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

The information in the following tables contains the CMS-required outcomes for Claims Processing 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-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-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 |