Medicare Managed Care Manual

Chapter 19 - The Enrollment and Payment User's Guide

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Note To Readers

The Enrollment and Payment Guide has become Chapter 19 in the Managed Care Manual. You will see references to Chapter 19 and to Chapter 20 (Plan Communications Guide) throughout this document. This updated version is being published separately in order to insure that necessary information is available timely to users.

10 - Overview of Enrollment and Payment Process

(Rev. 31, 09-05-03)

10.1 - Purpose of the Chapter

(Rev. 31, 09-05-03)

This chapter provides information to managed care organizations (MCOs) regarding the processing of Medicare membership information. This information includes enrollments, disenrollments, corrections, and payments for MCO members.

Chapter 19 is for use by MCO management and staff who are responsible for establishing and maintaining MCO Medicare membership records. Procedural guidelines on how to interact (i.e., exchange information) with CMS are included in this Chapter.

It should be noted that Chapter 20 of this manual, the Plan Communications User's Guide, contains detailed instructions on the formats and processes that MCOs must use in transmitting and receiving Medicare membership information. Both Chapters should be used to provide a full picture of the requirements for the submittal, receipt and validation of enrollment and payment data.

10.2 - MCO Data Processing Responsibilities

(Rev. 31, 09-05-03)

The MCOs are required to submit information electronically to CMS about their Medicare members, including enrollments, disenrollments, and other data relating to the status of the beneficiary.

A summary of the Medicare managed care enrollment and disenrollment process, the related submission of Medicare membership records by MCOs, and the receipt of membership and payment reports from CMS are presented in this Chapter.

When a Medicare beneficiary enrolls in your Medicare MCO, or a current commercial member of your MCO becomes eligible for Medicare and enrolls in your Medicare MCO, you must send a Medicare membership record to CMS. This is done through an electronic process.

Medicare membership information must be sent promptly to CMS so that it can be included in CMS' monthly processing of MCO enrollment, disenrollment, and correction records. Correction records are submitted to annotate specific health status information, i.e., Medicaid, Institutional or NHC or to remove specific health status information, i.e., Medicaid.

10.3 - CMS' Group Health Plan (GHP) System

(Rev. 31, 09-05-03)

The Group Health Plan (GHP) system is the primary system that CMS uses to receive, update and maintain Medicare Managed Care membership information from MCOs and others.

There are two interfaces that allow MCOs to access the CMS managed care systems (which are located in the CMS Data Center).

The two interfaces that allow MCOs to access the GHP are:

- The Managed Care Option Information System (McCoy). The McCoy system is used by MCOs to access the GHP master file to send transaction files, view reports, check beneficiary specific records and payment rates, check the monthly exception list, and to check the plan transfer tracking report; and

- The Group Health Plan Report Output User Communication Help (GROUCH) System. This System allows MCOs to view and download reports detailing the enrollment and payment status of their membership. The GROUCH also provides payment and adjustment data to the MCOs for verification purposes.

Detailed information on the functionality of these systems and how MCOs are to access them is contained in Chapter 20, the Plan Communication User's Guide.

20 - Enrollment/Disenrollment Requirements and Effective Dates

(Rev. 31, 09-05-03)

20.1 - General

(Rev. 31, 09-05-03)

Requirements for submission of enrollment and disenrollment information differ depending on whether the MCO is cost-based or risk-based. The latter type is now referred to as a Medicare+Choice organization (M+C organization).

20.2 - Enrollments

(Rev. 31, 09-05-03)

20.2.1 - Cost-Based MCOs Only

(Rev. 31, 09-05-03)

For requests received during a current month, you may submit enrollment transaction records to CMS with an effective date of from 1 to 3 months **after** that current month. Requests for any other effective date will be rejected by CMS. For 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. 31, 09-05-03)

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 (previously Operational Policy Letter 99.100). Chapter 2 discusses in detail the effective dates for elections made during any of these periods. Elections are defined as enrollments, disenrollments and changes of plan benefit packages (PBPs).

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 and signed application;
- 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. For example, an enrollment request with an effective date of September 1, 2000, submitted by the cutoff date (September 6, 2000) would be accepted by CMS and would be processed.

EXAMPLE

September 2000 is the current processing month. September 6 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.

Enrollment records for applications received during August are to be effective September 1, 2000. Those submitted for applications received from September 1-6 are to be effective October 1, 2000.

20.3 - Disenrollments

(Rev. 31, 09-05-03)

20.3.1 - Cost-Based MCOs Only

(Rev. 31, 09-05-03)

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 of the month that the beneficiary no longer wants to be enrolled in your MCO as the effective date. For example, disenrollment request records with an effective date of October 1, 2000, will process with the disenrollment date of September 30, 2000. This means as of October 1 the beneficiary is disenrolled from your MCO.

EXAMPLE

September is the current processing month, and September 6 is the date MCO data is due to CMS. A MCO may submit a disenrollment record up to September 6 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+COs Only

(Rev. 31, 09-05-03)

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.

20.4 - M+C MCOs Only – Employer Group Health Plan Retroactive Enrollment

(Rev. 31, 09-05-03)

If you are an M+C organization that provides health services to an employer group, you may enroll Medicare beneficiaries who are employer group members retroactively up to 90 days from the current payment date.

The effective date of the enrollment can be no earlier than the signature date on the election form. The resulting effective date can be up to 90 days retroactive to the current payment month.

EXAMPLE

September is the current processing month and the current payment date is October 1. A M+C organization submits an enrollment record for an employer group member. In this example, July, August, and September effective dates would be acceptable. A transaction type code of 60 is to be used for July and August.

30 - Medicare Membership Information

(Rev. 31, 09-05-03)

30.1 - The CMS/MCO Interface

(Rev. 31, 09-05-03)

The MCO provides CMS, through an electronic interface, with the Medicare membership information needed to accurately calculate monthly payments.

MCO Responsibilities:

To provide CMS with timely, accurate information about beneficiaries including enrollments, disenrollments, and special membership status information (i.e., correction records).

CMS Responsibilities:

To provide the MCO with payments based on submitted membership data.

To provide the MCO with timely and accurate reports so that membership and payment information can be verified.

30.2 - Submitting Medicare Membership Information to CMS

(Rev. 31, 09-05-03)

30.2.1 - Submission of Enrollment/Disenrollment Transaction Records

(Rev. 31, 09-05-03)

Cost and M+C MCOs must submit enrollment and disenrollment information to CMS monthly in a specified, electronic format. The format is called the Enrollment/Disenrollment Transaction; the record layout is contained in Chapter 20, the Plan Communication User's Guide. It includes beneficiary identifying information, the MCO contract number, the PBP number, transaction codes, effective dates, etc. This data allows CMS to accurately update your membership information to reflect enrollments, disenrollments, PBP changes, and certain health status payment adjustments.

30.2.2 - Submission of Correction Transaction Records

(Rev. 31, 09-05-03)

Medicare+Choice Organizations Only

The M+C organizations must inform CMS as to which of the MCO's 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.

30.2.3 - Health Insurance Claim Number (HICN)

(Rev. 31, 09-05-03)

Each individual who becomes entitled to health insurance benefits receives a Medicare card bearing his/her name, sex, Health Insurance Claim Number (HICN), and the effective dates of entitlement to hospital insurance and/or medical insurance.

Both SSA and the Railroad Retirement Board (RRB) issue health insurance cards with a HICN. Most HICNs are Social Security Numbers (SSNs) with letter/number suffixes. However, the claim number may also be a RRB number or SSN with letter prefixes. Additional information concerning HICNs:

- CMS Assigned HICNs--A complete list of valid HICN formats can be found in CMS Pub. 100-1, Chapter 2.

- RRB assigned HICNs--The RRB did not begin using SSNs until 1964. Numbers assigned prior to that time were 6-digit numbers assigned in numerical sequence. The 6-digit numbers and the 9-digit SSNs always have letter prefixes. A complete list of valid RRB claim number prefixes can be found in CMS Pub. 100-1, Chapter 2.

- Special Precautions for Entering HICNs:

- The HICN must be left justified. Leave any unused spaces in the field blank;
- No claim number is complete without at least one letter prefix or suffix;
- No claim number can have both a prefix and a suffix;
- You must use the complete suffix. This suffix may consist of several alpha-numeric characters, e.g., "D4;" and
- Hyphens are not to be included in records sent to CMS.

30.3 - Transaction Type Code and the Prior Commercial Indicator

(Rev. 31, 09-05-03)

30.3.1 - Transaction Type Codes

(Rev. 31, 09-05-03)

There are five **transaction type** codes that you can use:

- A code 61 on the Enrollment/Disenrollment Transaction is used to enroll a Medicare beneficiary for a current month or prospectively;
- A code 60 on the Enrollment/Disenrollment Transaction is used only by M+C organizations to retrospectively enroll a beneficiary of an employer group;
- A code 71 on the Enrollment/Disenrollment Transaction is used to change the PBP number for a current member of the M+C organization for a current month or prospectively. Cost-based MCOs do not submit this transaction type;
- A code 51 on the Enrollment/Disenrollment Transaction is used to disenroll a Medicare beneficiary; and
- A code 01 on the Correction Transaction is used to report institutional status and Medicaid status (MAO only). Cost-based MCOs do not submit this transaction type.

There are two additional codes that you may see on the Transaction Reply/Monthly Activity Report. They represent disenrollments submitted by the SSA Field Office (code 53) and by the Medicare Customer Service Center (code 54).

30.3.2 - Prior Commercial Months Field

(Rev. 31, 09-05-03)

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. 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. 31, 09-05-03)

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;
- 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. For example, if a beneficiary is institutionalized and has ESRD, the payment will be at the rate applicable to ESRD status.

30.5 - Special Status Beneficiaries

(Rev. 31, 09-05-03)

The following sections provide more detailed information regarding the special status categories.

30.5.1 - "Special Status" - Hospice

(Rev. 31, 09-05-03)

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 CMS risk-based MCO 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. 31, 09-05-03)

A Medicare beneficiary who has been certified to have ESRD under Medicare cannot become a Medicare member of a M+C organization unless the beneficiary was a commercial member of the MCO in the month immediately preceding the month of enrollment as a Medicare member. In this case, the beneficiary can become a member. 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 enrollments 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. Should 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. 31, 09-05-03)

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 Operational Policy Letter, #54 for further details on the institutions)

The beneficiary must be enrollee 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.

30.5.4 – "Special Status" - Medicaid/Medical Assistance Only (MAO)

(Rev. 31, 09-05-03)

The beneficiary meets "special status" requirements if a State Medicaid Agency pays some or all of their Medicare Part A and/or Part B premiums. Such beneficiaries are those who are considered to be a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) or Qualifying Individual (QI). All beneficiaries who are a part of these groups and others having Medicaid eligibility status are reported by the states via CMS' Third Party Master system.

When a Medicare member of your MCO is part of one of these groups or otherwise has Medicaid eligibility, CMS' GHP system is updated. The **MCO is automatically notified** via the Transaction Reply/Monthly Activity Report and the payment rates for impacted members are adjusted according to the status priority ranking. Medicaid status information reported by the states is not available for direct updating by MCOs.

Exception-Action required by the MCO: Some Medicare beneficiaries do not receive cash financial aid from the state but do receive medical assistance such as free dental care or prescription drugs from the state. This is called "Medical Assistance Only" (MAO). Some of the state Medicaid agencies that provide MAO do not "buy-in" or pay Medicare premiums for the individuals who are MAO. If a MCO is located in one of these states, the MCO must identify MAO eligibles and report this information to CMS so that the applicable payment rate is calculated for these individuals.

The states in which MCOs must identify and report MAOs are:

CONNECTICUT	MINNESOTA	PENNSYLVANIA
DELAWARE	MISSOURI	RHODE ISLAND
IDAHO	MONTANA	SOUTH DAKOTA
ILLINOIS	NEBRASKA	TENNESSEE
KENTUCKY	NEW HAMPSHIRE	TEXAS
		UTAH
LOUISIANA	NEW YORK	VERMONT
MAINE	NORTH DAKOTA	VIRGIN ISLANDS
MASSACHUSETTS	OKLAHOMA	WEST VIRGINIA
WISCONSIN		

MCOs can only report MAO status prospectively. States can report Medicaid status retrospectively and prospectively.

When a State Medicaid Agency terminates its "buy-in" (i.e., no longer pays for some or all of a beneficiary's Medicare premiums) for one of your Medicare members, the MCO will automatically receive notice through the Transaction Reply/Monthly Activity report that it has ended. Likewise, when "buy-in" status begins for a beneficiary, the MCO will be notified via the Transaction Replies/Monthly Activity report.

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

(Rev. 31, 09-05-03)

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.

The GHP system acts as a conduit for MCOs to submit WA period information; i.e., beginning or ending a WA period. 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. 31, 09-05-03)

Transmit Medicaid (MAO), working aged 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 disenrollments if members lose Medical Assistance.

30.7 - Other Medicare Membership Information

(Rev. 31, 09-05-03)

30.7.1 - Risk Adjustment Payment

(Rev. 31, 09-05-03)

In effect since CY 2000, payments to M+C organizations have been adjusted by the risk adjustment methodology. This method is based on the assignment of health status risk factors to each Medicare beneficiary. These factors are based on diagnostic data related to inpatient hospital stays. In the future, additional diagnostic data associated with other medical services, e.g., physician, outpatient will be included in the risk factors.

The risk adjustment factors will be used along with the risk adjustment rate book, modified by applicable special statuses, in the calculation of the capitated amount for each beneficiary. Note that for the Hospice and ESRD statuses, the risk adjustment method does not apply; payment will be at the demographic rate.

Payment under risk adjustment will be phased-in based on a statutorily defined schedule; i.e., CY 2000-CY 2003 payments will consist of a blend of 90 percent of the demographic amount and 10 percent of the risk adjustment amount. Information relating to each member's payment rate under this method will be displayed on the Monthly Membership Report. See OPL #99.096, Changes to the CMS Managed Care Systems to Reflect the Risk Adjustment Payment Methodology, for more information regarding risk adjustment.

30.7.2 - Bonus Payment

(Rev. 31, 09-05-03)

Effective CY 2000, M+C organizations can become eligible for a bonus payment for some of their members. If an M+C organization offers a plan in a service area that is not served by another M+C organization as of January 1, 2000, and January 1, 2001, payments for enrollees residing in that area (county) will include a bonus amount. For the first 12 months that the M+C organization offers the plan in the previously unserved area, the payment will include a 5 percent add-on. This add-on will be 3 percent for the next 12 months. Information relating to each member's payment rate under this program will be displayed on the monthly Bonus Payment Report. See Chapter 20, The Plan Communications User's Guide, for the layout of this report.

30.7.3 - Extra Payment in Recognition of Quality Congestive Heart Failure (CHF) Outpatient Care

(Rev. 31, 09-05-03)

In 2002 and 2003, M+C organizations that participate in specified Quality Assurance Program Improvement (QAPI) projects, are eligible for an enhanced payment for members diagnosed with CHF. If the member had an inpatient discharge for CHF during the encounter data collection period 2 years prior to the payment year, payment would be the higher of one-third of the amount based on the Principal Inpatient Diagnostic Cost Group (PIP-DCG) currently assigned to the member. The Monthly Membership Report (MMR) will contain fields that will notify the M+C organizations which encounter data collection period(s) resulted in a CHF discharge for each member. (See OPL 129 for more information.)

30.7.4 - Benefit Stabilization Fund (BSF)

(Rev. 31, 09-05-03)

Beginning in March 2001, M+C organizations could elect to have an amount withheld from each month's payment and placed in a fund for future use. The withhold rate is specified on the Adjusted Community Rate proposal and is applied to all members in the M+C organization (during 2001 and part of 2002) or all members in the PBP (beginning mid-2002). The amounts withheld are reported on the Plan Payment Letter. Beginning in 2002, M+C organizations can withdraw from the BSF.

40 - Electronic Submission of Membership Records to CMS

(Rev. 31, 09-05-03)

40.1 - Timeliness Requirements

(Rev. 31, 09-05-03)

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 CMS 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 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.

40.2 - Record Submission Schedule

(Rev. 31, 09-05-03)

The CMS provides a schedule of submission dates to all MCOs every year. The schedule provides information for the calendar year, January through December. If you need a copy of the latest schedule, it can be located at: http://www.cms.hhs.gov/healthplans/systems/monthlysched.htm.

Records received after the due date, as noted on the processing schedule for a particular month, will not be processed in the CMS monthly run. You must check the "Plan Transfer Tracking" report in McCoy, described in Chapter 20, the Plan Communications User's Guide, immediately after you send your records. The report will provide the information you need to determine if your transmission was received and if you used the correct payment month date. If the date you reported does not match the Reporting Month Date on the Transfer Tracking Report, your file will not process. You should also check your transaction file totals. If you send records only once each month, you must allow sufficient time to do more than one transmission attempt for the records in case of problems.

40.3 - Sending the Transaction File to CMS

(Rev. 31, 09-05-03)

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 Acxiom, Inc. is providing this service for MCOs.

40.4 - Electronic Data Transfer

(Rev. 31, 09-05-03)

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 Demanoy OC 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.

40.5 - CMS Data Center Access

(Rev. 31, 09-05-03)

You must have both a User ID and a Password to gain access to CMS' mainframe systems. To obtain them, please go to http://www.cms.hhs.gov/mdcn/access.pdf or call your Regional Program Manager to obtain an access request form. It must be completed and mailed to:

If you prefer sending your request by regular mail it can be sent to:

CMS/CBC/HBG/DEPO
Central Building, C1-05-07
7500 Security Boulevard
Baltimore MD 21244-1850
Attn: HDC Access Request

In addition to HDC access, MCOs must also obtain a User ID/Password from AT&T Global Services (AGS). The AGS operates the telecommunications network that allows MCOs to access the HDC. Contact the AGS Help Desk at 1-800-905-2069 to obtain a User ID and Password.

40.6 - Data Processing Vendor

(Rev. 31, 09-05-03)

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.

ACXIOM, Inc.
9171 Oso Avenue
Chatsworth, CA 91311
Contact: Medicare Account Representative

(301) 957-9616

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 - Receiving Medicare Membership Information From CMS

(Rev. 31, 09-05-03)

50.1 - General

(Rev. 31, 09-05-03)

You have access to CMS reports containing your MCO's Medicare membership information. In general, these reports will allow you to compare your Medicare membership and payment information with that maintained by CMS and to assist you in identifying and correcting any discrepancies. (See below for detailed information about each report.)

50.2 - CMS' Transaction Reply/Monthly Activity Report

(Rev. 31, 09-05-03)

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**. If you encounter inaccuracies or potential problems, report them immediately to your CMS Regional Office.

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. 31, 09-05-03)

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 MCOs 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

*Note to risk-based MCOs:

If you believe the ESRD annotation is incorrect contact your CMS Regional Office for instructions. The correct code must be added to CMS' GHP master to enable you to receive the ESRD payment rate.

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 be 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. 31, 09-05-03)

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 MCO.

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. 31, 09-05-03)

The report displays an MCO'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 MCO'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 MCO'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 MCO 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.

50.6 - Medicare Fee-For-Service (FFS) Bill Itemization and Summary Report

(Rev. 31, 09-05-03)

Used mainly by cost-based and HCPP MCOs, this report notifies you when bills have been paid or processed by FFS Medicare on behalf of the Medicare members of your MCO (Exhibits D1 through D3). All MCOs are to use these reports to detect potential duplicate payment situations.

50.7 - Monthly Membership Report

(Rev. 31, 09-05-03)

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 that amount.

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 will be added. Note that not all of the new fields will be populated with data until later in 2002.

- **Congestive Heart Failure (CHF) flags for 2002 and 2003**. This field will be populated for 2002 beginning with the January 2002 report. It will identify beneficiaries that had a discharge for CHF in the associated encounter data collection period.

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

- **Racial Ethnicity Code.** This field will be populated late in 2002. It will identify the race of a member.

50.8 - Bonus Payment Report

(Rev. 31, 09-05-03)

Effective with the July 1, 2000 payment, a new report detailing the bonus payments applicable to eligible members is 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.

50.9 - Working Aged Transaction Status Report

(Rev. 31, 09-05-03)

This report is to be used in conjunction with the McCOY Working Aged online system to analyze and correct any plan keyed/electronically submitted working aged records. The information on the report is data submitted electronically in batches or data keyed manually into the McCOY Working Aged online system, and is a cumulative account of

all the working aged records as their status changes in the working aged process. All information listed is received before the working aged cutoff day (the last working day of the month).

60 - Retroactive Payment Adjustment Policy

(Rev. 31, 09-05-03)

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, working aged 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 Medicare +Choice organizations (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.

   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. It is possible in some situations for this time frame to be greater than 36 months from the current payment month by the time the request is processed. Should this occur, CMS will use the override option.

2. **"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;
- Working Aged 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) Changes

Detailed instructions governing the processing of retroactive enrollments/disenrollments are contained in Chapter 2 of the Medicare Managed Care Manual. 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. If the 36-month timeframe would be exceeded, the RO will use the override option to allow complete payment to the M+C organization.

Retroactive Disenrollment

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

IntegriGuard Submission Process for M+C organizations

The M+C organizations can submit requests to IntegriGuard on CD, diskette, or paper. The specific format and required fields for submission of the retroactive status changes addressed in this memo is shown below under each category. However, IntegriGuard will accept the information on an Excel spreadsheet, in a Word document, or in an Access database. **Please note that this information cannot be sent by fax or 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 organizations should 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 organizations 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 entitled "Probe Study.")

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

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

Mailing Address **Phone #:**

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

					SCC			
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: All fields must be completed. If the M+C organization does not have the end date because the beneficiary still resides in the SCC requested, please place "N/A" in the "End Date" field. Also, please enter dates as mm/dd/yyyy (example, 01/01/2002).

Submitting Institutional Status Changes

The M+C organizations 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 **Contact Name:**

Mailing Address **Phone #:**

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

					INSTITUTIONAL	
H#	**CMS Region #**	**HIC #**	**Beneficiary's Last Name**	**Beneficiary's First Name**	**INSTStart Date mm/dd/yyyy**	**INSTEnd Date mm/dd/yyyy**

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

Submitting Institutional Removal Status Changes

The M+C organizations 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 removal status change 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**

Please note: All fields must be completed. The month(s) to be removed field is defined as the month(s) for which the M+C organization received institutional status payment, but is now requesting the institutional status be removed, as it was not applicable.

Submitting Medicaid Status Changes

The M+C organizations 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 Medicaid change is as follows:

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

Contact Name:
Phone #:
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**

Please note: The "Verified Period From Date" is defined as the date the requested Medicaid status change is to be initiated. The "Verified Period Thru Date" is defined as the date the requested Medicaid status change is to end. If the M+C organization does not have the thru date because the beneficiary still qualifies for Medicaid status, place "N/A" in the "Verified Period Thru Date" field. All fields must be completed.

Submitting the Removal of Medicaid Status Changes

The M+C organizations 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 change 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**

Please note: The month(s) to be removed field is defined as the month(s) the M+C organization is requesting the removal of Medicaid status. All fields must be completed.

Submitting ESRD Status Changes

The M+C organizations 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 **Contact Name:**
Mailing Address **Phone #:**
City, State, Zip Code **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**

Please note: The Beginning and Ending Date of discrepancy period is defined as the month(s) the beneficiary qualified for ESRD status, but the M+C organization did not receive a payment at ESRD capitation rate. All fields must be completed.

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 organizations as defined in the CMS Standard Operating Procedures (SOP).

A five 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 four to five 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 state and county code and institutional status categories to:

IntegriGuard
MMC Enrollment Project
10040 Regency Circle, Suite 260
Omaha, Nebraska 68114

Phone: 402-955-2781

60.1 - Standard Operating Procedures for State and County Code Adjustments

(Rev. 31, 09-05-03)

State and County Code Description

Beneficiaries' state and county of residence have 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 should 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.

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.

60.2 - Standard Operating Procedures for Processing of Institutional Adjustments

(Rev. 31, 09-05-03)

Institutional Description

Institutional refers to a health status that is attributed to a beneficiary who is a resident in an institution or distinct part of an institution that has been certified by Medicare. This health status can only be assigned after they have been a resident of a certified institution for a qualifying period. (The definition of certified institution can be found in §§170 and 170.1 of Chapter 7 of the Medicare Managed Care Manual.) The beneficiary is not required to be a member of the M+C organization nor Medicare during the qualifying period.

General Information about institutional payments:

The institutional rate is paid retroactively for those members that meet the criteria for the institutional rate. For the M+C organization to be eligible to receive payment at the institutional rate, the beneficiary must have been a resident in a Medicare certified institution for a 30-day period including the last day of that month. This is referred to as the "qualifying period". Additionally, the beneficiary must be living and enrolled in the M+C organization the first day of the following month. Once the M+C organization has verified that a beneficiary has met the criteria, including both the qualifying period and enrollment requirements, the M+C organization may request they be paid the institutional rate for that beneficiary for the month following the qualifying period.

The qualifying period must be 30 consecutive days that includes the last day of that month. The M+C organization does not get the institutional rate for the qualifying period; rather they receive the institutional rate for the month following the qualifying period. If a beneficiary resides in a Medicare Certified Institution from April 1 to April 30, then the M+C organization will receive the institutional rate for that beneficiary for the month of May.

In our example the beneficiary must remain enrolled in the M+C organization the first day of May for the plan to receive any payments for this beneficiary, including the institutional rate adjustment.

The normal method for M+C organizations to request the institutional rate for beneficiaries requires the M+C organization to submit electronic records, transaction type "01" to be included in the normal batch processing done by CMS. Each beneficiary record must include the claim number, the beneficiary name, action code "D", the M+C organization's contract number (HXXXX), and the transaction code "01." The correct layout is found in the Plan Communications Guide. These transactions will be processed during the normal monthly processing for payments, so they must be received by the established cut-off dates indicated on the GHP monthly schedule. These transactions effect payment related to the previous month (e.g., only April's qualifying period for May 1 payment can be submitted by the May cut-off). If for any reason the entire electronic submission is not processed during the normal period, the M+C organization should contact the Retro-Processing Contractor for assistance. The Plan Communication Guide provides the specific directions for the M+C organization process.

The following are examples of common situations that are likely to be encountered.

EXAMPLE 1

Institutionalized on February 14. Resided in the institution on March 31.

Enrolled in the plan on April 1.

The qualifying period: March 1 - March 31.

Institutional payment allowed: April 1 - April 30.

M+C organization submits the beneficiary information electronically to CMS by April cut-off.

The May monthly payment will include the institutional adjustment for April.

NOTE: The beneficiary could have been, but did not need to be enrolled in the M+C organization or in Medicare during the qualifying period.

CMS will continue to pay the institutionalized rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave, if the member returns to a certified institution, or distinct part of an institution, as defined in Chapter 7 of the Medicare Managed Care Manual. Temporary absences (less than 15 days) for medical necessity will be counted toward the 30-day requirement. Absences totaling 15 days or more during a month ends the institutional stay and the qualifying period of 30 days, including the last day of the month must be met before institutional status can be reinstated.

EXAMPLE 2

Beneficiary is absent from the institution January 1 through January 4 AND

Beneficiary is absent from the institution January 10 through January 20.

The temporary absence is 15 days, which totals more than 14 days in the month.

The M+C organization is not eligible to receive the institutional rate for this beneficiary.

The qualifying period must be met before the institutional rate can begin.

EXAMPLE 3

Institutionalized on September 16 through November 29.

Beneficiary is temporarily absent (hospitalized) from October 5-21.

The beneficiary did not meet the qualifying period in October because the beneficiary was absent from the institution for more than 14 days during October.

The beneficiary did not meet the qualifying period for November because the beneficiary did not remain in the institution the last day of November.

The M+C organization is not eligible to receive the institutional rate because the beneficiary did not meet the 30-day qualifying period.

EXAMPLE 4

Institutionalized on January 7, hospitalized on February 15-27. Returns to the institution.

Enrolled in the plan on March 1.

The beneficiary was absent from the institution for 13 days during February.

The qualifying period was January 29 - February 28.

Institutional payment allowed: March 1 - March 30.

M+C organization submits the beneficiary electronically to the CMS.

The April monthly payment will include the institutional payment adjustment for March.

General Guidelines for M+C organizations requesting institutional adjustments for other than the preceding month

It is the M+C organization's responsibility to verify whether a beneficiary has met the criteria for institutional status and to submit the required documentation to the Retro-Processing Contractor within 45 days of the monthly reports in becoming available via GROUCH to the M+C organizations.

The M+C organization may submit requests for the institutional rate for periods other than the preceding month including both a single month and multiple months. The Retro-Processing Contractor will review the request and may make the change in status directly in McCoy. The retroactive adjustments will be processed in the next normal payment cycle.

If the documentation submitted by the M+C organization is incomplete, it will be returned without action.

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.

If the M+C organization is following up on specific previously submitted adjustments, the letter of inquiry should be sent separately from other adjustments and clearly indicate that it is a follow-up to request(s) previously submitted. It must include the claim number of the individual, the period involved, and the date the original request(s) was submitted.

Documentation Required by the Retro-Processing Contractor to Change the Institutional Health Status Retroactively:

- M+C organization Contract Number (H#);
- Beneficiary Name and Claim Number;
- Period that the Beneficiary resided at the Institution;
- Months to be affected for institutional payment by this request;
- Periods of Absence from the institution, including attestation that it was for hospitalization or therapeutic reasons;
- Verification of the institutional stay including:
    - The name of the facility;
    - The date the verification with the facility was accomplished by the M+C organization;
    - The name and phone number (or e-mail/fax) of the person who was contacted at the facility;
    - The name of the person who did the verification at the M+C organization; and
    - Attestation that the facility is certified and the member resided in a certified part of the facility. (The M+C organization does not have to provide the certification number, but should assure the certification documentation to support this attestation is available upon request.)

Retro Processing Contractor Review and Processing of the Institutional Status 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 institutional residence are within the 36 months prior to the request.

The Retro-Processing Contractor will return the request without action if the total days of temporary absence were 15 days or more, during the period for which institutional status is requested.

The Retro-Processing Contractor will return the request without action if the beneficiary was not a member of the plan for the period the institutional payment rate is requested.

If the institutional period requested in the adjustment request reflects the institutional period already in McCoy, it will be returned to the M+C organization without action.

The Retro-Processing Contractor will validate the requested change and enter the period that the M+C organization will receive the institutional capitation rate for that beneficiary into McCOY. Note that the M+C organization does not receive the increased capitation rate for the qualifying period, and that the start date should always be the first day of the month following the month during which the qualifying period ended.

Adjustments to the payment will be made during the 45 days following receipt of the requested adjustment. Payment will be processed in accordance with the normal GHP cut-off cycles.

The following are examples of common situations that are likely to be encountered.

EXAMPLE 6

Institutionalized on January 7, hospitalized on February 14-27.

Discharged from the institution on May 13.

The qualifying period: January 30 - February 28 institutional stay (Temporary absence was less than 15 days)

Institutional Payment allowed: March 1 - March 31

Qualifying Period: March 1 to March 30

Institutional payment allowed: April 1 - April 30

Qualifying Period: April 1 to April 30

Institutional Payment allowed: May 1 - May 31

The payment for the entire period is entered in McCoy as "Start 3/01/YYYY and End 05/31/YYYY."

EXAMPLE 7

Institutionalized on June 6. Died on November 13.

The qualifying period: July 1- July 31

Institutional payment allowed: August 1 - August 31

The qualifying period: August 1 - August 31

Institutional payment allowed: September 1 - September 30

The qualifying period: September 1 - September 30

Institutional payment allowed: October 1 - October 31

The qualifying period: October 1 - October 31

Institutional payment allowed: November 1 - November 30

The payment for the entire period is entered in McCoy as "Start 08/01/YYYY and End 11/30/YYYY"

Although the member died the middle of the month, the M+C organization would not receive the institutional rate due to death. The member was not enrolled in the M+C organization the first day of December.

60.3 - Standard Operating Procedures for Medicaid Retroactive Adjustments

(Rev. 31, 09-05-03)

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 should 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	• Has Medicare Part A	YES

Name of Medicaid Program	Qualification Criteria	M+C organization Medicaid Adjustments
(SLMB)	• 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	
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 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	NO
Qualified Disabled and Working Individual (QDWI)	• Lost Part A but can purchase Part A benefits when they return to work	NO

Name of Medicaid Program	Qualification Criteria	M+C organization Medicaid Adjustments
(QDWI)	• 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	

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. 31, 09-05-03)

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. The Renal Beneficiary Utilization (REBUS) System 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, REBUS 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).

60.5 - Processing of Working Aged Retroactive Adjustments

(Rev. 31, 09-05-03)

Health Status Description

A beneficiary, who has Part A, receives the working aged status when the beneficiary or their spouse is employed and the beneficiary receives medical benefits from the employer. The employers medical insurance pays as the primary insurer and Medicare pays as the secondary payer (MSP), therefore the capitation rate is less than the normal Medicare rate. Additionally, some situations occur when Medicare is not the primary insurer, but these are incident related and do not affect the beneficiary's status. For specific criteria for Medicare to be the Secondary Payer, refer to CMS Pub. 100-5, Medicare Secondary Payer **.**

General Information about the Working Aged Payment Process and General Guidelines for all transactions.

The primary sources of the information are the Social Security Administration/IRS Data Match, the Initial Enrollment Questionnaire that the beneficiary completes when first eligible for Medicare, the beneficiary's employer insurance company, the beneficiary themselves, the M+C organization enrollment application, or the annual survey.

The M+C organization is responsible for obtaining the most accurate information possible concerning the working aged status of the beneficiary. There are a variety of sources that the M+C organization should use to validate the beneficiary's working aged status. These include:

- A survey that M+C organizations require beneficiaries to complete annually;
- MSP screens shown in the CMS' Common Working File;

- Data provided by the insurance company providing primary coverage; and
- Data provided by the beneficiary's employer, etc.

A copy of the survey is attached. (If an M+C organization chooses to develop its own Working Aged Survey, the appropriate CMS Regional Office must approve it.)

Once the M+C organization has validated the working aged start and stop dates, the M+C organization submits working aged transactions to the CMS via electronic transfer using the CMS' Managed Care On-line System (McCoy) or CMS' vendor, Acxiom Computer Services.

Through an automated process, the CMS systems edit the transactions to ensure that all fields are completed and match the beneficiary data residing in the Group Health Plan System (GHP). Incorrect transactions are rejected and returned to the M+C organization with a code "U" (unacceptable) via McCoy or the Working Aged Status Report, a TSO monthly report. The M+C organization must correct and resubmit these transactions. Acceptable transactions are forwarded to General Health Inc. (GHI), a contractor who has been retained by CMS to validate the working aged information and submit the data to the CMS' Common Working File. (GHI can be contacted at 1-800-999-1118). The GHI reviews each transaction to ensure that the M+C organization has the authority to make the change; the beneficiary meets the working aged requirements, etc. If the termination date is within 6 months of the date that the SSA/IRS data match transaction occurred, the M+C organization cannot submit a change. The M+C organization can determine this by reviewing the transaction reply report.

The CMS Common Working File (CWF) transmits the working aged status to the CMS' managed care payment systems monthly.

Each working aged transaction submitted electronically by an M+C organization receives a status. Possible statuses received for plan-submitted working aged transactions in McCoy are: N, U, G, S, P, A, and R. Please refer to the Plan Communications Users Guide for a description of these status codes. Statuses of all transactions submitted appear in the McCOY Working Aged screens, and the Working Aged Transaction Status Report.

Documentation Required to Place a Beneficiary in Working Aged Status

- Beneficiary Name;
- Health Insurance Claim Number;
- Source of working aged period includes one or more of the following:
    - Survey completed by the beneficiary;
    - Initial Enrollment Questionnaire;

- Document reflecting insurance coverage from an employer, insurance company; etc.
- Record of telephone conversation with the individual, employer or insurer that includes:
    - Beneficiary's Name;
    - Beneficiary's Health Insurance Claim Number;
    - Date of conversation;
    - Person contacted;
    - Relationship to the beneficiary;
    - Date insurance coverage began; and/or
    - Date insurance coverage terminated.

- Access to a copy of the Working Aged HUSP record that is submitted through McCoy (Reference Plan Communication Guide Appendix C: Record Layouts); and
- General Guidelines for M+C organizations processing working aged adjustments.

The M+C organizations may enter working aged status adjustments for any period of time.

Payment will be limited to the 36 months previous to the system interface date, which is the date the transaction is processed in GHP for payment. This may be as long as two months after the M+C organization enters the transaction into McCOY or submits the request to GHI.

The M+C organization should never submit duplicate working aged transactions 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 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 health status, the period involved, and the date the original adjustment(s) was submitted.

Retro-Processing Contractor Review and Processing of the Request

The Retro-Processing Contractor does not have a role in processing Working Aged transactions.

Any requests related to Working Aged adjustments received by the RO or the Retro-processing Contractor, will be forwarded to the appropriate DEPO Health Insurance Specialist for your RO.

Sources provided to M+C organization's to assist with the updating of Working Aged are accessible through the CMS Web site at http://cms.hhs.gov/healthplans/systems.

60.6 - Standard Operating Procedures for Retroactive Adjustment of Plan Elections

(Rev. 31, 09-05-03)

(Enrollments, Disenrollments, and Plan Benefit Package (PBP) Changes)

This SOP applies to retroactive enrollments, disenrollments and Plan Benefit Package (PBP) changes involving all types of Medicare Managed Care Organizations (MCOs) and Demonstration project sites. This includes Cost-Based Health Maintenance Organizations (HMOs), 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-Based HMOs 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 (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, disenrollment or change in PBP, included in Chapter 2 of 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 to Retroactively Enroll, Disenroll, or Change a PBP for a Beneficiary

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 PBP changes and for enrollments on or after 6/1/2002. PBP#s are not required for disenrollments;
- Beneficiary Name and Claim Number; and
- Verification of enrollment, change in PBP, or disenrollment including 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 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 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, Plan Benefit Package Changes, and Disenrollments

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, Disenrollment, and Plan Benefit Package change requests are not eligible for the PROBE Studies. Copies of supporting documentation as 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
10040 Regency Circle
Suite 260
Omaha, Nebraska 68114
Phone: 402-955-2781

CMS
Div. of Enrollment and Payment Operations
Mail stop C1-05-08
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Phone: 410-786-1125

70 - CMS, SSA, and Customer Service Center Disenrollments

(Rev. 31, 09-05-03)

70.1 - General

(Rev. 31, 09-05-03)

A Medicare beneficiary may use a neutral third party to disenroll from a MCO, e.g., an SSA field office (SSAFO).

- The beneficiary will complete Form CMS-566 (Exhibit F1).
- The SSAFO will give the beneficiary a copy and send one to the CMS RO.

70.2 - Medicare Customer Service Center Disenrollments

(Rev. 31, 09-05-03)

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

70.3 - CMS Disenrollments

(Rev. 31, 09-05-03)

The CMS will initiate a disenrollment for different reasons, e.g., death of member, termination of Part A and/or Part B entitlement, the beneficiary is found to have ESRD prior to enrollment.

The effective date of the disenrollment will be the first day of the month after the month the beneficiary died or in which Part A or Part B entitlement was terminated. In the case of ESRD, the system will cancel the enrollment. This information will be documented in CMS' Monthly Membership Report.

80 - Coordination With the Medicare Fee-For-Service (FFS) Program

(Rev. 31, 09-05-03)

80.1 - Interface Between Medicare FFS and Medicare Managed Care Programs

(Rev. 31, 09-05-03)

Eligibility, utilization, and payment records for all beneficiaries are maintained in computer files at nine host sites throughout the United States. Generally, beneficiary records are retained at the host site nearest the beneficiary's residence. These files are routinely updated in CMS' Medicare claims processing activities. Information about the Medicare beneficiary's membership in a Medicare managed care MCO is supplied to the fee-for-service (FFS) claims processing system by the GHP system. Note the FFS claims processing system will only approve for payment claims for members of cost-based MCOs

80.2 - Pro-Rata Deductible

(Rev. 31, 09-05-03)

Beneficiaries enrolled in Medicare managed care MCOs will have their records credited by a national actuarial equivalent of the $100, Part B deductible.

The pro-rata deductible is posted monthly to beneficiary records until the current year's Part B deductible is satisfied, usually by the end of March of each year.

80.3 - Duplicate Payment Prevention by Cost-Based MCOs

(Rev. 31, 09-05-03)

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 should 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.

Exhibit A: Transaction Reply/Monthly Activity Report

*

1RUN DATE: 04/16/2002 TRANSACTION REPLIES/MONTHLY ACTIVITY REPORT ID:
10
REPORTING MONTH: 05/2002 PLAN: H0XXX THE HEALTH PLAN, INC. PAGE: 1
* * * PLAN-SUBMITTED TRANSACTIONS: ACCEPTED * * *
---------- T R A N S A C T I O N R E P L Y ----------

TC	CLAIM NUMBER	SURNAME	F I	S E X	DATE OF BIRTH	EFF DATE	SCC	SCC IND	SRCE ID	RPLY CODE	P B P	-AAPCC PT A	RATE- PT B	SPECIAL STATUS	REMARKS
61	WA000000	WELBORN	A	F	04/05/06	05/01/02	01360		H0XXX	011	001	.00	.00		
61	WA000000	TELLIS	L	F	09/24/18	05/01/02	01360		H0XXX	011	002	.00	.00		
61	A000000000	BURNETT	F	F	10/12/05	05/01/02	01360		H0XXX	011	003	.00	.00		
61	A000000000	FENNOY	V	M	01/06/08	05/01/02	01480		H0XXX	011	004	.00	.00		
61	A000000000	MIMS	L	M	12/24/30	05/01/02	01360		H0XXX	011	005	.00	.00		
61	MA000000000	MIMS	E	F	09/22/29	05/01/02	01360		H0XXX	011	006	.00	.00		
51	A000000000	LEWIS J	A	M	03/26/50	04/30/02	01360		H0XXX	013	007	.00	.00		
51	A000000000	STOTT	E	F	03/03/31	03/31/02	01360		H0XXX	013	008	.00	.00		
51	A000000000	STOKES	R	M	06/19/31	03/31/02	01360		H0XXX	013	009	.00	.00		
51	MA000000000	STOKES	M	F	04/13/35	03/31/02	01360		H0XXX	013	010	.00	.00		
51	WA000000000	BANKS	E	F	10/28/08	04/30/02	01360		H0XXX	013	011	.00	.00		
51	000000000A	RAYNES	C	M	04/29/27	04/30/02	01580		H0XXX	013	012	.00	.00		
51	000000000A	ODGERS	M	F	04/10/31	04/30/02	01360		H0XXX	013	013	.00	.00		
51	000000000A	ODGERS	M	F	04/10/31	03/31/02	01360		H0XXX	014	014	.00	.00		ENR IN OTHER PLAN
51	000000000A	HANILY	M	F	09/08/08	04/30/02	01360		H0XXX	013	015	.00	.00		
51	000000000A	BEAN	S	M	03/05/34	03/31/02	01360		H0XXX	013	016	.00	.00	W	
51	000000000A	BRAINAR	M	F	10/02/30	03/31/02	33080		H0XXX	013	017	.00	.00		
51	000000000A	WHITTEN	G	F	10/16/24	04/30/02	01360		H0XXX	014	018	.00	.00		ENR IN OTHER PLAN
51	000000000A	THORNTO	J	M	02/27/34	04/30/02	46170		H0XXX	013	019	.00	.00		
51	100000000D	MUSALL	O	F	06/13/14	04/30/02	01360		H0XXX	013	020	.00	.00		
51	100000000A	SATTERW	D	F	01/28/35	04/30/02	01360		H0XXX	013	021	.00	.00		
51	100000000A	SATTERW	D	F	01/28/35	03/31/02	01360		H0XXX	014	022	.00	.00		ENR IN OTHER PLAN
51	100000000A	HUDSON	M	F	12/16/18	03/31/02	01360		H0XXX	013	023	.00	.00		
51	100000000A	ATKINSO	H	M	12/26/13	03/31/02	01360		H0XXX	014	024	.00	.00		ENR IN OTHER PLAN
51	200000000A	HOOD	B	F	08/26/17	04/30/02	01360		H0XXX	013	025	.00	.00		
51	200000000A	HUNSING	R	M	01/15/29	04/30/02	01570		H0XXX	013	026	.00	.00		
51	200000000A	CATES	R	M	03/29/20	03/31/02	01360		H0XXX	013	027	.00	.00		
51	200000000A	WINSLET	C	M	04/16/16	04/30/02	01360		H0XXX	013	028	.00	.00		
51	200000000A	WOOD JR	C	M	08/26/25	04/30/02	01360		H0XXX	013	029	.00	.00		
51	200000000A	DEUTSCH	M	F	11/25/17	04/30/02	01630		H0XXX	013	030	.00	.00		
51	200000000D2	MACKLIN	P	F	07/25/30	04/30/02	01360		H0XXX	013	031	.00	.00		

* * * PLAN-SUBMITTED TRANSACTIONS: REJECTED * * *

T R A N S A C T I O N R E P L Y

TC	CLAIM NUMBER	SURNAME	F I	S E X	DATE OF BIRTH	EFF DATE	SCC	SCC IND	SRCE ID	RPLY CODE	P B P	-AAPCC PT A	RATE- PT B	SPECIAL STATUS	REMARKS
51	A000000000	MCCLOY	E	M	06/20/24	04/30/02	05440		H0XXX	050	875	.00	.00		
51	000000001D	DIXON	B	F	07/12/31	04/30/02	01360		H0XXX	050	876	.00	.00	M	
51	000000000A	SCOTT	J	F	08/10/29	04/30/02	01360		H0XXX	052	877	.00	.00		DUPLICATE TRANSACT
51	000000000A	BRADBER	E	M	09/28/24	03/31/02	01360		H0XXX	052	878	.00	.00		DUPLICATE TRANSACT
51	400000000A	TUCKER	R	F	02/17/23	04/30/02	01360		H0XXX	050	879	.00	.00		
51	400000000A	KENT	M	F	04/08/34	04/30/02	01360		H0XXX	050	880	.00	.00		
51	400000000D	ALLEN	C	F	07/04/17	04/30/02	01360		H0XXX	052	881	.00	.00		DUPLICATE TRANSACT
51	400000000A	HOOVER	J	M	02/28/32	04/30/02	01360		H0XXX	052	882	.00	.00		DUPLICATE TRANSACT
51	400000000A	ALLISON	B	F	08/08/16	04/30/02	01360		H0XXX	050	883	.00	.00		
51	400000000A	GOLDSBY	C	F	05/31/29	04/30/02	01360		H0XXX	052	884	.00	.00		DUPLICATE TRANSACT
51	400000000A	RODGERS	S	F	10/28/16	03/31/02	01360		H0XXX	052	885	.00	.00		DUPLICATE TRANSACT
51	400000000A	SEWELL	B	F	08/04/30	03/31/02	01360		H0XXX	050	886	.00	.00		

* * * PLAN-SUBMITTED WA TRANSACTIONS: PENDING * * *

T R A N S A C T I O N R E P L Y

TC	CLAIM NUMBER	SURNAME	F I	S E X	DATE OF BIRTH	EFF DATE	SCC	SCC IND	SRCE ID	RPLY CODE	P B P	-AAPCC PT A	RATE- PT B	SPECIAL STATUS	REMARKS

NO TRANSACTIONS FOUND FOR THIS SECTION

* * * REGIONAL OFFICE 00 - SUBMITTED TRANSACTIONS * * *

T R A N S A C T I O N R E P L Y

TC	CLAIM NUMBER	SURNAME	F I	S E X	DATE OF BIRTH	EFF DATE	SCC	SCC IND	SRCE ID	RPLY CODE	P B P	-AAPCC PT A	RATE- PT B	SPECIAL STATUS	REMARKS
51	A000000000	BREWER	H	M	03/19/30	02/28/02	01360		REG 00	013	893	.00	.00		
51	A000000000	MCCLOY	E	M	06/20/24	02/28/02	05440		REG 00	013	894	.00	.00		
01	000000000A	LIBERMA	B	M	08/14/26	12/31/01	01360		REG 00	084		.00	.00		DISENROLL DATE CHG
01	400000000B6	DICKSON	V	F	11/24/27	05/31/01	01360		REG 00	084		.00	.00		DISENROLL DATE CHG
01	400000000D	SWAFFOR	I	F	01/02/09	01/31/02	01360		REG 00	084		.00	.00		DISENROLL DATE CHG
01	400000000A	SMITH	J	M	10/04/24	01/31/02	01360		REG 00	014		.00	.00		ENR IN OTHER PLAN
01	400000000D	EDMONSO	D	F	06/23/23	12/31/01	01360		REG 00	084		.00	.00		DISENROLL DATE CHG
01	400000000A	RAY	J	M	11/17/22	12/31/01	01360		REG 00	084		.00	.00		DISENROLL DATE CHG
01	400000000A	LEWIS	J	F	12/14/27	12/31/01	01360		REG 00	084		.00	.00		DISENROLL DATE CHG

* * AUTOMATIC DISENROLLMENTS* *

T R A N S A C T I O N R E P L Y

TC	CLAIM NUMBER	SURNAME	FI	SEX	DATE OF BIRTH	EFF DATE	PBP	-AAPCC PT A	RATE- PT B	SPECIAL STATUS	REMARKS
01	000000000D	DIXON	B	F	07/12/31	03/31/02		.00	.00	M	REPORT OF DEATH
01	000000000D	GRAINGE	G	F	10/14/17	03/31/02		.00	.00		REPORT OF DEATH
01	000000000A	BRADBER	E	M	09/28/24	03/31/02		.00	.00		REPORT OF DEATH
01	000000000A	TUCKER	R	F	02/17/23	02/28/02		.00	.00		REPORT OF DEATH
01	000000000A	GOODWIN	I	F	11/25/33	02/28/02		.00	.00	H	REPORT OF DEATH

* * * MAINTENANCE ACTIONS * * *

T R A N S A C T I O N R E P L Y

TC	CLAIM NUMBER	SURNAME	FI	SEX	DATE OF BIRTH	EFF DATE	PBP	-AAPCC PT A	RATE- PT B	SPECIAL STATUS	REMARKS
01	A000000000	EVANS	A	M	01/22/11	02/25/02		11.76	.00	H	HOSPICE STATUS SET
01	A000000000	EVANS	A	M	01/22/11	05/25/02		11.76	.00	H	HOSPICE TERMINATED
01	100000000A	ATKINSO	H	M	12/26/13	05/01/86		454.48	329.64	W	WA CANCELLED
01	100000000A	ATKINSO	H	M	12/26/13	05/01/86		454.48	329.64	W	WA STATUS SET
01	100000000A	ATKINSO	H	M	12/26/13	08/06/01		454.48	329.64	W	WA STATUS TERMINATED

PLAN: H0XXX THE HEALTH PLAN, INC.

* * * TRANSACTION REPLY SUMMARY * * *

	TC 71	TC 60	TC 61	TC 51	TC 53	TC 54	TC 30	TC 31	TC 32	TC 01	ALL	
ACCEPTED ACTN		0	0	0	861	0	0	0	0	0	13	874
REJECTED ACTN		0	0	0	18	0	0	0	0	0	0	18
REPLY 001:		0	0	0	0	0	0	0	0	0	0	0
REPLY 002:		0	0	0	0	0	0	0	0	0	0	0
REPLY 003:		0	0	0	0	0	0	0	0	0	0	0
REPLY 004:		0	0	0	0	0	0	0	0	0	0	0
REPLY 005:		0	0	0	0	0	0	0	0	0	0	0
REPLY 006:		0	0	0	0	0	0	0	0	0	0	0
REPLY 007:		0	0	0	0	0	0	0	0	0	0	0
REPLY 008:		0	0	0	0	0	0	0	0	0	0	

PLAN: H0XXX THE HEALTH PLAN, INC.

* * * TRANSACTION REPLY SUMMARY * * *

AUTOMATIC DISENROLLMENTS	TOTALS
PART B TERMINATION	0
PART A REQUIRED - TERMINATION	0
REPORT OF BENEFICIARY DEATH	12
TERMINATION OF CONTRACT (HCFA)	0
TERMINATION OF CONTRACT (PLAN)	0
UNRESOLVED SERVICE AREA DISCREPANCY	0
BENE DOES NOT MEET AGE CRITERION	0
ROLLOVER	0
* * * TOTAL * * *	12

Exhibit B: Plan Payment Reports - M+C and Cost

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                                        CMS PLAN PAYMENT REPORT
PLAN NUMBER: H9999      RUN DATE: 09/21/2000      PAYMENT DATE: 10/2000

PLAN NAME: XXXXXXXXXXXXXXXXXX
1. DEMOGRAPHIC REPORT PAYMENT:
                              MEMBERS:    14,270......$      7,016,498.13
2. ENROLLMENT ADJUSTMENTS TO PRIOR MONTHS:
   A. DEATH OF BENEFICIARY.....COUNT:        34......$        -21,007.02
   B. RETROACTIVE ACCRETION....COUNT:        53......$         44,933.87
   C. RETROACTIVE DELETION.....COUNT:        46......$        -25,395.40
   D. CORRECTION TO ACCRETION..COUNT:         2......$          5,312.05
   E. CORRECTION TO DELETION...COUNT:         1......$         -1,652.16
   F. PART A ENTITLEMENT LOSS..COUNT:         0......$              0.00
   G. CORRECTION TO DEATH......COUNT:         0......$              0.00
   H. CORRECTION TO BIRTH......COUNT:         0......$              0.00
   I. CORRECTION TO SEX........COUNT:         0......$              0.00
   J. RETRO SCC................COUNT:         0......$              0.00
   K. GRH......................COUNT:         0......$              0.00
   L. AAPCC....................COUNT:         0......$              0.00
   M. CORRECTION TO PART A ENT.COUNT:         1......$           -292.58
   N. CORRECTION TO PART B ENT.COUNT:         1......$           -229.37
   O. RETRO DELETE DUE TO ESRD.COUNT:         0......$              0.00
3. HEALTH STATUS ADJUSTMENTS TO PRIOR MONTHS:
   A. MEDICAID.................COUNT:         1......$              0.00
   B. HOSPICE..................COUNT:        15......$         -7,200.78
   C. ESRD.....................COUNT:         1......$              0.00
   D. WORKING AGED.............COUNT:         6......$         -4,460.81
4. PLAN ADJUSTMENTS:
5. CHPP ADJUSTMENTS:
                                                          ===============
6. NET PAYMENT.......................................$      7,006,505.93
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CMS PLAN PAYMENT REPORT

PLAN NUMBER: H9999 RUN DATE: 09/21/2000 PAYMENT DATE: 10/2000

PLAN NAME: XXXXXXXXXXXXXXXXX

1. CALCULATED MONTHLY PAYMENT: PART A MEMBERS: 662 @ $ 0.00 = $ 0.00
   PART B MEMBERS: 703 @ $ 221.00 = $ 155,363.00

2. ENROLLMENT ADJUSTMENTS TO PRIOR MONTHS:

A. DEATH OF BENEFICIARY.....COUNT:	3.....$	-663.00	
B. RETROACTIVE ACCRETION....COUNT:	0.....$	0.00	
C. RETROACTIVE DELETION.....COUNT:	2.....$	-442.00	
D. CORRECTION TO ACCRETION..COUNT:	0.....$	0.00	
E. CORRECTION TO DELETION...COUNT:	0.....$	0.00	
F. PART A ENTITLEMENT LOSS..COUNT:	0.....$	0.00	
G. CORRECTION TO DEATH.....COUNT:	0.....$	0.00	
H. CORRECTION TO BIRTH.....COUNT:	0.....$	0.00	
I. CORRECTION TO SEX.....COUNT:	0.....$	0.00	
J. RETRO SCC.....COUNT:	0.....$	0.00	
K. GRH.....COUNT:	0.....$	0.00	
L. AAPCC.....COUNT:	0.....$	0.00	
M. CORRECTION TO PART A ENT.COUNT:	0.....$	0.00	
N. CORRECTION TO PART B ENT.COUNT:	0.....$	0.00	
O. RETRO DELETE DUE TO ESRD.COUNT:	0.....$	0.00	

3. CHPP ADJUSTMENTS:

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4. NET PAYMENT.....$ 154,258.00

Exhibit C: Demographic Report

DEMOGRAPHIC REPORT FOR HMO xxxx 102000 OPERATING MONTH
ST/CTY CODE 01360

PART A ENTITLEMENT - MALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	6	4784.03	228	96642.43	1	263.33
80-84	0	0.00	7	5063.32	429	161650.24	9	2119.77
75-79	0	0.00	13	7666.80	814	266756.24	29	5932.25
70-74	0	0.00	28	13258.29	1308	347360.81	71	9391.34
65-69	0	0.00	20	7289.23	1053	215213.40	49	5749.66
60-64	0	0.00	6	2518.22	124	28541.51	0	0.00
55-59	0	0.00	2	729.93	111	22076.92	0	0.00
45-54	0	0.00	17	5201.27	111	16731.88	0	0.00
35-44	0	0.00	7	1890.21	32	5062.09	0	0.00
- 35	0	0.00	3	727.56	11	1471.91	0	0.00

PART A ENTITLEMENT - FEMALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	68	43718.58	549	207268.32	3	700.95
80-84	0	0.00	42	22231.76	659	217025.09	7	1429.62
75-79	0	0.00	67	30253.60	1088	290042.19	29	4707.79
70-74	0	0.00	101	33594.31	1670	364900.80	57	7558.67
65-69	0	0.00	65	16458.06	1472	254366.46	35	3589.87
60-64	0	0.00	17	6041.35	98	29109.19	0	0.00
55-59	0	0.00	13	4015.76	72	15546.40	0	0.00
45-54	0	0.00	25	6877.14	87	15426.25	0	0.00
35-44	0	0.00	8	2202.06	19	2622.36	0	0.00
- 35	0	0.00	3	787.77	4	493.48	0	0.00

DEMOGRAPHIC REPORT FOR HMO xxxx 102000 OPERATING MONTH
ST/CTY CODE 01360 (CONT)

PART B ENTITLEMENT - MALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	6	2487.33	228	64073.70	1	223.17
80-84	0	0.00	7	2886.13	429	119096.50	9	1817.27
75-79	0	0.00	13	4736.24	814	213064.52	29	5168.43
70-74	0	0.00	28	9238.26	1309	294614.56	71	10271.92
65-69	0	0.00	20	5363.96	1053	199127.05	49	4930.83
60-64	0	0.00	6	1703.22	124	22953.69	0	0.00
55-59	0	0.00	2	510.18	111	16627.51	0	0.00
45-54	0	0.00	17	3926.73	111	13112.19	0	0.00
35-44	0	0.00	7	1533.64	32	3429.73	0	0.00
- 35	0	0.00	3	614.94	11	953.92	0	0.00

PART B ENTITLEMENT - FEMALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	68	20892.21	549	134816.30	3	568.79
80-84	0	0.00	42	12909.54	659	151826.01	7	1169.64
75-79	0	0.00	67	20246.55	1088	245723.82	29	4547.30
70-74	0	0.00	101	27919.29	1670	333837.78	57	7021.85
65-69	0	0.00	65	16135.57	1472	242760.11	35	3126.63
60-64	0	0.00	17	5090.04	98	22816.42	0	0.00
55-59	0	0.00	13	3383.95	72	14368.58	0	0.00
45-54	0	0.00	25	6013.14	87	16011.95	0	0.00
35-44	0	0.00	8	1785.17	19	3040.50	0	0.00
- 35	0	0.00	3	587.46	4	556.60	0	0.00

TOTAL CRD-A.....0000031 TOTAL MONEY.....$ 40745.78 TOTAL CRD-B.....0000031 TOTAL MONEY...$ 68622.84
TOTAL HOSPICE A.0000017 TOTAL MONEY.....$ 1923.38 TOTAL HOSPICE B.0000017 TOTAL MONEY...$ 0.00
TOTAL MEMBER-A..0010795 TOTAL-A MONEY...$ 2857729.63 PTA AAPCC....$ 264.73
TOTAL MEMBER-B..0010796 TOTAL-B MONEY...$ 2368243.66 PTB AAPCC....$ 219.36

DEMOGRAPHIC REPORT FOR HMO xxxx 102000 OPERATING MONTH
ST/CTY CODE 99999

PART A ENTITLEMENT - MALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	0	0.00	2	780.47	0	0.00
80-84	0	0.00	1	663.47	7	2433.49	0	0.00
75-79	0	0.00	0	0.00	9	2746.39	1	211.20
70-74	0	0.00	1	363.33	12	2931.49	1	135.36
65-69	0	0.00	1	357.16	22	4299.25	1	120.62
60-64	0	0.00	2	866.73	6	1271.31	0	0.00
55-59	0	0.00	1	431.43	8	1494.39	0	0.00
45-54	0	0.00	0	0.00	4	683.87	0	0.00
35-44	0	0.00	1	248.79	3	464.01	0	0.00
- 35	0	0.00	0	0.00	0	0.00	0	0.00

PART A ENTITLEMENT - FEMALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	0	0.00	7	2569.15	1	204.36
80-84	0	0.00	0	0.00	5	1368.16	0	0.00
75-79	0	0.00	3	1337.27	11	2788.83	0	0.00
70-74	0	0.00	2	638.57	12	2562.49	1	134.50
65-69	0	0.00	5	1333.99	19	3053.73	2	210.01
60-64	0	0.00	0	0.00	5	1416.44	0	0.00
55-59	0	0.00	0	0.00	2	476.90	0	0.00
45-54	0	0.00	0	0.00	1	170.56	0	0.00
35-44	0	0.00	0	0.00	3	440.73	0	0.00
- 35	0	0.00	0	0.00	0	0.00	0	0.00

DEMOGRAPHIC REPORT FOR HMO xxxx 102000 OPERATING MONTH
ST/CTY CODE 99999 (CONT)

PART B ENTITLEMENT - MALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	0	0.00	2	516.72	0	0.00
80-84	0	0.00	1	375.74	7	1792.05	0	0.00
75-79	0	0.00	0	0.00	9	2193.14	1	184.04
70-74	0	0.00	1	251.52	12	2483.89	1	148.12
65-69	0	0.00	1	262.33	22	3977.50	1	103.48
60-64	0	0.00	2	590.53	6	1023.07	0	0.00
55-59	0	0.00	1	300.72	8	1124.55	0	0.00
45-54	0	0.00	0	0.00	4	535.27	0	0.00
35-44	0	0.00	1	202.00	3	313.20	0	0.00
- 35	0	0.00	0	0.00	0	0.00	0	0.00

PART B ENTITLEMENT - FEMALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	0	0.00	7	1670.29	1	165.79
80-84	0	0.00	0	0.00	5	955.73	0	0.00

75-79	0	0.00	3	893.38	11	2360.35	0	0.00
70-74	0	0.00	2	531.37	12	2339.42	1	125.12
65-69	0	0.00	5	1291.43	19	2907.77	2	182.96
60-64	0	0.00	0	0.00	5	1110.17	0	0.00
55-59	0	0.00	0	0.00	2	441.58	0	0.00
45-54	0	0.00	0	0.00	1	179.47	0	0.00
35-44	0	0.00	0	0.00	3	496.65	0	0.00
- 35	0	0.00	0	0.00	0	0.00	0	0.00

TOTAL CRD-A.....0000000 TOTAL MONEY.....$ 0.00 TOTAL CRD-B.....0000000 TOTAL MONEY...$ 0.00

TOTAL HOSPICE A.0000001 TOTAL MONEY.....$ 113.14 TOTAL HOSPICE B.0000001 TOTAL MONEY...$ 0.00

TOTAL MEMBER-A..0000163 TOTAL-A MONEY...$ 39321.59 PTA AAPCC....$ 241.24

TOTAL MEMBER-B..0000163 TOTAL-B MONEY...$ 32029.35 PTB AAPCC....$ 196.50

DEMOGRAPHIC REPORT FOR HMO xxxx 102000 OPERATING MONTH

PART A ENTITLEMENT - MALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	10	8439.18	283	122563.93	1	263.33
80-84	0	0.00	12	8765.07	541	207696.14	10	2406.91
75-79	0	0.00	20	12273.06	1007	337206.25	32	6580.22
70-74	0	0.00	44	21051.30	1666	452463.33	84	11331.22
65-69	0	0.00	41	15292.68	1461	307328.71	66	8034.96
60-64	0	0.00	23	10183.41	240	56607.08	0	0.00
55-59	0	0.00	12	4560.70	206	41452.20	0	0.00
45-54	0	0.00	34	10318.86	218	33378.95	0	0.00
35-44	0	0.00	13	3599.86	59	9454.66	0	0.00
- 35	0	0.00	5	1218.90	14	1939.62	0	0.00

PART A ENTITLEMENT - FEMALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	94	62422.68	681	261806.40	4	905.31
80-84	0	0.00	60	32585.59	814	272612.90	8	1646.69
75-79	0	0.00	97	44889.72	1400	381359.94	32	5255.34
70-74	0	0.00	135	45931.44	2076	463429.95	69	9313.01
65-69	0	0.00	104	27276.33	1918	339195.47	45	4717.98
60-64	0	0.00	33	12032.88	176	53374.37	0	0.00
55-59	0	0.00	23	7367.69	115	25335.18	0	0.00
45-54	0	0.00	44	12385.48	127	22897.32	0	0.00
35-44	0	0.00	14	3920.08	33	4668.56	0	0.00
- 35	0	0.00	4	1056.27	6	745.78	0	0.00

DEMOGRAPHIC REPORT FOR HMO xxxx 102000 OPERATING MONTH

PART B ENTITLEMENT - MALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	10	4386.98	283	81280.79	1	223.17
80-84	0	0.00	12	4986.25	541	153011.28	10	2063.66
75-79	0	0.00	20	7600.58	1007	269332.61	32	5732.79
70-74	0	0.00	44	14657.14	1667	383684.20	84	12391.69
65-69	0	0.00	41	11246.59	1461	284308.31	66	6889.78
60-64	0	0.00	23	6904.64	240	45520.25	0	0.00
55-59	0	0.00	12	3184.77	206	31217.94	0	0.00
45-54	0	0.00	34	7784.97	218	26158.47	0	0.00
35-44	0	0.00	13	2919.81	59	6397.54	0	0.00
- 35	0	0.00	5	1030.54	14	1264.32	0	0.00

PART B ENTITLEMENT - FEMALE

AGE GROUP	INST		MEDICAID		NON MEDICAID		WORKING AGED	
85 +	0	0.00	94	29852.14	681	170277.47	4	734.58
80-84	0	0.00	60	18896.68	814	190690.47	8	1347.22
75-79	0	0.00	97	30043.81	1400	323105.25	32	5075.69
70-74	0	0.00	135	38173.10	2076	423868.31	69	8651.28
65-69	0	0.00	104	26691.18	1918	323746.95	45	4108.05
60-64	0	0.00	33	10134.86	176	41835.88	0	0.00
55-59	0	0.00	23	6206.89	115	23394.76	0	0.00
45-54	0	0.00	44	10818.00	127	23760.03	0	0.00
35-44	0	0.00	14	3178.65	33	5397.72	0	0.00
- 35	0	0.00	4	787.68	6	841.14	0	0.00

TOTAL CRD-A.....0000036 TOTAL MONEY.....$ 47317.68 TOTAL CRD-B.....0000036 TOTAL MONEY...$ 79691.04

TOTAL HOSPICE A.0000019 TOTAL MONEY.....$ 2149.66 TOTAL HOSPICE B.0000019 TOTAL MONEY...$ 0.00

TOTAL MEMBER-A..0014269 TOTAL-A MONEY...$ 3841010.23 PTA AAPCC....$ 269.19

TOTAL MEMBER-B..0014270 TOTAL-B MONEY...$ 3175487.90 PTB AAPCC....$ 222.53

NET REIMBURSEMENT TO 0150 $ 7016498.13 FOR 14270 MEMBERS AVG. PAYMENT RATE $ 491.70

Exhibit D: Bill Itemization and Summary Reports

PART A BILLS POSTED IN AUG 2000 PAGE 1

* * * * * HMO H9999 * * * * *

BILL TYPE: INPATIENT

CLAIM NUM	NAME	PROV	HMO INTER PD	ADM DATE	TOTAL CHARGES	NON-COV CHARGES	INP DED	NC BLD DEDUCT	DAYS	COINSURANCE CHGS	AMOUNT	TOTAL DEDUCT	FROM DATE	THRU DATE	COV DAYS	REIM AMT	NP CD	CR
999999999A	XXXXXX	999999	99999	20000718	1065	1065	0	0	0	0	0	0	20000718	20000720	0	0	N	
999999999A	XXXXXX	999999	99999	20000205	34974	34974	0	0	0	0	0	0	20000205	20000223	0	0	N	

BILL TYPE: HOSPICE

CLAIM NUM	NAME	PROV	HMO INTER	PD	ADM DATE	TOTAL CHARGES	NON-COV CHARGES	INP DED	NC BLD DEDUCT	COINSURANCE DAYS	CHGS	AMOUNT	TOTAL DEDUCT	FROM DATE	THRU DATE	COV DAYS	REIM AMT	NP CD	CR
999999999A	XXXXXX	999999	99999		20000503	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999D	XXXXXX	999999	99999		20000711	2031	0	0	0	0	0	0	0	20000711	20000731	0	2031		
999999999A	XXXXXX	999999	99999		20000727	483	0	0	0	0	0	0	0	20000727	20000731	0	483		
999999999D	XXXXXX	999999	99999		20000605	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000425	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000627	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999B	XXXXXX	999999	99999		20000423	2901	0	0	0	0	0	0	0	20000601	20000630	0	2901		
999999999D	XXXXXX	999999	99999		20000623	773	0	0	0	0	0	0	0	20000701	20000708	0	773		
999999999A	XXXXXX	999999	99999		20000607	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000509	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000630	870	0	0	0	0	0	0	0	20000701	20000709	0	870		
999999999A	XXXXXX	999999	99999		20000504	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000720	1160	0	0	0	0	0	0	0	20000720	20000731	0	1160		
999999999D	XXXXXX	999999	99999		20000712	1934	0	0	0	0	0	0	0	20000712	20000731	0	1934		
999999999D	XXXXXX	999999	99999		20000428	2134	0	0	0	0	0	0	0	20000701	20000725	0	2134		
999999999A	XXXXXX	999999	99999		20000615	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000518	5430	0	0	0	0	0	0	0	20000701	20000731	0	5429		
999999999A	XXXXXX	999999	99999		20000616	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000608	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000623	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000518	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000707	1548	0	0	0	0	0	0	0	20000707	20000723	0	1548		
999999999D	XXXXXX	999999	99999		20000604	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999D	XXXXXX	999999	99999		20000527	2646	0	0	0	0	0	0	0	20000701	20000731	0	2646		
999999999A	XXXXXX	999999	99999		20000426	2901	0	0	0	0	0	0	0	20000601	20000630	0	2901		
999999999D	XXXXXX	999999	99999		20000712	1934	0	0	0	0	0	0	0	20000712	20000731	0	1934		
999999999A	XXXXXX	999999	99999		20000511	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999D	XXXXXX	999999	99999		20000524	386	0	0	0	0	0	0	0	20000701	20000704	0	386		
999999999A	XXXXXX	999999	99999		20000617	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000613	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		
999999999A	XXXXXX	999999	99999		20000105	2805	0	0	0	0	0	0	0	20000201	20000229	0	2805		
999999999B	XXXXXX	999999	99999		20000701	2998	0	0	0	0	0	0	0	20000701	20000731	0	2998		

MONTHLY SUMMARY OF BILLS PAID BY INTERMEDIARIES FOR HMO ENROLLEES

HMO NO Hxxxx HMO NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX HMO FY ENDING 12/2000 CURRENT MONTH 08/2000
BILLS THROUGH 08/25/2000

	INPATIENT BILLS					OUTPATIENT BILLS			HHA BILLS			
	TOTAL CHARGES	NON COVERED CHARGES	REIMB AMOUNT	COVERED DAYS	TOTAL BILLS	COVERED CHARGES	REIMB AMOUNT	TOTAL BILLS	TOTAL CHARGES	REIMB AMOUNT	TOTAL VISITS	TOTAL BILLS
INTER NO xxxxx												
PROV NO												
xxxxxx	34,974	34,974	0	0	1	0	0	0	0	0	0	0
xxxxxx	1,065	1,065	0	0	1	0	0	0	0	0	0	0
INT TOTAL	36,040	36,040	0	0	2	0	0	0	0	0	0	0
INTER NO xxxxx												
PROV NO												
xxxxxx	43,528	0	43,528	0	16	0	0	0	0	0	0	0
xxxxxx	4,780	0	4,780	0	2	0	0	0	0	0	0	0
xxxxxx	2,805	0	2,805	0	1	0	0	0	0	0	0	0
xxxxxx	2,901	0	2,901	0	1	0	0	0	0	0	0	0
xxxxxx	870	0	870	0	1	0	0	0	0	0	0	0
xxxxxx	4,159	0	4,159	0	2	0	0	0	0	0	0	0
xxxxxx	8,815	0	8,814	0	3	0	0	0	0	0	0	0
xxxxxx	11,510	0	11,510	0	5	0	0	0	0	0	0	0
xxxxxx	1,548	0	1,548	0	1	0	0	0	0	0	0	0
INT TOTAL	80,920	0	80,919	0	32	0	0	0	0	0	0	0
HMO TOTAL	116,960	36,040	80,919	0	34	0	0	0	0	0	0	0
FY TOTAL	$376,064		$319,651		154		$0		$0		0	
		$38,643		42		$0		0		$0		0

MONTHLY SUMMARY OF CLAIMS PAID BY CARRIERS FOR HMO ENROLLEES

HMO NO Hxxxx HMO NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX HMO FY ENDING 12/2000 CURRENT MONTH 08/2000

TOTALS FOR THIS MONTH

CARRIER NUMBER	MEDICAL CHARGES	REIMB AMOUNT	TOTAL BILLS
xxxxx	0	0	1
xxxxx	315-	252-	1
xxxxx	323	258	2
HMO TOTAL	8	6	4
FY TOTAL	$835-	$687-	43

PART B CLAIMS RECORDS POSTED IN SEP 2000 PAGE 1

* * * * *HMO H9999 * * * * *

CLAIM NUMBER	NAME	EXPENSE FIRST	DATES LAST	ALLOWED TOTAL CHARGES	REIMB AMT	COINSURANCE AMT	DED APP	PHYS SUPP ID	PAY IND	CARRIER NUMBER	CARRIER PAID	INFORMATION CONTROL NUMBER
99999999999	XXXXXX	19990311	19990311	17.68	12.72	4.96	.00	999999999	1	99999	20000826	00234300626000
99999999999	XXXXXX	19990314	19990324	26.52	19.09	7.43	.00	999999999	1	99999	20000826	00234300625000
99999999999	XXXXXX	19990315	19990315	8.84	6.36	2.48	.00	999999999	1	99999	20000826	00234300627000
99999999999	XXXXXX	19981016	19981016	3.35	3.01	.34	.00	999999999	1	99999	20000923	00263815024000
99999999999	XXXXXX	19981202	19981202	3.35	3.01	.34	.00	999999999	1	99999	20000929	00269810754000
99999999999	XXXXXX	20000119	20000124	389.85	311.88	77.97	.00	999999999	1	99999	20000824	00234803271000
99999999999	XXXXXX	19990321	19990321	10.73	7.72	3.01	.00	999999999	1	99999	20000826	00234300628000
99999999999	XXXXXX	20000723	20000723	40.49	32.39	8.10	.00	999999999	1	99999	20000905	1002340068478
99999999999	XXXXXX	20000723	20000723	8.74	6.99	1.75	.00	999999999	1	99999	20000905	1002340068969

Exhibit E: SSAFO HMO Disenrollment Form (Form CMS-566)

☆ U.S. GOVERNMENT PRINTING OFFICE: 1997-572-077

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

MEDICARE MANAGED CARE DISENROLLMENT FORM

1. Beneficiary Name *(last)* *(first)* *(MI)*

BN _____ , _____ _____

2. HI Claim Number BIC

CN _____ _____ _____ _____

3. Sex *(M or F)*

SEX _____

4. Effective Date *(Mo-Day-Yr)*

ED _____ – 0 1 – _____

5. Transaction Code

TC _____

6. Disenrollment Code

DC _____

7. Unit

UN _____

PLEASE COMPLETE THE FOLLOWING:

I _____, request to terminate my membership
(first name, last name)

from _____. If this Health Plan is a "Lock-In" Plan, I understand that I
(Managed Care Plan Name)

must continue to receive medical services from this Plan until effective date of disenrollment, the last day of

_____ beginning with _____.
(Month, Year) *(Month, Day, Year)*

I understand that I may receive medical care either through the regular Medicare Fee-For Service System (assuming responsibility for co-insurance amounts and deductibles,) or from any other Medicare-contracting managed care health plan in which I may enroll.

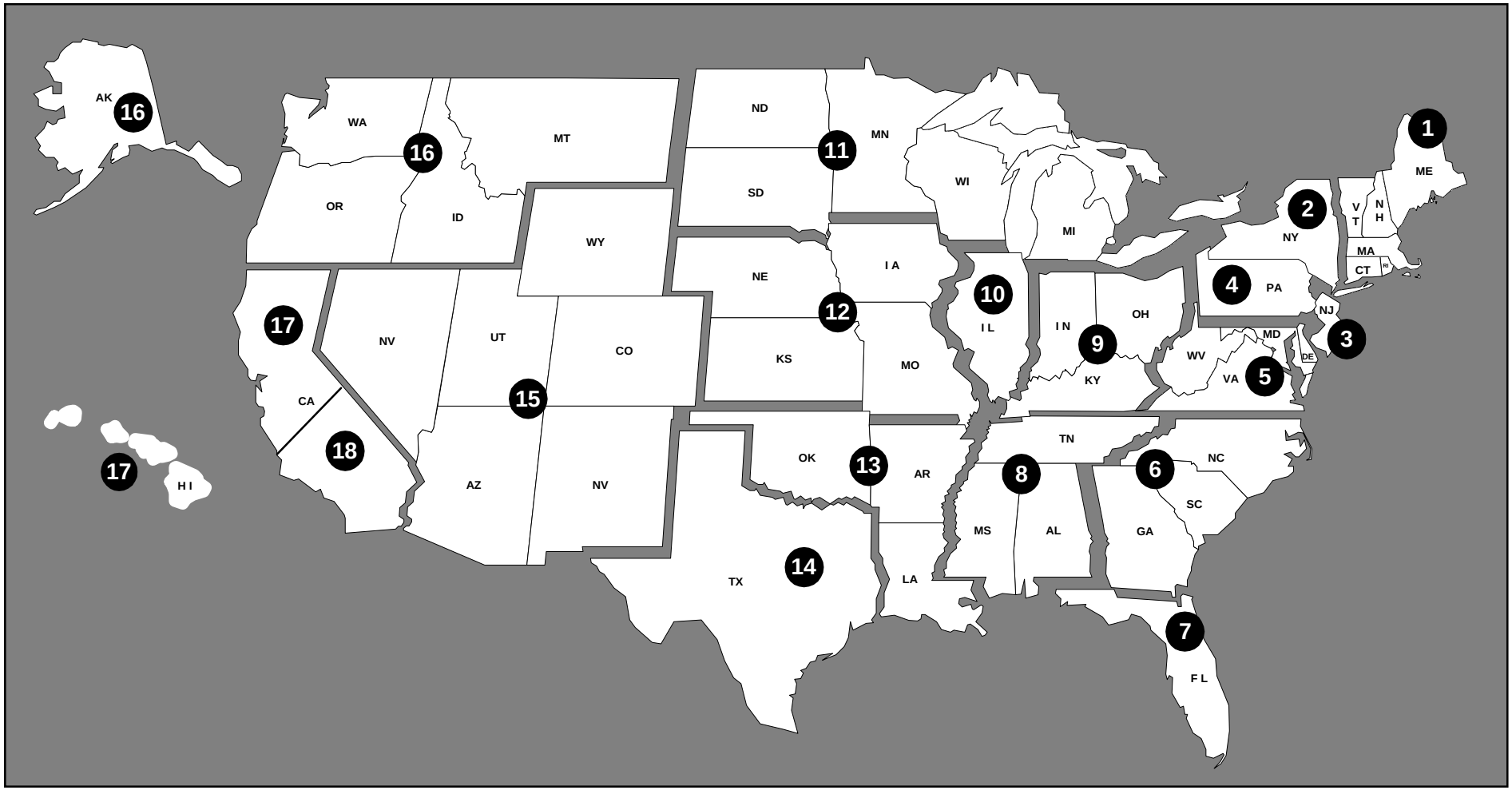
BENEFICIARY SIGNATURE	DATE
BENEFICIARY ADDRESS (*STREET, APT., CITY, STATE, ZIP CODE*)	BENEFICIARY DAYTIME TELEPHONE NO.

PRIVACY ACT STATEMENT

Reduction 9312(h) of the Omnibus Reconciliation Act of 1986 authorizes collection of this information. The primary use of this information is to enable Social Security personnel to update your Medicare record in order to disenroll you from your HMO/CMP. Additional disclosures of the information may be to provide suppliers of services, directly or dealing thorough Fiscal Intermediaries or Carriers, for administration of Title XVIII. In addition, the information you provide may be verified by a computer match (P.L. 100-503)

Furnishing the information on this form is voluntary, but failure to do so may result in disapproval of your disenrollment request.

Exhibit F: ESRD Network Boundaries and Contacts



Puerto Rico and Virgin Islands are part of Network 3.

Hawaii, Guam, Saipan, and American Samoa are part of Network 17.

ESRD Network Contact Information:

Net-work	Reg-ion	States	Name and Address	Contact Information
1	1	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	ESRD Network of New England Jenny Kitsen, Project Director 951 Elm St. New Haven, Connecticut 06511	Phone: (203) 387-9332 Fax: (203) 389-9902
2	1	New York	ESRD Network of New York, Inc. Geraldine Rasmussen, Project Director 1249 Fifth Avenue, Room A-419 New York, New York 10029	Phone: (212) 289-4524 Fax: (212) 289-4732
3	1	New Jersey Puerto Rico Virgin Islands	Trans Atlantic Renal Council Joan C. Solanchick, Project Director Cranbury Gate Office Park 109 S. Main St., Suite 21 Cranbury, New Jersey 08512-9595	Phone: (609) 395-5544 Fax: (609) 655-3432
4	1	Delaware Pennsylvania	UPMC Health System Margaret Washington, Project Director 200 Lothrop Street Pittsburgh, Pennsylvania 15213-2582	Phone: (412) 647-3428 Fax: (412) 683-6814
5	1	D of Columbia Maryland Virginia West Virginia	Mid-Atlantic Renal Coalition Nancy C Armistead, Project Director 1527 Huguenot Road Midlothian, Virginia 23113	Phone: (804) 794-3757 Fax: (804) 794-3793
6	6	Georgia North Carolina South Carolina	Southeastern Kidney Council, Inc. Jenna Krisher, Executive Director 1000 St. Albans Drive, Suite 270 Raleigh, North Carolina 27609	Phone: (919) 788-8112 Fax: (919) 788-9399

Net-work	Reg-ion	States	Name and Address	Contact Information
7	6	Florida	ESRD Network of Florida, Inc. Rosa Rivera-Mizzoni, Project Director 1 Davis Boulevard, Suite 304 Tampa, Florida 33606	Phone: (813) 251-8686 Fax: (813) 251-3744
8	6	Alabama Mississippi Tennessee	Network Eight, Inc. Jerry W. Fuller, Project Director P.O. Box 55868 Jackson, Mississippi 39296-5868	Phone: (601) 936-9260 Fax: (601) 932-4446
9	7	Kentucky Indiana Ohio	The Renal Network, Inc. Susan A. Stark, Project Director 911 East 86th Street, Suite 202 Indianapolis, Indiana 46240	Phone: (317) 257-8265 Fax: (317) 257-8291
10	7	Illinois	The Renal Network, Inc. Susan A. Stark, Project Director 911 E 86th Street, Suite 202 Indianapolis, Indiana 46240	Phone: (317) 257-8265 Fax: (317) 257-8291
11	7	Michigan Minnesota North Dakota South Dakota Wisconsin	Renal Network of the Upper Midwest Diane Carlson, Project Director 970 Raymond Avenue, Suite 205 St. Paul, Minnesota 55114	Phone: (651) 644-9877 Fax: (651) 644-9853
12	7	Iowa Kansas Missouri Nebraska	ESRD Network 12 Lisa Taylor, Project Director Suite 230 7505 NW Tiffany Springs Parkway Kansas City, Missouri 64153	Phone: (816) 880-9990 Fax: (816) 880-9088
13	6	Arkansas Louisiana Oklahoma	ESRD Network 13 Patricia Philliber, Project Director 6600 N Meridian Ave, Suite 155 Oklahoma City, Oklahoma 73116-1421	Phone: (405) 843-8688 Fax: (405) 842-4097
14	6	Texas	ESRD Network of Texas, Inc. Glenda Harbert, Project Director 14114 Dallas Parkway, Suite 660 Dallas, Texas 75240-4381	Phone: (972) 503-3215 Fax: (972) 503-3219

Net-work	Reg-ion	States	Name and Address	Contact Information
15	10	Arizona Colorado Nevada New Mexico Utah Wyoming	Intermountain ESRD Network, Inc. Sharon K. Stiles, Project Director Penn Center Building 1301 Pennsylvania Street, Suite 220 Denver, Colorado 80203-5012	Phone: (303) 831-8818 Fax: (303) 860-8392
16	10	Alaska Idaho Montana Oregon Washington	Northwest Renal Network Lorabeth Lawson, Project Director 4702 42nd Avenue, SW Seattle, Washington 98116	Phone: (206) 923-0714 Fax: (206) 923-0716
17	10	Amer Samoa Hawaii N. California Pacific Islands	TransPacific Renal Network Arlene Sukolsky, Project Director 25 Mitchell Boulevard, Suite 7 San Rafael, California 94903	Phone: (415) 472-8590 Fax: (415) 472-8594
18	10	S. California	Southern California Renal Disease Council Douglas Marsh, Executive Director 6255 Sunset Boulevard, Suite 2211 Los Angeles, California 90028	Phone: (213) 962-2020 Fax: (213) 962-2891

Exhibit G: Working Aged Transaction Status Report

Transactions Keyed Online and Batch Transmitted
Data Submitted: MM/DD/YYYY

Reporting Month: MM/YYYY
Contract: **H1234**

Rejected Records ("R" status)

Claim No	Bene Name	Doc Control No.	DOB	Sex	MSP Start	MSP End	Trans Type	Ins. Type	Valid Ind	Status Code	SP Code
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	R	SP51
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	R	SP51
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	R	SP51
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	R	SP51
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	R	SP51
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	R	SP51

Total Rejected Records: 9999

Unaccepted Records ("U" status)

Claim No	Bene Name	Doc Control No.	DOB	Sex	MSP Start	MSP End	Trans Type	Ins. Type	Valid Ind	Status Code
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	U
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	U
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	U
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	U
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	U
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	U
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	U

Total Unaccepted Records: 9999

Pending Records ("P" status)

Claim No	Bene Name	Doc Control No.	DOB	Sex	MSP Start	MSP End	Trans Type	Ins. Type	Valid Ind	Status Code
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	P

012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	P
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	P
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	P
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y	P

Total Pending Records: 9999

Reporting Month: MM/YYYY

Contract: **H1234**

Sent Records ("S" status)

Claim No	Bene Name	Doc Control No.	DOB	Sex	MSP Start	MSP End	Trans Type	Ins. Type	Valid Ind	Status Code
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y

Total Sent Records: 9999

Accepted Records ("A" status)

Claim No	Bene Name	Doc Control No.	DOB	Sex	MSP Start	MSP End	Trans Type	Ins. Type	Valid Ind	Status Code
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y
012345678A	YODE	A	H1234YYMMDD0000	MM/DD/YYYY	1	MM/DD/YYYY	MM/DD/YYYY	0	A	Y

Total Accepted Records: 9999

Total Working Aged Records Per Report: 99999

Exhibit H: List of Transaction Reply Codes

Code 001 - Invalid Transaction Code

An enrollment, disenrollment or correction transaction attempted to process. The transaction was rejected, because the supplied input **transaction code** was an invalid value. The valid transaction code values are 01, 51, 60, and 61. The transaction should be resubmitted with a valid transaction code.

Code 002 - Invalid Correction Action Code

A correction transaction attempted to process. The transaction was rejected, because the supplied **action code** was an invalid value. The valid action code values are D, E, F, and P. The transaction should be resubmitted with a valid action code.

Code 004 - Beneficiary Name Required

An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary **name** was not included on the enrollment transaction record. In order for the enrollment of a beneficiary not yet in the GHP System to process, Medicare entitlement data must be retrieved. The Beneficiary's name is a required element in the search performed. The enrollment transaction should be resubmitted with beneficiary name included.

Code 007 - Invalid Claim Number

An enrollment, disenrollment or correction transaction attempted to process. The transaction was rejected, because the **claim number** was not **in a valid format. The valid format for a claim number could take one of two forms:**

1. HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions alphanumeric.

2. RRB is a 5- to 12-position value, with the first 1 to 3 positions alpha and the last 4 to 12 positions numeric.

The transaction should be resubmitted with a valid claim number (HICN) or RRB.

Code 008 - Beneficiary Not Found on GHP

A disenrollment or correction transaction attempted to process. The transaction was rejected, because the claim number was not found in the GHP System. The transaction should be resubmitted with a valid claim number.

Code 009 - No Match on Name

A transaction attempted to process. The transaction was rejected because the name on the incoming record did not match a record on the database. The transaction should be resubmitted with the correct name.

Code 010 - Invalid Medicaid Transaction

A correction transaction attempted to process with an action code of "F" (turn Medicaid off). The transaction was rejected, because the Medicaid status was not set by the plan and for that reason may not be turned off by the plan.

Code 011 - Enrollment Accepted as Submitted

The new enrollment has been successfully processed. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.

Code 013 - Disenrollment Accepted as Submitted

The disenrollment has been successfully processed. The effective date of the disenrollment is shown in field 23 (see codes 18-28) of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.

Code 014 - Disenrollment Due to Enrollment in Another Plan

A new enrollment was successfully processed for the beneficiary, which placed them in another MCO. As a result, the beneficiary was disenrolled from the MCO receiving this message. The effective date of the disenrollment is shown in field 23 of the Transaction Reply record. In field 27 the Contract number of the source is shown. On the printed report, the disenrollment date is shown in the EFF DATE column, and the MCO causing the disenrollment is shown in the SOURCE ID column.

Code 015 - Enrollment Canceled

An enrollment was canceled due to a MCOs disenrollment request dated the month prior to enrollment, due to loss of Part A, B Entitlement, or the beneficiary is in the ESRD health status prior to enrollment.

Code 016 - Enrollment Accepted, Conditional Enrollment Started

A new enrollment was processed, but a conditional enrollment period was established, because the beneficiary's residence state and county code is outside of the plan's service area. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column. If the SCC shown on the printed report differs from your records prompt the beneficiary to visit the Social Security Administration Field Office (SSAFO) to change their address. This will enable a more accurate payment for this beneficiary to be made.

Code 017 - Enrollment Accepted, Payment USPCC Rate

The new enrollment was processed, but valid residence state and county codes were not available and could not be derived from the ZIP code. The enrollment is considered valid by the system; however, since there is no valid residence state and county codes payment is made for this beneficiary at the USPCC rate. When valid residence information is provided to the system, payment will be made using the updated residence information. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.

Code 018 - Automatic Disenrollment

An action occurred which caused an automatic disenrollment of this beneficiary. A disenrollment action was not submitted by CMS or the plan. This action could result from a change in the beneficiary's personal characteristics. For example, a death notice, loss of Part A or Part B Entitlement would cause an enrolled beneficiary to be automatically disenrolled. The effective date of the disenrollment is shown in field 23 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column, and the reason for disenrollment is shown in the REMARKS column.

Code 019 - Individual Lacks Part A/B (PACE Only)

This code applies only to National PACE organizations. The PACE organization can include individuals with Part A only, Part B only or no Medicare entitlement at all. Due to payment issues, the system will not allow an individual not entitled to Medicare to be enrolled or to remain in the PACE organization. This code will appear if the M+C organization attempts to enroll such an individual or the system receives notification that the individual has lost Medicare entitlement.

Code 20 - Beneficiary is <55 Years of Age (PACE Only)

This code applies only to National PACE organizations. The PACE organizations cannot enroll beneficiaries under the age of 55. This code will appear if the M+C organization attempts to enroll such a beneficiary or the system receives a date of birth change resulting in the member's age falling below 55.

Code 022 - Enrollment Accepted, Claim Number Change

A new enrollment was successfully processed for a beneficiary whose claim number has changed. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. The new claim number is shown in field 23. The old claim number will appear in field 1. On the printed report the enrollment date is shown in the EFF DATE column, and the new claim number is shown in the REMARKS column. Any further actions submitted for this beneficiary **must** use the new claim number.

Code 023 - Enrollment Accepted, Name Change

A new enrollment was successfully processed for a beneficiary whose name has changed. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. The new name will appear in fields 2, 3, and 4. On the printed report, the enrollment date is shown in the EFF DATE column, and the new name is shown in the SURNAME, FIRST NAME and MI columns.

Code 025 - Disenrollment Accepted, Claim Number Change

A disenrollment was successfully processed for a beneficiary whose claim number has changed. The effective date of the disenrollment is shown in field 21 of the Transaction Reply record. The new claim number is shown in field 23. The old claim number will appear in field 1. On the printed report the disenrollment date is shown in the EFF DATE column, and the new claim number is shown in the REMARKS column. Any further actions submitted for this beneficiary should use the new claim number.

Code 026 - Disenrollment Accepted, Name Change

A disenrollment was successfully processed for a beneficiary whose name has changed. The effective date of the disenrollment is shown in field 21 of the Transaction Reply record. The new name will appear in fields 2, 3, and 4. On the printed report, the disenrollment date is shown in the EFF DATE column, and the new name is shown in the SURNAME, FIRST NAME and MI columns.

Code 027 - Demonstration Beneficiary Factor Set

A demonstration factor was successfully processed for a beneficiary. The effective start date of the factor is shown in field 23 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.

Code 028 - Demonstration Beneficiary Factor Terminated

A demonstration factor was successfully processed for a beneficiary. The effective end date of the factor is show in field 23 of the Transaction Reply record. On the printed report the value is shown in the EFF DATE column.

Code 031 - Enrollment Rejected, Not Found on Enrollment Data Base (EDB)

A enrollment transaction attempted to process. The enrollment was rejected because the beneficiary could not be located in the EDB System, system of record. Verify the claim number and name and resubmit the transaction.

Code 032 - Enrollment Rejected, Not Entitled to Part B

An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary did not have Medicare Part B Entitlement. Part B entitlement is required for enrollment in a managed care plan.

Code 033 - Enrollment Rejected, Not Entitled to Part A

An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary did not have Medicare Part A Entitlement. Part A entitlement is required for enrollment in a managed care plans.

Code 034 - Enrollment Rejected, Beneficiary is Not Age 65

An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary was not age 65 or older. The age requirement is MCO-specific.

Code 035 - Enrollment Rejected, Beneficiary is in Hospice Status

An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary was in Hospice status. The Hospice requirement is MCO-specific (e.g., applies only to §1876 Cost Plans). The attempted enrollment date is shown in field 23 of the Transaction Reply record.

Code 036 - Enrollment Rejected, Beneficiary is Deceased

An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary is deceased. The attempted enrollment date is shown in field 23 of the Transaction Reply record. On the printed report, the value is shown in the REMARKS column.

Code 037 - Enrollment Rejected, Invalid Date

An enrollment transaction attempted to process. The enrollment was rejected, because the submitted enrollment effective date was either an invalid numeric value; a date more than 3 months in the future; or a code 60 was with a future date. The transaction should be resubmitted with a valid date.

Code 038 - Enrollment Rejected, Duplicate Transaction

An enrollment transaction attempted to process. The enrollment was rejected because another enrollment transaction submitted by the same plan, with the same effective date, was already processed. No action is required by the plan.

Code 039 - Enrollment Rejected, Already Enrolled in Same Plan

An enrollment transaction attempted to process. The enrollment was rejected because the beneficiary was already enrolled in this plan. No action is required by the plan.

Code 040 - Enrollment Rejected, Multiple Enrollment Transactions

An enrollment transaction attempted to process. The enrollment was rejected because the transaction was one of several that were submitted by different plans and/or for different effective dates during the same GHP processing run.

Code 041 - Invalid Demonstration Beneficiary Factor Date

A beneficiary factor update request attempted to process. The transaction was rejected because the effective start and/or end date was not in a valid format; or the request specified an effective start date that was greater than the effective end date.

Code 042 - Enrollment Rejected, Blocked

An enrollment transaction attempted to process. The enrollment was rejected because the MCO is currently blocked from enrolling new beneficiaries.

Code 043 - Invalid Demonstration Beneficiary Factor

A beneficiary factor update request attempted to process. The transaction was rejected because the factor was not in a valid format; or the factor was larger than allowed.

Code 044 - Enrollment Rejected, Outside Contracted Period

An enrollment transaction attempted to process. The enrollment was rejected because the submitted enrollment date is outside the contracted period with CMS.

Code 045 - Enrollment Rejected, Beneficiary is in ESRD Status

An enrollment transaction attempted to process. The enrollment was rejected because the beneficiary is in ESRD (end-stage renal disease) status. The attempted enrollment effective date is shown in field 23 of the Transaction Reply record. On the printed report, the value is shown in the REMARKS column.

Code 047 - Enrollment Rejected, Retroactive Effective Date

An enrollment transaction attempted to process. The enrollment was rejected because the enrollment effective date submitted was not within the acceptable retroactive period. The enrollment should be resubmitted with an effective date that is valid for the month in which it is submitted or prior.

Code 048 - Nursing Home Certifiable Set

A transaction has been processed placing the beneficiary in Nursing Home Certifiable (NHC) status. The NHC health status is MCO-specific (e.g., applies only to SHMO plans). The NHC effective start date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 050 - Disenrollment Rejected, Not Enrolled

A disenrollment transaction attempted to process. The disenrollment was rejected because the beneficiary was not currently enrolled in the plan.

Code 051 - Disenrollment Rejected, Invalid Date

A disenrollment transaction attempted to process. The disenrollment was rejected because the effective date was one of invalid numeric value or a date outside the allowable time frame. The transaction should be resubmitted with a valid date.

Code 052 - Disenrollment Rejected, Duplicate Transaction

A second disenrollment transaction attempted to process. The disenrollment was rejected, duplicate transaction, no process necessary. No action is required by the plan.

Code 053 - Disenrollment Rejected, Before Current Enrollment

A disenrollment transaction attempted to process. The disenrollment was rejected because the disenrollment effective date submitted was earlier than the effective enrollment date on record. The transaction should be resubmitted with a valid date.

Code 054 - Disenrollment Rejected, Retroactive Date

A disenrollment transaction attempted to process. The disenrollment was rejected because the effective date was outside the allowable time frame. The disenrollment should be resubmitted with a valid date.

Code 055 - ESRD Status Canceled

The ESRD status information which was previously set has been canceled. The effective date of the status period canceled is shown in field 23 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.

Code 056 - Demonstration Enrollment Rejected

An enrollment transaction attempted to process. The enrollment was rejected because the beneficiary did not meet the Demonstration requirements. For example, the beneficiary is currently known to be Working Aged or not known to be ESRD. These requirements are MCO-specific (e.g., applies only to the ESRD Demonstration MCOs). The attempted enrollment effective date is shown in field 23 of the Transaction Reply record. On the print report, the value is shown in the EFF DATE column.

Code 058 - SSA Disenrollment Rejected

A disenrollment transaction from an SSAFO attempted to process. The disenrollment was rejected because the effective date of the disenrollment if applied, would result in a cancellation of the enrollment period. The attempted disenrollment effective date is shown on the printed report under the EFF DATE column.

Code 059 - Working Aged Status Canceled

The working aged status information which was previously set has been canceled. The effective date of the status period canceled is shown in field 23 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.

Code 060 - Correction Rejected, Not Enrolled in Plan

A correction transaction attempted to process. The correction was rejected because the beneficiary is no longer enrolled under the incoming contract number. The MCOs are not permitted to process transactions against beneficiaries that are not enrolled in their plan.

Code 062 - Correction Rejected, Overlaps Other Period

A correction transaction attempted to process. The correction was rejected, because another correction transaction submitted by the same plan, with the same effective date, was already processed. No action is required by the MCO.

Code 065 - Working Aged Transaction Received

A Working Aged transaction has been received by CMS. The transaction was sent on for further processing by GHP. This reply is to confirm that the request has been received by CMS and forwarded for processing. This does not mean that the information has passed all edits and been updated to the CMS files.

Code 066 - WA Status Set

A Working Aged status has been set for a beneficiary. The effective Working Aged start date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 067 - WA Status Terminated

A Working Aged status has been terminated for a beneficiary. The effective Working Aged termination date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 068 - Working Aged Status Rejected

A Working Aged transaction attempted to process. The transaction was rejected, because the supplied input transaction did not pass all required edits. The failed edits are noted by the SP Error code, which can be found in the Plan Communications User's Guide under the appendix marked "M.P. Maintenance Transaction Error Codes".

Code 069 - Working Aged Status Pending

A Working Aged transaction has been received by CMS, but is pending because it has not completed processing.

Code 071 - Hospice Status Set

A notification has been received from CMS' Hospice system placing the beneficiary in Hospice status. The effective Hospice start date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 072 - Hospice Status Terminated

A notification has been received from CMS' Hospice system terminating the beneficiary's Hospice status. The effective Hospice end date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 073 - ESRD Status Set

A notification has been received from CMS' ESRD system placing the beneficiary in ESRD status. The effective ESRD start date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 074 - ESRD Status Terminated

A notification has been received from CMS' ESRD system terminating the beneficiary's ESRD status. The effective ESRD end date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 075 - Institutional Status Set

A transaction has been received placing the beneficiary in Institutional status. The effective Institutional start date is shown in field 21 and 23 of the Transaction Reply record. On the printed report this value is shown in the EFF DATE column. Institutional automatically ends each month; therefore, there is no termination status transaction.

Code 076 - Institutional Status Termination

An action has been taken by CMS staff to remove a period of Institutional status. The effective end date is shown in field 21 and 23 of the Transaction Reply record. On the printed report this value is shown in the EFF DATE column.

Code 077 - Medicaid Status Set

A transaction has been received placing the beneficiary in Medicaid Status. The effective Medicaid start date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 078 - Medicaid Status Terminated

A transaction has been received terminating the beneficiary Medicaid status. The effective Medicaid end date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 079 - Part A Termination

A notification has been received terminating the beneficiary's Part A Entitlement. The effective Part A Entitlement end date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 080 - Part A Reinstatement

A notification has been received reinstating the beneficiary's Part A Entitlement. The effective Part A Entitlement start date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 081 - Part B Termination

A notification has been received terminating the beneficiary's Part B Entitlement. The effective Part B Entitlement end date is shown in field 23 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code 082 - Part B Reinstatement

A notification has been received reinstating the beneficiary's Part B Entitlement. The effective Part B Entitlement start date is shown in field 23 of the Transaction Reply Record. On the printed report, this value is shown in the EFF DATE column.

Code 083 - Enrollment Date Change

The correction has been completely processed by the GHP System. This action was taken by CMS staff. The new effective date of the enrollment is shown in field 23 of the Transaction Reply record. This value is also present in field 18. On the printed report, this value is shown in the EFF DATE column.

Code 084 - Disenrollment Date Change

The correction has been completely processed by the GHP System. This action was taken by CMS staff. The new effective date of the disenrollment is shown in field 23 of the Transaction Reply record. The effective enrollment date is shown in field 18. On the printed report, the effective disenrollment date is shown in the EFF DATE column.

Code 085 - State and County Code Change

A notification has been received indicating that the beneficiary's State and County Code (SCC) information has changed. The new SCC is shown in field 9 and 23 of the

Transaction Reply record. On the printed report, the new SCC is shown in the REMARKS column.

Code 086 - Claim Number Change

A notification has been received indicating that the beneficiary's claim number has changed. The new claim number is shown in field 23 of the Transaction Reply record. On the printed report, the new claim number is shown in the REMARKS column.

Code 087 - Name Change

A notification has been received indicating that the beneficiary's name has changed. The new name is shown in fields, 2, 3, and 4 of the Transaction Reply record. On the printed report, the new name is shown in fields 2, 3, and 4 of the Transaction Reply record. On the printed report, the new name is shown in the SURNAME, FIRST NAME and MI columns.

Code 088 - Sex Code Change

A notification has been received indicating that the beneficiary's sex code has changed. The new Sex code is shown in field 5 of the Transaction Reply record. On the printed report, the new Sex code is in the SEX column.

Code 089 - Date of Birth Change

A notification has been received indicating that the beneficiary's date of birth has changed. The new date of birth is shown in field 6 of the Transaction Reply record. On the printed report, the new birth date is shown in the DATE OF BIRTH and EFF DATE columns.

Code 090 - Date of Death Established

A notification has been received indicating that the beneficiary is deceased. The date of death is shown in field 23 of the Transaction Reply record. On the printed report, the date of death is shown in the EFF DATE column.

Code 092 - Date of Death Corrected

A notification has been received indicating that the beneficiary's date of death has been corrected. The corrected date of death is shown in field 23 of the Transaction Reply record. On the printed report, the corrected date of death is shown in the EFF DATE column.

Code 097 - Medicaid Previously Turned On

A transaction attempted to process the start of a Medicaid period and was rejected because the Medicaid status for the beneficiary was already on for the month in question. No action required by the plan.

Code 098 - Medicaid Status Previously Turned Off

A transaction attempted to process the end of a Medicaid period and was rejected because the Medicaid status was already off for the month in question. No action required by the plan.

Code 099 - Medicaid Period Change

A change has been made to a period of Medicaid status information for the beneficiary. No action required by the plan.

Code 100 - Election Change Accepted as Submitted

An M+C organization has submitted a transaction type 71 to move a member from one benefit package to another. All applicable edits have been passed; the transaction has successfully processed. The effective date of the PBP election is shown in field 24 of the Transaction Reply record.

Code 101 - Reserved for Future Use

Code 102 - Rejected, Invalid or Missing Application Signature Date

A transaction was rejected (60/61/71) because it was submitted with an invalid or missing application signature date. The application signature date must be present, represent a valid date, and precede the effective date on the transaction (effective date of the enrollment or PBP change). Note that the application signature date is not a required field on transaction type 51. The transaction should be resubmitted with a valid date.

Code 103 - Reserved for Future Use

Code 104 - Reserved for Future Use

Code 105 - Reserved for Future Use

Code 106 - Rejected, Another Transaction Received with a Later Application Signature Date

The transaction was rejected (60/61/71) because a transaction with a more recent application signature date was received for the same effective date. When multiple transactions are received for the same beneficiary with the same effective date but with different contract/PBP #s, the application signature date will be used to determine which election to accept. Note that this code does not apply to transaction type 51. If the application signature dates are different, the system will accept the election containing the most recent date. If the application signature dates are the same, they will all be rejected with a code of 040.

Code 107 - Rejected, Invalid or Missing PBP #

The transaction was rejected (60/61/71) because the PBP # was missing or invalid. Note that the PBP # is not required on transaction type 51. The PBP # submitted on the 60/61/71 must be valid for the contract number on the transaction. The transaction should be resubmitted with a valid PBP #.

Code 108 - Reserved for Future Use

Code 109 - Rejected, Duplicate PBP#

The transaction was rejected (71) because the member was already enrolled in the PBP # on the transaction. This code only applies to transaction type 71.

Code 110 - Rejected, No Part A and No EGHP Enrollment Waiver

The transaction was rejected (60/61/71) because the beneficiary lacked Part A and there was no EGHP Part B-only waiver in place. The M+C organizations can offer PBPs for EGHP members only and, if the M+C organization chooses, it can define such PBPs for individuals who do not have Part A.

Code 111 - PBP Rejected, Invalid Contract Number

The transaction was rejected (71) because the contract number on the transaction does not match the member's enrollment record. This code applies only to transaction type 71. The transaction should be resubmitted with the correct contract number.

Code 112 - Rejected, Conflicting Effective Dates

NOTE: This edit will be modified for 2003.

During 2002, the transaction was rejected (71) because it contained an effective date prior to or equal to an existing PBP start date or the current MCO enrollment period is closed. This code applies only to transaction type 71.

Code 113 - BIPA606 Reduction Rate

This code is when the BIPA606 payment reduction rate changes during the payment year. **NOTE:** This code will not be reported if the rate changes from one payment to the next.