CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12390	**Date: November 30, 2023**
	Change Request 13392

SUBJECT: Making Care Primary (MCP) Model Implementation

I. SUMMARY OF CHANGES: The Innovation Center has secured approval for the Making Care Primary (MCP) model, a demonstration testing alternative payment models and support to primary care organizations. MCP is designed to test whether implementing new payment methodology and care delivery goals can reduce program expenditures and improve outcomes on key measures.

The purpose of this Change Request (CR) is to implement all of the tenants of the Making Care Primary (MCP) model as it relates to claims-based payments. This includes:

- The implementation of two new Physician Fee Schedule (PFS) and Prospective Payment System (PPS) codes, called the Ambulatory Care Management code (ACM) and the MCP e-Consult Code (MEC)
- Appending the demonstration code for MCP based on the date-of-service (DOS), provider and beneficiary files (which will identify model participant and model beneficiaries), and CPT/HCPCS code
- Reducing codes found in Appendix A by 50% of the normally paid rate for participants in Track 2
- Reducing codes found in Appendix B by 100% of the normally paid rate for participants in Track 3
- Deny claims found in Appendix C for all participants across all tracks, as they are paid through other model mechanisms not utilizing the Medicare FFS Shared Systems

EFFECTIVE DATE: July 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2024 - Analysis, Design and Coding; July 1, 2024 - Complete Coding, Testing, and Implementation; October 1, 2024 - Implementation of BR 13392.12.4 for CWF only.

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
N/A	N/A

III. FUNDING:

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 obligated 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:

Demonstrations

Attachment - Demonstrations

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I. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Innovation Center to test innovative payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Title XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii) and certain provisions of section 1934 of the Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b).

For this model and consistent with the authority under section 1115A(d)(1), the Secretary may consider issuing waivers of certain fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document; fraud and abuse waivers, if any, would be set forth in separately issued documentation. Any such waiver would apply solely to MCP and could differ in scope or design from waivers granted for other programs or models. Thus, participants must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to Section 1115A(d)(1) specifically for MCP.

In addition to or in lieu of a waiver of certain fraud and abuse provisions in sections 1128A and 1128B of the Act, CMS has determined that the anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (42 CFR § 1001.952(ii)) will be available to protect remuneration exchanged pursuant to certain financial arrangements or patient incentives permitted under the MCP participation documentation.

The Innovation Center has secured approval for the Making Care Primary (MCP) model, a demonstration testing alternative payment models and support to primary care participants. MCP is designed to test whether implementing new payment methodology and care delivery goals can reduce program expenditures and improve outcomes on key measures.

MCP participants will begin operations under the model starting July 1, 2024. The model will continue for 10.5 years, and conclude on December 31, 2034. New participants and providers may be added and removed throughout the model and CMS will provide updated files of participants and providers as well as attributed beneficiaries on a monthly basis. Participating providers will continue to submit claims using normal fee-for-service (FFS) processing. In addition to claims-based payments, participating providers may receive enhanced service payments, prospective primary care payments, upfront infrastructure payments and performance incentive payments. These payments shall be processed separate from the claims system and are not addressed

in this CR.

The Ambulatory Care Management (ACM) code does not apply to MCP participants organizations, but rather to specialists that choose to partner with them. As described in the business requirements, the ACM code is for specialty care partners, which are not delineated in our provider files. There must be an attributed beneficiary, valid date of service, and valid specialty type as described in Appendix D for an ACM code to be paid.

This model will have one demonstration code applied to claims processed under any track in the model, as described in the business requirements below. However, some requirements will only apply to specific tracks. If true, the specific track the requirement applies to will be named. If not otherwise stated, the requirement applies to all tracks. Tracks will be delineated in the provider and beneficiary attribution files.

B. Policy: Under MCP, the Innovation Center will engage with primary care organizations that have a majority of physical locations within our designated regions. MCP participants will change tracks throughout the life of the model. This will not happen more than once annually.

MCP participants shall continue to bill HCPCS and CPT codes for all patients as they normally do under the traditional Medicare program. The model should have no impact to deductibles or coinsurance required by the beneficiary. No new claims-based payments should be made while the beneficiary is still meeting their deductible, and the 50% payment rate for T2 should not be added unless normal FFS payment would have been added.

The beneficiary attribution process will be conducted outside of the claims system although a list of beneficiaries attributed to the model shall be provided to contractors for the purposes of claims adjudication every month. Patient coinsurance and deductible will, however, be calculated based on traditional fee for service processing for the original code that the provider billed at the allowed amount. Occasionally, claims are incorrectly processed in models, and MCP participating providers and beneficiaries may retroactively be added or removed. In this case, there will be a retroactive effective date. Systems should go back and reprocess the claim, adding or removing payments as necessary based on the track.

Separate from these claims-based payments, MCP participating providers may receive population-based per beneficiary per month payments for attributed beneficiaries as well as performance-based payments. These payments shall be processed outside the fee for service claims processing system and are not addressed in this CR.

MCP participating providers are prohibited from billing HCPCS and CPT Codes listed in Appendix C on any of their attributed beneficiaries. CMS has interpreted Appendix C codes duplicative of the non-claims-based payments participants are receiving under the MCP model.

Except as otherwise specified, MCP claims shall be subject to all other adjustments (e.g., sequestration) and policies applicable to other fee for service claims.

For the ACM code, shared systems should check that:

- *Claim is for an MCP-attributed beneficiary that is attributed to a provider in Track 3*
- *Claim is an appropriate DOS for beneficiary attribution dates*
- *Claim is not billed by institutional provider/FQHC (reject if so)*
- *Rendering Provider is valid specialty type (see Appendix D for specialty types) (not applicable to FQHCs)*
- *Claim has not already been billed three times by the same specialist type for the same beneficiary in the past 12 months*
    - *First come (i.e., first billed), first-serve basis for this, regardless of claim DOS*

For MCP participants billing codes, systems should take action based on Track and participant type.

Criteria necessary for claims edits for Health Centers:

- CCN is included in provider file
- Beneficiary is included in the beneficiary alignment file, identified by HICN or MBI
- MCP office E/M codes are on PPS claim (see Appendix A and Appendix B, depending on participant track)
- OR, codes are on list of services to deny (see Appendix C)
- Otherwise, claim will process as normal

Criteria necessary for claims edits for non-Health Centers:

- TIN and NPI are both included in provider alignment file
    - Clinician NPI (Type 1), not organizational NPI (Type 2) is CMS 1500 field 24j Rendering Provider ID #
    - Clinician TIN is in CMS 1500 Field 25 Federal Tax ID #
- Beneficiary is included in the beneficiary alignment file, identified by HICN or MBI
- MCP office visit E/M codes are on Part B claim (see Appendix A and Appendix B, depending on participant track)
- OR, codes are on list of services to deny (see Appendix C)
- Otherwise, claim will process as normal

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.1	The contractors shall prepare their systems to process Making Care Primary (MCP) claims with dates of service on or after July 1, 2024.	X	X			X	X		X	CMS, CVM, HIGLAS, NCH, VDC
13392.1.1	The contractors shall use Demonstration Code A5 to identify MCP claims (Benefit Enhancement Indicator is L (indicates Track 1), M (indicates Track 2, or N (indicates Track 3).					X	X		X	CMS, HIGLAS, NCH, VDC
13392.1.2	The contractors shall ensure that the MSP (Medicare Secondary Payer) Claims are exempt from the MCP demonstration code A5.					X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.2	CMS shall provide MCP contractors with the MCP provider participant files via the Cloud Storage and Retrieval System (CSRS). File format will be CSV and layout will conform to the attached ICD.						X			CMS, VDC
13392.2.1	MCS shall receive a provider participant test file from CMS via CSRS on or about March 11th, 2024 to validate the file layout.						X			
13392.2.2	Contractors shall accept the CSV files from the CSRS and shall process the updated Provider and Beneficiary Alignment files as full replacement files.						X		X	CMS, VDC
13392.2.3	The contractors shall perform validation edits against the new Provider Files to ensure file contains all information needed for the MCP project.						X			
13392.2.4	The contractors shall provide a response file to CMS via the CSRS with accepted and rejected records. CMS shall correct returned invalid MCP Provider Participant files or file records and return the corrected files or file records to MCS.						X			CMS
13392.2.5	MCS shall send the Fiscal Intermediary Shared System (FISS) the initial Provider Alignment file records.					X	X			
13392.2.6	Contractors shall accept and process the Provider Alignment File according to the batch jobs and/or any off-cycle direction that CMS provides. NOTE: CMS will send the first production file on or before June 10, 2024, so the claims can start processing as of July 1, 2024					X	X			
13392.2.7	MCS shall update the Model Test Data Entry (MTDE) application for the MCP Provider Participant file. Provider participant test file name:						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MCP_prov_impl.csv									
13392.2.7.1	FISS shall test the UI and extract process of the Model Test Data Entry (MTDE) application for the MCP Provider Participant file.					X				
13392.2.8	MCS shall modify the Provider Accountable Care Organization online screen (NP) to display the new MCP participating provider records, and will include the Benefit Enhancement Indicator.						X			
13392.3	CMS shall send the Common Working File (CWF) the initial beneficiary alignment files in Mainframe format via the CSRS, detailing beneficiaries aligned to the MCP participating providers. **NOTE**: The beneficiary alignment file will be a national file accessible by all MACs. Beneficiary alignment file name which will be sent through CSRS : MCP_bene_prod.csv								X	CMS
13392.3.1	CWF shall receive a beneficiary test file from CMS on or about March 11th, 2024.								X	
13392.3.2	CMS shall include the following data elements on the aligned beneficiary file for the Making Care Primary (MCP) record identifier 'M': • Record Identifier • ACO ID Number • Delete Flag (Value D or Space) • Beneficiary HICN • Beneficiary Start Date • Beneficiary Termination Date • Beneficiary Host ID • Gender • Medical data sharing preference • MCP Benefit Enhancement Indicator Track 1								X	CMS, NCH

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	value 'L' • MCP Benefit Enhancement Indicator Track 2 value 'M' • MCP Benefit Enhancement Indicator Track 3 value 'N' Note: Benefit Enhancement Indicators L, M, N will be included as new values for the existing "Population Indicator" Field on the beneficiary alignment file.									
13392.3.3	CMS shall send updated aligned beneficiary files on a monthly basis and shall be processed as full replacement files.								X	CMS
13392.3.4	CWF shall perform limited editing to ensure the MCP Beneficiary Alignment file is well-formed. If errors exist a response will be generated with defined error codes. The validation checks will include the actual count of detail records that must match the count in the Trailer record. NOTE: The Interface Control Document (ICD) will define the response file layout and detailed error conditions.								X	
13392.3.5	CWF shall send the beneficiary alignment files with the most current Health Insurance Claim Number (HICN) to MCS and FISS, and CWF shall send the file to the Virtual Data Centers (VDCs) when they become available.								X	VDC
13392.3.6	The contractors shall be prepared to accept the data elements on the initial Beneficiary Alignment file for each MCP.					X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The Beneficiary Alignment file will contain the data elements identified in the Interface Control Document (ICD) submitted with this CR.									
13392.3.7	The contractors shall maintain an update date in their internal file which will reflect the date the updated files were loaded into the shared system. NOTE: The field shall be viewable to the MACs.								X	
13392.3.8	MCS shall modify the Beneficiary Accountable Care Organization online screen (NB) to display the new MCP participating Beneficiary records and will include the Benefit Enhancement Indicator.						X			
13392.4	The Contractor shall modify Accountable Care Organization Beneficiary (ACOB) File and online Health Insurance Master Record (HIMR) Display to include the new MCP Model based on the updated Beneficiary Alignment File and the new identifier.								X	
13392.5	CMS shall provide a list of accepted and prohibited services under the MCP. Appendix A = Accepted HCPCs for Track 1 and 2 Appendix B = Accepted HCPCs for Track 3 Appendix C = Prohibited HCPCs for Track 1, 2 and 3									CMS
13392.6	The contractors shall accept and process Track 1 claim details without a reduction in pricing, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary's HICN/MBI is on the Beneficiary File (Benefit Enhancement Indicator of L), • Provider's TIN/NPI is found on the Provider file (Benefit Enhancement Indicator of L),						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Procedure code is found on Appendix A.									
13392.7	The contractors shall accept and process Track 2 claim details with a 50% reduction in pricing, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary's HICN/MBI is on the Beneficiary File (Benefit Enhancement Indicator of M), • Provider's TIN/NPI is found on the Provider file (Benefit Enhancement Indicator of M), • Procedure code is found on Appendix A.						X			
13392.8	The contractors shall accept and process Track 3 claim details with a 100% reduction in pricing, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary's HICN/MBI is on the Beneficiary File (Benefit Enhancement Indicator of N), • Provider's TIN/NPI is found on the Provider file (Benefit Enhancement Indicator of N), • Procedure code is found on Appendix B.						X			
13392.9	The contractors shall accept and deny Track 1 claim details, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary is on the Beneficiary File (Benefit Enhancement Indicator of L), • Corresponding Provider is found on the Provider file (Benefit Enhancement Indicator of L), • Procedure code is found on Appendix C.						X			
13392.9.1	Contractors shall deny the claim lines using the following messaging: Claim Adjustment Reason Code (CARC) 96		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.									
13392.10	The contractors shall accept and deny Track 2 claim details, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary is on the Beneficiary File (Benefit Enhancement Indicator of M), • Corresponding Provider is found on the Provider file (Benefit Enhancement Indicator of M), • Procedure code is found on Appendix C.						X			
13392.10.1	Contractors shall deny the claim lines using the following messaging: Claim Adjustment Reason Code (CARC) 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.									
13392.11	The contractors shall accept and deny Track 3 claim details, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary is on the Beneficiary File (Benefit Enhancement Indicator of N), • Corresponding Provider is found on the Provider file(Benefit Enhancement Indicator of N), • Procedure code is found on Appendix C.						X			
13392.11.1	Contractors shall deny the claim lines using the following messaging: Claim Adjustment Reason Code (CARC) 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.									
13392.12	The contractors shall accept and process ACM code (G9038) on a detail, when the following circumstances are met: • Beneficiary is on the Beneficiary File as a Track 3 (Benefit Enhancement Indicator N), • Provider specialty is on Attachment D.						X			
13392.12.1	The contractors shall not allow ACM Code (G9038) to be more than 1 time in a 30 day period per Specialty Type. NOTE: Claims shall be adjudicated on a first come (i.e., first billed), first-serve basis, regardless of the date of service.						X		X	
13392.12.2	The contractors shall allow ACM Code (G9038) to be billed up to 3 times in a 12-month time frame that coincides with the 12-month beneficiary alignment period per Specialty Type. NOTE: Claims shall be adjudicated on a first come (i.e., first billed), first-serve basis, regardless of the date of service.						X		X	
13392.12.3	CWF will create new Auxiliary file ‘MCPL’ that will have the following data elements to maintain counts						X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	and frequency, based on the Provider Specialty Type, applicable to Part B claims only, under Track 3: • Beneficiary HIC, MBI • Provider Specialty Type • Service Date • G9038 HCPCS • Start/End date for the 12 months • Claim DCN • Claims count/occurrences • Billing TIN • Billing NPI • Diagnosis code(s)									
13392.12.4	CWF shall create a new HICR function for the MCP Auxiliary File.								X	
13392.13	The contractors shall use the following messages for claim lines processed and paid in accordance with the rules of the MCP model, unless otherwise specified in this CR: Claims Adjustment Reason Code (CARC) 132: "Prearranged demonstration project adjustment" Group Code: CO (Contractual Obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.		X							
13392.13.1	The contractors shall deny ACM claim lines when claims have already been billed three times by the same specialist type for the same beneficiary in the past 12 months. and shall use the following messages: CARC 119: “Benefit maximum for this time period or occurrence has been reached.”		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	RARC N640: "Exceeds number/frequency approved/allowed within time period." Group Code: CO (for contractual obligation) MSN 20.5 - "These services cannot be paid because your benefits are exhausted at this time." Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."									
13392.13.2	The contractors shall reject or return as unprocessable claim lines when the MCP ACM code is not billed by an eligible provider specialty and shall use the following messages: **CARC 8** **"The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."** Remittance Advice Remark Code (RARC): N95 "This provider type/provider specialty may not bill this service." Remittance Advice Remark Code (RARC): N211 "ALERT - YOU MAY NOT APPEAL THIS DECISION." Group Code: CO (for contractual obligation)		X							
13392.13.3	The contractors shall deny ACM claim lines when the ACM code is billed within 30 days of another ACM code for the same beneficiary with the same specialty type and shall use the following messages: CARC 119: "Benefit maximum for this time period or occurrence has been reached."		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	RARC N640: "Exceeds number/frequency approved/allowed within time period." Group Code: CO (for contractual obligation) MSN 20.5 - "These services cannot be paid because your benefits are exhausted at this time." Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."									
13392.13.4	The contractors shall ensure the amount in the, *"Maximum You May Be Billed,"* section reflects the Beneficiary's liability prior to the MCP reductions, i.e. BE indicators L or M.						X			
13392.13.5	The contractors shall display the full allowed amount on the MSN when the Track 3 reduction is 100%, i.e. BE indicator N.						X			
13392.14	The contractors shall adjust claims: • processed as MCP and the beneficiary and provider combination is no longer active for claim's date of service. OR: • not processed as MCP when the beneficiary and provider combination is active for claim's date of service.	X				X	X		X	
13392.14.1	The contractor shall trigger an IUR when the Beneficiary alignment file is received, and the dates of service on the history claim are no longer in the model.								X	
13392.14.2	The contractor shall create an adjustment based on the IUR.	X				X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.15	The contractors shall accept Making Care Primary (MCP) Demo Code 'A5' in the first position for Part B (HUBC) claims								X	
13392.16	The contractors shall accept Making Care Primary (MCP) Demo Code 'A5' in the first position for Outpatient (HUOP) claims.								X	
13392.17	Effective for Dates of Service on or after July 1, 2024, CWF will modify Part B claims processing to accept MCP Demo 'A5' with the following benefit enhancement indicators: • MCP Benefit Enhancement Indicator Track 1 value 'L' • MCP Benefit Enhancement Indicator Track 2 value 'M' • MCP Benefit Enhancement Indicator Track 3 value 'N'								X	
13392.18	CWF shall ensure existing consistency edit '0014' to include MCP Demo Code 'A5' as a valid Demo when received on Part B (HUBC) claim.								X	
13392.19	CWF shall ensure existing consistency edit '0014' to include MCP Demo Code 'A5' as a valid Demo when received on Outpatient (HUOP) claim.								X	
13392.20	CWF shall ensure MCP Demo Code 'A5' is posted to claims history (HIMR/CLMH) and transmit to the NCH file when present on HUBC claim.								X	
13392.21	CWF shall ensure MCP Demo Code 'A5' is posted to								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	claims history (HIMR/CLMH) and transmit to the NCH file when present on HUOP claim.									
13392.22	CWF shall ensure existing consistency edits 92x5 and 97x1 do not set when Other Amount Indicators (‘B4') are present on a detail line of a Part B (HUBC) record for MCP Demo ‘A5’. MCP Track 2 Payment Reduction (Paid at 50% of FFS rate) value = ‘M’ MCP Track 3 Payment Reduction (Paid at 0% of FFS rate) value = ‘N’								X	
13392.23	CWF shall ensure that the new Other Amount Indicators ‘B4' for MCP Part B (HUBC) claim is accepted on the detail line. Note: Professional claims, Part B								X	
13392.23.1	The Contractor shall send the new Reduction indicator on the HUBC Transmission Record.						X			
13392.24	CWF shall ensure that the new Other Amount Indicators ‘B4' for MCP Part B (HUBC) claim is transmitted to the HCFACLM file (NCH).								X	NCH
13392.25	CWF shall ensure that the MCP Part B (HUOP) claim posts to claim history (HIMR/CLMH). Note: Institutional claims								X	
13392.26	The CMS specialty contractor shall send the Multi-Carrier System (MCS) the initial Provider alignment files detailing MCP participating providers. NOTE: The provider participant file will be a national file accessible by all MACs.						X			CMS
13392.27	The Contractors shall send the Fiscal Intermediary						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Shared System (FISS) Provider Alignment file records. NOTE: The Provider Alignment File will be sent on a monthly basis initially beginning on or about June, 2024, but based on business need, an ad-hoc file may be sent more frequently, e.g. daily, weekly, etc.									
13392.27.1	MCS shall provide an updated Provider Alignment file to the Fiscal Intermediary Shared System (FISS).						X			
13392.27.1.1	The Contractors shall be prepared to accept the data elements on the updated Provider Alignment file for each MCP participant. NOTE: The Provider Alignment file will contain the data elements identified in the Interface Control Document (ICD). The file shall be processed as a full file replacement.					X				
13392.28	The Contractor shall be prepared to accept the data elements on the initial Provider Alignment file for each MCP participant. NOTE: The Provider Alignment file will contain the data elements identified in the Interface Control Document (ICD).									VDC
13392.29	The Contractors shall send the Fiscal Intermediary Shared System (FISS) the updated Beneficiary Alignment file records.					X			X	
13392.29.1	The Contractors shall create/modify online screens to display Beneficiary Alignment File data to include file update history, similar to BR 13392.30 for the Provider Alignment file.					X				
13392.30	The Contractor shall create/modify an online screen(s) to display Demo Code A5 on the MCP Provider Alignment File to include file updates/history.					X				
13392.31	The Contractors shall ensure the ACO ID, Demo code, Benefit enhancement indicators, Other adjustment indicator, and value codes for MCP claims are passed to the downstream systems including but not limited to					X	X		X	IDR, NCH

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	National Claims History (NCH) and Integrated Data Repository (IDR)									
13392.32	The Contractor shall apply the MCP demo code A5 according to the demo code precedence: MCP is usurped by all demos except 96, 83, and 78. Codes that take priority over MCP are 31, 94, 87, 93, 97, 92, 74, 86, 75, 98, 99, 82, 91					X	X			
13392.33	The Contractor shall apply demo code A5 for Track 1 of the MCP Model to Institutional claims when: • Type of Bill (TOB) 77X. • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in Track 1 based on BE Indicator/Record Type value 'L' in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The from date on the claim-header is on or within the effective start and end date for the matching records in the beneficiary and provider participant file. • Medicare is the primary payer on the claim. Note: Deductible does not apply to FQHC claims.					X				
13392.34	The Contractor shall create and edit to reject the line when the MEC code is billed on an FQHC claim. • TOB 77X • HCPCS code G9037 • Track 1 Note: The demo code should not be added.					X				
13392.34.	The following ANSI Information should be used:	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
1	The Contractors shall reject the claim lines using the following ANSI information: CARC 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)									
13392.35	The Contractor shall allow the MEC code G9037 if billed on an FQHC claim if the following criteria is met for track 2: • TOB 77X • The criteria had been met for demo code A5 to be applied. • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in Track 2 based on BE Indicator /Record Type value 'M' in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The HCPCS code should be allowed at the full rate and no reductions should apply.					X				
13392.36	The Contractor shall allow the MEC code G9037 if billed on an FQHC claim if the following criteria is met for track 3: • TOB 77X					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The criteria had been met for demo code A5 to be applied. • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in Track 3 based on BE Indicator /Record Type value 'N' in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The HCPCS code should be reduced by 100%									
13392.37	The Contractor shall create a reason code and return to provider (RTP) when HCPCS code G9038 is billed on an FQHC claim.	X				X				
13392.38	The Contractor shall apply demo code A5 for Track 2 (Appendix A) of the MCP Model to Institutional claims when: • TOB is 77X (FQHC). • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in Track 2 based on BE Indicator/Record Type value 'M' in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The from date on the claim-header is on or within the effective start and end date for the matching records in the beneficiary and provider participant file. • Medicare is the primary payer on the claim. • The HCPCS code listed on the claim detail line is from Appendix A. • Services should be reduced by 50%					X				
13392.39	The Contractor shall apply demo code A5 for Track 3 (Appendix B) of the MCP Model to Institutional claims when:					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Type of Bill (TOB) 77X; • The claim from date is on or after 07/01/2024; • The claim has an aligned provider that is participating in Track 3 based on BE Indicator /Record Type value N in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The from date on the claim-header is on or within the effective start and end date for the matching records in the beneficiary and provider participant file. • Medicare is the primary payer on the claim. The HCPCS code listed on the claim detail line is from Appendix B. • Services should be reduced by 100%									
13392.40	The Contractor shall create a reason code to reject HCPCS codes identified in Appendix C at the line level for demo A5 when: • Type of Bill (TOB) 77X. • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in model. • The claim is for an aligned beneficiary participating in model. • Medicare is the primary payer on the claim.					X				
13392.41	The Contractors shall use the ANSI information below for all HCPCS codes rejected from Appendix C . • Group Code: CO Contractual Obligation • Claims Adjustment Reason Code (CARC): 132 "Prearranged demonstration project adjustment."	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Remittance Advice Remark Code (RARC): N211 "ALERT - YOU MAY NOT APPEAL THIS DECISION."									
13392.42	The Contractor shall define an aligned provider using the NPI-CCN to apply the payment mechanisms for Track 2 and Track 3, (BE indicator M or N') for institutional FQHC claims.					X				
13392.43	The Contractor shall apply a 50% reduction for MCP claims with the BE indicator 'M' for Track 2 (Appendix A), when the following criteria is met: • TOB is 77X (FQHC). • The claim has met the criteria to assign demo code A5. • The provider is aligned to the MCP Model. • The beneficiary is aligned to the same MCP Model Identifier as the provider. • The claim from date is on or within the beneficiary's effective start and end date from the ACOB Auxiliary File. • Line item date of service on the claim is equal to or falls within the effective start and end date of the Track 2 BE indicator M. • Line item date of service on the claim must be equal to or within the effective and end dates of the beneficiary ACOB alignment file. • Do not consider the beneficiary aligned if the ACOB Drop flag is set. • The billing providers CCN is found on the NPI-CCN provider file based on the from and through dates of service on the claim. • Line item date of service must be equal to or within the effective and end dates of the provider (using the NPI-CCN) alignment file. • The HCPCS code listed in Appendix A • Do not consider the provider aligned if the effective and end dates are the same.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.44	The Contractor shall apply a reduction for MCP claims with the BE indicator 'N' for Track 3 (Appendix B) when the following criteria is met: • The claim TOB is 77X (FQHC). • The claim has met the criteria to assign demo code A5. • The HCPC code is listed on Appendix B (Track 3) reduced by 100% • The provider is aligned to the MCP Model. • The beneficiary is aligned to the same MCP Model Identifier as the provider. • The claim from date is on or within the beneficiary's effective start and end date from the ACOB Auxiliary File. • Line item date of service on the claim is equal to or falls within the effective start and end date of the Track 3 BE indicator 'N'. • Line-item date of service on the claim must be equal to or within the effective and end dates of the beneficiary ACOB alignment file. • Do not consider the beneficiary aligned if the ACOB Drop flag is set. • The billing providers CCN is found on the NPI-CCN provider file based on the from and through dates of service on the claim. • Line-item date of service must be equal to or within the effective and end dates of the provider (using the NPI-CCN) alignment file. • The HCPCS code listed in Appendix B that are eligible to a reduction 100%. • Do not consider the provider aligned if the effective and end dates are the same.					X				
13392.45	The Contractor shall follow NGACO processing rules and systematically remove Value Code Q0 and/or Q1 on an incoming Institutional claim if the provider appends either to the claim. NOTE:					X				NCH

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Q0 (Q Zero) = Making Care Primary (MCP) non-model payment Q1 = Making Care Primary (MCP) payment amount including reduction									
13392.46	The Contractors shall send fields related to the MCP Track 2 and Track 3, (BE indicator M and N) reductions and value codes to support the Provider Statistical and Reimbursement (PS&R) reporting.					X				PS&R
13392.47	The Contractors shall use the ANSI information below for all claims with the MCP reduction applied. • Group Code: CO Contractual Obligation • Claims Adjustment Reason Code (CARC): 132 "Prearranged demonstration project adjustment."	X				X				
13392.48	The Contractor shall ensure that demo code A5 is included on all outbound 837 crossover claims transmitted to the COB Contractor (COBC) and shall balance in accordance with Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 837 version 5010 requirements.					X				BCRC
13392.49	The Contractor shall calculate coinsurance for claims with demo code A5 present in the same manner as they would in the absence of the demonstration, i.e. based on the amount Medicare would have paid in the absence of the demonstration. Note: Deductible does not apply to FQHC claims					X				
13392.50	The Contractor shall apply any clean claim interest payments based off the amount after applying the MCP Reduction for claims with BE indicators L or M. The clean claim interest calculation will occur after the application of the reduction.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.51	The Contractor shall send the Value Code "Q0" (zero) for institutional claims and Value Code of "Q1" for Institutional Claims on the CWF claim transmission record and to the IDR for purposes of data analysis and reporting.					X			X	IDR
13392.52	The Contractors shall apply and tally the actual amount of the MCP reduction to Value Code "Q1".					X				HIGLAS
13392.53	The Contractor shall send the MCP FQHC payment adjustment, Value Code "Q0" (zero) and Value Code "Q1" to the Common Working File (CWF) for the (HUOP) record.					X			X	NCH
13392.54	The Contractors shall report all claims paid under the MCP Model on the provider Remittance Advice (RA) together with all FFS claim payments.					X				
13392.55	The Contractors shall show the final payment amount and the reduction amount for claims where the Provider's BE indicators M or N was applied to the claim on all RAs created.					X				
13392.56	The Contractor shall display the reductions for Track 2 and Track 3 in the REDUCTION field on the Standard Paper Remittance (SPR) and PC-Print. NOTE: The reduction amount field is a header field on the SPR and therefore cannot be changed based on the BE flags and demo codes found on a claim. The field name needs to be all-encompassing.					X				
13392.57	The Contractors shall ensure that the MSN will show the amount that would have been paid if not for the Provider's MCP reduction as the provider paid amount, i.e. BE indicators M or N.					X				
13392.58	The Contractors shall ensure the amount in the, "Maximum You May Be Billed," section reflects the Beneficiary's liability prior to the MCP reductions, i.e. BE indicators M or N.	X				X				
13392.59	The Contractors shall display the full allowed amount					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	on the MSN when the Track 3 reduction is 100%, i.e. BE indicator N.									
13392.60	The Contractors shall display MSN Message, 63.10 on MCP claims where BE indicator L, M or N for Track 1 through 3, is present on the claim-header or claim-detail. MSN 63.10 You received this service from a provider who coordinates your care through an organization participating in a CMMI Model. For more information about your care coordination, talk with your doctor or call 1-800-MEDICARE (1-800-633-4227). Spanish translation: "Recibió este servicio de un proveedor que coordina su cuidado a través de una organización que participa en el Modelo CMMI. Para obtener más información sobre la coordinación de su cuidado, hable con su médico o llame al 1-800-MEDICARE (1-800-633-4227)."	X				X				
13392.61	For all claims with the MCP FQHC adjustment amount, the contractors shall use the following ANSI information: Group Code: CO (Contractual Obligation) CARC 132 – Prearranged demonstration project adjustment. Spanish Translation - Esta reclamación está siendo procesada bajo un projecto especial.	X				X				
13392.62	The Contractor shall calculate 1) the total allowed charges (after Traditional FFS processing); then 2) apply the sequestration adjustment when applicable; 3) then apply the MCP reduction for claims when: The Provider has BE indicators, M or N identified on the Provider Alignment File for Track 2 and Track 3.					X				
13392.63	The Contractor shall continue to apply sequestration,					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	when applicable, to the value code amounts. Note: The value codes on the face of the claim should continue to show the full amount before Sequestration, the reduction should occur in the background.									
13392.64	CMS shall create a future recurring CR to update changes to tables found in Appendix's that store information for: • HCPCS in Track 2 (Appendix A) • HCPCS in Track 3 (Appendix B) • HCPCS to be denied (Appendix C) • Specialty types – MCS only (Appendix D) Note: **For HCPCS in Appendix C : Institutional claims will be rejected and Professional/ Provider HCPCS codes will be denied.**									CMS
13392.65	CMS shall send the Shared System Maintainer (SSM) the initial provider participant file for MCP via the Cloud Storage and Retrieval System (CSRS) User Interface (UI) After the initial file, full replacement files with any updates will be supplied as needed and will be processed by the SSMs. NOTE: The file(s) will be a national file(s) accessible by all Medicare Administrative Contractors (MACs). Provider participant test files are: MCP_prov_impl.csv Provider participant regular production files are: MCP_prov_prod.csv CMS contacts are: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Sonja Madera sonja.madera@cms.hhs.gov									
13392.66	MCS shall accept the MCP provider participant file layout to support the MCP processing change.						X			
13392.67	MCS shall create response files acknowledging receipt of the MCP provider participant file.						X			
13392.68	MCS shall produce response files that indicate the file was processed and whether or not there were any errors. The response files shall be accessible through the CSRS UI.						X			
13392.69	CMS shall provide MCS with the MCP provider participant file no later than the ALPHA testing time frame. CMS Contacts: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov Sonja Madera sonja.madera@cms.hhs.gov									CMS
13392.70	CMS shall upload the initial MCP provider participant testing files in the CSRS application on or before Jun 3, 2024 so the test data can become available in User Acceptance Testing(UAT) for the contractor. CMS Contacts: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov Sonja Madera sonja.madera@cms.hhs.gov									CMS
13392.71	CMS shall send the Shared System Maintainer (SSM) the initial beneficiary alignment file for MCP via the Cloud Storage and Retrieval System (CSRS) User Interface (UI) After the initial file, full replacement files with any updates will be supplied as needed and will be processed by the SSMs.									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The file(s) will be a national file(s) accessible by all Medicare Administrative Contractors (MACs). Beneficiary Alignment test files are: MCP_bene_impl.csv Beneficiary Alignment regular production files are: MCP_bene_prod.csv CMS contacts are: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov Sonja Madera sonja.madera@cms.hhs.gov									
13392.72	CWF shall accept the MCP beneficiary alignment file layout to support the MCP processing change.								X	
13392.73	CWF shall create response files acknowledging receipt of the MCP beneficiary alignment file.								X	
13392.74	CWF shall produce response files that indicate the file was processed and whether or not there were any errors. The response files shall be accessible through the CSRS UI.								X	
13392.75	CMS shall create a CSV test file using the file format in the attached standard ICD file layout and upload the file using the Cloud Storage and Retrieval System (CSRS) user interface (UI) on or before Jun 3, 2024. CMS contacts: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov Sonja Madera sonja.madera@cms.hhs.gov									CMS
13392.76	CMS shall provide MCS/SSM with the MCP provider participant file no later than the ALPHA testing time frame.									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CMS Contacts: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov Sonja Madera sonja.madera@cms.hhs.gov									
13392.77	CMS shall upload the initial MCP beneficiary alignment testing files in the CSRS application on or before Jun 3, 2024 so the test data can become available in User Acceptance Testing(UAT) for the contractor. CMS Contacts: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov Sonja Madera sonja.madera@cms.hhs.gov									CMS
13392.78	The MACs shall provide to CMS that data to create the test files no later than May 3, 2024. To assist with the creation of the test files, the MACs shall: • Provide a list of at a minimum 5 to 15 providers as indicated by TIN-oNPI-CCN for Part A MACs and TIN-iNPI for Part B MACs • Provide a list of 5 to 15 beneficiaries as indicated by their HICN/MBI Send test data to: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov Sonja Madera sonja.madera@cms.hhs.gov	X	X							
13392.79	CMS shall facilitate a 1-hour User Acceptance Testing (UAT) Kickoff to discuss testing, on or about the week of May 15, 2024.									CMS
13392.80	CMS shall facilitate 1-hour weekly calls during UAT testing, beginning the week of June 10, 2024.									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.81	The Contractors and SSMs shall submit to CMS the list of attendee's email addresses to be invited to the testing calls within 5 days after the CR is issued in final. Contact for emails: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov Sonja Madera sonja.madera@cms.hhs.gov	X	X			X	X		X	CMS, HIGLAS, VDC
13392.82	CWF shall provide an updated Beneficiary Alignment file with the most current Health Insurance Claim Number (HICN) to MCS/FISS.								X	
13392.82.1	The Contractors shall be prepared to accept the data elements on the updated Beneficiary Alignment file for each MCP participant. NOTE: The Beneficiary Alignment file will contain the data elements identified in the Interface Control Document (ICD). The file shall be processed as a full file replacement.					X				
13392.83	The Contractor shall create an edit to return as unprocessable claim lines when the MEC code G9037 is billed and the beneficiary and provider are not aligned to Tracks 2 or 3 with the following criteria: • HCPCS code G9037 • Track 1 Note: Demo code A5 should not be added as criteria has not been met.						X			
13392.83.1	The Contractors shall return as unprocessable claim lines using the following messages: CARC 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)									
13392.84	The Contractor shall create an edit to accept and process the MEC code G9037 billed on a claim line if the following criteria is met for track 2: • The criteria had been met for demo code A5 to be applied and added to the claim. • The claim from date is on or after 07/01/2024 • The claim has an aligned provider that is participating in Track 2 based on BE Indicator /Record Type value ‘M’ in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier ‘M’ as the provider. • The HCPCS code should be allowed at the full rate and no reductions should apply.						X			
13392.84.1	The Contractors shall return as unprocessable claim lines for MEC code G9037 not meeting the criteria of BR 13992.84 using the following messages: Claim Adjustment Reason Code (CARC) 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)									
13392.85	The Contractor shall create an edit to accept and process the MEC code G9037 billed on a claim line if the following criteria is met for track 3: • The criteria had been met for demo code A5 to be applied. • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in Track 3 based on BE Indicator /Record Type value ‘N’ in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier ‘N’ as the provider. • The HCPCS code should be reduced by 100%						X			
13392.85.1	The Contractors shall return as unprocessable claim lines for MEC code G9037 not meeting the criteria of BR 13992.85 using the following messages: Clain Adjustment Reason Code (CARC) 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	present. Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)									
13392.86	The contractor shall conduct UAT testing.	X	X							
13392.87	Contractors shall make table/file updates to create a new adjustment reason code for overpayments identified under Making Care Primary (MCP) Model. 38 - Overpayment Identified under Making Care Primary (MCP) Model	X	X							HIGLAS
13392.87.1	The Contractor shall modify reason code(s) as necessary to allow the contractors to add Adjustment Reason code 38.					X				
13392.88	HIGLAS shall map the Shared System Reason code ‘38’ to the HIGLAS Reason Code ‘38’ for both Part A and Part B Orgs.									HIGLAS
13392.89	Contractors shall use the Reason Code ‘38’ when initiating the MCP model adjustments for the recoupment of overpayments.	X								
13392.90	Contractors shall use the Reason Code ‘38’ and existing Discovery Code ‘C’ when initiating the MCP model adjustments for the recoupment of overpayments.		X							
13392.91	Contractors shall follow the normal non-935 recoupment process for these adjustments.	X	X							HIGLAS
13392.92	Contractors shall ensure the 935 Indicator is not set (i.e., set the 935 Indicator to ‘N’ for these adjustments as they are not eligible for the Section 935 appeal rights).		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.93	HIGLAS shall map the MCP overpayments to existing Part A transaction types for adjustment reason code '38'. APROV-CLA (Non-935 overpayment) ABENE-CLA (Beneficiary non-935 overpayment) Note: HIGLAS will ignore the 935 Indicator and create the non-935 transactions for Part A when adjustments received with Adjustment Reason Code '38' as the MCP model overpayments are not eligible for 935 appeal rights.									HIGLAS
13392.94	Contractors shall use the following verbiage for the 'Reason for Overpayment' in the provider (Part A and Part B) demand letter enclosure for the new HIGLAS Reason code '38': ‘Per the Making Care Primary (MCP) Model billing rules, this payment was made to you in error.’									HIGLAS
13392.95	Contractors shall use the following verbiage for the 'Reason for Overpayment' in the beneficiary (Part A and Part B) demand letter enclosure for the new HIGLAS Reason Code '38': "The claim was processed incorrectly causing an overpayment to be made." Spanish Translation: "La reclamación fue procesada incorrectamente ocasionando un pago en exceso."									HIGLAS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	HHH	MAC	I
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 obligated 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.

ATTACHMENTS: 5

Appendix A – codes to be reduced by 50% for Track 2 participants

Service	Code
Administration of health risk assessment (HRA)	96160, 96161
Office/outpatient visit for the evaluation and management (E&M) of a patient	99202-99205, 99211-99215
Home care/domiciliary care E&M	99341, 99342, 99344, 99345, 99347-99350
Prolonged E&M with direct patient contact	G2212
Remote therapeutic monitoring (RTM) non-face-to-face treatment management services	98975-98977, 98980, 98981
Online digital E&M	99421-99423
Telephone E&M services	99441-99443
Remote physiologic monitoring (RPM) non-face-to-face treatment management services	99453, 99454, 99457, 99458, 99091
Technology-based check-in services	G2010, G2012, G2252
Advance care planning	99497, 99498
Welcome to Medicare and annual wellness visits	G0402, G0438, G0439
FQHC Virtual Communication Services	G0071
FQHC Distant Site Telehealth visit	G2025
FQHC All-Inclusive visit	G0466, G0467
FQHC IPPE or AWV visit	G0468

Appendix B – codes to be reduced by 100% for Track 3 participants

Service	Code
Administration of health risk assessment (HRA)	96160, 96161
Office/outpatient visit for the evaluation and management (E&M) of a patient	99202-99205, 99211-99215
Home care/domiciliary care E&M	99341, 99342, 99344, 99345, 99347-99350
Prolonged E&M with direct patient contact	G2212
Remote therapeutic monitoring (RTM) non-face-to-face treatment management services	98975-98977, 98980, 98981
Online digital E&M	99421-99423
Telephone E&M services	99441-99443
Remote physiologic monitoring (RPM) non-face-to-face treatment management services	99453, 99454, 99457, 99458, 99091
Technology-based check-in services	G2010, G2012, G2252
Advance care planning	99497, 99498
Welcome to Medicare and annual wellness visits	G0402, G0438, G0439
FQHC Virtual Communication Services	G0071
FQHC Distant Site Telehealth visit	G2025
FQHC All-Inclusive visit	G0466, G0467
FQHC IPPE or AWV visit	G0468
Interprofessional consult (IPC) services	99451, 99446-99449
MCP eConsult (MEC) code	G9037
Behavioral health integration (BHI) services	99484, 99492, 99493, 99494, G2214, G0512, G0323

Depression, substance use disorder, and alcohol misuse screening and counseling services	G0396-G0397, G0442-G0444
Cognition and functional assessment for patient with cognitive impairment	99483

Appendix C – codes to be denied for Track 1, 2 and 3

Service	Code
Prolonged Clinical Staff Services	99415, 99416*
Principal care management (PCM) services	99424, 99425*, 99426, 99427*
Prolonged CCM services	99437*
Non-complex CCM	99439*
Complex chronic care coordination services	99487
Chronic care management (CCM) services	99489*, 99490, 99491
Transitional care management (TCM) services	99495, 99496
Assessment/care planning for patients requiring CCM services	G0506
CCM or General Behavioral Health Integration (BHI) Services (for FQHCs)	G0511
Chronic Pain Management (CPM)	G3002, G3003
Community Health Integration (CHI) Services	TBD
Social Determinants of Health Risk Assessment	TBD
Principal Illness Navigation (PIN) Services	TBD

CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; PCM = principal care management; CCM = Chronic care management; TCM = transitional care management.
Notes: * Add-on codes are also excluded when billed with other duplicative services.

Please note that all CPT and HCPCS codes listed in this table are current as of August 2023 and are subject to change based on future Medicare PFS Final Rules.

Appendix D – Approved Rendering Provider specialty types for ACM code billing

specialty_rfrnc_desc	specialty_rfrnc_cd
Addiction Medicine	79
Advanced Heart Failure and Transplant Cardiology	C7
Allergy-Immunology	03
Cardiac Electrophysiology	21
Cardiovascular Disease (Cardiology)	06
Medical Oncology	90
Nephrology	39
Neurology	13
Neuropsychiatry	86
Obstetrics-Gynecology	16
Ophthalmology	18
Dermatology	07
Endocrinology	46
Gastroenterology	10
Geriatric Medicine	38
Geriatric Psychiatry	27
Hematology	82
Hematology-Oncology	83
Hospice-Palliative Care	17
Infectious Disease	44
Internal Medicine	11
Interventional Cardiology	C3
Orthopedic surgery	20
Interventional Pain Management	09
Peripheral Vascular Disease	76
Physical Medicine and Rehabilitation	25
Psychiatry	26
Pulmonary Disease	29
Rheumatology	66
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CMMI Model ICD

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Overview

The purpose of this interface control document (ICD) is to provide common templates for the exchange of beneficiary, provider and other support data for all CMMI models.

As new models are added, any new values for existing fields are added to the applicable template in the valid values column. If a model has a business need to add a new field to an existing template, it is added to the end of the record for both flat (if applicable) and CSV version of the files. The 'Valid Values' column is used to reflect which model uses the data and the default value for any models that don't need it.

Requirements for CMMI Model Beneficiary Alignment and Response (Flat File Format)

General Processing

The file is a fixed-length format.

Each CMMI Model beneficiary alignment file and the corresponding response file has a header, record details, and trailer as described in the section below.

A common format is used for all beneficiary files. Separate sets of files are created for each unique model.

The CMMI model entity sends a full refresh of the beneficiary file to the CWF at the CWF Peraton Host on each month and as needed by CMS/CMMI.

The CMMI model entity beneficiary files are transferred to the CWF Host using electronic file transfer (EFT) service. If there are any problems transferring data from the CMMI model entity, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

The SSM processes the beneficiary alignment files received from the CMMI model entity in the batch cycle after the file is received. A response file is generated from the SSM along with a response code that the SSM then sends back to the CMMI model entity.

Response Files

As noted above, incoming files are processed in the batch cycle after the file is received. The response file will be sent back to the CMMI model entity via EFT to indicate the file was processed as well as the results.

The response file is the same layout as the incoming file with a Response Code field added after the Record Identifier field. All other records are shifted two positions and the filler is reduced by two positions.

Response files include all records with appropriate response code values in the Response Code field. A value of “00” is returned on all records that are processed successfully. CMMI model teams should review the response file to ensure all records processed successfully. If some records failed, the CMMI model teams will need to correct those records and resubmit THE ENTIRE file to shared systems again. They will then need to review the response file for the resubmit to ensure everything processed correctly.

Only valid records are accepted and brought into claims processing. Invalid records are rejected.

Record Layout

Table 1 – CMMI Model Beneficiary Alignment File Header Record

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Identifier	Record indicator which identifies the line entry is header information for the Beneficiary file	7	CHAR	HDR_BEN	10 – Invalid value 98 - Header record is missing
File Creation Date	Date the file is created	8	CHAR	CCYYMMDD	11
Detail Record Count	Number of detail rows or records	6	NUM	000001-999999	32
Filler	Unused area filled with spaces.	40	CHAR	Spaces	N/A

Table 2 – CMMI Model Beneficiary Alignment File Detail Record

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Refer to Appendix D for model specific information.

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Identifier	Record indicator which identifies the line entry is record detail information for the Beneficiary file	7	CHAR	DTL_BEN Alphanumeric	20
Model Identifier/Practice Location ID	Unique identifier for model	10	CHAR	Refer to Appendix A for the list of valid values	21
Delete Flag	Beneficiary who never should have been aligned, thus removed from the alignment	1	CHAR	'D' or Blank	N/A
Beneficiary HICN [I] [H]	Beneficiary Health Insurance Claim Number (HICN)	12	CHAR	Alphanumeric characters Health Insurance Claim Number (Field will not contain an MBI) The CMMI model entity will include the most current Health Insurance Claim Number (HICN) and/or Railroad Retirement Board (RRB) Numbers associated with the beneficiary.	29
Beneficiary Effective Date	Effective date of the beneficiary's association with the CMMI model entity	8	CHAR	CCYYMMDD	25

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Beneficiary End Date	End date of the beneficiary's association with the CMMI model entity	8	CHAR	CCYYMMDD Use the model's end date if there is not a specific end date for the beneficiary's participation.	26
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific	N/A
Beneficiary Gender	Beneficiary gender	1	CHAR	M = Male F = Female U = Unknown	N/A
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	1	CHAR	Y = Yes N = No	N/A

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
QCP Indicator	QCP indicator	1	CHAR	Y = Qualified for QCP payment “indicates CKD beneficiary” Blank for all other models. For CKCC model, blank means Not Qualified for QCP payment indicates ESRD beneficiary	N/A
Population Indicator	Indicates whether the Beneficiary is in Seriously Ill Population (SIP)	1	CHAR	S = PCF model SIP Population Blank for all other models	N/A
Performance Based Adjustment (PBA)	Indicates whether the beneficiary is qualified for the PBA	1	CHAR	Y= Qualified for PBA Blank= Not Qualified for PBA or concept does not apply	N/A
Filler	Unused area filled with spaces.	3	CHAR	Spaces	N/A

Table 3 – CMMI Model Beneficiary Alignment File Trailer Record

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Identifier	Record indicator which identifies the line entry is trailer information for the Beneficiary file	7	CHAR	TRL_BEN	30 – Invalid value 99 - If trailer record is missing
File Creation Date	Date when the file was created	8	CHAR	CCYYMMDD	31
Detail Record Count	Number of rows or records sent by the CMMI model entity	10	NUM	Numbers	32
Filler	Unused area filled with spaces.	30	CHAR	Spaces	N/A

Requirements for CMMI Model Beneficiary Alignment and Response (Comma-Separated Values or CSV Format)

General Processing

The file is a variable length format with data fields on a record separated by commas.

The record format is described in the section below.

A common format is used for all CSV beneficiary files. A separate file is created for each unique model.

The CMMI model entity sends a full refresh of the beneficiary file to the CWF Host each month and as needed by CMS/CMMI.

The CMMI model entity CSV format beneficiary files are sent to the SSM using Secure File Transfer Protocol (SFTP). If there are any problems transferring data from the CMMI model entity, a notification will be displayed in the Cloud Storage and Retrieval System (CSRS) user interface. The SSM processes the files in the batch cycle after the file is received from the CMMI model entity.

Please refer to Appendix H for naming conventions of the CSV file(s).

Response Files

As noted above, incoming files are processed in the batch cycle after they are received from the CMMI model entity. A response file generated from the cycle will be sent back to the CMMI Model folder area, signifying the file was processed by the SSM.

The response file is the same layout as the incoming file with a Response Code column/field added after the Record Type (2nd column/field).

CMMI model teams should review the response file to ensure all records processed successfully.

Two response files will be sent back to the CMMI Model folder.

One file will only include records in error with the appropriate response code value in the Response Code column/field. The filename will be the input filename with a suffix of "_response" added before the file extension.

The other response file will contain all records with appropriate response code values in the Response Code field. A value of "00" is returned on all records that are processed successfully. The filename will be the input filename with a suffix of "_summary" added before the file extension.

If some records failed, the CMMI model teams will need to correct those records on the FULL FILE, save the FULL FILE as CSV and upload to the cloud again. They will then need to review the response file for the resubmit to ensure everything processed correctly.

Only valid records are accepted and brought into claims processing. Invalid records are not loaded into the mainframe system.

Record Layout

Table 4:CMMI Model Beneficiary Alignment CSV Record

Data Fields marked with an I contain Personally Identifiable Information (PII).

Data Fields marked with an H contain Protected Health Information (PHI).

Refer to Appendix D for model specific information.

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Type*	Record indicator which identifies the line entry is record detail information for the Beneficiary file	3	CHAR	BEN Alphanumeric	20
Model Identifier/Practice Location ID*	Unique identifier for Entity	3 - 10	CHAR	Refer to Appendix A for the list of valid values Models currently using the CSV format: TBD	21
Delete Flag	Beneficiary who never should have been aligned, thus removed from the alignment	1	CHAR	'D' for delete or null/blank if not used	N/A
Beneficiary HICN* I H	Beneficiary Health Insurance Claim Number (HICN)	7 - 12	CHAR	Alphanumeric characters Health Insurance Claim Number (Field will not contain an MBI) The CMMI model entity will include the most current Health Insurance Claim Number (HICN) and/or Railroad Retirement Board (RRB) Numbers associated with the beneficiary.	29
Beneficiary Effective Date	Effective date of the beneficiary's association with the CMMI model entity	8	CHAR	CCYYMMDD	25

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Beneficiary End Date	End date of the beneficiary's association with the CMMI model entity	8	CHAR	CCYYMMDD Use the model's end date if there is not a specific end date for the beneficiary's participation.	26
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific	N/A
Beneficiary Gender	Beneficiary gender	1	CHAR	M = Male F = Female U = Unknown	N/A
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	1	CHAR	Y = Yes N = No	N/A

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
QCP Indicator	QCP indicator	1	CHAR	Y = Qualified for QCP payment "indicates CKD beneficiary" Null/blank for all other models. For CKCC model, blank means Not Qualified for QCP payment "indicates ESRD beneficiary"	N/A
Population Indicator	Indicates whether the Beneficiary is in Seriously Ill Population (SIP) or for MCP model indicates which track the bene is in	1	CHAR	S = PCF model SIP Population L=Track 1 MCP bene M= Track 2 MCP bene N= Track 3 MCP bene Null/blank for all other models	N/A
Performance Based Adjustment (PBA)	Indicates whether the beneficiary is qualified for the PBA	1	CHAR	Y= Qualified for PBA Null/blank for beneficiaries not qualified for PBA or where concept does not apply	N/A

Requirements for CMMI Model Provider Participant and Response (Flat File Format)

General Processing

The file is a fixed-length format.

Each CMMI Model provider participant file and the corresponding response file has a header, record details, and trailer as described in the section below.

A common format is used for all provider participant files. Separate sets of files are created for each unique model.

The CMMI model entity sends a full refresh of each provider participant file.

The CMMI model entity sends the provider participant flat file format to the SSM (either MCS or VMS, depending on the file) at the Peraton VDC using EFT. If there are any problems transferring data from the CMMI model entity, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

The SSM processes the provider files received from the CMMI model entity in the Friday batch cycle. A response file is generated from the SSM along with a response code that the SSM then sends back to the CMMI model entity.

Response Files

As noted above, incoming files are processed once a week in the Friday batch cycle. The response file generated from that weekly processing cycle will be sent back to the CMMI model entity via EFT to indicate the file was processed as well as the results.

The response file is the same layout as the incoming file with a Response Code field added after the Record Identifier field. All other records are shifted two positions and the filler is reduced by two positions.

Response files include all records with appropriate response code values in the Response Code field. A value of “00” is returned on all records that are processed successfully.

Only valid records are accepted and brought into claims processing. Invalid records are rejected.

Record Layout

Table 5: CMMI Model Provider Participant File Header.

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Identifier	Record indicator which identifies the line entry is header information for a Provider file	7	CHAR	HDR_PRV	10 – Invalid value 98 - Header record is missing
File Creation Date	Date the file is created	8	CHAR	CCYYMMDD	11
Filler	Unused area filled with spaces.	85	CHAR	Spaces	N/A

Table 6: CMMI Model Provider Participant File Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an I contain PII.

Refer to Appendix E for model specific information.

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Provider file	7	CHAR	DTL_PRV	20
Organization Identifier*	Unique identifier for entity	10	CHAR	Refer to Appendix A for the list of valid values	21
Provider Type*	Model defined provider classifications	1	CHAR	ACO-OS Type Model Values: • P = Preferred • S = Provider/Supplier • A = Affiliate	N/A
Participant TIN [l]	The Tax Identification Number (TIN) for the ACO Participant	9	NUM	Numbers	22
Participant NPI	The National Provider Identifier (NPI) for the Participant (This field supports individual NPIs and organizational NPIs)	10	NUM	Numbers	N/A
Participant CCN	The CMS Certification Number (CCN) for the Participant	6	CHAR	This field is only populated on Part A records. The field is all spaces on Part B record.	N/A
Record Type	Detail Record Type. Also referred to as the Benefit Enhancement Indicator.	1	CHAR	Refer to Appendix B for the list of valid values and descriptions.	N/A
Participant/ Enhancement Effective Date*	Effective date for the associated record type.	8	CHAR	CCYYMMDD	25

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Participant/ Enhancement End Date*	End date for the associated record type.	8	CHAR	CCYYMMDD Use the model's end date if there is not a specific end date for the provider's participation.	26

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Percentage Adjustment 1	Claims Adjustment Percentage 1. For PBP/APO/AIPBP/TCC/PCC, this field reflects the Part A reduction percentage.	3	DECIMAL	A zero value is applicable when a reduction does not apply to a model. For the PBP/APO Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than PBP/APO (or) when Part A Reduction Percentage is not available. For the AIPBP/TCC/PCC Record: Value is greater than “0” but less than or equal to (1) or 100% with two (2) implied decimal places when AIPBP/TCC/PCC is applicable. Ex. 1.00 will appear as 100. For the QCP Record: Value is always “100” or 100% with two (2) implied decimal places when QCP is applicable. Ex. 1.00 will appear as 100.	N/A

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Percentage Adjustment 2	Claims Adjustment Percentage 2. For PBP/APO/AIPBP/TCC/PCC, this field reflects the Part B reduction percentage.	3	DECIMAL	A zero value is applicable when a reduction does not apply to a model. For the PBP/APO Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than PBP/APO (or) when Part B Reduction Percentage is not available. For the AIPBP/TCC/PCC Record: Value is greater than “0” but less than or equal to (1) or 100% with two (2) implied decimal places when AIPBP is applicable. Ex. 1.00 will appear as 100. For the QCP Record: Value is always “100” or 100% with two (2) implied decimal places when QCP is applicable. Ex. 1.00 will appear as 100.	N/A
Filler	Unused area filled with spaces.	34	CHAR	Spaces	N/A

Table 7: CMMI Model Provider Participant File Trailer

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Identifier	Record indicator which identifies the line entry is trailer information for the Part A/Part B NGACO/VT APM Provider file	7	CHAR	TRL_PRV	30 – Invalid value 99 - If trailer record is missing
File Creation Date	Date when the file was created	8	CHAR	CCYYMMDD	31
Detail Record Count	Number of detail rows or records sent by CMMI Model entity	10	NUM	Numbers	32
Filler	Unused area filled with spaces.	75	CHAR	Spaces	N/A

Requirements for CMMI Model Provider Participant and Response (CSV Format)

General Processing

The file is a variable length format with data fields on a record separated by commas.

The record format is described in the section below.

A common format is used for all CSV provider participant files. Separate sets of files are created for each unique model.

The CMMI model entity sends a full refresh of the provider participant file to the SSM as needed by CMS/CMMI.

The CMMI model entity CSV format provider participant file is sent to the SSM using Secure File Transfer Protocol (SFTP). If there are any problems transferring data, a notification will be displayed in the Cloud Storage and Retrieval System (CSRS) user interface. The SSM processes the files in the Friday batch cycle.

Please refer to Appendix H for naming conventions of the CSV file(s).

Response Files

As noted above, incoming files are processed once a week in the Friday batch cycle. A response file generated from that weekly processing cycle will be sent back to the CMMI Model folder area, signifying the file was processed by the SSM.

Response files are the same layout as the incoming file with a Response Code column/field added after the Record Type(2nd column/field).

CMMI model teams should review the response file to ensure all records processed successfully.

Two response files will be sent back to the CMMI Model folder.

One file will only include records in error with the appropriate response code value in the Response Code column/field. The filename will be the input filename with a suffix of "_summary" added before the file extension.

The other response file will contain all records with appropriate response code values in the Response Code field. A value of "00" is returned on all records that are processed successfully. The filename will be the input filename with a suffix of "_response" added before the file extension.

If some records failed, the CMMI model teams will need to correct those records on the FULL FILE, save the FULL FILE as CSV and upload to the cloud again. They will then need to review the response file for the resubmit to ensure everything processed correctly.

Only valid records are accepted and brought into claims processing. Invalid records are not loaded into the mainframe system.

Record Layout

Table 8: CMMI Model Provider Participant Record

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an I contain PII.

Refer to Appendix E for model specific information.

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Type*	Record indicator which identifies the line entry is record detail information for the Provider file	3	CHAR	PRV	20
Model ID	Unique identifier for entity	3 - 10	CHAR	Refer to Appendix A for the list of valid values	
Provider Type	Model defined provider classifications	1	CHAR	**ACO-OS Type Model Values**: • P = Preferred • S = Provider/Supplier • A = Affiliate	N/A
Participant TIN [I]	The Tax Identification Number (TIN) for the model participant	9	NUM	Either this field (Participant TIN) or the next field (Participant NPI) is required for Part B provider participants Null/blank for Part A provider participants	22
Participant NPI	The National Provider Identifier (NPI) for the participant (This field supports individual NPIs and organizational NPIs)	9 - 10	NUM	Either a TIN or a NPI is required for Part B provider participants If populated, must be numerics	N/A
Participant CCN	The CMS Certification Number (CCN) for the participant	6	CHAR	Required for a Part A provider participants. Null/blank for Part B provider participants.	N/A

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Benefit Enhancement ID	An indicator that signifies the model benefit enhancement the provider has selected	1	CHAR	Null/blank allowed for models that do not use benefit enhancements. Refer to Appendix B for the list of valid values and descriptions.	N/A
Participant/ Enhancement Effective Date*	Effective date for the associated record type.	8 – 10	CHAR	Formats supported: CCYYMMDD CCYY/MM/DD MM/DD/CCYY	25
Participant/ Enhancement End Date*	End date for the associated record type.	8 – 10	CHAR	Formats supported: CCYYMMDD CCYY/MM/DD MM/DD/CCYY Use the model's end date if there is not a specific end date for the provider's participation.	26

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Percentage Adjustment 1*	Claims Adjustment Percentage 1.	6	DECIMAL	Value is 1 followed by four decimal positions. The decimal is required, i.e. 9.9999 A payment Increase is represented with a value greater than 1. Example: 1.0500 will result in a 5% increased payment. A payment decrease is represented with a value less than 1. Example: 0.9500 will result in a 5% decreased payment. No change in payment is represented with a value of 1. 1.0000 will result in no payment change. A full payment decrease is represented with a value of 0. 0.0000 will result in no payment.	27

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Percentage Adjustment 2	Claims Adjustment Percentage 2.	6	DECIMAL	Value is 1 followed by four decimal positions. The decimal is required. i.e: 9.9999. A payment Increase is represented with a value greater than 1. Example: 1.0500 will result in a 5% increased payment. A payment decrease is represented with a value less than 1. Example: 0.9500 will result in a 5% decreased payment. No change in payment is represented with a value of 1. 1.0000 will result in no payment change. A full payment decrease is represented with a value of 0. 0.0000 will result in no payment. Null/blank can be used if a model does not involve a payment adjustment.	N/A
Cap Limit	A limitatation of the number of claims a provider can submit between the effective start date through effective end date for the NPI/TIN/CCN combination	5	Numeric	Null/blank can be used if a model does not have a cap limit	N/A

Requirements for CMMI Model Criteria File (CSV format)

General Processing

The file is a variable length format with data fields on a record separated by commas.

The record format is described in the section below.

A common format is used for all CSV model criteria files. Separate sets of files are created for each unique model and record type. For example, if a model uses both ZIP codes and ICD-10 diagnosis codes as criteria for participation, two files are created: one to communicate ZIP codes and another for the ICD-10 diagnosis codes.

The CMMI model entity sends a full refresh of the model criteria file to the SSM as needed by CMS/CMMI.

The CMMI model entity CSV format model criteria file is sent to the SSM using Secure File Transfer Protocol (SFTP). If there are any problems transferring data from the CMMI model entity, a notification will be displayed in the Cloud Storage and Retrieval System (CSRS) user interface. The SSM processes the files in the Friday batch cycle.

Please refer to Appendix H for naming conventions of the CSV file(s).

Response Files

As noted above, incoming files are processed once a week in the Friday batch cycle. A response file generated from the weekly processing cycles will be sent back to the CMMI Model folder area, signifying the file was processed by the SSM.

Response files are the same layout as the incoming file with a Response Code column/field added after the Record Type (2nd column/field).

CMMI model teams should review the response file to ensure all records processed successfully.

Two response files will be sent back to the CMMI Model folder.

One file will only include records in error with the appropriate response code value in the Response Code column/field. The filename will be the input filename with a suffix of "_summary" added before the file extension.

The other response file will contain all records with appropriate response code values in the Response Code field. A value of "00" is returned on all records that are processed successfully. The filename will be the input filename with a suffix of "_response" added before the file extension.

If some records failed, the CMMI model teams will need to correct those records on the FULL FILE, save the FULL FILE as CSV and upload to the cloud again. They will then need to review the response file for the resubmit to ensure everything processed correctly.

Only valid records are accepted and brought into claims processing. Invalid records are not loaded into the mainframe system.

Record Layout

Table 9: CMMI Model Criteria File Record

Data Fields marked with an asterisk (*) are required.

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Type*	Record indicator which identifies the line entry is record detail information	3	CHAR	ZIP – 5-position Zip Code DIA – ICD010 Diagnosis Code	20

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Model ID*	Identifies the model	3 - 10	CHAR	TBD – example included for illustrative purposes only: CHT = CHART Model NM2 = New Model 2 NM3 = New Model 3 P = PCF ACO D = Direct Contracting ACO Values are pre-defined at model implemenatioin ACO Layouts: 1 unique Alpha followed by any A/N can vary in length Non-ACO layouts: 3 unique characters, may be A/N	21

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Model Criteria Code*	Model criteria code value	up to 10	CHAR	Formatting is based on the value in the Record Type field. *NOTE: It is not necessary to add leading zeroes or spaces if the value in the field is less than 10 positions. **Record Type = ZIP** - Valid 5 digit zip code, all numeric **Record Type = DIA** - Valid ICD10 diagnosis code. - Decimal allowed but not required.	23 – Invalid Zip 24 – Invalid Diagnosis
Model Criteria Code Effective Date*	Effective date of the model criteria code	8 – 10	CHAR	Formats supported: CCYYMMDD CCYY/MM/DD MM/DD/CCYY	25

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Model Criteria Code End Date*	End date of the model criteria code	8 - 10	CHAR	Formats supported: CCYYMMDD CCYY/MM/DD MM/DD/CCYY Use the model's end date if there is not a specific end date for the criteria code.	26

Requirements for CMMI Model Payment Reconciliation File (CSV format) – Future Use

General Processing

The file is a variable length format with data fields on a record separated by commas.

The record format is described in the section below.

A common format is used for all CSV CMMI model payment reconciliation files.

The CMMI model entity sends files to the SSM as needed.

The CMMI model entity CSV format payment reconciliation file is sent to the Peraton VDC using Secure File Transfer Protocol (SFTP). The SSM processes the files in the TBD cycle.

Please refer to Appendix H for naming conventions of the CSV file(s).

Acknowledgement File

Incoming files are SFTPed to the Peraton VDC in near real time. No validation is performed on the data content at this time. However, an acknowledgement file is returned indicating whether or not the SFTP was successful.

Record Layout

Table 10: CMMI Model Payment Reconciliation File Record

Data Fields marked with an asterisk (*) are required.

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Type*	Record indicator which identifies the line entry is record detail information	3	CHAR	PMT	TBD

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Model ID*	Identifies the model	3 - 10	CHAR	TBD – example included for illustrative purposes only: EOM = Enhanced Oncology Care Model CHT = CHART Model NM2 = New Model 2 NM3 = New Model 3 P = PCF ACO D = Direct Contracting ACO Values are pre-defined at model implemenatioin ACO Layouts: 1 unique Alpha followed by any A/N can vary in length Non-ACO layouts: 3 unique characters, may be A/N	TBD
Contractor/Intermediary Number*	Medicare Administrative Contractor (MAC) workload identifier	5	CHAR	Valid contractor/intermediary number Five position numeric value	N/A
Model Transaction/Payment Type*	Indicator that identifies the model transaction type	1	CHAR	Valid values are TBD	N/A

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
CCN/ PTAN*	Internal Part A CMS Certification Number (CCN) or Part B Provider Transaction Access Number (PTAN) identifier for the provider	6 - 10	CHAR	Pseudo Number for Non-Provider Participants Actual Provider Number for Provider Participants	N/A
NPI	National Provider Identifier (NPI) associated with the provider	10	CHAR	Valid alphanumeric NPI Required for Part B providers	N/A
Parent Model Participant ID	Identifier assocaited with the model participant	8	CHAR	Any alphnumeric value NOTE: Initial use of field was by Bundled Payments for Care Initiatve for episode initiators	N/A
Current Model Participant ID	Identifier associated with the model participant	8	CHAR	Any alphnumeric value	N/A
Part A Reconciliation Amount	Reconciliation amount associated with Part A claims processing	4 – 12	CHAR	Valid dollar amount in the format $$$$$$$$.cc Negative amount is preceded with a “-“.	N/A
Part B Reconciliation Amount	Reconciliation amoutn associated with Part B claims processing	4 – 12	CHAR	Valid dollar amount in the format $$$$$$$$.cc Negative amount is preceded with a “-“.	N/A
Accounts Receivable (AR) Interest Amount	AR interest amount	4 – 12	CHAR	Valid dollar amount in the format $$$$$$$$.cc Negative amount is preceded with a “-“. NOTE: Initial use of field was by Bundled Payments for Care Initiatve for episode initiators.	N/A

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Original AR Invoice Number	AR invoice number associated with overpayments	1 -20	CHAR	Any alphanumeric value NOTE: Initial use of field was by Bundled Payments for Care Initiatve for episode initiators.	N/A

Requirements for CMMI Model Claim Adjustment File (CSV format) – Future Use

General Processing

The file is a variable length format with data fields on a record separated by commas.

The record format is described in the section below.

A common format is used for all CMMI model claim adjustment files.

The CMMI model entity sends files to the SSM as needed.

The CMMI model entity CSV format claim adjustment file is sent to the Peraton VDC using Secure File Transfer Protocol (SFTP). The SSM processes the files in the daily batch cycle.

Please refer to Appendix H for naming conventions of the CSV file(s).

Acknowledgement File

Incoming files are SFTPed to the Peraton VDC in near real time. No validation is performed on the data content at that point. However, an acknowledgement file is returned indicating whether or not the SFTP was successful.

Response File

As noted above, incoming files are processed in the daily batch cycle. A response file generated from the daily processing cycles will be sent back to the CMMI Model folder area, signifying the file was processed by the SSM.

Response files are the same layout as the incoming file with a Response Code column/field added after the Record Type (2nd column/field). In addition, a field containing an adjustment ICN is added to the end of the file if the submitted ICN has already been adjusted.

CMMI model teams should review the response file to ensure all records processed successfully.

Two response files will be sent back to the CMMI Model folder.

One file will only include records in error with the appropriate response code value in the Response Code column/field. The filename will be the input filename with a suffix of "_summary" added before the file extension.

The other response file will contain all records with appropriate response code values in the Response Code field. A value of "00" is returned on all records that are processed successfully. The filename will be the input filename with a suffix of "_response" added before the file extension.

If some records failed, the CMMI model teams will need to correct those records and upload to the Cloud again. They will then need to review the response file for the resubmit to ensure everything processed correctly.

Only valid records are accepted and brought into claims processing. Invalid records will not trigger a claim adjustment in the mainframe system.

Record Layout

Table 11: CMMI Model Claim Adjustment File Record

Data Fields marked with an asterisk (*) are required.

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Record Type*	Record indicator which identifies the line entry is record detail information	3	CHAR	ADJ	20 50 – Exceeds the daily limit of adjustment requests
Model ID*	Identifies the model	3 - 10	CHAR	EOM = Enhanced Oncology Care Model	21

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Contractor/Intermediary Number*	Medicare Administrative Contractor (MAC) workload identifier	5	CHAR	Valid contractor/intermediary number Five position numeric value	51
Claim Internal Control Number (ICN)*	ICN associated with the claim that requires adjustment	15	Numeric	Valid claim ICN found on active or purged history	52 – ICN found but has been adjusted 53 – ICN not found 54 - The claim is not in a final location 55 - One or more detail lines for the claim (other than the referenced detail line) received an error.
Claim Detail Number*	Claim detail number that requires adjustment	2	Numeric	Two position numeric value Valid detail on the claim ICN.	56
Billing Provider Tax Identificaiton Number (TIN)*	The Tax Identification Number (TIN) for the billing provider on the claim	9	NUM	Nine position numeric value that matches the billing TIN on the claim ICN	N/A
Rendering Provider National Provider Identifier (NPI)*	NPI for the claim detail rendering provider	10	NUM	Ten position numeric value that matches the rendering provider ICN on the claim ICN detail number	N/A

Data Field	Description	Length	Format	Valid Values	Invalid Values Response Code
Health Insurance Claim (HIC) Number*	Beneficiary HIC Number associated with the claim	7-12	CHAR	Valid alphanumeric HIC number that matches the claim ICN.	N/A
Claim Detail Procedure Code	Claim detail procedure code	5	CHAR	Valid five posiiton, alphanumeric procedure code that matches the value on the ICN claim detail number	57
Claim Detail From Date*	From date of service assocaited with the claim detail	8-10	CHAR	Formats supported: CCYYMMDD CCYY/MM/DD MM/DD/CCYY Valid from date of service that matches the from date of service on the ICN claim detail number.	N/A
Claim Detail To Date*	To date of service associated with the claim detail	8-10	CHAR	Formats supported: CCYYMMDD CCYY/MM/DD MM/DD/CCYY Valid to date of service that matches the to date of service on the ICN claim detail number.	N/A

Requirements for CMMI Model Weekly Claims Reduction File

General Processing

Refer to this section for more details on the file format.

The file format is text and is delivered weekly. The logical record length is 1071 bytes.

The files are prepared by CWF and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

CWF will send both “CLMH-MBI” and “CLMH-HIC-NUM” as the beneficiary identifiers during the New Medicare Card Project transition period. After the end of the transition period (December 2019), only “CLMH-MBI” will be populated and “CLMH-HIC-NUM” will be populated as blanks.

Record Layout

Table 12: Weekly Claims Reduction File Header

Data Fields marked with an asterisk (*) are required.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semicolon)
3	CLMH-CNTRCTR-NUM	Contractor Number	6	10	5	X(05)	Identification number of contractors submitting claim.
4	FILLER	Delimiter	11	11	1	X(01)	; (Semicolon)
5	CLMH-ACO-IDENTIFIER		12	21	10	X(10)	ACO identification number.
6	CLMH-ACO-QUAL-ID	ACO Qualification ID	12	12	1	X(01)	ACO Qualification Identifiers ‘D’, ‘K’, ‘C’
7	CLMH-ACO-ID-NUMBER	ACO Number	13	21	9	X(09)	ACO Number
8	FILLER	Delimiter	22	22	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLMH-MEDICARE-PART	Claim Type	23	26	4	X(04)	FISS or MCS
10	FILLER	Delimiter	27	27	1	X(01)	; (Semicolon)
11	CLMH-MBI	Medicare Beneficiary Identifier	28	38	11	X(11)	MBI is a beneficiary identifier
12	FILLER	Delimiter	39	39	1	X(01)	; (Semicolon)
13	CLMH-DCN	DCN	40	62	23	X(23)	Carrier assigned Document Control Number for claim
14	FILLER	Delimiter	63	63	1	X(01)	; (Semicolon)
15	CLMH-XREF-DCN	XREF DCN	64	86	23	X(23)	Cross-reference Document Control Number assigned to claim. **Note:** *This field only applies to Part A.* This field will contain the same value as in DCN for part B claims.
16	FILLER	Delimiter	87	87	1	X(01)	; (Semicolon)
17	CLMH-FROM-DT	From Date	88	95	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. **Note:** *This applies only to Part A.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18	FILLER	Delimiter	96	96	1	X(01)	; (Semicolon)
19	CLMH-THRU-DT	Thru Date	97	104	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the "Statement Covers Through Date". **Note:** *This applies to only Part A.*
20	FILLER	Delimiter	105	105	1	X(01)	; (Semicolon)
21	CLMH-PVDR-CCN	Provider CCN	106	111	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.
22	FILLER	Delimiter	112	112	1	X(01)	; (Semicolon)
23	CLMH-PVDR-NPI	Provider NPI	113	122	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
24	FILLER	Delimiter	123	123	1	X(01)	; (Semicolon)
25	CLMH-TYPE-OF-BILL	Type of Bill	124	129	6	X(06)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
26	CLMH-BILL-FACILITY	Bill Facility	124	124	1	X(01)	This code is the first digit of the type of bill (TOB1) and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1 = Hospital 2 = SNF 3 = Home Health Agency (HHA) 4 = Religious non-medical (hospital) 5 = Religious non-medical (extended care) 6 = Intermediate care 7 = Clinic or hospital-based renal dialysis facility 8 = Specialty facility or Ambulatory Surgical Center (ASC) surgery 9 = Reserved
27	FILLER	Delimiter	125	125	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
28	CLMH-BILL-CATEGORY	Bill Category	126	126	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital). Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
29	FILLER	Delimiter	127	127	1	X(01)	; (Semicolon)
30	CLMH-BILL-FREQUENCY	Bill Frequency	128	128	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).
31	FILLER	Delimiter	129	129	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
32	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	130	130	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0 = Original Claim 1 = Credit 2 = Debit
33	FILLER	Delimiter	131	131	1	X(01)	; (Semicolon)
34	CLMH-ADJUST-REASON-CODE	Adjustment Reason Code	132	134	3	X(03)	Reason code for claim adjustment, for example: • Beneficiary Alignment Change (Value 'B') • Provider Alignment Change (Value 'P') Other (Value 'O')
35	FILLER	Delimiter	135	135	1	X(01)	; (Semicolon)
36	CLMH-REIMB-AMT	Claim Payment Amount	136	146	11	X(11)	The amount that Medicare paid on the claim. $$$$$$$$:99
37	FILLER	Delimiter	147	147	1	X(01)	; (Semicolon)
38	CLMH-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	148	158	11	X(11)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment. $$$$$$$$:99 Only for FISS (Part A) Value-code – 'A2'(Not applicable for KCC)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
39	FILLER	Delimiter	159	159	1	X(01)	; (Semicolon)
40	CLMH-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	160	167	8	X(08)	The amount of money the beneficiary paid towards an annual deductible. $$$$$:99 Only for FISS (Part A) Value-code – 'A1'-(Not applicable for KCC)
41	FILLER	Delimiter	168	168	1	X(01)	; (Semicolon)
42	CLMH-SEQ-AMT	Claim Sequestration Payment Amount	169	176	8	X(08)	The amount of sequestration applied to the bill $$$$$:99 Value Code '73'
43	FILLER	Delimiter	177	177	1	X(01)	; (Semicolon)
44	CLMH-APO-RED-AMT	Advanced Payment Option Reduction Amount	178	185	8	X(08)	Total payment amount with PBP reduction percent applied. (For DC Benefit Enhancement "1"). $$$$$:99 Only for FISS (Part A) Value-code – 'Q1'
45	FILLER	Delimiter	186	186	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
46	CLMH-TCC-RED-AMT	Total Care Capitation Payment Reduction Amount	187	194	8	X(08)	(For DC/KCC, Benefit Enhancement "5"). $$$$$:99 Only for FISS (Part A) Value-code – 'Q1' Note: Benefit Enhancement '5' will be delayed for KCC until 2022
47	FILLER	Delimiter	195	195	1	X(01)	; (Semicolon)
48	CLMH-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	196	203	8	X(08)	(For DC, Benefit Enhancement "8"). $$$$$:99 Only for FISS (Part A) Value-code – 'Q1'
49	FILLER	Delimiter	204	204	1	X(01)	; (Semicolon)
50	CLMH-QCP-RED-AMT	Quarterly Capitation Payment Zeroed Amount	205	212	8	X(08)	(For KCC, Benefit Enhancement 'F') $$$$$:99 For CKCC, indicator is 'A5' For KCF, it is 'A4'
51	FILLER	Delimiter	213	213	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
52	CLMH-DRG-CODE	Diagnosis Related Group Code	214	217	4	X(04)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes. *Note: DRG code is changing from 3 to 4 bytes with CR12463/35247 for April 2022 Release*
53	FILLER	Delimiter	218	218	1	X(01)	; (Semicolon)
54	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	219	225	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.
55	FILLER	Delimiter	226	226	1	X(01)	; (Semicolon)
56	CLMH-DGNS-EXTERNAL	DGNS External	227	233	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. Note: CWF is using external cause of injury first diagnosis code.
57	FILLER	Delimiter	234	234	1	X(01)	; (Semicolon)
58	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	235	241	7	X(07)	Diagnosis code for patient's first visit.
59	FILLER	Delimiter	242	242	1	X(01)	; (Semicolon)
60	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	243	249	7	X(07)	Diagnosis code for patient's second visit.
61	FILLER	Delimiter	250	250	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
62	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	251	257	7	X(07)	Diagnosis code for patient's third visit.
63	FILLER	Delimiter	258	258	1	X(01)	; (Semicolon)
64	CLMH-PRCDR-DATA		259	683	425		Occurs 25 times
65	CLMH-PRCDR-CD	Procedure Code	259	265	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
66	FILLER	Delimiter	266	266	1	X(01)	; (Semicolon)
67	CLMH-PRCDR-DT	Procedure Date	267	274	8	YYYY MMDD	The date the indicated procedure was performed.
68	FILLER	Delimiter	275	275	1	X(01)	; (Semicolon)
69	CLMH-DIAG-DATA		684	933	250		Occurs 25 times
70	CLMH-DIAG-CODE	Diagnosis Code	684	692	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
71	FILLER	Delimiter	693	693	1	X(01)	; (Semicolon)
72	CLMH-DIAG-POA-IND	Diagnosis Code Present On Admission Indicator	694	694	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
73	FILLER	Delimiter	695	695	1	X(01)	; (Semicolon)
74	CLMH-DETAIL-LINES	Detail Lines	934	936	3	9(03)	Number of line items on claim.
75	FILLER	Delimiter	937	937	1	X(01)	; (Semicolon)
76	CLMH-PATIENT-NUM	Patient Control Number	938	957	20	X(20)	Patient Control Number

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
77	FILLER	Delimiter	958	958	1	X(01)	; (Semicolon)
78	CLMH-CARC-RSN-CD	Claim Adjustment Reason Code	969	963	5	X(05)	A code describing why a claim or service line was paid differently than it was billed
79	FILLER	Delimiter	964	964	1	X(01)	; (Semicolon)
80	CLMH-RARC-RSN-CD	Claim Remittance Advice Reason Code	965	969	5	X(05)	A code used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code or to convey information about remittance processing.
81	FILLER	Delimiter	970	970	1	X(01)	; (Semicolon)
82	CLMH-GC-CD	Claim Group Code	971	972	2	X(02)	A code identifying the general category of payment adjustment.
83	FILLER	Delimiter	973	973	1	X(01)	; (Semicolon)
84	FILLER	Filler	974	1071	98	X(98)	Filler

Table 13: Weekly Claims Reduction File Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semicolon)
3	CLML-LINE-NUMBER	Claim Line Number	6	8	3	9(03)	This number is a sequential number that identifies a specific claim line.
4	FILLER	Delimiter	9	9	1	X(01)	; (Semicolon)
5	CLML-REV-CD	Revenue Code	10	13	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. **Note:** *Include REV Code 0001.*
6	FILLER	Delimiter	14	14	1	X(01)	; (Semicolon)
7	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	15	24	10	X(10)	The rendering provider's Internal Revenue Employer Identification number or Social Security number. **Note:** *Billing TIN is always the same as Rendering TIN for Part B.*
8	FILLER	Delimiter	25	25	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	26	35	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. **Note:** *This will only apply to Part B.*
10	FILLER	Delimiter	36	36	1	X(01)	; (Semicolon)
11	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	37	43	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. **Note:** *Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
12	FILLER	Delimiter	44	44	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	45	51	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. **Note:** *Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
14	FILLER	Delimiter	52	52	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	53	59	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. **Note:** *Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
16	FILLER	Delimiter	60	60	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	61	67	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. **Note:** *Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
18	FILLER	Delimiter	68	68	1	X(01)	; (Semicolon)
19	CLML-FROM-DATE	Claim Line From Date	69	76	8	YYYY MMDD	This is the date the service associated with the line item began. UPDATE: CWF will carry the detail line-item date for Part A in both the From and Thru Date.
20	FILLER	Delimiter	77	77	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	CLML-THRU-DATE	Claim Line Thru Date	78	85	8	YYYY MMDD	This is the date the service associated with the line item ended.
22	FILLER	Delimiter	86	86	1	X(01)	; (Semicolon)
23	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	87	93	7	9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
24	FILLER	Delimiter	94	94	1	X(01)	; (Semicolon)
25	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	95	105	11	X(11)	Total submitted charge for line item. $$$$$$$$:99 Note: CWF will also be providing charges for non-covered and denied services.
26	FILLER	Delimiter	106	106	1	X(01)	; (Semicolon)
27	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	107	114	8	X(08)	The amount Medicare approved for payment to the provider. $$$$$:99 **Note:** *Part B only*
28	FILLER	Delimiter	115	115	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	116	126	11	X(11)	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge. $$$$$$$$:99
30	FILLER	Delimiter	127	127	1	X(01)	; (Semicolon)
31	CLML-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	128	136	9	X(09)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment. $$$$$$:99 (MCS Part B only)
32	FILLER	Delimiter	137	137	1	X(01)	; (Semicolon)
33	CLML-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	138	145	8	X(08)	The amount of money the beneficiary paid towards an annual deductible. $$$$$:99 (MCS Part B only)
34	FILLER	Delimiter	146	146	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
35	CLML-MIPS-POS-AMT	Claim Merit-based Incentive Payment Amount	147	154	8	X(08)	The amount of Merit-based Incentive payment that was applied to the bill (Positive amount). $$$$$$:99 Other-Amts-Ind - 'V' (MCS Part B only)
36	FILLER	Delimiter	155	155	1	X(01)	; (Semicolon)
37	CLML-MIPS-NEG-AMT	Claim Merit-based Incentive Payment Amount	156	163	8	X(08)	The amount of Merit-based Incentive payment that was applied to the bill (Negative amount). Other-Amts-Ind - 'W' (MCS Part B only) $$$$$$:99
38	FILLER	Delimiter	164	164	1	X(01)	; (Semicolon)
39	CLML-SEQ-PMT-AMT	Claim Sequestration Payment Amount	165	172	8	X(08)	The amount of sequestration applied to the bill. (MCS Part B only) $$$$$:99 Other-Amts-Ind - 'H'
40	FILLER	Delimiter	173	173	1	X(01)	; (Semicolon)
41	CLML-APO-RED-AMT	Advanced Payment Option Reduction Amount	174	181	8	X(08)	(For DC, Benefit Enhancement "1"). (MCS Part B only) $$$$$:99 Other-amts-ind - 'L'
42	FILLER	Delimiter	182	182	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
43	CLML-TCC-RED-AMT	Total Care Capitation Reduced Amount	183	190	8	X(08)	(For DC/KCC, Benefit Enhancement "5"). (MCS Part B only) $$$$$:99 Other-amts-ind - 'L' **Note:** *Benefit Enhancement '5' will be delayed for KCC until 2022.*
44	FILLER	Delimiter	191	191	1	X(01)	; (Semicolon)
45	CLML-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	192	199	8	X(08)	Total payment amount with PCC reduction percent applied. (For DC, Benefit Enhancement "8"). (MCS Part B only) $$$$$:99 Other-amts-ind - 'L'
46	FILLER	Delimiter	200	200	1	X(01)	; (Semicolon)
47	CLML-QCP-RED-AMT	Quarterly Capitation Payment Zeroed Amount	201	208	8	X(08)	(For KCC, Benefit Enhancement 'F') $$$$$:99 For CKCC, indicator is 'A5' For KCF, it is 'A4'
48	FILLER	Delimiter	209	209	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
49	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	210	214	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
50	FILLER	Delimiter	215	215	1	X(01)	; (Semicolon)
51	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	216	217	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service.
52	FILLER	Delimiter	218	218	1	X(01)	; (Semicolon)
53	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	219	220	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service.
54	FILLER	Delimiter	221	221	1	X(01)	; (Semicolon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
55	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	222	223	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service.
56	FILLER	Delimiter	224	225	1	X(01)	; (Semicolon)
57	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	225	226	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service.
58	FILLER	Delimiter	227	227	1	X(01)	; (Semicolon)
59	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	228	229	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line-item service. **Note:** *This applies only to Part A.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
60	FILLER	Delimiter	230	230	1	X(01)	; (Semicolon)
61	CLML-PATIENT-NUM	Patient Control Number	231	250	20	X(20)	Patient Control Number
62	FILLER	Delimiter	251	251	1	X(01)	; (Semicolon)
63	CLML-POS-CD	Claim Place of Service Code	252	253	2	X(02)	A code identifying the setting in which a service was rendered (e.g., Office, Home, Inpatient Hospital). This value is a 2-digit place of service code as defined by the Centers for Medicare and Medicaid Services (CMS).
64	FILLER	Delimiter	254	254	1	X(01)	; (Semicolon)
65	CLML-CARC-RSN-CD	Claim Adjustment Reason Code	255	259	5	X(05)	A code describing why a claim or service line was paid differently than it was billed
66	FILLER	Delimiter	260	260	1	X(01)	; (Semicolon)
67	CLML-RARC-RSN-CD	Claim Remittance Advice Reason Code	261	265	5	X(05)	A code used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code or to convey information about remittance processing.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
68	FILLER	Delimiter	266	266	1	X(01)	; (Semicolon)
69	CLML-GC-CD	Claim Group Code	267	268	2	X(02)	A code identifying the general category of payment adjustment.
70	FILLER	Delimiter	269	269	1	X(01)	; (Semicolon)
71	FILLER	Filler	270	300	31	X(31)	Filler

Appendix A: Model Identifiers

Table 14: Model Identifiers

Model	File Naming ID	Model Identifier
NG ACO	NGACO	V<nnn>, where ‘nnn’ is any numeric value
VT ACO	VTACO	F<nnn>
CEC ACO	CECACO	E<nnnn>
PCF	PCF	P<two character region cd><nnnn>
CKCC	CKCC	C<nnnn>
KCF	KCF	K<nnnn>
DC	DC	D<nnnn>
DME PCF	DMEPCF	P<two-character region cd><nnnn>
EOM	EOM	N/A
MCP	MCP	M<nnnn>

Appendix B: Benefit Enhancement Indicators

Table 15: Benefit Enhancement Indicators

Benefit Enhancement Indicator	Description
0	Base Record
1	PBP (NG ACO/VT APM) or APO (DC)
2	Telehealth
3	Post Discharge Home Visit
4	Skilled Nursing Facility (SNF) 3-Day Stay Waiver
5	AIPBP (NG ACT/VT APM) or TCC (DC)
6	CEC Telehealth
7	Care Management Home Visit
8	PCC
9	Home Health Homebound Waiver
A	Diabetic Shoe Order by Nurse Practitioners
B	Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits
C	Kidney Disease Education Benefit Enhancement
D	SIP (Represents only the providers who can bill the G code)
E	PCF (Represents all providers who can bill FVF codes)

Benefit Enhancement Indicator	Description
F	QCP *Note: QCP will only apply to nephrologists and nephrology practices and will not apply to all providers who are in CKCC.*
G	PBA
L	MCP Model Track 1 Beneficiary or Provider
M	MCP Model Track 2 Beneficiary or Provider
N	MCP Model Track 3 Beneficiary or Provider

Appendix C: Beneficiary Alignment File – CMMI Model Specific Information

Table 16: Beneficiary Alignment File - Model Specific Information

Note: A dataset Name (DSN) example of a PCF response file sent from CWF to the ACO-OS on January 4, 2021, at 10:00 AM would be:

P#EFT.ON.ACOT.CWFHP.PCFBR.D210104.T1000000

Model	File Format	Dataset Name (DSN)/Frequency
NG ACO	Flat	File from CMMI Model Entity: **P#EFT.ON.CWFHP.BENE.Dyymmdd.Thhmmsst** Response File from CWF: **P#EFT.ON.ACOT.BENE.CWFHP.Dyymmdd.Thhmmsst** Monthly or more frequently if required, full file replacement.
VT APM	Flat	File from CMMI Model Entity: **P#EFT.ON.CWFHP.VTBEN.Dyymmdd.Thhmmsst** Response File from CWF: **P#EFT.ON.ACOT.VTBEN.CWFHP.Dyymmdd.Thhmmsst** Monthly or more frequently if required, full file replacement. The CMMI model entity will include the most current HICN and/or RRB Numbers associated with the beneficiary in VT APM Beneficiary file
PCF	Flat	File from CMMS Model Entity: **P#EFT.ON.CWFHP.PCFBENE.Dyymmdd.Thhmmsst** Response File from CWF: **P#EFT.ON.ACOT.CWFHP.PCFBR.Dyymdd.Thhmmsst** Monthly or more frequently if required, full file replacement.

Model	File Format	Dataset Name (DSN)/Frequency
CEC ESCO	Flat	File from CMMI Model Entity: **P#EFT.ON.CWFHP.CECBEN.Dyymmdd.Thhmmsst** Response File from CWF: **P#EFT.ON.ACOT.CWFHP.CBNR.Dyymmdd.Thhmmsst** Monthly or more frequently if required, full file replacement but the file is only sent if there are updates

Model	File Format	Dataset Name (DSN)/Frequency
CKCC	Flat	File from CMMI Model Entity: **P#EFT.ON.CWFHP.CKCCBENE.Dyymmdd.Thhmmsst** Response File from SSM: **P#EFT.ON.ACOT.CWFHP.CKCCBR.Dyymmdd.Thhmmsst** Quarterly or more frequently if required, full file replacement
KCF	Flat	File from CMMI Model Entity: **P#EFT.ON.CWFHP.KCFBENE.Dyymmdd.Thhmmsst** Response File from SSM: **P#EFT.ON.ACOT.CWFHP.KCFBR.Dyymmdd.Thhmmsst** Quarterly or more frequently if required, full file replacement
DC	Flat	File from CMMI Model Entity: **P#EFT.ON.CWFHP.DCBENE.Dyymmdd.Thhmmsst** Response File from SSM: **P#EFT.ON.ACOT.CWFHP.DCBR.Dyymmdd.Thhmmsst** Monthly or more frequently if required, full file replacement
MCP	CSV	File from CMMS Model Entity: **MCP_bene_prod.csv** Response File from CWF: MCP_bene_prod_response.csv Monthly or more frequently if required, full file replacement.

Appendix D: Provider Participant File - Model Specific Information

Table 17: Provider Participant File - Model Specific Information

Note: A dataset Name (DSN) example of a PCF response file sent from MCS to the ACO-OS on January 4, 2021, at 10:00 AM would be:

P#EFT.ON.ACOT.MCSHPVDC.PCPR.D210104.T1000000

Model	File Format	DSN/Frequency	Benefit Enhancements	Provider Types
NG ACO VT APM	Flat	File from CMMI Model Entity: **P#EFT.ON.MCSHPVDC.PRV.Dyymmdd.Thhmmsst** Response File from SSM: **P#EFT.ON.ACOT.PRV.MCSHPVDC.Dyymmdd.Thhmmsst** Monthly, full file replacement.	0, 1, 2, 3, 4, 5, 7 NOTE: “5” is not applicable for PY1.	P, S and A Note: “A” is not valid for PY1
PCF	Flat	File from CMMS Model Entity: **P#EFT.ON.MCSHPVDC.PCFPRV.Dyymmdd.Thhmmsst** Response File from SSM: **P#EFT.ON.ACOT.MCSHPVDC.PCPR.Dyymmdd.Thhmmsst** Monthly, full file replacement	A, D, E	S
CEC ESCO	Flat	File from CMMI Model Entity: **P#EFT.ON.MCSHPVDC.CECPRV.Dyymmdd.Thhmmsst** Response File from SSM: **P#EFT.ON.ACOT.MCSHPVDC.CPVR.Dyymmdd.Thhmmsst** Monthly, full file replacement but the file is only sent if there are updates	0, 6	P

Model	File Format	DSN/Frequency	Benefit Enhancements	Provider Types
KCF/CKCC	Flat	File from CMMI Model Entity: **P#EFT.ON.MCSHPVDC.KCCPRV.Dyymmdd.Thhmmsst** Response File from SSM: **P#EFT.ON.ACOT.MCSHPVDC.KCPR.Dyymmdd.Thhmmsst** Monthly, full file replacement	KCF: 2, 3, B, C, F, G CKCC: 2, 3, 4, 9, B C, F	P, S, A
DC	Flat	File from CMMI Model Entity: **P#EFT.ON.MCSHPVDC.PCFPRV.Dyymmdd.Thhmmsst** Response File from SSM: **P#EFT.ON.ACOT.MCSHPVDC.PCPR.Dyymmdd.Thhmmsst** Monthly, full file replacement	0, 1, 2, 3, 4, 5, 7, 8, 9, B	P, S, A Note: “A” is not valid for PY1
DME PCF	Flat	File from CMMI Model Entity: **P#EFT.ON.VMS.PCFPRV.Dyymmdd.Thhmmsst** Response File from SSM: **P#EFT.ON.ACOT.VMS.PCFPR.Dyymmdd.Thhmmss** Monthly, full file replacement	A	S
MCP	CSV	File from CMMS Model Entity: **MCP_prov_prod.csv** Response File from SSM: MCP_prov_prod_response.csv Monthly, full file replacement	L, M, N	S

Appendix E: Weekly Claims Reduction File - Model Specific Information

Table 18 Weekly Claims Reduction File - Model Specific Information

Description	Filename
Weekly TCC / PCC/ APO Reduction File	Sent by the CWF to Entities: **P#EFT.ON.ACOT.R.D****.TPARC.Dyymmdd.Thhmmsst** Delivered via Data HUB **P.D****.TPARC.RP.Dyymmdd.Thhmmsst**.
Weekly CKD QCP Reduction File	Sent by the CWF to Entities: **P#EFT.ON.ACOT.C****.QCPRC.Dyymmdd.Thhmmsst** Delivered via Data HUB **P.C****.QCPRC.RP.Dyymmdd.Thhmmsst**.
Weekly CKD QCP Reduction File	Sent by the CWF to Entities: **P#EFT.ON.ACOT.K****.QCPRC.Dyymmdd.Thhmmsst** Delivered via Data HUB **P.K****.QCPRC.RP.Dyymmdd.Thhmmsst**.

Appendix F: Acronyms

Table 19: Acronyms

Term	Definition
ACO	Accountable Care Organization
CMMI model entity	Accountable Care Organization – Operational System
AIPBP	All Inclusive Population Based Payment
APO	Advanced Payment Option
ASC	Ambulatory Surgical Center
BENE	Beneficiary
CAH	Critical Access Hospital
CCN	CMS Certification Number
CDS	Companion Data Services
CEC	Comprehensive ESRD Care
CHAR	Character
CKCC	Comprehensive Kidney Care Contracting
CME	Common Medicare Environment
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits

Term	Definition
ConOps	Concept of Operations
CSV	Comma-sSeparated Values
CWF	Common Working File
DCE	Direct Contracting Entity
DME	Durable Medical Equipment
EFT	Electronic File Transfer
ESCO	ESRD Care Organization
ETC	ESRD Treatment Choices
FFS	Fee-For-Service
GTL	Government Team Lead
GPDC	Global and Professional Direct Contracting Model
HHA	Home Health Agency
HICN	Health Insurance Claim Number
HP	Hewlett Packard
IC	Innovation Center
ICD	Interface Control Document
ID	Identifier
IDR	Integrated Data Repository
IPPS	Inpatient Prospective Payment System

Term	Definition
IRF	Inpatient Rehabilitation Facilities
KCC	Kidney Care Choices
KCF	Kidney Care First
LILS	Legislative IT Lifecycle Support
MA OEP	Medicare Advantage Open Enrollment Period
MAC	Medicare Administrative Contractor
MBD	Medicare Beneficiary Database
MCP	Making Care Primary
MCS	Multi-Carrier System
NGACO	Next Generation Accountable Care Organization
NGD	Next Generation Desktop (1-800-Medicare)
NPI	National Provider Identifier
OMM	Operations & Maintenance Manual
PBA	Performance-Based Adjustment
PBP	Population-Based Payment
PCC	Primary Care Capitation
PCF	Primary Care First
PHI	Protected Health Information
PII	Personally Identifiable Information

Term	Definition
POC	Point of Contact
PY	Performance Year
QCP	Quarterly Capitation Payment
RACS	Receipt and Control System
RRB	Railroad Retirement Board
RTI	Research Triangle Institute
SDD	System Design Document
SIP	Seriously Ill Population
SNF	Skilled Nursing Facility
SSM	Shared System Maintainer
TBD	To Be Determined
TCC	Total Care Capitation
TIN	Tax Identification Number
TPCP	Total Primary Care Payment
VDC	Virtual Data Center
VMS	ViPS Medicare System
VT APM	Vermont All Payer Model

Appendix G: Glossary

Table 20: Glossary

Term	Definition
Advanced Payment Option	An adjusted percentage of the Medicare FFS revenues earned by each GPDC/Entity. The adjustment is based on submitted and payable claims for the services delivered to aligned beneficiaries.
All Inclusive Population Based Payment	Each year, NGACO/VT APM/GPDC/CKCC/KCF Entities will select a payment mechanism for the upcoming performance year. If an ACO selects AIPBP, the ACO will have written agreements regarding capitation with AIPBP-participating Participants and Preferred Providers.
Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits	CMS will make available to qualified GPDC and KCF/CKCC Entities, a waiver of the requirement that beneficiaries who elect the Medicare Hospice Benefit give up their right to receive curative care (sometimes referred to as “conventional care”) as a condition of electing the hospice benefit. All expenditures incurred by Medicare on behalf of such beneficiaries, whether for hospice or other non-hospices services, would be included as part of Total Cost of Care for the relevant performance year.
Entity	Unique for GPDC/KCC. This is a synonym to ACO/ESCO.
Home Health Homebound Waiver	CMS will make available to qualified GPDC and KCF Entities, a waiver of the homebound requirement to allow for modified application for beneficiaries aligned to the entity in order to receive home health services. The entity will have greater flexibility to ensure special populations (as specified in the GPDC and KCF Participation Agreement) have access to home health services in appropriate cases. Given the risk borne by the entity, the entity would be incentivized only to do so where such care would improve quality and be cost-effective from a Total Cost of Care perspective. This flexibility would aid GPDC and KCF Practices in reaching their own alternative payment arrangements with home health agencies and promote innovation and greater ability of beneficiaries to return to, remain in, and receive care in their home.

Term	Definition
Kidney Disease Education Benefit Enhancement	CMS will make available to qualified KCF Entities, the KDE waiver that would: • Waive the requirement that the KDE be performed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and allow qualified clinicians not currently allowed to bill for the benefit to furnish the services incident to the services of a participating KCF or CKCC nephrologist. • Waive the requirement that a beneficiary have Stage 4 CKD in order to test furnishing the KDE benefit to beneficiaries with CKD stage 5 and those in the first 6 months of ESRD, who can also benefit from KDE. • Waive the requirement that KDE sessions cover the topic of delaying initiation of dialysis to allow participating nephrologists to cover this topic as “as applicable” rather than mandated, as it is not 28 Name Description relevant to beneficiaries with ESRD who have already begun dialysis. • Waive the requirement that an outcomes assessment be conducted during one of the KDE sessions; and instead to test the provision of this assessment during a subsequent evaluation and management visit with the nephrologist.
Performance-Based Adjustment	A payment methodology for the Primary Care First model based on performance in five quality and patient experience of care measures, as well as a measure of acute hospital utilization that is calculated and applied on a quarterly basis.
Population-Based Payments	An adjusted percentage of the Medicare FFS revenues earned by each NGACO/VT APM Entity. The adjustment is based on submitted and payable claims for the services delivered to aligned beneficiaries.
Post Discharge	CMS will make available to qualified NGACO/VT APM/GPDC/CKCC/KCF Entities waivers to allow “incident to” claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision—instead of direct supervision—of NGACO/VT APM/GPDC/CKCC/KCF Providers/Suppliers or Preferred Providers. Licensed clinicians may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. Claims for post discharge home visits will only be allowed following discharge from an inpatient facility (including, e.g., inpatient prospective payment system (IPPS) hospitals, CAHs, SNFs, Inpatient Rehabilitation Facilities (IRF)) and will be limited to no more than one visit in the first 10 days following discharge and no more than two visits in the first 30 days following discharge. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner.

Term	Definition
Primary Care Capitation	Each year, GPDC Entities will select a payment mechanism for the upcoming performance year. If an Entity selects PCC, the Entity will have written agreements regarding capitation on certain primary care claims with PCC-participating Participants and Preferred Providers.
Primary Care First–General Component	Identifies beneficiaries who are in the non-SIP category and receive care from a PCF practitioner who is accountable for coordination and management of their care.
Professional Population-Based Payment	A payment mechanism available to PCF participants based on a group-based risk adjustment to reduce practice focus on individual risk scores.
Quarterly Capitation Payments	Alternate payment/risk sharing mechanism available for CKCC and KCF entities paid out quarterly for the services performed for the CKD4, CKD5 aligned beneficiaries.
Seriously Ill Population (SIP) Component	Identifies seriously ill beneficiaries who are experiencing fragmented, uncoordinated care under Medicare FFS, deliver an intensive, episodic intervention to stabilize their clinical condition, and establish a meaningful relationship between the beneficiary and a PCF practitioner who is accountable for coordinating and managing their care in the longer term.
Telehealth Benefit enhancement for DC and KCC	CMS will make available to qualified KCF and GPDC Entities, a conditional waiver that eliminates the rural geographic component of originating site requirements, allows the originating site to include a beneficiary's home, and for the use of asynchronous ("store and forward") telehealth services in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunication systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Payment will be permitted for services including dermatology and ophthalmology services furnished to eligible beneficiaries using asynchronous telehealth in single or multimedia formats and distant site practitioners will bill for these services using CMMI specific asynchronous telehealth codes. The distant site practitioner must be a KCE/DCE participant who has elected to participate in this benefit enhancement.

Term	Definition
TeleHealth Benefit Enhancement for NGACO and VT APM	CMS will make available to qualified NGACO/VT APM Entities, a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive TeleHealth services. The benefit enhancement will allow payment of claims for TeleHealth services delivered by NGACO/VT APM Providers/Suppliers (Participant Providers) or Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.
Three-day stay SNF waiver	CMS will make available to qualified NGACO/VT APM/GPDC/CKCC/KCF Entities, a waiver of the three-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or Critical Access Hospital (CAH) with swing-bed approval for SNF services ("swing-bed hospital"). This benefit will allow beneficiaries to be admitted to qualified Providers/Suppliers if a SNF or swing-bed hospital is on the NGACO/VT APM/GPDC/CKCC/KCF Provider/Supplier list directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to NGACO/VT APM/GPDC/CKCC/KCF Providers/Suppliers or Preferred Providers.
Total Care Capitation	Each year, GPDC Entities will select a payment mechanism for the upcoming performance year. If an Entity selects TCC, the Entity will have written agreements regarding capitation with TCC-participating Participants and Preferred Providers.
Total Primary Care Payment	A payment methodology for the Primary Care First model that is designed to move away from traditional fee-for-service (FFS) payment incentives. In order to balance these incentives, this methodology includes two payment types: (1) a professional population-based payment (professional PBP) paid on a quarterly basis; and (2) a flat fee for each primary care visit, paid on a claim-by-claim basis.
Term	Definition
Advanced Payment Option	An adjusted percentage of the Medicare FFS revenues earned by each GPDC/Entity. The adjustment is based on submitted and payable claims for the services delivered to aligned beneficiaries.
All Inclusive Population Based Payment	Each year, NGACO/VT APM/GPDC/CKCC/KCF Entities will select a payment mechanism for the upcoming performance year. If an ACO selects AIPBP, the ACO will have written agreements regarding capitation with AIPBP-participating Participants and Preferred Providers.
Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits	CMS will make available to qualified GPDC and KCF/CKCC Entities, a waiver of the requirement that beneficiaries who elect the Medicare Hospice Benefit give up their right to receive curative care (sometimes referred to as "conventional care") as a condition of electing the hospice benefit. All expenditures incurred by Medicare on behalf of such beneficiaries, whether for hospice or other non-hospices services, would be included as part of Total Cost of Care for the relevant performance year.

Term	Definition
Entity	Unique for GPDC/KCC. This is a synonym to ACO/ESCO.
Home Health Homebound Waiver	CMS will make available to qualified GPDC and KCF Entities, a waiver of the homebound requirement to allow for modified application for beneficiaries aligned to the entity in order to receive home health services. The entity will have greater flexibility to ensure special populations (as specified in the GPDC and KCF Participation Agreement) have access to home health services in appropriate cases. Given the risk borne by the entity, the entity would be incentivized only to do so where such care would improve quality and be cost-effective from a Total Cost of Care perspective. This flexibility would aid GPDC and KCF Practices in reaching their own alternative payment arrangements with home health agencies and promote innovation and greater ability of beneficiaries to return to, remain in, and receive care in their home.
Kidney Disease Education Benefit Enhancement	CMS will make available to qualified KCF Entities, the KDE waiver that would: • Waive the requirement that the KDE be performed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and allow qualified clinicians not currently allowed to bill for the benefit to furnish the services incident to the services of a participating KCF or CKCC nephrologist. • Waive the requirement that a beneficiary have Stage 4 CKD in order to test furnishing the KDE benefit to beneficiaries with CKD stage 5 and those in the first 6 months of ESRD, who can also benefit from KDE. • Waive the requirement that KDE sessions cover the topic of delaying initiation of dialysis to allow participating nephrologists to cover this topic as “as applicable” rather than mandated, as it is not 28 Name Description relevant to beneficiaries with ESRD who have already begun dialysis. • Waive the requirement that an outcomes assessment be conducted during one of the KDE sessions; and instead to test the provision of this assessment during a subsequent evaluation and management visit with the nephrologist.

Term	Definition
Performance-Based Adjustment	A payment methodology for the Primary Care First model based on performance in five quality and patient experience of care measures, as well as a measure of acute hospital utilization that is calculated and applied on a quarterly basis.
Population-Based Payments	An adjusted percentage of the Medicare FFS revenues earned by each NGACO/VT APM Entity. The adjustment is based on submitted and payable claims for the services delivered to aligned beneficiaries.
Post Discharge	CMS will make available to qualified NGACO/VT APM/GPDC/CKCC/KCF Entities waivers to allow "incident to" claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision—instead of direct supervision—of NGACO/VT APM/GPDC/CKCC/KCF Providers/Suppliers or Preferred Providers. Licensed clinicians may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. Claims for post discharge home visits will only be allowed following discharge from an inpatient facility (including, e.g., inpatient prospective payment system (IPPS) hospitals, CAHs, SNFs, Inpatient Rehabilitation Facilities (IRF)) and will be limited to no more than one visit in the first 10 days following discharge and no more than two visits in the first 30 days following discharge. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner.
Primary Care Capitation	Each year, GPDC Entities will select a payment mechanism for the upcoming performance year. If an Entity selects PCC, the Entity will have written agreements regarding capitation on certain primary care claims with PCC-participating Participants and Preferred Providers.

Term	Definition
Primary Care First–General Component	Identifies beneficiaries who are in the non-SIP category and receive care from a PCF practitioner who is accountable for coordination and management of their care.
Professional Population-Based Payment	A payment mechanism available to PCF participants based on a group-based risk adjustment to reduce practice focus on individual risk scores.
Quarterly Capitation Payments	Alternate payment/risk sharing mechanism available for CKCC and KCF entities paid out quarterly for the services performed for the CKD4, CKD5 aligned beneficiaries.
Seriously Ill Population (SIP) Component	Identifies seriously ill beneficiaries who are experiencing fragmented, uncoordinated care under Medicare FFS, deliver an intensive, episodic intervention to stabilize their clinical condition, and establish a meaningful relationship between the beneficiary and a PCF practitioner who is accountable for coordinating and managing their care in the longer term.

Term	Definition
Telehealth Benefit enhancement for DC and KCC	CMS will make available to qualified KCF and GPDC Entities, a conditional waiver that eliminates the rural geographic component of originating site requirements, allows the originating site to include a beneficiary's home, and for the use of asynchronous ("store and forward") telehealth services in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunication systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Payment will be permitted for services including dermatology and ophthalmology services furnished to eligible beneficiaries using asynchronous telehealth in single or multimedia formats and distant site practitioners will bill for these services using CMMI specific asynchronous telehealth codes. The distant site practitioner must be a KCE/DCE participant who has elected to participate in this benefit enhancement.
TeleHealth Benefit Enhancement for NGACO and VT APM	CMS will make available to qualified NGACO/VT APM Entities, a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive TeleHealth services. The benefit enhancement will allow payment of claims for TeleHealth services delivered by NGACO/VT APM Providers/Suppliers (Participant Providers) or Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

Term	Definition
Three-day stay SNF waiver	CMS will make available to qualified NGACO/VT APM/GPDC/CKCC/KCF Entities, a waiver of the three-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or Critical Access Hospital (CAH) with swing-bed approval for SNF services (“swing-bed hospital”). This benefit will allow beneficiaries to be admitted to qualified Providers/Suppliers if a SNF or swing-bed hospital is on the NGACO/VT APM/GPDC/CKCC/KCF Provider/Supplier list directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to NGACO/VT APM/GPDC/CKCC/KCF Providers/Suppliers or Preferred Providers.
Total Care Capitation	Each year, GPDC Entities will select a payment mechanism for the upcoming performance year. If an Entity selects TCC, the Entity will have written agreements regarding capitation with TCC-participating Participants and Preferred Providers.
Total Primary Care Payment	A payment methodology for the Primary Care First model that is designed to move away from traditional fee-for-service (FFS) payment incentives. In order to balance these incentives, this methodology includes two payment types: (1) a professional population-based payment (professional PBP) paid on a quarterly basis; and (2) a flat fee for each primary care visit, paid on a claim-by-claim basis.

Appendix H: CSV File Naming Conventions

This section contains the conventions to be used by CMMI model teams when naming CSV files that will be uploaded through the Cloud Storage and Retrieval System (CSRS) user interface to the CMMI model folder.

Filenames are case sensitive – the CMMI folder supports the use of both upper and lower case letters, but recognizes them as distinct values. For example, a file named *abcde* is considered a separate file from a one named *ABCDE*.

Each filename consists of 4 parts, separated by an underscore:

1. CMMI Model Team Name
2. Alignment type
3. Environment
4. Extension

CMMI Model Name – 3 to 6 alphanumeric character name that is assigned to the model by CMS. The name cannot include any spaces. Refer to Appendix A for examples of existing Model Names. For example, the Model Name listed in Appendix A for the Next Generation Accountable Care Organization is NG ACO. This would need to be translated to NGACO for the filename.

Alignment Type – 4 character value reflecting the type of data contained on the alignment file. Must be one of the following values:

- BENE – for Beneficiary Alignment file data
- PROV – for Provider Alignment file data
- ZIP5* – for Zip Code Alignment file data
- DIAG* – for ICD-10 Diagnosis Code Alignment data
- PAYR – for payment reconciliation file (Future Use)

- CADJ – for claim adjustment file (Future Use)

*NOTE: These are record types submitted on the CMMI Model Criteria File. As new record types are identified, a new alignment type value will be defined for the filename.

Environment – 4 character value reflecting the environment the file is intended to be applied to. Must be one of the following values:

- impl
- prod

Extension – 4 character value indicating the file format of *.csv*

Filename Examples

Example #1

A fictional CMMI model team named US DOC creates a provider alignment file for the test environment in CSV format to be transmitted to the CMMI model folder.

USDOC_PROV_impl.csv

Example #2

A fictional CMMI model team named XYZ creates a beneficiary alignment file for the production environment in CSV format to be transmitted to the CMMI model folder.

XYZ_BENE_prod.csv

Revision History

Table 21: Revision History

Version	Date	Organization/POC	Description of Changes
1.10	08/30/22	MCS	Created standard ICD
1.11	01/11/23	MCS	Added format for payment reconciliation file (future use)
1.12	02/13/23	MCS	Added format for claim adjustment file (future use)