

## **OVERVIEW AND FILE LAYOUT FOR QUARTERLY MFP SERVICES FILE (FOR FILES SUBMITTED FEBRUARY 15, 2009 OR LATER)**

### **OVERVIEW**

The MFP Services file will allow us to describe and assess the services MFP participants receive through the MFP demonstration. Specially, these data will be used to provide the U.S. Congress and state policymakers with answers to a range of critical research questions such as:

- How did the addition of new services permit money to follow the person?
- What types and volume of HCBS were provided by the demonstration, overall and by target population?
- How is the utilization of HCBS, overall and by type, associated with successful transition (length of stay in the community and reinstitutionalization)?

The MFP Services file will include one record for each home and community-based service people receive while participating in the MFP program. States have been instructed not to include claims for MFP-financed services in their routine MSIS files. As a result, grantees will need to submit a separate claims file for MFP demonstration services. This requirement means that MFP participants will generate two types of claims

1. regular MSIS claims for acute care and institutional services (such as physician visits, hospital discharges, and nursing home admissions)
2. MFP claims for home- and community-based services received

### **FILE CONTENT**

If possible, the development and processing of the MFP Services File should mirror what the state does when creating the MSIS Other claims file. Each MFP Services File submitted should include all claims records that were *paid* during the reporting period and for which the state claimed funds from your MFP grant. The MFP Services File will also include correction records when they occur for earlier paid claims.

The file layouts for the MFP Services File appear in Tables 1 and 2. Values for almost all data elements can be found in the Medicaid Statistical Information System (MSIS) Tape Specifications and Data Dictionary, Release 3 located at [www.cms.gov/MSIS/](http://www.cms.gov/MSIS/). The values for those data elements that do not appear in this reference are in the footnotes to these tables.

### **MANAGED LONG-TERM CARE**

To conduct a comprehensive evaluation of the impacts of the Money Follows the Person program, the evaluation will need individual level data on the use and costs of institutional and home and community based services for *all* MFP program participants receiving care in *all* types

of service systems. This includes MFP participants who transition into managed long-term care systems, which includes the Program of All Inclusive Care for the Elderly (PACE).

**Service Records.** Data that are analogous to what appears in Tables 1 and 2 are needed for MFP participants in states that purchase long-term care services for enrollees from managed care plans on a capitated basis, including MFP participants who are PACE enrollees. For each service received by an MFP participant, the evaluation needs a record indicating who received the service, when they received it, how much they received, the type of service received, and the amount the plan paid for the service. Grantees can use the default error tolerance levels as a guide to the data elements that are the most critical ones for the evaluation.

Some states also contract with managed care plans for institutional care and acute care services. Institutional care and acute care are NOT covered MFP services and states and managed care plans should report this type of service use for its MFP participants in the same manner they always have—through MSIS. If for some reason the state is not submitting managed care service claims data through MSIS, then it needs to do so for their MFP participants.

**Capitated Payment Records.** The MFP Services File must also include the capitated payments for which the state seeks reimbursement through MFP grant funds. The amount that appears on the claims record should only reflect the home and community-based portion of the capitated payment. If the capitated payment also covers acute care or institutional care or both, then the portion of the capitated payment that covers these services should be reported as usual through MSIS.

## **SUBMISSION PROCESS**

*Each grantee will submit this file, along with the crosswalk described below, 45 days after the end of each federal fiscal quarter beginning with the first quarter of paid program claims.*

Quarterly files are due February 15, May 15, August 15, and November 15 of each year. Each quarterly file will be sent by the Gentran system. Instructions for the submission of files are posted on the MFP Resource Center ([www.MFPResources.com](http://www.MFPResources.com)).

## **CROSSWALKS TO HCBS SERVICES**

To ensure Mathematica correctly classifies each MFP service claim into the correct type of service, grantees need to submit with each MFP services file a crosswalk that provides the information Mathematica needs to properly classify each claims record. The crosswalk is presented in Table 3. We are requesting you submit this crosswalk each quarter, because states are constantly revising state-specific service codes. Please send crosswalks to [MFPSupport@mathematica-mpr.com](mailto:MFPSupport@mathematica-mpr.com) and [SNelson@mathematica-mpr.com](mailto:SNelson@mathematica-mpr.com).

TABLE 1

PROPOSED FILE LAYOUT FOR HEADER RECORD IN THE QUARTERLY MONEY FOLLOWS THE PERSON (MFP) SERVICES FILE

Field Name	Record Type	Type of Field	Length
File-Name <sup>a</sup>	Header	Alphanumeric	8
File-Status-Indicator	Header	Alphanumeric	1
Filler	Header	Alphanumeric	2
State-Abbreviation	Header	Alphanumeric	2
Date-File-Created	Header	Numeric	8
Start-of-Time-Period	Header	Numeric	8
End-of-Time-Period	Header	Numeric	8
SSN-Indicator	Header	Numeric	1
<b>Filler</b>	<b>Header</b>	<b>Alphanumeric</b>	<b>242</b>

Source: Medicaid Statistical Information System (MSIS) Tape Specifications and Data Dictionary, Release 3.

Note: The first data record of each MFP Services file will be a header record, which will contain file identification information required for accurate validation of the file. This table summarizes the fields in the header file record in the order in which fields will be processed. Every header record field must contain valid data.

<sup>a</sup>MFP File-Name = *guid*.NONE.MFP.Q.Gxx.CLAIMMFP.z

- *guid* = the Gentran user identification number of the person(s) with rights to submit these files

- *xx* = the state's two letter abbreviation (for example, MO = Missouri).

- *z* = either a T for a test file or a P for a non-test file (production file).

- **Use all capital letters** in the file names as indicated above.

- Grantees may submit test files before submitting final files for the evaluation. For test files replace the *z* with a T. For files you wish MPR to use in its work replace the *z* with a P.

TABLE 2  
FILE LAYOUT FOR THE QUARTERLY MONEY FOLLOWS THE PERSON  
(MFP) SERVICES FILE

Field Name	Type of Field	Field Length	Default Error Tolerance <sup>a</sup>
MSIS-Identification-Number	Alphanumeric	20	0.1%
Adjustment-Indicator	Numeric	1	2.0%
Type-of-Service	Numeric	2	0.1%
Type-of-Claim	Numeric	1	2.0%
Date-of-Payment-Adjudication	Numeric	8	2.0%
Amount-Paid	Signed Numeric	8	0.1%
Beginning-Date-of-Service	Numeric	8	2.0%
Ending-Date-of-Service	Numeric	8	2.0%
Provider-ID-Number-Billing	Alphanumeric	12	5.0%
Amount-Charged	Signed Numeric	8	100.0%
Other-Third-Party-Payment	Signed Numeric	6	100.0%
Program-Type	Numeric	1	2.0%
Plan-ID-Number	Alphanumeric	12	2.0%
Quantity-of-Service	Signed Numeric	5	2.0%
Medicare-Deductible-Payment	Signed Numeric	5	100.0%
Medicare-Coinsurance-Payment	Signed Numeric	5	100.0%
<b>Diagnosis-Code-1<sup>b</sup></b>	<b>Alphanumeric</b>	<b>8</b>	<b>100.0%</b>
<b>Diagnosis-Code-2<sup>b</sup></b>	<b>Alphanumeric</b>	<b>8</b>	<b>100.0%</b>
Place-of-Service	Numeric	2	5.0%
Specialty-Code	Alphanumeric	4	100.0%
<b>Service-Code<sup>b</sup></b>	<b>Alphanumeric</b>	<b>8</b>	<b>5.0%</b>
Service-Code-Flag	Numeric	2	5.0%
Service-Code-Mod	Alphanumeric	2	5.0%
UB-92-Revenue-Code	Numeric	4	100.0%
Provider-ID-Number-Servicing	Alphanumeric	12	5.0%
<b>National-Provider-ID<sup>c</sup></b>	<b>Alphanumeric</b>	<b>12</b>	<b>5.0%</b>
<b>Provider-Taxonomy<sup>c</sup></b>	<b>Alphanumeric</b>	<b>12</b>	<b>5.0%</b>
<b>Internal-Control-Number-Orig<sup>c</sup></b>	<b>Alphanumeric</b>	<b>21</b>	<b>5.0%</b>
<b>Line-Number-Orig<sup>c</sup></b>	<b>Numeric</b>	<b>3</b>	<b>5.0%</b>
<b>Internal-Control-Number-Adj<sup>c</sup></b>	<b>Alphanumeric</b>	<b>21</b>	<b>5.0%</b>
<b>Line-Number-Adj<sup>c</sup></b>	<b>Numeric</b>	<b>3</b>	<b>5.0%</b>
Type-of-FMAP-Paid <sup>d</sup>	Alphanumeric	1	2.0%
Filler	Alphanumeric	47	

Source: Medicaid Statistical Information System (MSIS) Tape Specifications and Data Dictionary, Release 3.

Note: This table summarizes the fields in the Quarterly MFP Services File record in the order in which they physically occur in each record.

<sup>a</sup>The error tolerance describes, for each field, the maximum allowable percentage of records submitted that may have missing, unknown, or invalid codes.

<sup>b</sup>The field length has been increased from 7 to 8 starting with the February 2009 file submissions.

<sup>c</sup>New data elements as of the February 2009 file submissions.

<sup>d</sup>Valid values will be 1 = Qualified HCBS; 2 = HCBS Demonstration Services; and 3 = Supplemental Demonstration Services.

## **APPENDIX**

DATA DICTIONARY FOR NEW DATA ELEMENTS  
FOR FILES SUBMITTED FEBRUARY 2009 AND LATER

CLAIMS FILES

Data Element Name: INTERNAL-CONTROL-NUMBER-ORIG

Definition: A unique number (up to 21 alpha/numeric characters) assigned by the State's payment system that identifies an original claim. Field Description:

COBOL Error Example

PICTURE Tolerance Value

X(21) 5.0% "ABC000111222333444555666"

Coding Requirements:

Record the value exactly as it appears in the State system. Do not pad.

If the ADJUSTMENT-INDICATOR is '0' then this field must include the ICN for the original claim. On adjustment claims this field should show the ICN for the claim being adjusted

If Value is unknown, or the claim is a service tracking claim, fill with "99999999999999999999".

Error Condition Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE  
FOR GROSS ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=5)

1. Value = "99999999999999999999".....	301
2. Value is "Space Filled".....	303
3. Value is 0-filled.....	304

CLAIMS FILES

Data Element Name: INTERNAL-CONTROL-NUMBER-ADJ

Definition: A unique claim number (up to 21 alpha/numeric characters) assigned by the State's payment system that identifies the adjustment claim for an original transaction.

Field Description:

COBOL Error Example

PICTURE Tolerance Value

X(21) 5.0% "ABC111222333444555666"

Coding Requirements:

Record the value exactly as it appears in the State system. Do not pad.

This field should be 8-filled if the ADJUSTMENT-INDICATOR = 0

If Value is unknown, fill with "99999999999999999999".

Error Condition Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE

FOR GROSS ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=5)

- |  |     |
|--|-----|
| 1. Value = "99999999999999999999".....   | 301 |
| 2. Value is "Space Filled".....  | 303 |
| 3. Value is 0-filled.....  | 304 |
| 4. Value = "88888888888888888888" <u>AND</u> ADJUSTMENT-INDICATOR IS NE 0..... | 305 |

CLAIMS FILES

Data Element Name: LINE-NUMBER-ORIG

Definition: A unique number to identify the transaction line number that is being reported on the original claim.

Field Description:

COBOL Error Example

PICTURE Tolerance Value

9(3) 5.0% "001"

Coding Requirements:

Record the value exactly as it appears in the State system. Do not pad. This field should also be completed on adjustment claims to reflect the LINE-NUMBER of the INTERNAL-CONTROL-NUMBER on the claim that is being adjusted.

If Value is unknown, fill with "999".

Error Condition Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE  
FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = "999" .....	301
2. Value is "Space Filled" .....	303
3. Value is 0-filled.....	304
4. Value = "888" <u>AND</u> ADJUSTMENT-INDICATOR IS = 0.....	305

CLAIMS FILES

Data Element Name: LINE-NUMBER-ADJ

Definition: A unique number to identify the transaction line number that identifies the line number on the Adjustment ICN.

Field Description:

COBOL Error Example

PICTURE Tolerance Value

9(3) 5.0% "001"

Coding Requirements:

Record the value exactly as it appears in the State system. Do not pad.

This field should be 8-filled if the ADJUSTMENT-INDICATOR = 0.

If Value is unknown, fill with "999".

Error Condition Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE  
FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = "999" .....	301
2. Value is "Space Filled" .....	303
3. Value is 0-filled.....	304
4. Value = "888" <u>AND</u> ADJUSTMENT-INDICATOR IS NE 0.....	306

CLAIMS FILES

Data Element Name: NATIONAL-PROVIDER-ID

Definition: The unique number to identify the provider who treated the recipient (as opposed to the provider "billing" for the service).

Field Description:

COBOL Error Example

PICTURE Tolerance Value

X(12) 5.0% "01CA79300000"

Coding Requirements:

Record the value exactly as it appears in the State system. Do not 9-fill.

If legacy identifiers are available for providers, then report the legacy IDs in the Provider ID fields and the NPI in this field. If only the legacy Provider ID is available, then 9-fill the National Provider ID and enter the legacy IDs in the Provider ID fields.

8-fill field for premium payments (TYPE-OF-SERVICE = 20, 21, 22)

If Value is unknown, fill with "999999999999".

Error Condition Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE  
FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = "999999999999".....	301
2. Value is "Space Filled".....	303
3. Value is 0-filled.....	304
4. Value = "888888888888" <u>AND</u> TYPE-OF-SERVICE <> {20, 21, 22}.....	305
5. Value <> "888888888888" <u>AND</u> TYPE-OF-SERVICE = {20, 21, 22}.....	306
6. Value = PROVIDER-ID-NUMBER-BILLING .....	529

CLAIMS FILES

Data Element Name: PROVIDER-TAXONOMY

Definition: The taxonomy code for the provider who treated the recipient (as opposed to the provider "billing" for the service). The provider-taxonomy code is part of the HIPAA-standard code set, and is selected by providers as part of the National Provider Identification application.

Field Description:

COBOL Error Example

PICTURE Tolerance Value

X(12) 5.0% "01CA79300000"

Coding Requirements:

8-fill field for premium payments (TYPE-OF-SERVICE = 20, 21, 22)

If Value is unknown, fill with "999999999999".

Generally, the provider taxonomy requires 10 bytes. However, two additional bytes have been provided for future expansion.

Error Condition Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE  
FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = "999999999999".....	301
2. Value is "Space Filled".....	303
3. Value is 0-filled.....	304
4. Relational Field in Error.....	999
5. Value = "888888888888" AND TYPE-OF-SERVICE <> {20, 21, 22}.....	305
6. Value <> "888888888888" AND TYPE-OF-SERVICE = {20, 21, 22}.....	306
7. Value = PROVIDER-ID-NUMBER-BILLING AND TYPE-OF-SERVICE = {11,12}.....	529