

# **HIPAA Administrative Simplification Managed Care Frequently Asked Questions**

**Q1 Is the 834 Enrollment a required transaction when exchanged between CMS and Medicare MCOs?**

A1 The 834 is not a required transaction when exchanged between CMS and Medicare MCOs. The regulation defines the enrollment transaction as a request for an enrollment or a disenrollment from a sponsor or a health plan to another health plan. The exchange that occurs between CMS and Medicare MCOs is a notification action and not an enrollment. The beneficiary is enrolled in the health plan and the enrollment has already occurred at the point that CMS is notified. CMS is not enrolling the beneficiary.

**Q2 Is CMS a covered entity under HIPAA?**

A2 Yes, CMS is a health plan and therefore a covered entity under HIPAA.

**Q3 Does CMS consider Medicare MCOs to be its business associate?**

A3 CMS does not consider health plans to be its business associate. Medicare MCOs are operating as health plans and are not conducting business on behalf of CMS.

**Q4 Does CMS consider Medicare MCOs to be its sponsor?**

A4 A Medicare MCO is are not considered a sponsor when conducting business with CMS. A sponsor is an organization that will be paying the health plan premium on behalf of the enrollee.

**Q5 Does CMS consider States to be sponsors when conducting business with health plans?**

A5 Yes. The Medicaid agency or its enrollment broker is actually enrolling the Medicaid recipient in the health plan. In that case the State is acting in the role of a sponsor.

**Q6 If not using the 834, how will MCOs notify CMS of enrollments?**

A6 CMS will continue to accept the 80-byte record that is in place today. A copy of the 80-byte enrollment/disenrollment record is located in the Payment & Enrollment Guide, Tab 16, Page C-2 at the following web address: <http://www.hcfa.gov/medicare/mcoenrolpayconf2.htm>.

**Q7 Does an MCO have to accept an 834 from its business partners?**

A7 The business relationship will determine if the transaction is required. If the enrollment for a Medicare beneficiary comes from an employer group in electronic format, the MCO is required to accept the 834.

**Q8 Is the 834 from a State to a MCO a required transaction?**

A8 A Medicaid agency enrolling its Medicaid recipients (including subsequent enrollments) in a managed care plan would be required to use the 834.

**Q9 Has CMS waived the requirement for the beneficiary to sign an enrollment application for 834 transactions?**

A9 CMS is not waiving the requirement for a signed enrollment application. At this time, MCOs are still required to obtain a hardcopy enrollment form with an original signature.

**Q10 Are independent practice associations (IPA) considered health plans?**

A10 Independent practice associations operate in many ways. The structure of the IPA will determine if it is considered a health plan.

**Q11 Is the 270/271 Eligibility Inquiry and Response a required transaction when exchanged between CMS and Medicare MCOs?**

A11 Yes, the 270/271 is a required transaction when exchanged between CMS and Medicare MCOs.

CMS will continue to provide MCOs with the ability to obtain eligibility and utilization data via the common working file (CWF), that will be 270/271 compliant. The MCO's current process, that is online real-time via CMS' data center, will remain unchanged. CMS is currently working on a process to provide MCOs with the ability to obtain eligibility and utilization data by submitting an electronic batch 270/271 transaction file. Instructions for the batch transaction will be provided in a separate letter.

**Q12 Will the Medicare Data Base (MBD) replace the Common Working File for Medicare?**

A12 Yes, the Medicare Data Base will replace the Common Working File. CMS expects the MBD to be available later this year.

**Q13 Do automated voice response and fax systems have to be in standard format?**

A13 Voice response or fax systems do not have to meet the data content requirement of the HIPAA standard.

**Q14 Is the MCO limited to sending only one 270/271 transaction record per batch?**

A14 Yes, each 270/271 inquiry and response will be a separate transaction.

**Q15 What are the proposed transmission costs for the 270/271 transaction?**

A15 CMS will share cost information once it is developed.

**Q16 When a MCO is providing eligibility information to a vendor is the standard transaction required?**

A16 It depends on the relationship that the MCO has with its vendor. If the vendor is inquiring as to whether or not a certain person is a member of the health plan, then the vendor should be doing that via the 270. If the MCO is providing a database for the vendor to use to handle inquiries, then that database would not have to be produced in the 270 or 271 format.

**Q17 Is the 820 Health Plan Premium Payment a required transaction when exchanged between CMS and Medicare MCOs?**

A17 Yes, the 820 is a required transaction when exchanged between CMS and Medicare MCOs. CMS will use the 820 as a cover sheet to the Plan Payment Report. The 820 transaction with a Plan Payment Report attachment will be sent directly from CMS to MCOs. The monies will not be included in the 820 or in the attachment. The funds transfer will remain the same as it is today.

**Q18 Will MCOs have the option to designate where the 820 is sent?**

A18 MCOs will not have the option to designate where the 820 will be sent. The payment that MCOs receive from CMS does not come directly from CMS. The payment is sent via electronic funds transfer from the Department of Treasury to the bank designated by the MCO.

**Q19 Will CMS request a compliance extension under P. L. 107-105, dated December 27, 2001?**

A19 Yes, CMS will request an extension.

**Q20 Will CMS produce a crosswalk of the 820 Health Plan Premium Payment and the CMS Plan Payment Letter?**

A20 CMS has mapped the Plan Payment Letter to the 820 transaction. The crosswalk information is located under Tab 19 at the following web address: <http://www.hcfa.gov/medicare/mcoenrolpayconf2.htm>.

- Q21 Does CMS require a 997 acknowledgement for transactions?**  
A21 CMS does not require a 997 functional acknowledgement for transactions.
- Q22 What level of detail will CMS provide in the 820 provide?**  
A22 CMS will provide summary level detail in the 820. MCOs will continue to obtain beneficiary level detail from the Monthly Membership report.
- Q23 Can MCOs continue to receive the Plan Payment Letter through the CMS data center?**  
A23 Yes, MCOs will continue to receive the Plan Payment Letter through the CMS data center.
- Q24 Is the 837 Claim and Coordination of Benefits a required transaction when exchanged between CMS and Medicare MCOs?**  
A24 CMS will not require MCOs to use the 837 for the submission of data to support risk adjustment. However, CMS will accept the 837 from MCOs that use the 837 transaction. MCOs will use the 837 with other business partners.
- Q25 Is a delete transaction carried historically?**  
A25 Yes, CMS maintains a history of deleted transactions.
- Q26 Will draft formats for risk adjustment be available on the customer service support web site?**  
A26 Yes, CMS draft formats for risk adjustment will be available on the Customer Service Support Center website, located at:  
<http://www.mcoservice.com/>.
- Q27 Will CMS collect outpatient encounter data?**  
A27 CMS will not collect outpatient encounter data. However, CMS will collect inpatient and outpatient diagnoses.
- Q28 Will CMS issue a letter regarding the collection of encounter data?**  
A28 Yes, the information will be included in CMS' 2003 Instructions to MCOs.
- Q29 Will the CMS translator be able to pull in the 837 in full or abbreviated format?**  
A29 CMS will be able to pull in the risk adjustment data from the 837 that is submitted both in full or abbreviated format.

**Q30 Can MCOs continue to use the current format that was in place prior to the risk adjustment data requirements?**

A30 Yes, MCOs may continue to use the current format. If an MCO submits a full UB92 or other format, CMS will continue to extract the required data elements until the new format is developed.

**Q31 Will CMS provide a copy of the letter regarding the suspension of the collection of outpatient encounter data?**

A31 Yes, the suspension of the collection of outpatient encounter data letter is located at: <http://www.mcoservice.com/>.

**Q32 Will the six digit vendor number in field locator 51 remain the same?**

A32 Yes, the requirement for the six digit vendor number will remain the same.

**Q33 Is there an implementation guide for encounter data?**

A33 Yes, the Public Health Data Standards Consortium (PHDSC) is developing an X12 reporting guide. PHDSC is focusing on all reporting based on claims information that anyone might use. The initiative was started under ASC X12, using the 837 standard, by the public health community. The consortium has gone through all of the data elements in the 837 standard and selected those that are generally required by the state and county public health authorities that require encounter data reporting. The result is an abbreviated transaction, a small data element set, from the full-blown HIPAA 837 claims guide.

**Q34 What is the effective date for submitting an 837 transaction to Medicare for claims processing?**

A34 Medicare fee-for-service contractors will accept 837 transactions no later than October 16, 2002. Contractors will continue to accept both the old and the new format until October 16, 2003.