CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-16 Medicare Managed Care	Centers for Medicare & Medicaid Services (CMS)
Transmittal 112	**Date: May 10, 2013**
	Change Request 8243

Contractors Please Note: This note is being re-communicated because Transmittal # 122 was incorrectly assigned to the Transmittal Sheet. The Transmittal Sheet was corrected to show the correct Transmittal #112. All other information remains the same.

SUBJECT: Adding MSP Validity Indicator to the CWF to MBD Feed

I. SUMMARY OF CHANGES: The MBD GUI is being updated to include more MSP information. One error that has been noted in tracking MSP information from CWF to MARx is that the validity indicator which can indicate if an MSP record is under development or if it is a valid record has not been included in the feed. This information is needed by MARx to determine payment for Medicare Advantage plans. Once the MBD field is created to hold the validity indicator, CWF will need to do a clean-up to populate the new field.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013 - Coding Changes to create the new fields in the CWF feed to MBD will be made in October; January 6, 2014 - The utility and cleanup will be completed as part of the January release.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	8/70.4.1/Working Aged Adjustment

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-16	**Transmittal: 112**	**Date: May 10, 2013**	**Change Request: 8243**

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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) seeks to improve the quality of other health insurance (OHI) information that it makes available to external health plans. CMS is making concurrent changes under a Managed Care Prescription Drug (MAPD) Change Request (CR 2575) to ensure that the OHI information displayed via the Medicare Beneficiary Database (MBD) will be more robust and useful. This change request will ensure that the data feed between the Common Working File (CWF) and the MBD will contain any new elements that are not already included in the file layout and within the CWF copybook. This an operational improvement and not related to a change in policy. MAPD CR 2575 is effective the same date as CR 8243, and the two CRs will be released simultaneously.

B. Policy: The manual change included in this change request includes the policy that was implemented in 2010. The manual reference is in Pub 100-16 Managed Care Manual, Chapter 8/70.4.1-Working Aged Adjustment.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	**Requirement**	**Responsibility**										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8243.1	The Common Working File (CWF) shall modify its layout for exchanging Medicare Secondary Payer (MSP) information with the Medicare Beneficiary Database (MBD) to include these new elements: 1. Validity Indicator (valid values=Y, I, N) 2. Delete indicator (valid values=D or space) 3. MSP Originating Contractor										X	CMS

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	4. MSP Updating Contractor 5. MSP Date of Accretion (Creation Date) 6. MSP Last Maintenance Date ATTN: CMS MBD											
8243.2	CWF shall create a utility that identifies all MSP records that are effective 01/01/2009 or later and if prior to MSP effective 1/1/2009 also identify when no Term Date or if the Term Date is on or after 1/1/2009. This requirement will be completed as part of the January 2014 release.										X	
8243.3	CWF Hosts shall transmit the utility results to CMS MBD as part of the January 2014 release. ATTN: CWF Hosts and CMS MBD											CMS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Mary Stojak, 410-786-6939 or mary.stojak@cms.hhs.com

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
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Section B: For Medicare Administrative Contractors (MACs):
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70.4.1 – Working Aged Adjustment

(Rev.112, Issued:05-10-13,Effective:10-01-13, Implementation:10-07-12-Coding Changes to create the new field in the CWF feed to MBD will be made in October; January 6, 2014- The utility and cleanup will he completed as part of the January release)

CMS makes a payment adjustment for *managed care* enrollees who are working aged *or disabled and covered under another's employment insurance.* Beneficiaries are "working aged" if they are aged 65 or older, currently working for an employer with 20 or more employees, and have health insurance coverage through the employer's group health plan. Medicare-eligible spouses who are aged 65 or older, with health insurance coverage under a currently employed spouse's employer group health plan (if that employer has 20 or more employees) are also assigned working aged status (even if the currently employed spouse is under 65 years of age and not yet entitled to Medicare). *Disabled beneficiaries covered under other employment insurance benefits will only appear as "disabled" in MSP files.*

Medicare spending for *these* beneficiaries is significantly lower than spending for other beneficiaries because other insurers are primary to Medicare. In 1995, working aged status was added as a factor for adjusting payments to managed care organizations with §1876 risk contracts. *However, in 2010, CMS started reducing payments for MSP on a beneficiary instead of contract basis. MSP information received from insurance companies, the beneficiaries themselves, and managed care plans are used to adjust individual beneficiary payment amounts.*

CMS sends plans monthly reports that include all of the beneficiaries where Medicare is the Secondary Payer. These reports are explained in depth in the Plan Communications User Guide. If plans disagree with CMS' determination that their enrollees have other employer insurance coverage, they can submit a correction via ECRs as described in the IOM, Chapter 5.1 of Publication 100-05 Medicare Secondary Payer Manual.