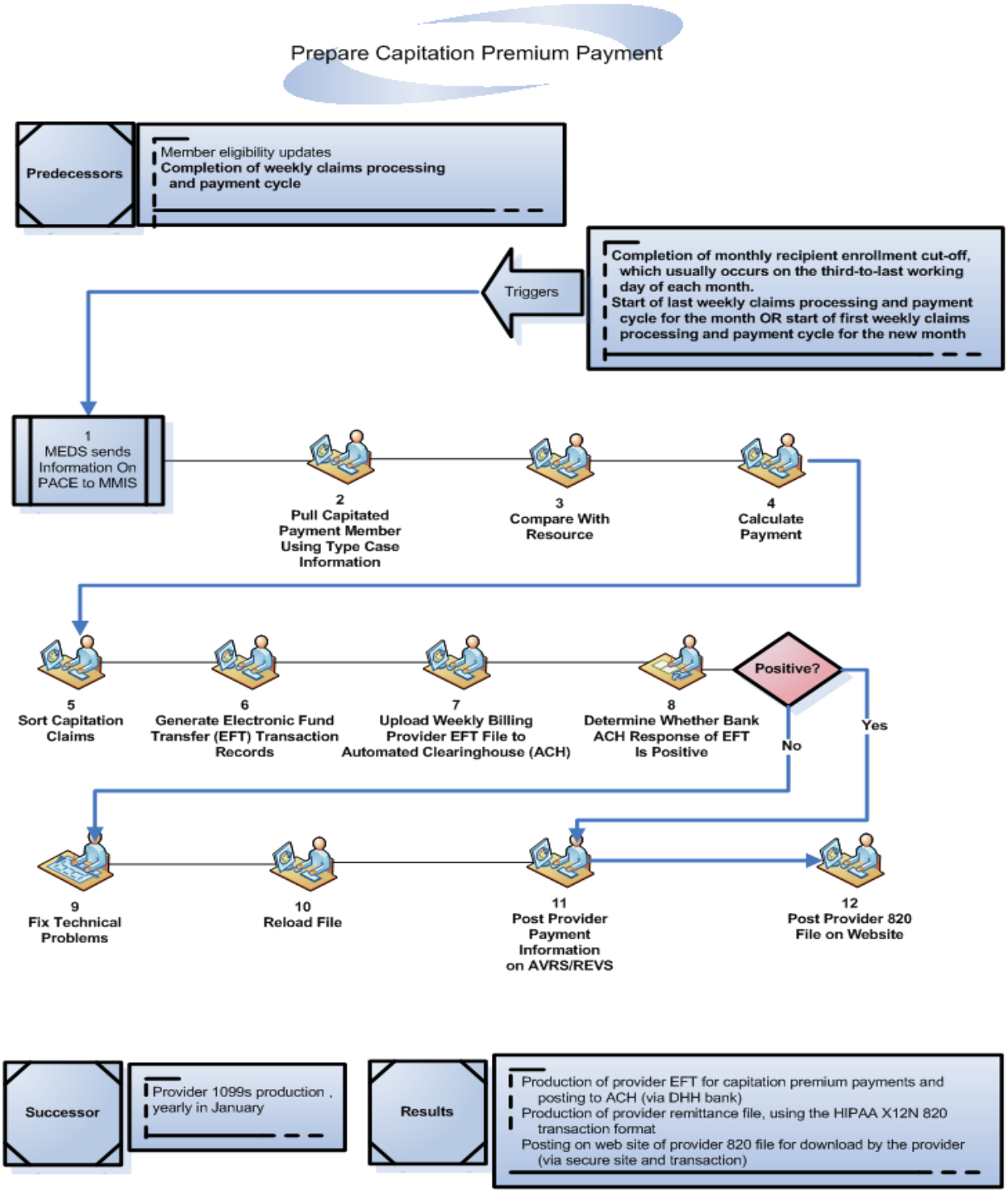


8.15 Prepare Capitation Premium Payment

8.15.1 Prepare Capitation Premium Payment Business Process Model

Item	Details
Description	The **Prepare Capitation Premium Payment** business process is responsible for preparing the prospective capitation premium payment.
Trigger Event	1. Completion of monthly recipient enrollment cut-off, which usually occurs on the third-to-last working day of each month 2. Start of last weekly claims processing and payment cycle for the month OR start of first weekly claims processing and payment cycle for the new month. This is dependent on item 1 above
Result	1. Production of provider EFT for capitation premium payments and posting to ACH (via DHH bank) 2. Production of provider remittance file, using the HIPAA X12N 820 transaction format 3. Posting on web site of provider 820 file, for download by the provider (via secure site and transaction)
Business Process Steps	1. MEDS sends information on PACE to MMIS 2. Pull capitated payment member via System using type case information 3. Compare with resource 4. Calculate payment by using information from the resource file and the procedure files 5. Sort capitation claims processed during the weekly CP cycle 6. Generate electronic fund transfer (EFT) transaction records based on published ACH guidelines 7. Upload weekly billing provider EFT file to automated clearing house (ACH) via DHH bank of record 8. Determine whether bank ACH response of EFT upload is positive a. If Yes upload is positive, proceed to Step 11 b. If No, proceed to Step 9 9. Fix technical problems 10. Reload file 11. Post provider payment information on Automated Voice Response System/Recipient Eligibility Verification System (AVRS/REVS) 12. Post providers 820 file on website
Shared Data	None
Predecessor	1. Member eligibility updates 2. Completion of weekly claims processing and payment cycle
Successor	Provider 1099s production, yearly in January
Constraints	1. Providers are required to utilize EFT 2. State and Federal Rules and Regulations
Failures	BBS for bank ACH is unavailable to upload provider EFT transactions
Performance Measures	Process EFT and 820 transaction file each month

8.15.2 Prepare Capitation Premium Payment Workflow

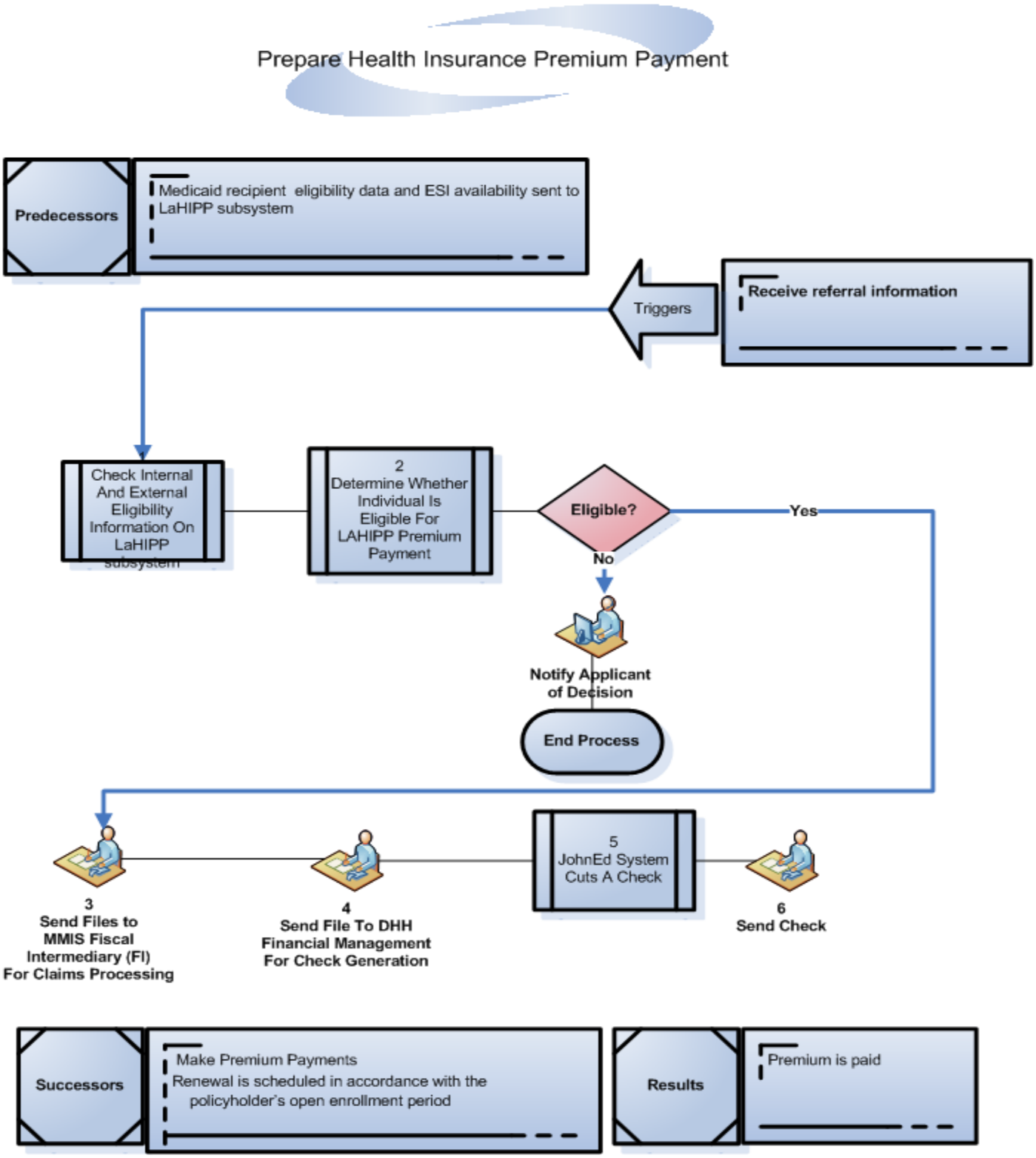


8.16 Prepare Health Insurance Premium Payment

8.16.1 Prepare Health Insurance Premium Payment Business Process Model

Item	Details
Description	The **Prepare Health Insurance Premium Payment** business process allows Medicaid to pay employer sponsored insurance (ESI) premiums for an employee and Medicaid eligible family members currently enrolled in the ESI. After a case is determined cost effective, a premium payment is prepared and sent.
Trigger Event	Receive referral information.
Result	Premium is paid
Business Process Steps	1. Check internal and external eligibility information on LaHIPP subsystem 2. Determine whether individual is eligible for LaHIPP premium payment a. If Yes, proceed to Step 3 b. If No, notify applicant of decision. End process. 3. Send file to MMIS Fiscal Intermediary (FI) for claims processing 4. Send file to DHH Financial Management Section for generation of a check for the policyholder, employer, or COBRA administrator. 5. Financial subsystem (referred to by staff as the JohnEd system) cuts the checks. 6. Send check.
Shared Data	1. Employer data 2. Insurance company data 3. External TPL databases
Predecessor	Medicaid recipient eligibility data and ESI availability sent to LaHIPP subsystem
Successor	1. Make Premium Payments 2. Renewal is scheduled in accordance with the policyholder's open enrollment period.
Constraints	State and federal rules and regulations
Failures	None
Performance Measures	Number of cases certified per year

8.16.2 Prepare Health Insurance Premium Payment Workflow

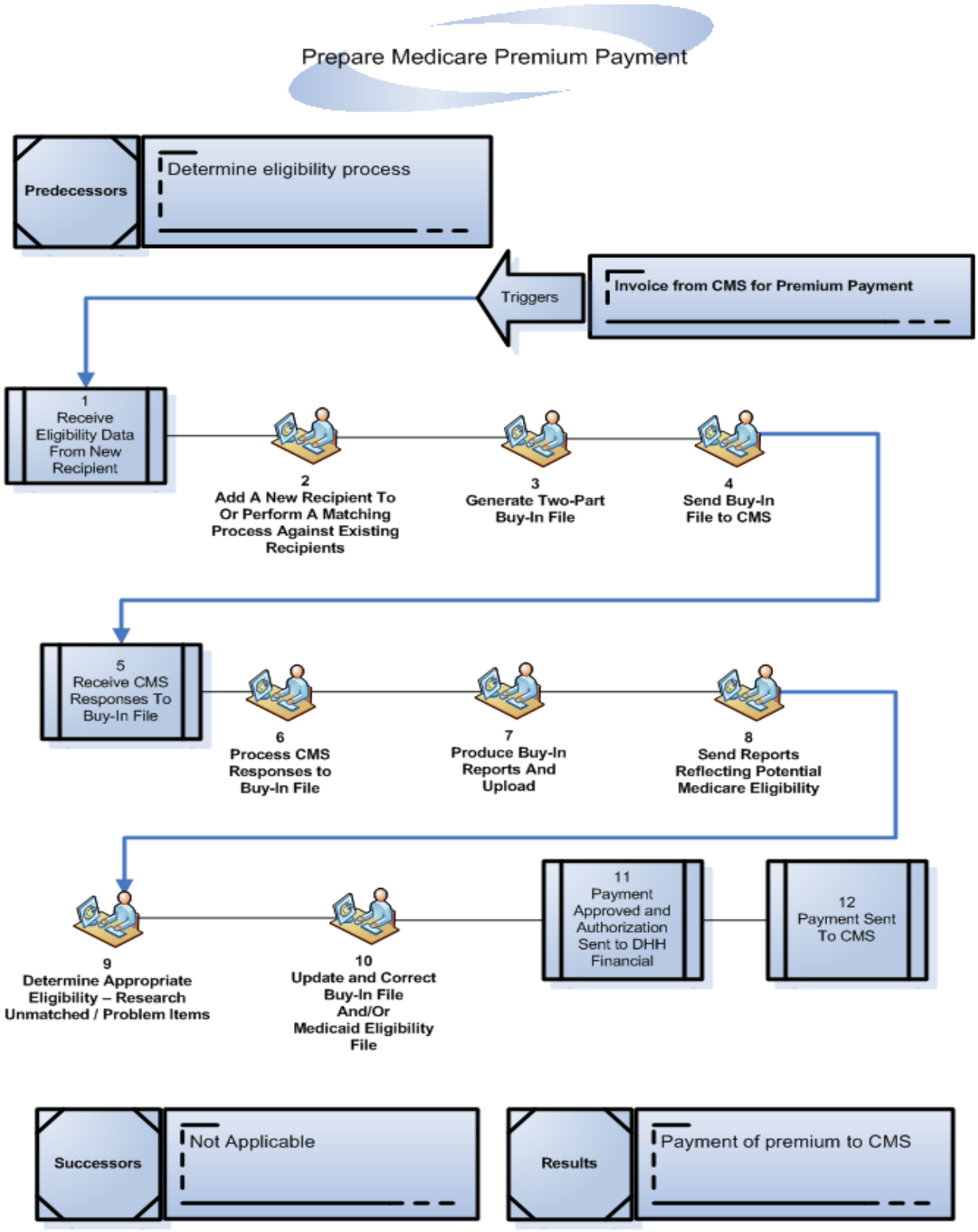


8.17 Prepare Medicare Premium Payments

8.17.1 Prepare Medicare Premium Payments Business Process Model

Item	Details
Description	State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as Buy-in. Under the Buy-in process, the Social Security Administration (SSA) and DHHS enter into a contract where the Louisiana pays the Medicare beneficiary share of premium costs. The **Prepare Medicare Premium Payments** business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This exchange is scheduled at intervals set by trading partner agreement. The process begins by input of eligibility data received from new recipients or data from Medicare that is matched against existing recipients on the Medicaid eligibility file thus generating buy-in files sent to CMS for verification and issuance of a monthly billing notice.
Trigger Event	Invoice from CMS for Premium payment
Result	Payment of premiums to CMS
Business Process Steps	1. Receive eligibility data from new recipients, Eligibility Data Base (EDB) or State Data Exchange (SDX) and Beneficiary Data Exchange (BENDEX) eligibility files 2. Add a new recipient to or perform a matching process against existing recipients on the Medicaid eligibility file/MEDS 3. Generate two-part buy-in file: one for Medicare Part A; one for Medicare Part B 4. Send Buy-in file to CMS 5. Receive CMS responses to the Buy-in file 6. Process CMS responses to the Buy-in file, assessing the file for accuracy and completeness 7. Produce buy-in reports and upload into TPL Resource file and the MEDS system 8. Send reports reflecting potential Medicare eligible, unmatched, and other problems to the Buy-in monitor 9. Research unmatched and problem items to determine appropriate eligibility 10. Update and correct Buy-in file and/or Medicaid eligibility file 11. Payment is approved and authorization is sent to DHH Financial 12. Payment sent to CMS
Shared Data	1. BENDEX 2. EDB 3. SDX
Predecessor	Determine eligibility process
Successor	Not Applicable
Constraints	Federal rules and regulations
Failures	None
Performance Measures	None

8.17.2 Prepare Medicare Premium Payments Workflow

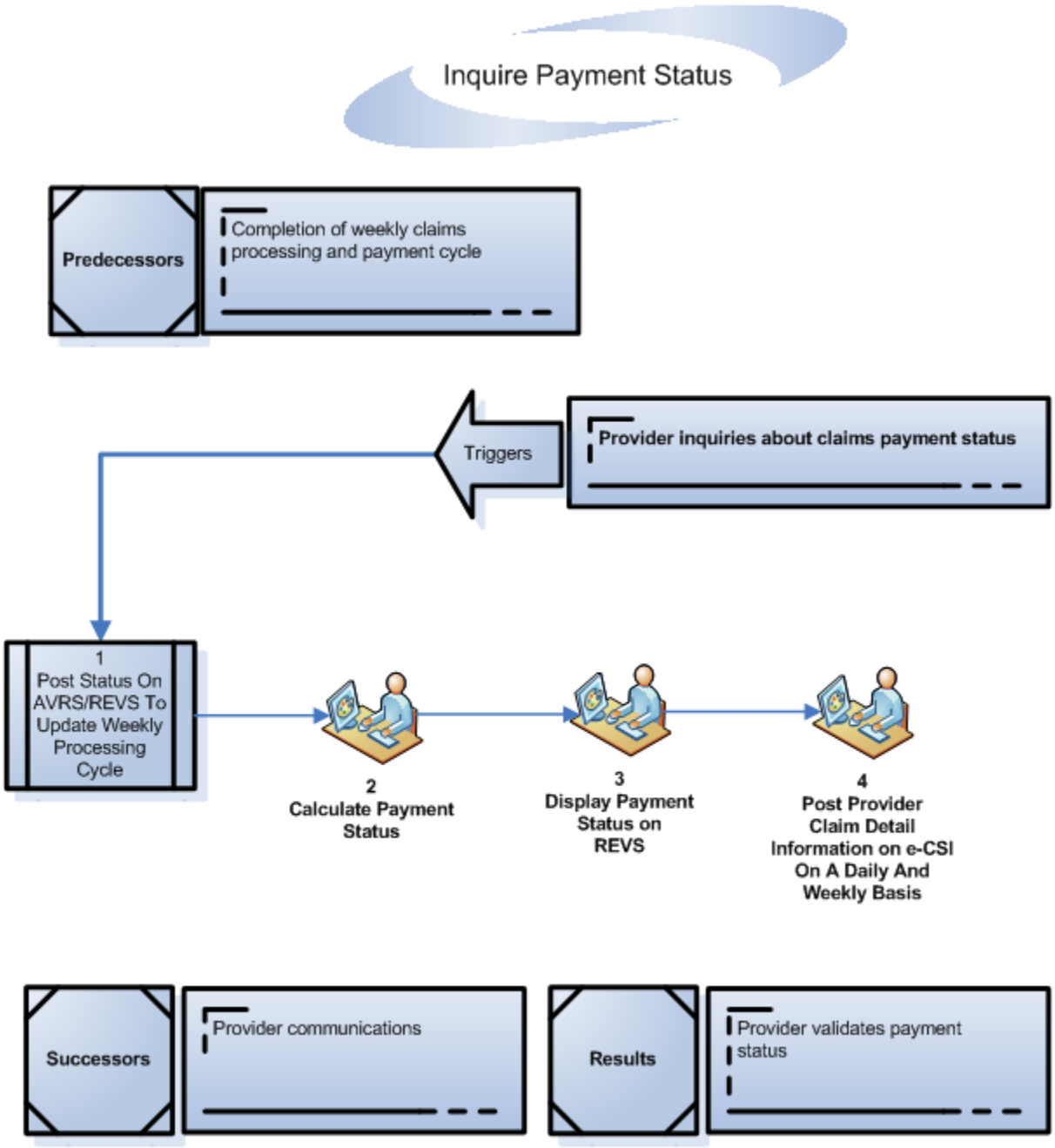


8.18 Inquire Payment Status

8.18.1 Inquire Payment Status Business Process Model

Item	Details
Description	The **Inquire Payment Status** business process allows inquiry of the payment status by billing provider in the aggregate (weekly) and by billing provider and claim ICN or recipient ID/DOS in the detail (at any time).
Trigger Event	Provider inquires about claims payment status
Result	Provider validates payment status
Business Process Steps	1. Post status on AVRS/REVS of provider payment information for the most recent weekly processing cycle 2. Calculate payment status 3. Display payment status on an aggregate basis, on REVS with its assigned check-digit provider ID 4. Post Provider claim detail information on a daily and weekly basis – with claim adjudication status – on e-CSI (electronic Claims Status Inquiry)
Shared Data	Provider security data
Predecessor	Completion of weekly claims processing and payment cycle
Successor	Provider communications
Constraints	Federal and State Rules and Regulations
Failures	Systems constraints
Performance Measures	1. Provider check information is required to be posted on REVS and made available each Monday morning. 2. Claims status information is required to be posted every evening on e-CSI after each daily CP cycle and weekly after each weekly CP cycle.

8.18.2 Inquire Payment Status Workflow

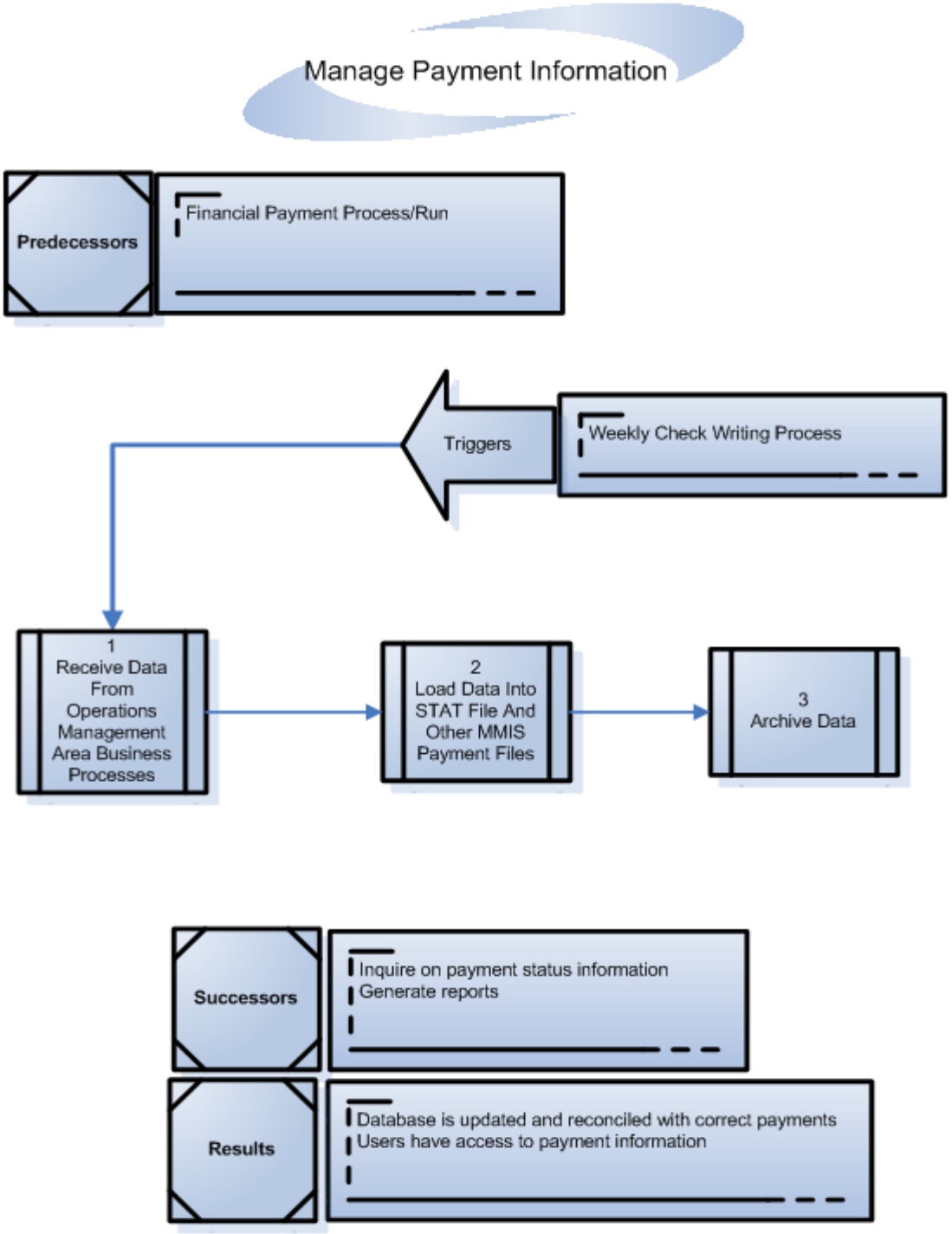


8.19 Manage Payment Information

8.19.1 Manage Payment Information Business Process Model

Item	Details
Description	The **Maintain Payment Information** business process supports the maintenance of provider payment information.
Trigger Event	Weekly Check write process
Result	1. Database is updated and reconciled with correct payments 2. Users have access to payment information
Business Process Steps	1. Receive data from Operations Management Area business processes 2. Load data into the STAT file and other MMIS payment files, building new records and updating, or status changes 3. Archive data in accordance with state and federal record retention requirements
Shared Data	None
Predecessor	Financial payment process/run
Successor	1. Inquire on payment status information 2. Generate reports
Constraints	State and federal rules and regulations
Failures	None
Performance Measures	None

8.19.2 Manage Payment Information Workflow

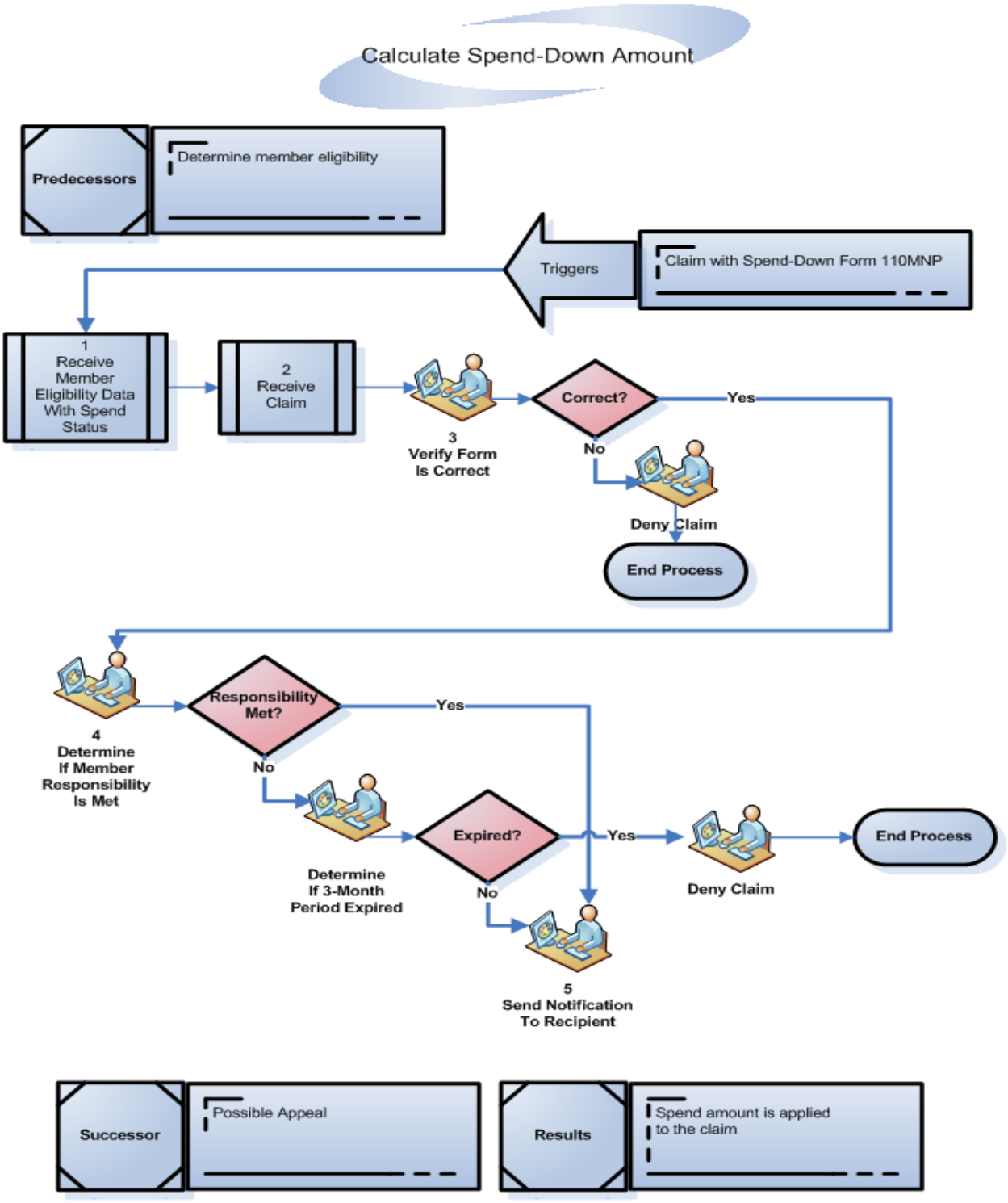


8.20 Calculate Spend-Down Amount

8.20.1 Calculate Spend-Down Amount Business Process Model

Item	Details
Description	A person that is not eligible for medical coverage when they have income and/or resources above the benefit package or program standards may become eligible for coverage through a process called "spend-down" (see Determine Eligibility). The **Calculate Spend-Down Amount** business process describes the process by which spend-down amounts are tracked and a client's responsibility is met through the submission of medical claims. Excess resources are automatically accounted for during the claims processing process resulting in a change of eligibility status once spend-down has been met which allows for Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels, but may also occur in other situations.
Trigger Event	Claim with Spend-Down Form 110MNP
Result	Spend-amount is applied to the claim
Business Process Steps	1. Receive member eligibility data with spend status, including spend-down amount and load 2. Receive claim 3. Verify form 110MNP is correct is with the claim a. If correct and with the claim, proceed to Step 4 b. If not correct, deny the claim. Process ends 4. Determine if member responsibility is met by monitoring and subtracting medical claim amounts from spend-down a. If Yes spend-down met, proceed to Step 5 b. If No, determine if 3-month period expired i. If expired, Deny the claim. Process ends ii. If Not expired, proceed to Step 5 5. Send notification that spend-down has been met to the recipient
Shared Data	Provider form 110MND
Predecessor	Determine Member Eligibility
Successor	Possible appeal
Constraints	State and Federal rules and regulations
Failures	None
Performance Measures	None

8.20.2 Calculate Spend-Down Amount Workflow

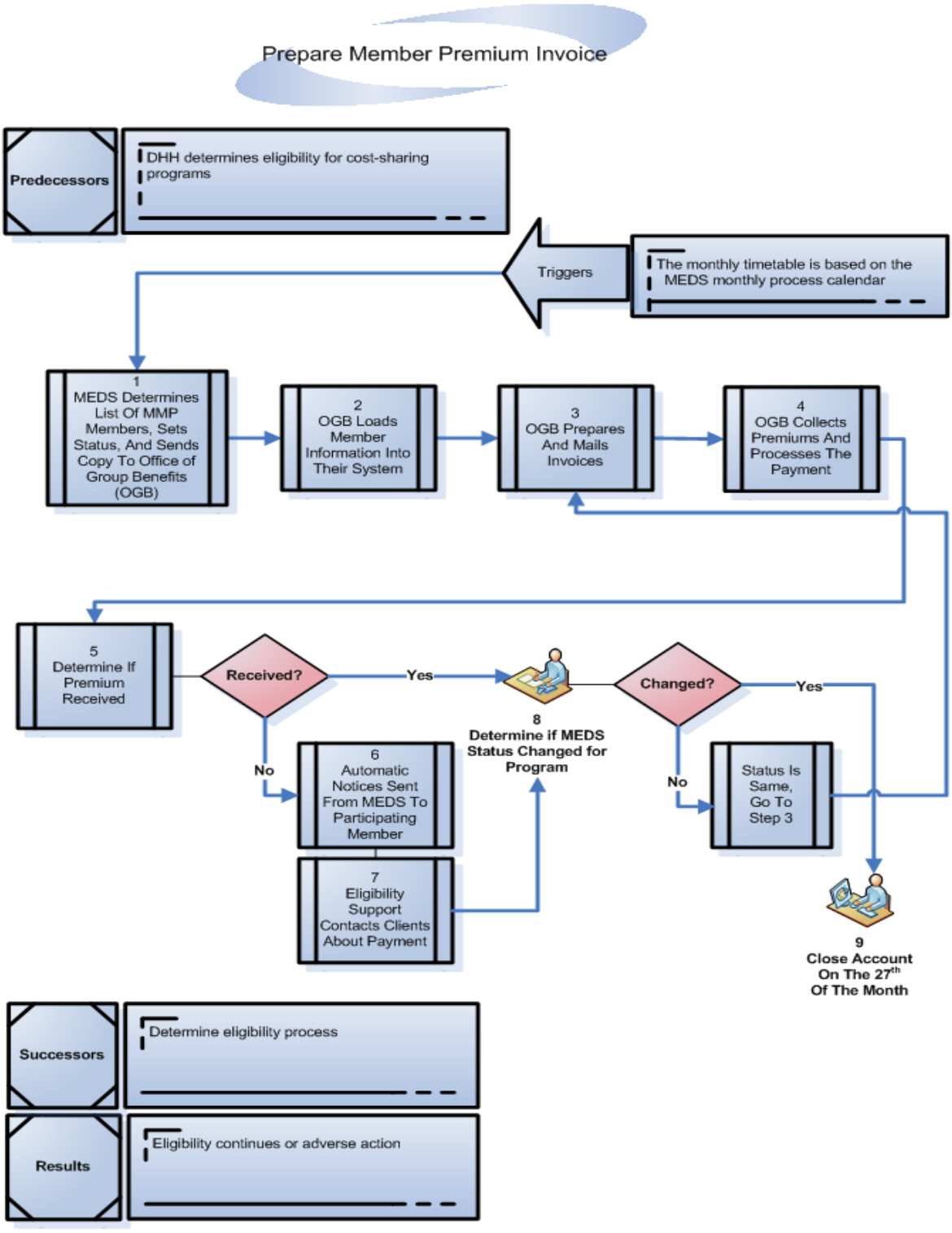


8.21 Prepare Member Premium Invoice

8.21.1 Prepare Member Premium Invoice Business Process Model

Item	Details
Description	The **Prepare Member Premium Invoice** business process affects two programs in DHH: 1. Medicaid Purchase Plan (MMP) – This covers people with disabilities between the ages of 16 and 65 who work. . 2. The LaCHIP Affordable Plan - This covers Louisiana children up to age 19. The **Prepare Member Premium Invoice** is a process that takes place in the ESS, MPP Premium Unit. MEDS generates a monthly file showing all current enrollees with premium amounts and all enrollees cancelled since the last monthly file was run and daily files with al new certifications. Monthly billing preparation falls on the second to last business day of the month. Bills are sent out at this time because the date falls after any eligibility related closures have taken place for the month. This prevents an ineligible member from receiving a premium invoice. MPP premium payments are due by the 10th day of the following month.
Trigger Event	The monthly timetable is based on the MEDS monthly process calendar.
Result	Eligibility continues or adverse action
Business Process Steps	1. The MEDS systems determines a list of MMP members based on eligibility rules, sets the status of these members to PEND on MEDS, and sends an electronic copy of this list to a contractor 2. The contractor (Office of Group Benefits), loads information into their system. 3. OGB Prepares and mails invoices according to data received 4. OGB collects premiums and processes the payment 5. Determine if premium received a. If premium received, proceed to Step 8 b. If no monthly premium received, proceed to Step 6 6. Automatic Notices are sent from MEDS to the participating member with delinquent payment. 7. Eligibility support contacts clients about payment 8. Determine if MEDS status changed for program a. If Yes status states not on program, proceed to Step 9 b. If No, status is the same, proceed to Step 3 9. Close account on the 27th of the month
Shared Data	None
Predecessor	DHH determines eligibility for cost-sharing programs
Successor	Determine eligibility processes
Constraints	State and federal rules and regulations
Failures	None
Performance Measures	None

8.21.2 Prepare Member Premium Invoice Workflow



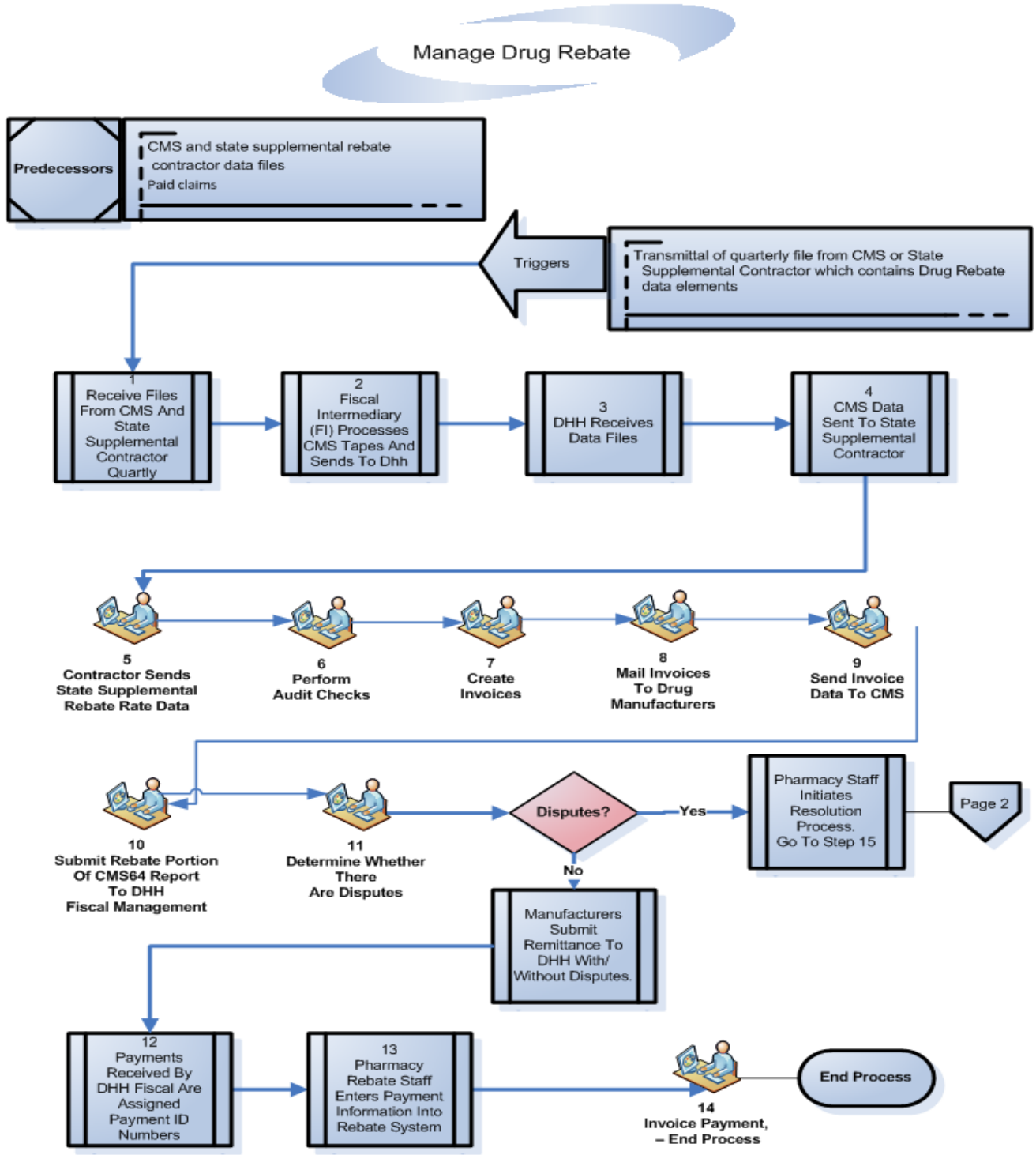
8.22 Manage Drug Rebate

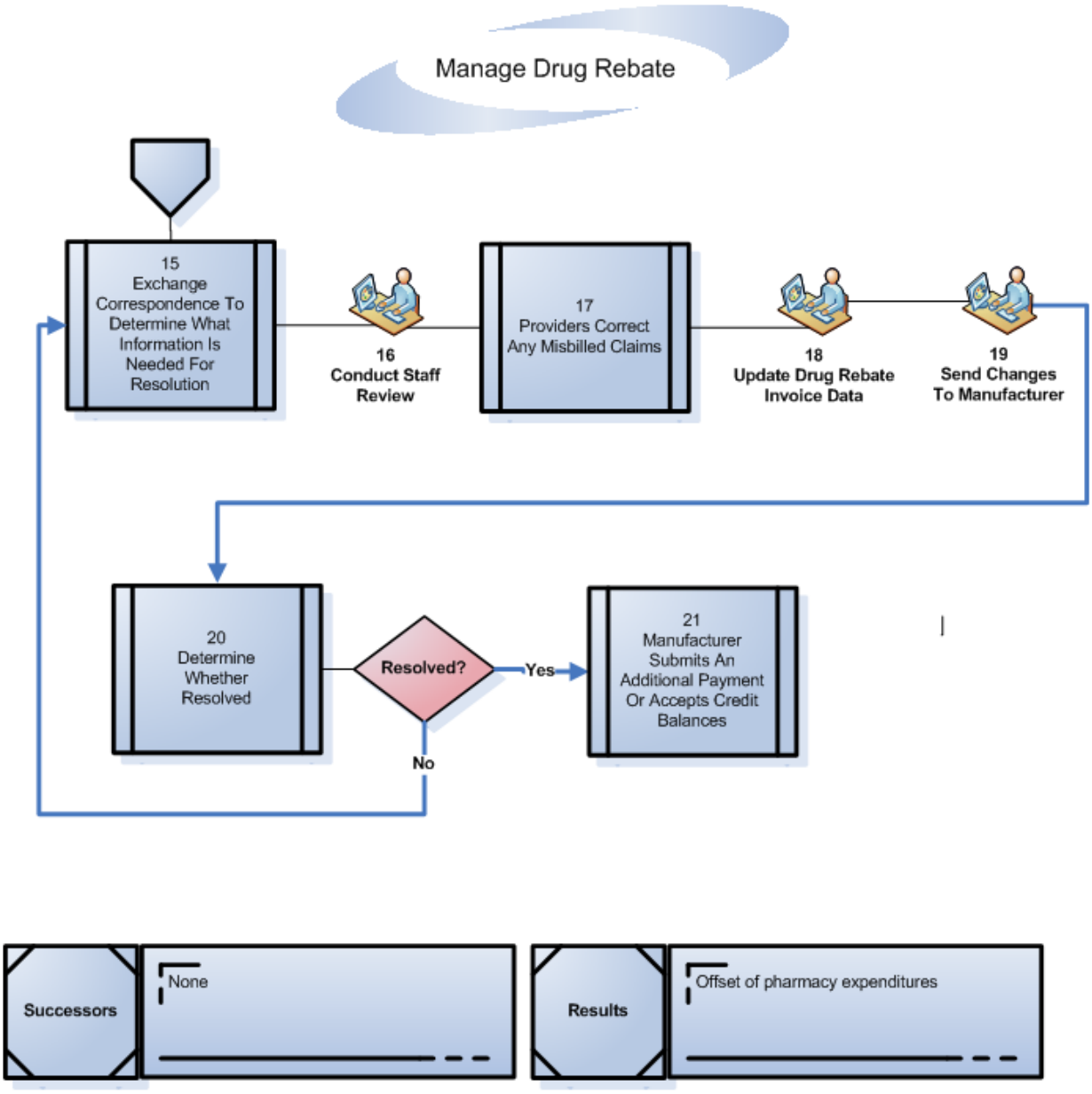
8.22.1 Manage Drug Rebate Business Process Model

Item	Details
Description	The **Manage Drug Rebate** business process describes the process of managing drug rebate that will be collected from manufacturers. Note: Rebate data is statutorily confidential.
Trigger Event	A quarterly file from CMS or state supplemental contractor which contains drug rebate data elements is transmitted via mail to Pharmacy Section.
Result	Offset of pharmacy expenditures
Business Process Steps	1. On a quarterly basis, files are received from CMS and state supplemental contractor 2. FI processes CMS tape and sends to DHH 3. DHH receives data files 4. For State Supplemental, CMS data is sent to contractor 5. Contractor sends state supplemental rebate rate data 6. Perform audit checks 7. Create invoices 8. Mail invoices to drug manufacturers 9. Send invoice data to CMS 10. Submit Rebate portion of CMS64 report to DHH Fiscal management 11. Determine whether there are disputes a. If Yes, the Pharmacy staff, Rebate staff, or the manufacturer initiates resolution process. Proceed to Step 15 b. If No, Manufacturers submit remittance to DHH with and without disputes. Proceed to Step 12 12. Payments received by DHH Fiscal are assigned Payment Identification numbers 13. Pharmacy Rebate staff enters payment information into rebate system. 14. Invoice payment. Process ends. 15. Exchange correspondence to determine what information is needed for resolution 16. Conduct Staff review of information to verify the disputed units 17. Providers correct any misbilled claims 18. Update Drug Rebate invoice data to reflect any changes 19. Send changes to the manufacturer with accurate units. 20. Determine whether resolved a. If resolved, go to Step 21 b. If Not resolved, go to Step 15 21. The manufacturer submits an additional payment or accepts credit balances.
Shared Data	1. CMS Rebate Data 2. CMS updates to Labeler File 3. Labeler Data 4. Provider Invoices
Predecessor	1. CMS and state supplemental rebate contractor data files 2. Paid claims
Successor	None
Constraints	State and Federal Laws and Regulations
Failures	Problems with CMS tape

Item	Details
Performance Measures	None

8.22.2 Manage Drug Rebate Workflow



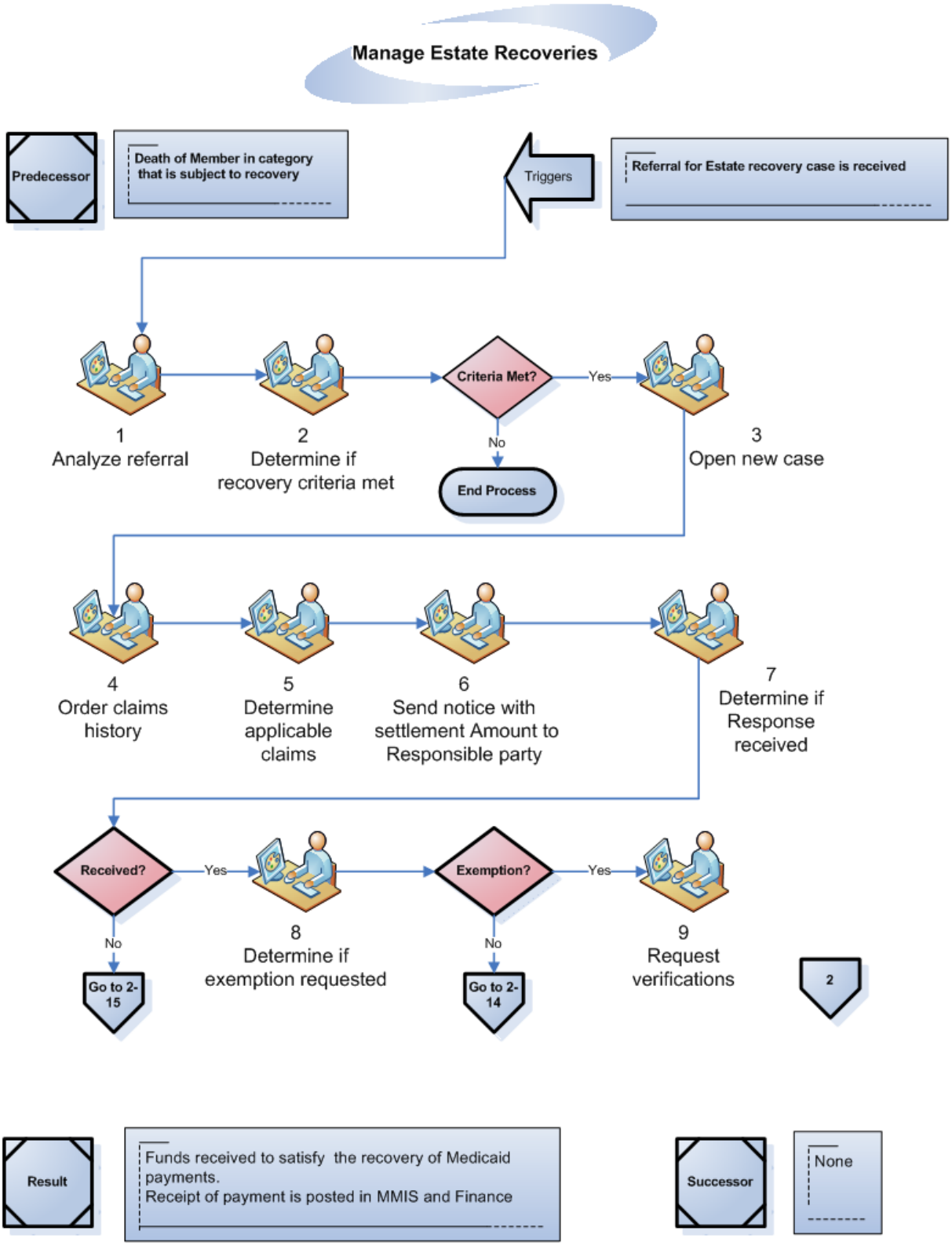

Manage Drug Rebate
15
Exchange Correspondence To Determine What Information Is Needed For Resolution
16
Conduct Staff Review
17
Providers Correct Any Misbilled Claims
18
Update Drug Rebate Invoice Data
19
Send Changes To Manufacturer
20
Determine Whether Resolved
Resolved?
Yes
No
21
Manufacturer Submits An Additional Payment Or Accepts Credit Balances
Successors
None
Results
Offset of pharmacy expenditures

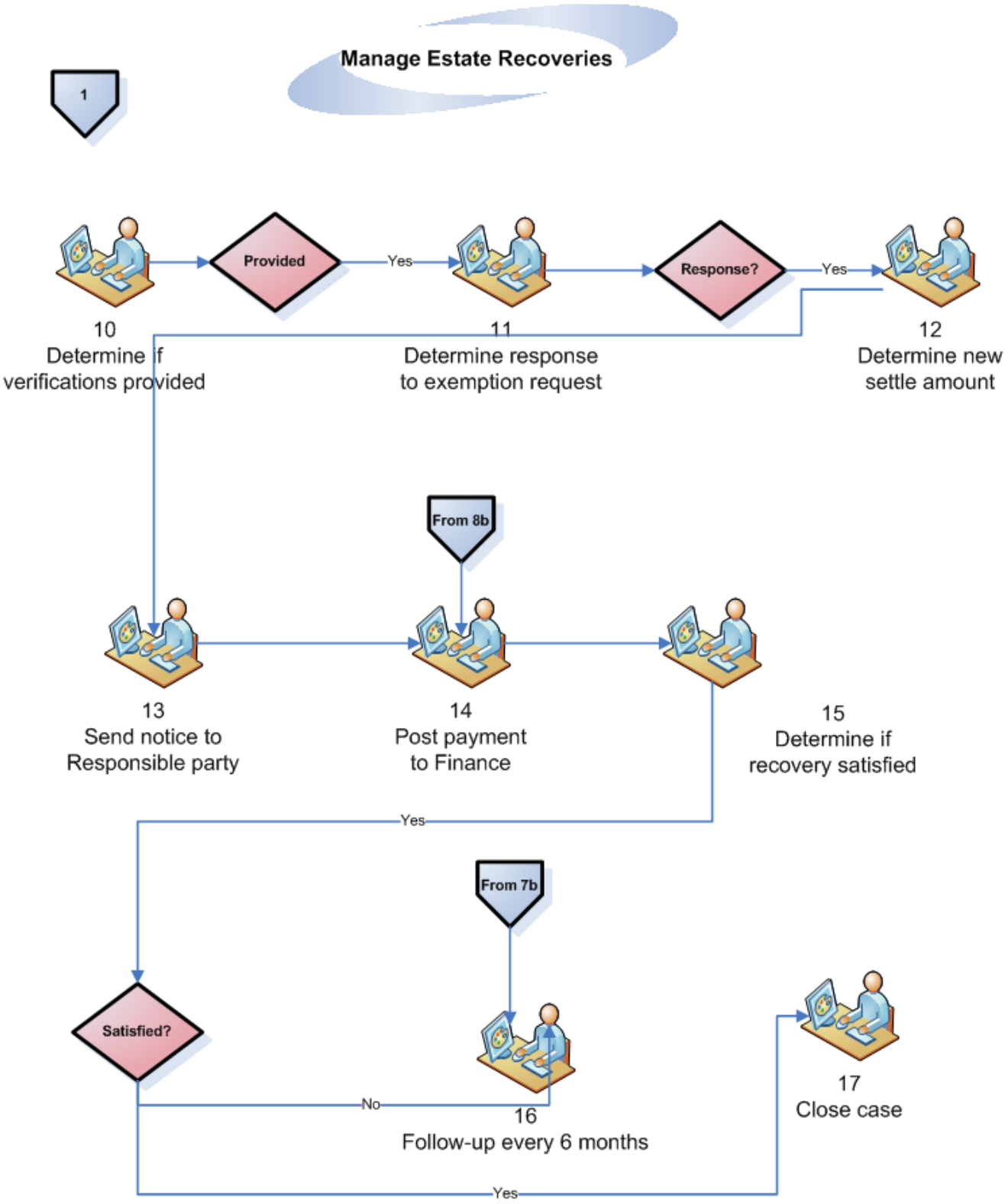
8.23 Manage Estate Recoveries

8.23.1 Manage Estate Recoveries Business Process Model

Item	Details
Description	**Manage Estate Recovery** is a process whereby States are mandated by Federal Law to seek recovery of the amount that Medicaid paid for Nursing Home services, Home and Community Based Services, and related hospital and prescription services from the estates of 55 or older deceased individuals. The Department of Health and Hospitals is granted a privilege equal to last illness on the succession of the deceased Medicaid recipient.
Trigger Event	Estate recovery referral is received.
Result	Manage Estate Recovery via waived, deferred, exempted, reduced or receipt of a check from decedent's estate.
Business Process Steps	1. Analyze referral to determine if it meets Recovery criteria a. If yes, go to step 2. b. If No, Process ends. 2. Open new case (may refer to DHH legal) 3. Order claims history detail 4. Determine applicable claims 5. Send notice to responsible party with settlement amount 6. Determine if response received a. If yes, go to step 7 b. If no, go to step 15 7. Determine if exemption requested a. If yes, go to step 8 b. If no, go to step 13 8. Request verifications from responsible party 9. Determine if verifications provided a. If yes, go to step 10 b. If no, go to step 10 10. Determine response to exemption request a. If yes, go to step 11 b. If no, go to step 12 11. Determine new settlement amount 12. Send notice to responsible party with settlement amount 13. Post payment to Finance 14. Determine if recovery is satisfied a. If yes, go to step 16 b. If no, go to step 15 15. Follow up every 6 months 16. Close case
Shared Data	Documents from the authorized representative
Predecessor	Death of Member in category that is subject to recovery and member is closed from eligibility case.
Successor	Funds sent to DHH Fiscal Management
Constraints	State and Federal Rules and Regulations
Failures	None
Performance Measures	None

Manage Estate Recoveries Workflow




Manage Estate Recoveries
1
Provided
Yes
Response?
Yes
10
Determine if verifications provided
11
Determine response to exemption request
12
Determine new settle amount
From 8b
13
Send notice to Responsible party
14
Post payment to Finance
15
Determine if recovery satisfied
Yes
From 7b
Satisfied?
No
16
Follow-up every 6 months
17
Close case
Yes

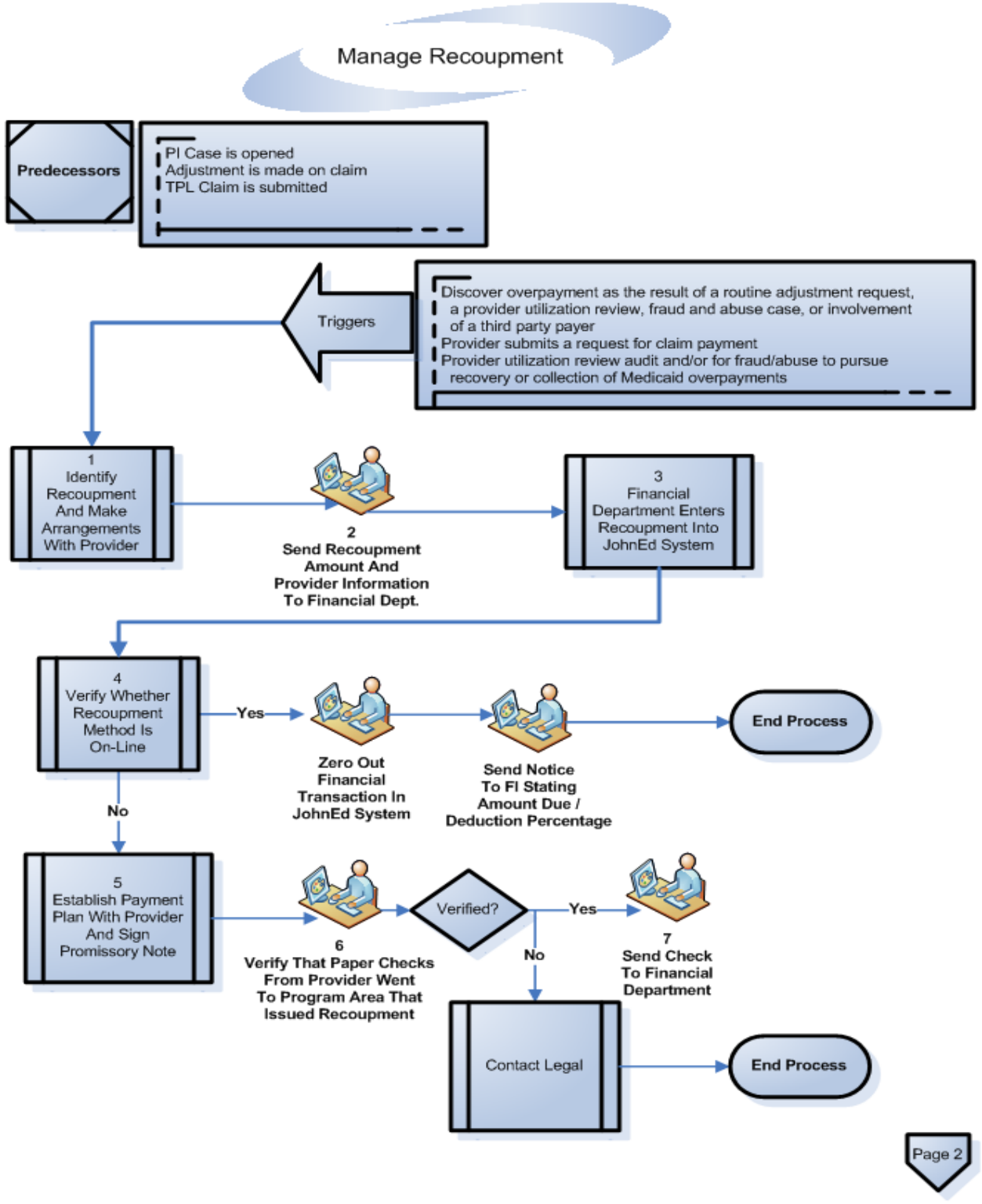
8.24 Manage Recoupment

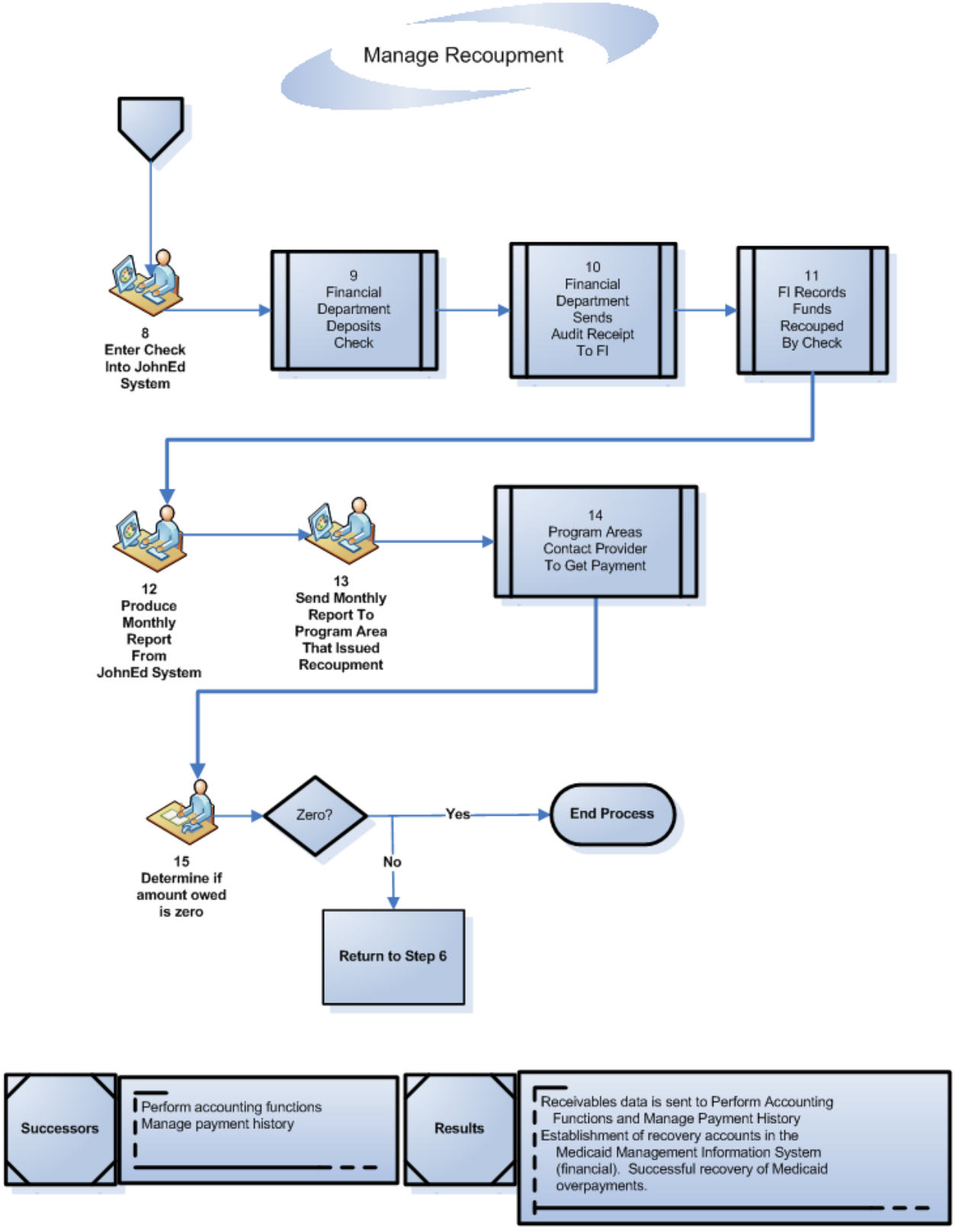
8.24.1 Manage Recoupment Business Process Model

Item	Details
Description	The **Manage Recoupment** business process describes the process of managing provider recoupment from identification of the overpayment amount to payment in full of what is owed. Provider recoupment's are initiated by: • The discovery of an overpayment as the result of a provider utilization review audit, for situations where monies are owed to the agency due to fraud/abuse or inappropriate billing. • An overpayment to the provider due to adjustments or other accounting functions Recoupment can be collected via check sent by the provider or Insurance carrier and credited against future payments for services via the check write.
Trigger Event	1. Discover overpayment as the result of a routine adjustment request, a provider utilization review, fraud and abuse case, or involvement of a third party payer. 2. Provider submitting a request for claim payment 3. Provider utilization review audit and/or for fraud/abuse to pursue recovery or collection of Medicaid overpayments
Result	1. Receivables data is sent to Perform Accounting Functions and Manage Payment History. 2. Establishment of recovery accounts in the Medicaid Management Information System (financial). Successful recovery of Medicaid overpayments
Business Process Steps	1. The different program areas (PI, Pharmacy, etc) identify recoupment and make arrangements with provider 2. Send recoupment amount and provider information to financial department 3. Financial department enters recoupment into financial subsystem, (JohnEd) 4. Verify on the request whether the recoupment method is On-Line a. If Yes , is on-Line, i. Zero out the financial transaction on the JonEd subsystem. ii. Send notice stating amount due and deduction percentage (full or partial) to the FI for entry into MMIS and recoupment of funds. Process ends. b. If No, is off-Line, proceed to Step 5 5. Business areas set up establish payment plan with provider and sign promissory note 6. Verify that the paper checks from providers for payment went to the program area that issued the recoupment a. If Yes correct program area, Proceed to Step 7 b. If No, contact legal department. Process ends 7. Send check to financial department 8. Enter check into JohnEd 9. Financial deposits check 10. Financial sends audit receipt to FI 11. FI records funds that were recouped by check into the MMIS financial subsystem 12. Produce monthly report from JohnEd outlining which providers still owe a recoupment amount 13. Send to appropriate people from each program area 14. Program areas contact the provider to get the payment 15. Determine if amount owned is zero a. If Yes, process ends b. If No, return to Step 6
Shared Data	1. Secretary of State on-line business database 2. Insurance Carrier Data
Predecessor	1. PI Case is opened 2. Adjustment in made on claim

Item	Details
	3. TPL Claim is submitted
Successor	1. Perform Accounting Functions 2. Manage Payment History
Constraints	1. Integration of the MMIS with state accounting systems 2. State and Federal Rules and Regulations
Failures	None
Performance Measures	None

8.24.2 Manage Recoupment Workflow




Manage Recoupment
8
Enter Check Into JohnEd System
9
Financial Department Deposits Check
10
Financial Department Sends Audit Receipt To FI
11
FI Records Funds Recouped By Check
12
Produce Monthly Report From JohnEd System
13
Send Monthly Report To Program Area That Issued Recoupment
14
Program Areas Contact Provider To Get Payment
15
Determine if amount owed is zero
Zero?
Yes
No
End Process
Return to Step 6
Successors
Perform accounting functions
Manage payment history
Results
Receivables data is sent to Perform Accounting Functions and Manage Payment History
Establishment of recovery accounts in the Medicaid Management Information System (financial). Successful recovery of Medicaid overpayments.

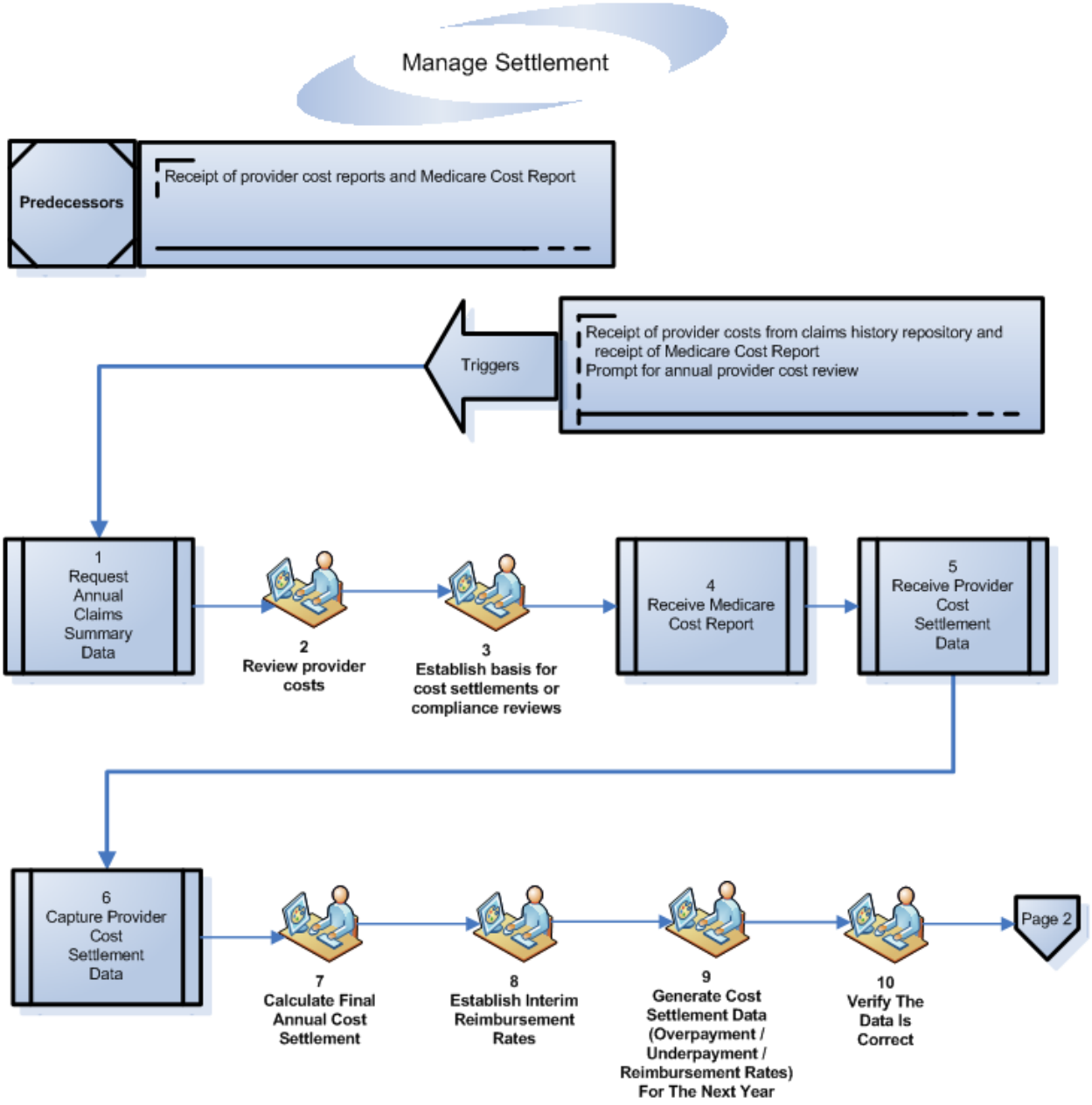
8.25 Manage Settlement

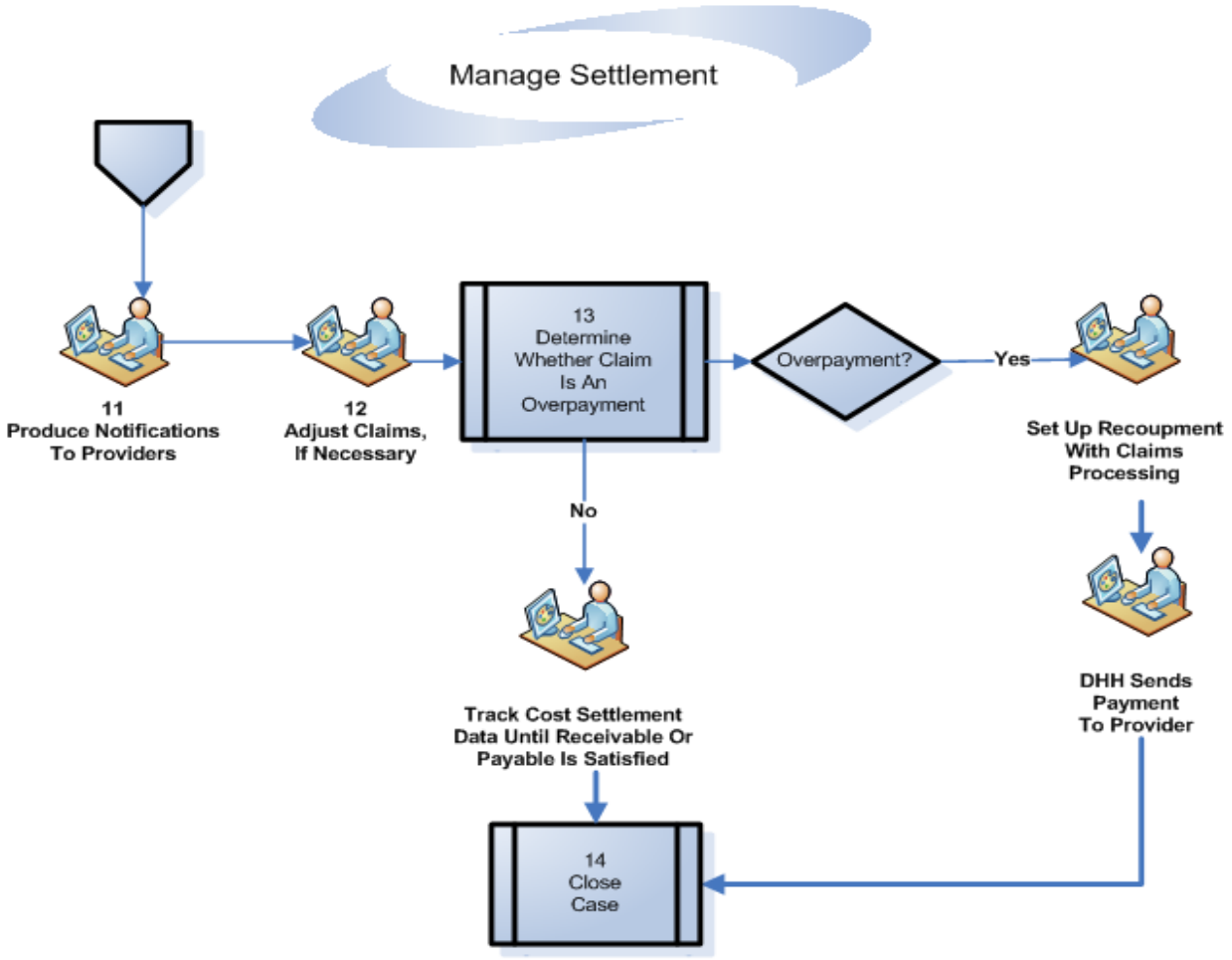
8.25.1 Manage Settlement Business Process Model

Item	Details
Description	The **Manage Settlement** business process begins with requesting annual claims summary data from **Manage Payment History**, reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving finalized Medicare cost report from intermediaries, capturing the necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates, sending the cost settlement data set via the **Send Outbound Transaction** process to **Manage Provider Communication**, **Manage Payment History**, **Manage Rate Setting** and sending receivables data to **Perform Accounting Functions**, and tracking settlement payments.
Trigger Event	1. Receipt of provider costs from claims history repository and receipt of Medicare Cost Report. 2. Prompt for annual provider cost review.
Result	Data set with determination of cost settlement data as calculated, reviewed, and modified.
Business Process Steps	1. Request annual claims summary data 2. Review provider costs 3. Establish a basis for cost settlements or compliance reviews 4. Receive Medicare Cost Report from intermediaries from electronic transfer and/or mail. 5. Receive provider cost settlement data from electronic transfer and/or mail. 6. Capture the necessary provider cost settlement data 7. Calculate the final annual cost settlement based on the Medicare Cost Report with updated information on Medicaid services 8. Establish interim reimbursement rates 9. Generate cost settlement data identifying the amount of overpayment or underpayment and the reimbursement rates to be considered for the next year 10. Verify the data is correct 11. Produce notifications to providers 12. Adjust Claims – If necessary 13. Determine whether claim is an overpayment a. If Yes, Set up a recoupment with claims processing. DHH sends payment to provider. Go to Step 14 b. If No, track cost settlement data until receivable or Payable is satisfied. Go to Step 14 14. Close Case
Shared Data	1. Payment History Repository 2. Provider Registry 3. Contractor's Database
Predecessor	Receipt of provider cost reports and Medicare Cost Report
Successor	1. Manage Provider Communication 2. Perform Accounting Functions 3. Manage Payment History 4. Manage Rate Setting
Constraints	Cost report Settlement data must conform to state specific reporting requirements and MSIS reporting requirements.
Failures	Providers are not held accountable for information found from audit findings.

Item	Details
Performance Measures	1. Time to complete the process 2. Consistency with which rules are applied 3. Accuracy with which rules are applied 4. Amount of overpayment 5. Amount of underpayment

8.25.2 Manage Settlement Workflow





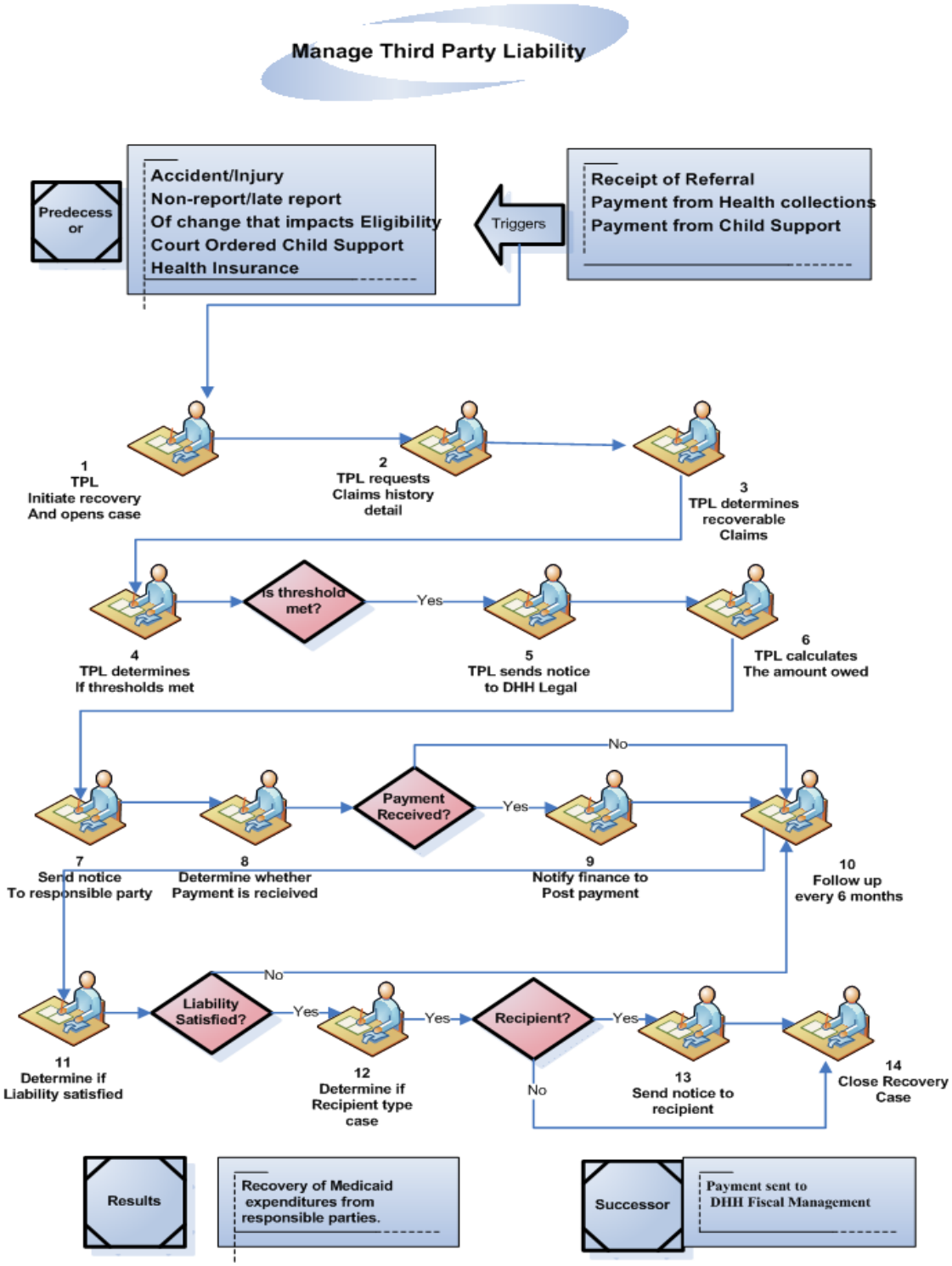
Successors	Manage Provider communication Perform Accounting functions Manage Payment history Manage Rate Setting
Results	Data set with determination of cost settlement data as calculated, reviewed and modified.

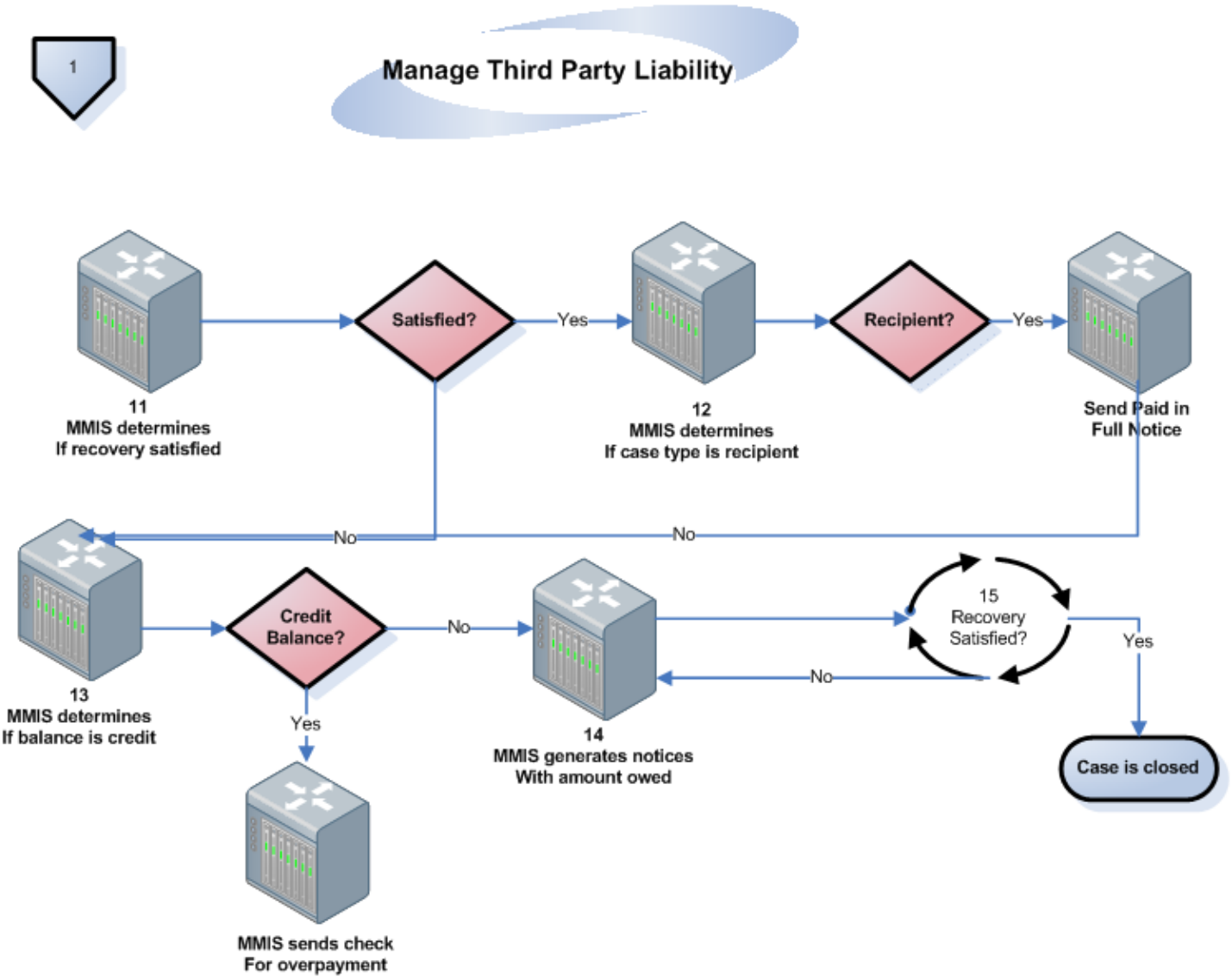
8.26 Manage Third Party Liability

8.26.1 Manage Third Party Liability Business Process Model

Item	Details
Description	The **Manage TPL Recoveries, Trauma, Recipient, Health or Child Support** business process is a state and federally mandated process that pursues recovery of the amount paid by Medicaid for services where there is liable third party or over payment of benefits.
Trigger Event	Receipt of referral Receipt of check
Result	Recovery of Medicaid expenditures from responsible parties.
Business Process Steps	1. Initiate recovery and open case 2. Order claims history detail 3. Determine Recoverable claims if thresholds met send notice to DHH legal 4. Calculate amount to be recovered 5. Send notice to the responsible party 6. Determine whether this is recipient recovery case a. If yes, go to Step 7 b. If not, go to Step 10 7. Negotiate reduction 8. Determine result 9. Send letter with result of negotiation, amount due and terms 10. Determine whether payment is received a. If Yes, notify finance to post payment, proceed to Step 12 b. If No, follow-up every 6 months, proceed to Step 5 11. Determine if liability is satisfied a. If yes, proceed to Step 12 b. If no, proceed to Step 5 12. Determine if this is recipient recovery case a. If yes, go to Step 14 b. If no, go to Step 15 13. Send notice to recipient that recovery is closed 14. Close Recovery case
Shared Data	Documentation from responsible parties
Predecessor	Accident or injury Non-report/late report of change that impacts eligibility Court Ordered Child Support
Successor	Payment sent to DHH Fiscal Management
Constraints	State and Federal Rules and Regulations.
Failures	None
Performance Measures	None

8.26.2 Manage Third Party Liability Workflow




1
Manage Third Party Liability
11
MMIS determines
If recovery satisfied
Satisfied?
Yes
12
MMIS determines
If case type is recipient
Recipient?
Yes
Send Paid in
Full Notice
No
No
13
MMIS determines
If balance is credit
Credit
Balance?
No
Yes
MMIS sends check
For overpayment
14
MMIS generates notices
With amount owed
15
Recovery
Satisfied?
No
Yes
Case is closed


Results
Recovery of erroneously
Paid Medicaid claims
Successors
Payment sent to DHH
Fiscal Management

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9.0 Program Management Overview

For DHH the Program Management business area handles all of the development and management of the MMIS program, rates, rules, and reporting. The DHH staff though dedication and hard work have been able to provide needed services to Louisiana's Medicaid population using these business processes. However, these business processes in their current form do not lend well to improving Louisiana's Medicaid. The processes are decentralized, mostly manual, time consuming and labor intensive with limited access and tracking. As a result, the DHH staff spends more time trying to get information than developing new solutions. The modernization of some of these business processes will greatly improve the efficiency at which these services are provided.

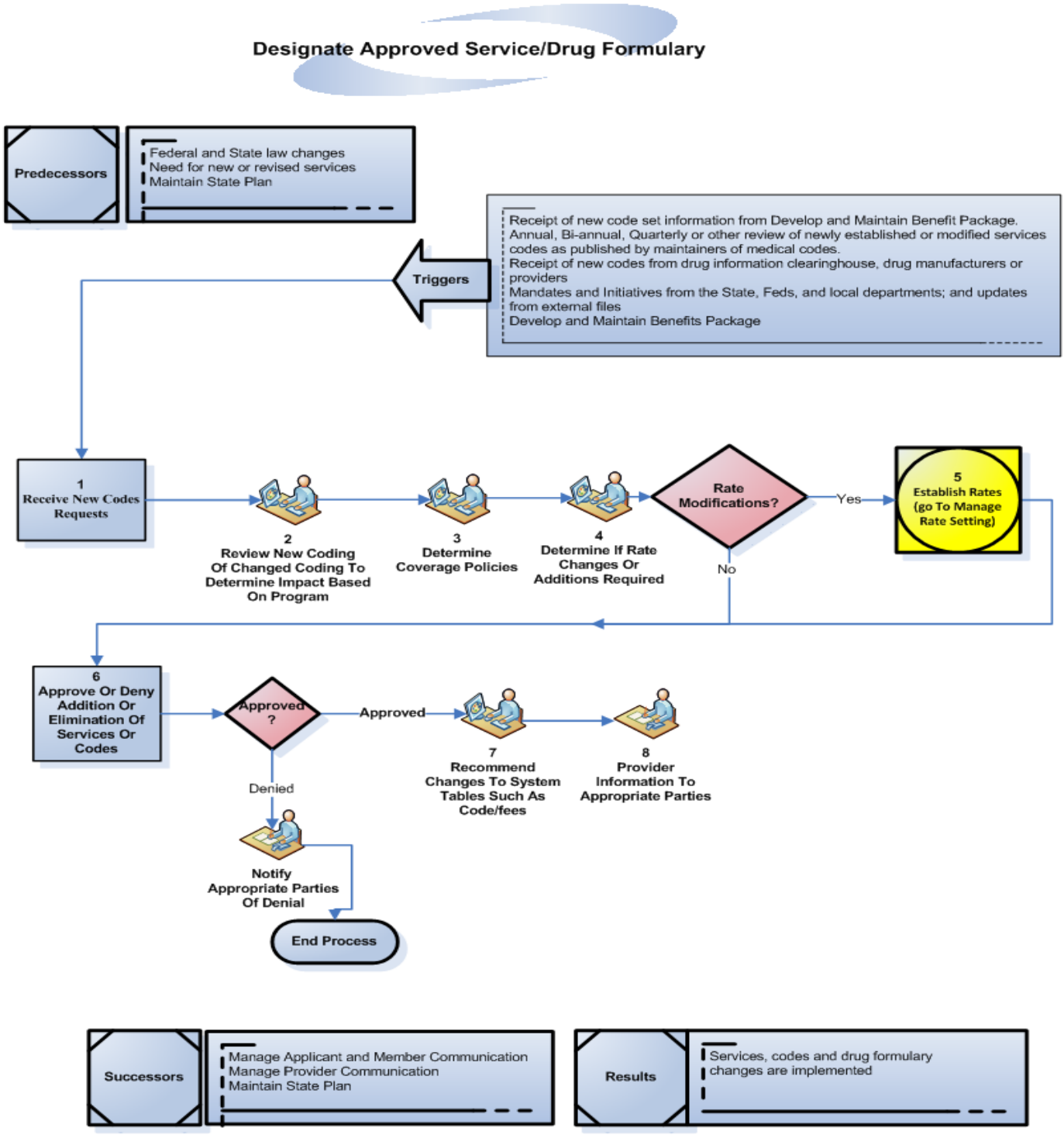
9.1 Designate Approved Service / Drug Formulary

9.1.1 Designate Approved Service / Drug Formulary Business Process Model

Item	Details
Description	The **Designate Approved Services** business process begins with a review of new and/or modified service codes for possible inclusion in various Medicaid Benefit programs. Certain services may be included or excluded for each benefit package. Service codes are reviewed by Operations, Policy, and/or Rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The assigned staff is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and state plan in order to accommodate the inclusion or exclusion of service/drug codes. The staff is responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes. **NOTE:** This does not include implementation of ***Approved Service***. The ***Designate Approved/Drug Formulary*** business process begins with a review of new and/or modified national drug codes (NDC) for possible inclusion in the pharmacy program. Drugs may be included or excluded. Drug codes are reviewed by a team of medical staff to determine if they meet program policy and medical appropriateness for the inclusion or exclusion. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and state plan in order to accommodate the inclusion or exclusion of drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.
Trigger Event	1. Receipt of new code set information from Develop and Maintain Benefit Package. 2. Annual, Bi-annual, Quarterly or other review of newly established or modified services codes as published by maintainers of medical codes. 3. Receipt of new codes from drug information clearinghouse, drug manufacturers or providers 4. Mandates and Initiatives from the State, Feds, and local departments; and updates from external files 5. Develop and Maintain Benefits Package
Result	Services, codes and drug formulary changes are implemented
Business Process Steps	1. Receive new code(s) request or change code(s) requests 2. Review coding request to determine impact based on program 3. Determine coverage policies

	4. Determine if Rate changes or additions required a. If Yes, go to Step 5 b. If No, go to Step 6 5. Establish Rates - Go to Manage Rate Setting Business Process 6. Approve or deny addition or elimination of services or codes a. If Approved, go to Step 7 b. If Denied, i. Notify appropriate parties of denial ii. End Process 7. Recommend changes to system tables such as codes/fees 8. Provide information to appropriate parties
Shared Data	1. Drug Formulary Table 2. CMS drug rebate file 3. Standard Code sets
Predecessor	1. Federal and State law changes 2. Need for new or revised services 3. Maintain State Plan
Successor	1. Manage Applicant and Member Communication 2. Manage Provider Communication 3. Maintain State Plan
Constraints	State and Federal laws and regulations
Failures	None
Performance Measures	None

9.1.1.1 Designate Approved Service / Drug Formulary Workflow



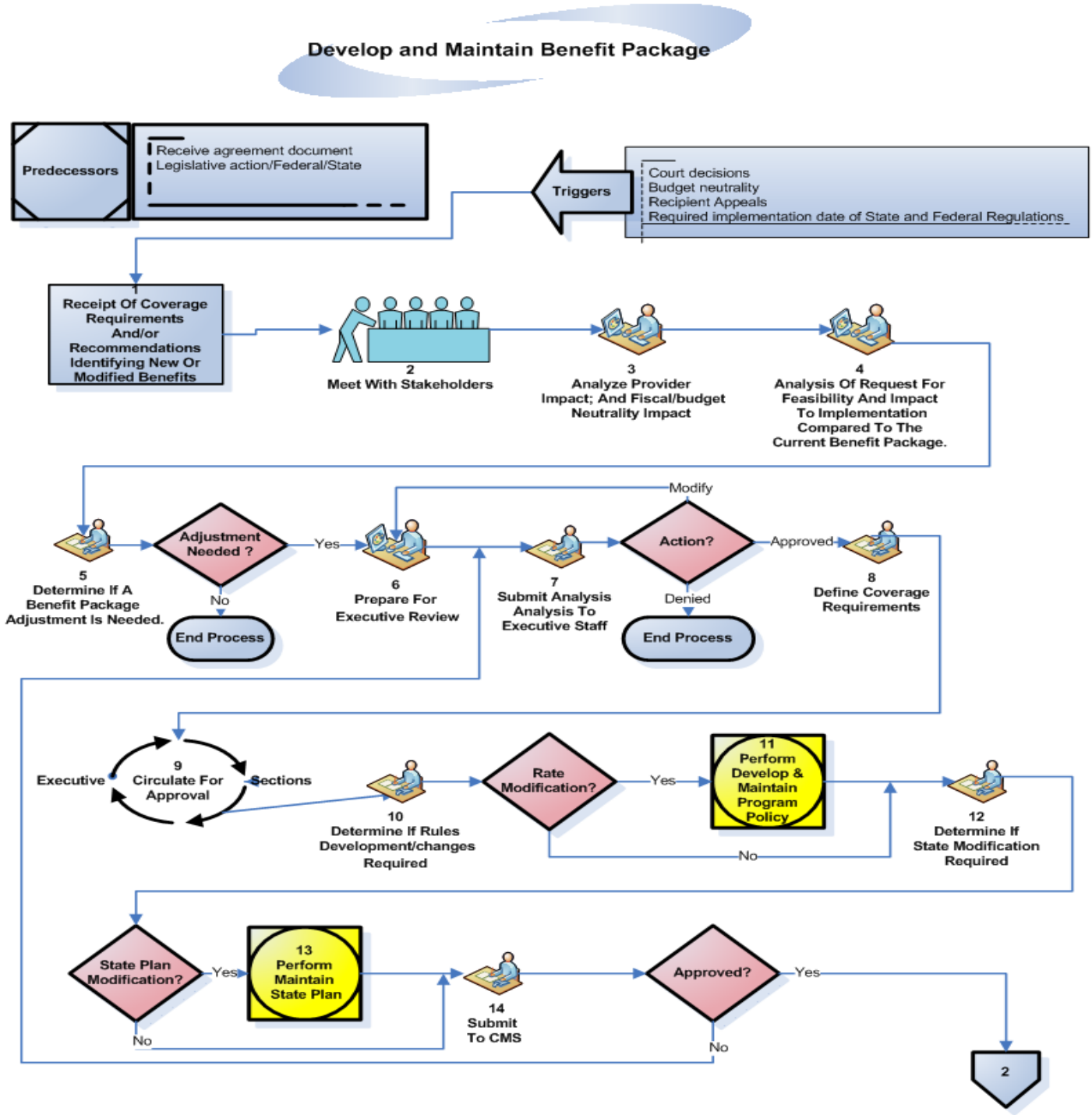
9.2 Develop and Maintain Benefit Package

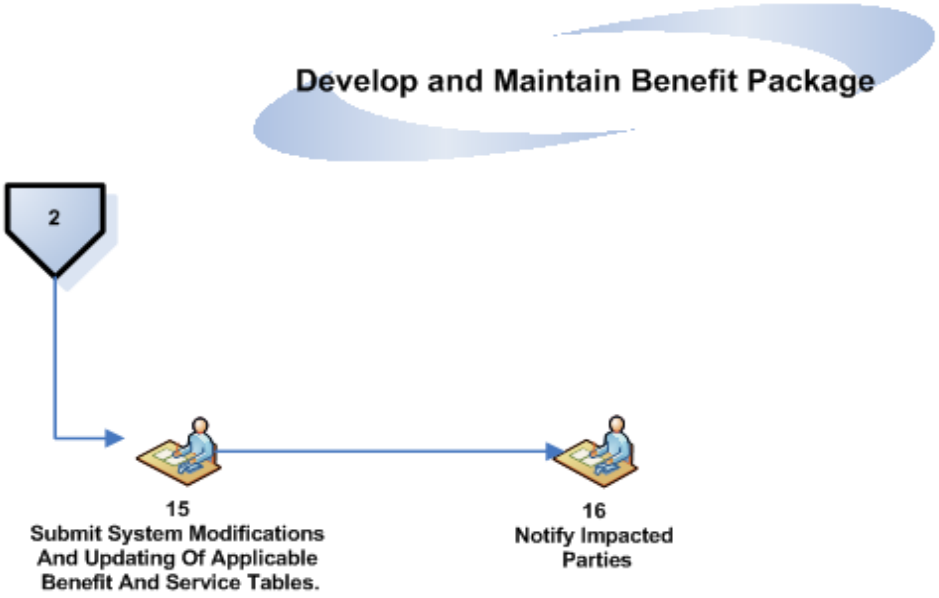
9.2.1 Develop and Maintain Benefit Package Business Process Model

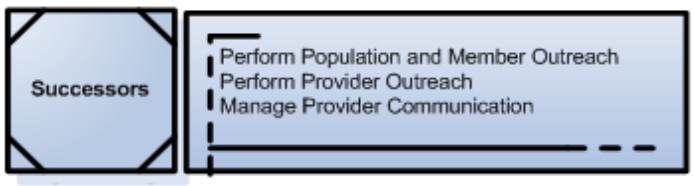
Item	Details
Description	The **Develop & Maintain Benefit Package** business process begins with receipt of coverage requirements and recommendations through new or revised: Federal / State statutes and/or regulations or mandates from external parties such as quality review organizations or changes resulting from court decisions. Benefit package requirements and approved recommendations are reviewed for impacts to state plan, waivers, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including: 1. Determination of scope and coverage 2. Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc. 3. Identification of impacted members and trading partners
Trigger Event	1. Court decisions 2. Budget neutrality 3. Recipient Appeals 4. Required implementation date of State and Federal Regulations
Result	Implementation of new or modified benefits
Business Process Steps	1. Receipt of coverage requirements and/or recommendations identifying new or modified benefits 2. Meet with stakeholders 3. Analyze provider impact; and fiscal/budget neutrality impact 4. Analysis of request for feasibility and impact to implementation compared to the current benefit package 5. Determine if a benefit package adjustment is needed a. If Yes, go to Step 6 b. If No, End Process 6. Prepare for executive review 7. Submit analysis to executive staff a. If Modify, go back to Step 6 b. If Approve, go to Step 8 c. If Deny, End Process 8. Define coverage requirements including: scope of coverage, eligibility criteria, rate and effective date 9. Circulate for approval to executive staff to department sections 10. Determine if rules development/changes required a. If Yes, go to Step 13 b. If No, go to Step14 11. Perform Develop and maintain Program Policy Business Process 12. Determine if State modification required a. If Yes, go to Step 13 b. If No, go to Step 14 13. Perform Maintain State Plan Business Process 14. Submit benefit package to CMS for approval a. If Yes, go to step 15 b. If No, go back to Step 7 15. Submit system modifications and updating of applicable benefit and service tables.

	16. Notify impacted parties - via Perform Population and Member Outreach and Perform Provider Outreach, Manage Provider Communication BHSF, and update manuals.
Shared Data	1. Other states benefit packages *2.* External Research data
Predecessor	Federal, State and local laws and regulation changes
Successor	1. Perform Population and Member Outreach 2. Perform Provider Outreach *3.* Manage Provider Communication
Constraints	State and Federal laws and regulations
Failures	None
Performance Measures	None

9.2.2 Develop and Maintain Benefit Package Workflow




Develop and Maintain Benefit Package
2
15
Submit System Modifications And Updating Of Applicable Benefit And Service Tables.
16
Notify Impacted Parties


Successors
Perform Population and Member Outreach
Perform Provider Outreach
Manage Provider Communication


Results
Implementation of new or modified benefits

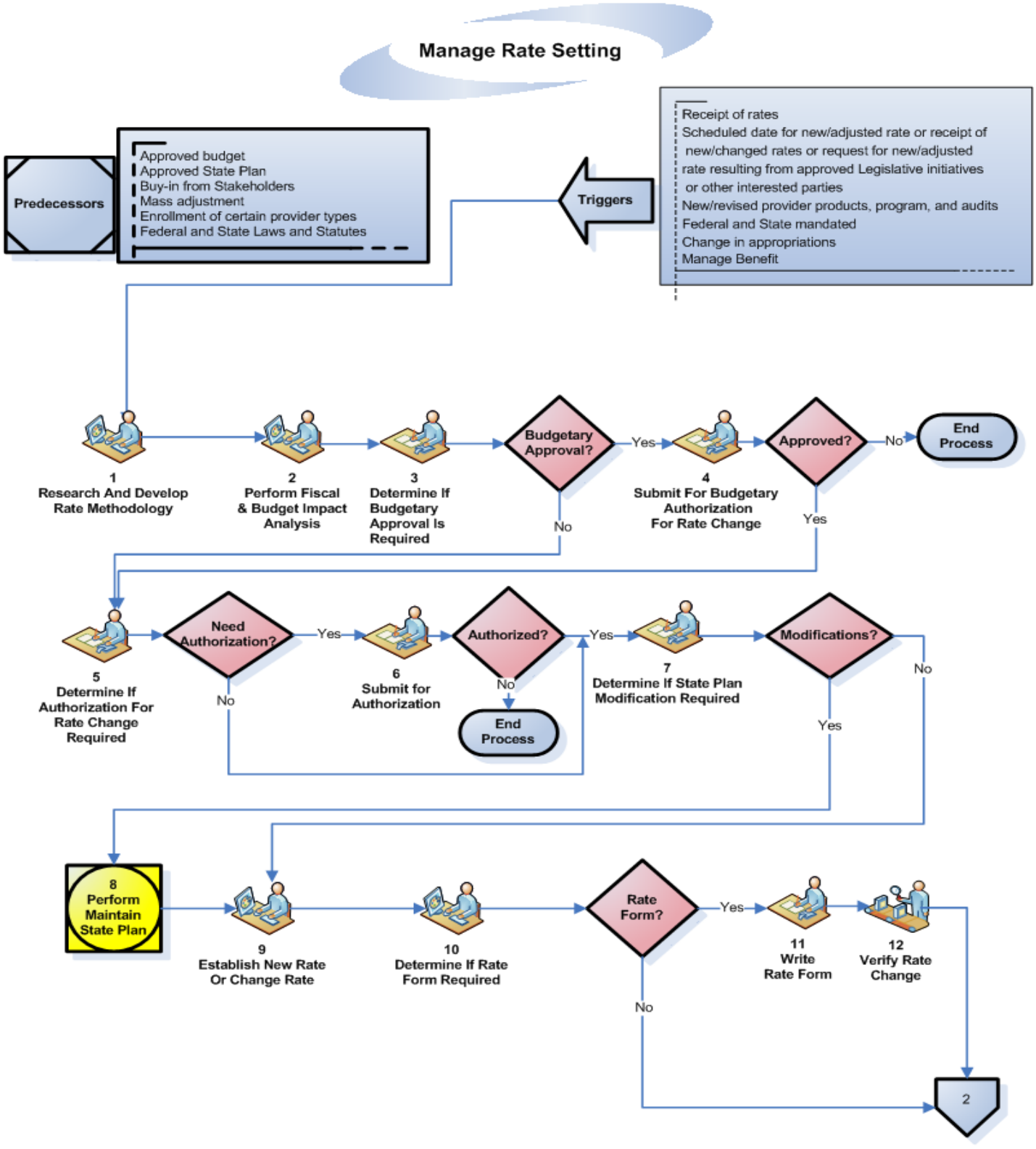
9.3 Manage Rate Setting

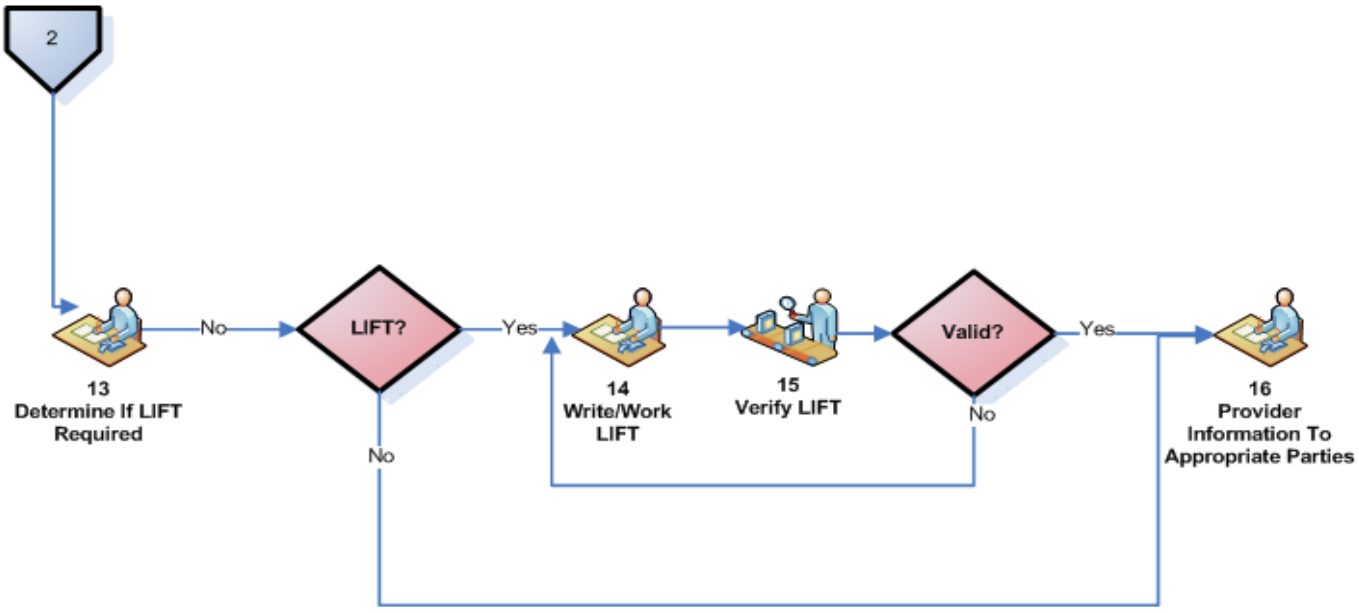
9.3.1 Manage Rate Setting Business Process Model

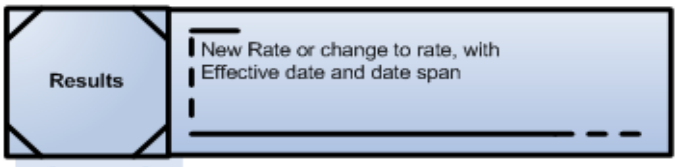
Item	Details
Description	The **Manage Rate Setting** business process is responsible for developing or modifying rates for any services or products covered by the Medicaid program.
Trigger Event	1. Receipt of rates 2. Scheduled date for new/adjusted rate or receipt of new/changed rates or request for new/adjusted rate resulting from approved Legislative initiatives or other interested parties 3. New/revised provider products, program, and audits 4. Federal and State mandated 5. Change in appropriations 6. Manage Benefit
Result	New Rate or change to rate, with effective date and date span
Business Process Steps	1. Research and develop Rate Methodology (Analyze, develop and calculate) 2. Perform fiscal and budget impact analysis 3. Determine if budgetary approval is required a. If Yes, go to Step 4 b. If No, go to Step 5 4. Submit for budgetary authorization for rate change a. If Yes, go to Step 5 b. If No, End Process 5. Determine if authorization for rate change (internal to Medicaid) required a. If Yes, go to Step 6 b. If No, go to Step 7 6. Submit for authorization a. If Yes, go to Step 7 b. If No, End Process 7. Determine if State Plan modification required a. If Yes, go to Step 8 b. If No, go to Step 9 8. Perform Maintain State Plan 9. Establish new rate or change rate 10. Determine if Rate Form needed a. If Yes, go to Step 11 b. If No, go to Step 13 11. Write Rate Form 12. Verify Rate Change 13. Determine if LIFT required a. If Yes, go to Step 14 b. If No, go to Step 16 14. Write / Work LIFT 15. Verify LIFT a. If Yes, go to Step 16 b. If No, go to Step 14 *16.* Notify appropriate parties
Shared Data	1. External cost reports (e.g., providers)

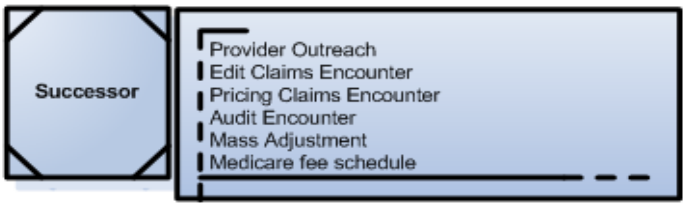
	2. Audit results 3. Drug Formulary File 4. Federal and State comparison information (include indexes) 5. New code sets 6. Medicare fee schedule
Predecessor	1. Approved budget 2. Approved State Plan 3. Buy-in from Stakeholders 4. Mass adjustments 5. Enrollment of certain provider types 6. Federal and State Laws and Statutes
Successor	1. Provider Outreach 2. Edit Claims Encounter 3. Pricing Claims Encounter 4. Audit Encounter 5. Mass Adjustment 6. Medicare fee schedule
Constraints	1. Budget Process completed 2. State and Federal Regulations and Policy 3. State Plan Process completed
Failures	1. Loss of buy in from stakeholders 2. Change in appropriation
Performance Measures	State and Federal mandated timelines

9.3.2 Manage Rate Setting Workflow




2
13
Determine If LIFT Required
No
LIFT?
Yes
No
14
Write/Work LIFT
15
Verify LIFT
Valid?
No
Yes
16
Provider Information To Appropriate Parties


Results
New Rate or change to rate, with
Effective date and date span


Successor
Provider Outreach
Edit Claims Encounter
Pricing Claims Encounter
Audit Encounter
Mass Adjustment
Medicare fee schedule

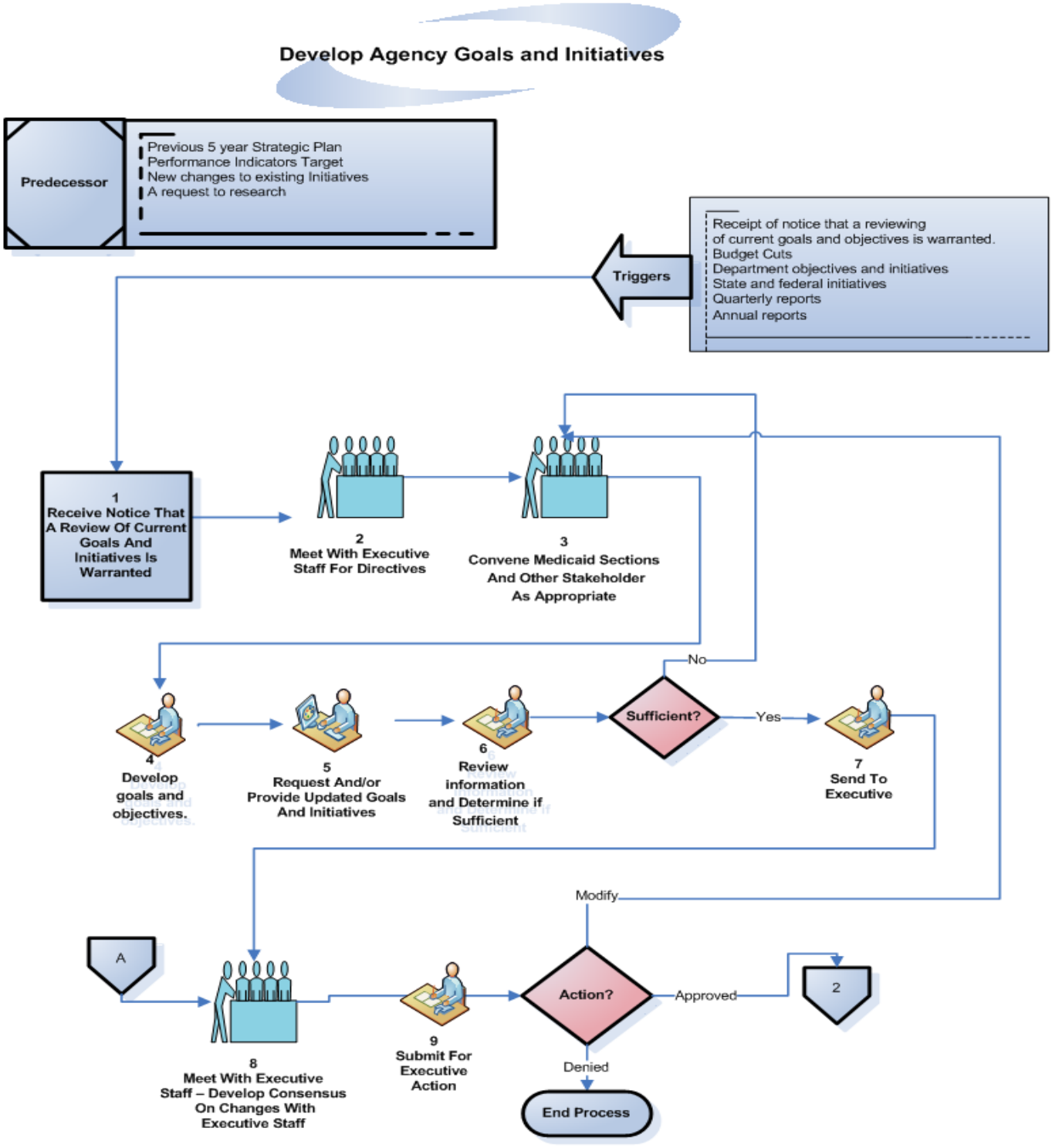
9.4 Develop Agency Goals and Initiatives

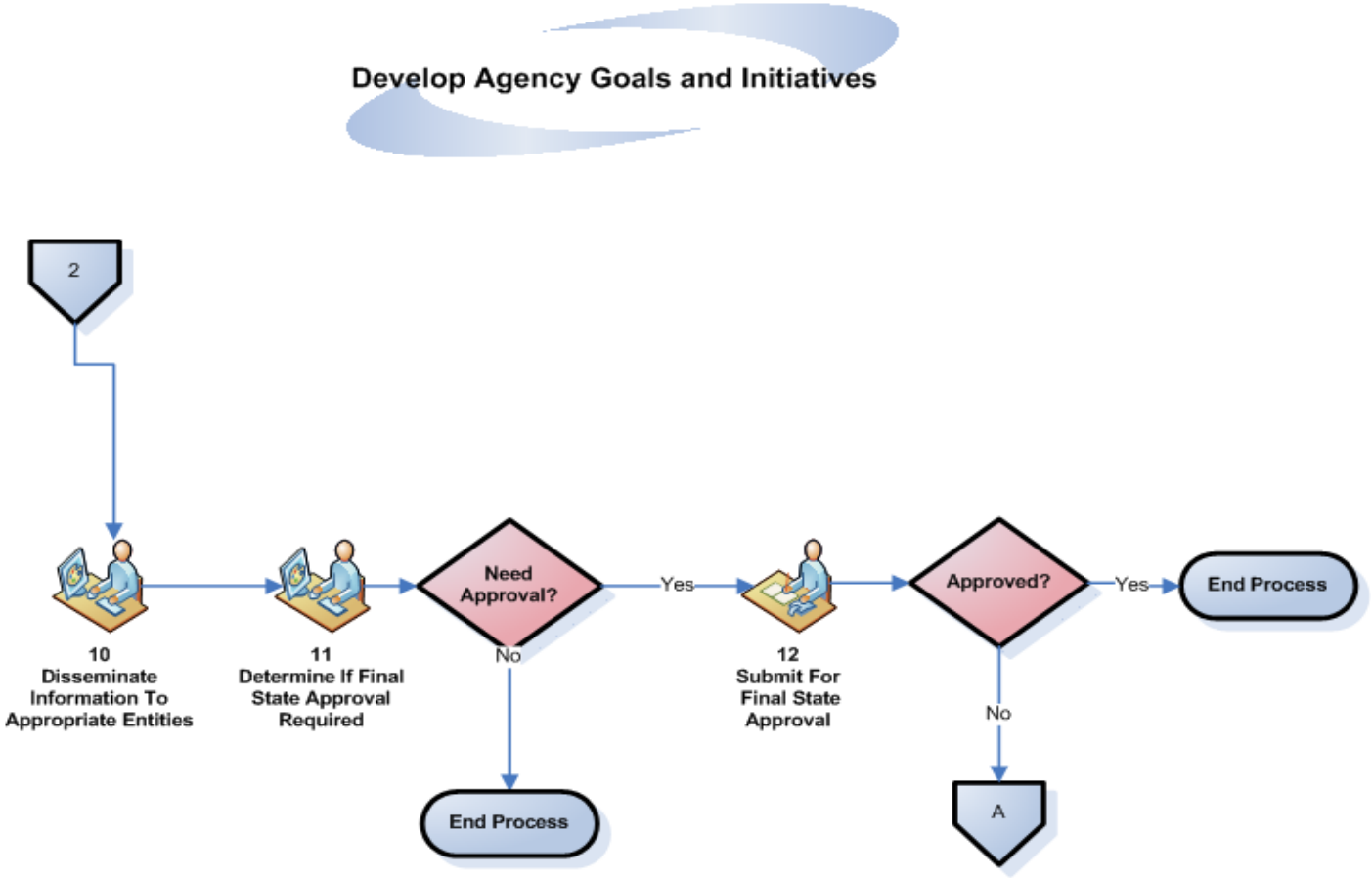
9.4.1 Develop Agency Goals and Initiatives Business Process Model

Item	Details
Description	The **Develop Agency Goals and Initiatives** business process annually assesses current mission statement, goals, and objectives to determine if changes are necessary within the framework of the 5-year strategic plan. Changes to goals and objectives could be warranted under a new administration or in response to changes in demographics or in response to natural disasters such as Katrina. If approved, formal report changes are done once a year.
Trigger Event	1. Receipt of notice that a reviewing of current goals and objectives is warranted. 2. Budget Cuts 3. Department objectives and initiatives 4. State and federal initiatives 5. Quarterly reports 6. Annual reports
Result	New statement of official goals and objectives.
Business Process Steps	1. Receive notice for or initiate review of current goals and initiatives is warranted 2. Meet with Executive Staff for directives 3. Convene Medicaid Sections and other Stakeholder as appropriate 4. Develop goals and objectives 5. Request and/or provide updated goals and initiatives 6. Review information and see if sufficient a. If Yes, go back to Step 7 b. If No, go to Step 2 7. Send to Executive 8. Meet with Executive Staff – Develop consensus on changes with Executive staff 9. Submit for Executive approval a. If Approved, go to Step 10 b. If Modify, Go back to Step 3 c. If Denied, End Process 10. Disseminate information to appropriate entities 11. Determine if final State approval required a. If Yes, go to Step 12 b. If No, End Process 12. Submit for Final State approval a. If Yes, End Process b. If No, go back to Step 8
Shared Data	1. Louisiana Performance Accountability System (LaPAS) 2. State Performance Indicators 3. Internal Management Reports 4. National Trends 5. State demographics 6. Other states goals and initiatives
Predecessor	1. Previous 5 year Strategic Plan 2. Performance Indicators Target 3. New changes to existing initiatives 4. A request to research
Successor	1. New Services and Programs 2. Publish new statement of goals and initiatives

Item	Details
Constraints	1. State and Federal Laws and Regulations 2. State or Federal funding 3. Stakeholder buy-in
Failures	Loss of buy in from stakeholders
Performance Measures	Quarterly & annual review of accomplishing goals and initiatives

9.4.2 Develop Agency Goals and Objectives Workflow





Successors	Results
New Services and Programs Publish new statement of goals and initiatives	New statement of official goals, objectives Initiatives.

9.5 Develop and Maintain Program Policy

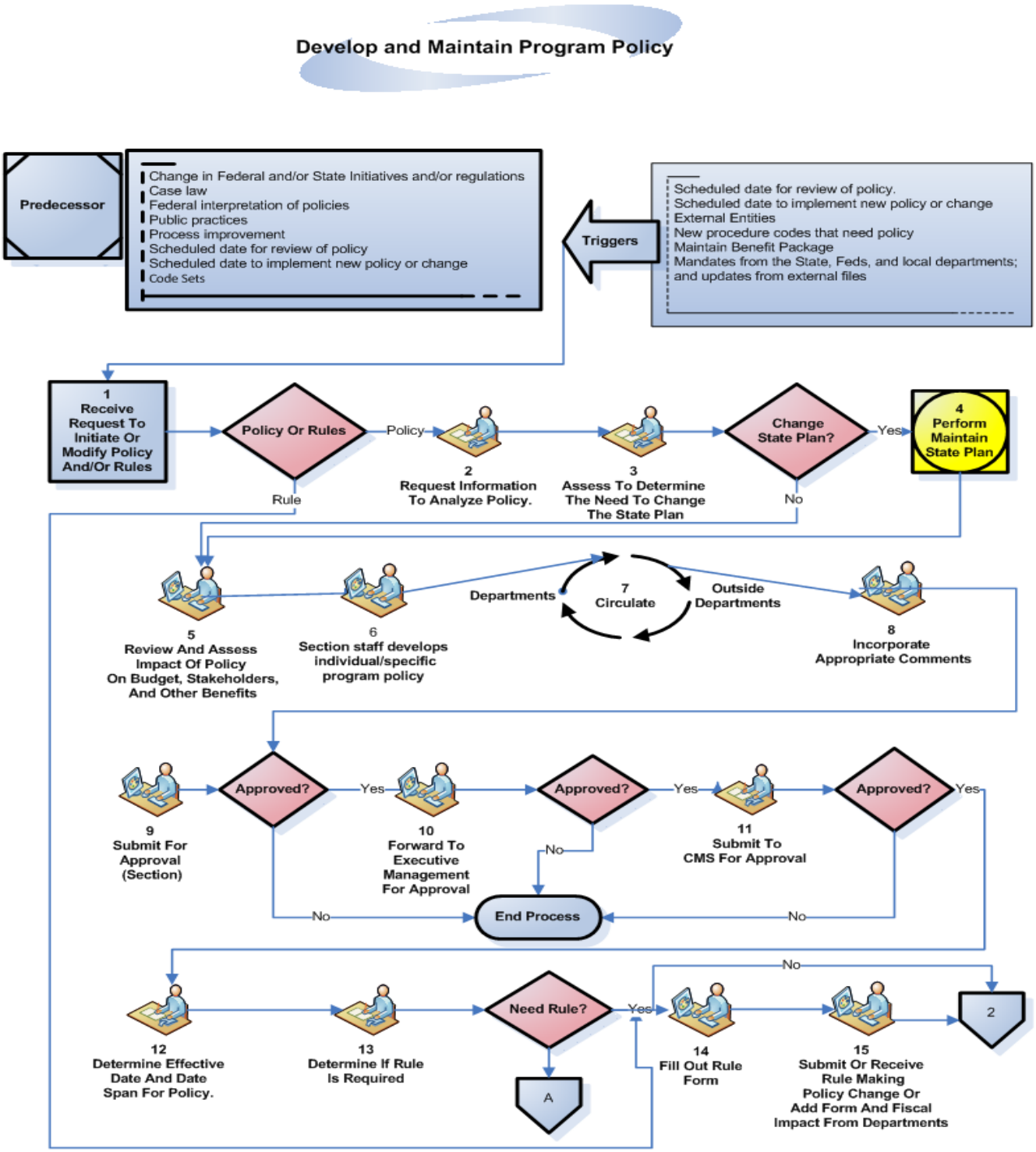
9.5.1 Develop and Maintain Program Policy Business Process Model

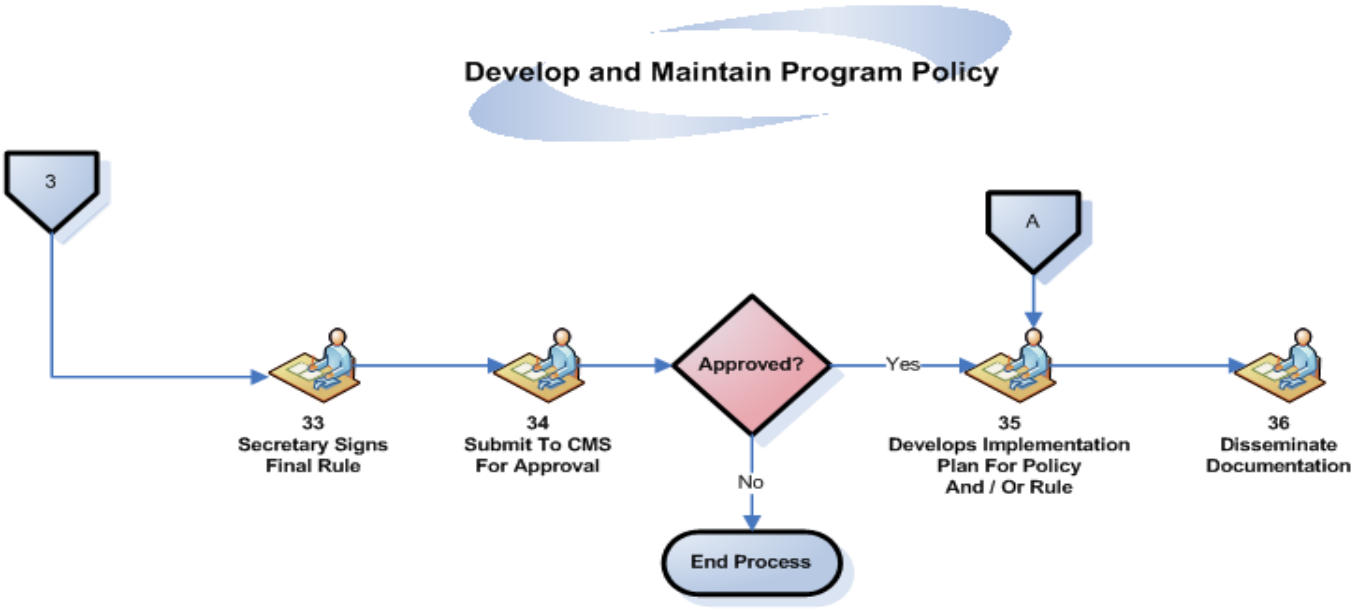
Item	Details
Description	The **Develop and Maintain Program Administrative Policy** Business Process responds to requests or needs for change in the agency's programs, benefits, or rules, based on federal or state statutes and regulations; governing board or commission directives; Internal and External quality findings; federal or state audits; agency decisions; and stakeholders interest pressure
Trigger Event	1. Scheduled date for review of policy 2. Scheduled date to implement new policy or change 3. External Entities 4. New procedure codes that need policy 5. Maintain Benefit Package 6. Mandates from the State, Feds, and local departments; and updates from external files
Result	1. New or changed policy 2. New or changed business rules 3. Change benefits
Business Process Steps	1. Receive request to initiate or modify policy and/or rules a. If Policy – Go to Step 2 b. If Rule - Go to Step 14 2. Request information to analyze policy 3. Assess to determine the need to change the state plan a. If Yes, go to Step 4 b. If No, go to Step 5 4. Go to Maintain State Plan business process 5. Review and assess impact of policy on budget, stakeholders, and other benefits. 6. Section staff develops individual/specific program policy 7. Circulate within department and outside the department for comments 8. Incorporate appropriate comments 9. Submit for approval (section) a. If Yes, go to Step 10 b. If No, End Process 10. Forward to Executive Management for approval a. If Yes, go to Step 11 b. If No, End Process 11. Approved policy is sent to CMS for review and approval a. If Yes, go to Step 12 b. If No, End Process 12. Determine effective date and date span for policy. 13. Determine if Rule is required a. If Yes, go to Step 14 b. If No, End Process 14. Fill out Rule form 15. Submit & Receive Rule Making policy change or add form and fiscal impact from departments. 16. Set up folder (including policy, add form, fiscal impact) and input in departmental stand

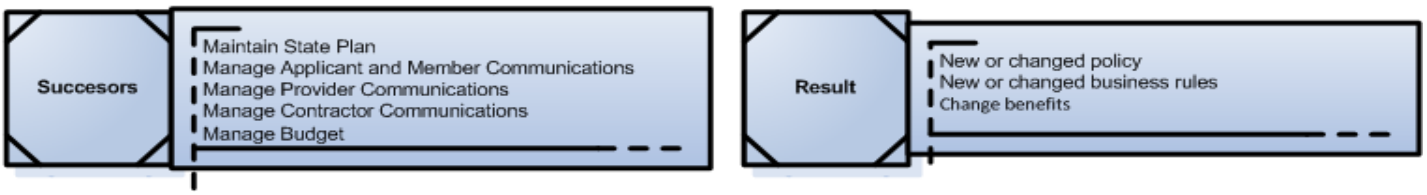
	alone tracking system 17. Develop Rule 18. Create a Notice of Intent 19. Approval of Notice of Intent a. If Yes, go to Step 20 b. If No, go back to Step 18 20. Determine if Emergency process should be used a. If Yes, go to Step 21 b. If No, go to Step 24 21. Publish ASAP in Register and/or newspapers 22. Forward to legislature 23. Secretary signs the rule, go to Step 35 24. Circulate within department and outside the department for comments 25. Send to legislative fiscal office for approval a. If Yes, go to Step 26 b. If No, End Process 26. Send to Secretary for Approval a. If Yes, go to Step 27 b. If No, End Process 27. Send to legislature and Publish Notice of Intent in Register or Newspapers 28. Conduct Public Herrings on Notice of Intent and take written comments 29. Written comments must be responded to in writing 30. Incorporate appropriate comments 31. Secretary Approval a. If Yes, go to Step 32 b. If No, End Process 32. Forward to Governor and legislature – have 30 days to call meeting and change 33. Secretary signs final rule 34. Approved rule is sent to CMS for review and approval a. If Yes, go to Step 35 b. If No, End Process 35. Develops implementation plan for Policy and / or rule 36. Disseminate documentation
Shared Data	1. Current Program Policy 2. Federal Regulations 3. National Measures 4. Standards 5. Other states policies
Predecessor	1. Change in Federal and/or State Initiatives and/or regulations 2. Case law 3. Federal interpretation of policies 4. Public practices 5. Process improvement 6. Scheduled date for review of policy 7. Scheduled date to implement new policy or change 8. Code Sets
Successor	1. Maintain State Plan 2. Manage Applicant and Member Communications 3. Manage Provider Communications

	4. Manage Contractor Communications 5. Manage Budget
Constraints	Federal State laws and regulations
Failures	1. Anticipated policy violates federal/state law, regulations, policy 2. Department chose not to implement
Performance Measures	None

9.5.2 Develop and Maintain Program Policy Workflow




Develop and Maintain Program Policy
3
33
Secretary Signs
Final Rule
34
Submit To CMS
For Approval
Approved?
Yes
No
End Process
A
35
Develops Implementation
Plan For Policy
And / Or Rule
36
Disseminate
Documentation

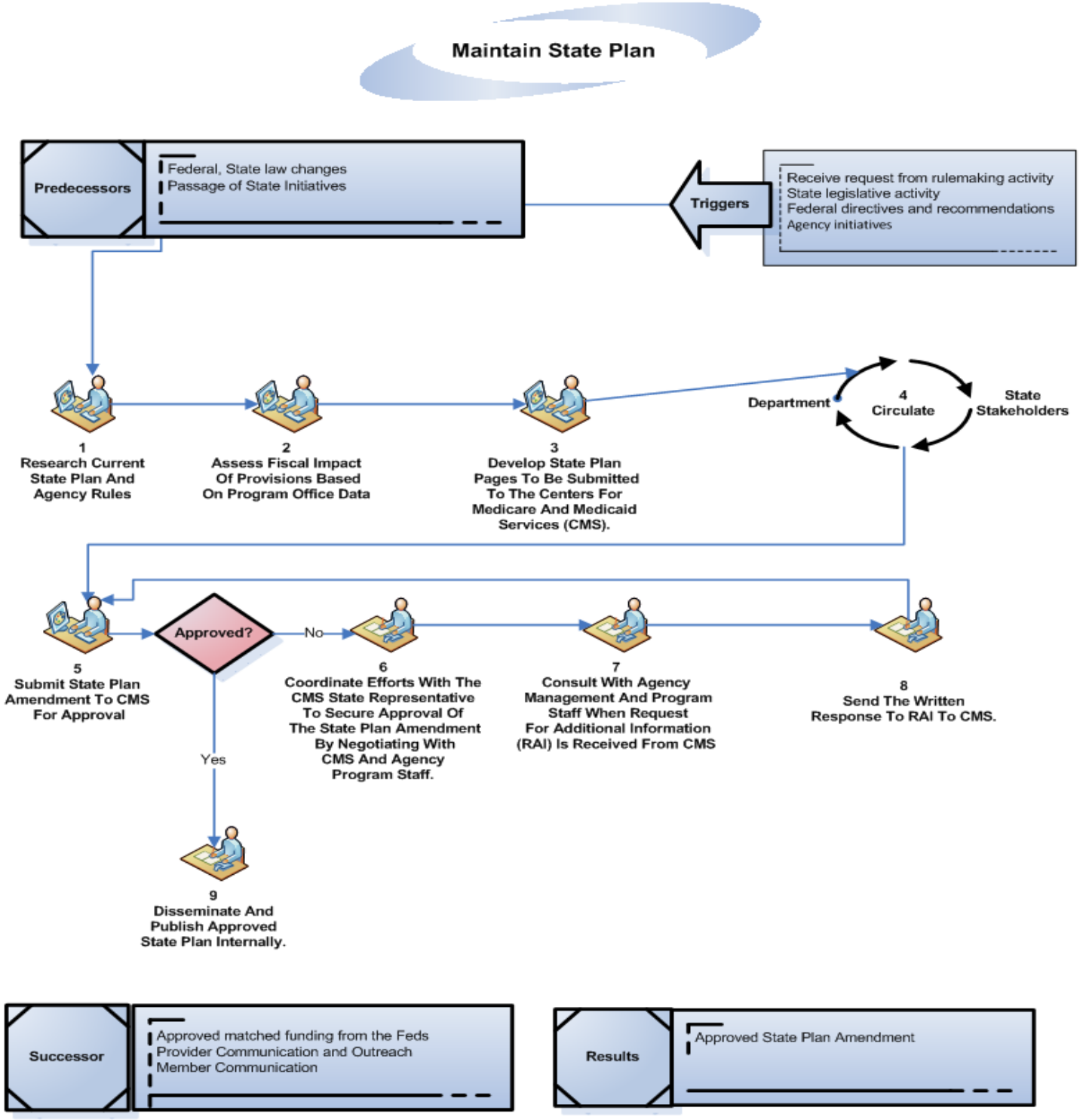

Succesors
Maintain State Plan
Manage Applicant and Member Communications
Manage Provider Communications
Manage Contractor Communications
Manage Budget
Result
New or changed policy
New or changed business rules
Change benefits

9.6 Maintain State Plan

9.6.1 Maintain State Plan Business Process Model

Item	Details
Description	The **Maintain State Plan** business process responds to the scheduled and unscheduled prompts to update and revise the State Plan. This information keeps the Department of Health and Hospitals updated with current information on the direction they are going.
Trigger Event	1. Receive request from rulemaking activity 2. State legislative activity 3. Federal directives and recommendations 4. Agency initiatives
Result	Approved State Plan Amendment
Business Process Steps	1. Research current State Plan and agency Rules 2. Assess fiscal impact of provisions based on program office data. 3. Develop State Plan pages to be submitted to the Centers for Medicare and Medicaid Services (CMS) 4. Circulate to department and state stakeholders 5. Submit State Plan Amendment to CMS for approval a. If Yes, go to Step 9 b. If No, Go to Step 6 6. Coordinate efforts with the CMS state representative to secure approval of the State Plan Amendment by negotiating with CMS and agency program staff 7. Consult with agency management and program staff when Request for Additional Information (RAI) is received from CMS. 8. Send the written response to RAI to CMS, go back to Step 5 9. Disseminate and Publish approved State Plan internally
Shared Data	1. CMS approval or denial communication 2. Other States information
Predecessor	1. Federal, State law changes 2. Passage of State Initiatives
Successor	1. Approved matched funding from the Feds 2. Provider Communication & Outreach 3. Member Communication
Constraints	State & Federal Laws, regulations and initiatives
Failures	None
Performance Measures	None

9.6.2 Maintain State Plan Business Workflow



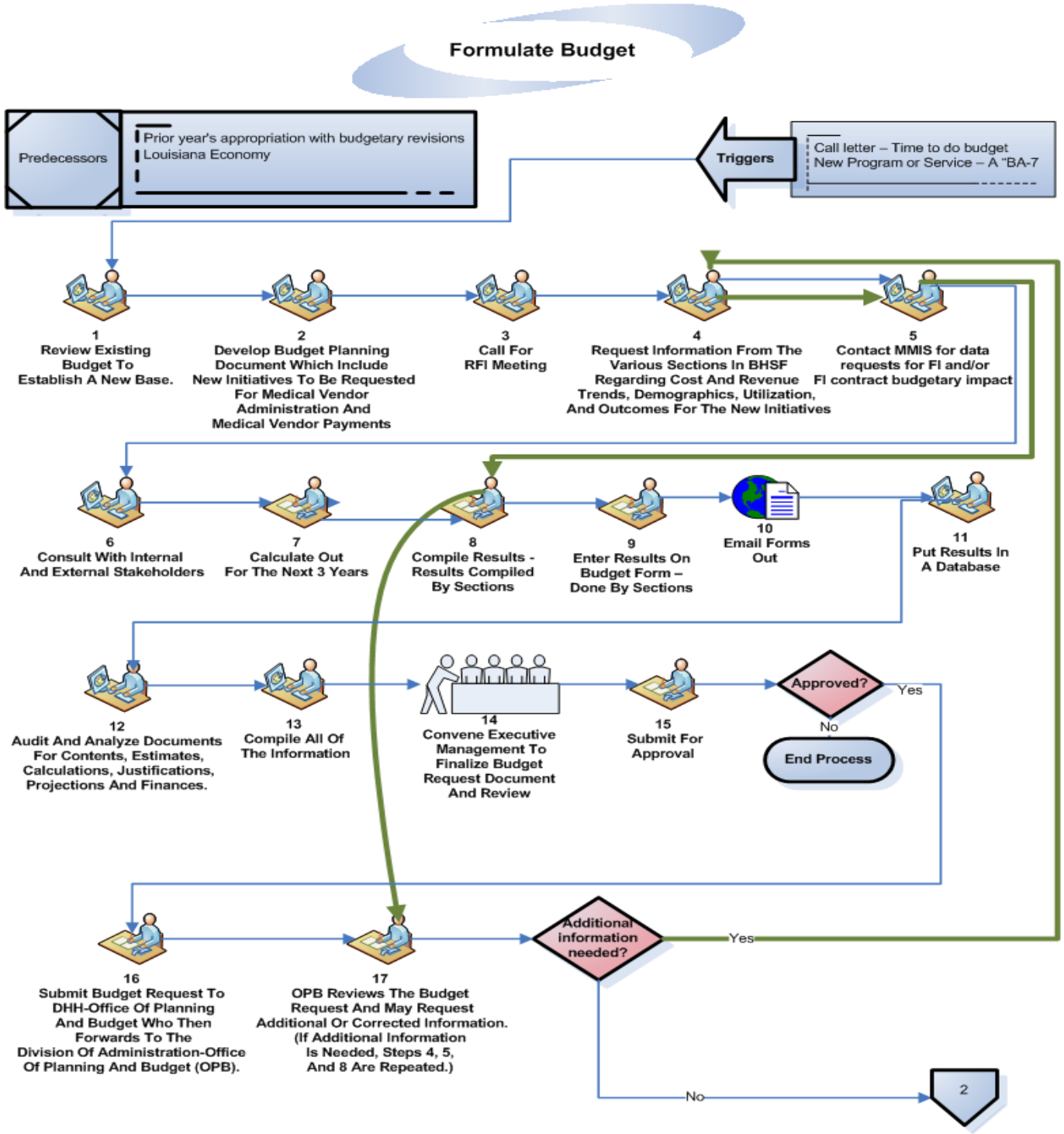
9.7 Formulate Budget

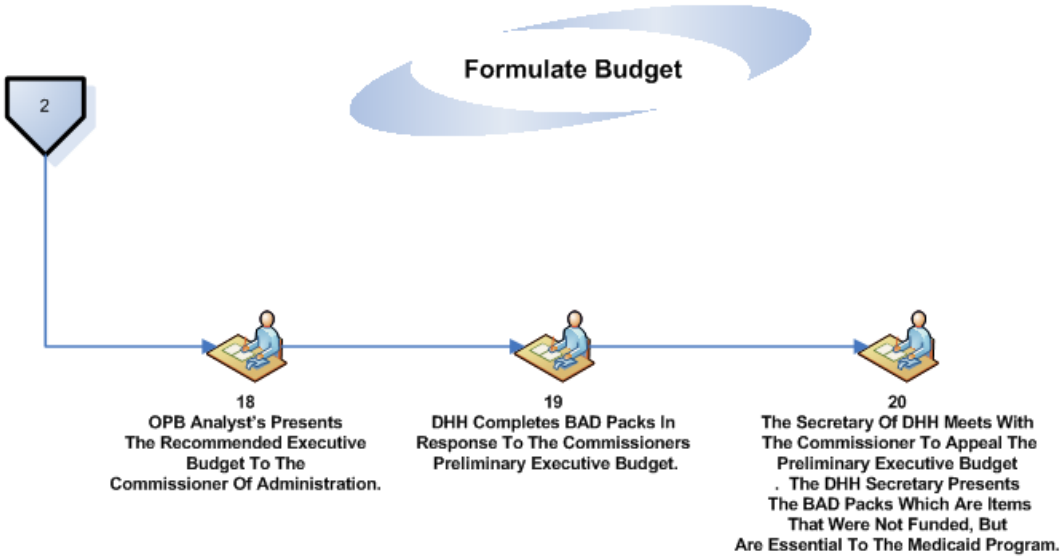
9.7.1 Formulate Budget Business Process Model

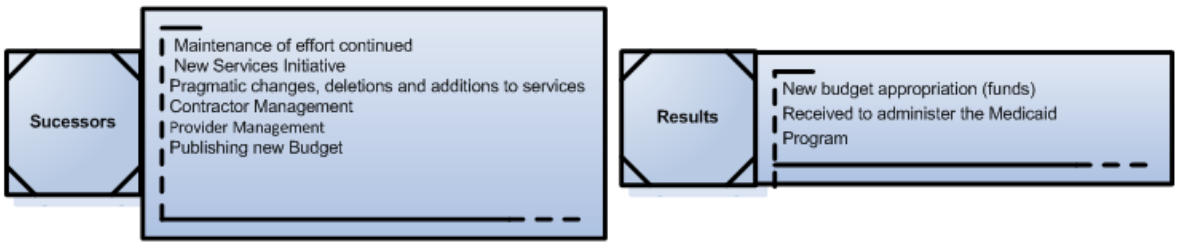
Item	Details
Description	The **Formulate Budget** business process examines the current budget, revenue stream and trends, and expenditures, assesses external factors affecting the program, assesses agency initiatives and plans, models different budget scenarios, and yearly produces a new budget.
Trigger Event	1. Call letter – Time to do budget 2. New Program or Service – A "BA-7"
Result	New budget appropriation (funds) received to administer the Medicaid Program.
Business Process Steps	1. Review existing budget to establish a new base 2. Develop budget planning document which include new initiatives to be requested for Medical Vendor Administration and Medical Vendor Payments 3. Call for RFI Meeting 4. Request information from the various sections in BHSF regarding cost and revenue trends, demographics, utilization, and outcomes for the new initiatives 5. Contact MMIS for data requests for FI and/or FI contract budgetary impact 6. Consult with internal and external stakeholders 7. Calculate out for the next 3 years 8. Compile Results – Results are compiled by the sections 9. Enter results on budget forms – done by sections 10. Email forms out 11. Put results in a database 12. Audit and analyze documents for contents, estimates, calculations, justifications, projections and finances 13. Compile all of the information 14. Convene executive management to finalize budget request document and review. 15. Submit for approval a. If Yes, go to Step 16 b. If No, End Process 16. Submit budget request to DHH-Office of Planning and Budget who then forwards to the Division of Administration-Office of Planning and Budget (OPB) 17. OPB reviews the budget request and may request additional or corrected information a. If Yes, additional information is needed, steps 4, 5, and 8 are repeated b. If No, go to Step18 18. OPB analyst's presents the recommended Executive Budget to the Commissioner of Administration 19. DHH completes BAD packs in response to the Commissioners preliminary executive budget 20. The Secretary of DHH meets with the Commissioner to appeal the preliminary Executive Budget. The DHH Secretary presents the BAD packs which are items that were not funded, but are essential to the Medicaid program
Shared Data	DOA-OPB
Predecessor	1. Prior year's appropriation with budgetary revisions 2. Louisiana Economy

Item	Details
Successor	1. Program and administrative budgets are submitted to ensure continuation of the provision and reimbursement of current services / activities 2. New Services Initiative 3. Pragmatic changes, deletions and additions to services 4. Contractor Management 5. Provider Management 6. Publishing new Budget
Constraints	1. State and Federal laws and regulations 2. Stakeholder buy-in
Failures	Governor's line-item Veto
Performance Measures	State law requires that the budget must be implemented by a specific date

9.7.2 **Formulate Budget Workflow**




Formulate Budget
2
18
OPB Analyst's Presents The Recommended Executive Budget To The Commissioner Of Administration.
19
DHH Completes BAD Packs In Response To The Commissioners Preliminary Executive Budget.
20
The Secretary Of DHH Meets With The Commissioner To Appeal The Preliminary Executive Budget . The DHH Secretary Presents The BAD Packs Which Are Items That Were Not Funded, But Are Essential To The Medicaid Program.


Sucessors
Maintenance of effort continued
New Services Initiative
Pragmatic changes, deletions and additions to services
Contractor Management
Provider Management
Publishing new Budget
Results
New budget appropriation (funds)
Received to administer the Medicaid
Program

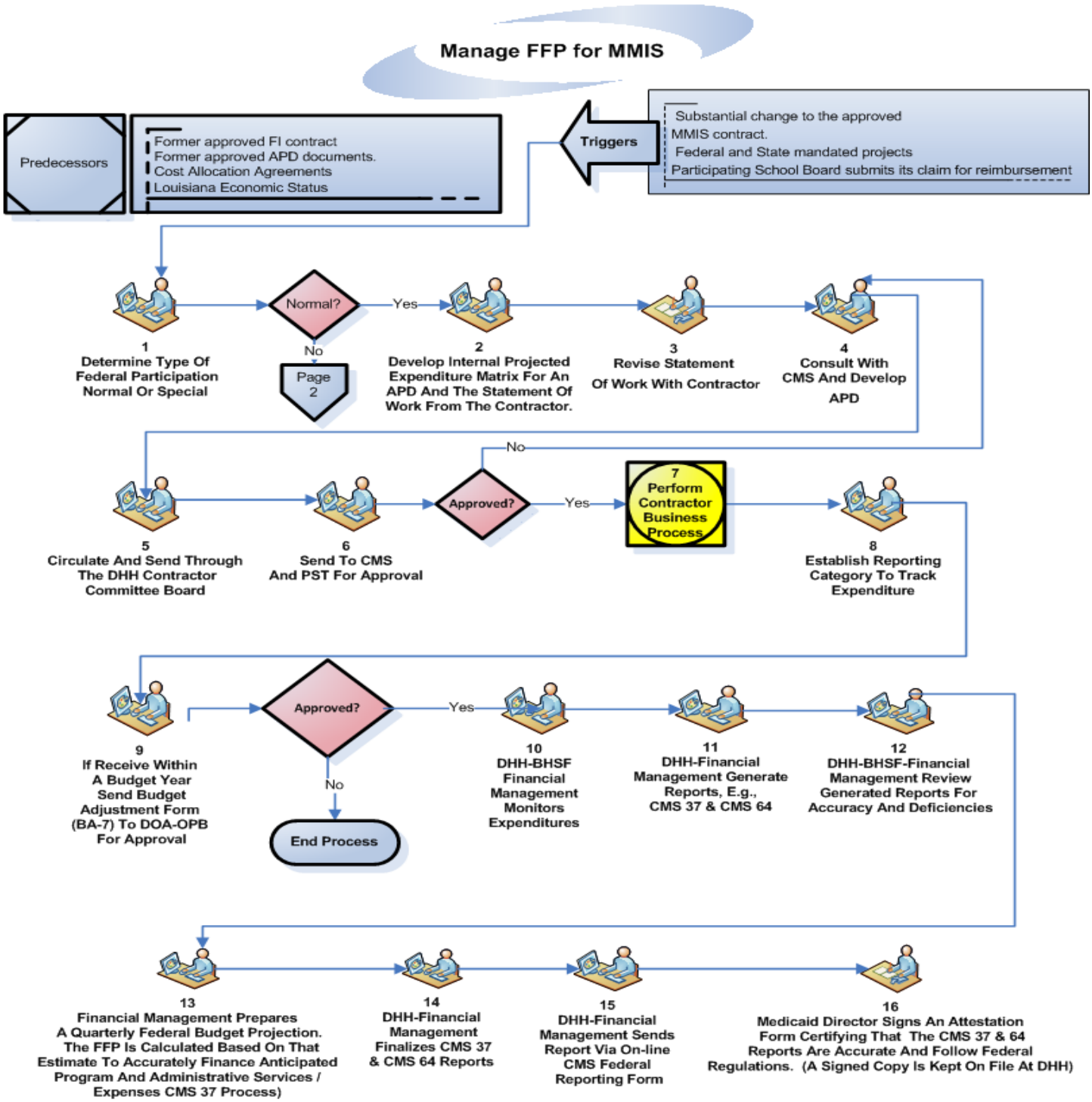
9.8 Manage FFP for MMIS

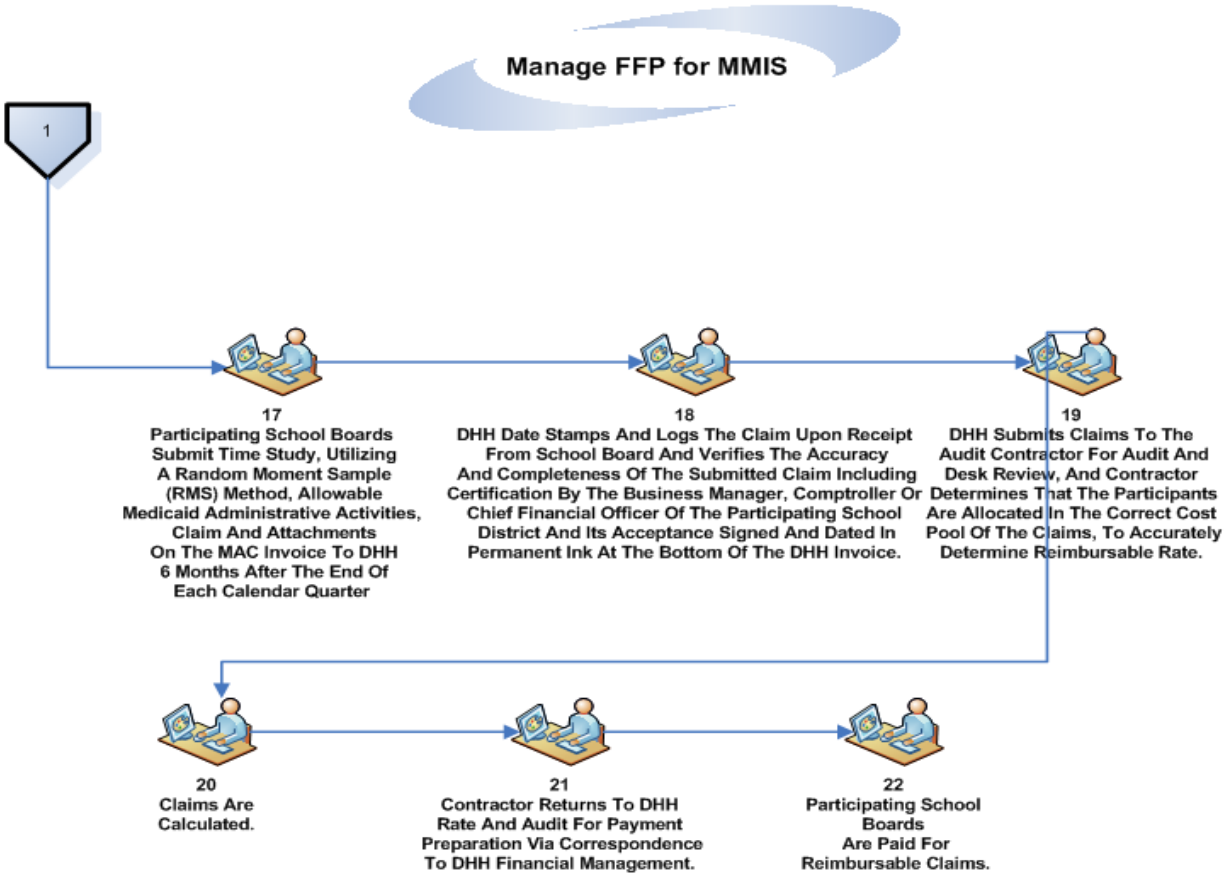
9.8.1 Manage FFP for MMIS Business Process Model

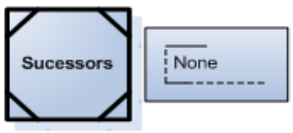
Item	Details
Description	The **Manage Federal Financial Participation** business process oversees reporting and monitoring of Advanced Planning Documents and other program documents and funds necessary to secure and maintain federal financial participation. The Federal government allows funding for the design, development, maintenance, and operation of a federally certified MMIS. Note: This is not a stand-alone process. Part of this process is contracted out through Cost-Allocation to DHH-Financial Management.
Trigger Event	1. Substantial change to the approved MMIS contract 2. Federal and State mandated projects 3. Participating School Board submits its claim for reimbursement
Result	1. State receives maximum Federal Financial Participation available for all eligible clients, systems, and administration of the MMIS 2. Send reporting information e.g. CMS 64 & CMS 37 report etc. via on-line CSM forms 3. Claims are desk reviewed by Audit Contractor and submitted to DHH for payment
Business Process Steps	1. Determine Type of Federal participation Normal or Special a. If Yes, go to Step 2 b. If No, go to Step 17 **Normal** 2. Develop internal Projected Expenditure Matrix for an APD and the statement of work from the contractor 3. Revise statement of work with contractor 4. Consult with CMS and develop APD 5. Circulate and send through the DHH Contractor Committee Board 6. Send to CMS and PST for approval a. If Yes, go to Step 7 b. If No, go to Step 3 7. Perform Contractor Business Processes 8. Establish reporting category to track expenditure 9. If receive within a Budget year send Budget Adjustment form (BA-7) to DOA-OPB for approval a. If Yes, go to Step 10 b. If No, End Process 10. DHH-BHSF Financial Management monitors expenditures 11. DHH-Financial Management Generate reports, e.g., CMS 37 & CMS 64 12. DHH-BHSF-Financial Management review generated reports for accuracy and deficiencies 13. Financial Management prepares a quarterly federal budget projection. The FFP is calculated based on that estimate to accurately finance anticipated program and administrative services / expenses CMS 37 process) 14. DHH-Financial Management finalizes CMS 37 & CMS 64 reports 15. DHH-Financial Management sends report via on-line CMS Federal Reporting Form 16. Medicaid Director signs an attestation form certifying that the CMS 37 & 64 reports are accurate and follow federal regulations. (A signed copy is kept on file at DHH)

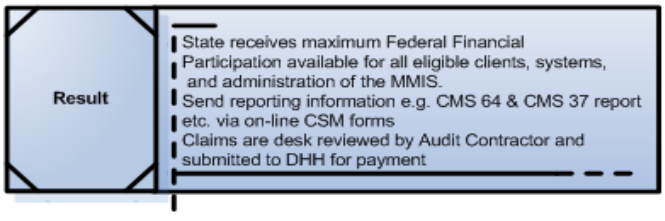
	Special 17. Participating School Boards submit time study, utilizing a random moment sample (RMS) method, allowable Medicaid administrative activities, claim, and attachments on the MAC invoice to DHH 6 months after the end of each calendar quarter. 18. DHH date stamps and logs the claim upon receipt from school board and verifies the accuracy and completeness of the submitted claim including certification by the Business Manager, Comptroller or Chief Financial Officer of the participating school district and its acceptance signed and dated in permanent ink at the bottom of the DHH invoice 19. DHH submits Claims to the Audit Contractor for audit and desk review, and Contractor determines that the participants are allocated in the correct Cost Pool of the claims, to accurately determine reimbursable rate 20. Claims are calculated 21. Contractor returns to DHH Rate and Audit for payment preparation via correspondence to DHH financial management 22. Participating School Boards are paid for reimbursable claims
Shared Data	ISIS
Predecessor	1. Former approved FI contract 2. Former approved APD documents 3. Cost Allocation Agreements 4. Louisiana Economic Status
Successor	None
Constraints	State and Federal laws and regulations
Failures	None
Performance Measures	Federal Requirements

9.8.2 Manage FFP for MMIS Workflow




Manage FFP for MMIS
1
17
Participating School Boards Submit Time Study, Utilizing A Random Moment Sample (RMS) Method, Allowable Medicaid Administrative Activities, Claim And Attachments On The MAC Invoice To DHH 6 Months After The End Of Each Calendar Quarter
18
DHH Date Stamps And Logs The Claim Upon Receipt From School Board And Verifies The Accuracy And Completeness Of The Submitted Claim Including Certification By The Business Manager, Comptroller Or Chief Financial Officer Of The Participating School District And Its Acceptance Signed And Dated In Permanent Ink At The Bottom Of The DHH Invoice.
19
DHH Submits Claims To The Audit Contractor For Audit And Desk Review, And Contractor Determines That The Participants Are Allocated In The Correct Cost Pool Of The Claims, To Accurately Determine Reimbursable Rate.
20
Claims Are Calculated.
21
Contractor Returns To DHH Rate And Audit For Payment Preparation Via Correspondence To DHH Financial Management.
22
Participating School Boards Are Paid For Reimbursable Claims.


Sucessors
None

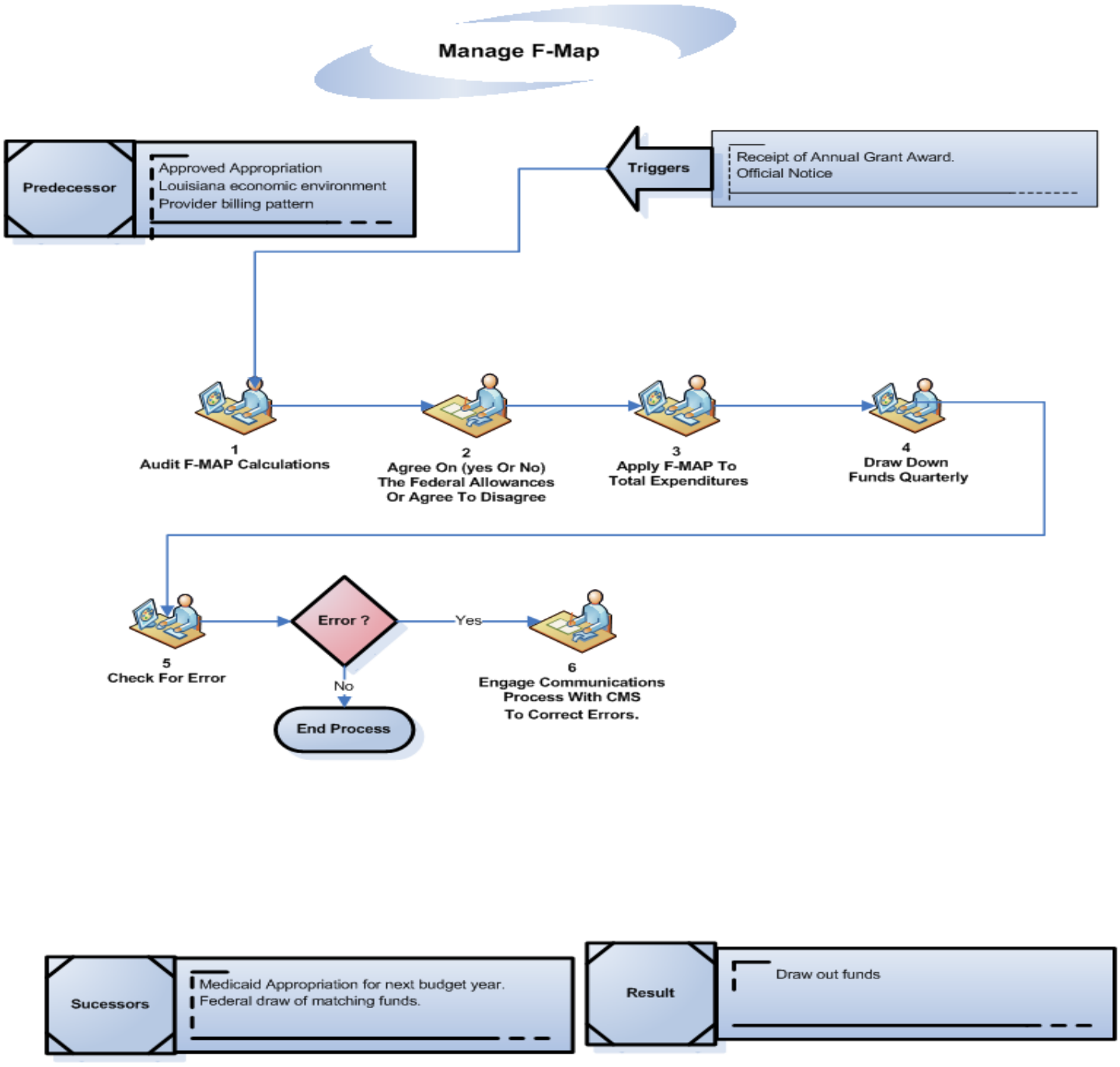

Result
State receives maximum Federal Financial Participation available for all eligible clients, systems, and administration of the MMIS.
Send reporting information e.g. CMS 64 & CMS 37 report etc. via on-line CSM forms
Claims are desk reviewed by Audit Contractor and submitted to DHH for payment

9.9 Manage F-MAP

9.9.1 Manage F-MAP Business Process Model

Item	Details
Description	The **Manage F-MAP** business process periodically assesses current Federal Medical Assistance Percentage (F-MAP) for benefits and administrative services to determine compliance with federal regulations and state objectives.
Trigger Event	1. Receipt of Annual Grant Award 2. Official Notice
Result	Draw out funds
Business Process Steps	1. Audit F-MAP Calculations 2. Agree on (yes or no) the Federal Allowances or agree to disagree 3. Apply F-MAP to total expenditures 4. Draw down funds quarterly 5. Check for Error a. If Yes, Go to Step 6 b. If No, End Process 6. Engage communications process with CMS to correct errors.
Shared Data	1. ISIS HR Reports 2. ISIS Financial Reports
Predecessor	1. Grant Award 2. Louisiana Economy
Successor	1. Medicaid Appropriation for next budget year 2. Federal draw of matching funds
Constraints	Must have updated cost allocation plan
Failures	None
Performance Measures	None

9.9.2 Manage F-MAP Workflow

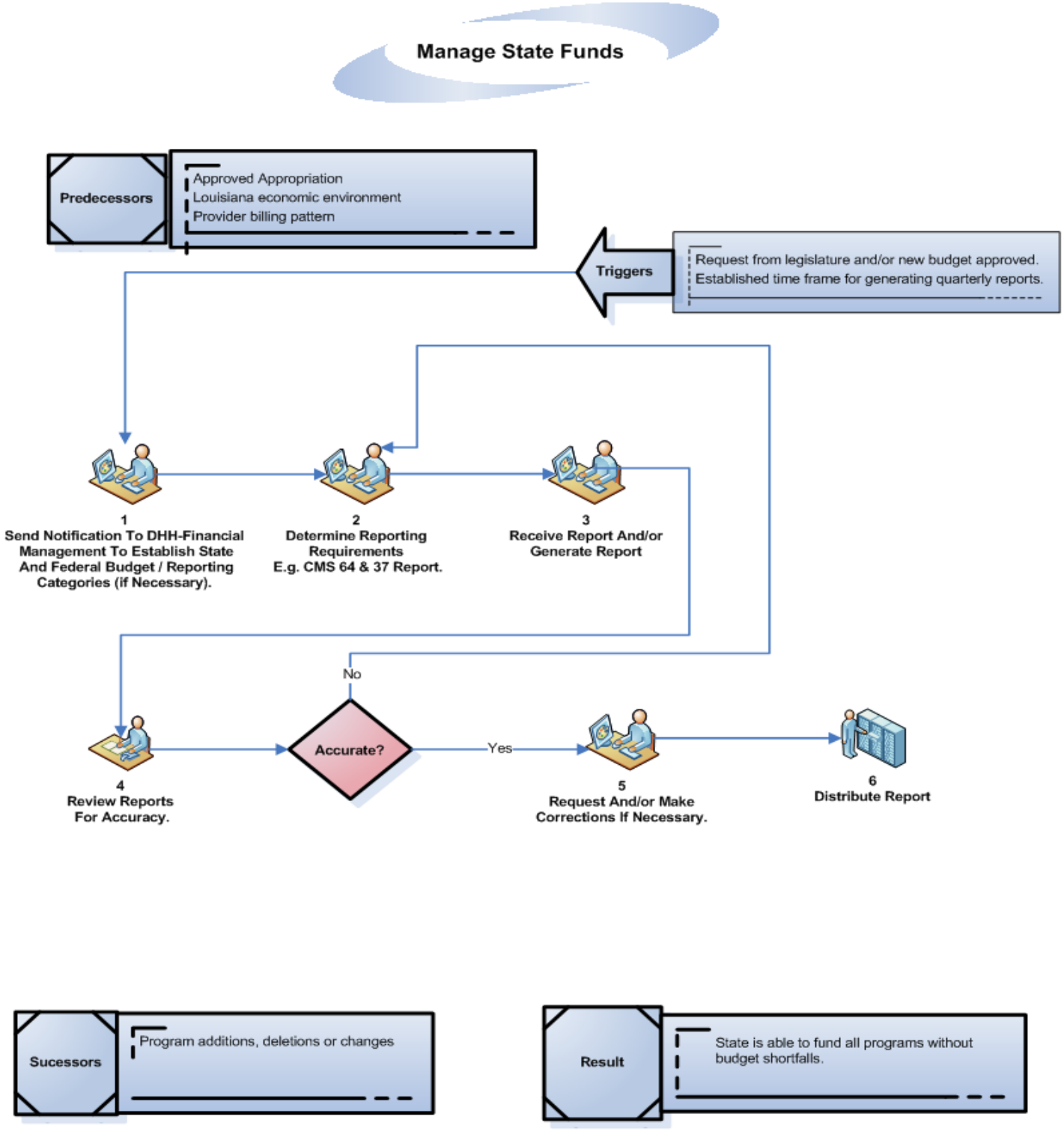


9.10 Manage State Funds

9.10.1 Manage State Funds Business Process Model

Item	Details
Description	The **Manage State Funds** business process oversees Medicaid state funds, ensures accuracy in reporting of funding sources and monitors state funds through ongoing tracking and reporting of expenditures. Note: This is not a stand-alone process. Part of this process is contracted out through Cost-Allocation to DHH-Financial Management.
Trigger Event	1. Request from legislature and/or new budget approved 2. Established time frame for generating quarterly reports
Result	State is able to fund all programs without budget shortfalls
Business Process Steps	1. Send notification to DHH-Financial Management to establish state and federal budget / reporting categories (if necessary) 2. Determine reporting requirements e.g. CMS 64 & 37report 3. Receive report and/or generate report 4. Review reports for accuracy a. If Yes, go to Step 5 b. If No, go back to Step 2 5. Request and/or make corrections if necessary 6. Distribute report
Shared Data	1. Accounting Tables 2. ISIS HR and Financial Management Applications 3. Statement of Expenditures 4. Medicaid Management Reports
Predecessor	1. Approved Appropriation 2. Louisiana economic environment 3. Provider billing pattern
Successor	Program additions, deletions or changes
Constraints	State and Federal laws and regulations
Failures	None
Performance Measures	None

9.10.2 Manage State Funds Workflow



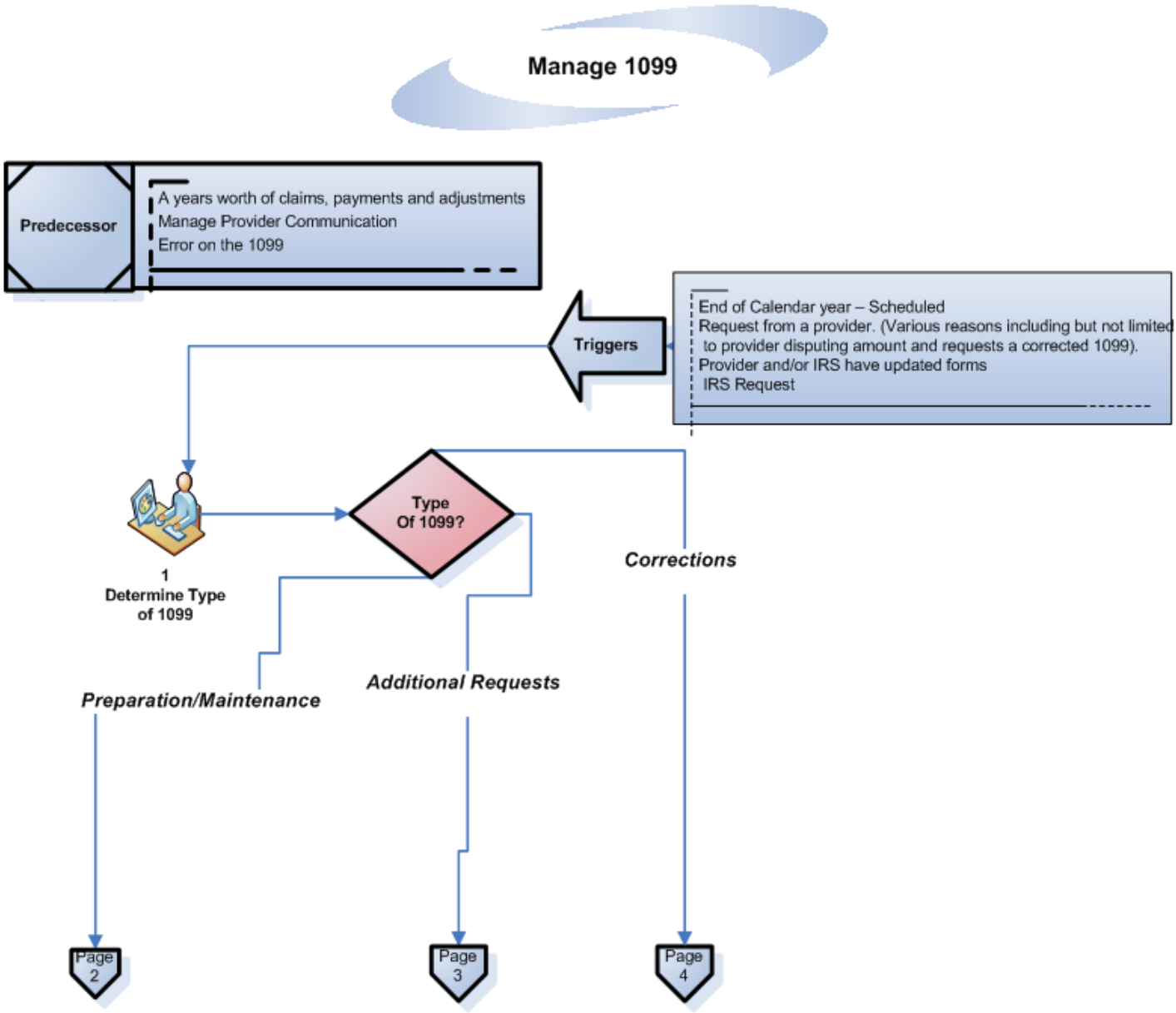
9.11 Manage 1099

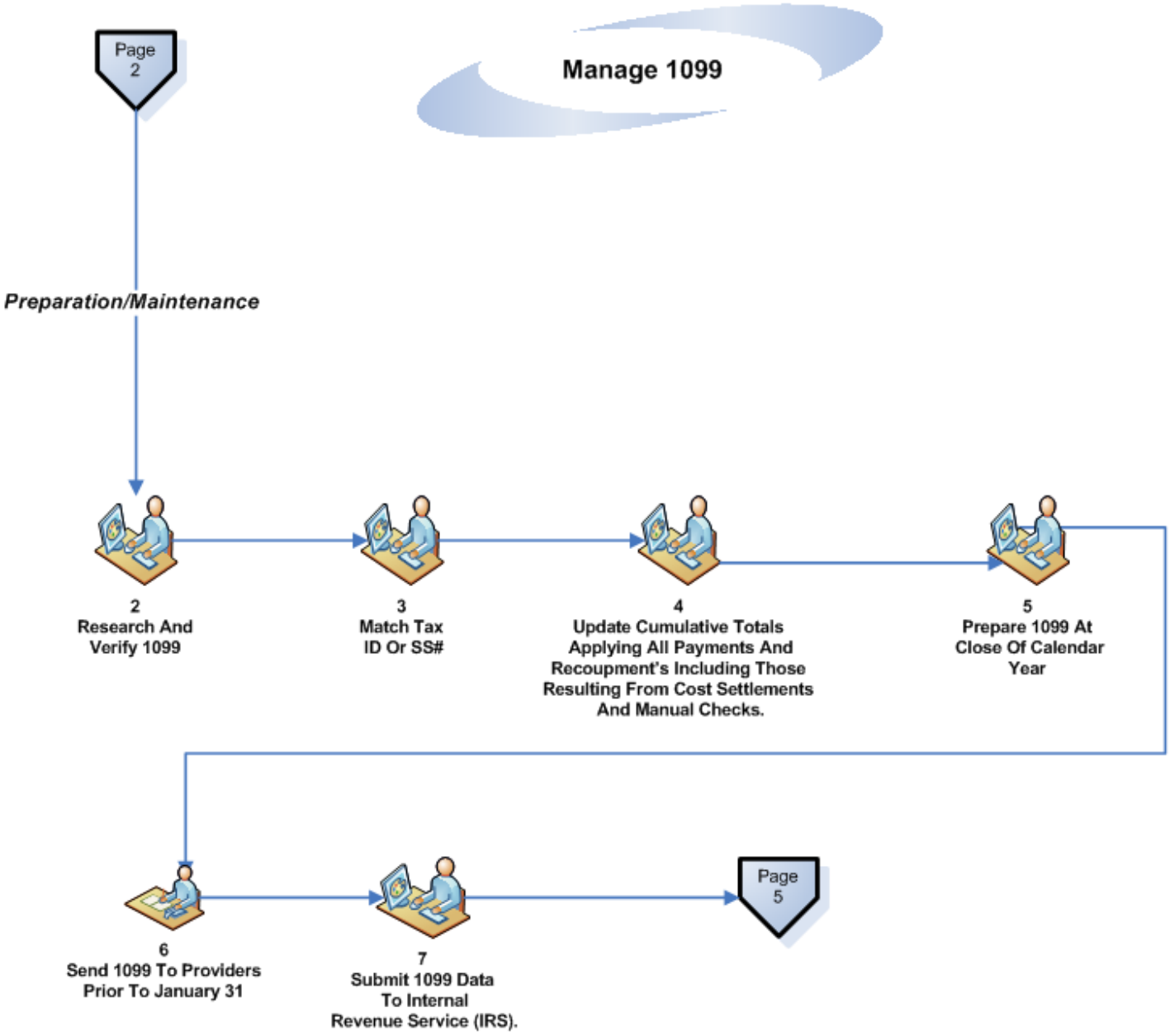
9.11.1 Manage 1099 Business Process Model

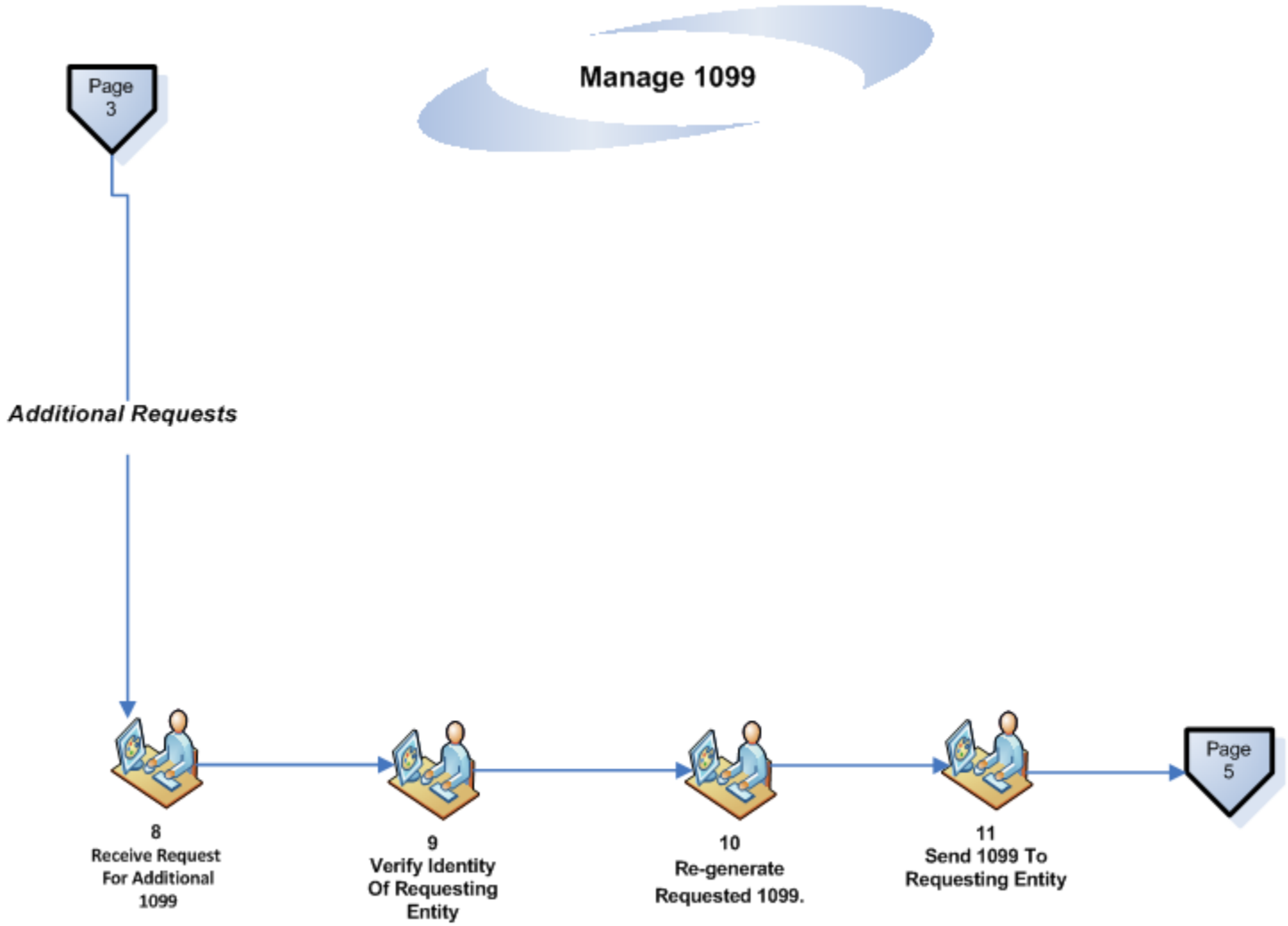
Item	Details
Description	The **Manage 1099s** business process describes the process by which 1099s are handled including preparation, maintenance, and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number. The Provider Enrollment Unit is responsible for assuring that there are no errors and/or mismatches reported to the Internal Revenue Service. The *Manage 1099s* process which is handled by the Provider Enrollment Unit may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies to be sent via mail to the requestor. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.
Trigger Event	1. End of Calendar year – Scheduled 2. Request from a provider (Various reasons including but not limited to provider disputing amount and requests a corrected 1099) 3. Provider and/or IRS have updated forms 4. IRS Request
Result	Updated and/or corrected 1099 forms sent to providers and IRS
Business Process Steps	1. Determine the Type of 1099 a. If Preparation/Maintenance, go to Step 2 b. If Additional Request, go to Step 8 c. If Correction, go to Step 12 **Preparation/Maintenance** 2. Research and Verify 1099 3. Match tax ID or SS# 4. Update cumulative totals applying all payments and recoupment's including those resulting from cost settlements and manual checks. 5. Prepare 1099 at close of calendar year. 6. Send 1099 to providers prior to January 31 7. Submit 1099 data to Internal Revenue Service (IRS), go to Step 24 **Additional Request** 8. Receive request for additional 1099 9. Verify identity of requesting entity 10. Re-generate requested 1099 11. Send 1099 to requesting entity, go to Step 24 **Correction** 12. Receive notification of error from provider 13. Verify identity of provider 14. Research error or update request. Review provider record to determine if there is truly an error. a. If Yes, go to Step 15 b. If No, Notify Provider of finding, End Process 15. PE must determine why and/or how the error occurred. If determined the discrepancy was a worker error; i.e. documentation in record but information was entered incorrectly

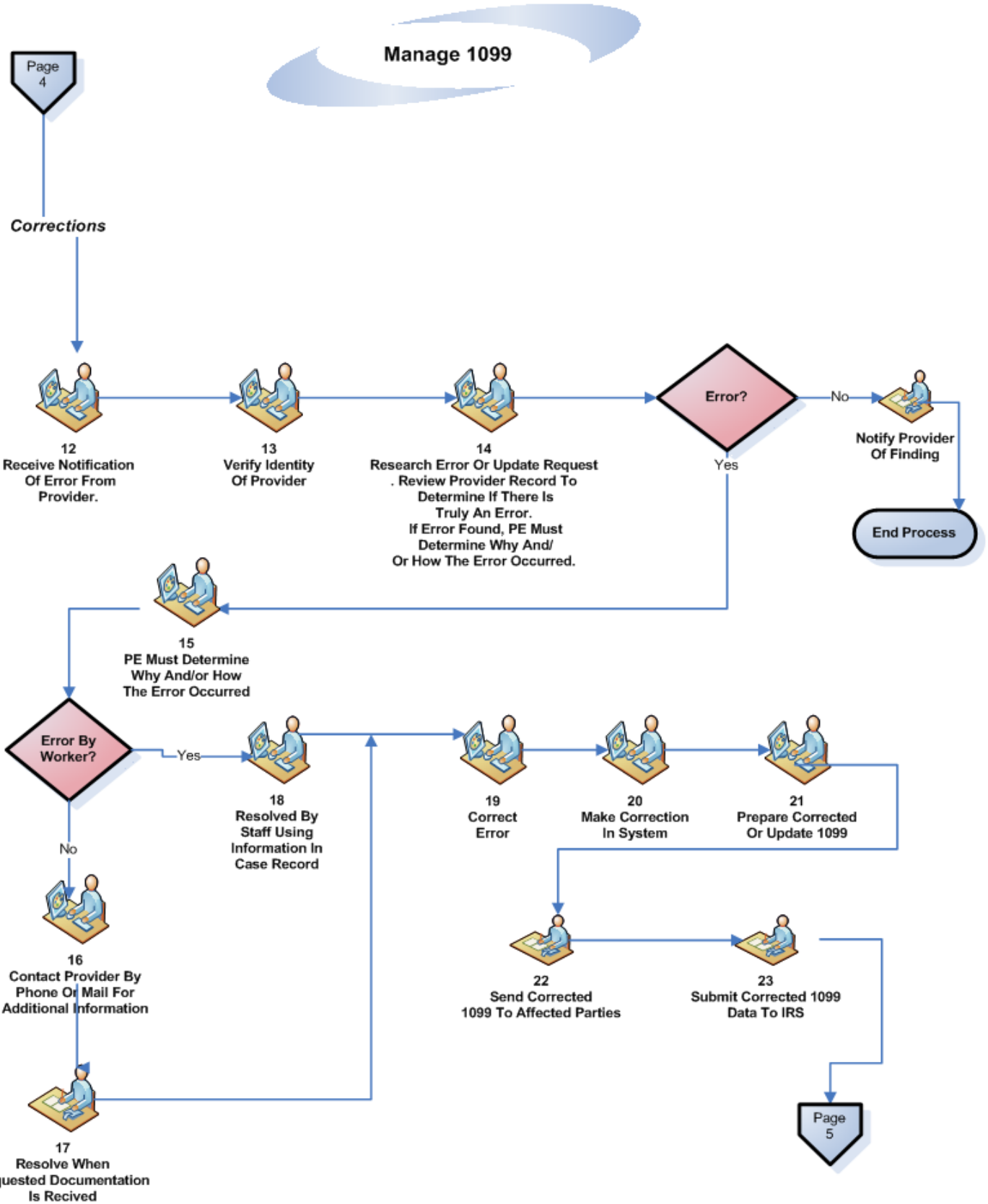
	a. If Yes, go to Step 18 b. If No, go to Step 16 16. Contact provider by phone or mail for additional information 17. Resolve when requested documentation is received, go to Step 19 18. Resolved by staff using information in case record 19. Correct Error 20. Make correction in system 21. Prepare corrected or updated1099 22. Send corrected 1099 to affected parties 23. Submit corrected 1099 data to Internal Revenue Service (IRS) 24. File hard copy of 1099
Shared Data	Internal Revenue Service
Predecessor	1. A years worth of claims, payments and adjustments 2. Manage Provider Communication *3.* Error on the 1099
Successor	None
Constraints	1. Provider must report accurate and updated information 2. State and Federal laws and regulations
Failures	Provider fails to follow through with information
Performance Measures	Number of mismatches received from Internal Revenue Service.

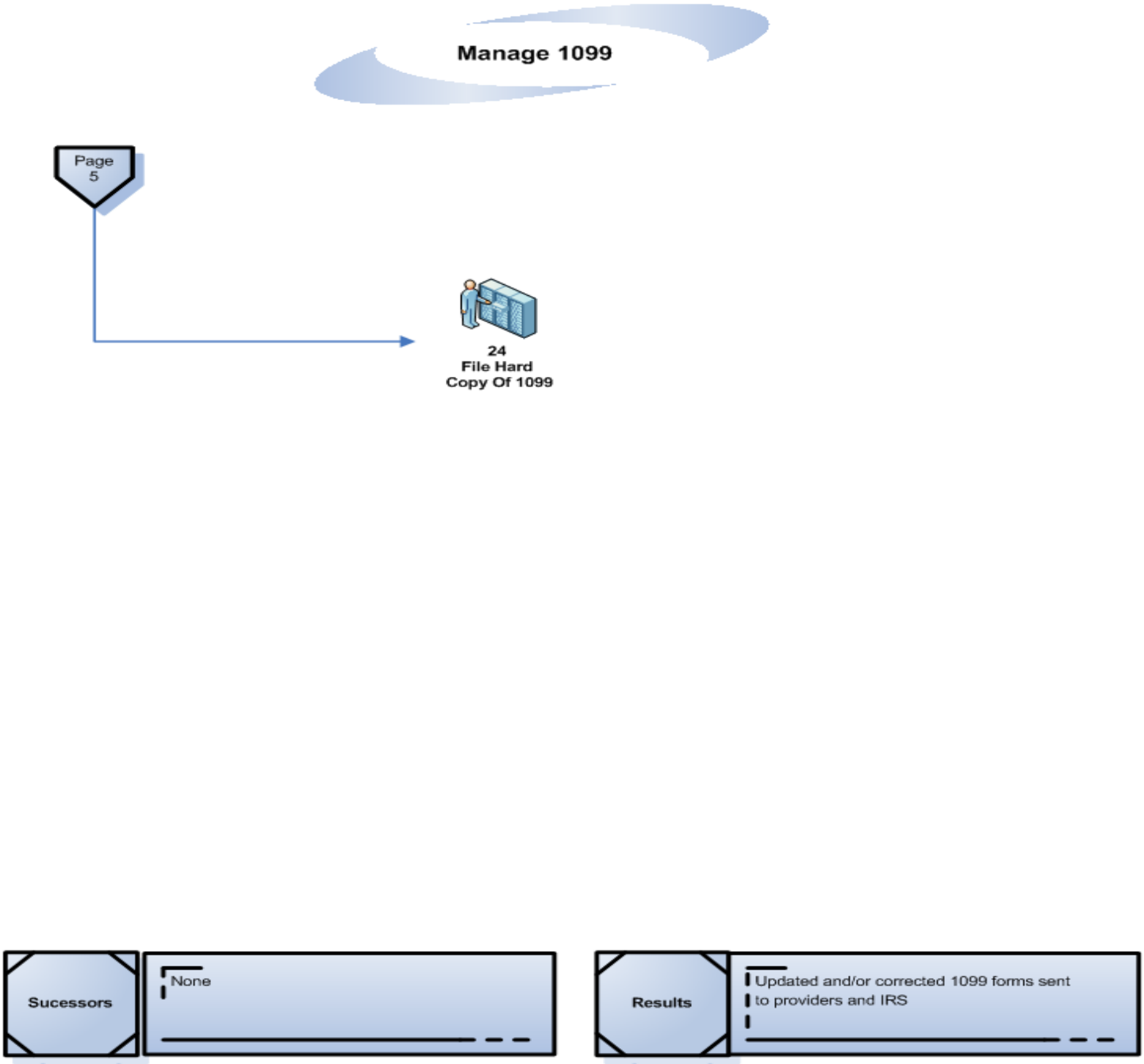
9.11.2 Manage 1099 Workflow




Page 2
Manage 1099
Preparation/Maintenance
2
Research And Verify 1099
3
Match Tax ID Or SS#
4
Update Cumulative Totals Applying All Payments And Recoupment's Including Those Resulting From Cost Settlements And Manual Checks.
5
Prepare 1099 At Close Of Calendar Year
6
Send 1099 To Providers Prior To January 31
7
Submit 1099 Data To Internal Revenue Service (IRS).
Page 5


Manage 1099
Page 3
Additional Requests
8
Receive Request For Additional 1099
9
Verify Identity Of Requesting Entity
10
Re-generate Requested 1099.
11
Send 1099 To Requesting Entity
Page 5


Manage 1099
Page 4
Corrections
12 Receive Notification Of Error From Provider.
13 Verify Identity Of Provider
14 Research Error Or Update Request . Review Provider Record To Determine If There Is Truly An Error. If Error Found, PE Must Determine Why And/ Or How The Error Occurred.
Error?
No
Notify Provider Of Finding
End Process
Yes
15 PE Must Determine Why And/or How The Error Occurred
Error By Worker?
Yes
18 Resolved By Staff Using Information In Case Record
19 Correct Error
20 Make Correction In System
21 Prepare Corrected Or Update 1099
No
16 Contact Provider By Phone Or Mail For Additional Information
22 Send Corrected 1099 To Affected Parties
23 Submit Corrected 1099 Data To IRS
17 Resolve When Requested Documentation Is Recived
Page 5

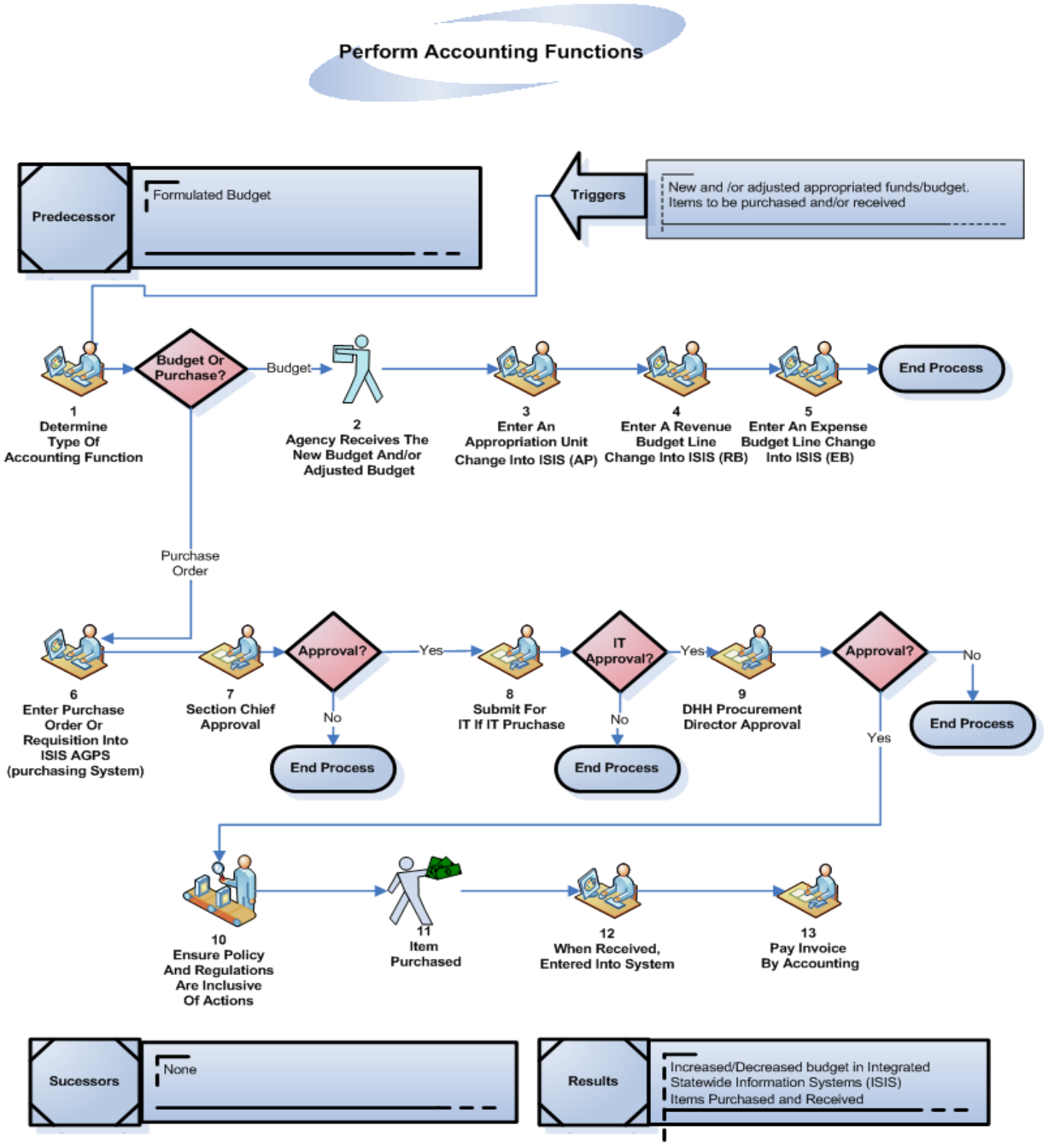

Manage 1099
Page 5
24
File Hard Copy Of 1099
Sucessors
None
Results
Updated and/or corrected 1099 forms sent to providers and IRS

9.12 Perform Accounting Functions

9.12.1 Perform Accounting Functions Business Process Model

Item	Details
Description	The **Perform Accounting functions** business process describes the process by which accounting tables are accessed to increase/decrease budgets; purchase and receive items. Note: Accounting functions for Revenues and Expenditures is contracted out through Cost Allocation to DHH-Financial Management.
Trigger Event	1. New and /or adjusted appropriated funds/budget 2. Items to be purchased and/or received
Result	1. Increased/Decreased budget in Integrated Statewide Information Systems (ISIS) 2. Items Purchased and Received
Business Process Steps	1. Determine the type of Accounting Function a. If Appropriated Budget, go to Step 2 b. If Purchase Orders (Tracked by individual managers), go to Step 6 2. Agency receives the new budget and/or adjusted budget. 3. Enter an Appropriation Unit change into ISIS (AP) 4. Enter a Revenue Budget line change into ISIS (RB) 5. Enter an Expense Budget line change into ISIS (EB), End Process 6. Enter Purchase Order or Requisition into ISIS AGPS (purchasing system) 7. Section Chief approval applied in ISIS AGPS a. If Yes, go to Step 8 b. If No, End Process 8. Submit for IT approval if IT purchases a. If Yes, go to Step 9 b. If No, End Process 9. DHH Procurement Director approval applied in ISIS AGPS a. If Yes, go to Step 10 b. If No, End Process 10. Ensure policy and regulations are inclusive of actions 11. Item Purchased 12. When received, entered into system 13. Pay invoice by accounting
Shared Data	1. Approved BA-7s 2. ISIS Accounting tables 3. ISIS Purchasing screens 4. ISIS Accounts receivable screens
Predecessor	Formulated Budget
Successor	None
Constraints	State and Federal laws and regulations
Failures	1. Disapproved BA-7 and/or Budget 2. Budget cuts
Performance Measures	None

9.12.2 Perform Accounting Functions Workflow



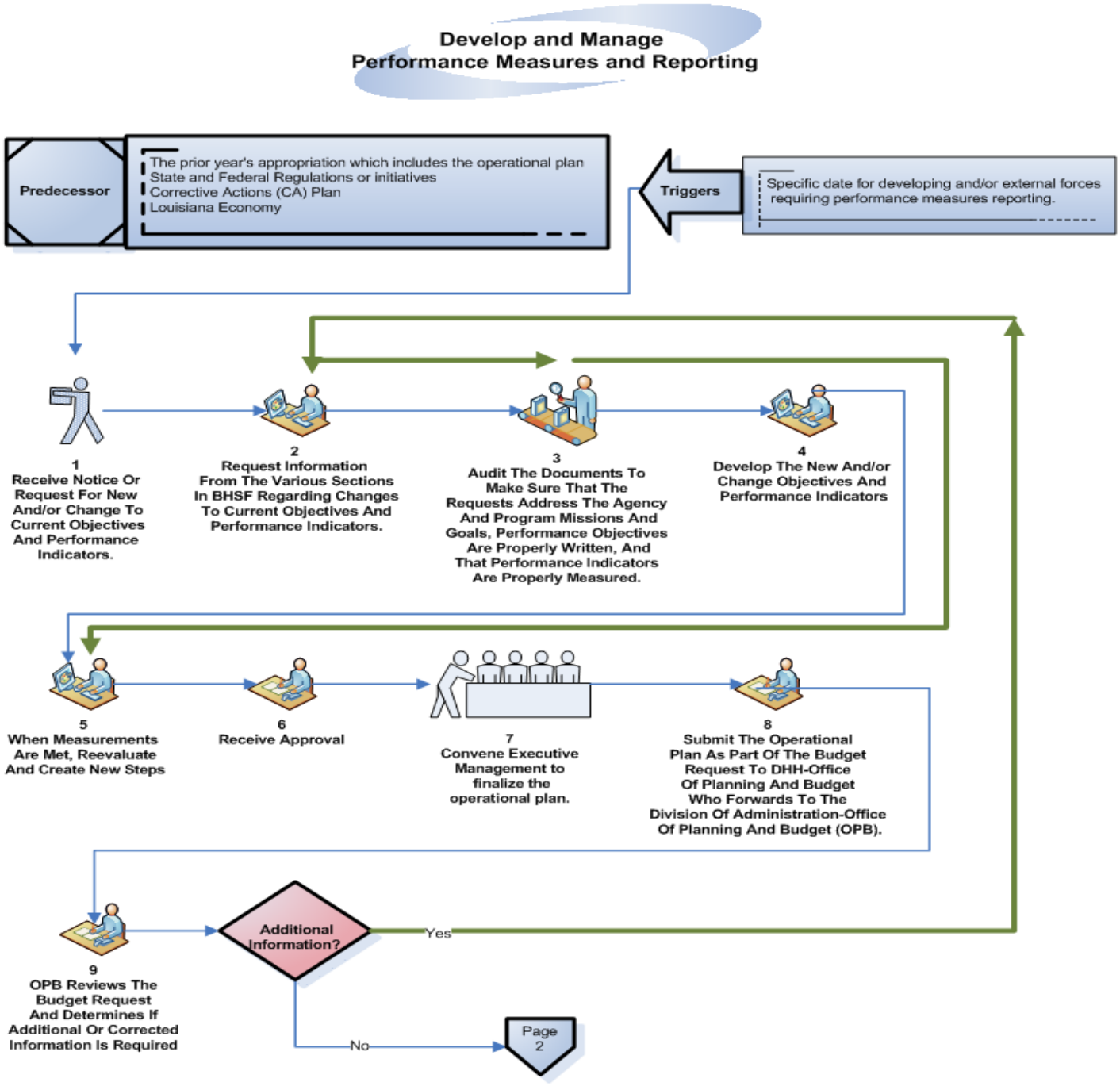
9.13 Develop and Manage Performance Measures and Reports

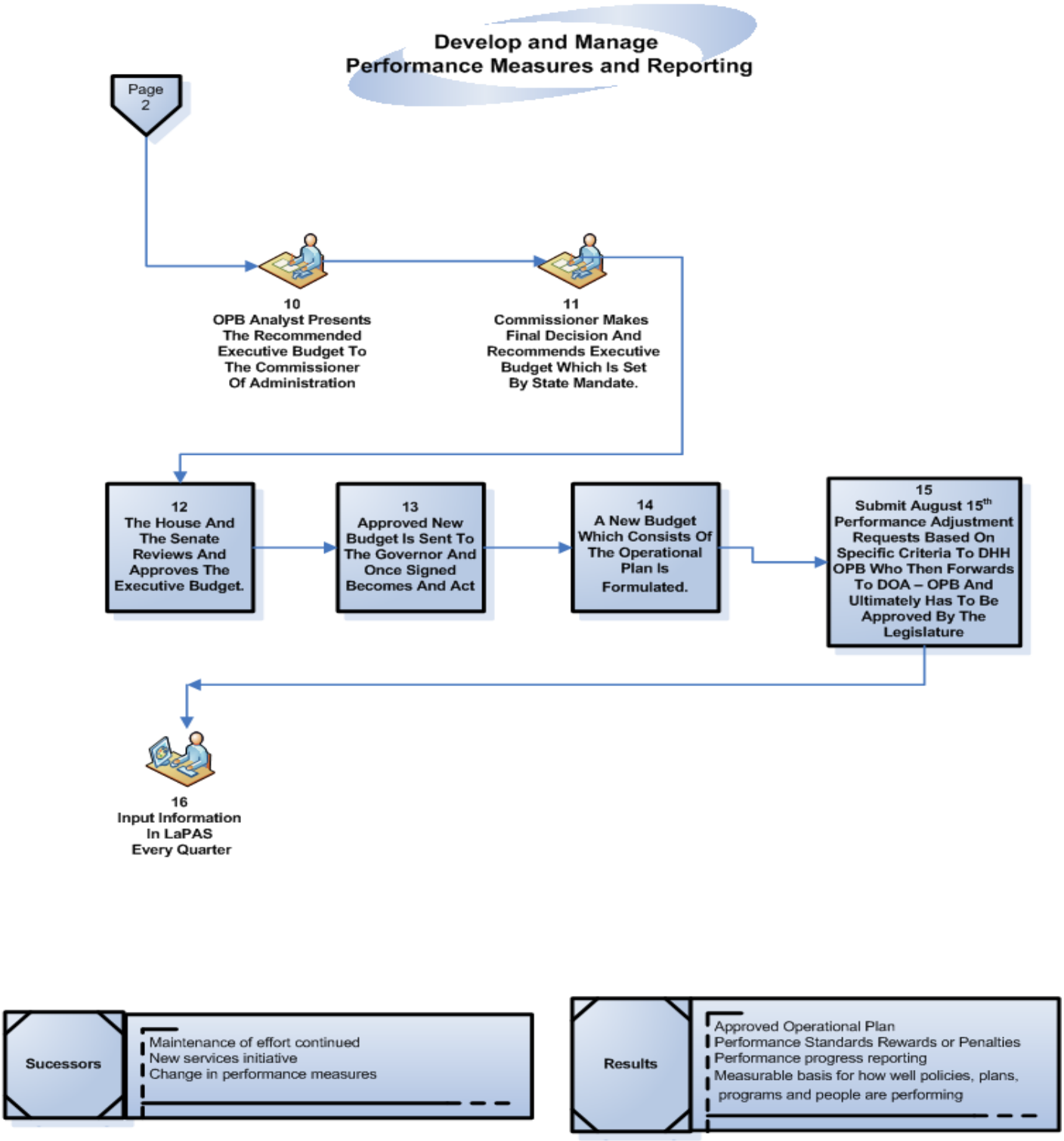
9.13.1 Develop and Manage Performance Measures and Reports Business Process Model

Item	Details
Description	The **Develop and Manage Performance Measures and Reporting** business process involves researching and developing more effective ways to measure your achievement of your stated mission objectives and goals.
Trigger Event	Specific date for developing and/or external forces requiring performance measures reporting.
Result	1. Approved Operational Plan 2. Performance Standards Rewards or Penalties 3. Performance progress reporting 4. Measurable basis for how well policies, plans, programs and people are performing
Business Process Steps	1. Receive notice or request for new and/or change to current objectives and performance indicators 2. Request information from the various sections in BHSF regarding changes to current objectives and performance indicators 3. Audit the documents to make sure that the requests address the agency and program missions and goals, performance objectives are properly written, and that performance indicators are properly measured 4. Develop the new and/or change objectives and Performance indicators 5. When Measurements are met, reevaluate and create new steps 6. Receive approval 7. Convene Executive Management to finalize the operational plan 8. Submit the Operational Plan as part of the budget request to DHH-Office of Planning and Budget who forwards to the Division of Administration-Office of Planning and Budget (OPB) 9. OPB reviews the budget request and determines if additional or corrected information. a. If Yes, Repeat Steps 2, 3, and 5 b. If No, go to Step 10 10. OPB analyst presents the recommended Executive Budget to the Commissioner of Administration 11. Commissioner makes final decision and recommends Executive Budget which is set by State mandate 12. The House and the Senate reviews and approves the Executive Budget 13. Approved new budget is sent to the Governor and once signed becomes and Act 14. A new budget which consists of the operational plan is formulate 15. Submit August 15th Performance Adjustment Requests based on specific criteria to DHH OPB who then forwards to DOA – OPB and ultimately has to be approved by the Legislature 16. Input information in LaPAS every quarter
Shared Data	1. Receipt of Operational Plan information and LaPAS reporting information from the different sections in BHSF 2. Contractor data 3. Data from other registry 4. Other states information/performance measures
Predecessor	1. The prior year's appropriation which includes the operational plan 2. State and Federal Regulations or initiatives 3. Corrective Actions (CA) Plan 4. Louisiana Economy
Successor	1. Maintenance of effort continued

	2. New services initiative 3. Change in performance measures
Constraints	1. Federal and State laws and regulations 2. Stakeholder buy-in
Failures	1. Data availability 2. Lack of funds
Performance Measures	State and Federal deadlines

9.13.2 Develop and Manage Performance Measures and Reporting Workflow



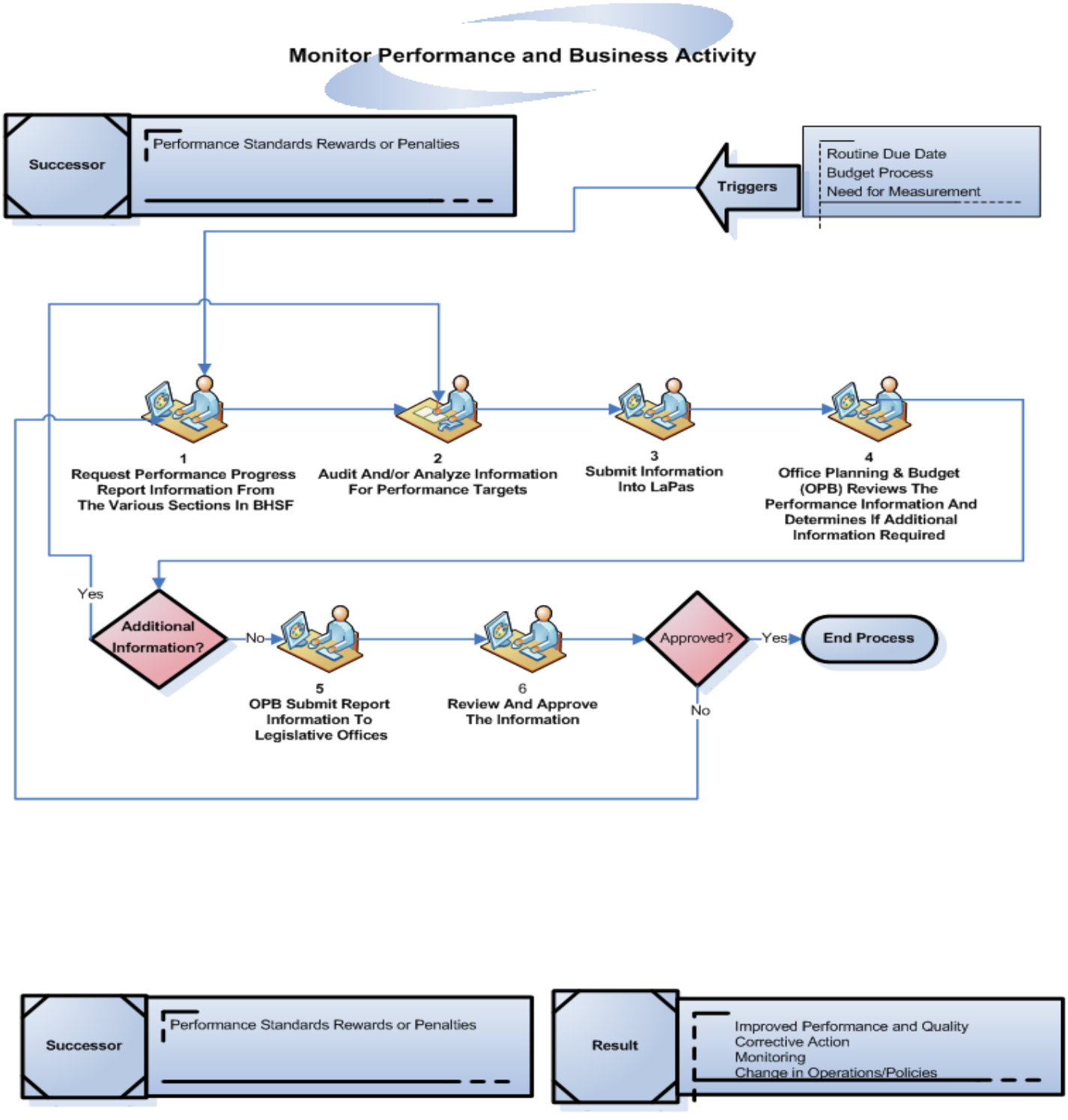

Develop and Manage
Performance Measures and Reporting
Page 2
10
OPB Analyst Presents The Recommended Executive Budget To The Commissioner Of Administration
11
Commissioner Makes Final Decision And Recommends Executive Budget Which Is Set By State Mandate.
12
The House And The Senate Reviews And Approves The Executive Budget.
13
Approved New Budget Is Sent To The Governor And Once Signed Becomes And Act
14
A New Budget Which Consists Of The Operational Plan Is Formulated.
15
Submit August 15th Performance Adjustment Requests Based On Specific Criteria To DHH OPB Who Then Forwards To DOA – OPB And Ultimately Has To Be Approved By The Legislature
16
Input Information In LaPAS Every Quarter
Sucessors
Maintenance of effort continued
New services initiative
Change in performance measures
Results
Approved Operational Plan
Performance Standards Rewards or Penalties
Performance progress reporting
Measurable basis for how well policies, plans, programs and people are performing

9.14 Monitor Performance and Business Activity

9.14.1 Monitor Performance and Business Activity Business Process Model

Item	Details
Description	The **Monitor Performance and Business Activity** business process measures and provides insight on how well Medicaid is performing today and where to gain the greatest results in the future. Business Activity Monitor tracks defined performance indicators (PIs), reporting on process performance, and providing variances that fall outside of designated thresholds.
Trigger Event	1. Routine Due Date 2. Budget Process 3. Need for Measurement
Result	1. Improved Performance and Quality 2. Corrective Action 3. Monitoring 4. Change in Operations/Policies
Business Process Steps	1. Request performance progress report information from the various sections in BHSF 2. Audit and/or analyze information for performance targets. 3. Submit information into LaPAS 4. Office Planning & Budget (OPB) reviews the performance information and determines if addition information required a. If Yes, go back to Step 2 b. If No, go to Step 5 5. OPB submits report information to the Joint Legislative Committee on the Budget (JLCB), legislative fiscal officer (LFO), legislative auditor, and the commissioner of administration 6. Review and approve the information a. If Yes, End Process b. If No, go back to 1
Shared Data	1. Contractual Data 2. National Measures 3. Data from External Registries
Predecessor	1. Approval of the operational plan or budget 2. Federal or State Initiatives 3. Establishment/revision of a performance measure
Successor	Performance Standards Rewards or Penalties
Constraints	1. Federal and State Regulations and Policies 2. Buy-in from Stakeholders
Failures	None
Performance Measures	Meeting State and Federal deadlines

9.14.2 Monitor Performance and Business Activity Workflow

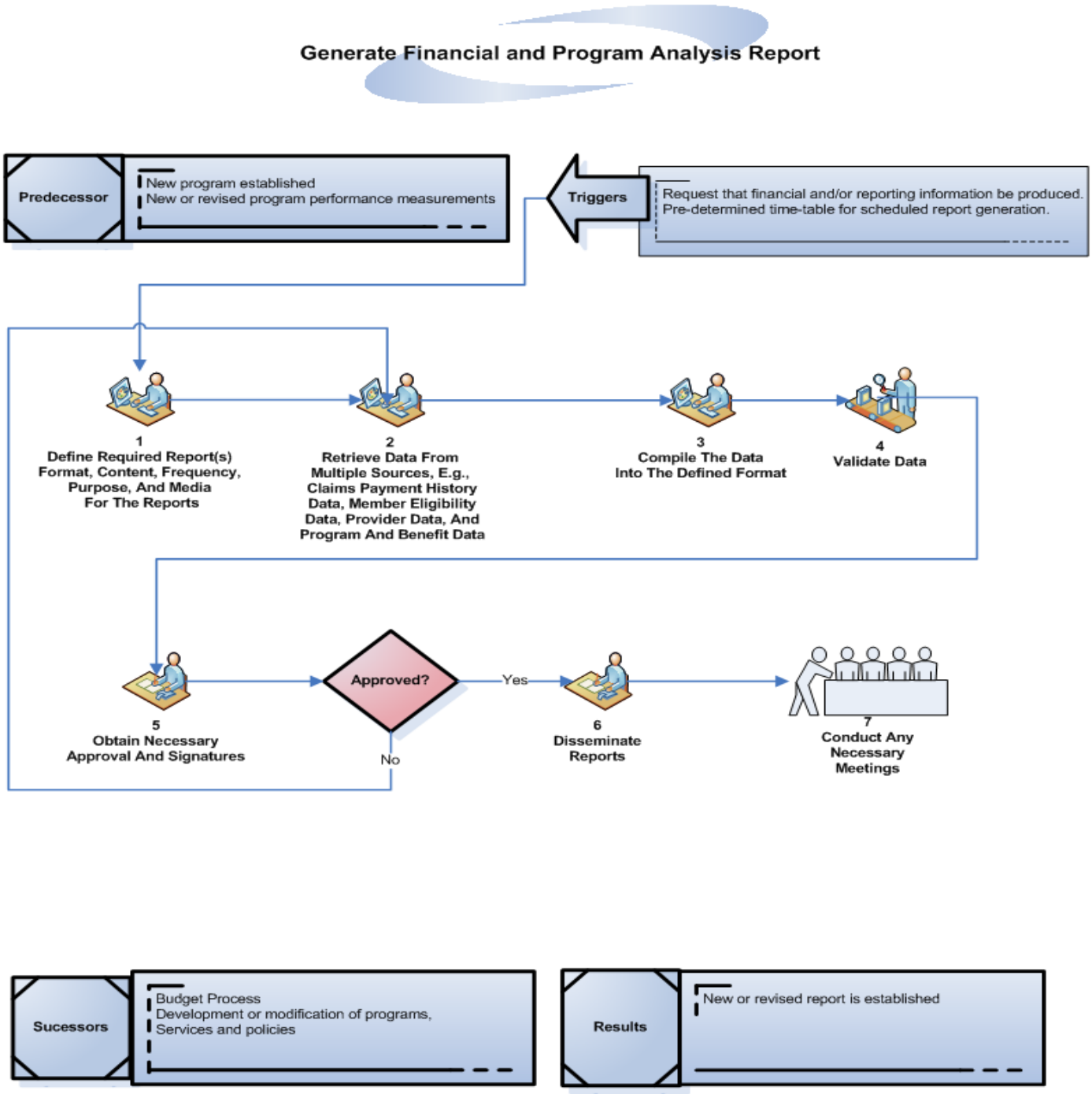


9.15 Generate Financial and Program Analysis Report

9.15.1 Generate Financial and Program Analysis Report Business Process Model

Item	Details
Description	The **Generate Financial & Program Analysis/Report** business process is essential for Medicaid agencies to be able to generate various financial and program analysis reports to assist with budgetary controls. Additionally to ensure that the benefits and programs established meet the needs of the member population and are performing according to the intent of the legislative laws or federal reporting requirements.
Trigger Event	1. Request that financial and/or reporting information be produced 2. Pre-determined time-table for scheduled report generation
Result	New or revised report is established
Business Process Steps	1. Define required report(s) format, content, frequency, purpose, and media for the reports 2. Retrieve data from multiple sources, e.g., claims payment history data, member eligibility data, provider data, and program and benefit data 3. Compile the data into the defined format 4. Validate data 5. Obtain necessary approval and signatures a. If Yes, go to Step 6 b. If No, go back to Step 2 6. Disseminate reports 7. Conduct any necessary meetings
Shared Data	1. Contract Management 2. Federal and State Comparison Data
Predecessor	1. New program established 2. New or revised program performance measurements
Successor	1. Budget Process 2. Development or modification of programs, services, and policies
Constraints	The generation of financial and program analysis reports must adhere to federal and state specific laws, regulations, and requirements
Failures	Inability to obtain data for the report
Performance Measures	Meeting State and Federal deadlines

9.15.2 Generate Financial and Program Analysis Report Workflow



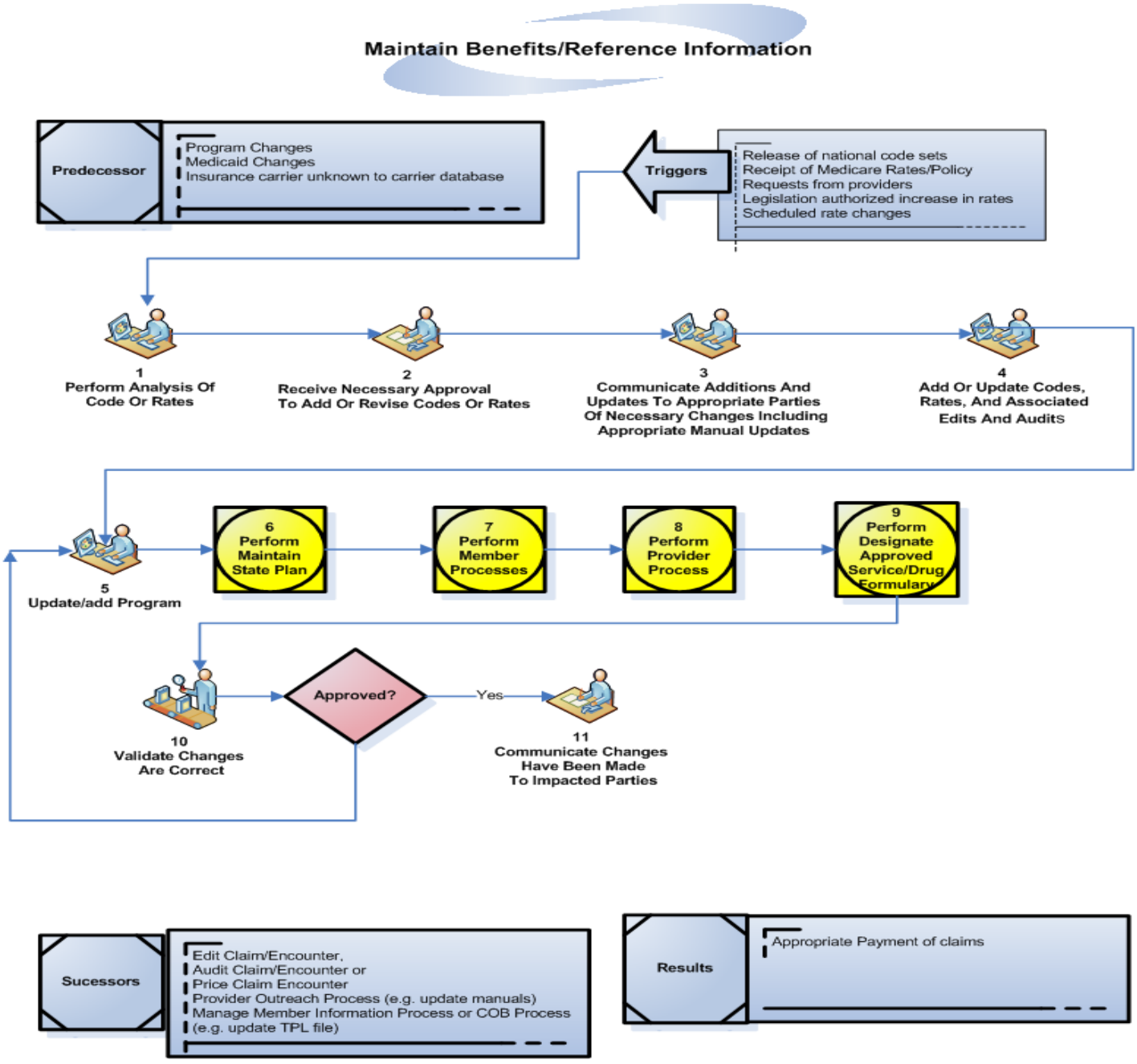
9.16 Maintain Benefits-Reference Information

9.16.1 Maintain Benefits-Reference Information Business Process Model

Item	Details
Description	The **Maintain Benefits/Reference Information** process is triggered by any addition or adjustment that is referenced or used during the Edit Claim/Encounter, Audit Claim/Encounter, or Price Claim/Encounter. It can also be triggered by the addition of a new program or the change to an existing program due to the passage of new state or federal legislation, or budgetary changes. The process includes adding new codes such as HCPCS, CPT, CDT and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the Manage Prospective & Current Member Communication, updating/adding provider information from the Manage Provider Information, adding/updating drug formulary information, adding/updating insurance carrier code information, and updating/adding benefit packages under which the services are available.
Trigger Event	1. Release of national code sets 2. Receipt of Medicare Rates/Policy 3. Requests from providers 4. Legislation authorized increase in rates 5. Scheduled rate changes
Result	Appropriate Payment of claims
Business Process Steps	1. Perform analysis of code or rates 2. Receive necessary approval to add or revise codes or rates 3. Communicate additions and updates to appropriate parties of necessary changes including appropriate manual updates 4. Add or update codes, rates, and associated edits and audits 5. Update/add program 6. Perform Develop & Maintain Program Policy if needed 7. Perform Member benefits Modification if needed 8. Perform provider information modification if needed 9. Perform Service/Drug formulary information modification if needed 10. Validate changes are correct a. If Yes, go to Step 11 b. If No, go to Step 4 11. Communicate changes have been made to impacted parties
Shared Data	1. National Code Sets (data) 2. Medicare Rates and Data 3. Reports from Providers 4. Comparison Data 5. Consumer Price Index 6. Fair Market Value Index 7. Drug Formulary Update 8. Insurance Carrier Information
Predecessor	1. Program Changes 2. Medicaid Changes 3. Insurance carrier unknown to carrier database

Item	Details
Successor	1. Edit Claim/Encounter, 2. Audit Claim/Encounter or 3. Price Claim Encounter 4. Provider Outreach Process (e.g. update manuals) 5. Manage Member Information Process or COB Process (e.g. update TPL file)
Constraints	1. Publishing and receipt of required data sets 2. Buy-in from stakeholders 3. Federal and State Regulations and Standards
Failures	Loss of stakeholder buy-in
Performance Measures	1. Stakeholders paid correctly 2. Recipient MEDS updates have a contracted turn-around limit

9.16.2 Maintain Benefits-Reference Information Workflow



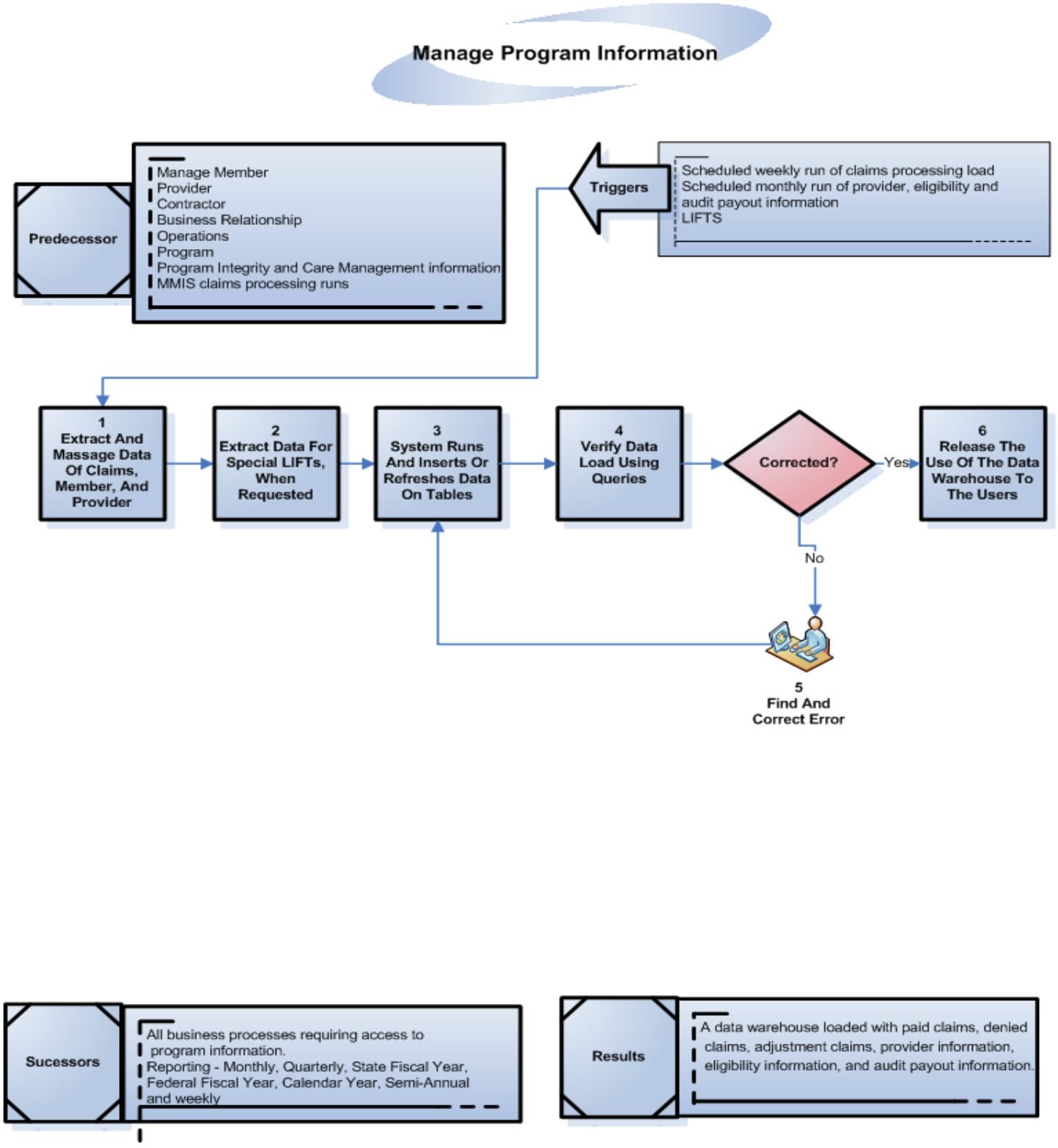
9.17 Manage Program Information

9.17.1 Manage Program Information Business Process Model

Item	Details
Description	The **Manage Program Information** business process is responsible for managing all the operational aspects of the Program Information Repository, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The Program Information Repository receives requests to add or delete data in program records. The Repository validates data upload requests, applies instructions, and tracks activity. The Program Information Repository provides access to payment records to other Business Area applications and users. The inputs to the program information repository are claims (Paid, Denied, and adjustments only), provider information, eligibility information, and audit pay-outs.
Trigger Event	1. Scheduled weekly run of claims processing load 2. Scheduled monthly run of provider, eligibility and audit payout information 3. LIFTS
Result	A data warehouse loaded with paid claims, denied claims, adjustment claims, provider information, eligibility information, and audit payout information.
Business Process Steps	1. Extract and massage data of claims, member, and provider 2. Extract data for special LIFTs, when requested 3. System runs and inserts or refreshes data on tables (a-c are informational only) a. Appends claims data to data warehouse tables b. Refreshes Member (eligibility) and provider data in the corresponding data warehouse files c. Appends audit pay-out data to data warehouse tables 4. Verify data load using queries a. If Yes, go to Step 6 b. If No, go to Step 5 5. Find error and correct, go to Step 3 6. Release the use of the Data Warehouse to the users
Shared Data	PA information
Predecessor	1. Manage Member 2. Provider 3. Contractor 4. Business Relationship 5. Operations 6. Program 7. Program Integrity and Care Management information 8. MMIS claims processing runs
Successor	1. All business processes requiring access to program information 2. Reporting - Monthly, Quarterly, State Fiscal Year, Federal Fiscal Year, Calendar Year, Semi-Annual and weekly e.g. MARS and requested reports

Item	Details
Constraints	1. Repository unavailable for users 2. Security to access 3. Updating of information
Failures	Inability or failure to load initial records or update data in existing records in the Program Information Repository Hardware and system failure
Performance Measures	None

9.17.2 Manage Program Information Workflow



10.0 **Program Integrity Overview**

This Program Integrity Management business area deals with the identification and management of Program Integrity cases. In Louisiana, these business processes are carried out by several different sections including Pharmacy, Eligibility Operations, Program Integrity, and Program Integrity – Payment Error Rate Measurement (PERM). Although these business processes meet the Federal requirements in their current state they are highly time consuming, labor intensive and have weak collaboration/coordination functions. There will be much to gain by re-tooling this business area with best of industry tools

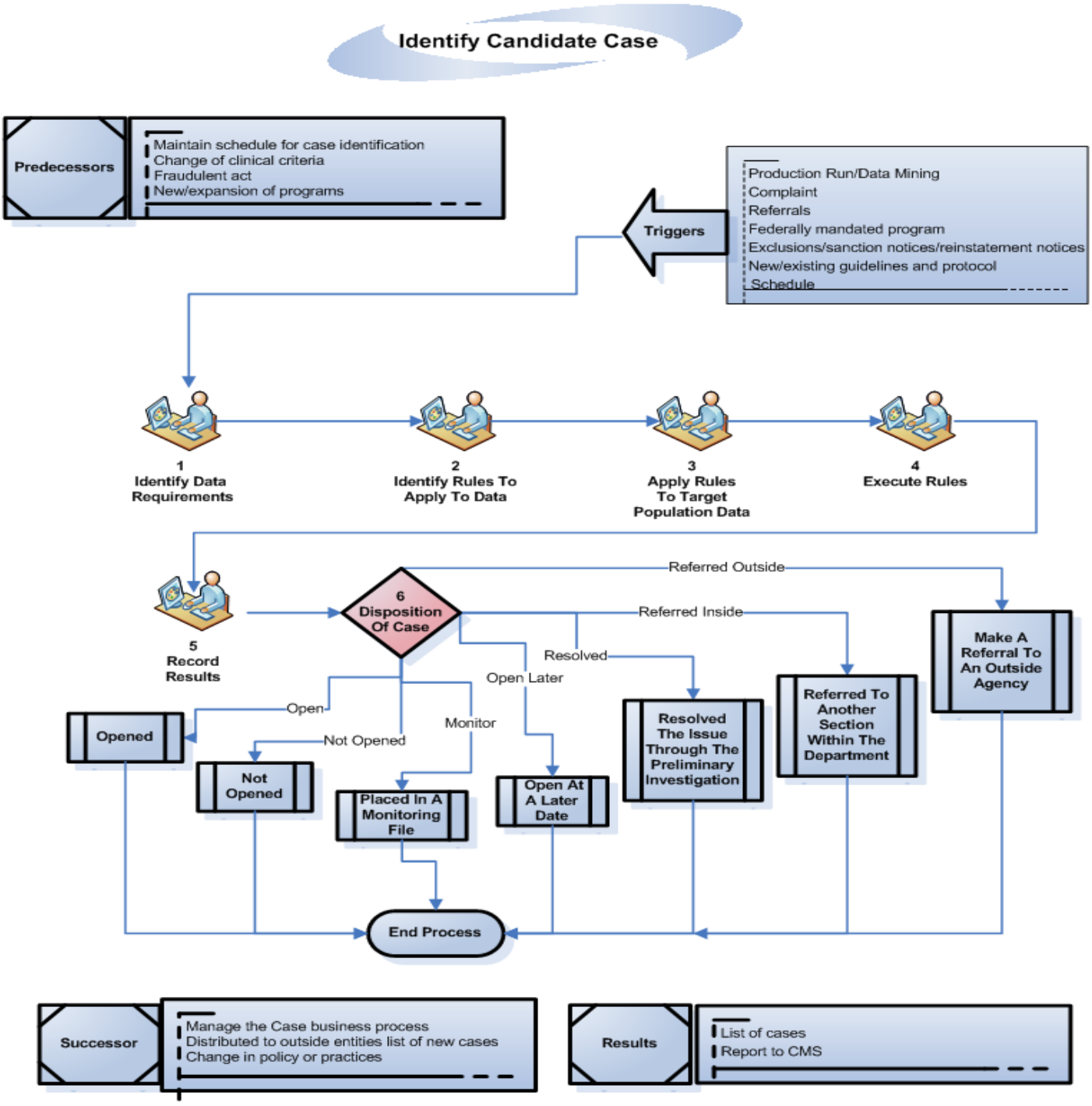
10.1 Identify Candidate Case

10.1.1 Identify Candidate Case Business Process Model

Item	Details
Description	The **Identify Candidate Case** business process uses Louisiana specific and Federal criteria and rules to identify target populations and or practices. Candidate cases may be identified for: 1. Payment Error Rate Measurement Eligibility Audits for CMS 2. Drug utilization review 3. Recipient 4. Provider
Trigger Event	1. Production Run/Data Mining 2. Complaint 3. Referrals 4. Federally mandated program 5. Exclusions/sanction notices/reinstatement notices 6. New/existing guidelines and protocol 7. Schedule
Result	1. List of cases 2. Report to CMS
Business Process Steps	1. Identify data requirements 2. Identify rules to apply to the data 3. Apply rules to target population data 4. Execute rules 5. Record results 6. Disposition of case – a case is • Opened • Not opened • Placed in a monitoring file • Open at a later date • Resolved the issue through the preliminary investigation • Referred to another section within the Department • Make a referral to an outside agency
Shared Data	1. Licensing/Certification Boards - medical board, nursing board, dental board, pharmacy board, etc. 2. Secretary of State Website 3. Clinical Guideline 4. Federal & State Office of Inspector General 5. LA Attorney General

Item	Details
	6. Vital Records 1. Public Assistance Records 2. Veterans Administration Records 3. Social Security Administration Records
Predecessor	1. Maintain schedule for case identification 2. Change of clinical criteria 3. Fraudulent act 4. New/expansion of programs
Successor	1. Manage the Case business process 2. Distributed to outside entities list of new cases 3. Change in policy or practices
Constraints	State and Federal Rules and Regulations
Failures	Insufficient Data
Performance Measures	None

10.1.2 Identify Candidate Case Workflow



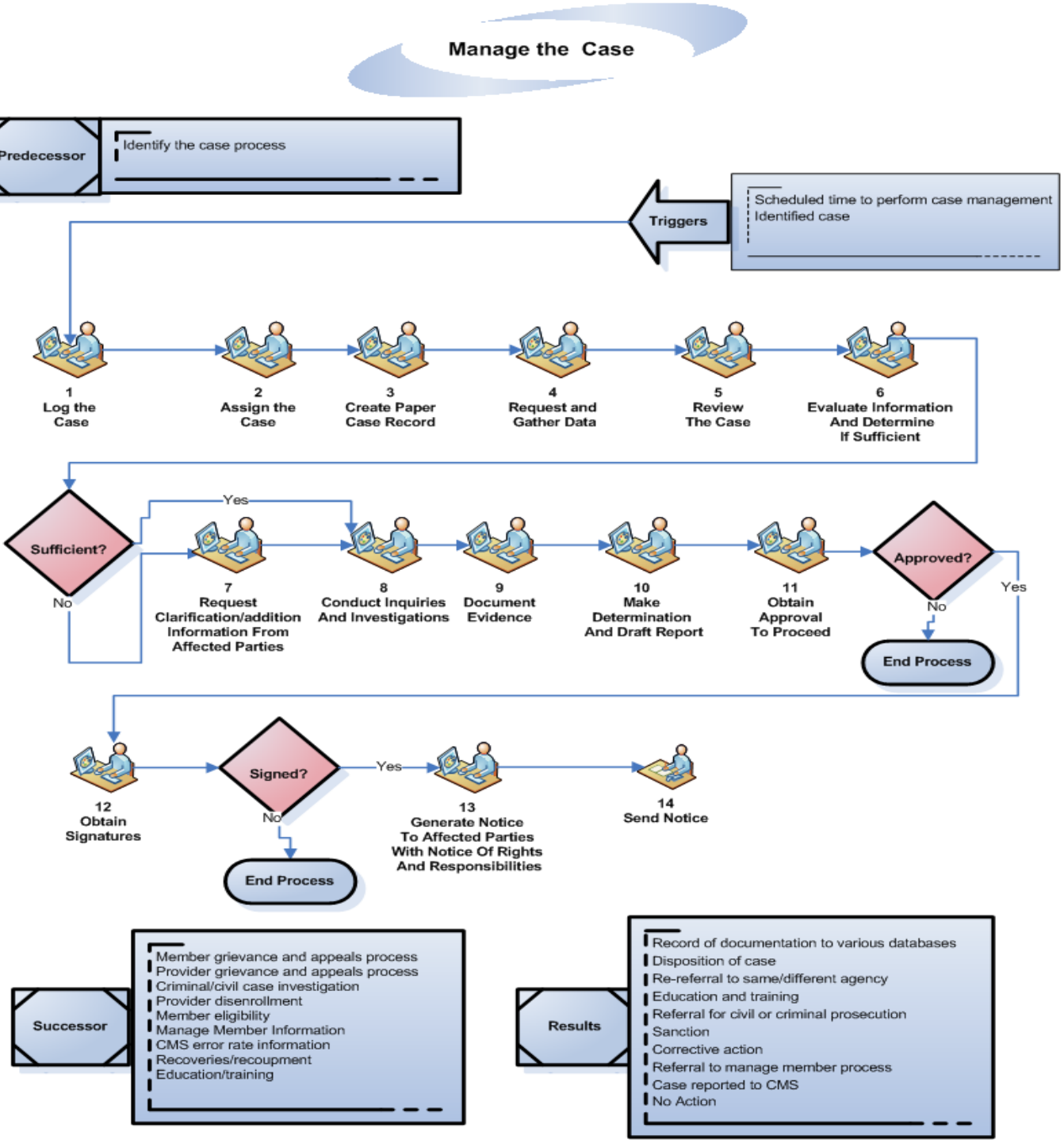
10.2 Manage the Case

10.2.1 Manage the Case Business Process Flow

Item	Details
Description	The **Manage the Case** business process receives a case file from the **Identify Candidate Case** process with the direction to pursue to its natural conclusion.
Trigger Event	1. Scheduled time to perform case management 2. Identified case
Result	1. Record of documentation to various databases 2. Disposition of case 3. Re-referral to same/different agency 4. Education and training 5. Referral for civil or criminal prosecution 6. Sanction 7. Corrective action 8. Referral to manage member process 9. Case reported to CMS 10. No Action
Business Process Steps	1. Log the case 2. Assign case 3. Create the paper case record 4. Request and gather data 5. Review the case 6. Evaluate Information and determine if sufficient a. If Yes, go to Step 8 b. If No, go to Step 7 7. Request clarification/addition information from affected parties 8. Conduct inquiries and investigations 9. Document evidence — Evidence is documented in the case file. 10. Make Determination and draft report 11. Obtain approval to proceed a. If Yes, go to Step 12 b. If No, End Process 12. Obtain signatures a. If Yes, go to Step 13 b. If No, End Process 13. Generate notice to affected parties with notice of Rights and Responsibilities 14. Send notice

Shared Data	1. Medical/prescription records 2. Attorney General 3. Office of Inspector General 4. State & US Attorney 5. Vital Records 6. Secretary of State 7. Clinical practice guidelines 8. Public Assistance record 9. Department of Labor records 10. Department of Social Services records 11. Child Support records 12. Insurance company information 13. Licensing/certification boards 14. General public 15. Internal Revenue Service records 16. Social Security Administration records 17. US Citizenship and Immigration Service (INS) records 18. Newspaper articles
Predecessor	Identify the case process
Successor	1. Member grievance and appeals process 2. Provider grievance and appeals process 3. Criminal/civil case investigation 4. Provider disenrollment 5. Member eligibility 6. Manage Member Information 7. CMS error rate information 8. Recoveries/recoupment 9. Education/training
Constraints	State and Federal Rules and Regulations
Failures	Insufficient Data
Performance Measures	1. Delinquent Report 2. 900 minimum per year

10.2.2 Manage the Case Workflow



11.0 **Care Management Overview**

The Care Management business area collects information about the needs of the individual member, plan of treatment, targeted outcomes, and the individual's health status. The business functions in this area mainly focus on identifying client's needs, registering those clients into programs, and maintaining the plan of care or case. The two areas that were identified in this group were Waivers and Disease Management, with Disease Management also focusing on member education and member communication follow-up. The results of Care Management targets groups of individuals with similar characteristics and needs, maintains their individual health needs, and promotes health education and awareness.

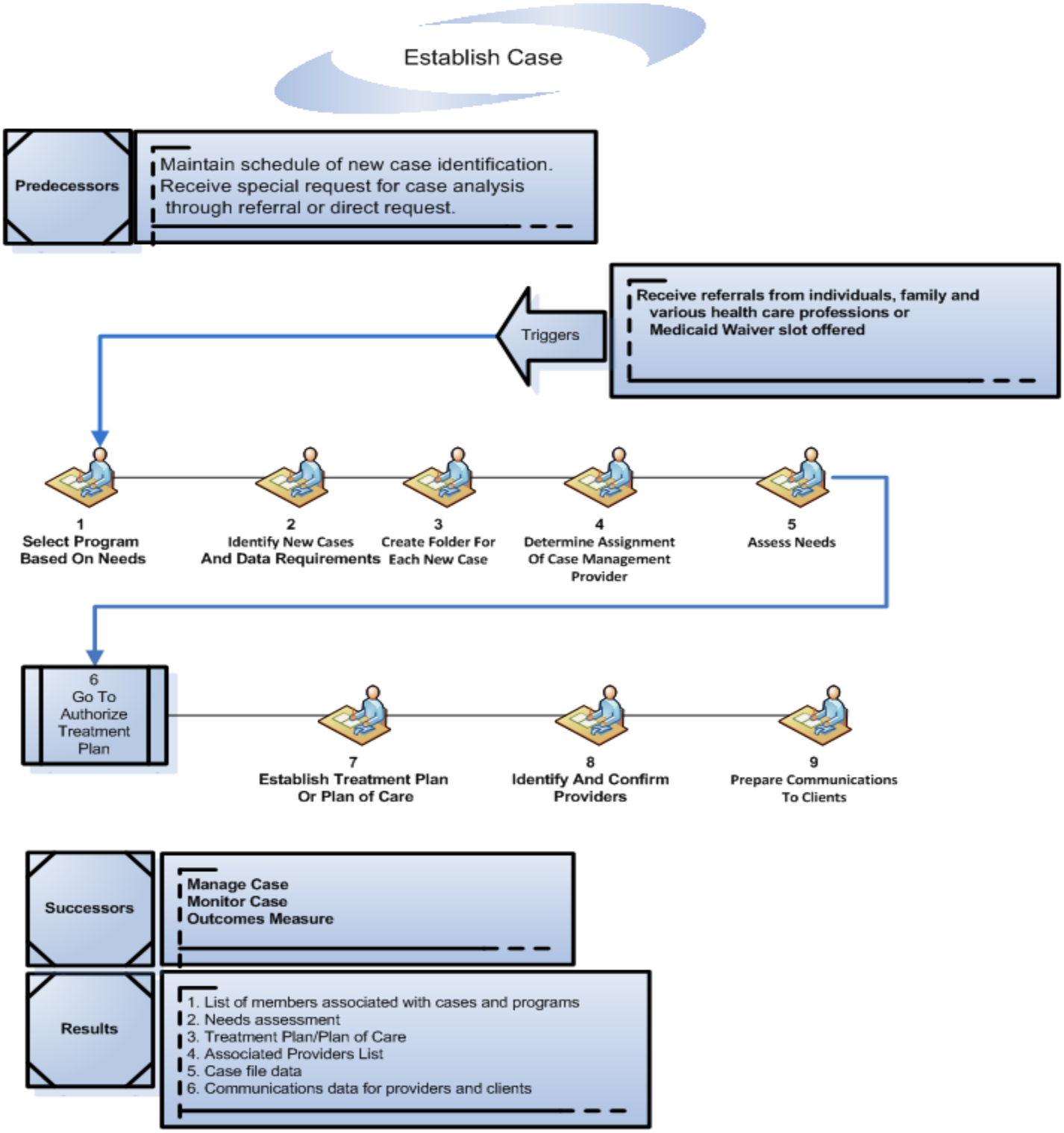
11.1 Establish Case

11.1.1 Establish Case Business Process Model

Item	Details
Description	The **Establish Case** business process uses criteria and rules to identify target member populations for specific programs, assigns a case manager, assess client's needs, select program, establish a plan of care, identify and confirm providers, and prepare information for communication. Cases may be established for : • Medicaid Waiver program case management • Elderly/Disabled Adult Waiver • Adult Day Health Care Waiver • Long-Term Personal Care Services • Program for the All-Inclusive Care of the Elderly • Adult Residential Care Waiver • Disease Management Each case type is driven by different criteria and rules, different relationships, and different data.
Trigger Event	Receive referrals from individuals, family and various health care professions or Medicaid Waiver slot offered.
Result	1. List of members associated with cases and programs 2. Needs assessment 3. Treatment Plan/Plan of Care 4. Associated Providers List 5. Case file data 6. Communications data for providers, clients
Business Process Steps	1. Select program- Based on needs, determined which program(s) are appropriate for the client (patient characteristics, medical conditions, location, age) 2. Identify new cases and data requirements – Apply rules to data (time elements, data elements, and data relationships) and identify new cases, 3. Create new folder for each new case 4. Determine assignment of Case Management Provider 5. Assess needs – apply needs template to individual case and record results. 6. Go To Authorize Treatment Plan business process 7. When Treatment plan authorized, Establish Treatment Plan or Plan of Care – Based on needs, established plan which identifies the services the client needs to receive, the types of providers, the care setting, frequency, and expected results 8. Identify and confirm providers- identify member's provider and confirm provider's awareness of program 9. Prepare communications to the clients, prepare content of case file for communication

Item	Details
	with clients and providers, and ongoing management of the case
Shared Data	None
Predecessor	1. Maintain schedule of new case identification. 2. Receive special request for case analysis through referral or direct request.
Successor	1. Manage Case 2. Monitor Case 3. Outcomes Measure
Constraints	1. Legislative Initiatives 2. Federal lawsuit 3. Volume of demand for allocated slots 4. Communication with other agencies who determine pre-requisite functions 5. Maintaining updated member file, provider file, and claims file
Failures	1. Non-compliance with Cost-Neutrality 2. Non-compliance with Treatment Plan
Performance Measures	1. Cases are established and services authorized within the timelines specified by State policy 2. Percentage of reduction of ER visits

11.1.2 Establish Case Workflow



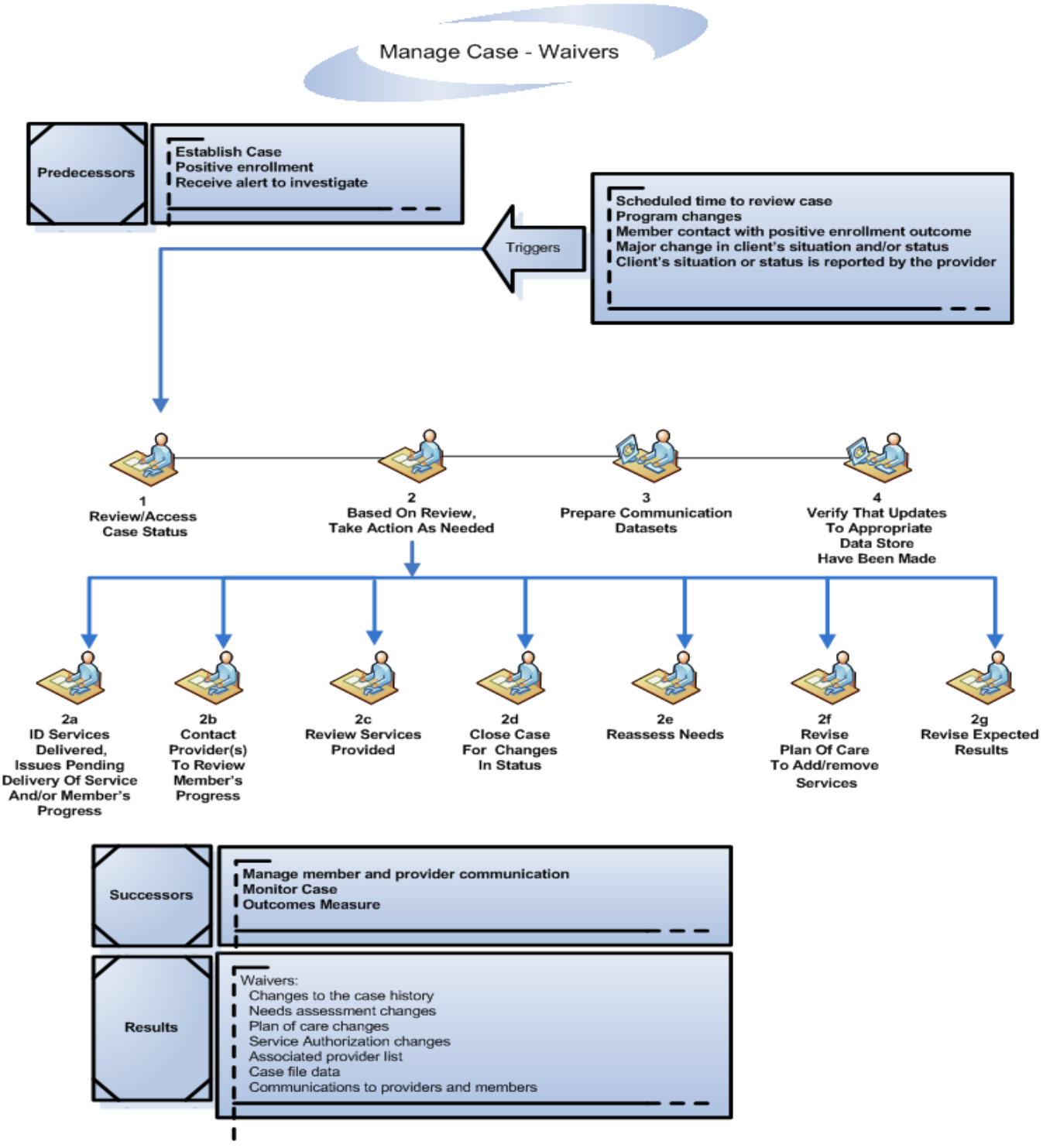
11.2 Manage Case

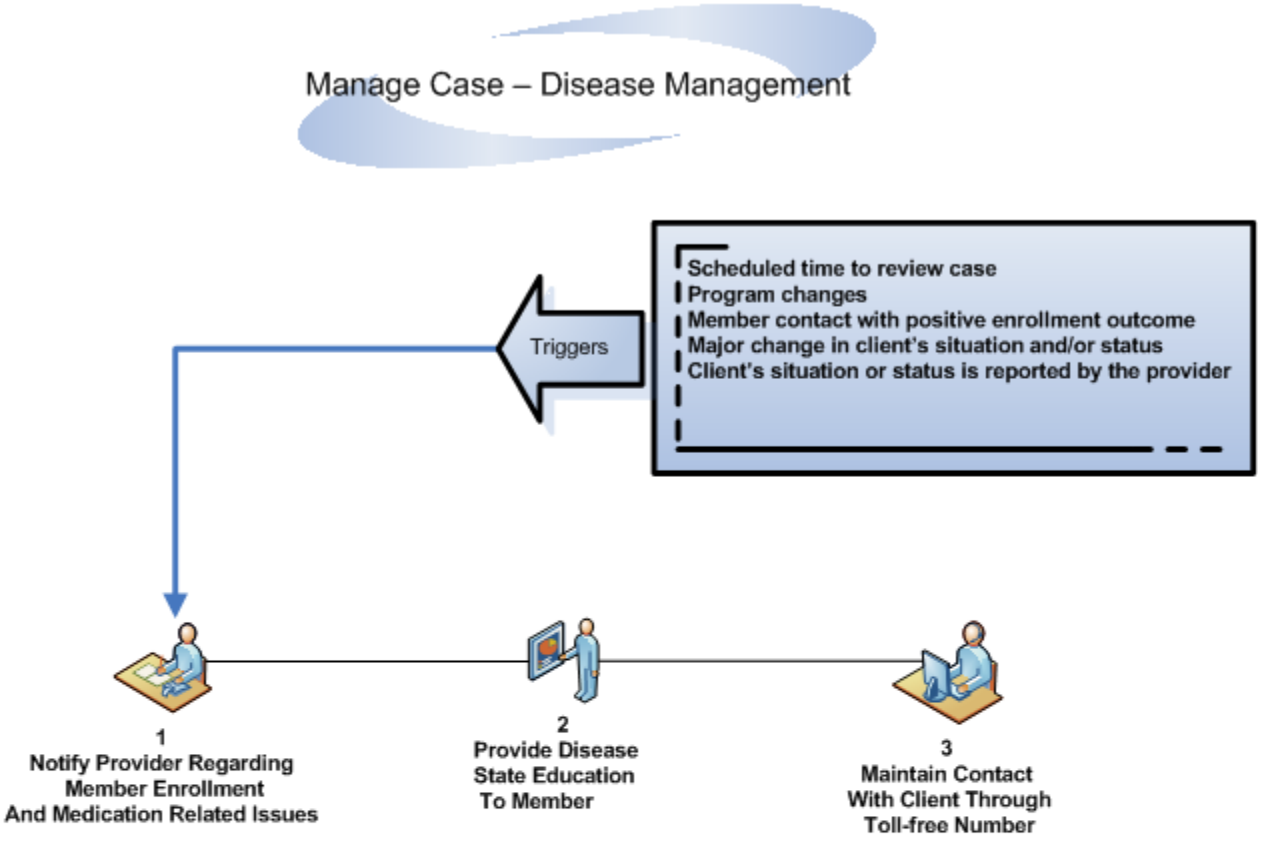
11.2.1 Manage Case Business Process Model

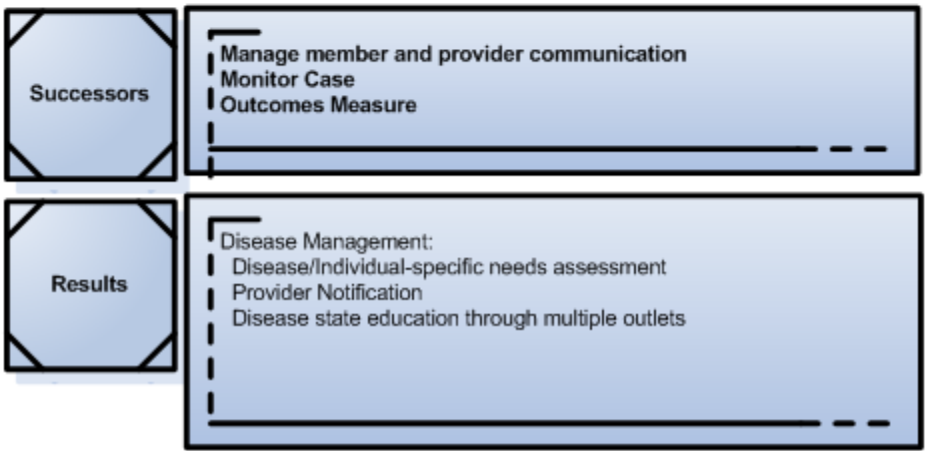
Item	Details
Description	The **Manage Case** business process uses State-specific criteria and rules to ensure appropriate and cost-effective services are identified, planned, obtained, communicated and monitored for individuals identified as eligible for care management services under such programs as: • Medicaid Waiver program Case Management • Home and Community-Based services • Disease Management
Trigger Event	1. Scheduled time to review case 2. Program Changes 3. Member contact with positive enrollment outcome 4. Major change in client's situation and/or status 5. Clients situation or status is reported by the provider
Result	**Waivers** Case history is updated with revision to the following: a. Changes to the case history b. Needs assessment changes c. Plan of care changes d. Service Authorization changes e. Associated provider list f. Case file data g. Content of communications to be sent to providers and members **For Disease Management** 1. Disease/individual-specific needs assessment 2. Provider Notification 3. Disease state education through multiple outlets
Business Process Steps	**Waivers** 1. Review/Access case status 2. Based on review, take action as needed to: 2a. ID services delivered, issues impeding delivery of service and/or member's progress 2b. Contact provider(s) to review member's progress 2c. Review services provided 2d. Close case for changes in status 2e. Reassess needs 2f. Revise Plan of Care to add/remove services 2g. Revise expected results 3. Prepare communication data sets to and from the members and providers, (Post and Prior Authorizations) 4. Verify that updates to appropriate data store have been made **Disease Management** 1. Notify provider regarding member enrollment and medication related issues 2. Provide disease state education to member 3. Maintain contact with client through toll-free number
Shared Data	National Disease Protocol
Predecessor	1. Establish Case 2. Positive enrollment

Item	Details
	3. Receive alert to investigate
Successor	1. Manage member and provider communication 2. Monitor Case 3. Outcomes Measure
Constraints	1. Maintaining updated member file, provider file, and claims file. 2. Staff limitations and fragmented data
Failures	1. Case Management infrastructure 2. Member failure to provide current contact information
Performance Measures	1. Disease Management – Program outcome measures, pre/post enrollment, related to specific disease state 2. 95% satisfaction +/- 5% based on sample of reduction in ER services 3. Cases are updated within the timeframes specified by State policy 4. Appropriate changes are made based upon changing needs

11.2.2 Manage Case Workflow




Manage Case – Disease Management
Triggers
Scheduled time to review case
Program changes
Member contact with positive enrollment outcome
Major change in client's situation and/or status
Client's situation or status is reported by the provider
1
Notify Provider Regarding
Member Enrollment
And Medication Related Issues
2
Provide Disease
State Education
To Member
3
Maintain Contact
With Client Through
Toll-free Number


Successors
Manage member and provider communication
Monitor Case
Outcomes Measure
Results
Disease Management:
Disease/Individual-specific needs assessment
Provider Notification
Disease state education through multiple outlets

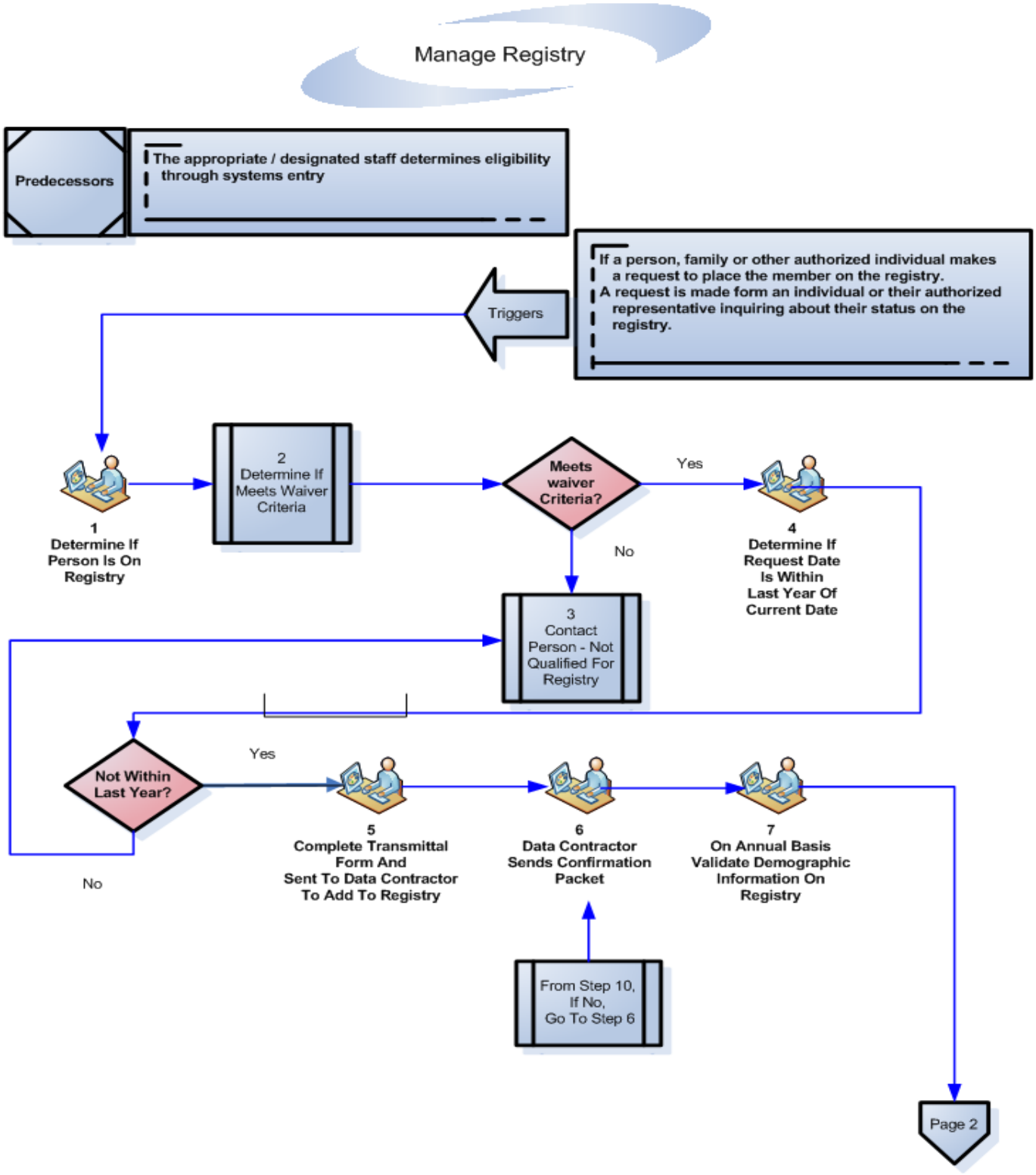
11.3 Manage Registry

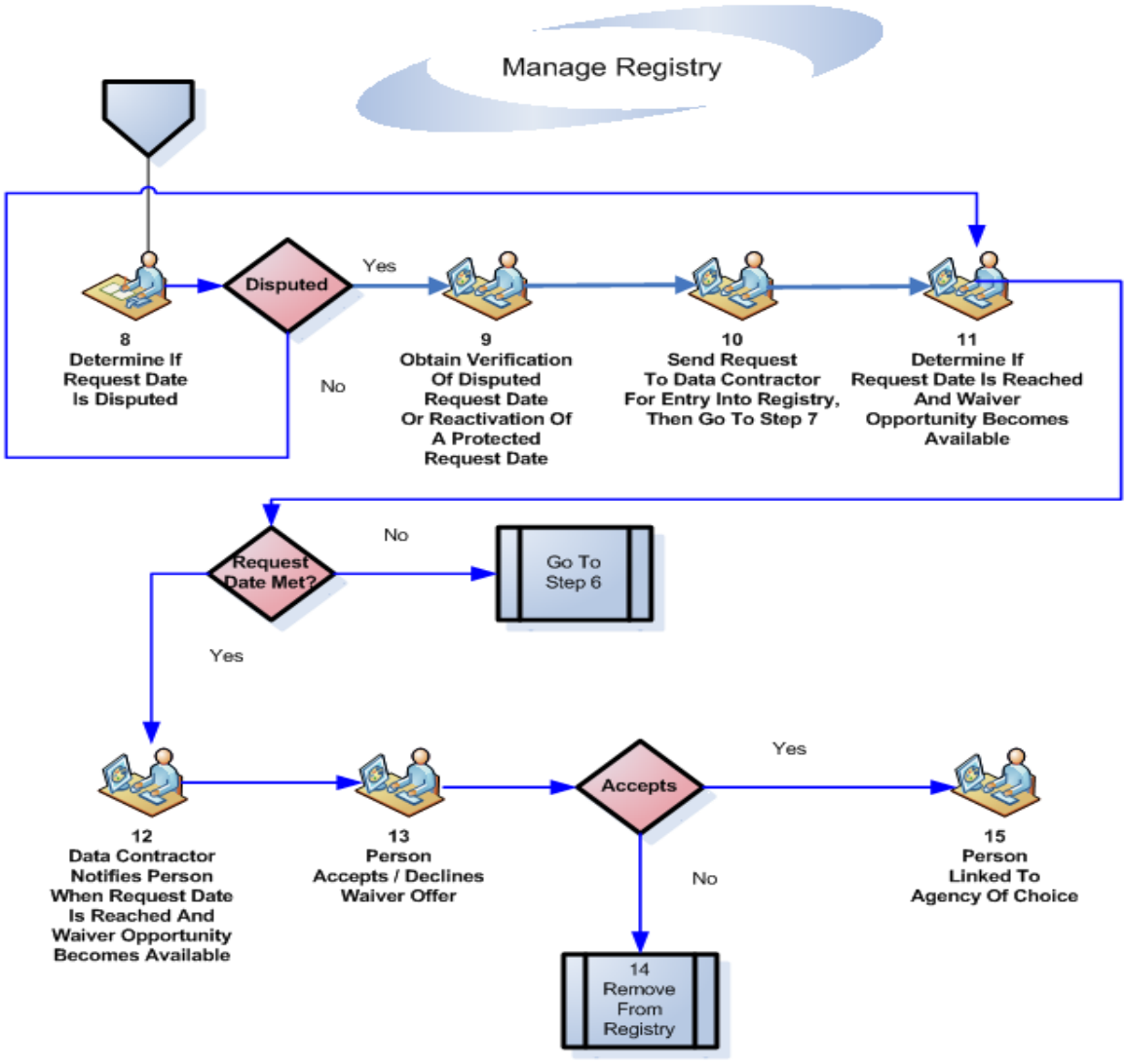
11.3.1 Manage Registry Business Process Model

Item	Details
Description	The **Manage Registry** business process operates a registry, receives continuous updates, responds to inquiries, and provides access to authorized parties. (Registry used by HCBS Waiver services)
Trigger Event	1. If a person, family, or other authorized individual makes a request to place the member on the registry. 2. A request is made from an individual or their authorized representative inquiring about their status on the registry
Result	The person's name is added to waiver program and deleted from registry as defined by criteria and rules
Business Process Steps	1. Determine if person is currently on Registry - appropriate/designated entry staff researches the Registry. The date the person is approved for entry into waiver services system becomes the persons' protected request date 2. Determine if person meets the waiver criteria with required documentation. a. If yes, proceed to 4 b. If no, person not qualified for registry, person contacted 3. Contact Person – Not qualified for registry 4. Determine if request date is within the last year of the current date. a. If yes, not within the last year, go to Step 5 b. If no, proceed to Step 3 5. Complete a transmittal form and send the form and documentation by fax or electronic mail to the data contractor to add the person to the registry. 6. Data contractor sends the person/authorized representative confirmation packet with all appropriate waiver documents 7. On an annual basis the data contractor validates the demographic information for people listed on the registry 8. Determine if request date is disputed while on Registry. a. If yes, proceed to Step 9 b. If no, proceed to Step 11 9. Obtain verification of disputed request dates or reactivation of a protected request date, and review for valid change. 10. In the case a change needs to be made, the request to change is sent to the data contractor by fax or electronic mail to incorporate this change on the registry. Proceed to Step 6. 11. Determine if the request date is reached and the waiver opportunity becomes available. a. If yes, proceed to Step 12 b. b. If no, proceed to 6 12. The data contractor notifies the person or authorized representative in writing when the person's request date is reached on the registry and the waiver opportunity becomes available. All required documents for the appropriate waiver offer are submitted to the person or authorized representative at this time 13. The person/authorized representative make the decision to accept/decline the waiver offer. a. a. If person accepts the waiver, proceed to Step 15 b. b. If person declines the waive, go to Step 14 14. Remove Person from the registry

Item	Details
	15. Once the person/authorized representative have accepted the waiver offer, the data contractor links the person to the Support Coordination Agency of his/her choice.
Shared Data	The data contractor compares the data from the registry against the Medicaid Eligibility Data System (MEDS) and MMIS for accuracy and updates.
Predecessor	The appropriate/designated staff determines eligibility through systems entry
Successor	1. The person receives support coordination through the Freedom of Choice (FOC) process. 2. Establish Case
Constraints	The individual has to be determined eligible to be assigned a protected request date.
Failures	1. Failure to submit the request to the data contractor or the request was not received by the data contractor. 2. Failure to update the demographic information could affect the offering of a waiver opportunity.
Performance Measures	1. Of the number of people who request waiver services through the system entry unit process, how many are placed on the registry. (Number added to Registry/ Number Requested) 2. Of the number of people who are offered waiver services how many respond to the offer. (Number responding/number offered)

11.3.2 Manage Registry Workflow





Successors	The person receives support coordination through the Freedom of Choice (FOC) process Establish case
Results	The person's name is added to waiver program and deleted from registry as defined by criteria and rules

12.0 **Business Relationships Overview**

The Business Relationship business area meets all current regulations and deals with the establishment and management of relationships between the State of Louisiana and its business partners. All DHH sections have relationships that are affected by these business processes. In most cases, the Policy section takes a driving role in the establishment of these relationships. However all sections are involved with these business process which are uncoordinated and time consuming, taking up to six months or more, and although some parts are available electronically the information is cumbersome to obtain. Cutting down on the timeframe and enhancing access are definitely areas that could see improvement

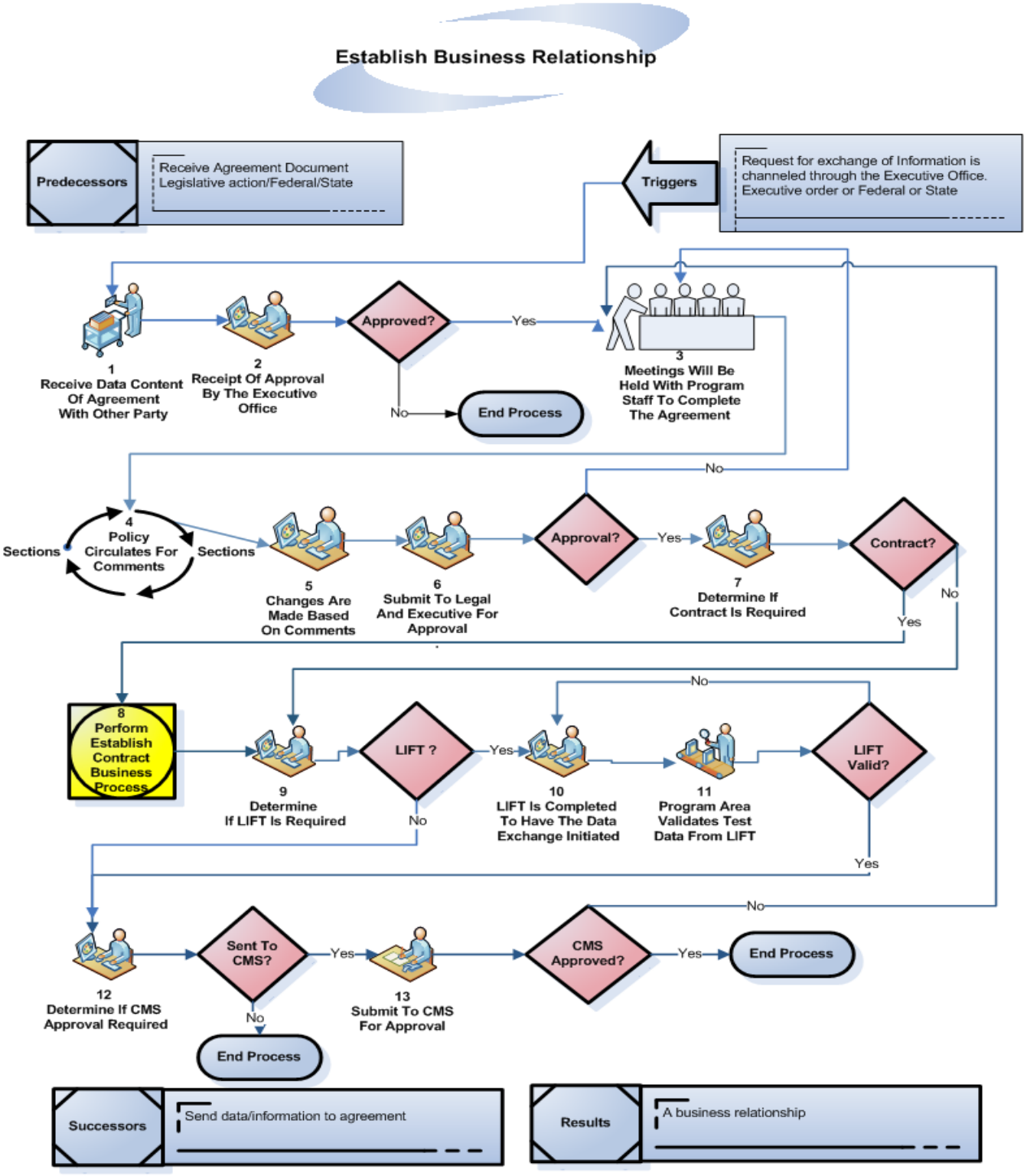
12.1 Establish Business Relationships

12.1.1 Establish Business Relationships Business Process Model

Item	Details
Description	The **Establish Business Relationship** business process encompasses activities undertaken by the State Medicaid agency to enter into business partner relationships with other stakeholders. These include Memoranda of Understanding (MOUs) with other governmental agencies, electronic data interchange agreements with providers, managed care organizations, and others, and CMS, other Federal agencies, and contracts, BA & State Plan waiver other OAAS The agreement to establish a business relationship is managed at the program level for the life of the agreement.
Trigger Event	1. Request for exchange of information is channeled through the Executive Office. 2. Executive order or Federal or State
Result	A business relationship
Business Process Steps	1. Receive data content of agreement with other party 2. Receipt of approval by the Executive office a. If Yes, go to Step 3 b. If No, End Process 3. Meetings will be held with program staff to complete the agreement 4. Policy circulates for comments 5. Changes are made based on comments 6. Submit to Legal and Executive for approval a. If Yes, go to Step 7 b. If No, go back to Step 3 7. Determine if contract is required a. If Yes, go to Step 8 b. If No, go to Step 9 8. Perform Establish contract business process 9. Determine if LIFT is required a. If Yes, go to Step 10 b. If No, go to Step 12 10. LIFT is completed to have the data exchange initiated 11. Program area validates test data from LIFT a. If Yes, go to Step 12 b. If No, go back to Step 10 12. Determine if CMS approval required a. If Yes, go to Step 13 b. If No, End Process

	13. Submit to CMS for approval a. If Yes, End Process b. If No, go back to Step 5
Shared Data	None
Predecessor	1. Receive Agreement Document 2. Legislative action/Federal/State
Successor	Send data/information to agreement
Constraints	Federal & State laws and regulations
Failures	None.
Performance Measures	N/A

12.1.2 Establish Business Relationships Workflow

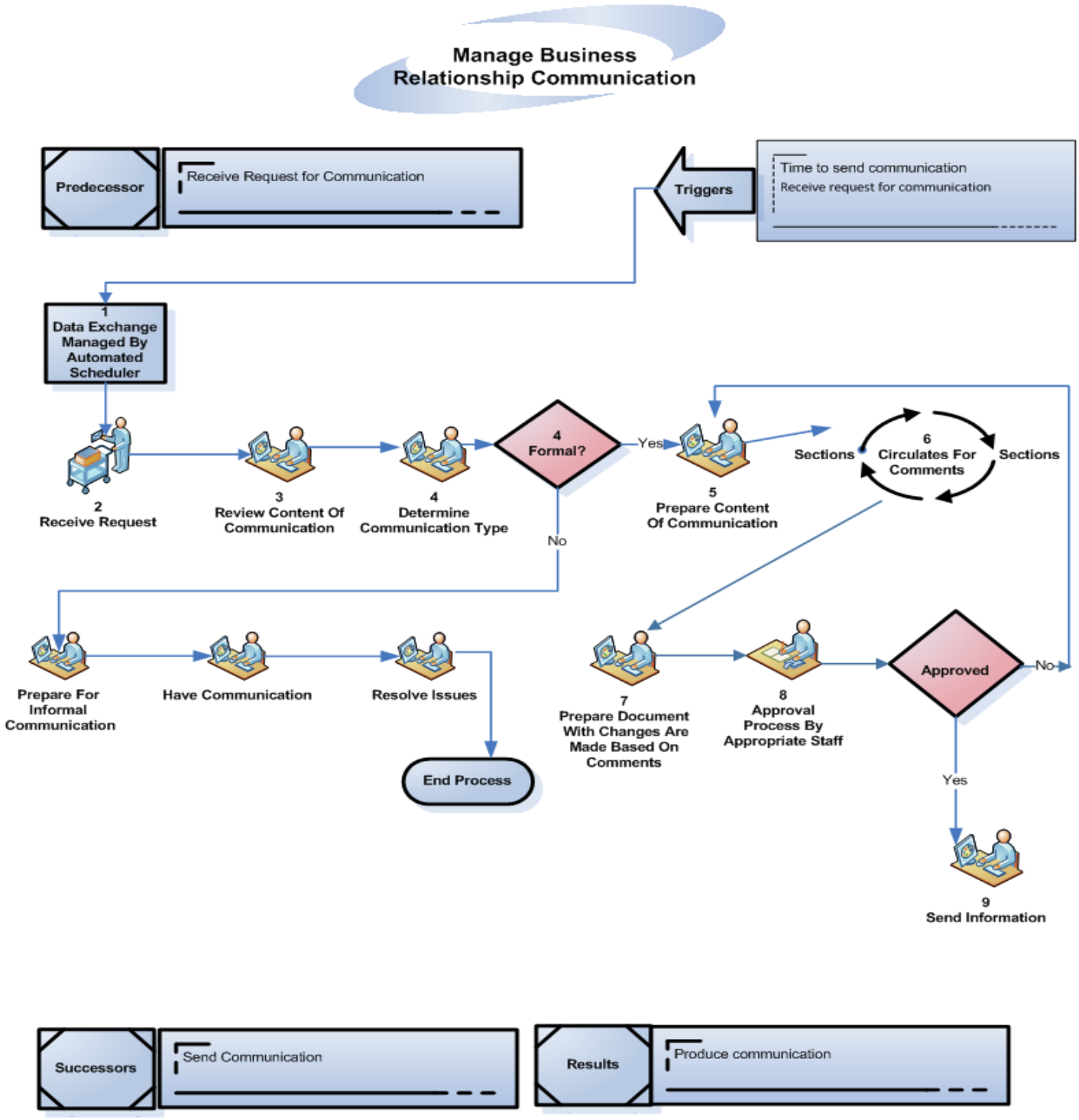


12.2 Manage Business Relationships Communication

12.2.1 Manage Business Relationship Communication Business Process Model

Item	Details
Description	The **Manage Business Relationship Communication** business process produces routine and ad hoc communications between the business partners. Note: There is no tracking of renewal requirements for agreements other than within the LIFTS specifying frequency of the job to create or receive data.
Trigger Event	1. Time to send communication 2. Receive request for communication
Result	Produce communication
Business Process Steps	1. Most ongoing exchanges of data are managed by an automated scheduler that initiates batch jobs 2. Receive request 3. Review content of communication 4. Determine communication type a. If formal, go to Step 5 b. If informal 5. Prepare for informal communication 6. Have communication 7. Resolve issues 8. End Process 9. Prepare content of communication 10. Circulates for comments 11. Prepare document with changes made based on comments 12. Approval process by appropriate staff a. If Yes, go to Step 9 b. If No, go back to Step 4 13. Send information
Shared Data	None
Predecessor	Receive Request for Communication
Successor	Send Communication
Constraints	Federal & State laws and regulations
Failures	None
Performance Measures	N/A

12.2.2 Manage Business Relationships Communication Workflow

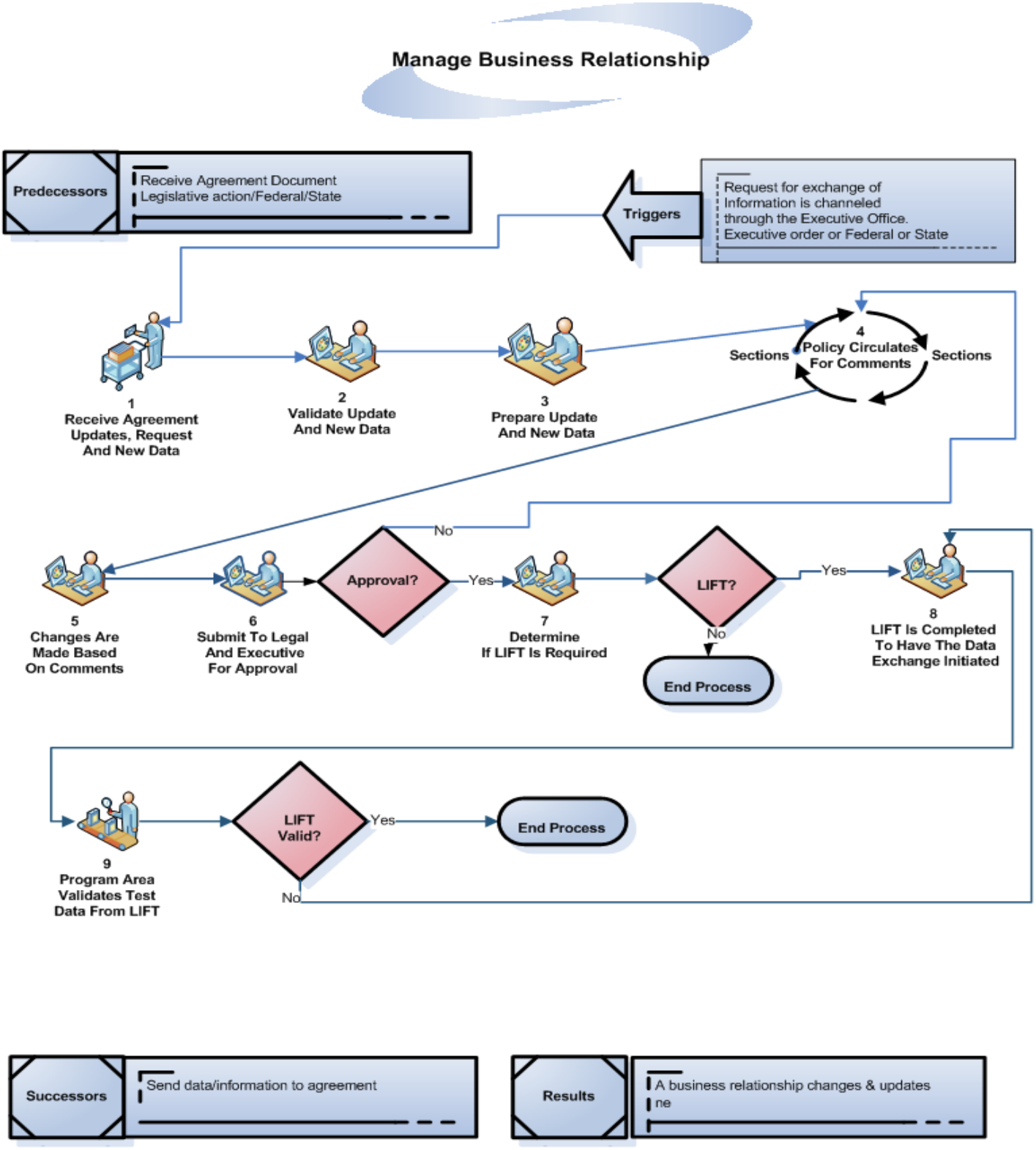


12.3 Manage Business Relationships

12.3.1 Manage Business Relationships Business Process Model

Item	Details
Description	The **Manage Business Relationship** business process maintains the agreement between the State Medicaid agency and the other party. This includes routine changes to required information such as authorized signers, addresses, coverage, and data exchange standards. These include Memoranda of Understanding (MOUs) with other governmental agencies, electronic data interchange agreements with providers, managed care organizations, and others, and CMS, other Federal agencies, and contracts, BA & State Plan waiver other OAAS The agreement to establish a business relationship is managed at the program level for the life of the agreement.
Trigger Event	1. Request for exchange of information is channeled through the Executive Office. 2. Executive order or Federal or State
Result	A business relationship changes & updates
Business Process Steps	1. Receive agreement updates, request and new data 2. Validate update and new data 3. Prepare update and new data 4. Policy circulates for comments 5. Changes are made based on comments 6. Submit to Legal and Executive for approval a. If Yes, go to Step 7 b. If No, go back to Step 4 7. Determine if LIFT is required c. If Yes, go to Step 8 d. If No, End Process 8. Prepare LIFT, if there are a lot of changes to the LIFT, prepare a new one. 9. Validate LIFT results e. If Yes, End Process f. If No, go back to Step 8
Shared Data	None
Predecessor	1. Receive Agreement Document 2. Legislative action/Federal/State
Successor	Send data/information to agreement
Constraints	Federal & State laws and regulations
Failures	None
Performance Measures	N/A

12.3.2 Manage Business Relationships Workflow



12.4 Terminate Business Relationships

12.4.1 Terminate Business Relationships Business Process Model

Item	Details
Description	The **Terminate Business Relationship** business process cancels the agreement between the State Medicaid agency and the business partner. This business process deals with termination of business relationships prior to the expected end of the agreement. Note: DHH has never terminated a business relationship
Trigger Event	Request for Termination of Agreement
Results	Terminate relationship
Business Process Steps	1. Receive request 2. Verify authority to terminate a. If Yes, go to Step 3 b. If No, End Process 3. Submit to Legal and executive (DHH Medicaid) for approval of termination a. If Yes, go to Step 4 b. If No, End Process 4. Prepare termination response 5. Notify associated persons of the termination
Shared Data	None
Predecessor	1. Receive Request for Termination 2. Violation / request /lack of funds
Successor	1. Send Response to Other Party 2. Provide notice to affected parties
Constraints	Federal & State laws and regulations
Failures	None
Performance Measures	N/A

12.4.2 Terminate Business Relationships Workflow