CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 46 **Date: February 13, 2004**

I. SUMMARY OF CHANGES:

NEW/REVISED MATERIAL - EFFECTIVE DATE:

Table of Contents - Title changed for sections 20.3.2 and 50.5. Section 60.5 is deleted.

Section 20.1 - General - Deleted the words "cost-based or risk-based," and replaced with "cost plan," which is currently used to describe an M+C organization.

Section 20.2.1 - Cost-Based MCOs Only - inserted the words "the current month to" to clarify the time period when enrollment transaction records may be submitted to CMS.

Section 20.2.2 - Medicare+Choice MCOs Only - In second paragraph, deleted the reference to "Operational Policy Letter 99.100," and clarified definition of "elections." In the second list item, replaced "signed application" with "election form." In following paragraphs, updated the years for the coming calendar year. Finally, the last paragraph regarding enrollment records for applications received is deleted.

Section 20.3.1 - Cost-Based MCOs Only - Throughout the section, updated the years for the coming calendar year.

Section 20.3.2 - M+C Organization Only - Changed section heading to spell out "M+CO."

Section 30.2.2 - Submission of Correction Transaction Records - Changed "MCO" to "M+C organizations" for clarification.

Section 30.3.2 - Prior Commercial Months Field - Added the words "or the other provisions, which allow enrollment of ESRD member" to indicate all conditions which may allow enrollment of a beneficiary with ESRD coverage.

Section 30.4 – "Special Status" Beneficiaries – Medicare + Choice Organizations - For the third item in the list, "Working Aged," added "(prior to 2004)" for clarification now that the new year has arrived.

Section 30.5.1 - "Special Status" - Hospice - Changed "MCO" to "M+C organization" in third paragraph for clarification.

Section 30.5.2 - "Special Status" - End Stage Renal Disease (ESRD) - Changed first paragraph to describe conditions for eligibility for individuals who develop ESRD while

enrolled in a health plan offered by the M+C organization. In addition, the sixth paragraph is split into two paragraphs.

Section 30.5.3 - "Special Status" - Institutionalized - Changed reference from Operational Policy Letter #54 to Chapter 7 of the Medicare Managed Care Manual.

Section 30.5.5 - "Special Status" - Working Aged (WA) - Added first paragraph and clarifying language to the third paragraph to describe how the working aged status is reflected in a plan level factor beginning January 2004.

Section 30.6 - When to Submit "Special Status" Information (Medicare + Choice Organizations Only) - Deleted the words "working aged" from the first sentence of the first paragraph. In "Beneficiary B" example, corrected capitalization of the word "qualifies" and in the last paragraph, changed "disenrollment" to "Medicaid off record."

Section 40.1 - Timeliness Requirements - In second paragraph, changed "CMS" to "'GHP' Processing Schedule." In third paragraph, added the word "completed," and corrected spelling of "When" in the fifth paragraph.

Section 40.3 - Sending the Transaction File to CMS - In list item #2, updated the name of the provider of electronic data transfer services for MCOs from Acxiom, Inc. to SMS, Inc.

Section 40.4 - Electronic Data Transfer - Corrected spelling of "Demand."

Section 40.6 - Data Processing Vendor - Updated the name, address, and phone number of the data processing vendor.

Section 50.2 - CMS' Transaction Reply/Monthly Activity Report - Added paragraph to correct instructions for reconciliation of the Monthly Membership and Transaction Reply reports.

Section 50.3 - Transaction Reply Field Information - After Field 17, changed "MCOs" to "M+C organizations," and deleted "Note to risk-based MCOs" paragraph at the end of Field 17.

Section 50.4 - Plan Payment Report - In list item 1, changed "MCO" to "M+C organization."

Section 50.5 - Demographic Report - M+C Organizations Only - Changed "MCO's" to "M+C organization's" throughout the section.

Section 50.7 - Monthly Membership Report - At the end of the first paragraph, corrected grammar and verb tense throughout the section.

Section 50.8 - Bonus Payment Report - Changed "is" to "became."

Section 60 - Retroactive Payment Adjustment Policy - Changed "working aged status" to "hospice" and "Medicare + Choice organizations" to abbreviation, "M+C organizations.

In unnumbered section "**Receipt of Data**," clarified that payment will be limited to 36 months only.

In unnumbered section "**Retroactive Demographic Adjustments**, " deleted previously sixth item, "working aged status."

In unnumbered section, "**Retroactive Election (Enroll/Disenroll),**" added Chapter 17D of this manual as a reference for instructions governing the processing of retroactive enrollments/disenrollments.

In unnumbered section, "**Retroactive Enrollment**," clarified that retroactive payment period will be limited to 36 months only.

In unnumbered section, "**Retroactive Disenrollment**," clarified that retroactive payment period will be limited to 36 months only. Corrected "RO" to "CMS."

In unnumbered section, "**Tab B**," added this section heading.

In unnumbered section, "**IntegriGuard Submission Process for M+C Organizations**," provided instructions regarding electronic submissions. Throughout, changed "M+C organization can" or "M+C organization should" to "M+C organization must."

Throughout subsections within this unnumbered section, made the opening phrase "M+C organizations" singular; changed word "entitled" to "titled" and added link to "Probe Study"; changed appearance of data tables; and in some cases updated instructions for submitting these data table formats.

Added new unnumbered section, "**Electronic Submission Data Field Specifications and Instructions**," regarding submitting retroactive payment adjustment requests. Specifications for each data field are included.

In unnumbered section, "**Probe Study,**" changed the time frame from "4 to 5 days" to "7 business days" for M+C organizations to submit supporting documentation when notified of inclusion in the probe study.

In unnumbered section, "**Submission Address**," updated the address to send submissions to and added a fax number.

Section 60.1 - Standard Operating Procedures for State and County Code Adjustments

In unnumbered section, "**State and County Code Description**," added the words "is an enrollment eligibility requirement" to indicate impact of a beneficiary's state and county of residence upon the capitation rate.

In unnumbered section, "**General Guidelines for M+C Organizations Requesting Retroactive Adjustments**," changed the word "should" to "must," and added cross reference to Chapters 2 and 17 of this manual.

In unnumbered section, "**Documentation Required to Retroactively Change a Beneficiary's State and County Code,**" corrected spelling of "MapQuest."

Section 60.3 - Standard Operating Procedures for Medicaid Retroactive Adjustments

In unnumbered section, "**General Guidelines for M+C Organizations Requesting Retroactive Adjustments**," changed the word "should" to "must."

Section 60.4 - Standard Operating Procedures for End Stage Renal Disease Retroactive Adjustments

In unnumbered section, "**General Information About the ESRD Payments**," updated the name of the renal information system to "System Renal Management Information System (REMIS)" in second paragraph and in bulleted list.

Material from old section 60.5 is incorporated into 60.4. An unnumbered section, "**Health Status Description**," is retained with a second subheading, "**Standard Operating Procedure for Retroactive Adjustment of Working Aged.**" A paragraph is added regarding application of the working aged factor to M+C organization payments at the contract level. A reference to CMS's Web site is provided for further information.

Section 60.5 - Processing of Working Aged Retroactive Adjustments - Deleted this section.

Section 60.6 - Standard Operating Procedures for Retroactive Adjustment of Plan Elections

In first unnumbered section, "**Enrollments and Disenrollments including Plan Benefit Package (PBP) Changes,**" changed this section title, made miscellaneous word changes, and added "cost plans" to this paragraph.

In second unnumbered section, "**Guidelines for Requesting Retroactive Adjustments – Cost Plans and HCPPs,**" changed this section title to include "Cost Plans."

In third unnumbered section "**Guidelines for Requesting Retroactive Adjustments – M+C Organizations, M+C Demonstrations, and PACE**," corrected capitalization of "Organization," and made miscellaneous word changes.

In fourth unnumbered section, "**Documentation Required for a Beneficiary to Retroactively Enroll or Disenroll, Including a PBP change**," changed the title to this subsection, and made miscellaneous word changes.

In fifth unnumbered section, "**Requirements for Submitting Retroactive Enrollment and Disenrollments (including PBP changes)**," changed the title to this subsection, updated submission addresses at the end of the section, and made miscellaneous word changes.

Section 70.2 - Medicare Customer Service Center Disenrollments - Changed "SSA disenrollment" to "Medicare customer service center disenrollment."

Section 80.3 - Duplicate Payment Prevention by Cost-Based MCOs - In second paragraph, changed "should" to "must."

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 19 / Table of Contents
R	Chapter 19 / Section 20.1 / General
R	Chapter 19 / Section 20.2.1 / Cost-Based MCOs Only
R	Chapter 19 / Section 20.2.2 / Medicare+Choice MCOs Only
R	Chapter 19 / Section 20.3.1 / Cost-Based MCOs Only
R	Chapter 19 / Section 20.3.2 / M+C Organizations Only
R	Chapter 19 / Section 30.2.2 / Submission of Correction Transaction Records
R	Chapter 19 / Section 30.3.2 / Prior Commercial Months Field
R	Chapter 19 / Section 30.4 / "Special Status" Beneficiaries – Medicare + Choice Organizations
R	Chapter 19 / Section 30.5.1 / "Special Status" - Hospice
R	Chapter 19 / Section 30.5.2 / "Special Status" - End Stage Renal Disease (ESRD)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 19 / Section 30.5.3 / "Special Status" - Institutionalized
R	Chapter 19 / Section 30.5.5 / "Special Status" - Working Aged (WA)
R	Chapter 19 / Section 30.6 / When to Submit "Special Status" Information (Medicare + Choice Organizations Only)
R	Chapter 19 / Section 40.1 / Timeliness Requirements
R	Chapter 19 / Section 40.3 / Sending the Transaction File to CMS
R	Chapter 19 / Section 40.4 / Electronic Data Transfer
R	Chapter 19 / Section 40.6 / Data Processing Vendor
R	Chapter 19 / Section 50.2 / CMS' Transaction Reply/Monthly Activity Report
R	Chapter 19 / Section 50.3 / Transaction Reply Field Information
R	Chapter 19 / Section 50.4 / Plan Payment Report
R	Chapter 19 / Section 50.5 / Demographic Report - M+C Organizations Only
R	Chapter 19 / Section 50.7 / Monthly Membership Report
R	Chapter 19 / Section 50.8 / Bonus Payment Report
R	Chapter 19 / Section 60 / Retroactive Payment Adjustment Policy
R	Chapter 19 / Section 60.1 / Standard Operating Procedures for State and County Code Adjustments
R	Chapter 19 / Section 60.3 / Standard Operating Procedures for Medicaid Retroactive Adjustments
R	Chapter 19 / Section 60.4 / Standard Operating Procedures for End Stage Renal Disease Retroactive Adjustments
D	Chapter 19 / Section 60.5 / Processing of Working Aged Retroactive Adjustments
R	Chapter 19 / Section 60.6 / Standard Operating Procedures for Retroactive Adjustment of Plan Elections
R	Chapter 19 / Section 70.2 / Medicare Customer Service Center Disenrollments
R	Chapter 19 / Section 80.3 / Duplicate Payment Prevention by Cost-Based MCOs

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Medicare Managed Care Manual

Chapter 19 - The Enrollment and Payment User's Guide

Last Updated - (Rev. 46, 02-13-04)

Table of Contents

Chapter 20 (Plan Communications Guide) is being published separately in order to insure that necessary information is available timely to users.

20.1 - General

(Rev. 46, 02-13-04)

Requirements for submission of enrollment and disenrollment information differ depending on whether the MCO is *a cost plan or* a Medicare+Choice organization (M+C organization).

20.2.1 - Cost-Based MCOs Only

(Rev. 46, 02-13-04)

For requests received during a current month, you may submit enrollment transaction records to CMS with an effective date of *the current month to* 1 to 3 months **after** that current month. Requests for any other effective date will be rejected by CMS.

EXAMPLE

An enrollment request record with an enrollment effective date of October 2000 submitted by the September cut-off date would be accepted by CMS and would be processed. An enrollment request record with an enrollment effective date of July 2000 would be rejected.

20.2.2 - Medicare+Choice MCOs Only

(Rev. 46, 02-13-04)

There are four coverage election periods during which a beneficiary may enroll in an M+C organization.

1. Initial coverage election period (ICEP): the 3-month period prior to an individual's entitlement to **both** Part A and Part B of Medicare;

2. Annual election period (AEP): occurs between November 15 and December 31 of each year for effective dates of January 1 of the next calendar year;

3. Special Election Period (SEP): occurs due to special circumstances that include MCO contract termination, beneficiary move out of the service area, etc.; and

4. Open enrollment period (OEP): any month that an MCO is open for enrollment. Until January 2005, this may be any month during the year.

The M+C organization enrollment and disenrollment policy instructions can be found in Chapter 2 of this manual. Chapter 2 discusses in detail the effective dates for elections made during any of these periods. Elections are defined as *enrollments (including enrollment in another plan offered by the same M+C organization) and* disenrollments.

In general, enrollments are to be submitted within 30 days of the date of receipt of a completed and signed application. The effective dates for enrollments are as follows:

- ICEP elections are effective the first day of the month of entitlement to Medicare Part A and Part B;

- OEP elections are effective the first day of the month after the month of receipt of the completed *election form;*

- AEP elections are effective January 1 of the following year; and

- SEP elections vary, depending on the situation.

Enrollment request records may be submitted with an effective date of the current month and up to one additional month after the current month.

EXAMPLE

An enrollment request with an effective date of September 1, *2003*, submitted by the cutoff date (September *12, 2003*) would be accepted by CMS and would be processed.

EXAMPLE

September *2003* is the current processing month. September *12* is the date MCO data is due. An M+C organization may submit an enrollment record designated to become effective September or October. The CMS will set the enrollment to become effective the first day of the month.

20.3.1 - Cost-Based MCOs Only

(Rev. 46, 02-13-04)

In general, unless a later date is requested, MCOs must process voluntary disenrollments to be effective the month following the month in which the disenrollment request is received. If later dates are requested, you may send disenrollment request records to CMS with dates up to 3 months into the future. Use the first of the month that the beneficiary no longer wants to be enrolled in your MCO as the effective date.

EXAMPLE

Disenrollment request records with an effective date of October 1, *2003*, will process with the disenrollment date of September 30, *2003*. This means as of October 1 the beneficiary is disenrolled from your MCO.

EXAMPLE

September is the current processing month, and September *12* is the date MCO data is due to CMS. A MCO may submit a disenrollment record up to September *12* to be effective September, October, November, and December. Any disenrollment date requested prior to September or after December would be rejected.

20.3.2 – *M+C Organizations* Only

(Rev. 46, 02-13-04)

As is the case with enrollments, disenrollments must be submitted during an election period. Beneficiaries can disenroll from an M+C organization during the following election periods:

- AEP;
- SEP; and
- OEP.

Note that a beneficiary cannot disenroll during the ICEP.

In general, disenrollments are to be submitted within 30 days of the date of receipt of a disenrollment request. The effective dates for disenrollments are as follows:

- AEP elections are effective January 1 of the following year;
- SEP effective dates vary depending on the situation; and
- OEP elections are effective the first day of the month after the month of receipt of the disenrollment request.

30.2.2 - Submission of Correction Transaction Records

(Rev. 46, 02-13-04)

Medicare+Choice Organizations Only

The M+C organizations must inform CMS as to which of the *M+C organizations* members meet the criteria of having "special status," i. e., they are institutionalized, nursing home certifiable (NHC) or are enrolled/disenrolled in Medicaid (medical assistance only). The data record layout that you will use for this transmission is included in Chapter 20, the Plan Communication User's Guide, and is referred to as the "Correction Transaction." It is similar to the record format used to report enrollments and disenrollments; however, there are differences. Most notable is that there is **no effective date in the correction record**. The "correction transaction" is **always** applied to the payment month. For Institutional and NHC statuses, this will always result in a 1-month retrospective adjustment. For Medicaid, this will result in a period being opened, effective with the prospective payment month.

NOTE: The NHC status information can only be submitted by the Social HMO Demonstration organizations. NHC correction records submitted by other MCOs will be rejected.

The M+C organizations must also provide CMS with working aged information related to your members. The record layout that you will use for transmitting this information is included in Chapter 20, the Plan Communication User's Guide.

All of the membership records that MCOs submit to CMS contain fixed fields and positions. Detailed information about the record layout, required information and how to send the information to CMS are in Chapter 20, the Plan Communications User's Guide. Points about some of the data contained in these records are highlighted below.

30.3.2 - Prior Commercial Months Field

(Rev. 46, 02-13-04)

This field is used to tell CMS that you know the Medicare beneficiary was a member of the MCO as a non-Medicare member in the month prior to the month you are effectively enrolling the member**.** This is position number 80 on the Enrollment/Disenrollment Transaction. It is important that you include the code in those cases where you know the Medicare beneficiary has End Stage Renal Disease coverage, but you want to enroll anyway because of the prior commercial member *provisions or the other provisions, which allow enrollment of ESRD members*. If you omit the code in these cases, the enrollment record will be rejected by the GHP system if there is an ESRD indicator on its database. The available codes are 0-9 and A-F (10-15), which CMS previously used to record the number of months a beneficiary was enrolled in the commercial part of the MCO. Currently, it does not matter which code is used; only that a code is used.

In addition, M+C organizations will use this field to enroll individuals that have ESRD, but have received a kidney transplant. A regular course of dialysis is no longer required and, for M+C organization enrollment purposes, the individuals are no longer considered to have ESRD. To enroll such individuals, M+C organizations are to use code F in the Prior Commercial Months field.

30.4 – "Special Status" Beneficiaries – Medicare + Choice Organizations

(Rev. 46, 02-13-04)

The CMS' beneficiary-level payments are broken into different rates applicable to each county of the MCO's Medicare service area.

The amount of monthly reimbursement that a MCO will receive for a Medicare beneficiary will be determined, in part, by whether the beneficiary qualifies to be placed in one of the "special status" categories that are discussed below.

If a beneficiary is placed in any one or more of the following "special status" categories, the payment for the beneficiary will be computed at the applicable rate using the following priority ranking.

- Hospice;
- ESRD;
- Working Aged *(prior to 2004);*
- Nursing Home Certifiable*;
- Institutionalized;
- Medicaid;
- Standard Medicare/Disabled; or

Nursing Home Certifiable (NHC) status can only be reported by the Social HMO Demonstration organizations. The NHC status information submitted by other MCOs will be rejected.

The priority ranking declines from Hospice; i.e., the highest priority status is Hospice and the lowest priority status is Standard Medicare/Disabled.

EXAMPLE

If a beneficiary is institutionalized and has ESRD, the payment will be at the rate applicable to ESRD status.

30.5.1 - "Special Status" - Hospice

(Rev. 46, 02-13-04)

When a Medicare member of your MCO elects the hospice benefit, the notice of this election is received by the GHP system from the CMS claims processing system **and the MCO is automatically notified** via the CMS Transaction Reply/Monthly Activity report. Also, the capitation rate for that beneficiary changes. The payment rate will be zero unless, through the Adjusted Community Rate (ACR) proposal, there is a portion of the payment that applies to specified additional benefits. In such instances, payment is at

the rate established in the ACR Proposal of the Medicare contract. Beginning in 2003, the Hospice rates will be tracked and paid at the PBP level.

When the Medicare beneficiary has made a "Hospice" election the Medicare certified Hospice will be paid directly by CMS for services related to the terminal illness of the beneficiary. For services provided by the MCO unrelated to the terminal illness, billing must be directed to the CMS fee-for-service (FFS) claims processors.

Hospice coverage is defined by periods; two 90-day periods followed by an unlimited third period. The Hospice provides election/cancellation information for a particular beneficiary to CMS as noted above (each election includes a beginning and an ending date). Since *M+C organization* payments are for full months only, when the beneficiary's hospice status is in effect on the first day of the month, the hospice rate is paid. If the hospice status is not in effect on the first day of the month, the regular or non-hospice rate is paid. Hospice election information can be annotated to the GHP master retrospectively. In this instance there will be a retrospective adjustment in payments made on behalf of the member. The election information and the adjustments will appear on the monthly reports made available to the MCOs.

If a hospice period is terminated after the first day of the month, the MCO must continue to bill fee-for-service Medicare for the remainder of that month.

NOTE: National PACE plans cannot enroll beneficiaries that have elected Hospice. Transactions for such beneficiaries will be rejected.

30.5.2 - "Special Status" - End Stage Renal Disease (ESRD)

(Rev. 46, 02-13-04)

Individuals who develop ESRD while enrolled in a health plan (e.g., a commercial or group health plan, Medicaid plan) offered by the M+C organization are *eligible to elect an M+C plan offered by that organization. In order to be eligible, there must be no break in coverage between enrollment in the health plan offered by an M+C organization, and the start of coverage in the Medicare M+C plan offered by the same organization.*

Once an enrollee of the MCO is certified as having ESRD, the ESRD rate will be established for the member.

In addition, beneficiaries that have received a kidney transplant and are no longer required to undergo a regular course of dialysis are allowed to enroll in a M+C organization. When submitting enrollment transactions for these beneficiaries, place an F in the Prior Commercial Months field.

A Medicare beneficiary will be assigned ESRD status by the Medicare ESRD system as a result of the attending physician certifying the ESRD status of the enrollee and completing a Form CMS-2728-U4, Chronic Renal Disease Medical Evidence Report.

The certification and the form are sent to the CMS ESRD Network. The Network electronically notifies CMS. Subsequently, the GHP system receives information about the start of ESRD status and the end of such status. The GHP system reacts by changing the rate of payment to the MCO on behalf of the Medicare member **and the MCO is automatically notified of this change** via the Transaction Reply/Monthly Activity Report.

It is critical to ensure your dialysis centers are sending completed Form CMS-2728-U4 forms to the ESRD Networks.

If you have any questions concerning the ESRD Medicare status of a member, contact your local network. If you do not know the telephone number of your local Network's offices, you may contact your CMS Regional Office HMO Coordinator for this information. Also, see Medicare Managed Care Systems Letter dated May 7, 1999, "Guidelines and Procedures for Reconciling Members with ESRD."

NOTE: National PACE plans can enroll beneficiaries with ESRD without conditions (or special coding).

30.5.3 - "Special Status" - Institutionalized

(Rev. 46, 02-13-04)

This information is reported by the M+C organization. The beneficiary's health status must meet the current definition for institutionalized; i.e., the beneficiary must have been a resident for a minimum of 30 consecutive days, which includes as the 30th day, the last day of the month for which the higher institutional rate is paid. To be considered institutionalized, an enrolled member must have been a resident of one of the following title XVIII (Medicare) of the Social Security Act (the Act), or title XIX (Medicaid) of the Act certified institutions:

- Skilled nursing facility;
- Nursing facility
- Intermediate care facility;
- Psychiatric hospital or unit;
- Rehabilitation hospital;
- Long-term care hospital; and

- Swing-bed hospital (hospital with an agreement under §1883).

(See *Chapter 7 of the manual for policy information on institutional status)*

The beneficiary must be *enrolled* in your MCO for the current month.

If the above is true, you must submit institutional correction records **each month** that the member is in such status. Please note that this status does not remain in force each month without being reported by the MCO. For reporting of this status for any periods other than the current month, MCOs must contact their CMS regional office. Only CMS staff can process retroactive institutional payment adjustments.

30.5.5 - "Special Status" - Working Aged (WA)

(Rev. 46, 02-13-04)

Beginning January 2004, the working aged status will be reflected in a plan level factor that is applied.

Prior to 2004, Working Aged status is another factor that can affect the rate of payment to a MCO on behalf of a Medicare member. The sources of the "working" status of a member are other CMS systems **and** data supplied by M+C organizations.

Until Spring 2004, the GHP system *will act* as a conduit for MCOs to submit *information ending a WA period prior to January 1, 2004; i.e., this* information is transmitted to other CMS systems where it is verified. Valid information is returned to update the GHP. A description of this process and the related reports can be found in Chapter 20, the Plan Communication User's Guide.

30.6 - When to Submit "Special Status" Information (Medicare + Choice Organizations Only)

(Rev. 46, 02-13-04)

Transmit Medicaid (MAO), and institutional status along with, and on, the same schedule as, the MCO's enrollment and disenrollment records.

If a beneficiary is both institutionalized and their MAO special status is beginning or ending, submit data for both categories. The CMS will place the beneficiary in the appropriate rate table cell as a consequence of this reporting.

EXAMPLES:

Beneficiary A: Institutional Record

Enrolled in your MCO with an effective date of July 1.

Meets the "institutionalized" definition during the month of August (spent 30 consecutive days prior to September 1 in a long term care facility).

You submit a report of "institutional status" (by or before the cutoff date for transmitting records in September).

You verify this status was accepted and used by CMS by reviewing the Monthly Membership Report. It will show the appropriate institutionalized status change for September 1, and an adjusted amount for the September 1 payment will be included with the October 1 payment.

Beneficiary B: Medicaid Record (MAOs)

Was enrolled in your MCO with an effective date of coverage of September 1.

Now *qualifies* for Medicaid (Is a MAO recipient).

Submit MAO status by due date in September to affect the September 1 payment.

Review MAO status monthly and submit *Medicaid off record* if members lose Medical Assistance.

40.1 - Timeliness Requirements

(Rev. 46, 02-13-04)

When a Medicare beneficiary joins your MCO, or a current MCO member becomes eligible for Medicare, an enrollment transaction must be sent to CMS.

This enrollment record must be submitted promptly and accurately so that it can be included in CMS' monthly process. (MCOs are sent a *GHP* Processing Schedule each year.) A capitation payment for a particular enrollee can only be paid when the member is entered into CMS' managed care system.

In general, M+C organizations are to provide services to beneficiaries beginning the first of the month after the month that the *completed* application is received. If, however, the M+C organization does not submit the enrollment request timely, the services provided to

the member during the month must be reimbursed under fee-for-service Medicare. Medicare payment may be given to the provider for Part A services or to the M+C organization for Part B services. M+C organizations can also submit such cases to the CMS RO for resolution. In some cases, the CMS RO will process a retroactive enrollment.

For submission of bills for Part B services payable by the carrier, an indirect billing number is required. Fax such requests to the Division of Enrollment and Payment Operations (DEPO), Attention: Yvonne Rice at 410-786-0322.

When a Medicare beneficiary is disenrolled from MCO membership, you must send a disenrollment transaction to CMS. If there are errors in this disenrollment record and it is rejected, the MCO is financially liable for any out-of-plan services up to the time a corrected transaction is accepted by CMS. This includes any deductible and coinsurance incurred by the beneficiary.

40.3 - Sending the Transaction File to CMS

(Rev. 46, 02-13-04)

Transaction files can be sent two ways:

1. Directly through one of three electronic data transfer methods described in Chapters 19 and 20 of this manual, or

2. Indirectly, through one of the data processing vendors authorized by CMS. Currently *SMS*, Inc. is providing this service for MCOs.

40.4 - Electronic Data Transfer

(Rev. 46, 02-13-04)

MCOs can transmit records through telecommunication lines directly to the CMS Data Center. Three transfer methods are available:

1. Web Browser-Based AGNS(ATT Global Networking Services)/Host on *Demand* Webconnect.

   This is accessed by Microsoft Internet Explorer Version 4.0 (IE 4.0) or greater, with 128-bit encryption.

2. Network Data Mover (NDM-CONNECT DIRECT), PC Version.

   This software must be purchased from a vendor. Its limit is 5 million bytes per transmission.

3. Network Data Mover (NDM-CONNECT DIRECT), Host Version.

   This software must be purchased from a vendor. It is a mainframe-to-mainframe version for MCOs needing to transfer more than 5 million bytes per transmission.

40.6 - Data Processing Vendor

(Rev. 46, 02-13-04)

The company mentioned below is under contract with CMS and is authorized to receive MCO records and send them to CMS. It provides instructions to the MCO about how to prepare reports for proper submission through their facilities to the CMS Data Center. MCOs are to negotiate directly with this contractor.

Systems Management Specialists, Inc.
21051 Warner Center Lane, Suite 200
Woodland Hills, CA 91367
Contact: Medicare Account Representative
1-714-986-8758

The MCOs wishing to contract with this contractor are not required to purchase more than minimum services. Minimum services are limited to online eligibility look-up for their members' records and online entry of enrollments. The charge for the minimum services cannot exceed the rate agreed to by the contractor in their contract with CMS. MCOs may also contract for online submission of disenrollments and correction records and for access to their reports in GROUCH. MCOs needing more information should contact the above contractor directly.

50.2 - CMS' Transaction Reply/Monthly Activity Report

(Rev. 46, 02-13-04)

To assure proper payment to your MCO, your Medicare membership records must agree with those maintained by CMS. The Transaction Reply/Monthly Activity report for your MCO identifies whether a submission for a beneficiary was accepted or rejected, and may provide additional information about other CMS systems, SSA District Office or

Medicare Customer Service Center updates. See Exhibits A1 through A3 for a sample copy of this report.

This report shows the outcome from the processing of your monthly and existing records by CMS. Also, it provides you with any changes to a beneficiary's record not initiated by your MCO.

The response for each beneficiary included in the report is called a transaction record. There are two types of records:

- Reply Records - Indicates the types of action CMS has taken on your submitted monthly records; if they were received and processed; and

- Maintenance Records - Indicates your existing membership records that CMS has initiated action to change or update.

When you receive the Transaction Reply/Monthly Activity report, it is **important that you reconcile your beneficiary records with CMS' records**.

You are to identify discrepancies during the monthly reconciliation of the Monthly Membership and Transaction Reply reports with your own records. The M+C organizations must submit requests for adjustments within 45 days of receiving their monthly reports from CMS to the retroactive payment processing contractor.

A transaction/reply record contains 31 fixed-fields with 133 positions. See Chapter 20 for the format.

Each record is supplied to you for a specific purpose that is defined by the reply code. A 3-digit reply code is supplied in field 15 of each record. Reply code definitions are provided in Exhibit G1 of this Guide. The numerical reply code information on the report is the same whether it is a data file or printed report. However, a remarks column has been added to the end of the record in the printed report that may provide further explanation.

50.3 - Transaction Reply Field Information

(Rev. 46, 02-13-04)

Field 1 - Positions 1-12: Claimant Account Number (Health Insurance Claim Number - HICN)

This field is always filled.

Reply Records - Lists the HICN you supplied to CMS.

Maintenance Records - Lists the claim number CMS has in its Group Health Plan Database. However, if Code 22, 25, or 86 appears in field 15, the number listed is the inactive HICN. Then, the active number appears in field 23.

Fields 2, 3 and 4 - Positions 13-32: Surname, Given Name and Middle Initial

Reply Records - The surname, given name, and middle initial you submitted.

Maintenance Records - The surname, given name, and middle initial in CMS' master file. In the case of a name change, the code in field 15 will be code 87.

Field 5 - Position 33: Beneficiary Sex Identification Code

The sex identification code submitted by the MCO.

Field 6 - Positions 34-41: Beneficiary's Date of Birth

An accepted enrollment or disenrollment from your MCO lists the date of birth in the CMS master file. A rejected enrollment or disenrollment from your MCO lists a blank field except for a zero in position 41, the last position in the field.

Field 7 - Position 42: Medicaid Indicator

See the section on Special Status - Medicaid in this Guide for additional information.

Field 8 - Positions 43-47: MCO Contract Number

The alpha/numeric identification number assigned to your MCO during the application process.

Field 9 and Field 10 - Positions 48-52: State and County Codes

Two position State and three position County Code from the beneficiary's address in the GHP system.

Field 11 - 14 - Positions 53-56: Indicators

These fields provide information about the Medicare beneficiary as it relates to disability, Hospice election, institutional/NHC status (as reported by the MCO) and ESRD status if it exists in the GHP system.

Field 15 - Positions 57-59: CMS Transaction/Reply Code

This field contains the 3 digit numeric code that identifies the results of system processing of your transactions. There is a listing of the codes with explanatory narratives located in Exhibit G1 of this Guide.

Field 16 - Position 60-61: Transaction Type Code

These fields contain a 2-digit numeric code that identifies the transaction submitted.

Field 17- Position 62: This field contains a letter code that indicates the enrollee's current status and type of eligibility for Medicare insurance benefits.

Restricted (M+C *organizations* report these codes.)

Code	Status
A	Disabled
B	Renal disease (ESRD)*
C	Disabled plus current or prior renal disease
D	Aged current or prior renal disease
E	Aged (65+)

Unrestricted (Cost-Based MCOs report these codes.)

Code	Status
J	Disabled
K	Renal disease (ESRD)
L	Disabled plus current or prior renal disease
M	Aged current or prior renal disease
N	Aged

Field 18 - Positions 63-70: Effective Date

This field will be completed when the reply code is 11, 12, 16, 17, 22, 23, 38, 52, 80, 82, 83, 84, 100, 109, and 112.

Field 19 - Position 71: Working Aged Indicator

For M+C MCOs, this provides information as to the status of the Medicare enrollee's work status as reported through CMS systems or by the MCO.

Field 20 - Position 72-74: Plan Benefit Package Identifier

The 3-digit number associated with the benefit package of the member.

Field 21- Position 75: Filler

Field 22 - Positions 76 -83: Transaction Date

This is an 8-digit numeric date field and is present to provide the start date of the transaction whether it *is* an enrollment, disenrollment or reject.

Field 23 - Filler

Field 24 and 25 - Positions 85-96:

An entry in this field will only be present for specific Field 15 Codes. Refer to the listing of Transaction Reply Codes in Exhibit G1 for more information.

Field 26 - Positions 97-99: Social Security Agency Field Office Code

This code is present only when a Field Office is the source of a disenrollment, identified by transaction type code 53. It identifies the SSA field office that submitted the disenrollment.

Fields 27 and 28 - Positions 100-115: Part A/B AAPCC Pay Rates

These are the demographic payment rates for M+C organization members or the risk-equivalent demographic payment rates for cost-based MCO members.

Field 29 - Position 116 - 120: Source ID

This provides the contract number of the entity that sent the transaction record to CMS.

Field 30 - Position 121-123: Prior Plan Benefit Package Identifier

The prior PBP number for a member that is electing another PBP offered by the M+C organization.

Field 31- Position 124-133: Filler

50.4 - Plan Payment Report

(Rev. 46, 02-13-04)

The Plan Payment Report displays the payment amount sent to the MCO's bank account for deposit each month. This report contains the total number of members and the amount paid for those members for the upcoming month (prospectively). The report also shows beneficiary and MCO-level adjustments to that payment amount.

There are two types of Plan Payment Reports, one for M+C organizations and one for Cost-based MCOs. These reports contain a detailed explanation of the components that make up the payment for the upcoming month for each contracted MCO.

1. M+C organization Plan Report

   A sample report is provided in Exhibit B1. The entries relate to actual payments and adjustments for the *M+C organization*.

2. Cost-based Plan Report

   The Cost-based Plan Payment Report is similar to the M+C organization-based Plan Report except for item 1 in the report, Calculated Monthly Payments. This item is divided into Part A and Part B entitlement for members, and simply multiplies the number of members times the established per member per month capitation rate to provide the appropriate payment subtotals. The remaining information on the report is the risk-equivalent payment data; i.e., what the MCO would have been paid under a M+C organization contract. A sample report is provided in Exhibit B2.

50.5 - Demographic Report - M+C *Organizations Only*

(Rev. 46, 02-13-04)

The report displays an *M+C organization's* enrolled Medicare population broken down into 164 different rate "cells" (82 for Part A and 82 for Part B entitlement) for each county of the *M+C organization's* service area as of the first day of each month. The CMS' actuary determines the rates in each table annually. The report also displays total amounts paid and the number of members for each line of a table.

As stated previously, a beneficiary is placed in **only one** line of a rate table using the following priority ranking.

- High
  - Hospice

- ESRD
- Working Aged
- Nursing Home Certifiable
- Institutionalized
- Medicaid
- Standard Medicare/Disabled

- Low

Institutionalized and nursing home certifiable (NHC) beneficiaries are not shown on this report but are shown by specific beneficiary on the Monthly Membership Report. This is because the payment for institutional and NHC status is always applied retrospectively based on what is reported by the M+C organization. The Demographic Report displays only prospective payments.

The state and county code (SCC) is compiled by SSA and is based on a beneficiary's mailing ZIP code. If the state and county code for a beneficiary is outside of your *M+C organization's* service area, the system will use that code and you will be paid at that rate. If the code cannot be derived from the beneficiary's residence ZIP code, a "99999" default code will be assigned and your *M+C organization* will be paid at the USPCC rate. The USPCC rate is derived from national data and is used when the SCC is missing or invalid. A sample of the report is shown as Exhibit C1.

50.7 - Monthly Membership Report

(Rev. 46, 02-13-04)

This report can be reproduced as a print image or be downloaded as a sequential data file. You will only receive the version associated with your contract in our system. It is created on a monthly basis to provide information to MCOs for use in reconciling the MCO Medicare membership and payment records to the records maintained by CMS. This report does not reflect the deduction of the Balanced Budget Act (BBA) user fee or any bonus payments. See the Plan Payment Report for *these amounts*.

This report is available in two formats – detail and summary:

- **Detail:** One format contains a **detailed** list of beneficiaries for which a payment was made to the MCO for that month: either a monthly payment or an adjustment

payment. This allows the MCO to compare its beneficiary records with those maintained by CMS.

- **Summary:** The second format presents a **summary** of the payments and adjustments applicable to the MCO's Medicare membership. For example, this format shows the total number of beneficiaries for whom a hospice, ESRD or institutionalized payment was received.

Effective with the December 1999 processing month (for January 1, 2000, payments), the Monthly Membership Detail report reflects risk adjustment information. Because the risk adjustment payment method is being phased-in using blended demographic/risk adjusted payments for a period of time, there is a need to include both types of data on this report. The report will continue to display beneficiary-level status and demographic information, but risk adjuster factor and payment rate information has been added. Both the print-image and the downloadable data file will contain this data. See Chapter 20, the Plan Communications User's Guide, for the report format.

Effective for the January 1, 2002, report, the following components *were* added. **Congestive Heart Failure (CHF) flags for 2002 and 2003**. This *field was* populated for 2002 beginning with the January 2002 report. It *identifies* beneficiaries that had a discharge for CHF in the associated encounter data collection period.

- **Plan Benefit Package Identifier.** This *field was* populated beginning with the June 2002 report. It *identifies* the PBP that the member has elected.

- **Racial Ethnicity Code.** This *field was populated* late in 2002. It *identifies* the race of a member.

50.8 - Bonus Payment Report

(Rev. 46, 02-13-04)

Effective with the July 1, 2000 payment, a new report detailing the bonus payments applicable to eligible members *became* available. Only M+C organizations who offer plans in counties that were previously unserved, can receive such payments. Bonus payments are applied to both the prospective and adjustment amounts occurring during the first 24 months that the M+C organization offers a plan in the county. See Chapter 20 for the format.

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60 - Retroactive Payment Adjustment Policy

(Rev. 46, 02-13-04)

These instructions provide guidance on the processing of retroactive payment adjustments. These adjustments occur due to evidence that the original payment was based on erroneous information about the following beneficiary demographic characteristics: age, sex, Part A and/or Part B coverage, enrollee's county of residence, Medicaid status, institutional status, *hospice* election, and ESRD status.

In **OPLs 95.012 and 95.013,** CMS established policy allowing health maintenance organizations/competitive medical plans (HMOs/CMPs) with risk contracts to request retroactive adjustment of certain membership records. With the passage of the Balanced Budget Act (BBA), CMS extended this policy to *M+C organizations.*

The date that updated information is received determines the time frame applicable to the payment adjustment.

Receipt of Data

There are two definitions of "receipt of data" depending on the category of the adjustment and the way the change is received.

(Please note additional information will be provided on the Monthly Attestation process in the next update prior to December 1.)

1. "**Receipt of data" means the date CMS or its agent receives documentation.** The date CMS receives from the M+C organization **complete documentation** supporting the correction request is the date used to define the retroactive payment period.

2. Demographic characteristics included under this definition are institutional, Medicaid (submitted by the MCO), and state and county of residence.

   The 36-month retroactive start date begins the first of the month the documentation was received from the M+C organization. *Although the corrected data will be for the actual period, payment will be limited to 36 months.*

   Receipt of data" means system interface date. The date that status corrections are received in the Group Health Plan (GHP) system from the Enrollment Database (some via multiple source systems, i.e., the Social Security Administration, ESRD system, the Enrollment Database and the Common Working File) is the date used to apply the retroactive payment period.

Demographic characteristics included under this definition are age, sex, residence state and county code, Part A and B coverage, hospice, Medicaid, ESRD and working aged status corrections.

During processing, the GHP will automatically apply the 36-month retroactive payment period back from the date the correction was received by the GHP, but will record the actual effective start and end dates of the changed status correction.

Retroactive Demographic Adjustments

Retroactive adjustments may be created based on changes to the demographic characteristics of the members of an M+C organization. The demographic characteristics of an enrollee include the following:

- Age;
- Sex;
- Enrollee's County of Residence;
- Hospice Election;
- ESRD Status;
- Institutional Status;
- Medicaid Status; and
- Coverage Under Part A (for remaining Part B only enrollees).

The retroactive payment period is limited to 36 months, which begins as defined by the "receipt of data" definition applicable to the characteristic being adjusted.

The following table defines the retroactive payment period for each demographic characteristic.

CHARACTERISTIC	WHO ADJUSTS	TIMEFRAME 36 months from the …
Age	SSA thru EDB	Date GHP is updated
Sex	SSA thru EDB	Date GHP is updated
Part A/B	SSA thru EDB	Date GHP is updated
State and County Code	SSA thru EDB	Date GHP is updated
	Retro-Processing Contractor thru McCOY	Date documentation is received from the M+C organization
Hospice	CWF thru the EDB	Date GHP is updated
ESRD	ESRD system thru EDB*	Date GHP is updated
Working aged	CWF thru the EDB**	Date GHP is updated
Institutional	Retro-Processing Contractor thru McCOY	Date documentation is received from the M+C organization
Medicaid	State buy-in system thru the EDB	Date GHP is updated
	Retro-Processing Contractor thru McCOY	Date documentation is received from the M+C organization

*-M+C organizations are to obtain completed Form CMS-2728 forms from the dialysis centers and to send them to central office (CO). The CO works with OCSQ staff to correct ESRD system.

** - M+C organizations are to submit normal corrections to GHP and to send problem cases with documentation to the COB contractor.

- The hierarchy of the status adjustments is applied as follows: Hospice, ESRD, Working Aged, Institutional, and Medicaid. If more than one status applies the payment will be calculated using the status highest in the order.

Retroactive Election (Enroll/Disenroll)

Detailed instructions governing the processing of retroactive enrollments/disenrollments are contained *in the* Medicare Managed Care Manual *in Chapter 2 for M+C organizations and in Chapter 17, subchapter D, for cost plans.* When CMS determines

that an election should be retroactive, the payment or recoupment period corresponds directly with the length of the enrollment period. This is true even if the 36-month period would be exceeded.

Retroactive Enrollment

The CMS-approved retroactive enrollments are made back to the statutorily required effective date if the beneficiary meets all eligibility requirements. *The retroactive payment period is generally limited to 36 months.*

Retroactive Disenrollment

The CMS-approved retroactive disenrollments are made back to the statutorily required effective date. *The retroactive payment period is generally limited to 36 months*. If the 36-month timeframe would be exceeded, the *CMS* would use the override option to allow complete recoupment of funds from the M+C organization.

Tab B

IntegriGuard Submission Process for M+C Organizations

M+C organizations *must* submit requests to IntegriGuard *either electronically* on a *CD or* diskette. The specific format and required fields for submission of the retroactive status changes addressed in this memo is shown below under each category. *The electronic submission process* is *outlined at the end of this document.* Please note that this information cannot be sent by e-mail as required under HIPAA regulations. A cover letter including the M+C organization number (H#) and certification must be submitted along with the requested changes. An example of appropriate language for the certification is as follows:

> "This signature verifies that the information submitted to IntegriGuard on (date) is accurate and complete and that supporting documentation is being maintained at the M+C organization for each request."

The M+C organization *must* retain the original supporting documentation for the requested changes as they may be required to produce it during a Government audit at a later date.

Submitting State and County Code Status Changes

The M+C organization will submit their requested changes to IntegriGuard. Requested changes will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+C organization with a report detailing the disposition of the requests. Supporting documentation will be required only as requested by IntegriGuard in conjunction with the probe study. (See section *titled* "Probe Study.")

The information and column order needed to process each state and county code change is as follows:

M+C organization Name

Mailing Address

City, State, Zip Code

Contact Name:

Phone #:

E-Mail Address:

H#	***CMS Region #***	***HIC #***	***Beneficiary's Last Name***	***Beneficiary's First Name***	***Start Date mm/dd/yyyy***	***End Date mm/dd/yyyy***	***Req SCC***	***Req Zip Code***
					State and County Code			
H#	*CMS Region #*	*HIC #*	*Beneficiary's Last Name*	*Beneficiary's First Name*	*Start Date mm/dd/yyyy*	*End Date mm/dd/yyyy*	*Req SCC*	*Req Zip Code*

Please note: If the M+C organization does not have the end date because the beneficiary still resides in the SCC requested, please *leave the End Date field blank*. Also, please enter dates as mm/dd/yyyy (example, 01/01/2002).

Submitting Institutional Status Changes

The M+C organization will submit their requested changes to IntegriGuard. Requested changes will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+C organization with a report detailing the disposition of the requests. Supporting documentation will be required only as requested by IntegriGuard in conjunction with the probe study. (See section titled "Probe Study.")

The information and column order needed to process each *Institutional* status change is as follows:

M+C Organization Name
Mailing Address
City, State, Zip Code

Contact Name:
Phone #:
E-Mail Address:

					INSTITUTIONAL	
H#	***CMS Region #***	***HIC #***	***Beneficiary's Last Name***	***Beneficiary's First Name***	***INST Start Date mm/dd/yyyy***	***INST End Date mm/dd/yyyy***
H#	*CMS Region #*	*HIC #*	*Beneficiary's Last Name*	*Beneficiary's First Name*	*INST Start Date mm/dd/yyyy*	*INST End Date mm/dd/yyyy*

Please note: The *"INST* Start *Date"* is defined as the *start* date of the period for which you are requesting payment at the *Institutional rate*. In other words, this is not the qualifying period. The *"INST End Date"* is defined as the *end* date of the period for *which you are requesting payment at the* Institutional *rate*. All fields must be completed.

Submitting Institutional Removal Status Changes

The M+C organization will submit their requested changes to IntegriGuard. Requested changes will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+C organization with a report detailing the disposition of the requests. Supporting documentation will be required only as requested by IntegriGuard in conjunction with the probe study. (See section titled "Probe Study.")

The information and column order needed to process *removal of the Institutional status* is as follows:

M+C organization Name ***Contact Name:***

Mailing Address Phone #:

City, State, Zip Code E-Mail Address:

					INST REMOVAL Months	
H#	***CMS Region #***	***HIC #***	***Beneficiary's Last Name***	***Beneficiary's First Name***	***Beginning Month mm/yyyy***	***Ending Month mm/yyyy***
					INST REMOVAL	
H#	*CMS Region #*	*HIC #*	*Beneficiary's Last Name*	*Beneficiary's First Name*	*Beginning Month mm/yyyy*	*Ending month mm/yyyy*

Changes

Please note: The "Beginning Month" field is defined as the start date of the period for which you are requesting the Institutional payment rate be removed. The "Ending Month" field is defined as the end date of the period for which you are requesting the Institutional payment rate be removed. The Institutional period will be removed through the last day of this month. All fields must be completed.

M+C organization Name
Mailing Address
City, State, Zip Code
City, State, Zip Code

Contact Name:
Phone #:
E-Mail Address:
E-Mail Address:

					Medicaid	
H#	***CMS Region #***	***HIC #***	***Beneficiary's Last Name***	***Beneficiary's First Name***	***Verified Period From Date mm/yyyy***	***Verified Period Thru Date mm/yyyy***
H#	*CMS Region #*	*HIC #*	*Beneficiary's Last Name*	*Beneficiary's First Name*	*Verified Beginning Date mm/yyyy*	*Verified Ending Date mm/yyyy*

Please note: The *"Verified Beginning Date" is defined as the start date of the period for which you are requesting payment at the Medicaid rate. The "Verified Ending Date" is defined as the end date of the period for which you are requesting payment at the Medicaid rate.* If the M+C organization does not have the thru date because the beneficiary still qualifies for Medicaid status, *then leave the Verified Ending Date field blank*.

Submitting the Removal of Medicaid Status Changes

The M+C organization will submit their requested changes to IntegriGuard. Requested changes will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+C organization with a report detailing the disposition of the requests. Supporting documentation will be required only as requested by IntegriGuard in conjunction with the probe study. (See section titled "Probe Study.")

The information and column order needed to process removal of Medicaid status is as follows:

M+C organization Name
Mailing Address
City, State, Zip Code

Contact Name:
Phone #:
E-Mail Address:

					Removal of Medicaid Status Months	
H#	***CMS Region #***	***HIC #***	***Beneficiary's Last Name***	***Beneficiary's First Name***	***Beginning Month mm/yyyy***	***Ending Month mm/yyyy***
					Medicaid Removal	
H#	*CMS Region #*	*HIC #*	*Beneficiary's Last Name*	*Beneficiary's First Name*	*Beginning Month mm/yyyy*	*Ending Month mm/yyyy*

Please note: The *"Beginning Month"* field is defined as the *start date of the period for which you are requesting the Medicaid payment rate be removed. The "Ending Month" field is defined as the end date of the period for which you are requesting the Medicaid payment rate be removed. The Medicaid payment rate will be removed through the last day of this month*. All fields must be completed.

Submitting ESRD Status Changes

The M+C organization will submit their requested changes to IntegriGuard. Requested changes will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+C organization with a report detailing the disposition of the requests. Supporting documentation will be required only as requested by IntegriGuard in conjunction with the probe study. (See section titled "Probe Study.")

The information and column order needed to process ESRD status changes are as follows:

M+C organization Name
Mailing Address
City, State, Zip Code

Contact Name:
Phone #:
E-Mail Address:

						ESRD	
H#	***CMS Region #***	***HIC #***	***Beneficiary Last Name***	***Beneficiary First Name***	***Date Regular Dialysis Began***	***Beginning Date of Discrepancy Period Mm/dd/yyyy***	***Ending Date of Discrepancy Period Mm/dd/yyyy***
H#	*CMS Region #*	*HIC #*	*Beneficiary's Last Name*	*Beneficiary's First Name*	*Date Regular Dialysis Began mm/dd/yyyy*	*Discrepancy Beginning Date mm/dd/yyyy*	*Discrepancy Ending Date mm/dd/yyyy*

Please note: The *"Discrepancy Beginning Date" field is defined as the start date of the period for which you are requesting payment at the ESRD rate. The "Discrepancy Ending Date" field is defined as the end date of the period for which you are requesting payment at the ESRD* rate. All fields must be completed.

Submitting ESRD Removal Status Changes

The M+C organization will submit their requested changes to IntegriGuard. Requested changes will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+C organization with a report detailing the disposition of the requests. Supporting documentation will be required only as requested by IntegriGuard in conjunction with the probe study. (See section titled "Probe Study").

The information and column order needed to process removal of the ESRD status is as follows:

M+C organization Name ***Contact Name:***

Mailing Address *Phone #:*

City, State, Zip Code *E-Mail Address:*

					ESRD REMOVAL	
H#	***CMS Region #***	***HIC #***	***Beneficiary's Last Name***	***Beneficiary's First Name***	***Beginning Month mm/yyyy***	***Ending month mm/yyyy***

Please note: The "Beginning Month" field is defined as the start date of the period for which you are requesting the ESRD payment rate be removed. The "Ending Month" field is defined as the end date of the period for which you are requesting the ESRD payment rate be removed. The ESRD period will be removed as of the last day of this month.

Electronic Submission Data Field Specifications and Instructions

It is preferable that M+C organizations must submit retroactive payment adjustment requests electronically using a formatted spreadsheet developed by IntegriGuard. M+C organizations can request a copy of this spreadsheet directly from IntegriGuard or it can be downloaded from their web site, www.integriguard.org. This spreadsheet has been developed using visual basic code to assist you in making sure that the data is being submitted in the appropriate format. In order to take advantage of this coding, it is necessary to click on the ***"Enable Macros"*** *button when opening the spreadsheet. A pop up box will appear when the file is opened which will indicate that the file contains macros. If you elect to* ***"Enable Macros,"*** *then you will be able to use the "validate ___" button. Once pressed, this button runs a program that checks your entire spreadsheet for incorrect entries based on the programming allowed for that cell. If you elect to* ***"Disable Macros,"*** *you will still be able to utilize this spreadsheet to submit your requests to IntegriGuard, but the validation process will not be functional.*

The specifications for each data field are as follows:

1. Data specifications for fields that are common to all spreadsheets

H Number	*Format as a text field. Field is limited to 5 characters*
Region	*Format as a text field. Field is limited to 2 characters and primary numbers*
HIC	*Format as a text field. Field is limited to 15 characters*
Last_Name	*Format as a text field. Field is limited to 20 characters*
First_Name	*Format as a text field. Field is limited to 20 characters*

2. Data specifications for fields specific to each status category

a. State and County Codes (SCC)

b.

SCC_Start_Date	*Format as a date field and enter the date as 03/01/1998.*
SCC_End_Date	*Format as a date field and enter the date as 03/31/1998.*
Req_SCC	*Format as a text field. Field is limited to 5 characters.*
	EXAMPLE*: 01234*

(Please note it is always necessary to put in the leading zero).

Req_Zip	*Format as a text field. Field is limited to 5 characters char*
	EXAMPLE*: 35405*

c. Institutional (INST):

Inst_Start_Date	*Format as a date field and enter the start date as 03/01/1998.*
Inst_End_Date	*Format as a date field and enter the end date as 03/31/1998.*

d. Institutional Removal:

Beg_Month	*Format as a text field. Field is limited to 7 characters*
	***EXAMPLE**: 12/2002*
End_Month	*Format as a text field. Field is limited to 7 characters*
	***EXAMPLE**: 12/2002*

d. Medicaid:

Ver_Beg_Date	*Format as a date field and enter the start date as 03/01/1998.*
Ver_End_Date	*Format as a date field and enter the end date as 03/31/1998.*

e. Medicaid Removal:

Beg_Month	*Format as a text field. Field is limited to 7 characters*
	***EXAMPLE**: 12/2002*
End_Month	*Format as a text field. Field is limited to 7 characters*
	***EXAMPLE**: 12/2002*

f. End Stage Renal Disease (ESRD):

Date_Regular_Dialysis_Began	*Format as a date field and enter the date as 03/01/1998.*
Discrepancy_Beg_Date	*Format as a date field and enter the start date as 03/01/1998.*
Discrepancy_End_Date	*Format as a date field and enter the end date as 03/31/1998*

g. End Stage Renal Disease Removal (ESRD):.

Beg_Month	*Format as a text field. Field is limited to 7 characters*
	***EXAMPLE**: 12/2002*
End_Month	*Format as a text field. Field is limited to 7 characters*
	***EXAMPLE**: 12/2002*

3. Acceptable Excel Versions:

Microsoft Excel 3.0

Microsoft Excel 4.0

Microsoft Excel 5.0

Microsoft Excel 97-2000

Probe Study

In order to assure appropriate oversight, IntegriGuard will periodically conduct a probe study by requesting supporting documentation from various M+C organizations. The purpose of these studies is to review and verify that appropriate documentation is maintained by the M+C organization as defined in the CMS Standard Operating Procedures (SOP).

A 5 percent random sample of M+C organization status changes will be chosen for inclusion in the study. When an M+C organization is notified of inclusion in the probe study, the M+C organization will have *7 business* days from the date of IntegriGuard's request to submit supporting documentation. After review of the documentation, IntegriGuard will send the M+C organization a report of the findings. If the documentation is not received or does not support the requested changes, the changes will be nullified. A report will be sent to the M+C organization and to CMS detailing this action.

Submission Address

Please send all payment adjustment requests for changes to status categories noted above to:

IntegriGuard
Attention: Health Status Category Changes
2121 North 117th Avenue, Suite 200
Omaha, NE 68164

Phone: 402-955-2781

Fax: 402-955-2789

60.1 - Standard Operating Procedures for State and County Code Adjustments

(Rev. 46, 02-13-04)

State and County Code Description

Beneficiaries' state and county of residence *is an enrollment eligibility requirement and has* a direct effect on the capitation rate regardless of health status. The source of the state and county code of residence is the Social Security Administration.

General Information about the State and County Code Designation and its Effect on M+C organization Payments

The beneficiary's state and county code is transmitted from Social Security Administration (SSA) to the CMS managed care payment systems (Group Health Plan master/McCoy) via the Enrollment Database (EDB). The SSA systems interface with the CMS' systems daily. The managed care system accepts and updates the state and county code information on managed care beneficiaries that it receives from SSA. The CMS regional offices can update a beneficiary's SCC information in McCoy and block the update from the EDB. If an SCC has been updated in McCoy, the GHP will compare the ZIP code information with the new information coming from the EDB before updating the SCC. (If the Retro-Processing Contractor used the SCC exception to prevent an update, the GHP compares the address in the M+C organization file with the address in the SSA file. If the entire ZIP code has changed from the previous ZIP code obtained from the SSA file then the block is automatically cancelled and SSA information is placed in the file as a real update.)

General Guidelines for M+C Organizations Requesting Retroactive Adjustments

The M+C organization *must* submit requests for adjustments within 45 days of receiving their monthly reports from CMS. The M+C organization may request a retroactive adjustment changing the state and county code when the beneficiary's state and county code included in the monthly membership report is different from the state and county of residence the M+C organization has on file for that beneficiary. The M+C organization would identify this during the normal monthly reconciliation process of comparing the Monthly Membership Report and Transaction Reply Report with the M+C organization's records.

Before submitting the requests to the Retro-Processing Contractor to retroactively adjust the SCC, the M+C organization must complete the following actions:

- Notify the beneficiary that the residence SCC information given to the M+C organization differs from the residence SCC information on record with the Social Security Administration; and

- Request the beneficiary notify SSA of his/her current residence address by calling the SSA 800 number - ((800) 772-1213). If the residence address is different from their mailing address, they should notify SSA of both addresses.

The M+C organizations must obtain documentation verifying the residence information the M+C organization has in their records*, as described in Chapters 2 and 17 of this manual.*

A SCC adjustment will be made retroactively for the dates requested, however, payment will be made for no more than 36 months from the date the request is received by the Retro-Processing Contractor.

The M+C organization should never submit duplicate information unless the CMS central office, Regional Office or the Retro-Processing Contractor specifically requests the duplicate information be submitted.

To follow up on specific previously submitted adjustments, a letter of inquiry should be sent separately from other adjustment requests. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, the state and county code, the period involved and the date the original adjustment(s) was submitted.

Documentation Required to Retroactively Change a Beneficiary's State and County Code

- M+C organization Contract Number (H#);
- Beneficiary Name and Claim Number;
- Verification of Residence including starting/ending dates;
- One or more of the following constitutes acceptable documentation:
    - Survey signed by the beneficiary (sample attached);
    - Copy of property tax statement;
    - Copy of income tax return;
    - Copy of voter's registration card;
    - Copy of a utility bill; and/or
    - Document showing the address and county from an internet mapping utility which is based on the U.S. Postal service data (i.e. *MapQuest*, Mapblast)

Retro-Processing Contractor Review and Processing of the Request

The Retro-Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retro-Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the M+C organization including the reason that the adjustment was not processed.

The Retro-Processing Contractor will return the request without action if the documentation is not complete.

The Retro-Processing Contractor will return the request without action if none of the dates of the revised state and county codes are within the 36 months prior to the request.

The Retro-Processing Contractor will return the request without action if the beneficiary was not a member of the plan for the discrepancy period.

The Retro-Processing Contractor will validate the requested change and then enter the revised SCC information into McCOY. **The Retro-Processing Contractor may have to correct all the information or just the effective date of the SCC.** The Retro-Processing Contractor may have to correct previous SCC information to effect the necessary changes.

When the transaction has been completed it will appear on the M+C organization's next Transaction Reply Report and Monthly Membership Report.

60.3 - Standard Operating Procedures for Medicaid Retroactive Adjustments

(Rev. 46, 02-13-04)

Medicaid Description

Medicaid is a Federal and state program that provides medical services to clients of state public assistance programs. Medicaid eligibility is determined by the State Medicaid Agency in the state where the beneficiary resides. Some Medicare beneficiaries are also eligible for Medicaid. These individuals are commonly referred to as Dual Eligible beneficiaries. The Centers for Medicare & Medicaid Services (CMS) administers the federal standards compliance aspects of this program and monitors the federal payments related to the Medicaid program for both Medicaid only and the dually eligible population. The law requires that all states pay the Part B premium to Medicare for dual eligible beneficiaries. The law does not require states to pay the Part B premium for individuals who are classified as Medical Assistance Only (MAO) even though the increased capitation rate applies, however, many states have elected to report these individuals as dually eligible and pay their Part B premium.

General Information About Medicaid Payments

In accordance with the Health Status hierarchy (Hospice, ESRD, Working Aged, Institutional, **Medicaid**), M+C organizations receive a higher capitation rate for Medicare beneficiaries who have been identified as Medicaid in the CMS systems.

The primary source of this information is the Third Party Master Premium Billing system (TPM), which is used by CMS to bill states for the Part B premiums paid by states on behalf of dually eligible individuals. All states report data in this system as all states pay the Part B premium for their dual eligibles (with the exception of MAOs in some states). This is the source data used by the managed care payment system (Group Health Plan (GHP) system to identify the dually eligible beneficiaries that have Medicaid status. The M+C organizations are required to rely on the data from the TPM billing system for this portion of the population. The TPM records this transaction. The GHP system then interfaces monthly with the TPM and updates its files to reflect any new information. This process may effect payments prospectively and retroactively. The M+C organization should notify the state office responsible for updating the CMS Third Party Billing system when discrepancies are identified for dually eligible individuals.

Guidelines for Prospective Medicaid Adjustments

The M+C organizations can identify beneficiaries as Medicaid in certain instances, for prospective payments only. Primarily this is to place individuals who are classified as Medical Assistance Only (MAOs) in a Medicaid status, but are not limited to this category. These prospective payments are submitted to CMS during the normal monthly process. The M+C organizations need only report the MAO status for members who reside in the states that do not report these individuals. All other dually eligible beneficiaries are reported to CMS via the TPM update process. The states that do not pay the premium for MAO individuals are:

Connecticut	Minnesota	Pennsylvania
Delaware	Missouri	Rhode Island
Idaho	Montana	South Dakota
Illinois	Nebraska	Tennessee
Kentucky	New Hampshire	Texas
Louisiana	New York	Vermont
Maine	North Dakota	Virgin Islands
Massachusetts	Oklahoma	West Virginia
		Wisconsin

General Guidelines for M+C Organizations Requesting Retroactive Adjustments

The M+C organization *must* submit requests for adjustments to the Retro-Processing Contractor within 45 days of identifying the discrepancy during the normal monthly reconciliation of the CMS Monthly Membership report against the M+C organization's records.

The M+C organization may request a retroactive adjustment either placing a beneficiary into the Medicaid health status or removing the beneficiary from the Medicaid health status.

The M+C organization should never submit duplicate information unless the CMS Central Office or Regional Office or the Retro-Processing Contractor specifically requests that duplicate information be submitted.

To follow up on specific previously submitted requests for adjustments, a letter of inquiry should be sent separately from other requests for adjustments. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, specific action requested, the discrepancy period involved and the date the original request(s) was submitted.

If the package submitted to CMS is incomplete, it will be returned to the M+C organization for completion. No action will be taken on the package until the complete documentation is received.

Retroactive Medicaid adjustments will be made for the dates requested, however, payment will be made for no more than 36 months from the date the complete documentation is received by the Retro-Processing Contractor.

The following chart illustrates the Medicaid programs available for beneficiaries, how beneficiaries qualify, and whether M+C organizations can request Medicaid adjustment for beneficiaries in a particular Medicaid program.

Name of Medicaid Program	Qualification Criteria	M+C organization Medicaid Adjustments
Qualified Medicare Beneficiary (QMB)	• Has Medicare Part A • Individual Monthly Income of $759 or less • Couple Monthly Income of $1015 or less • Individual Resources of $4000 or less • Couple Monthly Resources of $6000 or less	YES
Specified Low-Income Medicare Beneficiary (SLMB)	• Has Medicare Part A • Individual Monthly Income of > $759 < $906 • Couple Monthly Income of > $1015 < $1214 • Individual Resources of $4000 or less • Couple Monthly Resources of $6000 or less	YES
Qualifying Individual-1 (QI-1)	• Has Medicare Part A • Individual Monthly Income of at least $906 but less than $1017 • Couple Monthly Income of at least $1214 but less than $1364 • Individual Resources of $4000 or less • Couple Monthly Resources of $6000 or less • Must not be otherwise eligible for Medicaid benefits	NO
Qualifying Individual-2 (QI-2)	• Has Medicare Part A • Individual Monthly Income of at	NO

Name of Medicaid Program	Qualification Criteria	M+C organization Medicaid Adjustments
	least $1017 but less than $1313 • Couple Monthly Income of at least $1364 but less than $1762 • Individual Resources of $4000 or less • Couple Monthly Resources of $6000 or less • Must not be otherwise eligible for Medicaid benefits	
Qualified Disabled and Working Individual (QDWI)	• Lost Part A but can purchase Part A benefits when they return to work • Individual Monthly Income of less than $3309 • Couple Monthly Income of less than $4065 • Individual Resources of $4000 or less • Couple Monthly Resources of $6000 or less • Must not be otherwise eligible for Medicaid benefits	NO

Documentation Required to Retroactively Change the Medicaid Health Status of a Beneficiary

- M+C organization Contract Number (H#);
- Beneficiary Name and Claim Number;
- Verification of Medicaid Status including starting/ending dates;

  One or more of the following constitutes acceptable documentation:

  - A copy of the Medicaid card and documentation that the M+C organization verified Medicaid eligibility with the state including:

- The date of the verification call by the M+C organization;
- The phone number used to verify eligibility;
- The name of the state staff person who verified the Medicaid period;
- A copy of the state document that confirms Medicaid entitlement for the discrepant period.;
- A screen print from the State's Medicaid System that shows the Medicaid status for the discrepant period.

If a vendor provides the required information to request a change in the Medicaid status, the M+C organization must submit a document from that state authorizing the use of the vendor as a valid source for Medicaid information.

Retro-Processing Contractor and Processing of the Request

The Retro-Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retro-Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the M+C organization including the reason that the adjustment was not processed.

The Retro-Processing Contractor will return the request without action, if the documentation is not complete.

The Retro-Processing Contractor will return the request without action if the dates of Medicaid status are older than 36 months prior to the receipt of the request by the RO.

The Retro-Processing Contractor will return the request without action if the beneficiary was not a member of the plan for the discrepancy period.

If the Medicaid status for the period requested in the adjustment reflects the current Medicaid periods in GHP, return it to the M+C organization without action.

If not, the Retro-Processing Contractor will validate the requested change and enter the revised Medicaid status into McCOY.

60.4 - Standard Operating Procedures for End Stage Renal Disease Retroactive Adjustments

(Rev. 46, 02-13-04)

ESRD Description

A beneficiary receives the End Stage Renal Disease (ESRD) status when a physician prescribes a regular course of dialysis because the member has reached that stage of renal impairment that a kidney transplant or a regular course of dialysis is necessary to maintain life. Medicare will pay the M+C organization at the higher, ESRD capitation rate for that beneficiary (unless they have elected hospice care).

General Information About the ESRD Payments

Payments made based on the ESRD health status are paid prospectively. The process of passing the information through the various databases may take as long as four full months from the time a beneficiary is identified by the physician as having ESRD. Therefore, the M+C organization may not begin receiving the ESRD capitation rate for the beneficiary for at least 4 months.

When the health status is included in the capitation rate for the beneficiary who is already in Medicare, the managed care payment system will automatically pay retroactively to include the first month of ESRD health status within 36 months. However, if the beneficiary is entitled to Medicare as a result of ESRD, there is a 3-month waiting period before Medicare entitlement will begin. *Renal Management Information System (REMIS)* will automatically adjust for this requirement and M+C organizations receive payment at the ESRD capitation rate of pay. The health status is based on the first date of dialysis as indicated on the End Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration (Form CMS-2728). In addition, the physician's signature and signature date must be clearly legible before the Renal Networks can enter any information in the Standard Information Management System (SIMS)

Although, Managed Care staff at the Retro-Processing Contractor, Regional Office, or Central Office cannot enter ESRD status changes/corrections into the GHP managed care system, they can resynchronize the GHP to the EDB if the systems' data do not match. This process may result in a change in the ESRD status and the associated positive or negative payment. The Renal Networks enter the data from the Form CMS-2728, which is transmitted, to the CMS systems through an automated process. The Form CMS-2728 is the key source of documentation to ensure that a beneficiary will be identified with the ESRD health status indicator and must be completed within 45 days of beginning a regular course of dialysis or receiving a kidney transplant, which was prescribed by a physician.

- The ESRD facility forwards a copy of the Form CMS-2728 to its local Social Security Administration (SSA) Field Office and to its respective ESRD Renal Network organization.

- For individuals diagnosed with ESRD, the SSA determines eligibility for the Medicare ESRD entitlement based on Form CMS-2728 under the end stage renal disease provisions of the law.

- The Renal Network organization inputs the information into its data system, and transmits the information to CMS, Office of Clinical Standards and Quality (OCSQ).

- The CMS, Office of Clinical Standards and Quality (OCSQ), updates the information in the (REBUS). The REBUS is CMS' central repository for beneficiaries with ESRD.

- Daily, *REMIS* updates the Enrollment Database (EDB) with ESRD health status start and/or ends dates.

- Monthly, the EDB updates the Group Health Plan (GHP) system with ESRD health status start and/or end dates for the M+C organization member. The GHP managed care enrollment and payment system is the source of information used in computing the monthly capitation rates that the M+C organizations receive.

General Guidelines for M+C Organizations Requesting ESRD Retroactive Adjustments

The M+C organization may request a retroactive adjustment payment at the ESRD capitation rate when the M+C organization has received erroneous payment at the non-ESRD capitation rate for a Medicare beneficiary who is currently receiving maintenance dialysis treatments or has had a successful kidney transplant within the last 36 months. The M+C organization identifies this during the normal monthly reconciliation of the Monthly Membership report, received from CMS, against their own records. (Usually the M+C organizations work along with their medical management department to determine which members are currently receiving dialysis treatment or are within 3 years following a transplant.) By doing this, the M+C organization is able to determine whether they should be receiving the ESRD capitation rate of payment.

The M+C organization must wait at least 4 months from the date the Form CMS-2728 form was signed by the physician to allow for the normal processing of the data before submitting a request for retroactive adjustment.

In order to determine when an update will be posted to the GHP, note the "Plan Data Due" dates on the GHP Monthly schedule. If corrections are entered in the system prior to this date, then payment will be made the following month. However, if corrections to the beneficiary's record are after this date, payment will be the month following the next

payment month. Keep in mind; the above is based on each system being updated timely. The GHP Monthly schedule is produced annually by staff in the Division of Program Accountability and Payment and is distributed to all M+C organizations and Retro-Processing Contractor contacts. A copy of the schedule is also a part of the Plan Communications Guide located at http://cms.hhs.gov/healthplans/systems/Guides.asp.

The M+C organization may contact the appropriate Renal Network to verify specific data related to the discrepancy. The Renal Network will only supply the following information:

1. The first date of dialysis or date of transplant;

2. The Date the beneficiary's Form CMS-2728 was submitted to CMS by the Renal Network; and

3. The Current Renal Status (this information is not required for a retroactive adjustment).

The M+C organization should never submit duplicate information unless the CMS Central Office, Regional Office, or Retro-Processing Contractor specifically requests that the duplicate information be submitted.

To follow up on specific previously submitted adjustments, a letter of inquiry should be sent separately from other adjustments. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, the health status, the period involved, and the date the original adjustment(s) was submitted.

If the package requesting the retroactive adjustment is not in accordance with the instructions from the Retro-Processing Contractor, it will be returned to the M+C organization without action.

Documentation Required to Retroactively Place a Beneficiary in ESRD Status

- M+C Organization Contract Number (H#);

- Beneficiary Name and Health Insurance Claim Number;

- First date of dialysis or transplant date;

- Date Enrolled in M+C organization;

- Specific discrepancy period that the M+C organization is requesting the change to ESRD health status;

- Copy of the Form CMS-2728 form, if there is no period of ESRD established. (The M+C organization must request a copy of the Form CMS-2728 from the dialysis facility NOT from the Renal Network organization.); and

- The date Form CMS-2728 was originally sent to CMS.

Retro-Processing Contractor Review and Processing of ESRD the Request

Effective December 1, 2002, the Retro-Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retro-Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the M+C organization including the reason that the adjustment was not processed.

The Retro-Processing Contractor will return the request to the M+C organization without action if there have not been at least 4 months since the beneficiary began dialysis as a Medicare beneficiary.

The Retro-Processing Contractor will return the request to the M+C organization without action if all required information has not been submitted.

The Retro-Processing Contractor will return the request without action if none of the dates of the revised ESRD status are within the 36 months prior to the request.

The Retro-Processing Contractor will return the request without action if the beneficiary was not a member of the plan during the discrepancy period.

The Retro-Processing Contractor will return the request without actions if ESRD status is already reflected for the discrepancy period.

The Retro-Processing Contractor will take appropriate actions such as resynchronize the systems to make the adjustment, or forward the request to CO, Managed Care staff.

The CO Managed Care staff will review and make note of any programmatic problems or trends that could be system related. The cases are then forwarded to OCSQ for manual input and update.

You will need to take action on problem enrollment and disenrollment cases. These cases will be identified by a variety of means: your review of CMS reports or your internal records and contacts from CMS, providers, or beneficiaries. The CMS Regional Office (RO) can assist you in the resolution of these cases in certain instances (see below).

Health Status Description

Standard Operating Procedure for Retroactive Adjustment of Working Aged

Effective 2004, a Working Aged factor will be applied to M+C organization payments at the contract level. Information and instructions concerning the Working Aged Factor is available at http://www.cms.hhs.gov/healthplans/systems/workingaged.asp.

60.6 - Standard Operating Procedures for Retroactive Adjustment of Plan Elections

(Rev. 46, 02-13-04)

Enrollments and Disenrollments including **Plan Benefit Package (PBP) Changes**

This SOP applies to retroactive *enrollments and* disenrollments *including PBP changes involving* all types of Medicare Managed Care Organizations (MCOs) and Demonstration project sites. This includes *Cost Plans,* Health Care Prepayment Plans (HCPPs), Medicare+Choice Organizations (M+C organization's), National PACE Organizations and Demonstrations as defined in their agreements with CMS. The SOP includes specific instructions for submission of these retroactive adjustments to the Payment Validation Contractor, IntegriGuard.

This SOP is provided only as a tool to assist in preparing retroactive enrollment and disenrollment cases for submission to IntegriGuard. Please refer to the Medicare Managed Care Manual or other appropriate CMS guidance resource for policy questions and additional details. These include Chapter 2 of the Medicare Managed Care Manual for the M+C program, and Chapters 17 and 18 for the Cost-based HMO's and HCPPs.

Guidelines for Requesting Retroactive Adjustments – ***Cost Plans*** **and HCPPs**

As a general rule, cost plans and HCPPs may not request retroactive adjustments. If a beneficiary should have been enrolled or disenrolled on a certain date and was not, the plan is reimbursed either by submitting a claim to fee-for-service Medicare, by an adjustment to their per member per month payment rate (based on a submitted budget request) or upon settlement of a cost report. However, in some limited cases, a cost plan can request a retroactive adjustment such as if it was caused by a CMS system error. This situation should be documented and immediately brought to the attention of the CMS Central Office, Division of Enrollment and Payment Operations. Should a cost plan require a retroactive enrollment or disenrollment, the request should be sent to CMS Central Office, Division of Enrollment and Payment Operations, with appropriate documentation (as described in this SOP).

Cost plans must retain original documentation supporting the request in their files.

If approved, an enrollment/disenrollment adjustment will be made retroactively to the statutory effective date, and payment adjustments will be made accordingly.

The cost plan should never submit duplicate information to Central Office unless specifically instructed to do so.

To follow up on specific previously submitted adjustments, a letter of inquiry should be sent separately from other adjustment requests. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, the contract number, the period involved, and the date the original adjustment(s) was submitted.

Guidelines for Requesting Retroactive Adjustments – M+C *Organizations,* M+C Demonstrations, and PACE

The M+C organizations must submit requests for adjustments within 45 days of receiving their monthly reports from CMS. You are to identify enrollment/disenrollment discrepancies during the monthly reconciliation of the Monthly Membership and Transaction Reply reports with your own records.

Prior to submitting requests to the Retro-Processing Contractor to retroactively adjust enrollment/disenrollment, the M+C Plan must complete the following actions:

- Ensure the beneficiary has proof of Medicare coverage;
- Ensure that a completed/signed Election form, or a record of another allowable M+C election format, is on file *where appropriate*; (Note that Election forms are not required in the case of a PBP change that is classified as a passive election. Passive elections are where the beneficiary's choice requires no action taken.);
- Ensure that the date the beneficiary signed the Disenrollment Request or Election form precedes the effective date as necessary; and
- Ensure the reason for the retroactive enrollment, disenrollment or PBP change, is documented.

There are a variety of situations that may result in the need for a retroactive *enrollment or disenrollment, including PBP changes. These are* included in Chapter 2 of the Medicare Managed Care Manual. Some examples are:

- Beneficiary chooses to disenroll (but it was not acted upon - for example, a request is made to SSA who failed to process it in a timely manner);
- Beneficiary claims to have made a disenrollment request (and has not utilized Plan services);

- Lack of intent to enroll;
- Lack of intent to enroll (medical condition);
- Move out of service area;
- CMS Systems problems;
- Multiple Transaction reject;
- Not eligible for an MCO;
- Not in HI master file/Not entitled to Part B;
- Part B termination;
- Employer Group Delays;
- Erroneous Death; and
- Erroneous Cancellation.

The M+C organizations must retain original documentation supporting the enrollment/ disenrollment or change in PBP in their files.

Documentation Required *for a Beneficiary* to Retroactively *Enroll or Disenroll, Including a PBP Change*

Review Chapter 2 to ensure submittal of appropriate documentation for the action being requested.

- MCO Contract Number (H#);
- M+C Plans must submit a PBP# for all *enrollments, including PBP changes*, on or after 6/1/2002. PBP#s are not required for disenrollments;
- Beneficiary Name and Claim Number; and
- Verification of *enrollment or disenrollment, including a PBP change, must include* starting/ending dates.

For retroactive *enrollment, including PBP changes,* you must submit documentation supporting your case as appropriate. Multiple documents may be required to support your request. Acceptable examples of documentation *may* include:

- Completed Election form or other election format including:
    - Date received by the MCO and welcome letter sent to beneficiary;
    - Beneficiary signature and Application signature date;
    - Sex;
    - Date of Birth;
    - PBP Identifier (M+C Plans only);
    - Effective date of enrollment;
    - Evidence of Part A and Part B coverage (examples are listed in Chapter 2 of the Medicare Managed Care Manual); and
    - Reason for retroactive enrollment.
- Election form or other election record with corrected HIC number and documentation supporting the corrected HIC# such as a letter from SSA, or a copy of the Medicare card;
- Reinstatement for disenrollment based on the member being out of service area, when it is determined that the member did not permanently move. Documentation that the member did not move must be provided;
- Copy of CMS reply listing showing that the MCO attempted to correctly enroll the beneficiary;
- Copy of the acknowledgement /acceptance letter sent to the beneficiary according to the time frames described in CMS policy guidance notifying the beneficiary that the Plans services are available as of the effective date;
- Copy of the CMS reply listing showing the erroneous termination due to death, or loss of Part A and/or Part B;
- Documentation from SSA which states that the beneficiary is living and SSA has corrected or is correcting the data to show the beneficiary is alive, or has never been shown as deceased;
- Letter from member showing that they wish to continue as a member of the MCO and the letter to the member advising them to continue using the MCO services.
- To correct erroneous enrollment rejections due to ESRD health Status,

- Letter from a physician or dialysis facility that documents date of transplant or last month of dialysis, or states that the beneficiary did not have ESRD during the period requested;

- Proof that the member was enrolled in the MCO prior to converting to Medicare status;

- Proof that the application was completed before the ESRD diagnosis. (A copy of the ESRD diagnosis signed by the physician and the beneficiary's signed and dated election form.);

- Completed enrollment election form or election format to change benefit plans including beneficiary signature and signature date, as appropriate; and

- If an individual other than the beneficiary signs any documents for the beneficiary, documentation of power of attorney or other legal support must be provided.

For retroactive disenrollment you must submit documentation supporting your case as appropriate. Multiple documents may be required to support your request. Acceptable examples of documentation *may* include:

- Death Certificate;

- Completed, signed and dated form 566;

- Original disenrollment request, signed and dated by the beneficiary, or other disenrollment election method allowed by CMS, showing date of receipt at the MCO;

- Retroactive disenrollment request signed by the member explaining either lack of intent to enroll or their alleged disenrollment date;

- Claims for out of plan services during the month after the alleged disenrollment date;

- Lack of primary care physician or MCO use;

- Documentation that the beneficiary did not pay the plan premiums;

- Documentation that the beneficiary purchased a Medicare supplement;

- Change of address records showing that the member has permanently moved out of the service area;

- Evidence in medical records of deteriorated mental comprehension dated prior to the election form signature date;

- A court decree of mental incompetence;

- A letter from the member giving the date he/she moved out of the service area;

- Any other information that supports the request such as no record of utilization of plan services after the stated date of the move such as out of area claims, copy of the CMS reply listing showing move; and

- CMS Reply listing showing the attempt to disenroll was made timely;

If the requested changes are approved, an enrollment/disenrollment adjustment will be made retroactively to the statutory effective date, and payment adjustments will be made accordingly.

To follow up on specific previously submitted adjustments, a letter of inquiry should be sent separately from other adjustment requests. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, the contract number, the PBP number (if appropriate), the period involved and the date the original adjustment(s) was submitted.

The M+C organization should never submit duplicate information unless the Retro-Processing Contractor specifically requests the duplicate information be submitted.

Retro-Processing Contractor Review and Processing of the Request

The Retro-Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retro-Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the MCO including the reason that the adjustment was not processed.

The Retro-Processing Contractor will validate the requested change and then enter the change in enrollment, change in PBP or disenrollment into McCOY.

The Retro-Processing Contractor will return the request without action if the documentation is not complete and include the reason. The MCO may resubmit the request to the Retro-Processing Contractor including adequate and appropriate documentation.

The Retro-Processing Contractor will contact the appropriate Regional Office (RO) if the situation or documentation is not strictly addressed in Chapter 2 or Chapter 17 of the Medicare Managed Care Manual. If necessary, the RO will review the documentation and make a decision on the request, or contact the MCO to provide additional documentation to support the request.

When the action has been completed, it will appear on the MCO's Transaction Reply and Monthly Membership Reports.

The Retro-Processing contractor will provide a report to the MCO, which includes the action taken regarding each requested adjustment.

If an MCO disagrees with the decision of the Retro-Processing Contractor, they may immediately request that the RO review the documentation provided to the Retro-Processing Contractor along with a letter explaining the reason for the disagreement. The request must be received by the RO within 45 days of the retro-processing contractors response.

The MCO must submit the following documentation to the Regional Office to request a review of the Contractors' decision:

- A copy of the entire package the MCO submitted to the Retro-Processing Contractor;
- A copy of the response from the Retro-Processing Contractor, including the disposition code; and
- An explanation of the reason that the MCO believes the Regional Office should reconsider the case.

Requirements for Submitting Retroactive *Enrollment and Disenrollments (Including PBP Changes)*

The M+C organizations will submit their requested adjustments to IntegriGuard. IntegriGuard will acknowledge receipt of the requested retroactive enrollment adjustment request within 10 days of receipt. This may be done via mail, e-mail, or telephone. Requested retroactive enrollment adjustments will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+C organization with a report detailing the disposition of the requests, including an explanation of reasons for not entering the change as submitted into the system. Supporting documentation must be attached to the spreadsheet detailing the requested retroactive enrollment adjustments.

Enrollment and Disenrollment including PBP change requests are not eligible for the PROBE Studies. Copies of supporting documentation as *required and* outlined in Chapter 2 of the Managed Care Guide and summarized in this SOP, must be included with the submission for each action requested.

A spreadsheet that lists all requested changes included in each submission is required. The required information and specific column order needed to track each retroactive adjustment is as follows:

M+C Organization Name: **Contact Name:**

Mailing Address: **Phone #:**

City, State, Zip Code: **E-Mail Address:**

H#	PBP #	CMS Region #	Action Requested	HIC #	Beneficiary's Last Name	Beneficiary's First Name	Beginning Date mm/dd/yyyy	Ending Date mm/dd/yyyy

Please note:

All fields must be completed.

Action requested should be "enrollment" or "disenrollment."

If there is no beginning date or ending date, enter "N/A."

The Plan Benefit Package (PBP) number is required for all requested retroactive enrollment adjustments after May 31, 2002. If the M+C organization does not have the PBP number because the enrollment start date requested occurred prior to June 1, 2002, and does not extend into the PBP implementation timeframe of June 1, 2002, please place "N/A" in the PBP field. If the enrollment period does extend beyond the PBP implementation time frame of June 1, 2002, a PBP number must be provided.

The PBP number is not necessary for disenrollments.

These requests may not be submitted electronically or by fax due to HIPPA.

Submission Addresses:

M+C Organization's, M+C Demonstrations, and PACE Cost Plans

IntegriGuard
MMC Enrollment Project
2121 North 117th Avenue
Suite 200
Omaha, Nebraska 68114

Phone: 402-955-2781

CMS
Div. of Enrollment and Payment Operations
Mail *S*top C1-05-*17*
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Phone: 410-786-1125

70.2 - Medicare Customer Service Center Disenrollments

(Rev. 46, 02-13-04)

A Medicare beneficiary can also disenroll by contacting the customer service call center. The MCO should send written confirmation to the beneficiary when *a Medicare customer service center* disenrollment appears on the Transaction Reply Report.

80.3 - Duplicate Payment Prevention by Cost-Based MCOs

(Rev. 46, 02-13-04)

Cost/HCPP-based MCOs are required to set up a system designed to prevent duplicate reimbursement. This is important because several agencies may be involved in processing Medicare Part B bills.

At a minimum, the MCO's system *must* employ two elements:

- First, the MCO must ensure that it is receiving all Explanation of Medicare Benefits (EOMB) forms from the CMS carrier whenever a bill for services is processed for a Medicare member. The MCO should compare the MSNs with its own payment records to ensure Medicare payment has only been made for provided services.

- Second, the MCO must review the bill summary and itemization report created monthly by the GHP. These reports show the Part A and Part B bills paid by fee-for-service Medicare on behalf of the MCO's Medicare members. These reports are to be reviewed to ensure only appropriate payments have been made.
