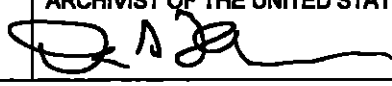



<b>REQUEST FOR RECORDS DISPOSITION AUTHORITY</b>		JOB NUMBER <b>NI-440-09-4</b>	
To: NATIONAL ARCHIVES & RECORDS ADMINISTRATION 8601 ADELPHI ROAD COLLEGE PARK, MD 20740-6001		Date received <b>9-22-2009</b>	
1. FROM (Agency or establishment) <b>Department of Health and Human Services</b>		<p align="center"><b>NOTIFICATION TO AGENCY</b></p> <p>In accordance with the provisions of 44 U.S.C. 3303a, the disposition request, including amendments, is approved except for items that may be marked "disposition not approved" or "withdrawn" in column 10.</p>	
2. MAJOR SUBDIVISION <b>Centers for Medicare and Medicaid Services (CMS)</b>			
3. MINOR SUBDIVISION			
4. NAME OF PERSON WITH WHOM TO CONFER <b>Vickie Robey, CMS Records Officer</b>	5. TELEPHONE NUMBER <b>410-786-7883</b>	DATE <b>9/22/2009</b>	ARCHIVIST OF THE UNITED STATES 
<p><b>6. AGENCY CERTIFICATION</b> I hereby certify that I am authorized to act for this agency in matters pertaining to the disposition of its records and that the records proposed for disposal on the attached <u>4</u> page(s) are not needed now for the business for this agency or will not be needed after the retention periods specified; and that written concurrence from the General Accounting Office, under the provisions of Title 8 of the GAO Manual for Guidance of Federal Agencies,</p> <p align="center"> <input checked="" type="checkbox"/> is not required                              <input type="checkbox"/> is attached; or                              <input type="checkbox"/> has been requested.       </p>			
DATE <b>09/22/2009</b>	SIGNATURE OF AGENCY REPRESENTATIVE <b>S:// Yvonne K. Wilson</b> 		TITLE <b>HHS Records Officer</b>
<b>7. ITEM NO.</b>	<b>8. DESCRIPTION OF ITEM AND PROPOSED DISPOSITION</b>	<b>9. GRS OR SUPERSEDED JOB CITATION</b>	<b>10. ACTION TAKEN (NARA USE ONLY)</b>
	<p><b><u>Medicare Advantage and Rx Plan Operations (MARPO)</u></b></p> <p>See attached.</p>		

**Attachment to SF-115, for CMS Electronic Systems Schedule**

**Medicare Advantage and Rx Plan Operations (MARPO)**

A collection of automated systems that support collection and maintenance of beneficiary enrollments, premiums and payments for affordable health care and prescription drug coverage (Medicare Part D) by offering Medicare beneficiaries, affordable health care and prescription drug coverage as legislated by Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. Includes but not limited to:

**Automated Plan Payment System (APPS)** – The CMS System of Record for Managed Care Organization (MCO) payment processing. Calculates the MCO-level payment amounts and reports based on the plan payments received from MARx and the premium payments received from PWS. The APPS uses the MCO status in determining whether or not a payment should be generated for a MCO. APPS interfaces with HPMS, MARx, PWS and FACS systems.

**Health Plan Management System (HPMS)** – The Primary plan-based information system supporting the Medicare Advantage (MA) and Medicare Part D Prescription Drug Program (PDP) components of the Medicare program. HPMS is an information and data exchange system designed to provide CMS, Medicare Advantage, PDP, other external user communities, and other government agencies and researchers with a centralized repository for data related to the MA and Part D programs (manage plan benefit offerings and costs; to provide and obtain related information through reporting and data extract facilities; to communicate information through ongoing and automatic email notifications; and to ensure access to a wide variety of functions, data and information required to support these aspects of the Medicare program). Along with the Medigap insurance option, the MA and Part D programs offer Medicare beneficiaries the “choice” in beneficiary-centered health care purchasing. HPMS supports this choice, as well as the functions and program support mechanisms related to CMS management and oversight of these programs.

- The Enterprise Security System is the CMS system of record for approving tracking and maintaining EES User IDs. All HPMS users are required to have an EES User ID in order to access the system.
- The 1-800 Medicare is the system of record for the Part D complaint data loaded into the HPMS daily. 1-800 Medicare provides a daily file (seven days a week) to HPMS that is loaded into the Complaints Tracking Module for use in tracking and resolving beneficiary complaints about the Part D prescription drug program. There is no direct data feed between HPMS and 1-800 Medicare.
- The CMS Office of Information Systems Common tables receives routine monthly file write-offs from HPMS for use by the Medicare Advantage prescription Drug System, the Medicare Appeals System, the Medicare Beneficiary Database, the RIC T file and the Individuals Authorized to Access CMS Computer Services System. HPMS receives monthly enrollment data from MARx. A standard procedure is in place to export/import the data to/from HPMS and MARx. There is no direct data feed between the HPMS and MARx. HPMS does not receive any data in return from MAs, MDB, or IACS.
- The Peer Review Organization or Quality Improvement Organization Database receives routine monthly file write-offs from HPMS. HPMS does not receive information back from PRO/QIO.
- The Common Working File (CWF) receives routine monthly file write-offs from HPMS. HPMS does not receive information back from CWF.

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- Health Outcomes Survey (HOS) data is collected annually and provided to HPMS as an annual file write-off. There is no direct data feed between HPMS and HOS.
- Health Plan Employer and Data Information Set (HEDIS) survey data is collected annually and provided to HPMS as an annual file write-off. No direct data feed between HPMS and HEDIS.
- Consumer Assessment of Health Plans Survey (CAHPS) survey data is collected annually and provided to HPMS as an annual file write-off. No direct data feed between HPMS and CAHPS.
- Medicare Current Beneficiary Survey (MCBS) – MCBS survey data is collected annually and provided to HPMS as an annual file write-off. No direct data feed between HPMS and MCBS.
- Risk Assessment Payment (RAPS) is a mainframe system that provides periodic write-offs to HPMS. No direct data feed between HPMS and RAPS.
- Social Security Administration receives routine monthly file write-offs from HPMS. HPMS does not receive information back from SSA.
- The Medicare.gov website receives routine month file write-offs from HPMS to update the Medicare Personal Plan Finder; Medicare Options Compare/Medicare Out of Pock Cost and Medicare Prescription Drug Plan Finder databases. HPMS does not receive information back from Medicare.gov.
- The CMS Medicare & You Handbook Production System receives one annual and three quarterly write-offs from HPMS. HPMS does not receive related information back from CMS.

**Drug Data Processing System (DDPS)** – This system processes all Medicare covered and non-covered prescription drug events (PDEs) and related data, including non-Medicare dug events, as necessary to validate/authenticate Medicare payment of covered drugs made by plans for Medicare beneficiaries enrolled in Part. The DDPS performs validation and authentication of the drug event data in an operational database, and the extraction and loading of DDPS-related data into the integrated data repository (IDR). It supports fraud, waste, and abuse analysis; risk adjustment; drug utilization analysis; auditing; trends analysis; payment reconciliation; benefit adjustment analysis; and general PDE reporting. The DDPS interconnects with internal CMS applications: Health Plan Management System, Medicare advantage Prescription Drug Plan System, the Master Beneficiary Database, Payment reconciliation System, Risk Adjustment System. Data validation is performed by the source system prior to transmitting to DDPS.

It is from this sub-system that the Prescription Drug Event (PDE) files are created; PDEs are summary reports of all Medicare Part D expenditures, and include information on the patient (date of birth, gender), provider (identifier) and statistical information on the prescribed drug (compound code, dispense type, quantity, supply, costs).

**Medicare Advantage and Prescription Drug System (MARx)** – Supports the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) legislation that offers Medicare beneficiaries more affordable health care and prescription drug coverage. The four main function of the MARx system include the following:

- Processes transaction for beneficiary enrollment into Medicare Advantage Organizations (MAO) and Prescription Drug Sponsors (PDS);
- Calculates payment for Medicare Advantage and Prescription Drug plans;
- Calculates Part C and Part D beneficiary premiums;
- Generates daily, weekly and monthly enrollment, premium and payment reports for the MAOs and Prescription Drug Sponsors

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**Premium Withhold System (PWS)** – The Agency’s system to reconcile premiums to be withheld by the Social Security Administration (SSA), Railroad Retirement Board (RRB), and office of the Personnel Management (OPM). PWS interfaces with SSA’s Validation Systems, MARX, Medicare Beneficiary Database System, and the APPS. The PWS operates once each month to analyze data, and to produce a file of payment requests to APPS and a report of withheld premiums to the plans which is distributed by MARx.

**Risk Adjustment System (RAS)** – Receives the demographic and diagnosis data feeds from Medicare Beneficiary Database/CME (beneficiary data for Risk Adjustment processing), National Medicare Utilization Database (beneficiary claims data, beneficiary claims adjustment (final action) data and fee-for-service diagnosis data), Risk Adjustment Processing System (Medicare Advantage Organization diagnosis data), Health Plan Management System (information on the contract level data and stratification of the contracts). RAS provides a Risk Adjustment Factor file to MARx to calculate payment amounts to the service providers.

**State Phase Down Billing (SPDBS)** – Calculates the “phased-down” amounts States must contribute, and to send each State a monthly bill. As part of the MMA, the States and the District of Columbia are required to make contributions to CMS towards the costs of drug benefits being assumed by Medicare. Data exchanges and interfaces with the States via the Medicare Beneficiary Database, CMS’ Office of Financial Management via the Financial Accounting Control System, and with CMS’ Office of the Actuary via a monthly OACT generated State Rate Table.

**True Out of Pocket (TrOOP)** - The purpose of this System of Record is to collect and maintain a master file to establish a “True Out of Pocket” facilitation process, maintain information on individuals and entities that make payments on covered drugs under the Medicare Part D Program, and coordinate TrOOP relevant data from State Pharmaceutical Programs (SPAPs) and other health insurers. Information retrieved from this system may be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, grantee, consultant or other legal agent; (2) support Medicare Prescription Drug Plans (PDP) and Medicare Advantage Prescription Drug Plans (MAPD) directly or through a CMS contractor for the administration of Title XVIII of the Act; (3) assist another Federal or state agency with information to enable such agency to administer a Federal health benefits program, or to enable such agency to fulfill a requirement of Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; (4) assist Quality Improvement Organization (QIO) in connection with review of claims; (5) assist insurance companies and other groups providing protection against medical expenses of their enrollees; (6) assist an individual or organization engaged in the performance activities of the demonstration or in a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects; (7) support constituent requests made to a congressional representative; (8) support litigation involving the agency; and (9) combat fraud and abuse in certain health benefits programs. The system will maintain individually identifiable information (name, address, Health insurance claim number, gender type and date of birth) on individuals and entities that make payments on covered drugs under the Medicare Part D Program.

**Payment Reconciliation System (PRS)** – Compares Part D prospective payment information to actual cost in order to perform plan payment reconciliations (low income cost-sharing subsidy (LICS), Reinsurance and Risk sharing/risk corridor, final reconciliation payment adjustments). PRS provides year-end adjustments amounts (payments or recovery) for each contract for these reconciliations. Receives flat files from HPMS, MARx, DDPS and CMS/Center for Drug and Health Plan Choice (CPC) that contain

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enrollment and prospective payment information at the beneficiary/plan level, actual drug costs and plan level adjustments, to input data elements related to the Part D contracts and plans.

**Medicare Plus Choice (MPC)** - The primary purpose of this system is to determine the annual Medicare Advantage capitation rate for each Medicare Advantage payment area for year and to supply rate books and supporting data for publication on CMS' web site. Information retrieved from this system of records will be disclosed to: (1) support regulatory, reimbursement and policy functions performed within the agency or by a contractor, consultant or CMS grantee; (2) assist another Federal or state agency; (3) support Medicare Advantage organizations offering Medicare Advantage plans under part C; (4) fill requests for information from the general public upon request; (5) facilitate research on the quality and effectiveness of care provided and well as payment related projects; and (6) support litigation involving the agency.

**Adjusted Average Per Capita Cost (AAPCC) System of Record** - The primary purpose of this system is to support the determination of the annual Medicare Advantage capitation rate for each Medicare Advantage payment area for year and to supply rate books and supporting data for publication on CMS' website. Information retrieved from this system of records will be disclosed to: (1) support regulatory, reimbursement and policy functions performed within the agency or by a contractor, consultant or CMS grantee; (2) assist another Federal or state agency; (3) support Medicare Advantage organizations offering Medicare Advantage plans under part C; (4) fill requests for information from the general public upon request; (5) facilitate research on the quality and effectiveness of care provided and well as payment related projects; and (6) support litigation involving the agency.

MARPO systems reside on the agency's mainframe environment in accordance with Privacy Act, Computer Fraud and Abuse Act, Computer Security Act of 19987, Paperwork Reduction Act, Clinger-Cohen Act of 1986, Freedom of Information Act, Government Information Security Reform Act, Health Insurance Portability and Accountability Act, Social Security Act, OMB Circulars: A-123, A-127, A-130; Security of Federal Automated Information resources, Federal Information System Controls Audit Manual, Tax Information Security Guidelines for Federal, State and Local Agencies, Guide for Developing Security Plans for IT Systems. MPC County Level data resides on mainframe system and is maintained in compliance with based on requirements of the CMS Information Security Acceptable Risk Safeguards (ARS) version 3.1, April 2008 and the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53, Recommended Security Controls for Federal Information Systems, December 2007. Any standards which cannot be followed due to technical constraints, lack of resources, etc., must be documented in the CMS IS RA for the system and the mitigating controls associated with the vulnerability must also be documented.

~~1. **Inputs** — Health Insurance Claim Numbers, Plan Member IDs, Complaint IDs, health plan and package information, monthly counts of beneficiary enrollment for each plan package, National drug codes, national pharmacy information, secondary payer information, Part D drug plan information, Prescription Drug event data, beneficiary demographic and plan information, drug utilization costs at the beneficiary/plan level used in calculating Part D payment reconciliations; received and/or rejected PDE records and repot files; out-of-pocket costs to the DDPS; plans submit transactions for enrollment, disenrollment and enrollment changes; withheld premiums; monthly state enrollment counts; state payments received; State monthly rates table; MBD Enrollment Counts File, FACS Payments Received File, OACT State Monthly Rates Table File; eligibility, enrollment, or other health insurance information enrollment and prospective payment information at the beneficiary/plan level, actual drug costs and plan level adjustments; data collected and maintained in the MPC system are retrieved from the following SOR databases: Medicare Beneficiary Database, Medicaid Statistical Information System,~~

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**INACTIVE - ALL ITEMS SUPERSEDED**

~~National Claims History, Enrollment Database, Risk Adjustment System. MPS consists of Medicare Parts A, B, and C entitlement, enrollment, demographic, claims and risk score data; Medicaid data, buy-in data, institutional data, Medicare demographic data, Medicare fee-for-service enrollment & claims data, Managed Care enrollment data, age, gender, Census Bureau institutionalized counts and geographic location; data collected and maintained in the AAPCC system are retrieved from the following SOR databases: Medicare Beneficiary Database, Medicaid Statistical Information System, National Claims History, Enrollment Data Base. The application consists of Medicare Parts A, B, and C entitlement, enrollment, demographic, claims and risk score data.~~

~~DISPOSITION: Temporary. Cutoff annually. Delete/destroy 5 year after cutoff, or when no longer needed for Agency business, whichever is later. (GRS 20, Item 2)~~

~~2. Master Files Includes but not limited to: Health Insurance Claim Numbers, Plan Member IDs, Complaint IDs, health plan and package information, monthly counts of beneficiary enrollment for each plan package, National drug codes, national pharmacy information, secondary payer information, Part D drug plan information, Prescription Drug event data, beneficiary demographic and plan information, drug utilization costs at the beneficiary/plan level used in calculating Part D payment reconciliations; received and/or rejected PDE records and repot files; out-of-pocket costs to the DDPS; plans submit transactions for enrollment, disenrollment and enrollment changes; withheld premiums; monthly state enrollment counts; state payments received; State monthly rates table; MBD Enrollment Counts File, FACS Payments Received File, Office of the Actuary State Monthly Rates Table File; eligibility, enrollment, or other health insurance information enrollment and prospective payment information at the beneficiary/plan level, actual drug costs and plan level adjustments; Medicaid data, buy-in data, institutional data, Medicare demographic data, Medicare fee-for-service enrollment & claims data, Managed Care enrollment data, age, gender, Census Bureau institutionalized counts and geographic location. The input data is summarized by nation, county, age and gender; data collected and maintained in the AAPCC system are Medicare Parts A, B, and C entitlement, enrollment, demographic, claims and risk score data.~~

~~DISPOSITION:~~

~~2a. Beneficiary enrollment, premium and payment records – TEMPORARY. Cut off annually. Delete/destroy 6 years 3 months after cutoff.~~

~~2b. Prescription Drug Records – TEMPORARY. Cut off annually. Delete/destroy 10 years after cutoff.~~

~~2c. Capitation Rate Records – TEMPORARY. Cut off annually. Delete/destroy 5 years after cutoff.~~

~~3. Outputs~~

~~3a. Prescription Drug Event (PDE) output files Outputs of the DDPS, that provide summary data of all annual prescription approvals. PDEs contain summary data related to all Medicare Part D expenditures, and include information on the patient (date of birth, gender), provider (identifier) and statistical information on the prescribed drug (compound code, dispense type, quantity, supply, costs).~~

~~DISPOSITION: PERMANENT. Cut off annually. Pre-accession files to the National Archives 5 years after cutoff. Legally transfer individual files in an acceptable format (following current CFR guidelines) to the National Archives annually, 20 years after cutoff.~~

Superseded by job / item number:

DAA-0440-2015-0009-0001

Date (MM/DD/YYYY):

7/13/2017

Superseded by job / item number:

DAA-0440-2015-0006-0001

Date (MM/DD/YYYY):

8/15/2017

## **INACTIVE - ALL ITEMS SUPERSEDED**

~~3b. Other Outputs—Ad hoc reports (includes but not limited to: MCO level payment amount, beneficiary complaints, prescription drug events, Medicare Advantage, Prescription Drug Costs, premium and payment reports, withheld drug premiums; monthly SPDBS reports to States, MBD, OACT, OFM; SPBDS billing activity; PRS Inputs to CPC & Plans; PRS Reconciliation Reports, PRS Reconciliation Results Report Detail & Beneficiary Detail, Data Anomalies Report); State Bills and Itemized Liability reports; payment requests to APPS; Beneficiary data at the part D plan level; Medicare Demographic Data, Medicare Fee for Service Reimbursements and Enrollments (summarized by nation, county, Medicare entitlement status, age and gender); Medicare Advantage Ratebook for payment to Medicare Advantage plans under part C, Medicare Advantage Rate Calculation data showing details of the components of rate calculation, Medicare Demographic Data, Medicare United States Per Capita Costs, Medicare Advantage Regional Rates and Benchmarks, and Medicare Fee for Service Reimbursements and Enrollments. The output data is summarized by nation, county, age, and gender.~~

~~DISPOSITION: Temporary. Cutoff annually. Delete/destroy 5 years after cutoff, or when no longer needed for Agency business, whichever is later. (GRS 20, Item 16)~~

### ~~4. System Documentation~~

~~4a. System Documentation, Master Files: User manuals, data dictionaries, system plans, and other documentation required to operate the main utilization databases.~~

~~DISPOSITION: TEMPORARY. Destroy when superseded. (GRS 20, Item 11a1)~~

~~4b. System Documentation—documentation related to the Prescription Drug Event (PDE) files, including data dictionaries and field listings.~~

~~DISPOSITION: PERMANENT. Transfer current files to the National Archives along with first transfer of Standard Analytical Files; transfer additional copies to the National Archives as superseded or updated. (GRS 20, Item 11a2)~~