

Michelle Hoke

From: Sanchez, Ada (CMS/CM) <Ada.Sanchez@CMS.hhs.gov>
Sent: Friday, September 13, 2013 1:21 PM
To: Kendall, Glenn W. (CMS/CM); Gorner, Julia (CMS/OFM)
Cc: michellehoke@coeha.com
Subject: RE: HCPP 2nd request

Glenn

HETS is reporting the data to the providers/suppliers as it has been transferred/downloaded from the source.

This Plan is registered as a HMO Medicare non-risk with a MCO bill option code of 1

PLAN TYPE: "HMO" PLAN: "H4906" OPT: "1" ENR DATE: "09/01/05" TRM DTE: "00/00/00"

In the HETS Companion guide reference. This plan is listed with a 01 Bill option code, which is crossed-walked to Insurance type code of HM. Both 01 and HM are returned on the 271.

MCO Bill Option Code will be returned only for Insurance Type Code values "HM", "HN", "IN", "PR" and "PS". The MCO Bill Option Codes returned by the HETS 270/271 application are:

Medicare Beneficiary "locked in" to MCO

"A" – Fiscal Intermediary should process all claims

"B" – MCO should process only in-plan Part A claims and in-area Part B claims

"C" – MCO should process all claims

Medicare Beneficiary NOT "locked in" to MCO

"1" – Fiscal Intermediary should process all claims

"2" – MCO should process only in-plan Part A claims and in-area Part B claims

I also verify the data in HPMS.

In HPMS, H4906 is an HCPP, which is an 1833 cost plan. They are NOT an MA plan.

When we crosswalked the HPMS plan types to the available HIPAA plan types for the purposes of 270/271, 1833 cost plans were mapped to the HIPAA value "HM - Health Maintenance Organization (HMO)." This is the best option available when we did the crosswalk.

We included the bill option code in the 270/271 transaction and on the CWF display to give providers more information on how to interpret the data beyond the "plan type" value. Bill option value 1 tells the provider that "CMS will process all provider claims." This is the guidance that users should be following for H4906, as it explains that this contract is not a regular MA plan.

If it were an MA plan, the bill option value would be C, which indicates "Lock-In Beneficiary - plan to process all Part A and Part B claims." That's why providers need to be educated to look at the bill option code, not solely the plan type. CMS has provided an educational articles, such as the Medicare Learning Network, in the past to promote this.

As it stands, all of the data are correct for this contract. Rather it is an interpretation issue.

Please let me know if you have any additional questions.

Thanks