

<b>REQUEST FOR RECORDS DISPOSITION AUTHORITY</b>		JOB NUMBER N1-440-09-16	
To NATIONAL ARCHIVES & RECORDS ADMINISTRATION 8601 ADELPHI ROAD COLLEGE PARK, MD 20740-6001		Date received 9-24-2009	
1 FROM (Agency or establishment) Department of Health and Human Services		NOTIFICATION TO AGENCY  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request, including amendments, is approved except for items that may be marked "disposition not approved" or "withdrawn" in column 10	
2 MAJOR SUBDIVISION Centers for Medicare and Medicaid Services (CMS)			
3 MINOR SUBDIVISION			
4 NAME OF PERSON WITH WHOM TO CONFER Vickie Robey, CMS Records Officer	5 TELEPHONE NUMBER 410-786-7883	DATE 13 July 10	ARCHIVIST OF THE UNITED STATES 
6 AGENCY CERTIFICATION 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.  <input checked="" type="checkbox"/> is not required <input type="checkbox"/> is attached, or <input type="checkbox"/> has been requested			
DATE 09/23/2009	SIGNATURE OF AGENCY REPRESENTATIVE S // Yvonne K Wilson		TITLE HHS Records Officer
7 ITEM NO	8 DESCRIPTION OF ITEM AND PROPOSED DISPOSITION	9 GRS OR SUPERSEDED JOB CITATION	10 ACTION TAKEN (NARA USE ONLY)
	<u><b>CMS Medicare Financial Management &amp; Payment Systems (MFMPs)</b></u>  See attached		

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

### **Medicare Financial Management & Payment Systems (MFMPs)**

The collection of automated systems that support Medicare Contractor workload and budget administration and provider cost reporting. The systems track the behavior, financial and progress status and contract compliance of CMS' Medicare contractors, known as Medicare Administrative Contractors (MACs), previously the Fiscal Intermediaries (FIs) or Carriers. Includes but not limited to

**Contractor Administrative Budget and Financial Management System (CAFM and CAFMII)** - Manages Medicare contractor reporting to CMS of administrative expenses and benefits paid. Provides automated capabilities to CMS staff for monitoring the Medicare Contractors' administrative expenses and financial operations and for determining each Contractor's compliance with its individual budget. CAFM serves as the vehicle for tracking all benefit payments, banking issues, and CFO data. The CAFMII system is the main vehicle for planning, administering and monitoring the administrative expenses of the Medicare contractor community. It also allows CMS to issue the Medicare Contractor's funding for a fiscal year using the separate allotments for Program Management and Medicare Integrity Program activities. Extract files are created from CAFM data and transferred by NDM for PIMR and CMIS. Data is collected from 32 input forms and housed on directly on-line storage for FYs 1985 through the current FY. Over 70 customized reports, an ad hoc reporting capability and download capability and provided for analytical and monitoring purposes. All budget-related data for FYs 1998 and beyond are entered into the CAFMII system, while all prior years (historical) data are entered into the CAFM system.

**Contractor Audit and Settlement Reporting System (CASR)** – Tracks budgeted and incurred costs for the Part A contractor audit and settlement functions by type of activity and type of provider or reporting entity. This report is Central office's instrument to develop a financial operating plan for audit related expenditures, to develop the cost effectiveness or savings of the audit and settlement function, to monitor the audit related expenditures and savings of each contractor and to alert the appropriate regional office of potential problems with a particular fiscal intermediary's performance. CASR Receives uploaded files from the System for Tracking Audit reimbursement system as input data. Data is shared with CROWD and CAFM, two other systems dealing with contractor performance and monitored by CMS staff in the Office of Financial Management. Audit-related data that pertain to eight CASR input forms are updated into the CASR database. Data is maintained on direct-online storage for fiscal years 1988 through the current FY is used for audit purposes only. Nineteen customized reports, ad hoc reporting capability, and a download capability are provided for analytical and monitoring purposes.

**Comprehensive Error Rate Testing Program (CERT)** – System of Record for processing and reviewing Medicare claims data to produce national, contractor-specific, and benefit category error rates for paid claims as computed from a sample. The CERT Review Contractor (CRC) manages the independent reviewers, CERT applications and files on the CSM mainframe and the associated IT tracking and database systems. Interface with the CICS online system and the DMERC Part B and Part A, Medicare Contractors Claims systems.

**Contractor Management Information System (CMIS)** – Assists CMS with managing and overseeing the operations of its Medicare Fee-For-Service (FFS) contractors. CMIS allows the Regional and Central Office staff to quantify contractor performance through metrics and to compare those metrics against pre-established thresholds. The CROWD and PULSE systems are the major data sources for CMIS. CMIS

contains aggregated contractor performance data used for analytical purposes, with the intention of assessing the performance of CMS' Medicare FFS contractors

CMS Activity Reporting and Tracking System (CMS-ART) – System of Record for tracking contractor business proposals, cost reports, deliverables, and workload information as well as copies of contractors and other government documents for all components that use the system. Contains no privacy data (Deliverables that may contain privacy data are not submitted in CMS-ART). CMS-ART does not interface with any other CMS systems.

Contractor Reporting of Operational and Workload Data System (CROWD) – Monitors each Medicare contractor's performance in processing claims and paying bills, the system contains workload reporting capabilities that allow the data to be used for estimating budgets, defining operating problems, comparing performance among Contractors, and determining regional and national workload trends. CROWD also provides metrics that help MCS staff determine how effectively the contractors are administering the program on a national level. Contractors that fall below certain performance levels can be removed from the Medicare program. The flexibility in terms of criteria to be used for evaluation purpose each year is a key customer satisfaction feature. Data is collected from 29 input forms and housed on direct on-line storage for FYs 1990 through the current FY. Over 400 customized reports, Ad hoc reporting and download capabilities are provided for analytical and monitoring purposes. Extract files are created from CROWD data and transferred by NDM for PIMR and CMIS.

Demonstration Payment System (DPS) – Used to prepare electronic payment files to be used by the agency's Financial Accounting Control System (will be replaced with Healthcare Integrated General ledger Accounting System (HIGLAS)) in generating payments through the United States Department of the Treasury. The payments are for demonstration claims processed by the agency's Office of Financial Management in two subsystems: Medicare Lifestyle Modification Program Demonstration (LMP) and the Municipal Health Services Program (MHS). A payment file is created monthly by the LMP system. This along with payment data which is entered into DPS from the MHS subsystem is the input for DPS. Upon receipt of the payment data, monthly processing initiated by CMS staff by the submission of batch SAS programs. An output file is created containing the provider payment information for input into FACS. There is no interconnection or information sharing with other systems.

Health Care Cost Report Information System (HCRSI) – Tracks the initial receipt and subsequent processing of all Medicare (Part A) hospital, independent end-stage renal disease facility and skilled nursing facility cost reports, home health agency cost reports, hospice cost reports, and generates routine and user specific reports.

Program Integrity Management Reporting (PIMR) System – system to obtain report on workload and savings of Medicare medical review activities. The system is used to provide reports on the effectiveness, costs and workload of Medicare medical review activities. Benefit Detailed budgeting and planning for medical review activities.

Production Performance Monitoring System (PULSE) – Provides real-time analysis of claims processed, providing CMS immediate feedback to critical performance issues for all Medicare Contractors as well as the Common Working File (CWF) hosts. PULSE collects workload data from various reports that contractors send via Network Data Mover (NDM) to the CMS Data Center. All contractors input CMS monthly standard reports directly into the CROWD system for prior workload data. PULSE collects data from the forms CMS 1566/1565, CMS 1522 and CWF 207 and uses the data extracted from these reports to calculate key indicators, averages and standard deviations to identify variances, which are used for

performance monitoring Financial data reports contain the number of claims processed and the benefit dollars paid by claim type CMS uses PULSE as a contactor management tool for monitoring purposes The PULSE system displays information daily that is loaded into the CROWD system monthly This information does not contain specific beneficiary level data but reflects a summary of contractor workload and financial data daily

System Tracking for Audit and Reimbursement Medical Review System (STAR) – A CMS-owned system that is maintained by Mutual of Omaha and used by MACs for tracking the receipt and subsequent actions taken on all providers cost reports Also known as “System for Tracking & Reimbursement” or “System Tracking Audit and Reimbursement ”

Coordination of Benefits (COB) – The purpose of COB is the collection, management and reporting of Medicare beneficiary other health information (OHI) The COB System is a working database that receives, filters and transmits OHI to Medicare’s eligibility and entitlement databases, i.e. Common Working File (CWF) and Medicare Benefits Database

Recovery Audit Contract or Demo (RAC) – The Recovery Audit Contractor Data Warehouse facilitates the activities of CMS and its partners in the RAC project by functioning as a multifaceted tool that enables participating users to view, upload and track the status of claims under review by the RACs The RAC DW performs numerous coordinating, tracking and reporting functions

Provider Statistical and Reimbursement System (PS&R) – The goal of the PS&R system is to accurately accumulate statistical and reimbursement data constructed from finalized Part A claims processed in the FISS claim system for each fiscal intermediary The reports created in the PS&R system must be accurate since they are used in the providers’ cost reporting and settlement processes Benefit(s) The PS&R system is a key component in the Medicare payment cycle as it bridges the gap between claims processing and cost reporting It summarized the claims processing activities and payments made to Medicare providers by Fiscal Intermediaries for all Medicare covered services PS&R data is subsequently utilized to effectuate final settlement of a provider’s Medicare cost report The PS&R system permits the MACs (previously FIs) and providers to utilize the system-produced reports to accumulate statistical and payment data for hospitals, hospital complexes, skilled nursing facilities, and home health agencies

CROWD, CASR, CMIS, CMS-ART, DPS, HCRIS, PIMR, PULSE data resides on the Agency’s mainframe system and CERT systems resides in Richmond, VA All data is maintained and will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy

~~1 Inputs – Financial/Payment data (administrative expenses and financial operations from Medicare contractors, FY funding to Medicare contractors), Provider audit/settlement, error rates for paid claims, CERT applications, contractor performance data, Cost Reports from MACs (previously FIs), Hospice, HHA, Hospitals, SNF and Renal providers, contactor business proposals, cost reports deliverables, workload information, budget and financial Data Files from Fiscal Intermediaries for each provider service (data includes but not limited to Number of Providers Reporting per FY, Types of Providers, Conservative estimate (for growth), number of reports per provider per year, estimated number of records per report, estimated size per record, estimated size per report), CMS Workload/Performance Report Forms 1566/1565, Claims Reconciliation Form 1522~~

~~DISPOSITION Temporary Cutoff annually Delete/destroy 1 year after cutoff, or when no longer needed for Agency business, whichever is later (GRS 20)~~

2 Master Files – Financial/payment data related to cost reports (administrative expenses and financial operations from Medicare contractors), FY funding to Medicare contractors, Provider audit/settlement, error rates for paid claims, CERT applications, contractor performance data, Cost Reports from MACs (previously Fis/Carriers), Hospice, HHA, Hospitals, SNF and Renal providers, contractor business proposals, cost reports deliverables, workload information, budget and financial Data Files from Fiscal Intermediaries for each provider service (data includes but not limited to Number of Providers Reporting per FY, Types of Providers, Conservative estimate (for growth), number of reports per provider per year, estimated number of records per report, estimated size per record, estimated size per report), provider payment information for input into FACS/HIGLAS for demonstration claims, Medicare contractor’s summarized performance in processing claims

~~DISPOSITION Temporary Cutoff at the end of the FY in which cost reports are produced Delete/destroy 8 years after cutoff, or when no longer needed for Agency business, whichever is later~~

~~3a Outputs – Medicare Financial and Payment Reports (e.g., contractor workload reports, provider payments, FY funding, Medicare contractor budget and financial reports, number of claims processed and benefit dollars paid by claim type, performance monitoring)~~

~~DISPOSITION Cutoff at the end of the FY Delete/destroy 7 years after cutoff or when no longer needed for Agency business, whichever is longer (output reports covered by N1-440-79-01, item 26; any reports mandated by Congress covered by N1-440-95-01, item 6)~~

~~3b Ad Hoc Reports~~

~~DISPOSITION Temporary Cutoff annually Delete/destroy 1 year after cutoff, or when no longer needed for Agency business, whichever is later (GRS 20)~~