DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

DATE: November 26, 2002

FROM: Regional Inspector General
for Audit Services, Region IV

SUBJECT: Audit of Duplicate Capitation Payments Under Medicare and Medicaid Managed Care Programs in Florida (CIN: A-04-99-01198)

TO: Rose Crum-Johnson, Regional Administrator
Centers for Medicare & Medicare Services

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's final report entitled *Audit of Duplicate Capitation Payments Under Medicare and Medicaid Managed Care Programs in Florida (CIN: A-04-99-01198).*

On June 28, 2001, Humana, Inc. (Humana), a managed care organization (MCO) operating in the State of Florida agreed to pay the State of Florida approximately $8 million to settle an overpayment because it had charged both Medicaid and Medicare for the same services. This settlement was based on a referral to the Florida Medicaid Fraud Control Unit (FMFCU) regarding duplicate capitation payments under both the Medicare and Medicaid programs for dually eligible beneficiaries. The matter was referred to the FMFCU because Florida State Medicaid contracts specifically prohibit concurrent enrollment in both Medicare and Medicaid MCOs.

This audit originated during our audit of Medicaid fee-for-service payments for Medicare and Medicaid dually eligible beneficiaries enrolled in a Medicare MCO[1]. During the course of conducting the audit, we identified $5.1 million in duplicate Medicaid capitation payments at 50 MCOs in calendar year 1996 for beneficiaries concurrently enrolled in a both Medicare and Medicaid MCOs. Based on this condition and the duplicate fee-for-service payments, the FMFCU expanded the investigation to other calendar years. The FMFCU investigation continues to pursue its efforts with other 49 MCOs identified in our audit.

We are recommending that CMS emphasize to Florida that they should have payment systems that are capable of detecting and preventing duplicate payments for services furnished to beneficiaries under both the Medicare and Medicaid programs including those enrolled in an MCO.

In their written response dated October 15, 2002, CMS generally concurred with our findings and recommendations. The CMS officials agreed with our recommendation to emphasize to Florida that they have payment systems that are capable of detecting and preventing duplicate payments for services furnished to beneficiaries under both the Medicare and Medicaid programs

1 *Medicaid Fee-for-Service Payments for Services on Behalf of Beneficiaries Enrolled in Medicare Health Maintenance Organizations (A-04-97-01168)* issued December 1999.

including those enrolled in an MCO. The complete text of CMS' comments is included as Appendix A to this report.

Your formal response to the report is included in the body of our final report. as well as attached as Appendix A. In accordance with the principles of the Freedom of Information Act, 5 United State Code 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 Code of Federal Regulations Part 5.) As such, within 10 business days after our final report is issued, it will be posted on the World Wide Web at http://www.hhs.gov/progorg/oig.

We would also appreciate the status of any action taken or contemplated on our recommendations. If you have any questions, please call Andrew A. Funtal of my staff at (404) 562-7762.

Charles J. Curtis

Attachment

cc:
Eugene Grasser, Jr.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF DUPLICATE CAPITATION PAYMENTS UNDER MEDICARE AND MEDICAID MANAGED CARE PROGRAMS IN FLORIDA

JANET REHNQUIST
Inspector General

NOVEMBER 2002
A-04-99-01198

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Office of Audit Services

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Room 3T41
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DATE: November 26, 2002

FROM: Regional Inspector General
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SUBJECT: Audit of Duplicate Capitation Payments Under Medicare and Medicaid Managed Care Programs in Florida (A-04-99-01198)

TO: Rose Crum-Johnson, Regional Administrator
Centers for Medicare & Medicaid Services

This final report provides you the results of our ***Audit of Duplicate Capitation Payments Under the Medicare and Medicaid Managed Care Programs in Florida.***

EXECUTIVE SUMMARY

OBJECTIVE

The objective of this audit was to determine if managed care organizations (MCO) in Florida received capitation payments under the Medicare and Medicaid programs for the same services provided to the same beneficiaries during concurrent enrollment periods.

FINDINGS

On June 28, 2001, Humana, Inc. (Humana), a MCO operating in the State of Florida agreed to pay the State of Florida approximately $8 million covering the period July 1, 1992 through December 31, 2000 to settle an overpayment because it had charged both Medicaid and Medicare for the same services. This settlement was based on a referral to the Florida Medicaid Fraud Control Unit (FMFCU) regarding duplicate capitation payments under both the Medicare and Medicaid programs for dually eligible beneficiaries. The matter was referred to the FMFCU because Florida State Medicaid contracts specifically prohibit concurrent enrollment in both Medicare and Medicaid MCOs.

This audit originated during our audit of Medicaid fee-for-service payments for Medicare and Medicaid dually eligible beneficiaries enrolled in a Medicare MCO[1]. During the course of conducting the audit, we identified $5.1 million in duplicate Medicaid capitation payments at 50 MCOs in calendar year (CY) 1996 for beneficiaries concurrently enrolled in a both Medicare and Medicaid MCOs. Based on this condition and the duplicate fee-for-service payments, the FMFCU expanded the investigation to other CYs. The FMFCU investigation continues to pursue its efforts with the other MCOs identified in our audit.

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1 *Medicaid Fee-for-Service Payments for Services on Behalf of Beneficiaries Enrolled in Medicare Health Maintenance Organizations (A-04-97-01168)*, issued December 1999.

pursue its efforts with the other MCOs identified in our audit.

We are recommending that CMS emphasize to Florida that they should have payment systems that are capable of detecting and preventing duplicate payments for services furnished to beneficiaries under both the Medicare and Medicaid programs including those enrolled in an MCO.

In their written response dated October 15, 2002, CMS generally concurred with our findings and recommendations. The CMS officials agreed with our recommendation to emphasize to Florida that they have payment systems that are capable of detecting and preventing duplicate payments for services furnished to beneficiaries under both the Medicare and Medicaid programs including those enrolled in an MCO. The complete text of CMS' comments is included as Appendix A to this report.

BACKGROUND

The Tax Equity and Fiscal Responsibility Act of 1982 authorized prospective per capita payments to MCOs such as health maintenance organizations and competitive medical plans under a risk based contract. The CMS contracts with MCOs to provide comprehensive health services on a prepayment basis to enrolled Medicare beneficiaries. The CMS authorizes fixed monthly payments to MCOs for each enrolled Medicare beneficiary.

In exchange for these monthly payments, the MCOs agree to provide the same package of services that is covered under the traditional Medicare fee-for-service system. If the average Medicare payment amount is greater than the amount the MCO estimates it needs to cover the cost of the Medicare package, excess is noted. The MCO is required to use the excess to either improve their benefit package to the Medicare enrollees, reduce the Medicare enrollee's premium, contribute to a benefit stabilization fund, or a combination of these[2]. Most MCOs elect to offer additional expanded benefits that are not covered under Medicare fee-for-service such as dental, eyeglasses, prescription drugs, or reduced deductible and coinsurance amounts.

The Medicaid program is a joint federal and state program for providing financial assistance to individuals with low incomes to enable them to receive medical care. Under the Medicaid program, each state establishes its own eligibility standards, benefits packages, payment rates and program administration in accordance with certain federal statutory and regulatory requirements. The provisions of each state's Medicaid program are described in the state's

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2 Prior to the Medicare+Choice program, another option available to an MCO would have been to accept a reduced payment.

Medicaid "State plan" that CMS approves. In addition to approving state plans and monitoring states for compliance with federal Medicaid laws, the federal role includes providing matching funds to state agencies to pay for a portion of the costs of providing health care to Medicaid recipients. Medicaid typically includes low-income children and their families, pregnant women, individuals age 65 and older, and individuals with disabilities.

When the Medicaid program was created, coverage typically was provided through reimbursements by the state agency to health care providers who submitted claims for payment after they provided health care services to Medicaid recipients. This reimbursement arrangement is referred to as fee-for-service payment. Before 1982, 99 percent of Medicaid recipients received Medicaid coverage through fee-for-service arrangements. Since 1982, state agencies increasingly have provided Medicaid coverage through contracts with MCOs. As of June 2000, over 18 million Medicaid recipients (approximately 55.7 percent of the total Medicaid population) were enrolled in an MCO. See Appendices A and B for MCO enrollment distribution by state.

Medicaid is always the payer of last resort. This means that payments are not to be made from the Medicaid program unless no other third party is liable. With respect to Medicare covered services, Medicaid is always secondary. This secondary responsibility extends to the expanded benefits pledged by the Medicare MCO. Because of this, Medicaid expenditures on behalf of dually eligible beneficiaries are not allowable if the Medicare MCO covers the services.

In developing its contracts for Medicaid MCOs, the Florida Agency for Health Care Administration (AHCA) specifically prohibits the enrollment of Medicaid MCO enrollees that are also enrolled in Medicare MCOs. The Medicaid MCO must request that the beneficiary disenroll from the Medicare MCO within 30 days of enrollment in the Medicaid MCO.

In developing a rate structure the Florida AHCA attempted to address the possibility of enrolling an individual that was eligible for Medicare and Medicaid in a Medicaid MCO by providing a reduced Medicaid capitation payment. This was done because the Medicare eligible beneficiary will have many of his or her services covered under Medicare fee for service and therefore utilize less services under Medicaid. However, this rate structure did not fully recognize the fact that some Medicare beneficiaries are enrolled in Medicare MCOs.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of the audit was to determine if MCOs in Florida received capitation payments under the Medicare and Medicaid programs for the same services provided to the same beneficiaries during concurrent enrollment periods.

Scope and Methodology

On July 07, 1998, the Office of Inspector General (OIG) referred $5.1 million in CY 1996 duplicate Medicaid payments to the FMFCU. Subsequent to that referral, the OIG Office of Audit Services (OAS) has assisted the FMFCU with access to our previous audit of *Medicaid Fee-for-Service Payments for Services on Behalf of Beneficiaries Enrolled in Medicare Health Maintenance Organizations* (CIN: A-04-97-01168); downloads of data from the CMS' data bases; and general testimonial support. We also conducted some limited interviews of CMS personnel to determine if the underlying cause of the erroneous payments still existed.

Since our audit was primarily limited to functioning in an investigative support role, we did not perform substantive testing, verify the validity of the FMFCU's settlement, perform a risk assessment, or assess the internal control structure of the FMFCU or the Humana HMO.

Fieldwork was performed from February 3, 1999 to September 14, 2001 in the OAS Regional Office in Atlanta, Georgia, OAS Field Offices in Tallahassee and Miami, Florida, OAS Baltimore Office, and in the FMFCU offices in Tallahassee, Florida.

Our audit was made in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

On June 28, 2001, the Humana agreed to pay the State of Florida approximately $8 million to settle an overpayment because it had charged both Medicaid and Medicare for the same services. This settlement was based on a referral to the FMFCU regarding duplicate capitation payments under both the Medicare and Medicaid programs for dually eligible beneficiaries. The matter was referred to the FMFCU because Florida state Medicaid contracts specifically prohibit enrollment in both Medicare and Medicaid MCOs.

This audit originated during our audit of Medicaid fee-for-service payments for Medicare and Medicaid dually eligible beneficiaries enrolled in a Medicare MCO. During the course of

conducting the audit, we identified $5.1 million in duplicate Medicaid capitation payments at 50 MCOs in CY 1996 for beneficiaries concurrently enrolled in both Medicare and Medicaid MCOs. Based on this condition and the duplicate fee-for-service payments, the FMFCU expanded the investigation to other CYs. The FMFCU investigation continues to pursue its efforts with the other 49 MCOs identified in our audit.

Previous Audit of Medicaid Fee-for-Service Payments

In our audit entitled *Medicaid Fee-for-Service Payments for Services on Behalf of Beneficiaries Enrolled in Medicare Health Maintenance Organizations* (A-04-97-01168) issued December 20, 1999, we found that Medicare beneficiaries, who were also eligible for Medicaid, received medical services and drugs that should have been provided by Medicare MCOs. However, the services were submitted to and paid by the Florida Medicaid fee-for-service program rather than the MCOs. Federal regulations require that states take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State Plan. However, the State of Florida did not seek recovery for these payments.

Review of Duplicate Capitation Payments

During the course of our audit of the duplicate fee-for-service payments, we determined that in 1996, Florida MCOs received as much as $5.1 million in Medicaid capitation payments for the same beneficiaries/recipients under both the Medicare and Medicaid MCO programs. From our sample of 100 capitation payments, we found that these dually eligible beneficiaries were concurrently enrolled in both Medicare and Medicaid MCOs. We determined that 100 percent of these capitation payments were unallowable.

Of 100 randomly selected sample items in the Medicaid capitation payments universe, 77 belonged to Humana and two other Florida MCOs. Further examination of these payments revealed that:

- of the 51 beneficiaries enrolled in Humana's Medicare MCO plan, 38 were also enrolled in their Medicaid MCO; and

- of the 26 beneficiaries enrolled in the other 2 Medicare MCO plans, 15 were also enrolled in their respective Medicaid MCO plan.

The other 23 beneficiaries were enrolled with one of the remaining 47 Medicare MCO plans and a Medicaid MCO plan.

In part, this condition occurred because the Florida AHCA Third Party Liability Unit did not make available to the Medicaid MCOs monthly data, from CMS' Group Health Plan (GHP) database, which listed the enrollment of Medicare MCO beneficiaries. Both the Humana and another MCO advised us that the State agency informed them that there was no Third Party Liability at the time of Medicaid enrollment. This may explain why beneficiaries enrolled in Medicare MCOs that were different entities than the Medicaid MCOs would go undetected. However, it does not explain how the same MCO could collect capitation payments for beneficiaries enrolled in both the Medicare and Medicaid programs. This occurred even though the MCOs signed contracts, which obligated them to the 30 days disenrollment criteria.

Humana and the other two MCOs claimed to be unaware that they had enrolled the same beneficiaries under both the Medicare and Medicaid MCO programs. Instead, they cited the fact that different personnel and different software were used to track the beneficiaries under the two programs. Although the state did not properly monitor the status of Medicare MCO enrollees, Humana and the other MCOs should have known that they were enrolling the beneficiaries under both programs while sending them to the same clinics and physicians. State agency officials have assured us that steps have subsequently been taken to add the Medicare coverage data from the CMS GHP database to the state's Third Party Resource database.

Actions Taken

We referred this matter to our Office of Investigations with the recommendation that the Florida Attorney General's Medicaid Fraud Control Unit expand on our findings. Subsequent to our initial work covering CY 1996, we worked with the FMFCU in developing the amount of duplicate payments to Humana. On June 28, 2001, the Florida Attorney General announced that Humana agreed to pay nearly $8 million to settle the overpayments it received between July 1, 1992 and December 31, 2000. Humana also agreed to revise its billing procedures to ensure that such double billing does not occur in the future. The FMCFU is continuing their investigation into the remaining MCOs identified in our initial universe.

Conclusion

Our audits have indicated there is a need for CMS to work with the Florida Medicaid agency to ensure that both duplicate capitation payments as well as duplicate fee-for-service payments will not occur. The CMS has made available to Florida, the Enrollment Data Base extract that would determine which Medicaid beneficiaries/recipients are also eligible for Medicare. The extract includes Medicare managed care enrollment information.

RECOMMENDATIONS

We are recommending that CMS emphasize to Florida that they should have payment systems that are capable of detecting and preventing duplicate payments for services furnished to beneficiaries under both the Medicare and Medicaid programs including those enrolled in an MCO.

CMS COMMENTS

In their written response dated October 15, 2002, CMS generally concurred with our findings and recommendations. The CMS officials agreed with our recommendation to emphasize to Florida that they have payment systems that are capable of detecting and preventing duplicate payments for services furnished to beneficiaries under both the Medicare and Medicaid programs including those enrolled in an MCO. The CMS response is included in its entirety as Appendix A to this report.

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Final determination as to actions taken on all matters reported would be made the Department of Health and Human Services (HHS) Action Official named of the second page of the letter preceding this report. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Charles J. Curtis

Attachments – as stated

APPENDIX

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

October 15, 2002

Mr. Charles Curtis
Regional Inspector General for Audit Services
Region IV
61 Forsyth Street, Room 3T41
Atlanta, GA 30303-8909

Reference: Florida Draft Audit A-04-99-01198

Dear Mr. Curtis:

Thank you for the opportunity to review and comment on the draft audit report (Audit of Duplicate Capitation Payments Under Medicare and Medicaid Managed Care Programs in Florida A-04-99-01198). The draft audit contained two recommendations directed towards the Centers for Medicare & Medicaid Services (CMS).

It was recommended that CMS:

1. encourage all states to participate in the data sharing program that will enable them to receive monthly managed care organization enrollment data information; and,

2. emphasize to the states that they should have payment systems that are capable of detecting and preventing duplicate payments for services furnished to beneficiaries under both the Medicare and Medicaid programs including those enrolled in a managed care organization.

The Private Health Insurance Group (PHIG) of CMS' Center for Medicaid and State Operations (CMSO) in Baltimore is the lead component for working with the state Medicaid agencies on issues that impact the beneficiaries eligible for both Medicare and Medicaid (dual eligibles). PHIG has organized a Medicare/Medicaid Technical Advisory Group (M/M TAG) consisting of CMS Medicare and Medicaid staff, and state Medicaid officials to address a wide range of topics including coordination of care and data sharing with the states. We have shared your draft report with PHIG. Below is the response that we received for the report's recommendations.

Recommendation #1 – We agree with this recommendation and are working with the state TAG members on simplification of the data sharing process and making it more time-sensitive. A letter was released to all State Medicaid Directors on January 9, 2002 (copy attached) providing instruction on the process to obtain Medicare enrollment data from CMS. The states still have concerns over timeliness and the extent of the data sharing. We continue to work with the states to address these concerns.

Recommendation #2 – While we agree that duplicate payments under both Medicare and Medicaid for the same service should be prohibited, we are concerned that this recommendation implies that all dual capitation payments to the plans enrolled in both Medicare and Medicaid managed care should be avoided. Florida is unique in its prohibition of a single managed care organization (MCO) from enrolling beneficiaries under both M+C and Medicaid managed care contracts. Accordingly, this recommendation should be addressed only to Florida, and not to the other states that do permit MCOs to serve beneficiaries in a dual capacity.

Over six million Americans are eligible for both Medicare and Medicaid. Dual eligibles comprise 16 percent of Medicare beneficiaries, but represent 30 percent of the Medicare costs. Similarly, they comprise 17 percent of the Medicaid beneficiaries, but account for 35 percent of the Medicaid costs. States should be permitted to address the rising costs of serving the dual eligible population by using creative capitation arrangements with single MCOs that provide both Medicare and Medicaid services to individual beneficiaries. A blanket prohibition against dual capitation payments would hinder this strategy.

If your staff have any questions about this matter, please contact Tom Couch, Financial Analyst for Florida Medicaid activities at 404-562-7495.

Sincerely,

Rhonda Cathell for

Rose Crum-Johnson
Regional Administrator

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #02-001

January 9, 2002

Dear State Medicaid Director:

The purpose of this letter is to provide you with updated information you will need to request a customized extract from the Medicare Enrollment Database (EDB) for your State, which is the established mechanism for states to access Medicare Enrollment files. This letter supercedes previous letters, dated June 21, 2000, and September 6, 2000, from the Centers for Medicare & Medicaid Services (CMS) on the same subject. We have improved the computer matching capability of our systems to produce a more complete and accurate matching of Medicaid beneficiary files with the EDB in order to identify dually-eligible individuals and we have developed an updated data use agreement (DUA) tailored specifically for EDB extracts. These materials and associated instructions are attached. Please note that if you have already signed an updated DUA for this purpose, you do not need to sign another one.

In order to ensure that the CMS Data Center can efficiently and effectively process state requests, while also ensuring that states receive timely and accurate dual-eligible matches, we have also developed submittal parameters (frequency and volume) for submitting EDB finder files as follows:

- To begin, on a one-time-only basis, each state may submit an initial finder file of their COMPLETE Medicaid population (active and inactive) dating back no more than 36 months. This will enable the state to verify both who their current dual eligibles are as well as any residual possible Medicare third party liabilities that had not been previously pursued.

- Then, each state may submit a monthly finder file, containing only active Medicaid beneficiaries who are over age 20. There are so few Medicare beneficiaries under 20 (fewer than 10,000 nationwide) that the one-time-only submittal noted above and the annual update submittal noted in the next bullet will capture them, thus eliminating the need to submit large files of Medicaid beneficiaries under the age of 20 on a monthly basis. While we expect that this reduced monthly volume will make it possible for CMS to manage monthly submittals, we will monitor the monthly workload, and if any adjustments are needed, we will communicate with you before any changes are made.

- After the first submission described in the first bullet, each state may submit on an annual basis all current active (including under age 20) and inactive Medicaid beneficiaries who have been inactive during the previous 12-month period from the date of submission to match against the EDB for Medicare entitlement and enrollment data.

Taken together, this schedule for finder file submissions will provide the states with very timely, accurate and complete data on their dual eligible beneficiary populations. This represents a real improvement in our customer service to states while at the same time bringing efficiencies and economies to the operation of the CMS Data Center. We also want to stress that this procedure does not preclude you from making special requests for Medicare data under separate DUAs.

For those states that have not yet signed new data use agreements, the materials needed to participate in this improved dual eligible data matching process include:

- Updated EDB Customized File Process and Steps for States to take (Enclosure A).
- an updated Data Use Agreement (DUA) template (Enclosure B), which is returned to CMS for approval. The enclosed package includes instructions for preparation of a DUA (Enclosure C);
- the record specification for the EDB Customized State File (Enclosure D); and
- CMS policy for submitting EDB finder file (as described above) (Enclosure E).

Please send your completed and signed DUA to Rebecca (Goldy) Rogers at the address specified in item 1 of Enclosure A, and a copy of the cover letter, only, to Andrea Armstead, whose address is also given in Enclosure A.

Once your DUA has been approved, you will be asked to submit a test file of beneficiary SSNs, following the format in item 5 of Appendix D. The test file will assure that data matches can be performed smoothly in the future. Please contact Dural Suite at (410) 786-0122 to discuss how the file will be conveyed to CMS. This file may not be transmitted over the Internet.

It will take approximately three weeks for CMS to respond to States after processing the test files. After your test file is approved you will be able to submit files of Medicaid eligibles according to the schedule described above (and in Enclosure E), which CMS will match against the EDB.

If you have any questions about any aspect of this process, please direct them to Rebecca (Goldy) Rogers at (410) 786-6450, or to one of the individuals listed in Enclosure A, as appropriate.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosures

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jennifer King
Director, Health and Human Services Task Force
American Legislative Exchange Council

ENCLOSURE A

UPDATED EDB CUSTOMIZED FILE REQUESTS: STEPS TO FOLLOW

1. The State should submit a request letter with a detailed justification for the data and the original signed Data Use Agreement (DUA) to the Centers for Medicare and Medicaid Services (CMS). See the attached DUA with instructions. This should be submitted to:

   Rebecca (Goldy) Rogers (Complete Package)
   S3-13-15
   7500 Security Blvd.
   Baltimore, MD 21244-1850
   (410) 786-6450

   Andrea Armstead (request letter only)
   S1-05-06
   7500 Security Blvd.
   Baltimore, MD 21244-1850
   (410) 786-7851

   At the same time the State is submitting the DUA and request letter with the detailed data justification, the State should pursue the option of setting up NDM (connect-direct) service with CMS in lieu of submitting data files via US Mail. Please contact Dural Suite (410) 786-0122 for guidance on establishing electronic data transmissions as well specific information on sending in an initial test file.

2. CMS will review the DUA and justifications. The State will be contacted to clarify any questions CMS may have. Once the DUA and data justifications are approved, the DUA will be signed by the CMS representative and assigned a DUA number. Please allow 2 to 4 weeks for initial processing of the DUA and justification.

3. A completed copy of the DUA with the assigned DUA number will be returned to the State.

4. The State's test finder file should contain no more than 100 records. Please see ENCLOSURE D for a record description.

ENCLOSURE B:

DATA USE AGREEMENT

BETWEEN CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) AND THE

STATE OF_____

AGREEMENT FOR USE OF CMS DATA CONTAINING INDIVIDUAL-SPECIFIC INFORMATION

In order to secure data that resides in a CMS Privacy Act System of Records, and in order to ensure the integrity, security, and confidentiality of information maintained by CMS, and to permit appropriate disclosure and use of such data as permitted by law, CMS and _____, enter into this agreement to comply with the following specific paragraphs.

1. This Agreement is by and between CMS, a component of the U.S. Department of Health and Human Services (DHHS), and _____, hereinafter termed "User."

2. This Agreement addresses the conditions under which CMS will disclose and the User will obtain and use the CMS Enrollment Database (EDB) Customized State File specified in section 7. This Agreement supersedes any and all agreements between the parties with respect to the use of the EDB Customized State File, and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to any grant award or other prior communication from the Department of Health and Human Services or any of its components with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement, or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by the CMS point-of-contact specified in section 5, or the CMS signatory to this Agreement shown in section 20.

3. The parties mutually agree that CMS retains all ownership rights to the data file(s) referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by CMS.

4. The parties mutually agree that the following named individual is designated as"Custodian" of the file(s) on behalf of the User, and will be personally responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify CMS within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian, or may require the appointment of a new custodian at any time.

_____
(Name of Custodian)

(Company/Organization)

(Street Address)

(City/State/ZIP Code)

(Phone Number Including Area Code and E-mail Address if applicable)

5. The parties mutually agree that the following named individual will be designated as "point-of-contact" (or "System Manager") for the Agreement on behalf of CMS.

(Name of Contact)

(Title/Component)

7500 Security Blvd.
(Street Address)

Baltimore, MD 21244-1850
(City/State/ZIP Code)

(Phone Number Including Area Code and E-mail Address if applicable)

6. The User represents, and in furnishing the EDB Customized State File, CMS relies upon such representation, that this file(s) will be used solely for the purpose(s) outlined below.

   The EDB Customized State File is used for the following:

   A. To enable the User to identify Medicare individuals who are potentially eligible for inclusion in a State Buy-In account, including Qualified Medicare Beneficiaries (QMBs), and

   B. To identify Medicare/Medicaid dually eligible individuals for whom Medicaid has secondary payer liability by:

      (1) Obtaining a beneficiary's correct health insurance claim number (HICN),
      (2) Verifying a beneficiary's name, date of birth and address, social security number, State buy-in indicator code, Railroad Board indicator code,
      (3) Avoiding duplicate claims payments by screening pre-payment of Medicaid claims, and

(4) Enabling recoupment of payments by reviewing post payment of Medicaid claims.

C. To support the development of risk adjustment factors which are a necessary element in establishing capitation rates or prospective payment levels, and which contribute to sound fiscal planning and the evaluation of future program initiatives.

The User represents further that, except as specified in an Enclosure to this Agreement or except as CMS shall authorize in writing, the User shall not disclose, release, reveal, show, sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement to any person(s). The User agrees that, within the User organization, access to the data covered by this Agreement shall be limited to the minimum number of individuals necessary to achieve the purpose stated in this section and to those individuals on a need-to-know basis only. Disclosure of this data is made pursuant to:

- Freedom of Information Act (5 U.S.C. Section 552)
- Privacy Act (5 U.S.C. Section 552a)
- Section 1106 of the Social Security Act (42 U.S.C. Section 1306)
- Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503)
- Section 1843 of the Social Security Act (42 U.S.C. Section 1395v)

7. CMS will provide the User with the EDB Customized State File, which is an extract from the Health Insurance Master Record (HIMR), System Number 09-07-0502. CMS warrants that the file is accurate to the extent possible. Beneficiaries included in the EDB Customized State File will vary from State to State depending on the number of Medicare beneficiaries residing in the State, present or past and on the size of the finder file submitted for the given month. The following files are covered under this Agreement:

EDB Customized State File	Current

8. The parties mutually agree that the aforesaid file(s) (and/or any derivative file(s) [includes any file that maintains or continues identification of individuals]) may be retained by the User only for the period of time required for any processing related to matching under this Agreement. The User agrees to notify CMS within 30 days of the completion of the purpose specified above in section 6. Upon such notice, CMS will notify the User either to return all data files to CMS at the User's expense, or to destroy such data. If CMS elects to have the User destroy the data, the User agrees to certify the destruction of the files in writing within 30 days of CMS's instruction. A statement certifying this action *must* be sent to CMS. If CMS elects to have the data returned, the User agrees to return all files to CMS within 30 days of receiving notice to that effect. The User agrees that no data from CMS records, or any parts thereof, shall be retained when the aforementioned file(s) are returned or destroyed unless authorization in writing for the retention of such file(s) has been received from the appropriate Systems Manager or the person designated in section 20 of this Agreement. The User acknowledges that stringent adherence to the aforementioned information outlined in this paragraph is required. The User further acknowledges that the EDB Customized State File received for any previous periods, and all copies thereof, must be destroyed upon receipt

of an updated version, and verification made to CMS. Certification of the destruction of these files is required in writing within 30 days of such destruction.

9. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data, and to prevent its unauthorized use or access. The safeguards shall provide a level and scope of security that is not less than the level and scope of security established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems (http://www.whitehouse.gov/omb/circulars/a130/a130.html), which sets forth guidelines for security plans for automated information systems in Federal agencies. The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable or deducible information derived from the file(s) specified above in section 7 is strictly prohibited. Further, the User agrees that the data must not be physically moved or transmitted in any way from the site indicated above in section 4, without written approval from CMS.

10. The User agrees that the authorized representatives of CMS, DHHS Office of the Inspector General or Comptroller General, will be granted access to premises where the aforesaid file(s) are kept for the purpose of inspecting security arrangements confirming whether the User is in compliance with the security requirements specified in section 9 above.

11. The User agrees that no findings, listing, or information derived from the file(s) specified in section 7, with or without identifiers, may be released if such findings, listing, or information contain any combination of data elements that might allow the deduction of a beneficiary's identification, without first obtaining written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement. (Examples of such data elements include, but are not limited to, address, sex, age, medical diagnosis, procedure, admission/discharge dates, date of death, etc.) The User agrees further that CMS shall be the sole judge as to whether any finding, listing, or information, or any combination of data extracted or derived from CMS's files identifies or would, with reasonable effort, permit one to identify an individual or to deduce the identity of an individual with a reasonable degree of certainty.

12. The User agrees that, absent express written authorization from the appropriate System Manager or the person designated in section 20 to do so or as outlined in this agreement, the User shall make no attempt to link records included in the file(s) specified in section 7 to any other identifiable source of information. This includes attempts to link to other CMS data files.

13. The User understands and agrees that they may not reuse original or derivative data file(s) without prior written approval from the appropriate System Manager or the person designated in section 20 of this Agreement.

14. The parties mutually agree that the following specified Enclosures are part of this Agreement:
    - The Federal Register notice which includes the routine use for disclosure of information in the system to a state agency, an agency of a state government, an agency established by state law, or its fiscal agent.

15. The User agrees that in the event CMS determines or has a reasonable belief that the User has made or may have made disclosure of the aforesaid file(s) that is not authorized by this Agreement, or other written authorization from the appropriate Systems Manager or the person designated in section 20, CMS in its sole discretion may require the User to: (a) promptly investigate and report to CMS the User's determinations regarding any alleged or actual unauthorized disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by CMS, submit a formal written response to an allegation of unauthorized disclosure; (d) if requested by CMS, submit a corrective action plan with steps designed to prevent any future unauthorized disclosures; and (e) if requested by CMS, return data files to CMS immediately. The User understands that as a result of CMS's determination or reasonable belief that unauthorized disclosures have taken place, CMS may refuse to release further CMS data to the User for a period of time to be determined by CMS.

16. The User hereby acknowledges that criminal penalties under § 1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), including a fine not exceeding $10,000 or imprisonment not exceeding 5 years, or both, may apply to disclosures of information that are covered by § 1106 and that are not authorized by regulation or by Federal law. The User further acknowledges that criminal penalties under the Privacy Act (5 U.S.C. § 552a(i) (3)) may apply if it is determined that the Requestor or Custodian, or any individual employed or affiliated therewith, knowingly and willfully obtained the file(s) under false pretenses. Any person found guilty under the Privacy Act shall be guilty of a misdemeanor and fined not more than $5,000. Finally, the User acknowledges that criminal penalties may be imposed under 18 U.S.C. § 641 if it is determined that the User, or any individual employed or affiliated therewith, has taken or converted to his own use data file(s), or received the file(s) knowing

    that they were stolen or converted. Under such circumstances, they shall be fined under Title 18 or imprisoned not more than ten years, or both.

17. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement for protection of the data file(s) specified in section 7, and acknowledges having received notice of potential criminal and administrative penalties for violation of the terms of the Agreement.

18. On behalf of the User, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein. This agreement shall be effective 40 days after notice of routine use is sent to Congress and OMB, or 30 days after publication of this notice in the Federal Register, or upon signature by both parties, whichever is latest. The duration of this Agreement is two years from the effective date. The User also acknowledges that this agreement may be terminated at any time with the consent of both parties involved. Either party may independently terminate the agreement upon written request to the other party, in which case the termination shall be effective 90 days after the date of the notice, or at a later date specified in the notice.

_____
(Name/Title of Individual)

_____
(State Agency/Organization)

_____
(Street Address)

_____
(City/State/ZIP Code)

_____
(Phone Number Including Area Code and E-mail Address if applicable)

_____
Signature Date

19. The Custodian, as named in section 4, hereby acknowledges his/her appointment as Custodian of the aforesaid file(s) on behalf of the User, and agrees personally and in a representative capacity to comply with all of the provisions of this Agreement on behalf of the User.

_____
(Typed or Printed Name of Custodian)

_____
Signature Date

20. On behalf of CMS, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

_____
(Typed or Printed Name and Title of CMS Representative)

_____
Signature

ENCLOSURE C

INSTRUCTIONS FOR COMPLETING THE DATA USE AGREEMENT (DUA)

This agreement is needed in order for you to receive the Enrollment Database Customized State File to ensure compliance to the requirements of the Privacy Act, and must be completed prior to the release of file.

Directions for the completion of the agreement follow:

- First paragraph, enter the Name of the State Agency.
- Item #1, enter the Name of the State Agency.
- Item #4, enter the Custodian Name, State Agency Department/Organization, Address, Phone Number (including area code), and E-Mail Address (if applicable). The Custodian of files is defined as that person who will have actual possession of and responsibility for the data files. This section should be completed even if the Custodian and Requestor are the same.
- Item #18 is to be completed by Requestor.
- Item #19 is to be completed by Custodian.
- Item #20 will be completed by the CMS representative.

If you have any questions about the DUA or need any assistance completing the DUA, please contact Kim Elmo on (410) 786-0161. Submit the original signed DUA and request letter to:

Rebecca (Goldy) Rogers
S3-13-15
7500 Security Boulevard
Baltimore, MD 21244-1850

ENCLOSURE D

EDB INPUT FINDER FILE DESCRIPTION

File Name: **Date: January 3, 2001**
OIS/DID STATE SSN INPUT FILE

Record Name:
OIS/DID STATE SSN RECORD (Page 1 of 1)

FIELD	Size	Usage	Location in File	Remarks
1. Social Security Number	9	alphanumeric	1 - 9	REQUIRED, ascending sequence
2. State's Requestor Id	8	alphanumeric	10 - 17	REQUIRED and constant in every record. The first two positions should contain the state's code (AZ, NY, etc)
3. Beneficiary's State Identification Number	25	alphanumeric	18 - 42	REQUIRED. Left justified. Blank filled.
4. Beneficiary's Birth Date	8	alphanumeric	43 - 50	OPTIONAL, YYYYMMDD
5. Beneficiary's Sex Code	1	alphanumeric	51	OPTIONAL, 1- Male, 2-Female
6. Beneficiary's Given Name	6	alphanumeric	52 - 57	OPTIONAL, Left justified. Blank filled.
7. Beneficiary's Surname	6	alphanumeric	58 - 63	OPTIONAL, Left justified. Blank filled.
8. File Creation Year/Month	4	alphanumeric	64 - 67	OPTIONAL, YYMM
9. State Miscellaneous Data	13	alphanumeric	68 - 80	For State Use

EDB OUTPUT FILE DESCRIPTION

JAN 03, 2001 HCFA RECORD SPECIFICATION FOR VIEW EYMH03T PAGE: 1

FILE:
RECORD FORMAT: FB RECORD LENGTH: 1005 BLOCK SIZE: 27135

FIELD NAME	LOC	SIZE	TYPE	OCC	FORMAT/VALUES
*** FINDER RECORD ***	1	80	CHAR		
STATE-SSN-NUM	1	9	CHAR		
STATE-REQ-ID		8	CHAR		
STATE-BENE-ID-NUM		25	CHAR		
STATE-BIRTH-DT		8	CHAR		
STATE-SEX-CD		1	CHAR		
STATE-GVN-NAME		6	CHAR		
STATE-SUR-NAME		6	CHAR		
STATE-CREATE-YYMM		4	CHAR		
STATE-MISC-DATA		13	CHAR		
*** FINDER STATUS ***	81	1	CHAR		
FINDER STATUS CODE:	81	1	NUM		012345678
0 = NOT ON FILE					
1 = BENE_CLM_NUM: EXACT MATCH					
3 = BENE_CLM_NUM: EQUATABLE BIC MATCH					
2 = XREF_CLM_NUM: EXACT MATCH					
4 = XREF_CLM_NUM: EQUATABLE BIC MATCH					
5 = BENE_SSN_NUM MATCH (USING PRIMARY BIC)					
8 = NO BIC: ALL FAMILY MEMBERS MATCHED					
*** BENEFICIARY IDENTIFICATION	82	209	CHAR		
BENE_IDENT_REL	82	209	CHAR		
BENE_CLM_NUM	82	11	CHAR		
BENE_CLM_ACNT_NUM	82	9	CHAR		
BENE_IDENT_CD	91	2	CHAR		
BENE_BIRTH_DT	93	8	DATE		YYYYMMDD
BENE_DEATH_DT	101	8	DATE		YYYYMMDD
BENE_SEX_IDENT_CD	109	1	NUM		210
BENE_GVN_NAME	110	15	CHAR		
BENE_MDL_NAME	125	1	CHAR		
BENE_SRNM_NAME	126	24	CHAR		
BENE_MLG_CNTCT_ADR_CNT	150	2	NUM		0 THRU 6
BENE_MLG_CNTCT_ADR_MAX	152	2	NUM		6
BENE_MLG_CNTCT_ADR	154	22	CHAR	6	
BENE_RPRSNTV_PYE_SW	286	1	CHAR		YN
EDB_BENE_PTA_PRM_PYR_CD	287	1	CHAR		017
EDB_BENE_PTB_PRM_PYR_CD	288	1	CHAR		0157
BENE_PTA_NENTLMT_STUS_CD	289	1	CHAR		DFHNPR
BENE_PTB_NENTLMT_STUS_CD	290	1	CHAR		DNPR

JAN 03, 2001 HCFA RECORD SPECIFICATION FOR VIEW EYMH03T PAGE: 2

FIELD NAME	LOC	SIZE	TYPE	OCC	FORMAT/VALUES
*** CROSS-REFERENCE NUMBERS ***	291	114	CHAR		
XREF_BENE_CLM_ACNT_CNT	291	2	NUM		0 THRU 10
XREF_BENE_CLM_ACNT_MAX	293	2	NUM		10
XREF_BENE_CLM_ACNT_REL	295	11	CHAR	10	
XREF_BENE_CLM_NUM	295	11	CHAR		
XREF_BENE_CLM_ACNT_NUM	295	9	CHAR		
XREF_BENE_IDENT_CD	304	2	CHAR		
*** SOCIAL SECURITY NUMBERS ***	405	49	CHAR		
BENE_SSN_NUM_CNT	405	2	NUM		0 THRU 5
BENE_SSN_NUM_MAX	407	2	NUM		5
BENE_SSN_NUM_REL	409	9	CHAR	5	
BENE_SSN_NUM	409	9	NUM		
*** PART A ENTITLEMENT ***	454	18	CHAR		
BENE_PTA_ENTLMT_REL	454	18	CHAR		
BENE_PTA_ENTLMT_STRT_DT	454	8	DATE		YYYYMMDD
BENE_PTA_ENTLMT_TRMNTN_DT	462	8	DATE		YYYYMMDD
BENE_PTA_ENRLMT_RSN_CD	470	1	CHAR		
BENE_PTA_ENTLMT_STUS_CD	471	1	CHAR		CEGSTWXY
*** PART B ENTITLEMENT ***	472	18	CHAR		
BENE_PTB_ENTLMT_REL	472	18	CHAR		
BENE_PTB_ENTLMT_STRT_DT	472	8	DATE		YYYYMMDD
BENE_PTB_ENTLMT_TRMNTN_DT	480	8	DATE		YYYYMMDD
BENE_PTB_ENRLMT_RSN_CD	488	1	CHAR		
BENE_PTB_ENTLMT_STUS_CD	489	1	CHAR		CFGSTWY
*** HOSPICE COVERAGE ***	490	124	CHAR		
BENE_HOSPC_CVRG_CNT	490	2	NUM		0 THRU 5
BENE_HOSPC_CVRG_MAX	492	2	NUM		5
BENE_HOSPC_CVRG_REL	494	24	CHAR	5	
BENE_HOSPC_CVRG_STRT_DT	494	8	DATE		YYYYMMDD
BENE_HOSPC_CVRG_TRMNTN_DT	502	8	DATE		YYYYMMDD
BENE_HOSPC_CVRG_PRCSG_DT	510	8	DATE		YYYYMMDD
*** ENTITLEMENT REASON ***	614	9	CHAR		
BENE_ENTLMT_RSN_CD_REL	614	9	CHAR		
BENE_ENTLMT_RSN_CD_CHG_DT	614	8	DATE		YYYYMMDD
BENE_ENTLMT_RSN_CD	622	1	NUM		0123
*** RESIDENCE ***	623	17	CHAR		
BENE_RSDNC_REL	623	17	CHAR		
BENE_RSDNC_CHG_DT	623	8	DATE		YYYYMMDD
BENE_MLG_CNTCT_ZIP_CD	631	9	CHAR		
*** DISABILITY INSURANCE ***	640	17	CHAR		
BENE_HCFA_DIB_ENTLMT_REL	640	17	CHAR		
BENE_HCFA_DIB_ENTLMT_STRT_DT	640	8	DATE		YYYYMMDD
BENE_HCFA_DIB_ENTLMT_END_DT	648	8	DATE		YYYYMMDD
BENE_DIB_ENTLMT_DT_JSTFCTN_CD	656	1	NUM		0123

JAN 03, 2001 HCFA RECORD SPECIFICATION FOR VIEW EYMH03T PAGE: 3

FIELD NAME	LOC	SIZE	TYPE	OCC	FORMAT/VALUES
*** GROUP HEALTH ORGANIZATION *	657	214	CHAR		
BENE_GHO_ENRLMT_CNT	657	2	NUM		0 THRU 10
BENE_GHO_ENRLMT_MAX	659	2	NUM		10
BENE_GHO_ENRLMT_REL	661	21	CHAR	10	
BENE_GHO_ENRLMT_STRT_DT	661	8	DATE		YYYYMMDD
BENE_GHO_DISENRLMT_DT	669	8	DATE		YYYYMMDD
BENE_GHO_CNTRCT_NUM	677	5	CHAR		
*** END STAGE RENAL DISEASE COVERAGE	871	17	CHAR		
BENE_ESRD_CVRG_REL	871	17	CHAR		
BENE_ESRD_CVRG_STRT_DT	871	8	DATE		YYYYMMDD
BENE_ESRD_CVRG_TRMNTN_DT	879	8	DATE		YYYYMMDD
BENE_ESRD_TRMNTN_DT_RSN_CD	887	1	CHAR		ABCDE
*** END STAGE RENAL DISEASE DIALYSIS	888	16	CHAR		
BENE_ESRD_DLYS_REL	888	16	CHAR		
BENE_ESRD_DLYS_STRT_DT	888	8	DATE		YYYYMMDD
BENE_ESRD_DLYS_STOP_DT	896	8	DATE		YYYYMMDD
*** END STAGE RENAL DISEASE TRANSPLANT	904	16	CHAR		
BENE_ESRD_TRNSPLNT_REL	904	16	CHAR		
BENE_ESRD_TRNSPLNT_STRT_DT	904	8	DATE		YYYYMMDD
BENE_ESRD_TRNSPLNT_STOP_DT	912	8	DATE		YYYYMMDD
*** THIRD PARTY PART A HISTORY	920	43	CHAR		
BENE_TP_PTA_HSTRY_REL	920	43	CHAR		
BENE_PTA_TP_STRT_DT	920	8	DATE		YYYYMMDD
BENE_PTA_TP_PRM_PYR_CD	928	3	CHAR		
BENE_PTA_TP_ACRTN_TRANS_CD	931	4	CHAR		
BENE_PTA_TP_ACRTN_ADJSTMT_CD	935	1	CHAR		EL578
BENE_PTA_TP_ACRTN_BLG_MO_DT	936	6	NUM		
BENE_PTA_TP_TRMNTN_DT	942	8	DATE		YYYYMMDD
BENE_PTA_TP_DLTN_TRANS_CD	950	4	CHAR		
BENE_PTA_TP_DLTN_ADJSTMT_CD	954	1	CHAR		ELNSY
BENE_PTA_TP_DLTN_BLG_MO_DT	955	6	NUM		
BENE_PTA_TP_BUYIN_ELGBLTY_CD	961	1	CHAR		
BENE_PTA_TP_RFND_SW	962	1	CHAR		R
*** THIRD PARTY PART B HISTORY	963	43	CHAR		
BENE_TP_PTB_HSTRY_REL	963	43	CHAR		
BENE_PTB_TP_STRT_DT	963	8	DATE		YYYYMMDD
BENE_PTB_TP_PRM_PYR_CD	971	3	CHAR		
BENE_PTB_TP_ACRTN_TRANS_CD	974	4	CHAR		
BENE_PTB_TP_ACRTN_ADJSTMT_CD	978	1	CHAR		EL578
BENE_PTB_TP_ACRTN_BLG_MO_DT	979	6	NUM		
BENE_PTB_TP_TRMNTN_DT	985	8	DATE		YYYYMMDD
BENE_PTB_TP_DLTN_TRANS_CD	993	4	CHAR		
BENE_PTB_TP_DLTN_ADJSTMT_CD	997	1	CHAR		ELNSY
BENE_PTB_TP_DLTN_BLG_MO_DT	998	6	NUM		
BENE_PTB_TP_BUYIN_ELGBLTY_CD	1004	1	CHAR		
BENE_PTB_TP_RFND_SW	1005	1	CHAR		R

ENCLOSURE E

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
POLICY FOR SUBMITTING THE
ENROLLMENT DATABASE (EDB) CUSTOMIZED STATE FINDER FILE

This policy applies to the size and frequency of the finder files submitted by the states requesting Medicare entitlement and enrollment data.

- To begin, on a one-time-only basis, each state may submit an initial finder file of their COMPLETE Medicaid population (active and inactive) dating back no more than 36 months. This will enable the state to verify both who their current dual eligibles are as well as any residual possible Medicare third party liabilities that had not been previously pursued.

- Then, each state may submit a monthly finder file, containing only active Medicaid beneficiaries who are over age 20. There are so few Medicare beneficiaries under 20 (fewer than 10,000 nationwide) that the one-time-only submittal noted above and the annual update submittal noted in the next bullet will capture them, thus eliminating the need to submit large files of Medicaid beneficiaries under the age of 20 on a monthly basis. While we expect that this reduced monthly volume will make it possible for CMS to manage monthly submittals, we will monitor the monthly workload, and if any adjustments are needed, we will communicate with you before any changes are made.

- After the first submission described in the first bullet, each state may submit on an annual basis all current active (including under age 20) and inactive Medicaid beneficiaries who have been inactive during the previous 12-month period from the date of submission to match against the EDB for Medicare entitlement and enrollment data.