Medicare Modernization Act (MMA)
Customer Support for Medicare Modernization (CSMM)
Help Desk FAQ Sheet # 525

December 1, 2008

The MMA Help Desk publishes Frequently Asked Questions (FAQs) as an additional resource for Plans. The questions are collected from various sources and reflect the topics referred to CMS as presenting difficulties for multiple Plans. This information reiterates current policy and is not meant to introduce any new policies. Plans should always refer to the Q&A database on the CMS website for the most up-to-date information.

New Questions:

1. **What is the CMS Customer Service and Support Center (CSSC) and how do Plans contact them? What kinds of issues should Plans be forwarding to them?**

2. **What is the Plan Connectivity Data (PCD) module? How do Plans access it and what do they use it for?**

3. **How can a Plan determine if an enrollee has a Medicaid period established in CMS systems in a particular year?**

4. **On the October 5, 2008 Weekly Transaction Reply Report (TRR) some Plans received thousands of Transaction Reply Code (TRC) 085's and TRC 154's. Where did all of these responses come from and what are Plans supposed to do with them?**

5. **How can a Plan tell if a beneficiary is a full-risk enrollee?**

6. **How can a Plan tell whether a full risk beneficiary was paid using a risk score that took Medicaid status into account?**

7. **How can a Plan tell if an enrollee was paid with a new enrollee risk score?**

8. **What does it mean if field 47 (RA Factor Type) is blank on the Monthly Membership Detail Data File?**

9. **How can a Plan tell whether an enrollee with a new enrollee risk score was paid using a risk score that took Medicaid status into account?**

New Answers:

1. **What is the CMS Customer Service and Support Center (CSSC) and how do Plans contact them? What kinds of issues should Plans be forwarding to them?**

   CSSC can assist Plans with questions about the Drug Data Processing System (DDPS), Risk Adjustment System (RAS) application, or the file formats for Prescription Drug Event (PDE) and Risk Adjustment Processing System (RAPS) files. They can be reached by phone at 1-877-534-2772 (Monday-Friday, 9 a.m. to 7 p.m., ET, except federal holidays), by e-mail csscoperations@palmettogba.com or through their website http://www.csscoperations.com.

   The MMA Help Desk provides support to Part D Plans that are submitting PDE and RAPS information to CMS. This responsibility is limited to the areas of Individuals Authorized Access to the CMS Computer Services (IACS) registration and troubleshooting, as well as Gentran file transfers. The MMA Help Desk can be contacted by phone at 1-800-927-8069 (Monday-Friday, 6 a.m. to 9 p.m., ET, except federal holidays) or by e-mail mmahelp@cms.hhs.gov.

2. **What is the Plan Connectivity Data (PCD) module? How do Plans access it and what do they use it for?**

   All Part C/D Plans participating in the Medicare Part D Program are required to complete a number of setup tasks in order to be properly authorized and accurately configured to transmit to and receive data from CMS.

   Effective November 16, 2007, Plan organizations that are contracted to do business with CMS as of January 1, 2008 will need to communicate their existing connectivity and access configuration data to CMS via the Plan Connectivity Data (PCD) module in HPMS (Health Plan Management System). Before November 16, 2007, Plan organizations established data exchange capabilities by manually completing a connectivity form and mailing a hard copy to the MMA Help Desk.

   As new organizations obtain contracts with CMS, or as current business partners obtain new contract numbers, they will need to complete their connectivity data in the PCD module as well.

   Questions about the specific data elements within the PCD module should be directed to the MMA Help Desk at 1-800-927-8069 or mmahelp@cms.hhs.gov.

   Questions about HPMS access, specifically access to the PCD module within HPMS, should be emailed to hpms_access@cms.hhs.gov. Please contact the HPMS Help Desk at 1-800-220-2028 if technical difficulties are encountered while using the PCD module.

3. **How can a Plan determine if an enrollee has a Medicaid period established in CMS systems in a particular year?**

   There are a few ways to check whether CMS has a Medicaid period established for a beneficiary enrolled in a plan:

   - The Common UI screen M236 can be used to look up beneficiaries enrolled in a plan to see if they have a Medicaid period in CMS systems, and the source of the information.
   - Field 40 (Current Medicaid Status), new as of July 2008, indicates if the beneficiary was Medicaid in CMS systems either one or two months prior to payment. *This is not a payment field* in that it does not indicate whether an enrollee is being paid Medicaid or if they have a

Medicaid period in our systems at any time during the year. This field should be watched over time to see if CMS reflects a Medicaid period for the beneficiary throughout the year.

Quick reference check for fields used for full risk and new enrollees:

	Risk score type indicated in field:		Medicaid status indicated in field:		Medicaid status based on Medicaid in:	
	23	47	19	21	Payment year*	Data collection year
Full risk enrollee, RAS risk score used in payment	Blank	√	Blank	√		√
Full risk enrollee, RAS risk score generated, but default risk score used in payment (became ESRD after last risk score run)	√	Blank	√	Blank	√	
New enrollee, RAS-generate new enrollee risk score used in payment	Blank	√	Blank	√	√	
New enrollee, default new enrollee risk score assigned in the payment system for payment	√	Blank	√	Blank	√	

*For new enrollees, both RAS and the payment system use months in the year prior to the payment year, as well as months in the payment year, to determine Medicaid status throughout the payment year. At final payment reconciliation, all new enrollees receive RAS risk scores, and only Medicaid during the payment year is used to determine the new enrollee risk score.

4. On the October 5, 2008 Weekly Transaction Reply Report (TRR) some Plans received thousands of Transaction Reply Code (TRC) 085's and TRC 154's. Where did all of these responses come from and what are Plans supposed to do with them?

As discussed in the Week-at-a-Glance (WAAG) memo dated October 5th through October 12th, and published by the MMA Help Desk, there was a Medicare Beneficiary Database (MBD) Beneficiary Address Resynchronization process which addressed an underlying issue causing a number of beneficiaries' addresses to become out of synch in MBD. In order to correct this information, CMS ran this resynchronization process to correct the beneficiary data. MAO/PDPs received successful notifications along with one or more of the following TRCs on their October 5th regular weekly TRR (P.Rxxxxx.TRWEEKR.D081005.Thhmmsst):

- TRC 085 – State and County Code Change
- TRC 138 – Beneficiary Address Change to Outside the U.S.
- TRC 154 – Out of Area Status

If the beneficiary received in the TRR is deceased or no longer in their Plan, the Plan needs to take no action. However if the person is not deceased, Plans should respond in accordance with the associated TRC instructions. Further questions or concerns regarding further instructions should to be directed to the Plan's CMS Department of Payment Operations (DPO) representative.

5. How can a Plan determine if a beneficiary is a full-risk enrollee?

A "full risk" beneficiary has 12 months of Part B in the data collection period. When the payment system uses a risk score generated for a full risk beneficiary by the Risk Adjustment System (RAS), field 47 (RA Factor Type Code) of the Monthly Membership Detail Data File will be populated with one of the following codes, indicating model was used to generate the risk score used in payment::

C = Community
C1 = Community Post-Graft I (ESRD)
C2 = Community Post-Graft II (ESRD)
D = Dialysis (ESRD)
G1 = Graft I (ESRD)
G2 = Graft II (ESRD)
I = Institutional
I1 = Institutional Post-Graft I (ESRD)
I2 = Institutional Post-Graft II (ESRD)

6. How can a Plan determine whether a full risk beneficiary was paid using a risk score that took Medicaid status into account?

If the payment system uses a RAS-generated risk score in payment, the Medicaid status used in determining the risk score will be indicated in field 21 of the Monthly Membership Detail Data File. Starting with payment for January 2009, field 21 will be referred to as the Medicaid Indicator. A "Y" in field 21 means that the beneficiary had at least one month of Medicaid in the data collection period. A blank in field 21, when the beneficiary is a full risk beneficiary, means that there was no Medicaid period established in the data collection year when the risk score was calculated.

7. How can a Plan determine if an enrollee was paid with a new enrollee risk score?

A beneficiary is treated as a new enrollee if they have less than 12 months of Part B in the data collection period. Because a new enrollee has less than 12 months of Part B in the data collection year, they do not have the full 12 months of diagnoses that are used to calculate a risk score for full risk beneficiaries. Instead, the enrolling plan is paid using a concurrent model based only on demographic characteristics of the enrollee. There are two scenarios for how a new enrollee risk score is determined for these beneficiaries:

A. If an enrollee is entitled to Medicare, but has less than 12 months of Part B in the data collection period, the Risk Adjustment System (RAS) generates a new enrollee risk score. In this case, field 47 (RA Factor Type Code) of the Monthly Membership Detail Data File will contain one of the following codes:

E = New Enrollee (non-ESRD)
ED = New Enrollee Dialysis (ESRD)
E1 = New Enrollee Post-Graft I (ESRD)
E2 = New Enrollee Post-Graft II (ESRD)

B. If a beneficiary was not entitled to Medicare during the data collection period, RAS will not generate a risk score for them and the payment system will need to assign a default risk score for these beneficiaries.

8. What does it mean if field 47 (RA Factor Type) is blank on the Monthly Membership Detail Data File?

If field 47 of the Monthly Membership Detail Data File is blank, this means that a default risk score was assigned in the payment system. Default risk scores are assigned whenever the payment system does not have the appropriate risk score on file. There are two situations in which field 47 should be blank:

A. The beneficiary was neither entitled to Medicare when CMS last calculated risk scores and subsequently entered the Medicare program. In these cases, when we pay the enrolling plan for the beneficiary, the payment system has to assign a risk score for payment. CMS calculates risk scores three times a year – an initial risk score run for the first half of the payment year, a mid-year update that is implemented in July of a payment year, and a final risk score run that is used in final payment reconciliation after the payment year is over. A Medicare beneficiary who enters the Medicare program after either the initial or mid-year risk score runs will have a default risk score assigned to them in the payment system. When the final risk scores are run, all beneficiaries enrolled in a plan during the payment year receive a risk score generated by the Risk Adjustment System (RAS).

B. If a beneficiary has a RAS-generated risk score, but becomes ESRD after the risk scores were run, they will not have a RAS-generated ESRD risk score and the payment system will need to assign the appropriate ESRD default risk score.

Whenever a default risk score is used, field 47 (RA Factor Type Code) will be blank and field 23 (Default Risk Factor Code) will indicate that a default risk score was used. Prior to January 2009 payment, field 23 = Y when a default risk score is assigned in the payment system. Starting with January 2009 payment, field 23 will be coded to indicate what type of default risk score was used in payment. The codes that will be used in field 23, starting with January 2000 payment, are:

1 - Default Enrollee - Aged/Disabled
2 - Default Enrollee - ESRD Dialysis
3 - Default Enrollee - ESRD Transplant Kidney Month 1
4 - Default Enrollee - ESRD Transplant Kidney Months 2-3
5 - Default Enrollee - ESRD Post Graft 4-9 months
6 - Default Enrollee - ESRD Post Graft 10+ months
Blank - Not a default enrollee - Risk Adjustment Factor calculated by CMS

9. How can a Plan determine whether an enrollee with a new enrollee risk score was paid using a risk score that took Medicaid status into account?

A new enrollee can have a RAS-generated risk score or a default risk score assigned in the payment system. Depending on whether a new enrollee has a RAS-generated risk score or a payment system-assigned default risk score, the field used to indicate whether Medicaid was used in determining the risk score differs, as does the period looked at to determine Medicaid status prior to final payment reconciliation.

	Field indicating Medicaid status	Time period use to determine Medicaid status:		
		For initial payments	After initial payment	At final payment reconciliation
RAS-generated risk score (risk score type indicated in field 47; field 23 blank)	21	July of year two years before payment year through June of the year prior to the payment year	Mid-year risk score run looks at January through December of year prior to payment year	Payment year
Payment system-applied default risk score (risk score type indicated in field 23; field 47 blank)	19	Year prior to payment year	Quarterly updates in payment system look at payment year	No default risk scores used at final payment reconciliation

For payment dates in 2008 and later, field 19 indicates the Medicaid status used to determine the default risk score. For any payment date prior to 2008, field 19 indicates that the Medicaid status used to determine the demographic payment. (See updated MMR data dictionary for a full description of field 19.)

Notice

This information reiterates current policy that is available to Plans on the CMS website. It does not introduce any new policy.

In an effort to improve accessibility and search capability of Frequently Asked Questions (FAQs) and answers, CMS has implemented a question and answer database to house questions and answers for CMS programs. Access can be gained from any page of the CMS website www.cms.hhs.gov/ by clicking the "Questions" tab at the top of the page. Plans should note the FAQ memos produced and distributed by the MMA Help Desk will continue to be emailed; however, the memos will no longer be available as downloads on the website per CMS web policy. The CMS Q&A database will be the source for all MMA Help FAQ information on the web.

The Plan Communications User Guide (PCUG) and Appendices can be accessed by clicking on this direct link: http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp

The MMA Help Desk can be reached at 1-800-927-8069 (Monday-Friday, 6 a.m. to 9 p.m., ET, except federal holidays) or mmahelp@cms.hhs.gov.

The MMA Help website, www.cms.hhs.gov/mmahelp, is the main source for Plan references.