**Appendix B: CMS-Required Outcomes for Specific MES Modules**

The information in the following tables contains the CMS-required outcomes for specific MES modules. These outcomes are aligned with regulatory and policy requirements that states must follow when implementing modules or capabilities. These are designed to be used as a starting point for aligning what the state is trying to accomplish with a project in accordance with CMS expectations. The list should be adjusted if any outcomes are deemed not applicable for a state project or if the state proposes other outcomes that are not covered in the applicable table(s) below.

**Table B-1: Eligibility and Enrollment (E&E) Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **EE1** **Application** | The eligibility system receives, ingests, and processes the single-streamlined applications, change of circumstances, renewal forms, and any supporting documentation requested by the state (including telephonic signatures) from individuals, for all Medicaid eligibility groups and CHIP through online via multiple browsers, mail (paper), phone, and in-person (e.g., via kiosk) applications to support eligibility determination for all Insurance Affordability Programs (Federal Health Insurance Exchange), state Medicaid or CHIP, State-Based Marketplace (SBM), Basic Health Program (BHP). | 42 CFR 435.907 42 CFR 435.916 42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE2 Application** | Individuals experience a user-friendly, dynamic, online application, such that subsequent questions are based on prior answers. | 42 CFR 435.907 42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE3** **Automatic Enrollment** | Individuals eligible for automatic Medicaid eligibility are promptly enrolled (e.g., SSI recipients in 1634 states, individuals receiving a mandatory state supplement under a federally- or state-administered program, individuals receiving an optional State supplement per 42 CFR 435.230 , and deemed newborns). (Automatic enrollment in Guam, Puerto Rico, and the U.S. Virgin Islands is required only for individuals receiving cash assistance under a state plan for OAA, AFDC, AB, APTD, or AABD, and deemed newborns.) | 42 CFR 435.117 42 CFR 435.909  42 CFR 436.909 and  42 CFR 436.124 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE4** **Income Methodologies** | The state correctly calculate income and household composition based on Modified Adjusted Gross Income (MAGI) and non-MAGI methodologies at application and renewal. Example business rules include subtracting 5 percentage points off FPL for applicable family size | 42 CFR 435.603 42 CFR 436.601 and 42 CFR 436.811-814 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE5** **Electronic Verification** | The eligibility system uses automated interfaces with electronic data sources to enable real-time or near real-time, no manual touch eligibility determinations. The data sources include (but are not limited to) SSA and the Department of Homeland Security (DHS) (directly or via the Federal Data Services Hub (FDSH)), state quarterly wage data, data from financial institutions for asset verification, Renewal and Redetermination Verification service through the FDSH, Public Assistance Reporting Information System (PARIS) to verify Medicaid coverage in other states. | 42 CFR 435.940-965  42 CFR 435.945(d) 42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE6** **Timely Determinations** | Individuals who apply for Medicaid based on disability receive an eligibility determination within 90 days and all other applicants receive an eligibility determination within 45 days. | 42 CFR 435.911-912  42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE7** **Reasonable Opportunity Period** | Individuals are enrolled for up to 90 days if pending verification of citizenship or immigration status. | 42 CFR 435.407  42 CFR 435.956  42 CFR 436.407 and 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE8** **SSN Verification** | Individuals are enrolled pending verification of SSN. | 42 CFR 435.910  42 CFR 435.956(d)  42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE9** **Notices** | Individuals receive system-generated timely automated (versus manual) eligibility notices and request for additional information for eligibility determination, as necessary. | 42 CFR 431.210-214 42 CFR 435.917-918  42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE10** **Notices** | Individuals receive electronic notices and alerts as applicable via their preferred mode of communication (e.g., email, text that notice is available in online account). | 42 CFR 431.210-214 42 CFR 435.917-918  42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE11** **Enrollment** | Following an eligibility determination, the system promptly sends the beneficiary information to MMIS to complete enrollment into the appropriate delivery system (e.g., FFS, managed care). | 42 CFR 435.914  42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE12** **Presumptive Eligibility Applications** | The system receives Presumptive Eligibility (PE) applications from all approved entities in an automated manner and facilitates eligibility termination if no full Medicaid application is received by the end of the month following the month of PE determination. | 42 CFR Parts 435.1110 |
| **EE13** **Annual Renewals** | The system uses electronic data sources to confirm eligibility, wherever possible, to facilitate ex-parte renewals. | 42 CFR 435.916  42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE14** **Annual Renewals** | If ex-parte renewal cannot be completed, the system can automatically generate pre-populated renewal forms and distribute those forms via individuals' preferred communication mode. | 42 CFR 435.916 42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE15** **Eligibility Category** | The system applies an automated eligibility hierarchy that places an individual in the most advantageous group for which they are eligible at initial application and renewal. | 42 CFR 435.404 42 CFR 436.404 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE16** **Eligibility Category** | The system uses automated business rules to assign accurate eligibility categories for all the mandatory and relevant optional eligibility groups at initial application and renewal. Example business rules include:   * Correct identification of individuals age 19-64 at or below 133 percent FPL (VIII group) * Correct alignment of eligibility categories to FMAP rate | 42 CFR 435.404 42 CFR 436.404 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE17** **Incarcerated individuals** | Incarcerated individuals receive timely access to inpatient services and receive a timely and accurate eligibility determination upon release. | 42 CFR 435.1009 42 CFR 436.1005 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE18** **Emergency Medicaid** | Individuals whose coverage is limited to emergency services due to immigration status receive timely and accurate eligibility determination. | 42 CFR 435.139 42 CFR 440.255 42 CFR 436.128 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE19** **Retroactive Eligibility** | Individuals receive timely and accurate determinations of eligibility for the three months prior to the date of application if the individual would have been eligible and received Medicaid covered services. | 42 CFR 435.915 42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE20** **Effective Date of Eligibility** | Individuals are promptly enrolled with the accurate effective date of eligibility in accordance with the approved State Plan. | 42 CFR 435.915 42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE21** **Multi-Benefit Application** | In states that have an integrated eligibility system with human services programs, the system is able to pend application for one program without having to do so for Medicaid or CHIP programs, if needed. | June 18, 2013, CMS Guidance on State Alternative Applications for Health Coverage |
| **EE22** **Integration with Other Programs** | The state maintains a coordinated eligibility and enrollment process with all insurance affordability programs by supporting bi-directional data-sharing for application-related data and adjudication status with all relevant insurance affordability programs (FFE, CHIP, SBE if applicable, BHP if applicable). | 42 CFR 435.1200 |
| **EE23** **Account Transfers (for FFE Determination****States)** | Account Transfer information for individuals applying at the FFE from a determination state is automatically ingested and the state promptly enrolls individuals determined eligible by the FFE. | 42 CFR 435.1200 |
| **EE24** **Account Transfers (for FFE Assessment States)** | Account Transfer information for individuals applying at the FFE from an assessment state is automatically ingested and the state conducts only the remaining verifications necessary to complete the determination process for individuals assessed as potential eligible by the FFE. | 42 CFR 435.1200 |
| **EE25** **Minimum Essential Coverage (MEC) Check** | The system receives and responds to requests from the FFE in real-time to confirm whether an individual applying for coverage through the FFE currently has Minimum Essential Coverage through Medicaid or CHIP. | 42 CFR 435.1200 |
| **EE26** **Accessibility** | Persons with disabilities or with Limited English Proficiency (LEP) can submit a single streamlined application with any necessary assistance (e.g., TTY for the hearing impaired for phone applications, and language assistance for persons with LEP). | 42 CFR 435.905 42 CFR 435.908  42 CFR 436.901 (for Guam, Puerto Rico, and the Virgin Islands) |
| **EE27** **Appeals** | Beneficiaries and applicants can submit an appeal against an adverse action via multiple channels (e.g., online, phone, mail, in person) and the status and adjudication of an appeal can easily be accessed by necessary state staff and appellants. | 42 CFR 431.221 |

**Table B-2: Claims Processing Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **CP1 Receipt and Ingestion** | The system receives, ingests, and retains claims, claims adjustments, and supporting documentation submitted both electronically and by paper in standard formats. | 45 CFR 162.1102 |
| **CP2 Validation** | The system performs comprehensive validation of claims and claims adjustments, including validity of services. | 42 CFR 431.052  42 CFR 431.055  42 CFR 447.26  42 CFR 447.45(f)  45 CFR 162.1002  SMD Letter 10-017  SMM Part 11 Section 11300 |
| **CP3 Prior Authorization** | The system confirms authorization for services that require prior approval to manage costs or ensure patient safety, and that the services provided are consistent with the authorization. The system accepts use of the authorization by multiple sequential providers during the period as allowed by state rules. Prior-authorization records stored by the system are correctly associated with the relevant claim(s). | SSA 1927(d)(5)  42 CFR 431.630  42 CFR 431.960  45 CFR 162.1302  SMM Part 4  SMM Part 11 Section 11325 |
| **CP4 Calculation and Resolution** | The system correctly calculates payable amounts in accordance with the State Plan and logs accounts payable amounts for payment processing. The system accepts, adjusts, or denies claim line items and amounts and captures the applicable reason codes. | 42 CFR 431.052 |
| **CP5 Provide Submission Status** | The state communicates claims status throughout the submission and payment processes and in response to inquiry. If there are correctable errors in a claims submission, the system suspends the claims, attaches pre-defined reason code(s) to suspended claims, and communicates those errors to the provider for correction. The system associates applicable error or reason code(s) for all statuses (e.g., rejected, suspended, denied, approved for payment, paid) and communicates those to the submitter. The system shows providers, case managers and members current submission status through one or more of the following:   * Automatic notices as appropriate based on claims decision or suspension. * Explanation of Benefits (EOB). * Providing prompt response to inquiries regarding the status of any claim through a variety of appropriate technologies, and tracking and monitoring responses to the inquiries. * Application programming interface (API) | 45 CFR Part 162.1402 (c)  45 CFR Part 162.1403 (a) & (b)  42 CFR 431.60 (a) & (b)  SMM Part 11 Section 11325 |
| **CP6 Record-Keeping** | The system tracks each claim throughout the adjudication process (including logging edits made to the claim) and retains transaction history to support claims processing, reporting, appeals, audits, and other uses. | 42 CFR 447.45  42 CFR 431.17  SMM Part 11 Section 11325 |

**Table B-3: Financial Management Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **FM1** | The system calculates FFS provider payment or recoupment amounts, as well as value-based and alternative payment models (APM), correctly and initiates payment or recoupment action as appropriate. | Section 1902(a)(37) of the Act  42 CFR 433.139  42 CFR 447.20  42 CFR 447.45 42 CFR 447.56  42 CFR 447.272 |
| **FM2** | The system pays providers promptly via direct transfer and electronic remittance advice or by paper check and remittance advice if electronic means are not available. | 42 CFR 447.45  42 CFR 447.46 |
| **FM3** | The system supports the provider appeals by providing a financial history of the claim along with any adjustments to the provider's account resulting from an appeal. | 42 CFR 431.152 |
| **FM4** | The system accurately pays per member/per month capitation payments electronically in a timely fashion. Payments account for reconciliation of withholds, incentives, payment errors, beneficiary cost sharing, and any other term laid out in an MCO contract. | 42 CFR 438  42 CFR 447.56(d) |
| **FM5** | The system accurately tallies recoupments by tracking repayments and amounts outstanding for individual transactions and in aggregate for a provider. | 42 CFR 447 |
| **FM6** | The state recovers third party liability (TPL) payments by:   * Tracking individual TPL transactions, repayments, outstanding amounts due, * Aggregating by member, member type, provider, third party, and time period, * Alerting state recovery units when appropriate, and * Electronically transferring payments to the state. | 42 CFR 433.139 |
| **FM7** | The system processes drug rebates accurately and quickly. | 42 CFR 447.509 |
| **FM8** | State and federal entities receive timely and accurate financial reports (cost reporting, financial monitoring, and regulatory reporting), and record of all transactions according to state and federal accounting, transaction retention, and audit standards. | 42 CFR 431.428  42 CFR 433.32 |
| **FM9** | The system tracks that Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household does not exceed an aggregate limit of five percent of the family's income. If the beneficiaries at risk of reaching the aggregate family limit, the system tracks each family's incurred premiums and cost sharing without relying on beneficiary documentation. | 42 CFR 447.56(f) |

**Table B-4: Decision Support System (DSS)/Data Warehouse (DW) Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **DSS/DW1** | The system supports various business processes' reporting requirements | 42 CFR 431.428 |
| **DSS/DW2** | The solution includes analytical and reporting capabilities to support key policy decision making | 42 CFR 433.112 |

**Table B-5: Encounter Processing System (EPS) Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **EPS1** | The system ingests encounter data (submissions and re-submissions) from MCOs and sends quality transaction feedback back to the plans to ensure appropriate industry standard format. (Quality transaction checks include, but are not limited to completeness, missing information, formatting, and the TR3 implementation guide business rules validations). | 42 CFR 438.242 |
| **EPS2** | The system ingests encounter data (submissions and re-submissions) from managed care entities in compliance with HIPAA security and privacy standards and performing quality checks for completeness and accuracy before submitting to CMS using standardized formatting, such as ASC X12N 837, NCPDP and the ASC X12N 835, as appropriate. (Quality checks include, but are not limited to completeness, character types, missing information, formatting, duplicates, and business rules validations, such as payment to dis-enrolled providers, etc.). | 42 CFR 438.604, 438.818, and 438.242 |
| **EPS3** | The state includes submission requirements (timeliness, re-submissions, etc.), definitions, data specifications and standards, and consequences for non-compliance in its managed care contracts. The state enforces consequences for non-compliance. | 42 CFR Part 438.3 |
| **EPS4** | The state uses encounter data to calculate capitation rates and performs payment comparisons with FFS claims data. | 42 CFR Part 438 |
| **EPS5** | The state complies with federal reporting requirements. These include but are not necessarily limited to:   * T-MSIS (Transformed Medicaid Statistical Information System) * CMS 416 (EPSDT) * CHIPRA core set quality measures - Medi-Medi, 1115 evaluation, and * CMMI demonstration evaluation reports. | 42 CFR 438.818, 438.242 |

**Table B-6: Long Term Services & Supports (LTSS) Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **LTSS1** | LTSS system generates notifications including eligibility determination; termination of state waiver (30 days in advance); and inspections taking place in a beneficiary's home when a beneficiary receives services in his/her own home or the home of a relative (HCBS waiver for individuals 65 and older) (48 hours in advance). | 42 CFR 441.307 42 CFR 441.356 42 CFR 441.365 42 CFR 431.206 42 CFR 431.210 42 CFR 433.112 |
| **LTSS2** | LTSS systems stores proof of beneficiary consent to enroll in HCBS state plan or waiver-based programs. | 42 CFR 441.301 |
| **LTSS3** | LTSS system assigns, tracks and changes beneficiary prioritization and waiver waitlist status. | 42 CFR 433.112 |
| **LTSS4** | LTSS system maintains a record of beneficiaries who have left the waiver program due to death or loss of eligibility for Medicaid under the State Plan to replace those beneficiaries with others on the waitlist. | 42 CFR 441.305 |
| **LTSS5** | LTSS system stores the person-centered plan, including any updates or changes containing all required information and consent signatures. | 42 CFR 441.302 |
| **LTSS6** | LTSS system supports conflict-free case management via role-based access, proper firewalls, and mitigation strategies that provide beneficiaries appropriate access to records. | HIPAA 42 CFR 441.301 |
| **LTSS7** | LTSS System supports completion of CMS Form 372. | 42 CFR 433.112 42 CFR 441.302 |
| **LTSS8** | LTSS system collects and saves prior authorizations to exchange with MMIS as needed to prevent the provision of unnecessary or inappropriate services and supports. | 42 CFR 441.301 |
| **LTSS9** | LTSS system documents and tracks reportable events related but not limited to instances of abuse, neglect, exploitation, and unexplained death from case initiation to case closeout. | 42 CFR 441.404 CMS Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers, March 12, 2014 42 CFR 441.585 and 42 CFR Part 438 |
| **LTSS10** | LTSS system collects grievances related but not limited to instances of abuse, neglect, exploitation, and unexplained death from case initiation to case closeout. | 42 CFR 441.464; 441.555 |
| **LTSS11** | LTSS system creates trend reports of critical incident causes and tracks trends of critical incidents after operational implementation of interventions/mitigations/corrective actions. | Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria p.242-243 (Appendix G-1-e)  Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers, Page 10 |

**Table B-7: Member Management Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **MM1** | The system auto-assigns managed care enrollees to appropriate managed care organizations, per state and federal regulations. | CFR 42 438.54 |
| **MM2** | The system sends notice, or facilitates, to the enrolled member with an initial assignment, a reasonable period to change the selection, and appropriate information needed to make an informed choice. If no selection is made, the system either confirms the original assignment, or assigns the member to FFS. | CFR 42 438.10, 438.54 |
| **MM3** | The system disenrolls members at the request of the plan and in accordance with state procedures. | 42 CFR 438.56(b) (c), and (d) |
| **MM4** | Disenrollments are effective in the system the first day of the second month following the request for disenrollment. | 42 CFR 438.56(e) |
| **MM5** | The system notifies enrollees of their disenrollment rights at least 60 days before the start of each enrollment period. This notification is in writing. | 42 CFR 438.56(f) |
| **MM6** | To prevent duplication of activities, enrollee's needs are captured by the system so that MCOs, PIHPs, and PAHPs can see and share the information (in accordance with privacy controls). | 42 CFR 438.208(b) |
| **MM7** | The system allows beneficiaries or their representative to receive information through multiple channels including phone, Internet, in-person, and via auxiliary aids and services. | 42 CFR 438.71 |
| **MM8** | The state provides content required by 42 CFR 438.10, including but not limited to definitions for managed care and enrollee handbook, through a website maintained by the state. | 42 CFR 438.10(c) |
| **MM9** | Potential enrollees are provided information about the state's managed care program when the individual become eligible or is required to enroll in a managed care program. The information includes, but is not limited to the right to disenroll, basic features of managed care, service area coverage, covered benefits, and provider directory and formulary information. | 42 CFR 438.10(e) |
| **MM10** | The system maintains an up-to-date (updated at least annually) fee-for-service (FFS) or primary care case-management (PCCM) provider directory containing the following:   * Physician/provider * Specialty * Address and telephone number * Whether the physician/provider is accepting new Medicaid patients (for PCCM providers), and * The physician/provider's cultural capabilities and a list of languages supported (for PCCM providers). | Section 1902(a)(83), 1902(mm), SMD # 18-007 |
| **MM11** | The system captures enough information such that the state can evaluate whether members have access to adequate networks. (Adequacy is based on the state's plan and federal regulations). | 42 CFR 438.68 |

**Table B-8: Prescription Drug Monitoring Program (PDMP) Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **PDMP 1**  **Qualified PDM** | Covered providers have near real-time access to:  a. Information regarding Medicaid beneficiary’s prescription drug history.  b. The number and type of controlled substances prescribed to and filled for the covered individual during at least the most recent 12-month period.  c. The name, location, and contact information (or other identifying number selected by the state, such as a national provider identifier issued by the CMS National Plan and Provider Enumeration System) of each covered provider who prescribed a controlled substance to the covered individual during at least the most recent 12-month period. | Section 1944(b) of the Act  Section 5042 – Medicaid PARTNERSHIP Act  CMS FAQs-SUPPORT for Patients and Communities Act |
| **PDMP 2**  **Qualified PDMP** | Providers can easily use the PDMP information though workflow integration, which may include electronic prescribing system for controlled substances. | Section 1944(b) of the Act  Section 5042 – Medicaid PARTNERSHIP Act  CMS FAQs-SUPPORT for Patients and Communities Act |
| **PDMP 3**  **Qualified PDMP** | The state has data-sharing agreements with all contiguous states to track patients, prescribers, and prescriptions across state lines. | Section 1944(f) of the Act  Section 5042 – Medicaid PARTNERSHIP Act  CMS FAQs-SUPPORT for Patients and Communities Act |
| **PDMP 4**  **Qualified PDMP** | The state medical and pharmacy directors and any designee has access to the PDMP information in an electronic format based on data-sharing agreements in place (subject to state law). | Section 1944(b) of the Act  Section 5042 – Medicaid PARTNERSHIP Act  CMS FAQs-SUPPORT for Patients and Communities Act |
| **PDMP 5**  **Required Reporting** | The state produces data for the reports that are required to be submitted in the Annual Report to HHS. | Section 1944(e) of the Act  Section 5042 – Medicaid PARTNERSHIP Act  42 CFR 433.112(b)(15)  CMS FAQs-SUPPORT for Patients and Communities Act |
| **PDMP 6**  **Utilization and Quality Reports** | The system produces reports to contribute to reports to HHS by the State Drug Utilization Review (DUR) Board and for program evaluation, continuous improvement in business operations, transparency and accountability, as well as identify patterns of fraud, abuse, gross overuse, excessive utilization related to limitations identified by the state, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization among Medicaid physicians, pharmacists and enrollees associated with specific drugs or groups of drugs. | Section 1944 (e)(1) of the Act  Section 1927(g)(2)(B) and (g)(3)(D) of the Act  Section 1004 of the SUPPORT Act  42 CFR 433.112(b)(15)  CMS FAQs-SUPPORT for Patients and Communities Act  Centers for Disease Control |
| **PDMP 7**  **Electronic Case Reporting (If Applicable)** | The PDMP uses electronic case reporting to track opioid-related hospitalizations, emergency department visits, and/or urgent care visits. | Section 5042 – Medicaid PARTNERSHIP Act  CMS FAQs-SUPPORT for Patients and Communities Act |

**Table B-9: Pharmacy Benefit Management (PBM) Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **PBM1** | The system adjudicates claims within established time parameters to ensure timely pharmacy claims payments. | Section 1927(h) of the SSA  42 CFR 456.722 - POS requirement to support claims adjudication or payment |
| **PBM2** | The system adjudicates claims accurately within established parameters. The module can be configured to provide authority/ability to override a reject/edit/denied claim and then resubmit to ensure timely provider claims payments. | 42 CFR 456.722 |
| **PBM3** | The system captures the necessary data to ensure timely processing of manufacturer rebates as well as the capability to track rebates to promote beneficiary cost savings. | Section 1927 of the SSA   42 CFR 447.509 |
| **PBM4** | The system has the capability to support cost savings by capturing, storing, and transferring data to the payment process system to generate invoices of participating drug manufacturers within 60 days of the end of each quarter. | Section 1927 of the SSA  42 CFR 447.520 Section 1927(b)(2) of the SSA  42 CFR 447.511 |
| **PBM5** | The system supports cost savings by enabling the tracking, monitoring, and reporting of manufacturer's pharmacy drugs and rebate savings. | Section 1927 of the SSA  42 CFR 447.520  Section 1927(b)(2) of the SSA  42 CFR 447.511 |
| **PBM6** | The system enables the beneficiary to have timely access to medication if the system has the  capability to perform prior authorization and provide a response by telephone or other telecommunication devices within 24 hours of a request and provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (unless excluded under the SSA ). | Section 1927(d)(5) of the SSA |
| **PBM7** | The system supports CMS oversight of the safe, effective, and appropriate dispensing of medications by enabling the capability to provide data to support the creation of the CMS annual report on the operation and status of the state's DUR program. | Section 1927(g)(3)(D) of the SSA  42 CFR 456.712  Section 1944(e)(1) of the SSA |
| **PBM8** | The system supports the safe, effective, and appropriate dispensing of medications by enabling the capability to provide point-of-sale or point of distribution prospective review of drug therapy based upon predetermined standards, including standards for counseling. | 42 CFR 456.703, 456.705(b) 456.709 Section 1927 (g) of the SSA |
| **PBM9** | The system supports the identification of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, or prescribing or billing practices indicating abuse or excessive utilization among physicians, pharmacists and individuals receiving benefits by enabling the collection of pharmacy data to be used in retrospective drug utilization reviews. | 42 CFR 456.703, 456.705(b) 456.709 Section 1927 (g) of the SSA |

**Table B-10: Provider Management Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **PM1** **Application** | A provider can initiate, save, and apply to be a Medicaid provider. | 42 CFR 455.410(a) |
| **PM2** **Screening** | A state user can view screening results from other authorized agencies (Medicare, CHIP, other related agencies) to approve provider if applicable. | 42 CFR 455.410(c) |
| **PM3** **Screening** | A state user can verify that any provider purporting to be licensed in a state is licensed by such state and confirm that the provider's license has not expired and that there are no current limitations on the provider's license ensure valid licenses for a provider. | 42 CFR 455.412 |
| **PM4** **Revalidation** | The system tracks the provider enrollment period to ensure that the state initiates provider revalidation at least every five years. | 42 CFR 455.414 |
| **PM5** **Termination** | A state user (or the system, based on automated business rules) must terminate or deny a provider's enrollment upon certain conditions (refer to the specific regulatory requirements conditions in 42CFR455.416). | 42 CFR 455.416 |
| **PM6** **Reactivation** | After deactivation, a provider seeking reactivation must be re-screened by the state and submit payment of associated application fees before their enrollment is reactivated. | 42 CFR 455.420 |
| **PM7** **Appeal** | A provider can appeal a termination or denial decision~~,~~ and a state user can monitor the appeal process and resolution including nursing homes and ICFs/IID. | 42 CFR 455.422 |
| **PM8** **Site Visits** | A state user can manage information for mandatory pre-enrollment and post-enrollment site visits conducted on a provider in a moderate or high-risk category. | 42 CFR 455.432(a) |
| **PM9** **Background Checks** | A state user can view the status of criminal background check~~s~~, fingerprinting, and site visits for a provider as required based on their risk level and state law. | 42 CFR 455.434 |
| **PM10** **External Systems Checks** | The system checks appropriate databases to confirm a provider's identity and exclusion status for enrollment and reenrollment and conducts routine checks using federal databases including: Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), and the Excluded Parties List System (EPLS). Authorized users can view the results of the data matches as needed. | 42 CFR 455.436 |
| **PM 11** **Risk Level Assignment** | A state user can assign and screen all applications by a risk categorization of limited, moderate, or high for a provider at the time of new application, re-enrollment, or re-validation of enrollment. A state user can adjust a provider's risk level due to payment suspension or moratorium. | 42 CFR 455.450 |
| **PM 12** **Application Fees** | The system can collect application fees. A state user ensures any applicable application fee is collected before executing a provider agreement. | 42 CFR 455.460 |
| **PM 13** **Moratoria** | A state user can set CMS and state-imposed temporary moratoriaon new providers or provider types in six-month increments. | 42 CFR 455.470 |
| **PM 14** **Network Adequacy** | A state user can determine network adequacy based upon federal regulations and state plan. | 42 CFR 438.68 |
| **PM 15** **Sanctions and Terminations** | A state user, and/or the system, can send and receive provider sanction and termination information shared from other states and Medicare to determine continued enrollment for providers. | 42 CFR 455.416(c) |
| **PM 16** **Notices and Communications** | The system can generate relevant notices or communications to providers to include, but not limited to, application status, requests for additional information, re-enrollment termination, investigations of fraud, suspension of payment in cases of fraud. | 42 CFR 455.23 |
| **PM 17** **Fraud** | A state user can report required information about fraud and abuse to the appropriate officials. | 42 CFR 455.17 |
| **PM 18** **Payment Suspension** | The system, or a state user, can suspend payment to providers in cases of fraud. | 42 CFR 455.23 |
| **PM 19** **Agreements and Disclosures** | A state user can view provider agreements and disclosures as required by federal and state regulations. | 42 CFR 455.104 42 CFR 455.105 42 CFR 455.106 42 CFR 455.107 |
| **PM 20** **Change in Circumstances** | A state user can view information from a managed care plan describing changes in a network provider's circumstances that may affect the provider's eligibility to participate in Medicaid, including termination of the provider agreement. | 42 CFR 438.608(a) |
| **PM 21** **Directory** | A beneficiary can view and search a provider directory. | 42 CFR 438.10(h) |

**Table B-11: Third Party Liability (TPL) Outcomes**

| **Reference #** | **Outcome** | **Source(s)** |
| --- | --- | --- |
| **TPL1**  **Application** | The system does the following:   * Records third parties, * Determines the liability of third parties, * Avoids payment of third-party claims, * Recovers reimbursement from third parties after Medicaid claims payment, and * Records information and actions related to the plan. | 42 CFR 433.138(k)(2)(i) |
| **TPL2**  **Health Insurance Information** | The system records other health insurance information at the time of application or renewal for Medicaid eligibility that would be useful in identifying legally liable third-party resources. | Section 1902(a)(25) of the Act  42 CFR 433.136  42 CFR 433.137  42 CFR 433.138 |
| **TPL3**  **Information to Determine Legal Liability** | The system uses electronic exchange state wage information collection agency   The system(s) regularly updates the member file with any third-party liability information, how long it is valid, and for what services, through regular automated checks with these databases. | 42 CFR 433.138(d) and (f) 42 CFR 435.4  State Plan |
| **TPL4**  **Rejection Based on TPL** | The system rejects and returns to the provider for a determination of the amount of liability for all claims for which the probable existence of third-party liability is established at the time the claim is filed. | 42 CFR 433.139(b) |
| **TPL5**  **Pay and Chase Identification** | For claims identified with a third-party liability and designated as “mandatory pay and chase,” the system makes appropriate payments and identifies such claims for future recovery. (Examples include preventive pediatric services provided to children, or medical child support from an absent parent.) | Section 1902(a)(25) of the Act  42 CFR 433.139(b)(3)(ii) |
| **TPL6**  **Pay and Chase Timeline** | The system(s) supports providing up to 100 days to pay claims related to medical support enforcement, preventive pediatric services, labor and delivery, and postpartum care that are subject to "pay and chase." If a state cannot differentiate the costs for prenatal services from labor and delivery on the claim, it will have to cost avoid the entire claim. | Bipartisan Budget Act of 2018, Sec. 53102  Section 1902(a)(25) of the Act  CMCS Informational Bulleting (CIB) November 14, 2019 (pg. 2) |
| **TPL7**  **Claims Identification for TPL** | The system identifies paid claims that contain diagnosis codes indicative of trauma, injury, poisoning, and other consequences of external causes on a routine and timely basis for the purposes of determining legal liability of third parties. | 42 CFR 433.138(e) and (f) |
| **TPL8**  **Probable TPL Determination Timeline** | The system identifies probable TPL within 60 days after the end of the month in which payment has been made (unless there is an approved waiver to not recoup funds). | 42 CFR 433.139(d) |
| **TPL9**  **Report Generation** | The system can generate reports on data exchanges and trauma codes so that the state can evaluate its TPL identification process. | 42 CFR 433.138(j) |
| **TPL10**  **Cost Effectiveness** | The system enables the agency to seek reimbursement from a liable third party on all claims for which it is cost effective. | 42 CFR 433.139(f) |
| **TPL11**  **MCO TPL Recovery** | As determined by the state policies, system(s) enables the state to manage and oversee TPL recoveries made by its MCOs. | COB/TPL Training and Handbook- 2020 (pg. 53-55) |
| **TPL12**  **Privacy and Security** | Appropriate privacy and security controls are in place so that information exchanged with other agencies is safeguarded. | 42 CFR 433.138(h) |
| **TPL13**  **Reimbursement Tracking** | The system tracks TPL reimbursements received so that the state can reimburse the federal government in accordance with the state's FMAP. | 42 CFR 433.140 (c) |