

May 2016

**CENTERS FOR MEDICARE & MEDICAID SERVICES
(CMS)
RECORDS SCHEDULE**

This schedule provides the disposition instructions for CMS' program-related records as approved by the National Archives and Records Administration (NARA) as well as the NARA-approved disposition authority.

Disposition instructions for administrative-type records (Payroll, Travel, Personnel, Accounting, Budget, Procurement, IT, FOIA, Privacy, etc.) are available on the NARA website at <http://www.archives.gov/records-mgmt/grs>

TABLE OF CONTENTS

SECTION	CATEGORY
I	Administrative/Management
II	Medicare - General
III	Medicare - Program Related
IV	Provider
V	Medicaid
VI	Grant
VII	Health Plan Organizations
VIII	Office of Hearings
IX	System of Records
X	Research and Demonstrations
XI	Clinical Laboratory Improvement Amendments (CLIA)
XII	Medigap
XIII	Press Office
XIV	Electronic Systems
XV	Audiovisual Records
XVI	Administrator's Office Files
XVII	Equal Employment Opportunity Files
XVIII	CMS Leadership
XIV	Safety, Occupational, Health, Emergency and Environmental
	ALPHABETICAL INDEX

I. ADMINISTRATIVE/MANAGEMENT RECORDS

A. Agreement Files (Disposition Authority: NC1-440-79-2, Item 1)

Documents relating to agreements between elements of CMS, between CMS and other DHHS components or other Federal agencies and between CMS and other nonfederal organizations or agencies. These agreements are negotiated to provide for continued understanding between recognized organizations and CMS for the purpose of providing or obtaining various types of support services. The services include logistic, medical, fire protection, administrative, facilities, and similar support on a one-time or continuing basis and on a reimbursable or non-reimbursable basis. Included are agreements, amendments, review comments, and related correspondence.

DISPOSITION: Destroy after a total retention of 5 years after supersession, cancellation, or termination of the agreement. However, if after the supersession, cancellation or termination of the Agreement, an amount of money remains owed to or by CMS under the Agreement, then destroy after a total retention of 5 years after the amount due is paid, collected, suspended, terminated, compromised, referred for collection or other appropriate action under the Federal Claims Collection Act or other relevant statute, or is otherwise resolved.

B. Temporary Commissions, Boards, Councils and Committees

1. Internal Agency Committees (e.g., Medicare 35th Anniversary, Routine Outreach Events, etc.)

a. Internal agency committees unrelated to an agency's mission - Committees established by an agency for facilitative or operational purposes unrelated to the agency's mission, composed wholly of full-time officers or employees of the Federal government, and not subject to the Federal Advisory Committee Act, e.g. committees tasked with organizing events, selecting of interior furnishings, overseeing volunteer activities or employee recreational activities.

DISPOSITION: Destroy/delete any files created and/or maintained by the committee, when no longer needed for administrative purposes. (**Disposition Authority: NARA's GRS 26, Item 1a**)

b. Internal agency committees related to an agency's mission - Committees established by agency authority (not established by Public Law or Executive Order) for facilitative or operational purposes, related to the agency's mission, composed wholly of full-time officers or employees of the Federal government, and not subject to the Federal Advisory Committee Act, e.g. committees tasked with reviewing policy, studying reorganizations, recommending new actions or developing multi-year plans. Files created and/or maintained by the committee including agenda, minutes, final reports, and related records documenting accomplishments of official boards and committees.

DISPOSITION: PERMANENT. Cutoff file when no longer needed for current operations and transfer to the Federal Records Center. Transfer to the National Archives when 15 years old. (**Disposition Authority: NARA's GRS 26, Item 1b**)

2. Records Created by Advisory Commissions, Committees, Councils, Boards and Other Groups Established under the Federal Advisory Committee Act (FACA)

[NOTE: The term “advisory committee” as defined by FACA means any committee, board, commission, council, conference, panel, task force, or other similar group, or any subcommittee or other subgroup which is (1) established by statute or reorganization plan or (2) established or utilized by the President, or (3) established or utilized by one or more agencies or officers of the Federal government. This term does not apply to any committee which is composed wholly of full-time officers or employees of the Federal government.]

a. Files documenting the Commission’s establishment, membership, policy, organization, deliberations, findings, and recommendations, including such records as:

- original charter, renewal and amended charters, organization charts, functional statements, directives or memorandums to staff concerning their responsibilities, and other materials that document the organization and functions of the Commission and its components;
- agendas, briefing books, minutes, testimony, and transcripts of meetings and hearings as well as audiotapes and/or videotapes of meetings and hearings which were not fully transcribed;
- one copy each of reports, studies, pamphlets, posters (2 copies) and other publications produced by or for the commission as well as news releases, commissioners’ speeches, formal photographs and other significant public affairs files;
- correspondence, subject and other files maintained by key commission staff, such as the chair, executive director, and legal counsel, documenting the functions of the commission;
- substantive records relating to research studies and other projects, including unpublished studies and reports and substantive research materials (may include electronic data).
- questionnaires, surveys and other raw data accumulated in connection with research studies and other projects where the information has been consolidated or aggregated in analyses, reports, or studies covered by Item 2(a) (may include data maintained electronically).
- Records created to comply with the provisions of the Government in the Sunshine Act, annual reports to Congress describing the agency's compliance with the act.
- Documentation of subcommittees, working groups, or other subgroups of advisory committees, that support their reports and recommendations to the full or parent committee. This documentation may include, but is not limited to minutes, transcripts, reports, correspondence, briefing materials, and other related records.
- Documentation of formally designated subcommittees and working groups. This documentation may include, but is not limited to minutes, transcripts, reports, correspondence, briefing materials, and other related records.

DISPOSITION: PERMANENT. Transfer to the National Archives on termination of the Commission. Earlier periodic transfers are authorized for commissions operating for 3 years or longer. **(Disposition Authority: NARA's GRS 26, Item 2a)**

b. Files that relate to day-to-day Commission activities and/or do not contain unique information of historical value, including such records as:

- correspondence, reference and working files of Commission staff [excluding files covered by Item 2(a)]
- audiotapes and videotapes of Commission meetings and hearings that have been fully transcribed, informal still photographs and slides of Commission members and staff, meetings, hearings, and other events
- other routine records, such as public mail, requests for information, consultant personnel files, records relating to logistical aspects of Commission meetings and hearings, etc.
- extra copies of records described in Item 2(a), e.g. copies of meeting agenda and minutes distributed to commission members and staff, files accumulated by agencies on interagency bodies other than the secretariat or sponsor.

DISPOSITION: Destroy/delete when 3 years old. **(Disposition Authority: NARA's GRS 26, Item 2b)**

c. Web site records **(Disposition Authority: NARA's GRS 26, Item 2c)**

DISPOSITION: (This can be only be applied when the official recordkeeping copy is paper)

(1) Electronic version of web site(s) - Destroy/delete on termination of commission or when no longer needed.

(2) Design, management, and technical operation records - Destroy/delete on termination of commission or when no longer needed.

(3) Electronic version of content records duplicated in textual series of commission records - Destroy/delete on termination of commission or when no longer needed.

3. Committee Records Not Maintained by the Sponsor or Secretariat

Copies of committee records, such as agendas, meeting minutes, final reports and related records created by or documenting the accomplishments of official boards and commissions, excluding those kept by the sponsor or Secretariat.

DISPOSITION: Destroy when 3 years old. **(Disposition Authority: NARA's GRS 26, Item 3)**

4. Committee Management Records - Records maintained by agency Committee Management Officers for committees established under the Federal Advisory Committee Act (FACA) as amended (5U.S.C. Appendix 2). Committee Management activities include the establishment, appointment of members, and operation and termination of chartered Federal advisory committees.

Committee management records include copies of charters, membership lists, agendas, policy statements, statistical data files, financial operating plans, General Service Administration reports and other statistical reports on the number of committees, types of committees, membership rosters, requests for approval of committee nominees, appointment documents for individual committee members, financial disclosure documents, material required to be available for public information and other related topics maintained by the Committee Management Officer.

DISPOSITION: Destroy/delete when 6 years old. (**Disposition Authority: NARA's GRS 26, Item 4**)

C. Staff Visit Files (Disposition Authority: NC1-440-79-2, Item 3)

Documents relating to scheduled or special visits (but exclusive of inspections, surveys, or audits) for the purpose of performing staff or technical supervision or conducting studies. Included are requests for permission to visit, reports of visits, recommendations and other directly related documents.

DISPOSITION:

Office Performing Visit - Destroy after a total retention of 1 year after the completion of the next comparable visit or on completion of a related study.

Office Visited - Destroy after a total retention of 2 years, except for files relating to recurring staff visits which will be destroyed on completion of the next visit.

D. Organization Planning Files (Disposition Authority: NC1-440-79-2, Item 4)

Documents relating to the establishment of and changes in organization functions and relationships of CMS components (Bureaus, Divisions, Branches, Sections, etc.). Included are staff studies, copies of organization and functions plans, functional statements, charts and related documents.

DISPOSITION:

PERMANENT. Cutoff annually except that plans, charts, and manuals or portions thereof will not be cutoff until superseded or rescinded. Transfer to the FRC, 2 years after cutoff or supersession or recession as applicable. Transfer to the National Archives when 10 years old.

E. Management Survey Case Files (Disposition Authority: NC1-440-79-2, Item 5)

Documents relating to the systematic formal review of organizational structure or operational procedures and accumulated in the office conducting the survey or the office sponsoring a contract for survey services. Individual studies and surveys may range in scope from a comprehensive review of organization and operative procedures to a study of one particular procedure, process, or method of a particular phase of management. Included are documents reflecting request or authorization to conduct the survey, the finished survey report, and actions taken as a direct result of the survey.

DISPOSITION:

Office conducting the survey or office sponsoring the contract - Cutoff on completion of action directed. Destroy after a total retention of 10 years.

F. Forms Management Case Files (Disposition Authority: NC1-440-79-2, Item 6)

Documents accumulated in approving forms and resulting from the consideration, approval, control during existence and revision or recession of specific forms. Included are requests for approval of form, justifications, coordination papers and similar papers.

DISPOSITION:

1. Record Copy of CMS created form - PERMANENT. Transfer to the FRC 2 years after obsolescence. Transfer to the National Archives in 5 year blocks (15 years after obsolescence).
2. Case History File - Destroy 15 years after form is obsolete.

G. Instruction Files (Disposition Authority: NC1-440-79-2, Item 7)

Manuals, directives, handbooks, regulations, other formal policy and procedural issuances, booklets, and directories prepared and published by components in performance of their program or administrative staff responsibilities.

DISPOSITION:

Office responsible for preparation - PERMANENT. Transfer to the FRC 3 years after the close of the calendar year in which published. Transfer to the National Archives 20 years after publication date.

Other Offices - Destroy when superseded or discontinued.

H. Instruction Background Files (Disposition Authority: NC1-440-79-2, Item 8)

Records accumulated in the preparation, clearance, and publication of manuals, directives, handbooks, regulations and other formal policy and procedural issuances. Included are studies,

clearance comments, recommendations, and similar records which provide a basis for publication or contribute to the content of the issuance.

DISPOSITION:

Office responsible for preparation of the issuance - Destroy 10 years after publication is issued.

Other Offices - Destroy 2 years after the close of the calendar year in which dated.

I. Policy and Precedent Files (Disposition Authority: DAA-0440-2012-0001; superseded disposition authority: NC1-440-79-2, Item 9)

Policy memorandums, interpretations, clarifications, and similar records which serve as precedent for future policy determinations. The files are used in the development of formal policy issuances, in responding to inquiries, and in commenting upon proposed legislation, regulations, standards, and similar documents.

DISPOSITION:

Office responsible for preparation - PERMANENT. Review files annually then transfer files which do not have continuing applicability to the local Federal Records Center in 5-year blocks. Transfer to the National Archives 30 years after review.

J. Delegation of Authority Files (Disposition Authority: NC1-440-79-2, Item 10)

Program and administrative delegation of continuing authority and revocation thereof. Included are approved program delegations having statutory basis in Titles II, XI, XVIII, and XIX of the Social Security Act. Also included are approved administrative delegations of authority, i.e., personnel, printing, procurement, travel, etc.

DISPOSITION:

Program Delegations - Destroy when 10 years old.

Administrative Delegations - Destroy 3 years after superseded or revoked.

K. Task Forces

1. Internal Review Control Task Force-Subject Files (Disposition Authority: NC1-440-89-5)

Documented internal control reviews of various CMS Medicare/Medicaid programs as well as CMS administrative functions.

DISPOSITION: Destroy after a total retention of 10 years.

2. Regulatory Reform Task Force (Disposition Authority: NC1-440-89-3)

The Regulatory Reform Task Force was established in 1981 to remove burdensome Federal requirements placed on the public. The records are dated from 1981 through 1982 and are public comments and in-house memoranda relating to the technical review of the Federal regulations.

DISPOSITION: Destroy after a total retention of 10 years.

L. Training Publication Files (Disposition Authority: NC1-440-79-2, Item 12)

Official file copies of manuals, textbooks, training aids, and similar materials developed in the performance of training courses, seminars and other activities.

Included are documents related to the various CMS program matters and administrative issues.

DISPOSITION:

Program Issuances - Destroy after a total retention of 10 years.

Administrative Issuances - Destroy after a total retention of 5 years after superseded or being obsolete.

M. Administrative Office Files (Disposition Authority: NC1-440-79-1)

Files created by most CMS offices in the performance of their assigned functions.

1. Official file copies of outgoing correspondence relating to office functions.
2. Comments on draft reports, studies, and proposals prepared by other offices.
3. Contributions to and/or comments on legislation or public information materials.
4. Program and management reports, such as overtime and staffing reports, workload and production reports, highlights, and other reports prepared to submit data to management offices (exclusive of specific reports described elsewhere in this schedule).

DISPOSITION: Destroy after a total retention of 2 years at the close of the calendar year in which dated.

N. Rulemaking Record for Regulations

A media-neutral collection of information (paper, electronic and other formats) that supports the rulemaking process for established regulations for the health care programs of CMS. Includes all data and records collected and maintained by the recordkeeping office.

- 1. Official Rulemaking Record** - Consists of the published proposed rule, all public comments received in response to the proposed rule or notice that the agency considered in developing the

final policy, the public comment log prepared by the recordkeeping office, any computer runs, internal/external studies, final actuarial determinations, and all data that supported the policy, data that refuted the policy and data that would support alternative options.

a. Substantial Rulemaking Records - Original record (paper or electronic). Consists of cases that generate substantial public interest, media, or legal precedent and any proposed or final regulation or notice that is signed by the Secretary of Health and Human Services. Examples are those involving the Prescription Drug Program, payment rules, and other agency policy. **(Disposition Authority: N1-440-05-02, Item 1a)**

DISPOSITION: PERMANENT. Cutoff after publication of final notice or rule and transfer to the Federal Records Center (if paper) or transfer physical custody to NARA through pre-accessioning process (see NARA Bulletin 2004-02) at end of year in which the final notice or rule is published. Transfer physical (if paper) and legal custody (paper and electronic) to the National Archives 30 years after cut off in accordance with National Archives and Records Administration's regulations at 36 CFR 1235 with any associated finding aids.

b. Non-Substantial Rulemaking Records - All other cases that have not met the threshold for Item 1.a. Example of non-substantial are those that are CMS-only notices that are delegated to the Administrator for signature, including meeting notices that announce a meeting between CMS staff and outside groups; deeming notices that inform providers of their accreditation status, and demonstration notices that solicit applications from providers for participation in specific CMS programs. **(Disposition Authority: N1-440-05-02, Item 1b)**

DISPOSITION: Cutoff after publication of final notice or rule and transfer to the CMS onsite Records Holding Area (if paper) or transfer to off line storage (if electronic) at end of year in which notice or rule is published. Destroy/delete 5 years after cut off.

c. Original paper records used to create the electronic record such as hard copy of public comments or correspondence that is scanned to .pdf or other electronic format. **(Disposition Authority: N1-440-05-02, Item 1c)**

DISPOSITION: Temporary. Destroy/delete after (1) verification of electronic record copy is maintained in 1.a. or 1.b. and, (2) verification that plans and procedures are in place to migrate records to accessible hardware and software as necessary throughout their retention period.

2. Rulemaking Support File (Disposition Authority: N1-440-05-02, Item 2)

Consists of internal, pre-decisional documents and drafts, including clearances, drafts of the rules, internal comments received on the drafts, regulation logs, regulation specifications, preliminary actuarial estimates, internal recommendations and briefing papers. This file may also contain the memorandum to the Secretary and copies of the signed proposed rule, the memorandum to the Secretary for the final rule, and the final rule signed by the Secretary.

DISPOSITION: Temporary. Cutoff file no later than 45 days after publication of final notice or rule. Destroy/delete 5 years after cutoff.

3. Web postings on Rulemaking Web site (Disposition Authority: N1-440-05-02, Item 3)

Records consist of public comments received in the FDMS System (operated by EPA) and then posted on the CMS Web site.

DISPOSITION: Temporary. CMS/OSORA/Regulations Staff downloads comments in .pdf format. Delete posted comments from CMS and EPA website 5 years after the comments are successfully downloaded and verified by OSORA/Regulations Staff.

4. Late Comments File (Disposition Authority: N1-440-05-02, Item 4)

Consists of comments submitted by the public that were received in CMS after the close of the comment period and were not considered in the development of the final policy.

DISPOSITION: Temporary. Destroy/delete 30 days after final notice or rule is published.

5. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy. (**Disposition Authority: N1-440-05-02, Item 5a**)

DISPOSITION: Temporary. Delete when 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision, or updating that are maintained in addition to the recordkeeping copy. (**Disposition Authority: N1-440-05-02, Item 5b**)

DISPOSITION: Temporary. Delete when dissemination, revision or updating is completed.

O. RESERVED

P. Posters (Disposition Authority: N1-440-92-1)

All formally published posters dealing with non-administrative topics, created by CMS.

DISPOSITION: PERMANENT. Transfer 2 copies of each poster in a mailing tube to the National Archives when produced. Add the National Archives to the distribution list.

Q. Appointee Clearance and Vetting Files (Disposition Authority: N1-440-97-1)

Files consist of records resulting from liaison with the White House to evaluate the suitability of individuals for non-career positions. The files include correspondence, applications for

employment, resumes, background information about individuals, financial disclosure forms, security clearances, notifications of personnel action, White House clearance checklists, and other documentation relating to the selection, clearance, and appointment of political appointees.

1. Appointees - Destroy at the end of the presidential administration during which the individual is hired, except for any original material appropriate for filing in OPFs, which should be placed in those files.
2. Non-appointees - Close file on termination of consideration. Destroy 1 year after file closed but not later than the end of the Presidential administration during which the individual is considered.

R. Y2K Project Files (Disposition Authority: N1-440-03-1)

Records created and received by CMS Central and Regional Office, and CMS contractors, which document activities for Y2K compliance.

1. Y2K Assessment, Testing, and Reporting Records (**Disposition Authority: N1-440-03-1, Item 1**).

Records maintained by CMS Central/Regional Offices and CMS Contractors (paper, electronic or both). May include instructions, procedures, guidelines, requirements, waivers, reports and letters issued, letters reports and deliverables received, hardware/software inventories, certification statements, project plans, testing plans, configuration management plans, risk mitigation/contingency plans, day one reports, metrics data, test cases, test scripts, submitter/provider testing data, contingency plan validation worksheets, workgroup charters, organizing and staffing data, agenda and information from conferences, outreach material, overtime, travel and supplies costs, and supplemental budget requests. Also includes self-certification, re-certifications, test schedules, test traceability matrix, configuration checklists, contingency plan, validation test plan and procedures, final day one plan and checklist.

DISPOSITION: Temporary. Destroy/delete 3 years after the Y2K certification process is completed.

2. Videotapes - Interoperability Meeting held in Los Angeles and the Y2K contingency planning training for YCOTS in 1999. (**Disposition Authority: N1-440-03-1, Item 2**)

DISPOSITION: Temporary. Destroy 3 years after the Y2K certification process is completed.

3. Electronic Mail and Word Processing System Copies

- a. Copies that have no further administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy. (**Disposition Authority: N1-440-03-1, Item 3a**)

DISPOSITION: Temporary. Delete within 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision, or updating that are maintained in addition to the recordkeeping copy. (**Disposition Authority: N1-440-03-1, Item 3b**)

DISPOSITION: Temporary. Delete when dissemination, revision, or updating is completed...

S. Data Use Agreements

Records which outline the terms and conditions between CMS and outside entities (e.g., contractor, private industry, academic institution, other Federal government agency, or state agency) that requests the use of CMS personal identifiable data that is covered by the Privacy Act of 1974. The agreement delineates the confidentiality requirements of the Privacy Act, security safeguards, and CMS' data use policies and procedures. The DUA serves as a control mechanism through which CMS can track the location of its data and the reason for the release of the data. A DUA requires that a System of Record be in effect, which allows for the disclosure of the data being used.

1. Electronic Database (Recordkeeping copy), CMS Privacy Office

Database is maintained by the CMS Privacy Office, but used and accessed by other CMS offices and contractors.

1a. Inputs

Data from paper data use agreement form (CMS Form R-0235), including Requesting Organization Name, Requesting Organization Contact, Requesting Organization address, Requesting Organization Phone Number, Requesting Organization email address, Disclosure Provision that permits disclosure of personally identifiable data, the expiration date, actual data files, custodial organization name, custodial organization contact, custodial organization address, custodial organization e-mail address, custodial organization phone number, Business Owner/System Manager authorizing use of the data that is being disclosed.

DISPOSITION: Temporary. Destroy 30 days after data is entered in the database and verified. (**Disposition Authority: NARA's GRS 20, item 2c**)

1b. Master Data Files

Requesting Organization Name, Requesting Organization Contact, Requesting Organization address, Requesting Organization Phone Number, Requesting Organization email address, Disclosure Provision that permits disclosure of personally identifiable data, the expiration date, actual data files, custodial organization name, custodial organization contact, custodial organization address, custodial organization e-mail address, custodial organization phone number, Business Owner/System Manager authorizing use of the data that is being disclosed.

DISPOSITION: Temporary. Cutoff when agreement is closed. Destroy/delete 5 years after cutoff, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-10-4, Item 1b)**

1c. Outputs

Adhoc reports created as needed.

DISPOSITION: Temporary. Destroy when no longer needed for Agency business. **(Disposition Authority: NARA's GRS 20, item 12)**

2. Textual (paper) forms, Other CMS Offices

Data Use Agreement forms (CMS Form R-0235), including Requesting Organization Name, Requesting Organization Contact, Requesting Organization address, Requesting Organization Phone Number, Requesting Organization email address, Disclosure Provision that permits disclosure of personally identifiable data, the expiration date, actual data files, custodial organization name, custodial organization contact, custodial organization address, custodial organization e-mail address, custodial organization phone number, Business Owner/System Manager authorizing use of the data that is being disclosed.

2a. Approved Forms - Cutoff when agreement is closed. Destroy 5 years after cutoff. **(Disposition Authority: N1-440-10-4, Item 2a)**

2b. Unapproved forms - Cutoff when agreement is closed. Destroy 2 years after cutoff. **(Disposition Authority: N1-440-10-4, Item 2b)**

3. Textual (paper) forms, State Health Insurance Assistance Programs (SHIP) - Data Use Agreement Forms

DISPOSITION: Maintain the two most recent DUAs in an active file until the Agency receives notice of new information from the SHIP per the terms and conditions of the SHIP Grant. **(Disposition Authority: N1-440-10-4, Item 3)**

T. Suspense Files.

Documents arranged in chronological order as a reminder that an action is required on a given date or that a reply to action is expected and, if not received, should be traced on a given date.

DISPOSITION:

1. A note or other reminder to take action.

Destroy after action is taken. **(Disposition Authority: NARA's GRS 23, Item 6a)**

2. The file copy or an extra copy of an outgoing communication, filed by the date on which a reply is expected.

Withdraw documents when reply is received. (1) If suspense copy is an extra copy, destroy immediately. (2) If suspense copy is the file copy, incorporate it into the official files. **(Disposition Authority: NARA's GRS 23, Item 6b)**

U. Transitory Files (Disposition Authority: NARA's GRS 23, Item 7)

Records of short-term (180 days or less) interest, including in electronic form (e.g., e-mail messages), which have minimal or no documentary or evidential value. Included are such records as:

- Routine requests for information or publications and copies of replies which require no administrative action, no policy decision, and no special compilation or research for reply;
- Originating office copies of letters of transmittal that do not add any information to that contained in the transmitted material, and receiving office copy if filed separately from transmitted material;
- Quasi-official notices including memoranda and other records that do not serve as the basis of official actions, such as notices of holidays or charity and welfare fund appeals, bond campaigns, and similar records;
- Records documenting routine activities containing no substantive information, such as routine notifications of meetings, scheduling of work-related trips and visits, and other scheduling related activities;
- Suspense and tickler files or "to-do" and task lists that serve as a reminder that an action is required on a given date or that a reply to action is expected, and if not received, should be traced on a given date.

DISPOSITION: Destroy immediately, or when no longer needed for reference, or according to a predetermined time period or business rule (e.g., implementing the auto-delete feature of electronic mail systems).

V. Tracking and Control Records (Disposition Authority: NARA's GRS 23, Item 8)

Logs, registers, and other records used to control or document the status of correspondence, reports, or other records that are authorized for destruction by the GRS or a NARA-approved SF 115.

DISPOSITION: Destroy or delete when 2 years old, or 2 years after the date of the latest entry, whichever is applicable.

W. Finding Aids (or Indexes) (Disposition Authority: NARA's GRS 23, Item 9)

Indexes, lists, registers, and other finding aids used only to provide access to records authorized for destruction by the GRS or a NARA-approved SF 115, EXCLUDING records containing

abstracts or other information that can be used as an information source apart from the related records.

DISPOSITION: Destroy or delete with the related records.

X. Publications

Outreach/educational publications and products created in conjunction with the mission-related functions of CMS (e.g., Medicare & You; Choosing a Doctor; Medicare Basics, etc.)

1. Official Recordkeeping Copy Official recordkeeping copy of all publications used for the dissemination of official CMS program policy to beneficiaries and other interested parties. CMS defines official recordkeeping copy as English, OR another format when English does not exist. **(Disposition Authority: DAA-0440-2012-0016-0001)**

DISPOSITION: Permanent. Cutoff at the close of the calendar year in which superseded or discontinued. Transfer to FRC at cutoff. Transfer to the National Archives for Accessioning in 5-year blocks when most recent records are 20 years old. When official recordkeeping copy is electronic, transfer to the National Archives 1 year after cutoff.

2. All Other Copies. Includes audio versions, different languages, etc. **(Disposition Authority: DAA-0440-2012-0016-0002)**

DISPOSITION: Cutoff when superseded or discontinued. Destroy when superseded or discontinued, or when no longer needed for agency business, whichever is longer.

II. MEDICARE RECORDS--GENERAL

The files described in this schedule are created in the administration of the Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) Programs pursuant to Title XVIII of the Social Security Act, as amended. They are accumulated by intermediaries, carriers, State agencies, and the Centers for Medicare & Medicaid Services (CMS) headquarters and regional offices.

A. General Program Administration Files

1. Medicare Instructions Files (Disposition Authority: NC1-440-79-02, item 7)

Manuals, directives, handbooks, and other formal policy and procedural issuances prepared and published by CMS components. Included are Part A and Part B Intermediary Manuals, numbered intermediary letters, regulations, provider manuals, Internet Only Manuals, Administrative Issuance System, and similar material.

DISPOSITION:

a) CMS Headquarters Offices Responsible for Instructions Coordination

PERMANENT. Close file when publication is superseded or discontinued. Hold 2 years and then transfer to the Federal Records Center (FRC). Transfer to the National Archives 20 years thereafter.

b) Other Offices

Destroy when superseded or discontinued.

2. Medicare Instructions Background Files (Disposition Authority: NC1-440-79-02, item 8)

Records accumulated in the preparation, clearance, and publication of manuals, directives, handbooks, and other formal policy and procedural issuances. Included are studies, clearance comments, recommendations, and similar records which provide a basis for publication or contribute to the content of the issuance.

DISPOSITION:

a) CMS Headquarters Offices Responsible for Instructions Coordination

Transfer to the when no longer needed for current operations. Destroy after a total retention of 10 years.

b) Other Offices

Destroy 2 years after the close of the calendar year in which dated.

3. Administrative Files (Disposition Authority: NC1-440-79-1)

Destroy when 2 years old.

III. MEDICARE RECORDS--PROGRAM RELATED

A. Part A Medicare Claims Records (Disposition Authority: N1-440-04-3, Item 1a) FROZEN--DO NOT DESTROY

Form CMS-1450 and other documents used to bill for services processed by intermediaries, i.e., inpatient hospital, outpatient hospital, skilled nursing facility, (SNF), hospice, home health, etc.

When fraud or over-utilization of services is involved, the hardcopy claim shall be retained until the resolution of the investigation plus 3 months or revert to normal disposition, whichever is longer.

DISPOSITION:

1. Intermediaries Who Microform Claims Records

a) Hardcopy Records - Cut off no later than the close of the calendar year (CY) in which paid. The hardcopy claim must be retained in accordance with the following:

(1) If a corresponding master microfilm record has been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy 3 years after the close of the CY in which paid.

(2) If a corresponding master microform record has NOT been made and verified, transfer to Federally-approved records storage facility or hold onsite. Destroy 6 years and 3 months after the close of the CY in which paid.

b) Microform Records

The master microform record must be retained for 6 years and 3 months following the close of the calendar year in which paid.

2. Intermediaries Who Do Not Microfilm Claims Records

Cut off at the close of the calendar year in which paid, then transfer to Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months. Earlier cutoff and transfer is authorized. However, the records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

3. When Fraud or Over-Utilization Has Been Identified

When potential fraud or over-utilization has been identified, retain the hardcopy onsite, or if it has already been transferred to a Federally-approved records storage facility, retrieve the hardcopy and retain onsite until the investigation and subsequent legal action, if any, has been completed (including the exhaustion of all appeals), plus 3 months. If at the close of this period, either of the schedules shown above remains applicable, retain, transfer, and destroy in

accordance with the applicable schedule. If at the close of this period, neither of the schedules shown above remains applicable, destroy after the 3 month period following completion of the investigation or subsequent legal action, if any. If any records are provided to a prosecutorial agency as evidentiary matter, consider such records as disposed of. If any such records are returned by the prosecutorial agency, retain for 3 months, and then destroy in accordance with the foregoing schedules unless otherwise directed by the prosecutorial agency.

**B. Part B Medicare Claims Records (Disposition Authority: N1-440-04-3, Item 1a)
FROZEN--DO NOT DESTROY**

All types of forms CMS-1490 and other documents used to support payments to beneficiaries, physicians, and other suppliers of service under the Supplementary Medical Insurance Program. Also included are itemized bills, correspondence, and comparable documents.

When fraud or over-utilization of services is involved, the hardcopy claim shall be retained until the resolution of the investigation plus 3 months or revert to normal disposition, whichever is longer.

DISPOSITION:

1. Carriers who Microform Claims

a) Hardcopy Records - Cut off no later than the close of the calendar year (CY) in which paid. The hardcopy claim must be retained in accordance with the following:

(1) If a corresponding master microfilm has been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 3 years after the close of the CY in which paid.

(2) If a corresponding master microform record has NOT been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 6 years and 3 months after the close of the CY in which paid.

b) Microform Records

The master microform record must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which paid.

2. Carriers Who Do Not Microfilm Claims Records

Cut off at the close of the calendar year (CY) in which paid, then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months. Earlier cutoff and transfer is authorized. However, the records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

a) Hardcopy Records - The hardcopy must be retained onsite until the microform has been verified. Cut off at the close of the calendar year in which paid; transfer hardcopy to a Federally-approved records storage facility only if there is a corresponding master microfilm record that can be retained for the period indicated in b. below; otherwise, the hardcopy shall be retained until the 6 years and 3 months period is reached. Earlier cutoff and transfer is authorized. However, the hardcopy must be retained for a total retention of 3 years after the close of the calendar year in which paid.

b) Microform Records - The master microform records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

3. When Fraud or Over-Utilization has been Identified

When potential fraud or over-utilization has been identified, retain the hardcopy onsite, or if it has already been transferred to a Federally-approved records storage facility, retrieve the hardcopy and retain onsite until the investigation and subsequent legal action, if any, has been completed (including the exhaustion of all appeals), plus 3 months. If at the close of this period, either of the schedules shown above remains applicable, retain, transfer, and destroy in accordance with the applicable schedule. If at the close of this period, neither of the schedules shown above remains applicable, destroy after the 3 month period following completion of the investigation or subsequent legal action, if any. If any records are provided to a prosecutorial agency as evidentiary matter, consider such records as disposed of. If any such records are returned by the prosecutorial agency, retain for 3 months, and then destroy in accordance with the foregoing schedules unless otherwise directed by the prosecutorial agency.

4. CMS Regional Offices – Destroy when 4 years old.

C. Medicare Benefit Check Records (Disposition Authority: N1-440-04-3, Item 1a) FROZEN--DO NOT DESTROY

1. Checks - Paid checks which intermediaries and carriers received from banks covering amounts paid to providers of service, beneficiaries, physicians, and other suppliers of service under the Hospital Insurance and Supplementary Medical Insurance programs. Also included are check vouchers and canceled or voided checks resulting for nonreceipt, loss, theft, or nondelivery.

Note: When fraud or over-utilization of services is involved, the hardcopy claim shall be retained until the resolution of the investigation plus 3 months or revert to normal disposition, whichever is longer.

DISPOSITION: Intermediaries and Carriers

Cut off at the close of the calendar year in which paid, or voided, as applicable, hold 1 additional year, and then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months.

2. Check Registers - (**Disposition Authority: N1-440-04-3, Item 1a**)

Register(s) listing checks issued to providers of service, beneficiaries physicians and other suppliers of service under the Hospital Insurance and Supplementary Medical Insurance Programs.

DISPOSITION: Intermediaries and Carriers

Cut off at the close of the calendar year in which issued, hold 1 additional year and then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months.

D. Medicare Summary Notices/Explanation of Medicare Benefit (EOMB) Records (Disposition Authority: N1-440-04-3, Item 1a) FROZEN--DO NOT DESTROY

Utilization and explanation of benefit notices used to advise beneficiaries of remaining Part A benefits, Part A and Part B deductible status, and about applying for complementary health benefits. These notices are prepared and sent to beneficiaries by Medicare intermediaries and carriers. Included are Forms CMS-1553, Medicare Hospital, Extended Care and Home Health Benefits record; RR-100, Part A Hospital Insurance Benefits Record; and forms that are developed locally by carriers regarding explanation of Medicare benefits.

DISPOSITION:

1. Intermediaries and Carriers Who Microform EOMB's

Destroy hard copies after microform has been verified as correct. Cut off microform at the close of the calendar year in which the benefit was paid or denied, as applicable. Destroy microform after a total retention of 6 years and 3 months.

2. Intermediaries and Carriers Who Do Not Microform EOMB's

Cut off at the close of the calendar year in which benefit was paid or denied, as applicable, hold 1 additional year, and then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months.

E. Reconsideration and Hearing Case Files--Hospital Insurance Program (Disposition Authority: N1-440-04-3, Item 1a) FROZEN--DO NOT DESTROY

Reconsideration records accumulate when a beneficiary or his representative files either an expressed or implied request for reconsideration because of dissatisfaction with an initial determination as to the amount of benefits payable on the beneficiary's behalf under the Hospital Insurance Program. Hearing case records accumulate when a beneficiary or his representative is dissatisfied with the reconsideration determination and requests a hearing, and, in some cases, files for a subsequent court review. Included are Forms CMS-2649, Request for Hearing; CMS-5011 U6, Request for Reconsideration; or their equivalents. Also included are evidence

furnished by beneficiaries or their representatives, correspondence, SSA determinations, Administrative Law Judge decisions, original bills, appeals Council decisions, and similar material.

DISPOSITION:

1. CMS Headquarters (**Disposition Authority: N1-440-04-3, Item 1a**)

Place in inactive file upon final action on the case. Cut off inactive file at the close of the calendar year in which final action was taken, hold 2 additional years, and transfer to a Federally-approved records storage facility. Destroy after a total retention of 7 years.

2. Intermediaries (**Disposition Authority: N1-440-04-3, Item 1a**)

Dispose of these records in accordance with instructions for Part A Medicare Claims Records (see item III.A. of this schedule).

3. Regional Offices (**Disposition Authority: N1-440-04-3, Item 1a**)

Destroy in accordance with Part A Claims files.

F. Review and Fair Hearing Case Files-Supplementary Medical Insurance Program (Disposition Authority: N1-440-04-3, Item 1a) FROZEN--DO NOT DESTROY

Files accumulated when a beneficiary, physician, provider, or other supplier of service is dissatisfied with the carrier's determination to deny a request for payment, with the amount of the payment, or with the reasonable promptness of action on a request for payment. Included are copies of claimant's requests for review, relevant written statements or evidence, notices of adverse informal review decisions, requests for hearings to protest the adverse decisions, hearings proceedings, hearing officers final decisions, and other comparable papers.

DISPOSITION:

CMS Regional Offices & Carriers - Place in inactive file upon final action on the case. Cut off inactive file at the close of the calendar year in which final action was taken, hold 2 additional years, and transfer to a Federally-approved records storage facility. Destroy after a total retention of 7 years.

G. Fraud & Abuse (Program Integrity Case Files) (Disposition Authority: NC1-440-79-1/75/23/2B7) FROZEN--DO NOT DESTROY

Files accumulated as a result of allegations or complaints of program abuse or potential fraud by physicians and other providers of services pursuant to sections 206, 208, 1106, and 1107 of the Social Security Act. They consist of complaints from beneficiaries or other sources that are referred to district offices, regional offices, intermediaries, carriers, etc. Included are correspondence, forms, and other papers used in developing and investigating complaints, such

as exhibits, copies of claims forms, bills, medical records, investigative reports, fiscal records, and other pertinent physician and provider records.

DISPOSITION: CMS Headquarters and Regional Offices

Place in inactive file after final action on the case. Cut off inactive file at the close of the calendar year in which final action was taken, hold 2 additional years, and then transfer to a Federally-approved records storage facility. Destroy after a total retention of 5 years.

**H. Intermediary and Carrier Administrative Budget Estimate and Cost Report Files
(Disposition Authority: 440-79-1/8) FROZEN--DO NOT DESTROY**

These files consist of all uses of the Administrative Cost and Budget Report, CMS-1523 for carriers and CMS-1524 for intermediaries. This form is a multi-use document and is used for budget and cost reporting activities.

Specific uses are:

1. Budget Request - The carrier/intermediary's initial request for funding for the fiscal year. Include all supporting schedules, correspondence and justifications.

DISPOSITION: Destroy after a total retention of 3 years after HHS audit and final settlement.

2. Supplemental Budget Request

DISPOSITION: Destroy after a total retention of 3 years after HHS audit and final settlement.

3. Notice of Budget Approval - The carrier/intermediary's certified funding authority for the fiscal year. Include all supporting schedules, correspondence and justification.

DISPOSITION: Destroy after a total retention of 3 years after HHS audit and final settlement.

4. Interim Expenditure Report - Cumulative fiscal year to date expenditures incurred by the carrier/intermediary. Include all supporting schedules, correspondence and justifications.

(Disposition Authority: 440-79-1, Item 5I)

DISPOSITION:

a. CMS: Destroy after a total retention of 7 years after HHS audit and final settlement.

b. Others: Destroy after a total retention of 3 years after HHS audit and final settlement.

5. Final Administrative Cost Proposal - The final statement of expenditures for the fiscal year. This form is used as the basis for final settlement of allowable costs. Include all supporting schedules, correspondence, HHS or GAO audit reports on administrative costs and benefit payments.

DISPOSITION:

- a. CMS - Destroy after a total retention of 6 years and 3 months after HHS audit and final settlement.
- b. Others - Destroy after a total retention of 3 years after HHS audit and final settlement.

I. Intermediary and Carrier Letter of Credit Files (Disposition Authority: N1-440-04-3, Item 1a)

Records authorizing a Federal Reserve Bank to disburse funds to designated intermediaries' and carriers' banks on behalf of CMS upon presentation of a Request for Funds for collection through a Federal Reserve System. Included are SF-1193, Letter of Credit, or its equivalent, and amending letters.

DISPOSITION: Destroy after a total retention of 6 years and 3 months after the year in which canceled.

J. Intermediary and Carrier Payment Vouchers and Transmittal Files (Disposition Authority: N1-440-04-3, Item 1a)

TFS-5805, Request for Funds, and similar documents prepared by the intermediaries' and carriers' servicing bank to obtain Federal funds for benefits paid in administering the Health Insurance and Supplementary Medical Insurance Programs. Also included is CMS-1521, Payment Voucher on Letter of Credit Transmittal, a transmittal that forwards information on Request for Funds to CMS and shows the purpose for which funds were drawn, i.e., hospital insurance benefits, supplementary medical insurance benefits and total amount of payment vouchers.

DISPOSITION: CMS Headquarters, Intermediaries, Carriers

Destroy after a total retention of 6 years and 3 months or HHS audit and final settlement, whichever is later.

K. Intermediary and Carrier Monthly Financial Report Files (Disposition Authority: N1-440-04-3, Item 1a)

Reports submitted monthly by the intermediaries and carriers to provide CMS with the basic data to reconcile its accounts with those maintained by intermediaries and carriers. Included is Form CMS-1522, Monthly Intermediary Financial Report, and attachments.

DISPOSITION: Destroy after HHS audit and final settlement.

L. Ambulance Services Certification (Disposition Authority: N1-440-04-3, Item 1a)

Certifications of suppliers of ambulance services.

DISPOSITION: Carriers - Destroy after a total retention of 1 year after the close of the calendar year in which certification requirements are no longer met.

M. Requests for Assistance from District Offices (Disposition Authority: N1-440-04-3, Item 1a)

Correspondence and forms submitted to district offices for development of additional information or documents relating to the Medicare claim, e.g., Form CMS-1490, Request for Medicare Payment; unreceipted bills, incorrect name or claim number; missing signature; and similar errors which prevent the processing of a claim.

DISPOSITION: Intermediaries and Carriers - Dispose of these records in accordance with instructions for Part A and Part B Medicare Claims Records (see items III.A. and III.B. of this schedule).

N. Intermediary Workload Report Files (Disposition Authority: N1-440-79-1)

Monthly statistical reports on the status of intermediary workloads used by CMS to identify basic management data needed for budgeting, financing, work planning, and progress evaluation. Included is Form CMS-1566, Health Insurance for the Aged Program Intermediary Workload Report, or its equivalent.

DISPOSITION:

1. CMS Headquarters - Destroy after a total retention of 5 years.
2. Intermediaries and CMS Regional Offices - Destroy after a total retention of 3 years.

O. Carrier Performance Report Files (Disposition Authority: N1-440-79-1)

Form CMS-1565, Health Insurance for the Aged Program Carrier Performance Reports, or equivalent documents prepared monthly by carriers to summarize their performance in processing claims under the Supplementary Medical Insurance program. The information contained in these reports provides management information needed for budgeting, financing work planning, performance evaluation, and identifying operating problems.

DISPOSITION:

1. CMS Headquarters - Destroy after a total retention of 5 years.
2. Carrier and CMS Regional Offices - Destroy after a total retention of 3 years.

P. Beneficiary Overpayment Report (Previously Overpayment and Duplicate Charge Detection Activity Report Files) (Disposition Authority: N1-440-79-1, Item 18)

Quarterly reports prepared by each carrier and sent to CMS summarizing overpayment and duplicate charge detection activities carried out during each calendar quarter. The reports are used to tabulate data on the number of cases in which the carrier recovers an overpayment, the total dollar amount of money overpaid, causes of overpayment, number of duplicated charges detected, and similar information.

DISPOSITION:

1. CMS Headquarters - Carrier report information is maintained in CMS computer system for 5 years. Destroy after a total retention of 10 years.
2. Carriers and CMS Regional Offices - Destroy after a total retention of 3 years.

Q. Routine Inquiries/Correspondence

These files accumulate as a result of a wide-range of correspondence, inquiries and complaints from beneficiaries, providers, etc., that are received by CMS headquarters, regional offices, and Medicare contractors. May include Items received by mail, (paper), fax, email, or via the CMS website's "Ask a Question" online portal. This schedule is media neutral. CMS components and/or regional offices may decide to keep the official recordkeeping copy within an electronic system (e g., Medicare Administrative Issues Tracking and Reporting of Operations (MAISTRO)). The disposition instructions below are for the record keeping copy, whether paper or electronic. These inquiries do not include any correspondence related to a claim file, to congressional offices, or on behalf of the White House, Administrator, or Secretary

NOTE:

1. When correspondence is required to document a specific claim, reconsideration, appeal, or similar case, destroy in accordance with the instructions for Medicare claims records **(Disposition Authority: N1-440-04-3, 6 years and 3 months after final payment/action. See Section III, Items A and B).**
2. When correspondence is in response to a Congressional inquiry or on behalf of the White House, Administrator or Secretary, follow the dispositions outlined below:
 - Section XVI, Item 9 -Administrator's Office Record Schedule – **PERMANENT.** Transfer copy in 5-year blocks to the FRC. Contact OSORA for transfer instructions. **(Disposition Authority: N1-440-07-1, Item 9)**
 - Section XVIII, Item 8a/b - CMS Leadership Records Schedule – **PERMANENT.** Transfer copy in 5-year blocks to the FRC. Contact OSORA for transfer instructions. **(Disposition Authority: N1-440-10-5, Item 8).**

DISPOSITION:

1. Inquiries/Correspondence - (Official Recordkeeping Copy). Response requires additional research staff or time.

Destroy 5 years after the date of the response to the correspondence, or when no longer needed for Agency business, whichever is longer. **(Disposition Authority: N1-440-10-6, Item 1)**

2. Inquiries /Correspondence – (Official Recordkeeping Copy). Response requires little effort on the part of CMS staff for response.

Destroy 2 years after the date of the response to the correspondence, or when no longer needed for Agency business, whichever is longer. **(Disposition Authority: N1-440-10-6, Item 2)**

3. Inquiries /Correspondence - No Response Required

Destroy 3 months after the date of the incoming correspondence, or when no longer needed for Agency business, whichever is longer. **(Disposition Authority: N1-440-10-6, Item 3)**

R. Intermediary and Carrier Contract Files (Disposition Authority: N1-440-79-1)

Agreements entered into with intermediaries and carriers by the Secretary of Health and Human Services under the provisions of sections 1816 and 1842 of the Social Security Act by which the intermediaries and carriers agree to perform certain functions in administering the Hospital Insurance and Supplementary Medical Insurance programs. As such, they provide basic documentation of the manner in which these programs are implemented. Included are modifications and amendments.

DISPOSITION:

1. CMS Headquarters-- **PERMANENT.**

Place in inactive file at the close of the calendar year in which superseded or terminated, as applicable, hold 2 years and then transfer to the FRC. Transfer to the National Archives after a total retention of 12 years.

2. Regional Offices, Intermediaries and Carriers

Destroy after a total retention of 3 years after supersession or termination, as applicable.

S. Intermediary and Carrier Subcontract Files (Disposition Authority: N1-440-79-1/7-21)

Copies of intermediaries' agreements with subcontractors regarding performance of audits and the providers' costs, leases for building space, equipment, consulting, and other services. Included are CMS approvals, amendments, and similar papers.

DISPOSITION:

1. CMS Headquarters

Cut off file at the close of the calendar year in which agreement was terminated, hold 1 additional year, and transfer to the FRC. Destroy after a total retention of 6 years.

2. Intermediaries and Carriers

Destroy after a total retention of 5 years after termination of agreement.

3. Regional Offices (**Disposition Authority: N1-440-79-1/5f**)

Destroy 3 years after termination of agreement.

T. Contract Performance Review Visit Files

Documents relating to scheduled or special visits to Medicare contractors to review their Medicare operations and to determine the degree of adherence to established policy, adequacy of service to the public, and to verify the accuracy of reporting. Included are reports of staff visits, follow-up reports, communications concerning improvements in operations, and other documents relating to contract performance review visits. CMS Headquarters maintains the national reports and the CMS Regional Offices maintain the local reports.

NOTE: Any records that contain beneficiary specific information and claims-related information (e.g., accuracy of reporting) are encompassed by the document preservation order (DOJ freeze) and cannot be destroyed.

DISPOSITION:

1. CMS Headquarters and Regional Offices (**Disposition Authority: N1-440-95-1, Item 11a**)

Cut off at the close of the calendar year in which action on the review is completed, hold 6 years, and then transfer to the FRC. Destroy after a total retention of 12 years.

2. Other Offices (**Disposition Authority: N1-440-95-1, Item 11b**)

Destroy after a total retention of 4 years after the close of the CY in which action on the review is completed.

U. Provider Nomination Files

Letters from providers of services stating their choice of intermediary, including changes of ownership and intermediaries. Also included are letters to intermediaries listing providers who have nominated them and letters used to update provider listings.

DISPOSITION:

1. CMS Regional Offices (**Disposition Authority: N1-440-79-1/7-23**)

Destroy change of ownership information after a total retention of 5 years after termination of provider participation. All other material may be destroyed after a total retention of 2 years from original date.

2. Intermediaries (**Disposition Authority: N1-440-79-1**)

Destroy after a total retention of 2 years from original date.

V. Intermediary and Carrier Closing Agreements (Disposition Authority: N1-440-95-1, Item 3)

These files contain the accepted final settlement for all intermediary and carrier costs of administration and consist of the Closing Agreement, Appendix, and Schedules of Balances due the Intermediary, Carrier, or Secretary.

DISPOSITION:

CMS Headquarters and Regional Offices, Intermediaries and Carriers

Cutoff file 3 years after HHS audit and final settlement. Destroy 10 years after cutoff.

W. Intermediary and Carrier Computer Printout Records (Disposition Authority: N1-440-79-1/7, Item 25)

Computer printouts used in processing, paying, and controlling Medicare claims.

1. Pending and process listing, payment listing, duplicate check control, master file update control, and profiles of physicians and other suppliers of services.

DISPOSITION: Carriers and Intermediaries

Destroy after a total retention of 4 years after the close of the calendar year in which payment was made.

2. Check listing and bank reconciliation.

DISPOSITION: Carriers

Destroy after a total retention of 6 years after the close of the calendar year in which paid or voided.

3. Query and query reply listing, transaction listing, activity listing, posting exceptions, analysis of posting errors, claims inventory control, edit input transactions, and aging of open claims.

DISPOSITION:

Carriers - Destroy after a total retention of 3 years after processing. (Carriers with capability of electronically retaining the data contained in the query and query reply listing may destroy the paper copies after tapes have been verified.)

X. Cost Report Files (Disposition Authority: N1-440-79-1/7, Item 26) FROZEN – Do Not Destroy

Cost reports submitted by providers to intermediaries for the purpose of determining Medicare reimbursable costs. In addition, samples of these reports are submitted to CMS in order to extract cost information, statistical, and financial data, as well as other pertinent information for monitoring reimbursable costs to intermediaries. Information and data developed from these cost report samples are used by CMS personnel for preparation of reports to management. Each cost report contains a provider's statement of reimbursable cost, cost-find schedules, auditor's comments, final settlement letters, and other data necessary to determine reimbursable costs prescribed by regulations and the principles of reimbursement.

DISPOSITION:

1. CMS and Intermediaries

Retain 3 years onsite after notice of amount of program reimbursement has been issued to the provider, then transfer to a Federally-approved records storage facility. Destroy after a total retention of 8 years.

NOTE: Do not transfer cost report files that are subject to an appeal, in the process of litigation, or subject to any other administrative proceedings, e.g., such as collection of outstanding overpayments, until the matter has been settled.

2. CMS Headquarters

a) Cost Report Sample Files - Retain for 3 months after completion of administrative review and/or analysis and preparation of management report, then transfer to Agency holding area. Destroy after a total retention of 9 months.

b) Management Reports - Destroy after a total retention of 2 years.

Y. Ambulatory Surgical Center Survey Responses (Disposition Authority: N1-440-95-1, Item 4)

Files contain ASC identification information and audited and non-audited charge and costs data used by CMS to establish the current ASC payment rates. Audited reports also contain the

Management Report of the Field Audit. ASC survey data used to develop a rule establishing ASC rates must also be included in the relevant Rulemaking Record file.

DISPOSITION:

- a) Reports and Summary Reports – Destroy 10 years after completion of the survey.
- b) Background Information - Destroy 5 years after the final and/or summary reports are completed.

Z. Studies

1) Program Operational - Documents related to reviews and special studies of CMS Central Office, Regional Office, and Medicare contractors to determine the degree of adherence to established policy, instructions, and specifications.

DISPOSITION:

- (a) Final Report - PERMANENT. Cutoff at the close of the calendar year in which the final report/study is completed or after final payment is made, whichever is later. Transfer to the FRC 10 years after cutoff. Transfer to the National Archives 20 years after cutoff. **(Disposition Authority: N1-440-95-1, Item 5a)**
 - (b) Background Information - Cutoff file after completion of the study. Destroy 5 years after completion of all reports. **(Disposition Authority: N1-440-95-1, Item 5b)**
- 2) Congressional - Files consist of studies mandated by public laws and contains the final report, surveys, survey materials, working papers correspondence, and related materials.

DISPOSITION:

- (a) Final Report - PERMANENT. Cut off after the final report is released to Congress. Transfer to the Federal Records Center 3 years after cutoff. Transfer to the National Archives 15 years after cutoff. **(Disposition Authority: N1-440-95-1, Item 6a)**
- (b) Background Information - Cutoff file when final report is released to Congress or after the survey process completed, whichever is later. Transfer to a Federally-approved records storage facility 6 months after cutoff. Destroy 5 years after cutoff. **(Disposition Authority: N1-440-95-1, Item 6b)**

AA. Completed Medicare Contractor Pension Cost Questionnaire and Supporting Documentation (Disposition Authority: N1-440-04-3, Item 1a)

Documents relating to Medicare contractor and subcontractor pension segmentation. In accordance with the Medicare contract/agreement Appendix B, Section XVI, the Medicare contractors were required to perform a pension asset allocation to substantiate the assets

allocated to the "Medicare Segment". Contractors were required to complete "The Medicare Contractor Pension Cost Questionnaire" and to maintain the documentation specified therein to assist HHS OIG auditors in determining compliance with that section of the contract. In cases where the contractor does not agree with the findings of the audits, legal action ensues until the disagreement is resolved. Involved are the questionnaire and all documents, records and files supporting the questionnaire.

DISPOSITION:

1. Carriers, Intermediaries and Subcontractors - Cutoff after final settlement and/or after all appeals are exhausted and provide a copy to the DHHS/Office of the Inspector General. Destroy 6 years and 3 months after cutoff.
2. CMS Headquarters - Cutoff after final settlement or after all appeals are exhausted. Retire to the Federal Records Center 1 year after cutoff. Destroy 6 years and 3 months after cutoff.

BB. Medicare Hospital Mortality Information (Disposition Authority: NC1-440-89-4)

Annual publications delineating the actual death rate with Medicare participating hospitals compared to what would have been expected for that facility given what is known of the characteristics of the beneficiaries.

DISPOSITION: PERMANENT. Cutoff at the end of the fiscal year. Hold in office for 1 fiscal year, then transfer to the FRC. Transfer to the National Archives when 10 years old.

CC. End Stage Renal Disease Cost Reports (Disposition Authority: NC1-440-87-1)

These cost reports are submitted by ESRD Medicare providers (hospital based and free-standing) at the close of each provider's reporting year.

DISPOSITION: Cutoff and send cost reports to a Federally-approved records storage facility at the end of the fiscal year. Destroy after a total retention of 5 years after the cutoff date.

DD. Medicare Waivers for Hospital Payments (Disposition Authority: N1-440-96-1, Item 1)

Includes the records for the evaluation, approval and monitoring of CMS waivers concerning payments for hospital services under the provisions of Section 1886 of the Medicare law.

DISPOSITION: Cut off at the end of the calendar year in which the waiver has been terminated, expired or after all appeals are exhausted. Transfer to a Federally-approved records storage facility. Destroy 6 years and 3 months after cutoff.

EE. Pension & Employee Benefits Actuarial Analysis (Disposition Authority: N1-440-95-1, Item 8)

Documents from completed actuarial analysis of pension, retiree health, and other employee benefit plans of Medicare contractors. Also included are documents related to special projects and reports, e.g., HMO loans, contract negotiations, in addition to documents relating to audits, reviews, or litigation (see Note below) of pension or other employee benefits. Occasionally, these documents pertain to audits, reviews, and litigation of other agencies of the U.S. Government, such as the Department of Defense, that can potentially affect the actuarial analysis of the pension, retiree health, and other employee benefit plans of Medicare contractors and providers.

NOTE: These documents are limited to the Office of the Actuary involvement in such Government contract litigation. These cases usually have no fraud involvement. The litigation usually relates to contract costs related to pension and other employee benefit plans, such as overpayment or underpayment of monies by the Government to contractors or providers of services, contractor non-renewals or terminations, and regulation promulgation and enforcement. Unless settled beforehand, contract litigation cases are heard in Federal (and rarely State) courts or at the Armed Services Board of Contract Appeals. Documentation in the case files may include but not be limited to, complaints and answers, court orders, transcripts, briefs, evidentiary material (cost reports, accounting data, affidavits, etc.), correspondence and related background information.

DISPOSITION: Cutoff after the final closing or settlement of the subject audit, review or litigation. Transfer to a Federally-approved records storage facility 1 year after cutoff. Destroy 6 years after cutoff.

FF. Medicare Data Match (Disposition Authority: N1-440-91-1) FROZEN—Do Not Destroy.

A data match between the Internal Revenue Service, the Social Security Administration and CMS. After conducting the match CMS is required to contact identified employers concerning potential situations where Medicare may be a secondary payer to employer sponsored group health coverage. Questionnaires will be in hard copy format and include case files, employer records and the data match, and will be forwarded to the New Jersey Federal Records Center by Group health Incorporated (a contractor selected by CMS) for over a 2-year period at approximately 350 cubic feet of records per month.

DISPOSITION: Cutoff files at the end of the calendar month and transfer to a Federally-approved records storage facility. Destroy 6 years and 3 months after cutoff.

GG. End Stage Renal Disease Exception Requests (Disposition Authority: N1-440-91-2)

Documentation for Reimbursement for ESRD services and supplies and consist of the intermediary's preliminary recommendation and work papers and the providers ESRD exception request and cost report.

DISPOSITION: Cutoff file at the end of the calendar year and transfer to a Federally-approved records storage facility. Destroy 7 years after cutoff.

**HH. Medicare Secondary Payer Files (Disposition Authority: N1-440-01-05, Item 1)
FROZEN—DO NOT DESTROY**

Case files developed to establish the government's right to recovery and/or impose other sanctions or corrective actions. Included are IRS data match, Medicare Secondary Payer, other employer group recoveries, workers compensation set-aside program, liability case waiver and compromise requests. Most of these involve pursuing recovery that contractors were unsuccessful with or clarifying Medicare policy. There may also be general correspondence reiterating Medicare policies.

DISPOSITION:

1. Official Recordkeeping Copy and related Data. Original format (paper or electronic) may be converted to another recordkeeping medium such as scanned images. Place in inactive file after final action on the case at the close of the calendar year in which final action was taken. Destroy 10 years after final action.
2. Source Documents (original incoming letters, checks, etc.) – Destroy once the originals are scanned and verified, and a quality assurance process has been completed.

II. Initial Enrollment Questionnaire (IEQ) FROZEN—DO NOT DESTROY

Section 1862(b)(5)(D) of the Social Security Act requires the CMS to mail a questionnaire to newly enrolled Medicare beneficiaries to obtain information on whether the individual is covered under a primary insurance plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan (this process is referred to as the IEQ). The IEQ is used to gather Medicare Secondary Payer information at or before the time of a beneficiary's Medicare entitlement. A contractor selected by CMS will conduct this process. Initial Enrollment Questionnaires are scanned in .tif file and maintained on magnetic media. All imaged documents are assigned a document control number which consists of a 5-digit Julian Date, 1-digit scanner number and a 4-digit sequential number.

NOTE: Due to a freeze imposed by the Department of Justice prohibiting the destruction of Medicare-related records, these records must be retained until the freeze is lifted.

DISPOSITION:

1. Electronic Image (recordkeeping copy) - Retain for 5 years, then delete/destroy when no longer needed. **(Disposition Authority: N1-440-00-1, Item A)**
2. Paper Copy - Destroy four month(s) after electronic image of the beneficiary-completed questionnaire is created and verified. **(Disposition Authority: N1-440-00-1, Item B)**
3. External Requests Report for IEQs (prepared by the contractor and submitted to CMS)

(a) Contractor - Retain for 5 years, then delete/destroy when no longer needed. **(Disposition Authority: N1-440-00-1, Item C1)**

(b) CMS - Retain for 5 years, then delete/destroy when no longer needed. **(Disposition Authority: N1-440-00-1, Item C2)**

4. Electronic Mail and Word Processing System Copies

(a) Copies that have no further administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

DISPOSITION: Delete within 180 days after the recordkeeping copy has been produced. **(Disposition Authority: N1-440-00-1, Item D1)**

(b) Copies used for dissemination, revision, or updating that are maintained in addition to the recordkeeping copy

DISPOSITION: Delete when dissemination, revision, or updating is complete. **(Disposition Authority: N1-440-00-1, Item D2)**

JJ. Part A Overpayment Files (Disposition Authority: N1-440-79-1, Item 39)

Documents accumulated in the recovery of overpayments to providers under the hospital insurance program (Part A). Included are reports from intermediaries on hospital overpayments, settlement worksheets, schedules of repayment and related correspondence.

DISPOSITION: Destroy 3 years after final resolution and settlement.

KK. Medicare Premium Bank Statements/Financial Documents (Disposition Authority: NARA's GRS 6, Item 1a)

Bank statements that reflect all daily deposits, credits, debits and return items (e.g., cancelled checks) processed through the Medicare premium collection center wholesale and retail operations for direct bill beneficiaries.

DISPOSITION: Temporary. Cutoff at the end of each fiscal year. Destroy 6 years and 3 months after cutoff.

LL. Consumer Research Records

Focus Groups and/or individual interviews conducted by the Center for Beneficiary Choices (CBC) and contractors with Medicare beneficiaries regarding various communication initiatives. Information collected is used for CBC research purposes.

1. Consent Forms - Signed by a Medicare beneficiary consenting to: the interview being audio/video taped, the information collected being for research purposes, and their names not tied to any results.

DISPOSITION: Temporary. Cutoff after report has been published. Destroy 2 years after cutoff. **(Disposition Authority: 440-04-01, Item 1)**

2. Audio/Video Tapes of Interviews with Medicare Beneficiaries

DISPOSITION: Temporary. Cutoff after report has been published. Destroy 2 years after cutoff. **(Disposition Authority: 440-04-01, Item 2)**

3. Other Background Records - Records created while developing report. Files may include reference materials, drafts that are circulated for internal discussion, copies of meeting notes, briefing materials, reference papers, diagrams, data used from tables and surveys, interim reports, and other materials used to create and support results/final report file.

DISPOSITION: Temporary. Cutoff after report has been published. Destroy 2 years after cutoff or when no longer needed as background material for additional reports whichever is later. **(Disposition Authority: 440-04-01, Item 3)**

4. Results/Final Report - Topline reports which present a high level overview of the research findings, presentations that summarize research, and policy decisions.

DISPOSITION: PERMANENT. Cutoff after report has been published. Transfer to the FRC 2 years after cutoff. Transfer to the National Archives 20 years after cutoff or when no longer needed for agency business purposes, whichever is sooner. **(Disposition Authority: 440-04-01, Item 4)**

5. Electronic Mail and Word Processing System Copies

(a) Copies that have no further administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

DISPOSITION: Temporary. Delete within 180 days after the recordkeeping copy has been produced. **(Disposition Authority: 440-04-01, Item 5a)**

(b) Copies used for dissemination, revision, or updating that are maintained in addition to the recordkeeping copy.

DISPOSITION: Temporary. Delete when dissemination, revision, or updating is completed. **(Disposition Authority: 440-04-01, Item 5b)**

MM. Medicare Claims Processing Systems (MCPS)

Media-neutral collection of information (paper, electronic and other formats) that supports the processing of bills and reimbursement claims for medical goods and services under the Medicare program. Includes data and records collected and maintained by Medicare contractors and sub-contractors.

1. MCPS Records. CMS forms and data created and maintained in the processing of claims for Medicare Part A, B and C. Forms may be requests for payments, insurance claim forms, provider billing for patient services and other documentation to support payments to providers of services or to support payment to beneficiaries' physicians and other suppliers of services. Electronic data may reside in databases referred to as Common Working Files. (Does not include the data that resides in the National Claims History File.)

a. Official Recordkeeping Copy and Related Data as determined by Medicare contractors and CMS. Original format (paper or electronic), may be converted to another recordkeeping medium such as scanned images, microfilm, or electronic data). (**Disposition Authority: N1-440-04-3, Item 1a**)

DISPOSITION: Temporary. Records and associated data should be cutoff at the close of CY in which paid. Destroy/delete 6 years and 3 months after cutoff. When the recordkeeping copy is paper, transfer to a Federally-approved records storage facility at cutoff. Destroy 6 years and 3 months after cutoff.

When fraud or overutilization of services is involved, the recordkeeping copy shall be retained until the resolution of the investigation plus 3 months or revert to normal DISPOSITION:, whichever is longer (e.g., Dept. of Justice Freeze, Tobacco Litigation, etc.).

b. Source Documents. Original paper claim and supporting documentation that are used to create imaged record copy on microfilm or electronic media. (**Disposition Authority: N1-440-04-3, Item 1b**)

DISPOSITION: Temporary. Destroy/delete after: (1) verification of microfilm or electronic record copy and (2) if record copy is electronic, verification that plans and procedures are in place to migrate records to accessible hardware and software as necessary throughout their retention period.

2. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy. (**Disposition Authority: N1-440-04-3, Item 3a**)

DISPOSITION: Temporary. Delete within 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision, or updating that are maintained in addition to the recordkeeping copy. (**Disposition Authority: N1-440-04-3, Item 3b**)

DISPOSITION: Temporary. Delete when dissemination, revision, or updating is completed.

NN. Professional Standards Review Organization (PSRO) Files (Disposition Authority: NC1-47-76-33, Item FF)

Files consist of copies of Memoranda of Understandings and related documents entered into with nonprofit professional associations pursuant to Section 1152 of the Social Security Act, as amended. For a given area, the PSRO reviews the professional activities of physicians, other health care practitioners and institutional and non-institutional providers of health care services to determine whether (2) services are or were medically necessary, (2) quality of services meets professionally recognized standards, etc. Record copies are maintained by CMS Headquarters.

DISPOSITION: Temporary. Destroy 1 year after termination of agreement.

OO. Program Review Team (PRT) Files (Disposition Authority: NC1-47-76-33, Item GG)

Files consist of charters and related documents entered into with physicians, health care professionals and consumer representatives pursuant to Section 1862(d) of the Social Security Act, as amended (Section 299 of P.L. 92-603), who serve under charter as members of PRTs for given areas. PRT's review the practice of physicians and other providers of services for billing substantially in excess of customary costs or charges, and for furnishing excess, harmful or grossly inferior services or supplies, to determine whether the physician or other provider of service should be excluded from participation in or terminated from the Medicare program. Files also include advisory (non-adjudicative) reports from the PRTs.

DISPOSITION: Temporary. Destroy 6 years after final termination of charter.

PP. Exclusion and Termination Actions (Sections 1862(d) and 1866(b)(2) (Disposition Authority: NC1-47-76-33, Item HH)

Files consist of cases reviewed and actions taken to exclude or terminate physicians or other providers of service from participation in the Medicare program. Documents included are investigatory materials, court actions, utilization reports, payment data and other related documents as well as PRT concurrence (adjudicative reports) or recommendations where required.

DISPOSITION: Temporary. Destroy 6 years after reinstatement to the program, or 5 years after the case is closed.

QQ. Physicians Annual Review Evaluation (Disposition Authority: NC1-440-79-1, Item 5Q)

Documents accumulated in a sample review of payments to physicians and other suppliers of services under Supplementary Medical Insurance Program (Part B). Included are computer reports containing payment information, lists of providers to be reviewed, review results and related correspondence.

DISPOSITION: Destroy 2 years after close of case.

RR. Annual Contractor Evaluation Report (ACER) (Disposition Authority: NC1-440-79-1, Item 5L)

An annual report evaluating contractor operations under Part A and B of the Medicare program. The report includes such information as claims processing, coverage and utilization safeguards, beneficiary and provider services, fiscal management, and administrative management. Included are final reports and background documents such as copies of Comprehensive Inspection Evaluation Performance (CIEP) reports, copies of draft ACER's, contractor resident representative comments on reports and related correspondence. Final ACERs are distributed to headquarters and all regional offices.

DISPOSITION:

1. Regional Office Responsible for Preparation of Final Report – Retain one copy of each final report for each contractor. Destroy after contractor terminates. Destroy background documents 2 years after publication of final report. Destroy extra copies of final report when administrative value ceases.
2. Other Regional Offices – Destroy upon receipt of updated ACER.

SS. Graduate Medical Education (GME) Agreements (NARA Approved Disposition Authority: DAA-0440-2012-0015-0001)

Graduate medical agreements (GME) are used to establish a methodology for determining payments to hospitals for the costs of approved GME programs. Section 1886(h)(2) of the Act, as added by COBRA, sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in the current FY (that is, the period of beginning between October 1 through September 30 (of the following year)). Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and non-hospital sites, when applicable), and the hospital's Medicare share of total inpatient days. Agreements are maintained electronically in an Enterprise Content Management System.

DISPOSITION: Cutoff at the end of the calendar year of the agreement. Destroy 15 year(s) after cutoff.

TT. Pre-Existing Condition Insurance Plan – State-Based Programs. (NARA Approved Disposition Authority: DDA-0440-2013-0007)

Retention guidelines for records created by CMS and State and State-Designated nonprofit entities operating a Pre-Existing Condition Insurance Plan (PCIP) under contract with CMS.

DISPOSITION:

1. Technical Approach Proposals (Disposition Authority: DDA-0440-2013-0007-0001)

Formal technical approach proposals submitted to CMS by States and State-Designated nonprofit Entities. These records document the method each State and State-Designated Non-profit Entity proposed to establish and administer PCIP in accordance with the Patient Protection and Affordable Care Act. These records provide substantial information, including but not limited to administrative processes related to eligibility determinations and enrollment procedures, coverage and benefits, premium administration and billing, appeals, customer service, case management, payment of health and prescription drug claims, marketing and outreach, anti-dumping procedures, and fraud, waste and abuse. Records include all versions approved by CMS. One time transfer, 5 years after cutoff (cutoff at contract termination).

2. Contracts (Disposition Authority: DDA-0440-2013-0007-0002)

Formal fully executed contract documents between HHS/CMS and States and State-designated entities to establish and operate PCIP to provide coverage for eligible individuals beginning in 2010 and ending December 31-2013. These records include the terms and conditions of the contract, including but not limited to specific service and delivery tasks, program requirements, data use agreements and contractor/HHS responsibility. One time transfer, 5 years after cutoff (cutoff at contract termination).

3. Data Reports and Statistical Models (Disposition Authority: DAA-0440-2013-0007-0003)

Formal data and financial audit reports submitted to CMS by States and State-Designated Nonprofit Entities and statistical models used by CMS for data analysis and other reports. These records document metrics related to the administration of PCIP, including application and enrollment, plan premiums billed and collected, administrative expenses, and incurred and paid claims. Records include monthly data reports along with “Guide for States on Reporting” documentation, financial audit reports, annual PCIP report, and statistical models. One time transfer, 5 years after cutoff (cutoff at contract termination).

4. States and State-Designated Nonprofit Entities Records (Disposition Authority: (DDA-0440-2013-0007-0004)

Records created and maintained by States and State-Designated Nonprofit Entities operating PCIP under contract with CMS. These records include application and supporting documentation for enrollment, eligibility and benefit appeals, claims and payment data, and program financial information. Destroy 6 years after cutoff (cutoff at contract termination).

UU. Contract Monitoring Files (NARA Approved Disposition Authority: DAA-0440-2013-0009-0001)

Documents relating to the monitoring and oversight of Medicare contractors (i.e., includes but is not limited to: Quality Improvement Organizations, End Stage Renal Disease Networks) to assess compliance with the scope of work and to determine the degree of adherence to established polity and adequacy of performance. Included are documents related to technical direction; performance and evaluation data; deliverables; monitoring reports; site visit reports; vouchers and supplemental information; communication concerning overall operations, and other documents related to contract oversight.

DISPOSITION: Cutoff after the close of the contract (established by CMS' Office of Acquisitions and Grants Management).

VV. Compromised Number Checklist (CNC) Database (NARA Approved Disposition Authority: DAA-0440-2013-0001)

Documents relating to Personal Identifiable Information (PII) and Protected Health Information (PHI) on providers and beneficiaries who have reported that their Medicare information has been compromised and suspects their Medicare information has been stolen through fraudulent methods.

DISPOSITION: Cutoff at the end of the calendar year of the completion of all legal activity. Destroy 7 years after cutoff.

IV. PROVIDER RECORDS

A. Provider Certification Files (Disposition Authority: N1-440-95-1, Item 9)

Documents relating to the survey and certification of suppliers and providers of service. Included are official certification and transmittal forms, survey report forms, utilization review plans, provider agreements, transfer agreements, plans of correction, civil rights compliance forms, intermediary designation and tie-in notices, certification letters, and various forms and correspondence used in the certification process with respect to individual facilities. Excluded from this definition are surveyor's notes, rough copy survey report forms (2567s), and other work papers which are merged into and superseded by a final product.

DISPOSITION:

1. CMS

a) Non-participating Facilities - Cutoff file after termination or denial. Destroy 6 years after cutoff. **(Disposition Authority: N1-440-95-1, Item 9a1)**

b) Participating Facilities –

(1) Maintain the Form CMS-1561-(Health Insurance Benefits Agreement) the two most recent certifications and background/support materials - Maintain in an active file for as long as the facility is participating. **(Disposition Authority: N1-440-95-1, Item 9a2a)**

(2) Survey report forms and related documents - Cutoff file after completion of survey. Destroy 6 years after cutoff. **(Disposition Authority: N1-440-95-1, Item 9a2b)**

(3) Survey report forms and related documents pertaining to access hospitals, nursing homes and home health agencies-Cutoff file after removal from the access category and completion of the survey (form 2567). Destroy 4 years after cutoff. **(Disposition Authority: N1-440-95-1, Item 9a2c)**

(4) Mammography Facilities Files - Cutoff file upon approval of schedule and transfer to the FRC. Destroy 3 years after cutoff. **(Disposition Authority: N1-440-95-1, Item 9a2d)**

2. State Agencies

a) Non-Participating Facilities- Cutoff file after termination, closure, withdrawal, or denial. Destroy 4 years after cutoff. **(Disposition Authority: N1-440-95-1, Item 9b1)**

(1) Non-Certified Facilities - Cutoff file after termination, closure, withdrawal, or denial. Destroy 1 year after cutoff. **(Disposition Authority: N1-440-95-1, Item 9b1a)**

b) Participating Facilities

(1) Retain a facility's (hospitals and skilled nursing facilities (SNFs)) current utilization review plan, transfer agreements and floor plan or physical plant layout. Destroy when superseded, obsolete or when facility becomes non-participating. **(Disposition Authority: N1-440-95-1, Item 9b2a)**

(2) Maintain the two most recent certification actions at all times. Destroy all other records when 4 years old. **(Disposition Authority: N1-440-95-1, Item 9b2b)**

B. Provider Statistical and Reimbursement Reports (Disposition Authority: NC1-440-79-1, Item 7/28)

EDP printouts or microfilms showing summaries of payments to hospitals, skilled nursing facilities, home health agencies, and other providers of service. They are used to effect cost settlements between the intermediaries and the providers for program validation purposes, and to determine accuracy of cost reports. These reports contain Part A and Part B inpatient and outpatient information, inpatient statistics, total bills, covered costs, and other related data.

DISPOSITION:

1. CMS Headquarters - Destroy printouts after a total retention of 3 years after the date issued. Destroy microfilm upon receipt and verification of subsequent film.
2. Intermediaries - Destroy after a total retention of 5 years after completion of audit and/or settlement process for provider cost report for corresponding fiscal year.

C. Medical Facilities Directory Files (Disposition Authority: NC1-440-79-1, Item 7/29)

Listing of providers of service showing provider identification and intermediary numbers, effective date, and city where located. Also included are alphabetical listing of facilities by State, cities within the State, and facility name within the city. These lists contain mailing addresses, provider numbers, intermediary numbers, effective dates, termination codes, billing elections, radiological and laboratory services, total beds, nursing beds, and accreditation by Joint Commission on Accreditation of Hospitals and the American Osteopathic Association.

DISPOSITION: Destroy when superseded or obsolete.

D. State Agency Budget and Financial Report Files

Files used to estimate, justify, and approve State agency health insurance program costs, and to account for funds received and expended by the State agencies. Included are Forms CMS-435 (used by the state agencies to request funding by CMS regional offices to approve budgets, by the state agencies to request supplemental funding, and by the state agencies to report quarterly expenditures)--State Survey Agency Budget/Expenditure Report; CMS-1465A--State Agency Budget List of Positions; CMS-1466--State Agency Schedule for Equipment Purchases; and indirect cost forms. (Form CMS-435 replaces Forms CMS-1465, CMS-1467, CMS-1468 and CMS-1469A.)

DISPOSITION:

1. CMS Headquarters and Regional Offices - Destroy after a total retention of 6 years following the close of the budget year. **(Disposition Authority: NC1-440-79-1, Item 50)**
2. State Agencies - Destroy after a total retention of 3 years after HHS audit or after a total retention of 5 years after the close of the budget year, whichever is earlier. **(Disposition Authority: NC1-440-79-1, Item 50)**

E. State Agency Agreements

Agreements entered into with the State agencies by the Secretary of Health and Human Services under the provisions of Section 1864 of the Social Security Act, by which the State agency assists CMS in determining whether health care providers and suppliers met and continue to meet the requirements for coverage or participation. Also included are "sub-agreements" by which State agencies subcontract some Medicare functions to other governmental or private organizations.

DISPOSITION:

1. CMS Headquarters - PERMANENT. Transfer to the FRC at the close of the calendar year in which terminated. Transfer to the National Archives 20 years thereafter. **(Disposition Authority: NC1-47-76-33)**
2. Regional Offices - Destroy after a total retention of 5 years after the close of the calendar year in which terminated. **(Disposition Authority: NC1-47-76-33)**
3. State Agencies - Dispose of according to State practice. **(Disposition Authority: NC1-47-76-33)**

F. State Agency Review Files

Documents relating to administrative review of State agency operations and certification procedures. Included are reports of visits, communications concerning improvements in operations, and other papers pertaining to reviews of State agency practices. Excluded from this definition are rough copy report forms and other work papers which are merged into and superseded by a final product.

DISPOSITION:

1. CMS Headquarters - Destroy after a total retention of 5 years after the close of the calendar year in which dated. **(Disposition Authority: NC1-440-79-1, Item 32a)**
2. State Agencies - Dispose of according to State practice. **(Disposition Authority: NC1-440-79-1, Item 32b)**

G. State Buy-In Agreements

Agreements entered into with the State agencies by the Secretary of Health and Human Services under the provisions of section 1843 of the Social Security Act. The agreements provide coverage under the Supplementary Medical Insurance Program for certain individuals receiving money payments under State approved public assistance plans. Buy-In Agreements allow coverage for individuals not normally eligible for coverage.

DISPOSITION:

1. CMS Headquarters - PERMANENT. Transfer to the FRC at the close of the calendar year in which terminated. Transfer to the National Archives 20 years thereafter. **(Disposition Authority: NC1-440-79-1, Item 33a)**
2. Regional Offices - Destroy after a total retention of 5 years after the close of the calendar year in which terminated. **(Disposition Authority: NC1-440-79-1, Item 33b)**

3. State Agencies - Dispose of according to State practice. **(Disposition Authority: NC1-440-79-1, Item 33c)**

H. Program Validation Reviews (Disposition Authority: NC1-440-79-1, Item 34)

Documents relating to program validation reviews conducted to identify the degree to which program provisions are being properly applied by the providers of health care services. Included are planned validation reviews, notice of visits, and other papers directly related to the program validation review process.

DISPOSITION: Place in inactive file after 2 years or upon receipt of subsequent review, whichever is earlier. Destroy after a total retention of 5 years.

I. Detailed Printouts (Depots)

EDP printouts showing individual bill and payment information for hospitals skilled nursing facilities, home health agencies, and other providers of service. These reports are used by intermediaries and providers to reconcile the Provider Statistical and Reimbursement Reports to their own records by itemizing which bills have been processed by CMS and are included in the PS&R report.

DISPOSITION:

1. CMS Headquarters - Destroy printouts after a total retention of 3 years after the date issued. **(Disposition Authority: NC1-440-79-1, Item 35a)**
2. Intermediaries - Destroy after a total retention of 5 years after the completion of the audit and/or settlement process for provider cost report for the corresponding fiscal year. **(Disposition Authority: NC1-440-79-1, Item 35b)**

J. Interim Rate Listings (Disposition Authority: NC1-440-79-1, Item 36)

Listings of interim rates in use by intermediaries in making interim payments to hospitals, skilled nursing facilities, home health agencies, and other providers of services. These listings are used as a source of information and for studies.

DISPOSITION: Destroy after a total retention of 5 years.

K. Provider Hearing Files (Disposition Authority: NC1-440-79-1, Item 39)

These files accumulate when a provider of services is dissatisfied with CMS's determination that it does not meet the conditions for participation in the Medicare program and requests an administrative hearing on the matter. The documents are used by CMS to support its initial determination at the hearing. Included are copies of provider inspection reports, correspondence, and similar records relating to provider operations. After the hearing, the files must be retained in the event that the provider seeks court review.

DISPOSITION:

Destroy after a total retention of 7 years after the hearing is held.

L. Supplementary Medical Insurance (SMI) General Enrollment Period (GEP) Records (Disposition Authority: N1-440-95-1, Item 10)

Records consisting of source documents, (the CMS-L40D) for all individuals who responded in the direct mail solicitation for SMI enrollment. The records contain such information as beneficiary name, claim number, address, premium amount, and a check mark reflecting individual's election or refusal of enrollment.

DISPOSITION:

1. Source Document - Cutoff at the close of the General Enrollment Period. Destroy 1 year after cutoff.
2. Timely Filed Yes Reply List - Cutoff at the end of the calendar year. Destroy 3 years after cutoff.

M. Quality of Carrier Claims Processing Operations Files (Previously, Quality Assurance File) (Disposition Authority: NC1-440-76-29, Item II)

The Medicare Part B Carrier Quality Assurance System was designed as a program for measuring the quality of carrier claims processing operations and to provide management tools for identifying and monitoring actions needed to derive improvements in claims processing. Claims processing files are transmitted electronically to CMS's Data Center (HDC) by all Part B carriers.

DISPOSITION: Retained at the HDC for a total retention of 3 years.

N. Correction Payment Action Summary Report (Disposition Authority: NC1-440-76-29, Item III)

Documents relating to corrective payment action taken on Part B claims selected for end-of-line or quality assurance sample review. Included are summary report forms and transmittal letters.

DISPOSITION: Destroy after a total retention of 1 year.

O. Civil Litigation/Bankruptcy Case Files (Disposition Authority: NC1-440-79-1, Item 3HH)

Case files documenting central office involvement in Medicare civil litigation/bankruptcy. Civil Litigation cases usually have no fraud involvement. They relate to any aspect of the Medicare program, such as overpayment or underpayment of monies by CMS to contractors or providers

of services, coverage and entitlement questions, provider terminations, and regulation promulgation and enforcement. Unless settled beforehand, civil litigation cases are heard in Federal (and rarely State) courts. Documentation in the case files may include but not be limited to, complaints and answers, court orders, transcripts, briefs, evidentiary material (cost reports, accounting data, affidavits, etc.), correspondence and related background information. The Department of Justice maintains the record copy of cases reaching the court level. The Civil Litigation and Hearings Branch maintains record copies of central office involvement in these cases.

DISPOSITION: Place in an inactive file after final action on the case. Destroy when inactive for a total retention of 5 years.

P. Professional Qualifications File (Disposition Authority: NC1-440-79-1, Item IV.A.)

Records of certain individuals who are employed in hospitals and clinical laboratories, or who are self-employed providing therapy and medical services who have taken HHS proficiency examinations. The records contain professional qualification information on the academic and experience qualifications of the individuals and identify information such as social security number, name, address, license number and eligibility, and results of HHS proficiency examination. Records are maintained by State agencies and regional Medicare offices, and are used to determine whether individuals rendering health care services meet qualification requirements.

DISPOSITION: Destroy after a total retention of 5 years after termination of individual's participation.

Q. Teaching Hospital Medical Records Audit Files (Disposition Authority: NC1-440-78-1, Item A)

Documents created from audits of teaching facilities' medical records, conducted nationwide by carriers. These audits, conducted annually or semi-annually, are intended to verify, through medical records, the degree of participation of supervising physicians in the care and treatment of beneficiaries for which payment is requested under Part B Medicare. Documents in these files include copies of Part B claims records, letters of inquiry and responses from facilities or physicians, copies of documentation supplied to carriers, and related correspondence.

DISPOSITION: Destroy after a total retention of 4 years after completion of audit.

R. Teaching Hospital Medical Record Recoupment Audit Files (Disposition Authority: NC1-440-78-1, Item B)

Documents relating to periodic audits of teaching facilities nationwide by carriers to recover overpayment. These audits are similar to the teaching hospital medical record audits. Findings adverse to the facility may be appealed through the fair hearing process. Documents in the files include copies of Part B claims records; correspondence or documentation supplied by the facility or physician; and documents relating to the fair hearing (transcripts, decisions, etc.).

DISPOSITION: Destroy 4 years after completion of audit.

S. Utilization Review Files (Disposition Authority: NC1-440-80-1)

Records documenting post payment utilization review of physicians, conducted by State and local medical societies. These files are maintained by carriers nationwide and contain copies of Part B claim forms, medical documentation, determination documentation, correspondence and related background documents. No original claims records are included in these files. Physician overpayment may be collected based on the results of the reviews.

DISPOSITION: Transfer to an inactive file upon completion of review. Close out inactive file at the end of each calendar year. Destroy after a total retention of 7 years.

T. Provider/Supplier and Durable Medical Equipment Supplier Application

Documents relating to the enrollment of providers and suppliers into the Medicare program. These include but are not limited to CMS-855 enrollment forms (OMB Approval No. 0938-0685) and all supporting documents. Also included are attachments that would be submitted with the application. These include but are not limited to copy(s) of: Federal, State and/or local (city/county) professional licenses, certifications and/or registrations; Federal, State, and/or local (city/county) business licenses, certification and/or registrations; professional school degrees or certificates or evidence of qualifying course work; curriculum vitae/resumes; CLIA certificates and FDA mammography certificates; controlled substances registrations from the Drug Enforcement Agency; Central Office letter issuing an indirect billing number to a managed care organization or plan.

1. Provider/Supplier and Durable Medical Equipment Supplier Application

DISPOSITION:

- a. Unprocessed applications as a result of provider/supplier failing to provide additional information - Destroy when 7 years old. **(Disposition Authority: N1-440-01-1, Item 1a)**
- b. Approved applications of provider/supplier - Destroy 15 years after the provider/supplier's enrollment has ended. **(Disposition Authority: N1-440-01-1, Item 1b)**
- c. Denied applications of provider/supplier. Destroy 15 years after the date of denial. **(Disposition Authority: N1-440-01-1, Item 1c)**
- d. Approved application of provider/supplier, but subsequently, the billing number has been revoked - Destroy 15 years after the billing number is revoked. **(Disposition Authority: N1-440-01-1, Item 1d)**
- e. Voluntary deactivation of billing number - Destroy 15 years after deactivation. **(Disposition Authority: N1-440-01-1, Item 1e)**

f. Provider/Supplier dies - Destroy 7 years after date of death. (**Disposition Authority: N1-440-01-1, Item 1f**)

U. Provider-Based Attestations (NARA Approved Disposition Authority: DAA-0440-2013-0011)

Documentation submitted by providers (that function as single entity while owning and operating multiple provider based departments, locations and facilities that were treated as part of the main provider for Medicare purposes) to obtain a determination of provider-based status for their facilities through a self-attestation process. Clear criteria for provider-based status designation can result in additional Medicare payments for services furnished at the provider-based facility and may increase the coinsurance liability of Medicare beneficiaries for those services. Medicare Administrative Contractors (MACs) receive and review attestations with final decision made by the CMS Regional Office.

DISPOSITION:

1. Attestations, supporting documentation, notifications of changes to the provider-based arrangements. Destroy 3 years from notification of change, 3 years from date of approval notification, or 3 years from expiration date of all appeal rights, whichever applies. (**Disposition Authority: DAA-0440-2013-0011-0001**)

2. Decision Letters. Transfer any paper record to a Federally-approved records storage facility, 5 years after cutoff. Destroy when 20 years old. (**Disposition Authority: DAA-0440-2013-0011-0002.**)

V. MEDICAID RECORDS

A. Technical Reference Materials (Disposition Authority: NC1-440-82-4, Item 1)

Printed manuals, directives, handbooks, instructions, regulations, schedules and other formal policy and procedural issuances related to Medicaid Administration and Programs, not originated in office. Record copy is retained by originating office.

DISPOSITION: Destroy when superseded or obsolete.

B. Extra Copy Convenience Files

1. Chronological (Day, Reading) Files (**Disposition Authority: NC1-440-82-4, Item 2a**)

Duplicate copies of all outgoing letters and memoranda, filed chronologically and maintained for reference and as indexes. Official copies are filed in appropriate case or subject files.

2. Trip Reports (**Disposition Authority: NC1-440-82-4, Item 2b**)

Duplicate copies of program specialists' reports of visits to State facilities included in the Medicaid Program, filed chronologically. Original is filed in appropriate State subject file.

3. Contact Reports (**Disposition Authority: NC1-440-82-4, Item 2c**)

Duplicate copies of reports documenting all staff personal or telephone contact on program issues. Original is filed in appropriate State subject file.

DISPOSITION: Cut off active file at the end of the fiscal year (FY). File in inactive file. Destroy after a total retention of 1 year after cutoff or when no longer required for reference, whichever is sooner.

C. Medicaid "All State Letters"

Printed RO issuances sent to State public welfare administrators which communicate information or requests pertaining to both administrative or program matters.

DISPOSITION:

1. Record Copy (signed original bulletin). File superseded or obsolete bulletins separately in FY increments. Destroy after a total retention of 2 years in which superseded or obsolete.

(Disposition Authority: NC1-440-82-4, Item 3a)

2. All other copies. Destroy when superseded, obsolete or no longer needed for reference.

(Disposition Authority: NC1-440-82-4, Item 3b)

D. Medicaid Administrative Subject Files (Division) (Disposition Authority: NC1-440-82-4, Item 4)

Correspondence, memoranda, reports, studies and other documents concerning the general administration, management and organization of HHS and CMS. Includes reports of meetings, unofficial copies of travel, personnel and attendance records retained only for reference.

DISPOSITION:

1. Cutoff active file at end of CY. Place in inactive file. Destroy after a total retention of 2 years after the cutoff date.

2. Exception: Bring forward to current file, file Maintenance Plans, Records Transmittals and Receipt forms. Destroy when superseded or obsolete.

E. Medicaid Program General Subject File (Disposition Authority: NC1-440-82-4, Item 5)

Correspondence, reports, policy and procedures information, reports of meetings and other general program related documents. Records specific to a State's program are filed in State subject files or in program case files described elsewhere.

DISPOSITION: Cutoff at end of CY. Retire to inactive file. Destroy 2 years after cutoff.

F. Medicaid Program State Subject Files (Disposition Authority: NC1-440-82-4, Item 6)

Correspondence, memoranda and reports not filed in specific program case files which are needed by the RO to carry out the day-to-day liaison, assistance, and review of State Medicaid program activities. Filed by State and there under by subject. These files do not include record copies of legal agreements or financial or other records held for HHS or the General Accounting Office (GAO) audit.

DISPOSITION: Cutoff active file at end of CY. Retire to inactive file. Destroy after a total retention of 2 years after cutoff.

G. Medicaid State Plan & Amendments

State plans used for the States' administration of the Medicaid program. Includes Attorney General certifications, formal transmittals (approved, disapproved, withdrawn amendments). Superseded materials are filed separately. Files are media neutral and are maintained by fiscal year, State plan number and State.

DISPOSITION:

1. Recordkeeping Copy of Approved State Plan - Maintain in the "State's active file" until superseded or obsolete. (**Disposition Authority: DAA-044-02012-0008-0001**)

2. Superseded/Obsolete State Plan Amendments & Related Information - Place in the "Completed States Plan" file by State and FY when superseded or obsolete. Destroy when 7 years old. (Consider Medicaid Eligibility Quality Control disallowance actions before destruction. This is in accordance with 42 CFR 431.17, and 45 CFR Part 74, Subpart D). (**Disposition Authority: N1-440-01-03, Item 1b**)

3. Disapproved/Withdrawn State Plan Amendments & Related Information - Place in "Completed States Plan" file. Destroy when 7 years old. (Consider Medicaid Eligibility Quality Control disallowance actions before destruction.) (**Disposition Authority: N1-440-01-03, Item 1c**)

4. Working and Duplicate Copies of State Plan Amendments - Destroy/delete when copies are no longer needed. (Consider Medicaid Eligibility Quality Control disallowance actions before destruction.) (**Disposition Authority: N1-440-01-03, Item 1d**)

5. Scanned State Plan Amendments Posted on CMS's Web site - Delete superseded or obsolete materials after updates are posted on the Web site. (**Disposition Authority: N1-440-01-03, Item 1e**)

6. Electronic Mail and Word Processing System Copies

(a) Copies that have no further administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy. -- DELETE within 180 days after the recordkeeping copy is made, or when no longer needed, whichever is later. **(Disposition Authority: N1-440-01-03, Item 1f(1))**

(b) Copies used for dissemination, revision, or updating that are maintained in addition to the recordkeeping copy -- DELETE when dissemination, revision, or updating is complete. **(Disposition Authority: N1-440-01-03, Item 1f(2))**

H. Medicaid State Plan Correspondence File (Disposition Authority: NC1-440-82-4, Item 8)

Correspondence, memoranda, background material and other working papers relating to State plan and amendments but not part of official State plan file.

DISPOSITION: Maintain separately from State plan. Cut off file at the end of the FY. Destroy after a total retention of 5 years after the cutoff date.

I. Compliance Records File (Disposition Authority: NC1-440-82-4, Item 9)

RO copies of narrative quarterly reports such as CMS OFO-2 equivalent prepared for CMS Headquarters which document old, new and continuing compliance issues. Includes copies of correspondence to States reporting non-compliance and CMS summary reports.

DISPOSITION: Cutoff file at end of CY. File in inactive file. Destroy when 1 year old or when no longer required for current operations, whichever is longer.

J. State ADP Systems Plans Files (MMIS or Mechanized Claims Processing Information Retrieval Systems) (Disposition Authority: NC1-440-82-4, Item 10)

RO file documents all phases of planning and bid selection process for State claims payment and management information ADP systems prior to award of contract. Includes advance planning documents, CMS RO and CMS Headquarters approval, and requests for proposals.

DISPOSITION: Cutoff active file upon award of contract. Retire to inactive file. Destroy after a total retention of 3 years after termination or completion of contract.

K. States ADP Contract Case Files (MMIS or Mechanized Claims Processing Information Retrieval Systems) (Disposition Authority: NC1-440-82-4, Item 11)

Copies of contracts made between States and suppliers of ADP systems used by States for claims payment and Medicaid management information. Includes all correspondence, background and briefing materials, technical reports and papers related to the development, installation and

maintenance of the system. CMS Headquarters maintains record copy of contract. RO file is used for RO approval and CMS Headquarters certifications.

DISPOSITION: Cut off file upon termination or completion of contract. File in inactive file. Destroy after a total retention of 3 years after the cutoff date.

L. Medicaid Program Reports from States (Disposition Authority: NC1-440-82-4, Item 12)

RO copies of NCSS 120, NCSS 2082 or equivalent, and other statistical reports sent directly to the ROs and/or CMS Headquarters by States. Data collected includes number of Medicaid recipients, type of services, expenditures, and other relevant data. RO copy is retained to assure States reporting compliance.

DISPOSITION: Cut off active file at the end of the FY. Retire to inactive file. Destroy after a total retention of 3 years after the cutoff date.

M. Utilization Control Quarterly Showings Reports (Disposition Authority: NC1-440-82-4, Item 13)

Includes RO copies of unmarked and marked "Quarterly Showings" (except marked copy used for survey), State certifications and all supporting documentation sent quarterly by States to RO for review and forwarded to CMS Headquarters. RO copies are used for RO validation surveys and may be used in preparation of disallowance cases by Regional Attorneys.

DISPOSITION: Cut off active file upon transmittal of correspondence to CMS Headquarters, or upon final settlement of all financial or legal issues, whichever is later. Destroy after a total retention of 3 years after the cutoff date.

N. Utilization Control Onsite Validation Survey Files (Disposition Authority: NC1-440-82-4, Item 14)

Includes marked copy of "Quarterly Showing" used in RO surveys, documentation of survey findings which either verify or refute data sent by States in that report and related materials.

DISPOSITION: Cutoff active file upon transmittal of verification correspondence to CMS Headquarters, or upon final settlement of all financial or legal issues, whichever is later. Destroy after a total retention of 3 years after cutoff date.

O. Federal Monitoring Re-review Eligibility Quality Control Schedule Case Files (Active)

Includes all documentation used for RO Quality Control re-review of State Medicaid program active cases. Includes Sample Selection Lists, Medicaid Federal review schedule, Recipient Claims for Medicaid Reimbursement computer printouts from States, State review schedule; may include State reviewer's finding sheets, summaries, copies of court orders and other source documents needed for RO review. Data elements from individual schedules are transmitted via DATAMED for calculation of State error rate.

DISPOSITION:

1. Cases not appealed by State. Cutoff active file 18 months after closeout of the review period. File in inactive file. Destroy 2 years after the close out of the review period or after four complete review periods, whichever is longer. Earlier cutoff is authorized as long as records are then inactive. **(Disposition Authority: NC1-440-82-4, Item 15A)**

2. Cases appealed by State. Cutoff file 18 months after resolution of an appeal by State. Destroy after a total retention of 2 years after cutoff date or after resolution of an appeal by the State or after four complete review periods, whichever is longer. **(Disposition Authority: NC1-440-82-4, Item 15B)**

P. Federal Monitoring Re-review Eligibility Quality Control Schedule Case Files (Negative) (Disposition Authority: NC1-440-82-4, Item 16)

Includes all documentation used in quality control re-review of State Medicaid program negative cases (termination or denial of eligibility).

DISPOSITION: Cutoff file 1 year after closeout of review period. Destroy after a total retention of 3 years after cutoff.

Q. State Review Schedules (Disposition Authority: NC1-440-82-4, Item 17)

Copies of State review schedules and documentation including universe tables sent by the State but not filed in Federal re-review case files. Used by RO as a source document from which to compute data on State error rates for transmission to CMS Headquarters via DATAMED. Also used to recompute error rates, or to support documentation in event of appeal or litigation.

DISPOSITION: Destroy 18 months after closeout of review period.

R. State Sampling Plans (Active and Negative) (Disposition Authority: N1-440-95-1, Item 12)

Basic plan and modifications which details States' methodology for selecting cases used in State Medicaid Quality Control Reviews. Plans are developed by State with RO assistance. Record copy maintained at CMS RO. States and CMS retain copies.

DISPOSITION: Move superseded or obsolete materials to an inactive file. Cutoff inactive file at end of FY. Destroy 3 years after cutoff.

S. Medicaid Program Review Files (Previously Medicaid State Assessment Files) (Disposition Authority: NC1-440-82-4, Item 29)

Includes Program Review Reports prepared by CMS ROs on selected States and all documents retained at the RO relevant to preparation of each report. Typical subjects are: Early and

Periodic Screening, Diagnosis and Treatment (EPSDT); Nurse Aide Training and Competency Evaluation Programs; Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and other subjects related to recent Medicaid legislation. Also included in the files are draft reports, correspondence and comments. Reports are provided to the State, CMS headquarters, other ROs and other interested parties.

DISPOSITION:

1. RO is responsible for preparation of the final report.
 - a. Issued Final Report - Destroy after a total retention of 10 years after the fiscal year for which it was prepared. **(Disposition Authority: NC1-440-82-4, Item A1)**
 - b. Draft Reports, background Materials - Destroy 2 years after the report is released. **(Disposition Authority: NC1-440-82-4, Item A2)**
2. All Other Offices - Destroy reports on receipt of updated report. **(Disposition Authority: NC1-440-82-4, Item B)**

T. Computer Printouts (Disposition Authority: N1-440-95-1, Item 13)

Includes all DATAMED reports from CMS Headquarters to RO, copies of DATAMED listings sent to CMS Headquarters; copies of minicomputer printouts generated at RO which include data analysis pertinent to error rate projections, and related subjects not maintained as part of another file.

DISPOSITION: Cutoff file 1 year after closeout of review period. File in inactive file. Destroy 3 years after cutoff and all appeals are exhausted.

U. State-Contractor Contracts for Administration of Medicaid Programs (Disposition Authority: NC1-440-82-4, Item 20)

Copies of contracts between States and contractors for administration of Medicaid programs, CMS approvals of contracts over \$100,000 and related documents.

DISPOSITION: Cutoff at the end of the FY in which all appropriate expenditures under the contract have been claimed by the State and approved by the CMS RO. File in inactive file. Destroy after total retention of 5 years after cutoff date.

V. State's Accountable Expenditures and Estimates of Account Files (Disposition Authority: NC1-440-82-4, Item 22)

Includes quarterly expenditures reports and estimated expenditures reports from States for approved programs. Included are CMS-64 (quarterly report of expenditures), CMS-21 (Child Health Insurance Budget and Expenditures), CMS-37 (budget requests for government allowances), copies of CMS grant awards approvals and computation sheets, review

correspondence, decision letters, reports and other related documents. Retained for HHS and GAO site audits.

DISPOSITION: Cutoff at end of FY covered by account. Place in inactive file. Destroy after a total retention of 6 years and 3 months after period covered by account.

(NOTE: General Records Schedule 6/1A and FPMR B-111, 7/7/81 states "records pertaining to American Indians are not authorized for disposal. Such records must be retained indefinitely since they may be needed in litigation involving the Government's role as trustee of property held by the Government and managed for the benefit of Indians.)

W. Disallowance Case File (Disposition Authority: NC1-440-82-4, Item 23)

Correspondence and related records which document CMS disallowance of a State claim for funding from inception of a disallowance through recovery of funds.

DISPOSITION: Cutoff active file upon final resolution and recovery of funds. Destroy after a total retention of 3 years after the cutoff date.

X. HHS Audit Agency Reports Files (Disposition Authority: NC1-440-82-4, Item 24)

Includes HHS Audit Agency reviews of financial and management practices of State agencies, project grantees and selected aspects of the States' Medicaid program administration. Also includes correspondence and other documents pertinent to RO resolution of findings and documents each audit from first action through final resolution of findings.

DISPOSITION: Cutoff file at the end of the FY following final closing of HHS audit. Place in active file and destroy after cutoff.

Y. State Re-approval Review Files (Mechanized Claims Processing Information Retrieval System)

RO file contains all work papers, review documentation, score sheets, and correspondence relating to the annual System Performance Review (SPR) for MMIS system re-approval and funding. File is used for RO re-approval/disapproval, funding notification and for CMS Headquarters review of appeals.

DISPOSITION:

1) If review does not result in appeal, cut off active file upon next subsequent notification of re-approval/disapproval and funding. Destroy after a total retention of 3 years after the review. **(Disposition Authority: NC1-440-82-4, Item 25A)**

2) If review results in appeal, cut off upon final resolution or next subsequent notification of re-approval/disapproval and funding, whichever comes later. Destroy after a total retention of 3 years after the review. **(Disposition Authority: NC1-440-82-4, Item 25B)**

Z. State Reapproval Review (SPR) Files (Files on Mechanized Claims Processing MMIS)

The SPR is used for MMIS re-approval/disapproval and funding decisions. The RO shall maintain a separate SPR file for each State MMIS in the region. Each SPR file shall contain all work papers, worksheets, review documentation, reports, correspondence and other records relating to the annual review of each State's MMIS. The information retained shall fully document the RO review findings and support RO recommendations to CO on the re-approval/disapproval and funding for each State's MMIS.

DISPOSITION:

1. Re-approval

If the review results in re-approval of a State MMIS, cutoff the active file on December 31 after the end of the FY under review. Retain in inactive file. Destroy 1 year after cutoff.

(Disposition Authority: NC1-440-85-1/a)

2. Disapproval

(a) If the review results in disapproval of a State MMIS with reduction in Federal Financial Participation (FFP) and the State appeals to the Grant Appeals Board, cutoff active file upon completion of all actions and final resolution of all issues which arose from it or on December 31 after the end of the next subsequent FY under review, whichever is later. Retain in inactive file. Destroy 2 years after cutoff. **(Disposition Authority: NC1-440-85-1/b1)**

(b) If the review results in disapproval of a State MMIS with reduction in FFP, but the State does not appeal to the Grant Appeals Board, cutoff the active file on December 31 after the end of the next subsequent FY under review. Retain in inactive file. Destroy 2 years after cutoff. **(Disposition Authority: NC1-440-85-1/b2)**

3. If the review results in disapproval of a State MMIS, but without reduction in FFP; (e.g., State was granted a waiver for good cause or a waiver due to circumstances beyond its control), follow the retention and DISPOSITION: procedures stated in paragraph 2(b) above. **(Disposition Authority: NC1-440-85-1/1b3)**

AA. Medicaid State Corrective Plans (CAPS) Files (Disposition Authority: NC1-440-82-4, Item 28)

Includes formal CAPS submitted by each State to the RO. CAPS are developed to correct deficiencies in a State's quality control of eligibility factors, so that the State does not incur funding liability penalties. Also includes background data, correspondence with the States and CMS Headquarters which relate to corrective action.

DISPOSITION: Cutoff active file at the end of the CY upon resolution of all elements in plan or after resolution of all appeals. Place in inactive file. Destroy 3 years after cutoff or when no longer needed for reference, whichever is sooner.

BB. Waiver Programs

1. Includes the approved waiver(s), correspondence, memoranda, background material and other working papers relating to State Waiver Programs maintained by Headquarters and the Regional Office.

DISPOSITION: Cutoff file annually upon replacement by another waiver renewal or when the waiver program is no longer operational. Destroy 5 years after cutoff. **(Disposition Authority: N1-440-94-1, Item 1)**

2. Section 1115 Medicaid waiver concept papers or proposals received from a State in which the State voluntarily withdrew or decided not to pursue.

DISPOSITION: Cutoff file annually. Destroy when 3 years old. **(Disposition Authority: N1-440-00-3)**

CC. State ADP Systems Plans Files (Integrated Eligibility Determination Systems or Medicaid-Related Administrative Systems) (Disposition Authority: N1-440-94-1, Item 2)

Copies of all State requests for title XIX grant monies including Advance Planning Documents and Updates, Requests for Proposals, Contracts, and correspondence including progress information from the States, and Headquarters approvals. CMS Headquarters files are used in CMS's approval of title XIX grant money to the States and for CMS Headquarters post-implementation reviews.

DISPOSITION: Hold until post-implementation review is complete then destroy 3 years and 6 months upon termination or completion of project.

DD. Reserved.

EE. State Annual Budget Projections (3-year estimates) (Disposition Authority: NC1-440-82-4, Item 21)

Includes CMS 25 reports, states estimated expenditures worksheets, CMS-Ro reviews and analysis data, transmittal and related correspondence sent to CMS headquarters. Retained for HHS audit.

DISPOSITION: Cutoff file at end of FY following final closing of HHS audit. File in inactive file and destroy 3 years after cutoff or 3 years 6 months after close of FY covered by estimate, whichever is longer.

VI. GRANT RECORDS

These files accumulate in administering the CMS grant management program. **DISPOSITION:** is not authorized by NARA's General Records Schedule Number 3.

A. Grant Files (Disposition Authority: NC1-440-80-3, Item 1)

Official copies of grants, including planning documents, applications, memorandums and other correspondence, technical evaluation reports, periodic reports, financial advisory reports, budget negotiations, award notices, and similar records. The files are maintained on a fiscal year basis in grant number sequence.

DISPOSITION: Close out file upon completion of project period or upon completion of final audit (if required), whichever is later. Destroy after a total retention of 6 years after the close out.

B. Final Product Files

Published reports, books, studies, audiovisual material or any other final grant or contract product and related records in textual or machine readable form.

DISPOSITION:

1. Office of record for grant or contract. **PERMANENT.** Retain one copy of the final report or product on each project for 1 year after the final report or product is received, then transfer to the FRC. Transfer to the National Archives when 15 years old. (**Disposition Authority: NC1-440-80-3, Item 2a**)
2. Other offices. Destroy copies when no longer needed. (**Disposition Authority: NC1-440-80-3, Item 2b**)

VII. HEALTH PLAN ORGANIZATION RECORDS

Medicare Health Plan Organizations (MHPOs) encompass any federally-qualified Medicare-contracting organization, which may provide a network of health providers and/or pharmacies and related services, under Titles XIII of the Public Health Service Act and XVIII of the Social Security Act Parts C and D as well as similarly constituted health plan organizations meeting future program expansion. This currently includes, but is not limited to, Medicare Advantage (MA) Plans (formerly known as HMOs), Medicare Advantage – Prescription Drug (MA-PD) Plans, Prescription Drug (PDP) Plans, Programs of All-Inclusive Care for the Elderly (PACE), Health Care Prepayment Plans (HCPP) and Cost-based Plans.

A. MHPO Application Files

1. Initial Application Files

This file consists of individual case folders on federally-qualified and Medicare-contracting Health Plan Organizations (MHPOs) pursuant to statutory and regulatory requirements under Titles XIII of the Public Health Service Act and XVIII of the Social Security Act, as amended. These files comprise the initial applications including supporting documentation related to functional areas such as health services delivery, structural and contractual, management information system, management, financial, marketing; formulary, Part D-related and other pertinent data as officially required.

DISPOSITION:

- a. Central Office (official file) – Cutoff at the end of the calendar year. Destroy 10 years after the case is closed (i.e., closed or no longer actively used, added to or otherwise modified; refers to being the final version). **(Disposition Authority: N1-440-99-2, Item 1a1)**
- b. Regional Office –Cutoff at the end of the calendar year. Destroy 2 years after the case is closed. **(Disposition Authority: N1-440-99-2, Item 1a2)**

2. Service Area Expansion Files

These files consist of material for complete service area expansion documentation. The files include application related material, guidelines, specialists reports, reviews, approvals, site visits, notes, and other required correspondence.

DISPOSITION:

- a. Central Office – Cutoff at the end of the calendar year. Destroy 10 years after the case is closed. **(Disposition Authority: N1-440-99-2, Item 4a1)**
- b. Regional Offices – Cutoff at the end of the calendar year. Destroy 2 years after the case is closed. **(Disposition Authority: N1-440-99-2, Item 4a2)**

3. Official Medicare Health Plan Organization (MHPO) Correspondence File

This file consists of incoming and outgoing correspondence and essential back up material pertaining to individual MHPO applications related to monitoring, compliance and enforcement. These files consist of, or relate to, correspondence on such matters as site visits, reviews, evaluations, specialty reports, meetings, letters of approval, denial, revocation, and other related documentation as necessary.

**DISPOSITION: Cutoff at the end of the calendar year. Destroy 10 years after cutoff.
(Disposition Authority: N1-440-99-2, Item 1b)**

B. Compliance Files

1. Official Compliance Files

These files consist of material in support of the continuing compliance with the statutory and regulatory requirements of Title XIII of the Public Health Service Act and Title XVIII of the Social Security Act. These files include or relate to program correspondence on such matters as analyses, reports, evaluations, non-compliance, revocations, financial reports and other associated documentation. Financial reporting is accomplished through the use of the National Data Reporting Requirements (NDRR) and audited financial reports.

DISPOSITION:

- a. Financial Reports (Audited and Revoked) – Cutoff at the end of the fiscal year. Destroy 7 years after cutoff. **(Disposition Authority: N1-440-99-2, Item 2a, 2b)**
- b. Annual NDRR Reports –Cut off at the end of the fiscal year. Destroy 3 years after cutoff. **(Disposition Authority: N1-440-99-2, Item 2c)**
- c. Quarterly NDRR Reports - Cut off at the end of the fiscal year. Destroy 1 year after cutoff. **(Disposition Authority: N1-440-99-2, Item 2d)**
- d. Compliance Program Correspondence – These files include but are not limited to: analyses, reports, evaluations, noncompliance actions, program compliance audit files; related compliance material such as warning letters, noncompliance notices and related audit material such as ad hoc compliance event correspondence, focused audit correspondence and file & use certification forms.

CMS Central & Regional Offices – Originator of the correspondence maintains and destroys after a total retention of 10 calendar years. **(Disposition Authority: N1-440-10-1, Item B1d)**

- e. Enrollment Certifications – This file includes but is not limited to, the certification form submitted by plans certifying that monthly enrollment and payment data is correct.

Cutoff at the end of the calendar year in which certification is submitted. Destroy 10 years after cutoff. **(Disposition Authority: DAA-0440-2012-0003-0003)**

f. Marketing Materials – These files include, but are not limited to, annual materials related to the marketing of MHPO benefits to the public.

DISPOSITION: Cutoff at the end of the calendar year in which the study/review is completed. Destroy 2 years after cutoff. **(Disposition Authority: N1-440-10-1, Item B1f)**

C. Loan/Loan Guarantee Files

This file is maintained for each loan made to or loan guarantee made on behalf of a Health Plan Organization. These records comprise the official file copy of the application, evaluation, recommendations, correspondence, standard commitment and loan closing documents (including certifications, promissory notes, Operating Cost Assistance Agreement, or Escrow Agreement, etc.) program narratives, and other related documentation.

DISPOSITION:

1. Loans Paid in Full - Cutoff at the end of the calendar year after final payment. Destroy when 7 years old on receipt of final payment. **(Disposition Authority: N1-440-93-4, Item 3a)**

2. Uncollected Loans - Transfer the original loan file to the Department of Justice (DOJ). Retain onsite one copy of all pertinent loan documentation. Destroy the onsite copy after a total retention of 7 calendar years from the date of transfer to DOJ. **(Disposition Authority: N1-440-93-4, Item 3b)**

D. MHPO Grantee Development Files (Disposition Authority: N1-440-99-2, Item 3)

These files consist of feasibility, planning, and initial development and expansion grant applications for funds, to develop an organization into a qualified MHPO. These files consist of application for funds specialists reports, notice-of-grants awards, audit reports, progress reports, consultants reports, reviews, grantee site visit reports, and related correspondence. The files include such materials as when the organizations became a qualified MHPO.

DISPOSITION: Cutoff at the end of the calendar year. Destroy 10 years after the case is closed.

E. Adjusted Community Rate (ACR) Proposal (Disposition Authority: N1-440-10-1, Item E)

These files consist of a MHPO's documentation supporting its proposed monthly premium charge to Medicare beneficiaries who enroll. Additionally, the file contains the value of health benefits it will provide to the Medicare enrollees which are over and above what Medicare covers. These benefits can be described as additional, optional and mandatory supplemental benefits. CMS's letters of approval to the health plans are also contained in each of the folders.

DISPOSITION: Cutoff at the end of the calendar year. Destroy 7 years after the case is closed.

F. Plan Submissions (Formulary Submissions, Medication Therapy Management Program, Health Plan Bids)

All files related to formularies such as the formulary reference file, administrative and program submissions; any submissions other than formulary submissions related to Part D prescription drug benefit not otherwise covered above; each Part D Sponsor is required to incorporate a Medication Therapy Management Program (MTMP) into their plans' benefit structure. Also includes bids received from prescription drug or other MHPOs.

DISPOSITION: Cutoff at the end of the calendar year for which submitted. Destroy 10 years after cutoff. . **(Disposition Authority: N1-440-10-1)**

G. Performance Measurement Reports

Documents relating to the establishment of minimum performance levels and setting benchmarks for MHPOs to achieve specific goals.

DISPOSITION: Cutoff at the end of the calendar year for which submitted. Destroy 10 years after cutoff. **(Disposition Authority: N1-440-10-1)**

H. Accountable Care Organizations Pioneer-Medicare Shared Savings Program (ACO Pioneer-MSSP) (NARA Disposition Authority DAA-0440-2012-0014).

DISPOSITION:

Master Files – Provider information from the ACO used to perform an annual beneficiary alignment to identify which beneficiaries belong to an ACO, beneficiary claims data provided by the Integrated Data Repository, information on beneficiary's preference to share their claims data, and beneficiary data preference sharing indicators are interrogated to determine for which beneficiaries' claims data should be provided. Destroy 6 years after cutoff (cutoff annually). **(Disposition Authority: DAA-0440-2012-0014-0001).**

VIII. OFFICE OF HEARINGS

1. Administrative Files

a. Instruction Files (**Disposition Authority: N1-440-02-2, Item 1a**)

Manuals, directives, handbooks, instructions, and other formal policy and procedural issuances prepared by the Office of Hearings (OH).

DISPOSITION: PERMANENT. Cutoff file and retire to the Federal Records Center (FRC) at the end of the calendar year when superseded or discontinued. Transfer to NARA 10 years after cutoff. (Estimated volume, 1 cubic foot, Arranged alphabetically by title.)

b. Instructions Background Files (**Disposition Authority: N1-440-02-2, Item 1b**)

Records accumulated in the preparation, clearance, and publication of manuals, directives, handbooks, instructions, and other formal policy and procedural issuances. Included are studies, clearance comments, recommendations and similar records, which provide a basis for publication and contribute to the content of the issuance.

DISPOSITION: Temporary. Destroy when superseded or discontinued.

c. Office of Hearings Database

Case Tracker serves as an index for the cases and tracks case actions in data fields such as date of request, date of acknowledgement, filing dates, hearing dates, decision, withdrawal or dismissal dates, case number, intermediary information, final actions taken, date of retention implementation, and others. Dates: 1990 to Present.

(1) Master Data File:

DISPOSITION: Temporary. Delete/destroy when superseded, obsolete, or when migrated to a new system. (**Disposition Authority: N1-440-02-2, Item 1c(1)**)

(2) Documentation. Contains data dictionaries, program codes and record layouts for the data fields, user manuals, glossaries for program terms and acronyms, and related materials.

DISPOSITION: Temporary. Destroy or delete when superseded or obsolete, or upon authorized migration of the database, whichever is sooner. (**Disposition Authority: N1-440-02-2, Item 1c(2)**)

(3) Outputs. Regular and ad hoc reports:

PRRB Reports: PRRB Monthly Progress Report (by fiscal year), PRRB Work In Process (by fiscal year), PRRB Aged Appeals (by Year of Receipt), Decision Inventory (as of Month and

FY), Decision Conferences (through Month and FY)), Position Paper Report (Month and FY), Preliminary Position Paper Report (Month and FY), Mediation Report.

MGCRB Reports: Case Status - By Case Number, Case Status - By Provider Number Case Listing - By Selected Provider Number.

Ad Hoc Reports: These are produced to get specific case information or when CMS receives a request for something specific, e.g.; all open PRRB or MGCRB appeals in a State.

DISPOSITION: Temporary. File with appropriate record series or destroy or delete when no longer needed for administrative, legal, fiscal, or reference purposes, as applicable. **(Disposition Authority: N1-440-02-2, Item 1c(3))**

(4) Back-up Files. Daily and weekly incremental backups, intended for restoration to its native environment in case of system failure. **(Disposition Authority: N1-440-02-2, Item 1c(4))**

DISPOSITION: Temporary. Destroy or delete when no longer needed for current business or when replaced by a subsequent security backup file.

2. Provider Reimbursement Review Board Files

a. Hearing Decisions **(Disposition Authority: N1-440-02-2, Item 2a)**

Case files containing documents accumulated in the hearing process. Included are the provider's request for a hearing, provider position papers, fiscal intermediary position papers, cost reports, notice of hearing, hearing transcripts, hearing decision by the Board, and related documents. Hearing decisions may be reviewed by the Secretary of HHS, and provider may seek judicial review of unfavorable decisions.

DISPOSITION: Destroy 6 years and 3 months after final decision.

b. Closed Case Files **(Disposition Authority: N1-440-02-2, Item 2b)**

Case files containing documents accumulated in the hearing process. Included are the provider's request for a hearing, provider position papers, fiscal intermediary position papers, cost reports, notice of hearing and related documents. Cases are usually closed without a formal hearing and have been withdrawn or dismissed by the Board.

DISPOSITION: Destroy 6 years and 3 months after final decision.

3. Medicare Geographic Classification Review Board Files (Disposition Authority: N1-440-02-2, Item 3)

Decisions issued by the Medicare Geographic Classification Review Board (MGCRB) on applications submitted by hospitals seeking geographic reclassification for purposes of determining a hospital's standardized amount or the applicable area wage index or both. The

MGCRB's decisions are subject to review by the Administrator. The Administrator's decisions reviewing MGCRB decisions will be placed in the MGCRB file and returned to the MGCRB. (Any pre-decisional attorney-client privileged material generated during the review will be maintained by the Office of the Attorney Advisor permanently.)

DISPOSITION: Temporary. Cutoff file upon issuance of the final agency action on a hospital's application. Place in an inactive file by fiscal year. Hold in the Office of Hearings for 36 months from the date the final agency action was taken, then retire to the a Federally-approved records storage facility by fiscal year. Destroy 6 years and 3 months after cutoff.

4. Hearing Officer Decisions or Proposed Decision Files (Disposition Authority: N1-440-02-2, Item 4)

Case files contain documents accumulated in the hearing process. Included are request for hearings, position papers of the parties, cost reports, notice of hearing, hearing transcript, hearing officer decision or proposed decision to the CMS Administrator, and related documents. The following types of cases are handled by the CMS Hearing Officers: Appeals from Denials of Medicaid State Plan Amendments, Appeals from Cost Determinations from HMO/CMP Cost Reports, Appeals from Denials of Medicare Provider or Supplier Enrollment Number, Appeals from Cost Determinations from Organ Procurement Organizations or Histocompatibility laboratory. With regard to Provider and Supplier Number appeals, the record includes initial Carrier Determination and Carrier Hearing Officer Decision. For State Plan Amendment and HMO/CMP appeals, the Hearing Officer prepares proposed decision to the CMS Administrator. The final decision of the CMS Administrator is included in the file.

DISPOSITION: Temporary. Cutoff after the final decision and retire to a Federally-approved records storage facility by fiscal year. Destroy 6 years and 3 months after cutoff.

5. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping (paper) copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

DISPOSITION: Temporary. Delete within 180 days after the recordkeeping copy has been produced. **(Disposition Authority: N1-440-02-2, Item 5)**

b. Copies used for dissemination, revision, or updating that are maintained in addition to the recordkeeping copy.

DISPOSITION: Temporary. Delete when dissemination, revision, or updating is completed. **(Disposition Authority: N1-440-02-2, Item 5)**

IX. SYSTEM OF RECORDS (Master Data Files)

A. Medicaid Integrity System (MIS) (System of Record 09-70-0599)

The primary purpose of this system is to establish an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims of Medicaid beneficiaries to assist in the detection of fraud, waste and abuse in the Medicare and Medicaid programs. Information retrieved from this system will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, consultant or a CMS grantee; (2) assist another Federal or state agency with information to enable such agency to administer a Federal health benefits program, or to enable such agency to fulfill a requirement of Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; (3) support a research or evaluation project; (4) support litigation involving the agency; and (5) combat fraud, waste, and abuse in a federally-funded health benefit program.

1a. Inputs – Information on Medicaid beneficiaries, and physicians and other providers involved in furnishing services to Medicaid beneficiaries. Information contained in this system includes, but is not limited to: assigned Medicaid identification number, name, address, social security number, health insurance claim number, date of birth, gender, ethnicity and race, medical services, equipment, and supplies for which Medicaid reimbursement is requested, and materials used to determine amount of benefits allowable under Medicaid. Information on physicians and other providers of services to the beneficiary consist of an assigned provider identification number, and information used to determine whether a sanction or suspension is warranted.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy 5 year after cutoff, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: NARA's General Record Schedule 20, item 2b)**

1b. Master Files - Information on Medicaid beneficiaries, and physicians and other providers involved in furnishing services to Medicaid beneficiaries (assigned Medicaid identification number, name, address, social security number, health insurance claim number, date of birth, gender, ethnicity and race, medical services, equipment, and supplies) for which Medicaid reimbursement is requested, and materials used to determine amount of benefits allowable under Medicaid. Physicians and other providers assigned provider identification number, sanctions or suspensions.

DISPOSITION: Temporary. Cutoff after the final determination of the case is completed. Delete/destroy 6 years after cutoff, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-9)**

1c. Outputs

1c1. Case Files (electronic or paper)

DISPOSITION: Cutoff on final action of the case. Destroy when inactive for 5 years. **(Disposition Authority: NARA's General Record Schedule 20, item 6)**

1c2. Ad Hoc Reports (for statistical analysis)

DISPOSITION: Temporary. Cutoff annually. Delete/destroy 1 year after cutoff, or when no longer needed for Agency business, whichever is later. (**Disposition Authority: NARA's General Record Schedule 20, item 16**)

B. Integrated Data Repository (IDR) – (System of Record) (Disposition Authority: N1-440-09-15)

The primary purpose of this system is to establish an enterprise resource that will provide one integrated view of all CMS data to administer the Medicare and Medicaid Part D program. Information retrieved from this system of records will also be disclosed to: (1) support regulatory, reimbursement and policy functions performed within the agency or by a contractor, consultant or CMS grantee; (2) assist another Federal or state agency; (3) support providers and suppliers of services for administration of Title XVIII; (4) assist third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (5) assist Medicare Advantage Plans and Part D Prescription Drug Plans; (6) support Quality Improvement Organizations; (7) assist other insurers for processing individual insurance claims; (8) facilitate research on the quality and effectiveness of care provided as well as payment related projects; (9) support litigation involving the agency; and (10) combat fraud, waste and abuse in certain health benefits program.

1a. Inputs – Includes but not limited to data: Standard data for identification such as health insurance claim number, Social security number, gender, race/ethnicity, date of birth, geographic location, Medicare enrollment and entitlement information, MSP data necessary for appropriate Medicare claim payment, hospice election, MA plan elections and enrollment, prescription drug (Part D) enrollment and eligibility, ESRD entitlement, historic and current listing of residences and Medicare eligibility and Managed Care institutional status. Additionally, this system will maintain identifying information on physicians, providers, employer plans, Medicaid recipients and Medicare secondary payers.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy 1 year after cutoff, or when no longer needed for Agency business, whichever is later.

1b. Master Files - Includes but not limited to: Standard data for identification such as health insurance claim number, Social security number, gender, race/ethnicity, date of birth, geographic location, Medicare enrollment and entitlement information, MSP data necessary for appropriate Medicare claim payment, hospice election, MA plan elections and enrollment, prescription drug enrollment and eligibility, ESRD entitlement, historic and current listing of residences and Medicare eligibility and managed Care institutional status; identifying information on physicians, providers, employer plans, Medicaid recipients and Medicare secondary payers.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy when 10 years old, or when no longer needed for Agency business, whichever is later.

1c. Outputs – Digital reports produced for individual users or bulk reports.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy 1 year after cutoff, or when no longer needed for Agency business, whichever is later.

C. Common Working File (Disposition Authority: N1-440-10-7)

The primary purpose of the CWF is to properly pay medical insurance benefits to or on behalf of entitled beneficiaries. The CWF is a single data source for Medicare entities (e.g., fiscal intermediaries, carriers, Medicare administrative contractors) to verify beneficiary eligibility and conduct prepayment review and approval of claims from a national perspective. It is the only place in the fee-for-service (FFS) claims processing system where full individual beneficiary information is housed.

1. Input/Sources

Electronic inputs. Includes but not limited to: the beneficiary's name, sex, health insurance claim number (HIC), address, date of birth, medical record number, prior stay information, provider name and address, physician's name, and or ID number, warranty information when pacemakers are implanted to explanted, date of admission or discharge, other health insurance, diagnosis, surgical procedures and a statement of services rendered for related charges and other data needed to substantiate claims.

DISPOSITION: Temporary. Delete when data have been entered into the master file or database and verified, or when no longer need to support reconstruction of, or serve as backup to, the master file or database, whichever is later. (NARA's GRS 20/2c)

2. Master File – The master file contains billing for medical and other health care services, uniform bill for provider services or equivalent data in an electronic format, and Medicare Secondary Payer records containing other third party liability information necessary for appropriate Medicare claims payment and other documents used to support payments to beneficiaries and providers of services. Master file also includes but not limited to: the beneficiary's name, sex, health insurance claim number (HIC), address, date of birth, medical record number, prior stay information, provider name and address, physician's name, and or ID number, warranty information when pacemakers are implanted to explanted, date of admission or discharge, other health insurance, diagnosis, surgical procedures and a statement of services rendered for related charges and other data needed to substantiate claims.

DISPOSITION:

a) Beneficiary/Enrollment data. Temporary. Delete when superseded. **(Disposition Authority: N1-440-10-7, Item 2a)**

b) Part A claims history data. Temporary. Destroy 30 years after final action/payment on claim. **(Disposition Authority: N1-440-10-7, Item 2b)**

c) Part B/DME claims history data. Temporary. Destroy 2 years from the date the claim was processed by CWF. (**Disposition Authority: N1-440-10-7, Item 2c**)

d) Outpatient claims history data. Temporary. Destroy 27 months from the date the claim was processed by CWF. (**Disposition Authority: N1-440-10-7, Item 2d**)

3. Outputs – Hard copy printouts created to meet ad hoc business needs

DISPOSITION: Temporary. Destroy when agency determines that they are no longer needed for administrative, legal, audit or other operational purposes. (**Disposition Authority: NARA's GRS 20/16**).

D. Data Collection Secondary to Coverage Decision (DCSCD) System (System of Record Notice 09–70–0547)

The purpose of this system is to collect and maintain data on patients to review national coverage determinations (NCDs) of “reasonable and necessary” with respect to whether or not a particular item or service is covered nationally under title XVIII of the Act § 1869(f)(1) (B). In order to be covered by Medicare, an item or service must fall within one or more benefit categories contained within Part A or Part B, and must not be otherwise excluded from coverage.

Master Files - The data collection includes baseline patient characteristics (individual clinical records of patients participating in data collection activities). The collected information will contain, but is not limited to, name, address, telephone number, health insurance claim (HIC) number, geographic location, race/ethnicity, gender, and date of birth, as well as, background information relating to Medicare or Medicaid issues.

DISPOSITION: Cutoff annually. Destroy/delete 10 years after cutoff, or when no longer needed for Agency business, whichever is later. (**Disposition Authority: DAA-0440-2012-0009-0001**)

E. Chronic Condition Data Repository (CCDR) – System of Record (NARA Approved Disposition Authority: DAA-0440-2012-0013)

The purpose of this system is to collect and maintain a person-level view of identifiable data to establish a data repository to study chronically ill Medicare beneficiaries. This system will utilize data extraction tools to support accessing data by chronic conditions and process complex customized research data requests related to chronic illnesses.

DISPOSITION

1. Master Files -- Individually identifiable and other data collected from multiple CMS databases pertaining to Medicare beneficiaries and their providers who provide service to those beneficiaries. Destroy 30 year(s) after cutoff (cutoff annually) (**Disposition Authority: DDA-0440-2012-0013-0001**)

2. Public Use Files (PUFs) created to support studies requiring the use and analysis of Medicare data related to chronic conditions. Transfer to the National archives 5 years after cutoff (cutoff at the end of the year in which PUF was created). **(Disposition Authority: DDA-0440-2012-0013-0002)**

X. Demonstration and Research and Development

A. Demonstration Cost Reports (Disposition Authority: N1-440-95-1, Item 14)

Cost reports are required for certain demonstrations to reimburse providers and collect data for the demonstration evaluation. The cost reports are unique to each demonstration. For cost type demonstrations, providers are granted hearing and appeal rights should they dispute the government determination of reimbursable costs. Cost reports are currently utilized for the Municipal Health Services Program, Alzheimer Disease Demonstration and the Community Nursing Organization Demonstrations.

DISPOSITION: Cutoff file upon final determination of program liability and all appeals are exhausted, or 1 year after the issuance of a report to Congress, whichever is later. Destroy 6 years and 3 months after cutoff.

B. Demonstration Project Files The demonstration file consists of the following information for management payment (capitation or cost) as well as for the evaluation: Award/initiation letter, cost reports, financial statements, correspondence, progress reports, corrective actions, site visit reports, interim and final reports, desk review programs, notices of program reimbursement, adjustment reports, appeals information (e.g., position papers), payment information, enrollee data, monthly and history edits.

DISPOSITION:

1. Completed Demonstrations - Close demonstration file at the end of the fiscal year after final action is completed (e.g., final payment, settlement, appeal or evaluation). Transfer to a Federally-approved records storage facility 2 years after closure. Destroy 10 years after closure. **(Disposition Authority: N1-440-98-1)**

2. Demonstrations which Never Occurred – Cutoff file at the end of the fiscal year, then transfer to a Federally-approved record storage facility. Destroy 5 years after cutoff. **(Disposition Authority: N1-440-11-4, Item b.)**

C. R&D Project Case File – Evaluation of the Arizona Health Care Cost Containment System (Disposition Authority: N1-440-89-2)

This file contains research and development records assembled by SRI, International, under a 5-year contract, No. CMS-500-83-0027, "Evaluation of the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is a project of CMS Office of Research and Demonstrations. The records in this file document the cost and delivery of acute health care in AHCCCS facilities. The SRI contract ends January 31, 1989.

DISPOSITION: Transfer immediately to a Federally-approved records storage facility. Destroy when 10 years old.

XI. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

The files described in this schedule are created in the administration of the Clinical Laboratory Improvement Amendments. CLIA establishes quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. CLIA requires facilities performing laboratory testing subject to CLIA apply for certification in the CLIA program. These facilities must pay biannual user fees to HHS which covers costs to administer the program.

A. Laboratory Personnel Report, Form CMS-114

Used to collect data regarding the qualifications of the laboratory director and all other laboratory staff which have supervisory or consultant responsibilities, or perform laboratory tests. It is used for laboratories which have been issued CLIA certificates and CLIA waivers.

DISPOSITION:

- a. Form CMS-114 (CYs 1992 through 1994) - Destroy immediately upon approval of schedule. **(Disposition Authority: N1-440-96-1, Item 5)**
- b. Form CMS-114 (from CY 1997 forward) - Cutoff file at the end of the calendar year. Transfer to a Federally-approved records storage facility 1 year after cutoff. Destroy 6 years after cutoff. **(Disposition Authority: N1-440-96-1, Item 5)**

B. Clinical Laboratory Application, Form CMS-116

Used to collect general information regarding clinical laboratories. This information includes address, CLIA identification number, name of director, type of laboratory, hours, number of operating sites, accreditation, and ownership information.

DISPOSITION:

- a. Form CMS-116 - Cutoff file at the end of the calendar year. Transfer to a Federally-approved records storage facility 2 years after cutoff. Destroy 6 years after cutoff. **(Disposition Authority: N1-440-96-1, Item 6)**
- b. CMS-116 Database - Destroy or delete data files when superseded, obsolete, or no longer needed for administrative, legal, audit, or other operational purposes. **(Disposition Authority: N1-440-96-1, Item 6)**

NOTE: If the CMS-116 application form data resides in a database management system with other CLIA program records, this DISPOSITION: applies only to the information in the system that was collected on the CMS-116 form.

C. User Fee Related Files

(1) Bank Media - These records document only the basic final transaction, money received by the lockbox bank and forwarded to CMS. Records include deposit tickets, debit vouchers, credit vouchers, account batch listings, and copies of checks received from laboratories to pay their CLIA User Fees.

DISPOSITION: Cutoff at the close of the calendar year in which paid, or voided, as applicable. Retire to a Federally-approved records storage facility 1 year after cutoff. Destroy 6 years and 3 months after cutoff. **(Disposition Authority: NC1-440-01-04, Item 1a(1))**

(2) Canceled Payments - These records are listings of refund checks that are returned to the United States Treasury. These listings include information necessary to reapply the money to the appropriate account(s).

DISPOSITION: Cutoff at the close of the calendar year in which paid, or voided, as applicable. Retire to a Federally-approved records storage facility 1 year after cutoff. Destroy 6 years and 3 months after cutoff. **(Disposition Authority: N1-440-01-04, Item 1a(2))**

(3) Refund Reports - These reports include the names and addresses of all person who overpaid CLIA and are receiving refunds. The reports are generated and forwarded to the United States Treasury who in turns sends the checks to the recipients.

DISPOSITION: Cutoff at the close of the calendar year. Retire to a Federally-approved records storage facility 1 year after cutoff. Destroy 6 years and 3 months after cutoff. **(Disposition Authority: N1-440-01-04, Item 1a(3))**

(4) Administrative Accounts Reconciliation Files - Correspondence, weekly reports and data relating to the user fee operation.

DISPOSITION: Cutoff at the close of the calendar year. Retire to a Federally-approved records storage facility 1 year after cutoff. Destroy 6 years and 3 months after cutoff. **(Disposition Authority: N1-440-01-04, Item 1a(4))**

D. CLIA Proficiency Testing Program Files

The proficiency testing (PT) is a means of measuring a laboratory's performance by comparing it to the accuracy of tests performed by laboratories across the nation. PT involves sending sample specimens with known values to each laboratory 3 times per year to evaluate which laboratory results match the specimens known value. PT samples are provided by private non-profit organizations, Federal or State agencies. The CLIA Amendments of 1988 require the annual approval of each PT program. The specific standards applicable to the annual approval of each PT program are found in 42 CFR 493.901 through 493.959. The PT program files include the letters, documents, correspondence and participant summary reports necessary for the annual approval of each PT program.

DISPOSITION: Annual Approval Letters, Documents and Correspondence - Maintain last 2 PT program approvals files onsite. **(Disposition Authority: N1-440-01-04, Item 1b(1))**

(1) Currently Approved PT programs - Cutoff at the end of the calendar year in which is approved, then retire to a Federally-approved records storage facility. Destroy 10 years after cutoff. **(Disposition Authority: N1-440-01-04, Item 1b1(a))**

(2) Discontinued PT programs - Cutoff at the end of the calendar year in which it is discontinued, then retire to a Federally-approved records storage facility. Destroy 5 years after cutoff. **(Disposition Authority: N1-440-01-04, Item 1b1(b))**

E. PT Participant Summary Reports - Cutoff at the end of the calendar year. Retire to a Federally-approved records storage facility 2 years after cutoff. Destroy 6 years after cutoff. **(Disposition Authority: N1-440-01-04, Item 1c)**

F. CLIA Validation Review Files (Disposition Authority: N1-440-01-04, Item 1d)

Documents related to annual validation review of laboratory accreditation organizations, whose accreditation programs have been approved as equivalent to the CLIA program requirements. The validation reviews evaluate the extent to which the accreditation organization's respective laboratories maintain equivalency in laboratory practices and testing.

DISPOSITION: Cutoff at the end of the validation review. Retire to a Federally-approved records storage facility 3 years after cutoff. Destroy 6 years after cutoff.

G. Electronic Mail and Word Processing System Copies

Electronic copies of records that are created on electronic and mail and word processing systems and used solely to generate a recordkeeping copy of the records covered by the other items on this schedule. Also includes electronic copies of records created on electronic mail and word processing systems that are maintained for updating, revision or dissemination.

(1) Copies that have no other administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

DISPOSITION: Delete after recordkeeping copy is made or when copies are no longer needed, whichever is later. **(Disposition Authority: N1-440-01-04, Item 1e(1))**

(2) Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy.

DISPOSITION: Destroy/delete when dissemination, revision, or updating is completed. **(Disposition Authority: N1-440-01-04, Item 1e(2))**

H. CLIA Accreditation Organization/Exempt State Approval Files (Disposition Authority: N1-440-08-1, Item A)

Documents related to CMS' approval under CLIA of a private nonprofit accreditation organization or a State with a State licensure program for laboratories in accordance with Subpart E of the CLIA regulations [42 CFR 493.551 to 493.575]. These files include the letters, documents and correspondence necessary to determine if the requirements of the accreditation organization or exempt State licensure program are equal to or more stringent than the CLIA condition-level requirements. CMS approval may not exceed 6 years (42 CFR 493.553(c)). Each CMS-approved accreditation organization or State may be approved from 1 to 6 years.

DISPOSITION: Maintain the most current approval onsite. Cutoff when the current approval is published in the Federal Register then transfer previous approvals to the CMS Records Storage Facility. Destroy 6 years after cutoff.

I. Post Clinical Laboratory Survey Questionnaire (Form CMS-668B) (Disposition Authority: N1-440-08-1, Item B)

The Post Laboratory Survey Questionnaire (form CMS-668B) is a 1-page questionnaire provided to a laboratory after their recent CLIA survey. The response questionnaire is entirely voluntary and is used to collect customer satisfaction data from laboratories to evaluate, on a nationwide basis, the laboratory's satisfaction with their recent CLIA survey. The information and suggestions provided by each laboratory will be used to evaluate and improve the CLIA survey process.

DISPOSITION: Maintain onsite the last two calendar years surveys. Transfer remaining survey responses to the CMS Records Storage Facility. Destroy when 6 years old.

XII. MEDIGAP

A. State Review Files

Documentation relating to the administrative review of State Medigap plan operations and certification procedures. Substantiates that the State has been and continues to meet the requirements as stated in Section 1882 of the Social Security Act. Included are State reviews that determine the degree of adherence to Federal Medigap requirements, plan approval, documentation, memoranda to insurance commissioners, regulations and similar material.

DISPOSITION:

(1) CMS Headquarters - PERMANENT. Cut off file annually. Maintain the last two reviews onsite. Transfer all other reviews to the Federal Records Center 3 years after cutoff. Transfer to the National Archives 13 years after cutoff. **(Disposition Authority: N1-440-96-1, Item 2)**

(2) Other Offices - Destroy 2 years after cutoff. **(Disposition Authority: N1-440-96-1, Item 2)**

B. Instructions/Background Files

Records accumulated in the preparation, clearance, and publication of manuals, directives, handbooks, and other formal policy and procedural issuances. Included are studies, clearance comments, recommendations, and similar records which provide basis for publication or contribute to the content of the issuance.

DISPOSITION:

(1) Office Responsible for Instructions Coordination - Cutoff file when no longer needed for current operations. Transfer inactive file to a Federally-approved records storage facility annually. Destroy 10 years after cutoff. **(Disposition Authority: N1-440-96-1, Item 3)**

(2) Other Offices - Destroy 2 years after the close of the calendar year in which dated. **(Disposition Authority: N1-440-96-1, Item 3)**

C. Program Files

Documents relating to reviews and special studies of CMS Central and Regional Offices, and Medicare contractors to determine the degree of adherence to established policy, instructions and specifications. Includes chronological files (also known as reading files).

DISPOSITION: Destroy 2 years after the close of the calendar year in which dated. **(Disposition Authority: N1-440-96-1, Item 4)**

XIII. PRESS OFFICE FILES

1. Press Release Files

Documents relating to the preparation coordination, clearance and dissemination of information to any public communications media. Includes drafts, clearance comments, forms, press releases and related papers.

DISPOSITION:

a. Record copy of Agency news releases, held by the CMS Press Office. PERMANENT. Transfer to the Washington National Records Center when 2 years old or until volume warrants. Transfer to the National Archives when 20 years old. **(Disposition Authority: N1-440-02-1, Item 1a)**

b. All other copies - Destroy when 2 years old. **(Disposition Authority: N1-440-02-1, Item 1b)**

2. Daily Press Service (News Clips) (Disposition Authority: N1-440-02-1, Item 2)

Daily compilation of articles and similar materials appearing in the press that relate to health care issues. The material is distributed for review by top-level CMS staff.

DISPOSITION: Destroy when 3 years old.

3. News Conference File (Disposition Authority: N1-440-02-1, Item 3)

Consists of transcripts of the Administrator's press conferences and some related background materials. Records are maintained in binders and arranged by date of press conference.

DISPOSITION: PERMANENT. Transfer to the FRC if volume warrants. Offer to NARA in blocks of 5 years when 20 years old.

4. Publication Planning and Clearance Request Form, HHS-615 (Disposition Authority: N1-440-02-1, Item 4)

This clearance form is used for the production of any CMS publication (as defined in the Public Affairs Management Manual). Approval of this form by the Public Affairs Office is mandatory before print production may proceed.

DISPOSITION: Destroy 5 years after the close of the fiscal year in which approved.

5. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories,

or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

DISPOSITION: Delete after the recordkeeping copy is made, or when copies are no longer needed, whichever is later. **(Disposition Authority: N1-440-02-1, Item 5)**

b. Copies used for dissemination, revision, or updating that are maintained in addition to the recordkeeping copy.

DISPOSITION: Destroy/delete when dissemination, revision, or updating is completed. **(Disposition Authority: N1-440-02-1, Item 5)**

XIV. ELECTRONIC SYSTEMS

A. NATIONAL HEALTH ACCUONTS ESTIMATES (NHEA) (previously named: MATRIX (MTX))

The database system that contains the National Health Accounts Estimates (NHEA) and other supporting data that is collected to identify all health expenditures in the nation and determine the amount and source of money used for the purchase of health related goods and services.

1. Input/Sources

a. **Paper inputs.** Paper records consisting of information obtained from both public and private sources, including reports from the Bureau of the Census, American Medical Association, and Bureau of Labor Statistics. Paper inputs are used both for initially entering new data into spreadsheets and also for later periodic benchmarking of NHEA data against new releases of Economic Census data and data quality verification.

DISPOSITION: TEMPORARY. Destroy upon verifying successful entry of data into NHEA system, or whenever no longer needed for administrative or operational purposes, whichever is later. (**Disposition Authority: N1-440-00-5, Item 1A1**)

b. **Electronic inputs.** Information obtained from both public and private sources, similar to those for paper inputs. Also includes spreadsheets into which analysts enter data they receive in order to load it into NHEA.

DISPOSITION: TEMPORARY. Destroy after verifying successful entry into the NHEA database or when no longer needed for administrative purposes, whichever is later. (**Disposition Authority: N1-440-00-5, Item 1A2**)

2. NHEA Data File. Accumulation of electronic data that is used to provide statistical information to track economy and forecast growth in health care expenditures. Includes historical and projected data from the National Health Expenditure Accounts including expenditures by source of funds (payer or program) and by type of service or product (goods and services). Data is cumulative. Data and analysis are conducted on an ongoing basis and provide current annual estimates as well as revisions to prior years.

DISPOSITION: PERMANENT. Cut off files annually. Transfer copy of the entire database (all years extant) to NARA immediately after cutoff in accordance with relevant NARA transfer guidance. Most recent transfer supersedes earlier transfers. (**Disposition Authority: DAA-0440-2013-0006-0001**)

3. Outputs (Annual Summary Reports)

CMS Publications that summarize the highlights of current spending and significant changes in spending and projections.

DISPOSITION: PERMANENT. Records are electronic. Cutoff annually. Transfer with NHEA data files. **(Disposition Authority: DAA-0440-2013-00006-0002)**

4. Documentation. Records required for planning, developing, operating, maintaining, and using the NHEA system. Included are systems specifications, file specifications, codebooks, records layout, user guides and output specifications.

DISPOSITION: PERMANENT. Transfer a copy to the National Archives with initial transfer of data files (Item 2) and output files (item 3) as specified in 36 CFR 1235.44. Any updates to documentation should be sent to NARA with subsequent transfers. **(Disposition Authority: N1-440-00-5, Item 1D)**

5. Backups of Files. Electronic copies of NHEA that are maintained in case the database is damaged or inadvertently erased.

DISPOSITION: TEMPORARY. Delete when replaced by a subsequent backup file or upon termination or migration of the NHEA system, whichever is sooner. **(Disposition Authority: N1-440-00-5, Item 1E)**

B. HEALTH CARE COMMON PROCEDURES CODES (HCPCS)

Records created and maintained for standardizing medical procedure codes used nationwide to bill physician/supplier products and services for Medicare.

1. Meeting Files. Consists of agendas, attendees, code requests, coding determinations, recommendations, meeting summaries, notices and related records documenting the meetings and accomplishments of the CMS HCPC Workgroup, National Panel, and Durable Medical Equipment Group.

a. Official Recordkeeping Copy maintained by HCPCS office.

DISPOSITON: Temporary. Cutoff when no longer needed for agency operations or reference. Transfer to Federal Records Center 10 years after cut off. Destroy 15 years after cutoff. **(Disposition Authority: N1-440-01-2, Item 1a)**

b. Other Copies

DISPOSITON: Temporary. Destroy when 3 years old or when no longer needed for reference, whichever is sooner. **(Disposition Authority: N1-440-01-2, Item 1b)**

2. HCPC Code Files. Requests received by CMS for alpha numeric or carrier defined codes (HCPCS coding). May contain correspondence, FDA approval letter, modification questionnaire, decision letters and related records supporting actions or requests such as videos or products.

a. Official Recordkeeping Copy of code files maintained by HCPCS office.

DISPOSITION: Temporary. Cutoff when no longer needed for agency operations or reference. Transfer to Federal Records Center 10 years after cut off. Destroy 15 years after cutoff. **(Disposition Authority: N1-440-01-2, Item 2a)**

b. Other Copies

DISPOSITION: Temporary. Destroy when 3 years old or when no longer needed for reference, whichever is sooner. **(Disposition Authority: N1-440-01-2, Item2b)**

c. Video Tapes

DISPOSITION: Temporary. Maintain videotape while the code is under review. After review is complete, transfer the videotape to the CMS Video-Tape Library. Destroy 5 years after transfer date or when no longer needed for agency operations, whichever is sooner. **(Disposition Authority: N1-440-01-2, Item2c)**

d. Sample Products

DISPOSITION: Temporary. Maintain product while the code is under review. After review is complete, dispose of 5 years after review or when no longer needed for agency business, whichever is sooner. **(Disposition Authority: N1-440-01-2, Item2d)**

3. Health Care Common Procedures Codes Database. Contains all procedure codes used to bill physician and supplier services for Medicare. The HCPCS system contains three levels of code: American Medical Association (all numeric); Health Common Procedure Codes (alpha-numeric); and Carrier-defined codes that begin with W, X, Y or Z.

a. **Data Input**

i. **American Medical Association (AMA) CPT-4 File.** Received electronically from AMA. (copyright material)

DISPOSITION: Temporary. Destroy AMA tape 1 year after receipt and data is verified. **(Disposition Authority: N1-440-01-2, Item 3a1)**

ii. **HCPCS Form.** Form is used to add, delete, or change procedure codes, carrier defined codes, and administrative data. Includes fields such as: procedure code, action, type of service, short description, coverage indicator, effective date, payment indicator, and other related information.

DISPOSITION: Temporary. Cutoff annually. Destroy 1 year after cutoff. **(Disposition Authority: N1-440-01-2, Item 3a2)**

b. **Data File.** Accumulation of electronic code data that is used to generate reports on medical codes. File contains information on procedure codes, descriptions, code action dates, and may contain applicable Medicare coverage, pricing indicators, and other related information.

DISPOSITION: Temporary. Destroy/delete data when superseded or obsolete, or when system is no longer needed for agency operations. (Also see PERMANENT Item 3(c)(1)(b), Electronic Copy of Annual Code Summary.) **(Disposition Authority: N1-440-01-2, Item 3b)**

c. **Outputs**

i. **Public Use Version of Annual Code Summary.** Alpha-Numeric Common Procedure Codes only that are published yearly along with the added, changed and discontinued codes.

a. Paper copy.

DISPOSITION: Temporary. Transfer one copy to CMS Library. Destroy all other copies annually when superseded by new annual code summary or no longer needed for agency business, whichever is later. **(Disposition Authority: N1-440-01-2, Item 3c1a)**

b. Electronic Copy.

DISPOSITION: PERMANENT. Transfer a copy of the Annual Code Summary, when codes are updated annually, to the National Archives and Records Administration (NARA) according to the NARA regulations in 36 CFR 1235.44, transfer of machine-readable records to NARA. A copy of the Annual Code Summary shall be sent to NARA immediately upon approval of the schedule and according to the schedule transfer regulations. **(Disposition Authority: N1-440-01-2, Item 3c1b)**

c. Web Publication.

DISPOSITION: Temporary. Delete 3 years after publication is superseded. **(Disposition Authority: N1-440-01-2, Item 3c1c)**

ii. **Internal Use Version.** Annual Summary that contains all levels of codes. Contains copyrighted material from AMA so it is for CMS use only.

a. Paper. Published annually and includes updates on added, changed and discontinued codes.

DISPOSITION: Temporary. Destroy annually when superseded by new annual code summary or no longer needed for agency business, whichever is later. **(Disposition Authority: N1-440-01-2, Item 3c2a)**

b. Electronic. Text file that resides on server maintained and accessed by CMS.

DISPOSITION: Temporary. Delete when superseded by new annual code summary. **(Disposition Authority: N1-440-01-2, Item 3c2b)**

d. **System Documentation.** Codebooks, record layout, user guides and other technical specifications.

i. **Copy sent to NARA (paper and electronic).**

DISPOSITION: Permanent. Transfer a copy annually to NARA along with electronic copy of Annual Code Summary (Item 3(c)(1)(b) as specified in 36 CFR 1235.44. **(Disposition Authority: N1-440-01-2, Item 3d1)**

ii. Copies maintained for agency use (paper and electronic).

DISPOSITION: Temporary. Destroy when superseded or obsolete. **(Disposition Authority: N1-440-01-2, Item 3d2)**

e. **Backup Files.** Electronic copies of the database that are maintained in case the database is damaged or erased.

DISPOSITION: Temporary. Delete when replaced by subsequent backup file or upon termination or migration of the system, whichever is sooner. **(Disposition Authority: N1-440-01-2, Item 3e)**

C. PHYSICIAN PRACTICE COST AND INCOME SURVEY (PPCIS) (Disposition Authority: N1-440-94-2)

The PPCIS system contains data collected to develop a Geographic Cost Practice Index, refine the cost share weights of the Medicare Economic Index, and evaluate Federal Reimbursement of Physicians participating in Medicare and Medicaid and other health care services, delivery and financing programs. Includes a sample of approximately 5,000 physicians who provide patient care at least 20 hours per week in an office or hospital setting, and who live in the 50 States and the District of Columbia. The data includes information on practice costs such as rent for space and equipment, employee salaries and compensation, malpractice insurance, physician gross and net income, and related fees and costs.

DISPOSITION: PERMANENT. Cutoff and offer files (along with a copy of the system documentation (codebooks, record layout, user guides and other technical specifications)) to the National Archives when 5 years old. If the National Archives refuses an offer, it may be destroyed when agency use ceases but not sooner than 1 year and 3 months after the cutoff.

D. ADMINISTRATIVE SIMPLIFICATION ENFORCEMENT TOOL (ASET)

ASET contains documentation of public complaints pertaining to the Administrative Simplifications provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ASET enables the Centers for Medicare & Medicaid Services (CMS) to collect, review, and manage documentation submitted by both the complainant and the Filed Against Entity (FAE), in order to evaluate the facts and determine if there are any issues related to compliance with the HIPAA regulations. The regulations for which CMS has enforcement authority include: The Transactions and Code Sets (TCS); the National Employer Identifier Number (EIN); and the National Provider Identifier (NPI). From 2003 through the summer of 2009, CMS did have authority to enforce the Security Rule, but on July 27, 2009, the Secretary of Health and Human Services transferred the authority to administer and enforce the Security Rule from CMS to the Office for Civil Rights.

1. Input/Sources

(a) Paper inputs. Paper inputs (complaint letters and forms downloaded from CMS website or mailed to CMS) scanned/entered into ASET from public and government sources. Inputs include filed complaint forms downloaded, and documentation to support an allegation of non-compliance filed against an organization and responses from the FAE (e.g. letters, policies, contracts, copies of other appropriate corporate documents; and corrective action plans).

DISPOSITION: Temporary. Delete 30 days after verifying successful entry of data per quality assurance procedures, pursuant to CMS Information, Eligibility, and Entitlement Manual: Publication 100-01, Chapter 7, Section 30 - Contract Administrative Requirements/Files Maintenance. **(Disposition Authority: NARA's GRS 20, Item 2a4)**

(b) Electronic inputs. Electronic inputs uploaded directly into ASET periodically from public and government sources and are accessible to CMS. Inputs include filed complaint forms and documentation to support an allegation of non-compliance filed against an organization and responses from the FAE (e.g. letters, policies, contracts, copies of other appropriate corporate documents; and corrective action plans). Inputs also include correspondence with the CMS Office of Civil Rights; CMS Contractor Enforcement Team recommendations for FAE responses; compliance review reports and documentation; and audit reports from the CMS Office of the Inspector General.

DISPOSITION: Temporary. Delete when data have been entered into the master file or database and verified, or when no longer need to support reconstruction of, or serve as backup to, the master file or database, whichever is later. **(Disposition Authority: NARA's GRS 20, item 2c)**

2. ASET Master File – The master file contains complaints and documentation to support allegations of non-compliance filed against an organization; responses from the FAE (e.g., letters, policies, contracts, copies of other appropriate corporate documents, and corrective action plans); correspondence with CMS Office of Civil Rights; CMS Contractor Enforcement Team recommendations for FAE responses; compliance reviews reports and documentation, audit reports from CMS Office of the Inspector General. The HIPAA Information Tracking System

(HITS) (a sub-system of ASET) maintains complaint data for tracking HIPAA complaint/compliance enforcement and reports.

DISPOSITION: Temporary. Destroy/delete 6 years after the CY in which the case is closed (includes complaints, compliance reviews and any other entries). **(Disposition Authority: N1-440-09-2)**

3. Outputs – Hard copy printouts created to meet ad hoc business needs (e.g., Enforcement Trends Reports, Tracking Reports, Open Case Reports, CMS Outstanding Action Item Reports, and ASET Weekly Statistics Reports).

DISPOSITION: Temporary. Destroy when agency determines that they are no longer needed for administrative, legal, audit or other operational purposes. **(Disposition Authority: NARA's GRS 20, Item 16)**

E. PERSONAL HEALTH RECORD (PHR) PILOT

The PHR pilot is a web-based electronic Personal Health Record offered to fee-for-service (FFS) Medicare beneficiaries in selected states across the United States which provides FFS beneficiaries with free access to a commercial off-the-shelf (COTS) electronic Personal Health record (PHR). The purpose of the system is to study the uptake and utilization of a Personal Health record to help Medicare develop the requirements for a Medicare-compliant Personal Health Record. Pilots include, but not limited to: MyPHRSC (My Personal Health Record – South Carolina); pilot for those living in South Carolina; PHR Choice: pilot for those living in Arizona and Utah.

1a. Inputs – Medicare beneficiary claims data who live in the selected states and who elect to participate in the pilot (hospitalizations; diagnoses which caused the inpatient stay, admission and discharge dates; procedures and/or surgeries, associated diagnoses, procedure dates, office visits, diagnoses; emergency contact information—name, relationship, phone number; medications-prescriptions, over-the-counter medications, vitamins, supplements; allergies—to medications, animals, insects and other substances; laboratory tests; medications); patient medication profile; medication data processed through TRICARE for Life. Inputs include the online registration form to use the PHR.

DISPOSITION: Temporary. Delete/destroy when pilot is completed or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-10-3, Item 1a)**

1b. Master Files – Medicare Part A, B, and Durable Medical Equipment claims data and medication profile of Medicare beneficiaries who live in the selected states and elect to participate in the 2-year pilot (hospitalizations; diagnoses which caused the inpatient stay, admission and discharge dates; procedures and/or surgeries, associated diagnoses, procedure dates, office visits, diagnoses; emergency contact information—name, relationship, phone number; medications-prescriptions, over-the-counter medications, vitamins, supplements; allergies—to medications, animals, insects and other substances; laboratory tests; medications); medication data processed through TRICARE for Life.

DISPOSITION: Temporary. Cutoff when pilot is completed. Delete/destroy 10 years after cutoff, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-10-3, Item 1b)**

1c. Outputs – Ad hoc reports.

DISPOSITION: Temporary. Destroy when no longer needed for administrative, legal, audit or other operation purposes, provided the printouts do not contain substantive information, such as substantive annotations, that is not included in the electronic records. **(Disposition Authority: N1-440-10-3, Item 1c)**

F. MEDICARE BENEFICIARY ENROLLMENT SYSTEMS (MBES)

A collection of automated systems that support the collection and maintenance of information (e.g., demographics, enrollment, insurance, premium payments) about Medicare beneficiaries. Includes but not limited to:

Enrollment Database – The authoritative source of information for anyone who has ever been entitled to receive Medicare. Both personal and financial information is stored on the system and is the single resource of managing Medicare entitlement data.

Medicare Beneficiary Database – The authoritative source of information required to support managed care enrollments and payments to Managed Care Organizations. Provides a centralized database that is able to communicate with other systems while being able to view, manage and update beneficiary information. Main repository for Medicare entitlement and demographic information for the entire managed care population of beneficiaries who are or have been entitled to receive Medicare. Additionally, the MBD collects and maintains data elements necessary for the new voluntary prescription drug benefit program required by Section 101 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

1a. Inputs – Personally identifiable information in the form of beneficiary name, birth date, address, date of death, Part A and Part B enrollment (current and historical), Medicare card issuance, Medicare Secondary Payer, third-party payer, Medicare Advantage enrollment, hospice information, cross-reference numbers, direct billing, disability data, ESRD data, prescription drug benefit program data. Enrollment and demographic information, entitlement and demographic changes, direct billing, death notices, third-party payments and Group Health Plan changes.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy 5 years after cutoff, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-6, Item 1a)**

1b. Medicare Beneficiary Enrollment System - Master Files

DISPOSITION: Temporary. Cutoff annually. Delete/destroy 30 years after cutoff or when no longer needed for Agency business, whichever is later.

1c. Outputs – Initial enrollment Period packages or enrollment letters; new, corrected or replacement Medicare cards; update Common Working File with new and changing beneficiary enrollment, entitlement and demographic information; monthly contractor files to mail new beneficiaries the Medicare handbook.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy 5 years after cutoff or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-6, Item 1c)**

G. MEDICARE FINANCIAL MANAGEMENT & PAYMENT SYSTEMS (MFMP)

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

Contractor Administrative Budget and Financial Management System (CAFM and CAFMII) - Manages Medicare contractor reporting to CMS of administrative expenses and benefits paid. Provides automated capabilities to CMS staff for monitoring the Medicare Contractors' administrative expenses and financial operations and for determining each Contractor's compliance with its individual budget. CAFM serves as the vehicle for tracking all benefit payments, banking issues, and CFO data. The FACMII system is the main vehicle for planning, administering and monitoring the administrative expenses of the Medicare contractor community. It also allows CMS to issue the Medicare Contractor's funding for a fiscal year using the separate allotments for Program Management and Medicare Integrity Program activities.

Contractor Audit and Settlement Reporting System (CASR) – Tracks budgeted and incurred costs for the Part A contractor audit and settlement functions by type of activity and type of provider or reporting entity. This report is Central office's instrument to develop a financial operating plan for audit related expenditures, to develop the cost effectiveness or savings of the audit and settlement function, to monitor the audit related expenditures and savings of each contractor and to alert the appropriate regional office of potential problems with a particular fiscal intermediary's performance.

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

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

CMS Activity Reporting and Tracking System (CMS-ART) – System of Record for tracking contractor business proposals, cost reports, deliverables, and workload information as well as copies of contractors and other government documents for all components that use the system.

Contractor Reporting of Operational and Workload Data System (CROWD) – Monitors each Medicare contractor's performance in processing claims and paying bills, the system contains workload reporting capabilities that allow the data to be used for estimating budgets, defining operating problems, comparing performance among Contractors, and determining regional and national workload trends.

Demonstration Payment System (DPS) – Used to prepare electronic payment files to be used by the agency's Financial Accounting Control System (will be replaced with Healthcare Integrated General ledger Accounting System (HIGLAS)) in generating payments through the United States Department of the Treasury.

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

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

Production Performance Monitoring System (PULSE) – Provides real-time analysis of claims processed, providing CMS immediate feedback to critical performance issues for all Medicare Contractors as well as the Common Working File (CWF) hosts. PULSE collects workload data from various reports that contractors send via Network Data Mover (NDM) to the CMS Data Center. All contractors input CMS monthly standard reports directly into the CROWD system for prior workload data. PULSE collects data from the forms CMS 1566/1565, CMS 1522 and CWF 207 and uses the data extracted from these reports to calculate key indicators, averages and standard deviations to identify variances, which are used for performance monitoring. Financial data reports contain the number of claims processed and the benefit dollars paid by claim type. CMS uses PULSE as a contractor management tool for monitoring purposes. The PULSE system displays information daily that is loaded into the CROWD system monthly. This information does not contain specific beneficiary level data but reflects a summary of contractor workload and financial data daily.

System Tracking for Audit and Reimbursement Medical Review System (STAR) – A CMS-owned system that is maintained by Mutual of Omaha and used by MACs for tracking the receipt

and subsequent actions taken on all providers cost reports. Also known as “System for Tracking & Reimbursement” or “System Tracking Audit and Reimbursement.”

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

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

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

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

DISPOSITION: Temporary. Cutoff at the end of the FY in which cost reports are produced. Delete/destroy 8 years after cutoff, or when no longer needed for Agency business, whichever is later. (**Disposition Authority: N1-440-09-16, Item 2**)

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

DISPOSITION:

- a. Any reports mandated by Congress. PERMANENT. Transfer the final report to the Federal Records Center 3 years after the report to Congress is released. Cutoff after the final report is released to Congress. **(Disposition Authority: N1-440-95-01, Item 6)**
- b. All other Reports. Temporary. Cutoff at the end of the FY. Delete/destroy 8 years after cutoff or when no longer needed for agency business, whichever is longer. **(Disposition Authority: N1-440-79-01, item 2b)**
- c. Ad Hoc Reports. Temporary. Destroy/delete when 1 year old or when no longer needed for Agency business, whichever is longer **(Disposition Authority: NARA's GRS 20)**

H. MEDICARE APPEALS SYSTEM

The Medicare Appeals System (MAS) is designed to support the new legislatively mandated appeals processes for traditional Medicare Fee-For-Service (FFS) and Managed Care (MC). The new FFS appeal process is required by the Benefits Improvement and Protection Act of 2000 (BIPA) where the methods of appeals for Part A and Part B claims are merged into one process. The Managed Care (Part C) process is required by the Balanced Budget Act of 1977 which required CMS ensure managed care enrollees have a formal appeals process to dispute an adverse determination by a Managed Care Organization (MCO).

Master Files – FFS and MC appeals data including appellant request(s) for appeal, medical documentation, additional evidence/documentation and appeal decision(s)/disposition(s).

DISPOSITION: Temporary. Cutoff at time of dismissal or final decision of the case. Delete/destroy 10 years after cutoff, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-5, Item 1b)**

I. MEDICARE PRICING SYSTEMS (MPS)

MPS is a family of subsystems that produce the pricing modules required to support the processing of claims via CMS' Shared Systems (Claims Processing Systems, job N1-440-04-03). Medicare contractors (Carriers, Fiscal Intermediaries, MACs, Regional Home Health Intermediaries, and Durable Medical Equipment Regional Carriers) use the Shared Systems/Claims Processing Systems (FISS, MCS and VMS) to process claims from providers such as physicians, laboratories and suppliers. The pricing modules support this process and contain rates, prices and pricing algorithms according to the type of service. After the pricing modules containing the Fee Schedules and Pricers have been produced by MPS, they are made available to the Shared Systems as files that can be downloaded from the CMS Mainframe. The modules or programs include the following:

- Pricers – pricing programs which contain computer code (there are several Pricers, such as an inpatient Pricer and a skilled nursing facility Pricer);

- Fee Schedules – files which contain prices (there are Fee Schedules for items such as clinical laboratory services, durable medical equipment, and physician services); and
- Grouper – software that translates variable such as age, diagnosis and surgical codes into a diagnosis related group (DRG).

The Medicare program provides for annual updates to the pricing modules, which occur on January 1 or October 1, the beginning of the new fiscal year. The annual updates are based on new regulations set forth by the federal register, changes to the wage index, and Congressional provisions. Quarterly updates are not performed unless required. MPS Includes, but is not limited to, the following subsystems:

Healthcare Common Procedure Coding System (HCPCS) - produces a file of Current Procedural Terminology (CPT) Codes from the American Medical Association (AMA) and American Dental Association (ADA), alphanumeric procedures form the HCPCS panel and descriptions and payment information for each code that is used for reporting medical services and procedures performed by physicians. Provides a list of descriptive terms and identifying codes as a uniform language to identify services. HCPCS codes are used throughout the MPS system, and are already scheduled as permanent under job N1-440-01-02.

Clinical Laboratory Fee Schedule (CLFS) – Maintains, updates, and disseminates Part B pricing data for services priced under the clinical lab fee schedule. CLFS prices claims submitted by Clinical Labs for Clinical Laboratory Services. Provides a file of prices by HCPCS for use in Contractor payment systems. Pricing is legislatively mandated.

Durable Medical Equipment Fee Schedule (DMEFS) – DMEFS prices claims submitted by Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers for Durable Medical Equipment (DME), orthotics, prosthetics and supplies. Provides a file of prices by HCPCS for use in contractor payment systems.

Investigational Device Exemption System (IDE) – Produces a file containing a number assigned to a device by the Federal Drug Administration (FDA), device category, device description, start and end dates. Used to add, change or delete information to track procedures to see if the number performed matches the number forecast. Provides a database of devices to FIs/MACs weekly for use in claims payment systems.

FDA Mammography Database (MQSA) – Inputs a file from the FDA; updates a database of certified mammography facilities and procedures creating a file containing facility ID, facility name and address and certification dates. MQSA provides information on certified facilities to contractors for claims payment.

Prospective Payment System (PPS) - Procedures, algorithms and other information used to perform various analyses based on legislation for the purpose of setting rates for paying services, covered under PPS.

PPS Pricing Software for Inpatient Stays System (PRICER) – PRICER prices claims submitted by a PPS provider for PPS covered services. Provides a software package to Contractors for use in payment systems.

Physician Fee Schedule (PSPRICE) – Produces a file of CPT and alphanumeric codes, i.e., HCPCS, fee schedule amounts, and payment indicators to price claims submitted by physicians. Provides a file of prices to the Contractors for use in payment systems.

Sustained Growth Rate (SGR) – Calculates the volume of services by fiscal year using physician reimbursement by carrier to provide CMS-Office of the Actuary with volume data for reports to Congress.

Wage Index (WI) – Part of the PPS system that calculates the adjustment factor for each core-based statistical area (CBSA) and rural area in each state to adjust standardized amounts for area differences in hospital wage levels by geographic area.

Master Files - The MPS receives data from sources both inside and outside of CMS. CPT-4 procedure codes from AMA, Device Data from FDA, Annual Service Counts from CMS' Part B Medicare Extract and Summary System (BESS), and information from CMS' Medicare Utilization Data Collection and Access Systems NCH Summary Process, and from CMS' Payment Policy Groups. The MPS data are updated annually. Systems include data on Fee Schedules; Procedure and Diagnosis Codes; ICD-9 Groupings; HCPCS Codes; CPT-5 procedure codes; Device Data and Mammography Equipment Certification Data from FDA; Pricing Information; Wage indices; Pricing Data Tables; Summarized physician/supplier data; SNF Pricing Algorithms; hospital wage data.

CLFS - Pricing information from CMS policy staff, procedure codes from HCPCS, annual services counts from BESS

DMEFS – Pricing amounts from DMERCs, procedure codes from HCPCS

GROUPER – Diagnosis related data

HCPCS – HCPCS Codes and data; CPT-5 Procedure Codes from AMA

IDE – Device Data from FDA (device category, device description, start and end dates)

MQSA – Mammography Equipment Certification Data from FDA

PPS, PRICER, SNFPRICER – Pricing Information; Hospital Wage Indices from PPS

PSPRICE – Pricing Data Tables, Procedure Codes

SGR – Summarized physician/supplier data from HCH Summary Process

WI – Hospital Wage Data from Cost Reports (from Health Date Provider Cost Report System – HCRIS)

DISPOSITION: Temporary. Cutoff at time of annual update. Delete/destroy each annual data file 10 years after cutoff or when no longer needed for Agency business, whichever is later.

(Disposition Authority: N1-440-09-8)

J. HEALTHCARE INTEGRATED GENERAL LEDGER ACCOUNTING SYSTEMS (HIGLAS)

HIGLAS is a dual-entry, general ledger accounting system that supports the Fee-For-Service Medicare contractor accounting systems with a single standardized system and processes approximately 4.5 million claims per day. HIGLAS improves accountability for Medicare

payments to physicians, hospitals and other providers servicing Medicare beneficiaries. HIGLAS is also used to support accounting for Medicaid and Children's Health Insurance program (CHIP) grants and to generate the CMS Financial Statements, including all vendor payments, payables and receivables.

Master Files – Claims, beneficiary, provider, non-claims, claim adjustments, one-time conversion data, check register updates, check status, Medicare Secondary Payer (MSP) debtor data and case data, grants, obligations, and commitments, vendor match, vendor acknowledgment, payments data, batch reports, and letters, voids and manual payments, grants, obligations, commitments, accruals, fund balances and expenditure, vendor offset updates, vendor extract

DISPOSITION: Temporary. Cutoff at the end of the FY. Delete/destroy 6 years and 3 months after cutoff, or when no longer needed for Agency business, whichever is later. (**Disposition Authority: N1-440-09-14**)

K. PROVIDER ENROLLMENT SYSTEMS (PES)

A collection of automated systems that support medical goods and services provider enumeration and enrollment in support of CMS' health insurance programs. Includes but not limited to:

National Plan and Provider Enumeration System – Assigns and manages unique identifiers for providers of health care systems. The system verifies the NPIs entered into PECOS during the enrollment process using asset of NPI matching criteria. The PECOS and NPPES applications operate together for the proper validation and verification of the NPIs entered by a user. PECOS produces a monthly Global Extract File that includes enrollment data for all approved enrollment records in PECOS. NPPES maintains one external connection to the Social Security Administration database for validation of Providers' social security numbers. NPPES is required to validate an individual provider's SSN when provided.

Provider Enrollment Chain and Ownership System (PECOS) – PECOS is the national Medicare enrollment system for Medicare providers and suppliers. The enrollment process is initiated when providers or suppliers submit a completed CMS 855 Medicare provider/supplier enrollment form type A, B, I, or R to a Medicare contractor. The CMS 855 form collects various types of provider/supplier data based on the provider's/supplier's reason for submittal. The submittal reasons are as follows:

- Initial Enrollment with Medicare
- Reactivation of Medicare enrollment
- Voluntary Termination of Medicare enrollment
- Revalidation of Medicare enrollment
- Change of Medicare enrollment information
- Change of Ownership of the Medicare enrolled provider
- Acquisition of or Merger with another organization
- Consolidation with another organization

- Enrollment with another fee-for-service contractor

Includes but is not limited to the following systems:

IRIS – A legacy mainframe system that stores a file with data concerning the assignments of interns and residents at teaching hospitals. The file contains personally identifiable employment, demographic and education data covered under the Privacy Act for the residents and interns. The data are used for research and to detect improperly overlapping assignments.

Medicare Exclusion Database (MED) – Central repository of sanctioned providers. The MED system receives updates each month from HHS OIG of new sanctions and reinstatements. New sanctions are added to providers to provide a history of a provider's sanctions.

Unique Provider Identification Numbers (UPIN) – National registry of physicians and other practitioners, which contains verified, approved Medicare physician Identification and Eligibility records (MPIERS) in ascending UPIN order.

National Provider Identifier (NPI) Crosswalk System – All health care payers must be able to cross-refer a provider identified by an NPI to master provider records identified by other legacy identifiers and housed in the respective claims processing or ancillary system. Thus, CMS must cross-refer an NPI to the various legacy provider identifiers in the Medicare systems.

Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS) Bidding System (DBidS)

DBidS is a web application for Durable Medical Equipment suppliers who wish to bid for specific product and service categories in a prescribed competitive bidding area. The bidding window is for a 60 day period, and those suppliers that do not participate or are not awarded a contract cannot bill for the product category. Datasets are received from the Provider Enrollment, Chain and Ownership System (PECOS), CBIC, and Individuals Authorized Access to CMS Computer Services (IACS).

Provider Enrollment, Economic and Attributes Reports (PEAR) System

PEAR reports contain information on Part D enrollment and Part D drug utilization. The reports enable Part D data to be sorted by geographical and demographical filters. The PEAR reports enable retirement of the MIIR System by placing all of MIIR's reports in the IDR. PEAR also provides enrollment reports on Part A and B Medicare enrollees.

1a. Inputs – Provider/supplier data based on the provider's/supplier's reason for submittal of form CMS 855 (Provider/Supplier and Durable Medical Equipment Supplier Application); monthly updates from HHS-OIG of new provider sanctions and reinstatements; monthly file of profile information on all Durable Medical equipment suppliers; profile information on all ID number such a date of birth, date of death or carrier numbers; assignments of interns and residents at teaching hospitals that contains personally identifiable employment, demographic

and education data; DMEPOS supplier information, user ID and p, bids from DMEPOS suppliers for DME products and services.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy when 15 years old, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-18, Item 1a)**

1b. Master Files – Static information developed by the NHIC Registry Staff such as newsletters, links and Frequently Asked Questions; UPIN Registry; provider/supplier enrollment information (CMS 855 (Provider/Supplier and Durable Medical Equipment Supplier Application); monthly updates from HHS-OIG of new provider sanctions and reinstatements; monthly file of profile information on all Durable Medical equipment suppliers; profile information on all ID number such a date of birth, date of death or carrier numbers; assignments of interns and residents at teaching hospitals that contains personally identifiable employment, demographic and education data; bid data for durable medical equipment products and related services, DMEPOS registration and supplier information; Part D enrollment and drug utilization information as well as enrollment information on Part A and B Medicare enrollees.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy when 15 years old, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-18, Item 1b)**

1c. Outputs – Ad hoc reports, electronic version of the Carrier Workload Report, Monthly Global Extract File that includes enrollment data for all approved enrollment records in PECOS; provider data, UPIN Registry; selected DMEPOS suppliers recommended for contracts to supply durable medical equipment; PEAR reports.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy 5 year after cutoff, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-18, Item 1c)**

L. RETIREE DRUG SUBSIDY (RDS)

A paperless enrollment and payment system designed to systematically account and disburse reimbursements to Plan Sponsors with approved applications that provide drug coverage for Medicare eligible retirees that is actuarially equivalent to Medicare Part D.

1a. Inputs –Plan Sponsor data (e.g., name, address, and EIN of Plan Sponsor, type of organization, identities of RDS Account Manager and Authorized Representative, etc.); application data (e.g., name of plan, start and end date of RDS plan year, name of benefit options, bank routing information, actuarial attestation, identity of designees, etc.); initial list of retirees for which a Plan Sponsor wishes to receive subsidy (e.g., name, SSN or HICN, date of birth, etc.); drug cost and price concession (e.g., rebate) data; requests for appeals (i.e., reconsideration requests and reopening requests); recorded phone calls and notes; written inquiries (hardcopy and e-mail); American Academy of Actuary membership files.

DISPOSITION: Temporary. Delete/destroy when 10 years old, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-12, Item 1a)**

1b. Master Files – Personal information such as, social security information, home address and phone number, payment information such as payments to plan sponsors, payroll, automated decision making, procurement, market-sensitive, inventory, other finally related systems and site operating and security expenditures.

DISPOSITION: Temporary. Delete/destroy when 10 years old, or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-12, Item 1b)**

1c. Outputs - Emails to Plan Sponsors and other parties (e.g., reminder e-mails, confirmation e-mails, payment and application determinations, etc.); Retiree list response files; Retiree notification files (sent when an event that could impact a given retiree's eligibility for RDS might be impacted); Payments; Education and training materials (e.g., announcements, newsletters, event documentation such as transcripts and meeting notes, RDS Secure Web Site User Guide, FAQs; Guidance materials (e.g., relevant statutes, regulations, sub regulatory guidance documents).

DISPOSITION: Temporary. Delete/destroy when 10 years old. **(Disposition Authority: N1-440-09-12, Item 1c)**

M. STRATEGIC WORK INFORMATION FOLDER TRANSFER (SWIFT)

SWIFT is a workflow/document management system for the Agency's inquiries and Freedom of Information Act requests. Includes but not limited to tracking and controlling Executive correspondence, Reports to Congress, invitations received by the Administrator's Office to make public appearances and attend meetings received on or after June 1, 2008; supports CMS offices and contractors function of complying with legal requirements in the administration of public requests for records under the FOIA necessary for the various workflow processes inherent in the tracking, searching, retrieving, redacting, and releasing of FOIA-requested records received on or after January 1 2009.

1. Input/Source Records

1a. Description of incoming correspondence (date of letter, addressee and sender's name, address, organization), folder creation date, CMS Coordinator's name, Status of assignment, due date, document details (subject/synopsis description); document category (e.g., White House, Congressional, Private Sector, lawyers, etc.); Reports to Congress; Closing Details (signed by, signature type, response type, closing office, closing remarks, date signed, date mailed, date closed)

DISPOSITION:

1a1. Paper Documents (Recordkeeping Copy). PERMANENT: Cutoff annually. Transfer to the National Archives and Records Administration in 5-year blocks in accordance with 36 CFR

1235.44. (**Disposition Authority: N1-440-07-1, Item 9 for Executive Correspondence and N1-440-95-1, item 6 for Congressional Reports**).

1a2. Electronic Records. Temporary. Cutoff annually. Destroy/delete 1 year after cutoff, or when no longer needed for Agency business, whichever is longer. (**Disposition Authority: NARA's GRS 20, Item 2a4**)

1b. Electronic and paper FOIA requests - Includes but are not limited to: names and addresses of requesters, scanned copies of incoming requests, types of records requested, FOIA-specified categories of requesters, notes regarding the efforts of staff / contractors to fulfill records requests, estimated and actual cost data to fulfill requests, current status of requests, types of fees assessed, names of program offices and contractors involved in the fulfillment of requests, etc.

Temporary. Destroy/delete after information has been converted to an electronic medium and verified (**Disposition Authority: NARA's GRS 20, Item 2a4**).

2. Master files

Includes but not limited to: Executive Correspondence/Reports/Requests for Meetings received on or after June 1, 2008 and FOIA requests and appeals received on or after January 1, 2009.

DISPOSITION:

a. Executive Correspondence/Reports/Meeting Requests - Temporary. Cutoff closed and/or inactive jobs annually. Destroy/delete 2 years after cutoff or when no longer needed for agency business, whichever is longer. (**Disposition Authority: N1-440-09-19, Item 2a**)

b. FOIA Completed/Inactive Requests - Temporary. Cutoff annually and destroy/delete 2 years after cutoff. (**Disposition Authority: NARA's GRS 14, item 13**)

c. FOIA Denials/Appeals – Temporary. Cutoff annually and destroy 6 years after the final decision/appeal. (**Disposition Authority: NARA's GRS 14, Item 13**).

3. Outputs

a. Summary Reports, Electronic – electronic copies of reports for all executive correspondence and Congressional Reports tracked by the SWIFT system, including all fields. (**Disposition Authority: N1-440-09-19, Item 3a**)

DISPOSITION: PERMANENT. Produce electronic report(s) of closed and/or inactive jobs at time master file is cutoff. Transfer electronic copy in an acceptable format (following current CFR guidelines) to the National Archives 3 years after master file is cutoff^{3b}. Summary Reports, Hardcopy – hardcopy copies of reports for all executive correspondence and congressional reports tracked by the SWIFT system, including all fields, arranged by close date.

b. Summary Reports, Hardcopy – hardcopy copies of reports for all executive correspondence and congressional reports tracked by the SWIFT system, including gall fields, arranged by close date. **(Disposition Authority: N1-440-09-19, Item 3b)**

DISPOSITION: PERMANENT. Produce hardcopy report(s) annually of closed and/or inactive jobs. Transfer copy during transfer of textual records that the report corresponds to (authorize by jobs N1-440-07-1, Item 9 for Executive Correspondence and N1-440-95-1, item 6 for Congressional Reports).

c. Reports – Other reports not covered above, i.e., FOIA Correspondence/FOIA status Reports, Activity Reports, Reports on the overall performance of FOIA activities and work processes within CMS. Statistical FOIA data for submission to HHS for inclusion in the annual report of FOIA activity. CMS FOIA activity data used to evaluate overall performance of FOIA work processes within the agency. **(Disposition Authority: NARA’s GRS 20, item 12)**

DISPOSITION: Temporary. Cutoff annually. Destroy/delete 2 years after cutoff.

d. Ad Hoc Reports

DISPOSITION: Temporary. Cutoff annually. Destroy/delete 1 year after cutoff, or when no longer need for Agency business, whichever is later. **(Disposition Authority: NARA’s GRS 20, item 12)**

N. WEBSITE RECORDS (Disposition Authority: N1-440-09-13)

1. Published Web Content - All the HTML-encoded pages, interactive applications, databases, and other information posted to the web. The agency website, (www.cms.hhs.gov), provides information to the public and agency clients about the agency and its services. Content published on the web/intranet site is covered by the records schedule of the component organization that originated the content. The website includes but not limited to web versions of the following: Information about the agency including mission statements, organizational structure, budgeting, and strategic planning; Press releases and information about special events and conferences; Agency policies and guidance; Statistics and research conducted by the agency; Grant opportunities; Information about agency programs and services; and links to online resources related to agency services and programs.

DISPOSITION: Temporary - Destroy/delete when superseded or obsolete.

2. Published Intranet Content – The agency’s Intranet Website (<http://cmsnet.cms.hhs.gov>) includes but not limited to web versions of information (news and events, information and links to staff resources and services, policy and guidance, organizational charts, staff directories, information about agency projects, strategic planning) for agency staff. Content published on the web/intranet site is covered by the records schedule of the component organization that originated the content.

DISPOSITION: Temporary. Destroy/delete when superseded or obsolete.

3. Web Content Snapshot - Snapshot of agency public website and intranet website taken before significant changes are implemented (i.e. change of administration, website redesign).

DISPOSITION: Temporary. Delete/Destroy when 1 year old or when no longer needed for administrative, legal, audit, or other operational purposes, whichever is later.

Web Management and Operations Records

4. Web policies and procedures - Records reflecting the policies and procedures established to ensure oversight of agency web content (internet and intranet). This includes policies outlining the process by which materials are added, changed and/or deleted from the websites.

DISPOSITION: Temporary. Delete/Destroy when 1 year old or when no longer needed for administrative, legal, audit, or other operational purposes, whichever is later.

5. Website design records - Records produced in the process of developing and updating design and implementation of pages on the agency websites (internet and intranet), including design records and templates.

DISPOSITION: TEMPORARY. Delete/destroy when 1 year old or when no longer needed for administrative, legal, audit, or other operational purposes, whichever is later.

6. Software records – Records about the products used in the creation and maintenance of the agency websites (internet and intranet). These records include identification of product versions and licenses.

DISPOSITION: Temporary. Cut off at the end of the calendar year when product is replaced. Destroy/delete 2 years after cutoff.

7. Records Relating to System Usage - Electronic files and hard copy printouts created to monitor system usage, including, but not limited to, log-in files, password files, audit trail files, system usage files, and cost-back files used to assess charges for system use.

DISPOSITION: Temporary. Delete/Destroy when 1 year old or when no longer needed for administrative, legal, audit, or other operational purposes, whichever is later.

8. Records Relating to System Performance Testing - Electronic files or records created solely to test system performance, as well as hard copy printouts and related documentation for the electronic files/records.

DISPOSITION: Temporary. Delete/Destroy when 1 year old or when no longer needed for administrative, legal, audit, or other operational purposes, whichever is later.

O. PAYMENT QUALITY REVIEW SYTEMS (PQRS) (Disposition Authority: N1-440-09-11)

A collection of automated systems that supports the review of Medicare Program payments for medical goods and services. Quality review areas include, but may not be limited to overpayment, duplicate payment, fraud and abuse, monetary penalty tracking, and overall benefit savings. Includes but not limited to:

Fraud Investigation Database (FID) – FID is a nationwide data entry and reporting system run out of the CMS Data Center that allows CMS to monitor fraudulent activity and payment suspensions related to Medicare and Medicaid providers. FID captures information on investigations of potential Medicare or Medicaid fraud, fraud and abuse cases that have been referred to law enforcement and payment suspensions that have been imposed on Medicare providers. FID tracks fraud cases as they move through development to final disposition as well as, provider payment suspensions from the imposition to removal, identifies emerging fraud issues on a national and regional level; improves the prevention and detection of fraud and abuse in the Medicare and Medicaid Programs; FID also provides reporting capabilities on the data captured in the system.

Mistaken Payment Recovery Tracking System (MPARTS) – MPARTS is the conduit for maintaining a summary database to serve as a master control file for mistaken payment recoveries resulting from the IRS/SSA/CMS Data Match Project. **(Superseded Disposition Authority: N1-440-01-05)**

Provider Overpayment Recovery (POR) System – POR is used to track overpayments of Medicare and Medicaid monies to hospitals, skilled nursing facilities, and other Part A entities. POR accepts overpayment information, such as the claim determination date, the initial overpayment balance and principal and interest collections and displaying the current balance due, the total principal amount recouped to date, and the total interest amount recouped to date. This data comes from the contractor's internal accounting systems and is entered into the CMS mainframe computer.

Physician/Supplier Overpayment Recovery (PSOR) System – PSOR tracks overpayments of Medicare and Medicaid monies to physicians and suppliers. PSOR accepts overpayment information, such as the claim payment date, the claim determination date, the initial overpayment balance and principal and interest collections and displaying the current balance due, the total principal amount recouped to date, and the total interest amount recouped to date from the contractor's internal accounting systems and is entered into the CMS mainframe computer.

Recovery Management and Accounting System (ReMAS) – Identifies potential Medicare overpayments resulting from Medicare paying claims as primary or conditionally, while legally being a secondary payer to group health plans, liability insurers, workers' compensation carriers and class action liability settlements. ReMAS transfers verified overpayment information to the Health Integrated General Ledger Accounting System (HIGLAS). ReMAS provides case creation and tracking, letter generation, correspondence tracking and a standard reporting capability. ReMAS identifies Medicare Secondary Payer debt in a more timely manner;

manages and controls MSP recovery cases in a centralized database; tracks all financial activity on the MSP case.

System for MSP Automated Recovery and Tracking (SMART) – SMART tracks debts owed to the Medicare Trust Fund due to Group Health Plan (GHP) MSP overpayments. GHP MSP overpayments are claims that Medicare paid as the primary payer when the beneficiary meets the condition of Working Aged, End Stage Renal Disease, or Disability Under Age 65 and is covered by another Insurer under a GHP who should have paid as the primary. SMART receives GHP Case Information from ReMAS for the purpose of establishing Account receivables and issuing Demand Letters. The case information includes Employer debtor information, insurer information and Paid Claim information, as well as, Beneficiary and Provider Information associated with the Paid Claims. Functions supported by SMART: generates and stores records of outgoing correspondence for reference of case activities, posting recoveries, adjusting and writing off account balances, establishing an audit trail of recoupment activities, generates CMS-mandated reports and letters, including CFO reporting and MSP Savings, referral of eligible debts to Treasury for collection.

MSP Automated Recovery and Tracking Initiative (MARTI) – Tracks debts owed to the Medicare Trust Fund due to Non-Group Health Plan (Non-GHP) MSP overpayment. Non-GHP MSP overpayments are claims that Medicare paid as the primary payer when liability, worker's compensation, malpractice, or no-fault insurance entitles should have paid as the primary payer. Functions supported by MARTI: Generating and storing a record of outgoing correspondence for reference of case activity, posting recoveries, adjusting and writing off account balances, establishing an audit trail of recoupment activities, generating CMS-mandated reports and letters, including COP reporting and MSP Savings; referral of eligible debts to Treasury for collection.

Payment Error Rate Measurement (PERM) System - PERM is a comprehensive, ongoing federal audit intended to measure how frequently errors occur when providers submit claims to states and when states pay those claims. PERM is designed to estimate the proportion of Medicaid payments made in error. The estimated payment error rate is calculated as the ratio of the dollar value of all inaccurate payments to the dollar value of the total payments. The dollar amounts of any errors identified (overpayments and underpayments) are tracked and used to calculate the final payment error rate. The state-specific estimates will be used to establish national payment error rates for Medicaid and SCHIP. States are required to reimburse CMS for payment errors identified. States will, in turn collect dollars in error from Providers.

1a. Inputs – outgoing correspondence for reference of case activity, posting recoveries, account balances, recoupment activities, CMS-mandated reports and letters, including COP reporting and MSP Savings; eligible debts for collection; overpayment data from providers; Medicare Secondary Payer, Medicaid/CHIP claims data from States and medical records from Providers.

DISPOSITION: Temporary. Cut off annually. Delete/destroy 5 years after cutoff, or when no longer needed for Agency business, whichever is later. (**Disposition Authority: NARA'S GRS 20, item 2**)

1b. - Master Files - outgoing correspondence for reference of case activity, recoveries, account balances, audit trail of recoupment activities, CMS-mandated reports and letters, eligible debts referred to Treasury for collection; provider overpayments; MSP, Medicaid/CHIP claims data, medical records from providers.

DISPOSITION: Temporary. Cut off annually. Delete/destroy 10 years after cutoff or when no longer needed for Agency business, whichever is later. **(Disposition Authority: N1-440-09-11)**

1c. Outputs

1c1. CMS Mandated Reports, Letters and Collection Referrals

DISPOSITION: Temporary. Cut off annually. Delete/destroy 10 years after cutoff or when no longer needed for Agency business, whichever is later. **(Disposition Authority: NARA's GRS 20, item 6)**

1c2. Adhoc Reports

DISPOSITION: Temporary. Cut off annually. Delete/destroy 1 year after cutoff or when no longer needed for Agency business, whichever is later. **(Disposition Authority: NARA's GRS 20, item 16)**

P. HEALTH CARE QUALITY IMPROVEMENT SYSTEMS (HCQIS) (Disposition Authority: N1-440-09-3)

Data system distributed over a Wide Area Network (WAN) in a client server environment, containing all the data and software a Peer Review Organization (PRO) needs to fulfill their contractual requirements with CMS. The PROs are required to initiate quality improvement projects and analyze data to improve processes or quality of care. HCQIS facilitates the timely provision of Medicare claims data for sophisticated data analysis and the development of local and national quality improvement projects for widespread implementation and impact on the Medicare population. Records include but not limited to:

- Clinical, survey and project data from Medicare and Medicaid providers
- Certification and assessment data from End Stage Renal Disease (ESRD) providers
- ESRD patient and provider information
- Summarized data for payment error rates by state and nationally
- Electronic data entry and reporting system for approximately 4000 dialysis facilities in the U.S.
- Survey & Certification and Patient Assessment
- Quality Indiciary Report for use by nursing homes and surveyors
- Clinical information on patients in nursing homes and patients in home health agencies, rehabilitation hospitals
- Financial incentives for eligible professionals to participate in a voluntary quality-reporting program.
- QIO

Includes but is not limited to the following systems:

Consolidated Renal Operations in a Web-Enabled Environment (CROWN) – Facilitates the collection and maintenance of information about the Medicare End Stage Renal Disease (ESRD) program, its beneficiaries and the services provided to beneficiaries. Includes but is not limited to the following applications and information collection activities: ESRD patient, provider, facility, facility personnel and events data; ESRD Medical Evidence Report, Medicare Entitlement and/or Patient Registration, ESRD Death Notifications, In-Center Hemodialysis Clinical Performance Measures; clinical performance measures. Includes but not limited to Vital Information System to Improve Outcomes in Nephrology (VISION), ESRD Standard Information Management System (SIMS), Renal Management Information System (REMIS).

Quality Improvement and Evaluation System (QIES) – Supports a suite of applications and tools designed to provide states and CMS with the ability to use performance information to enhance onsite inspection activities, monitor quality of care, and facilitate providers' efforts related to continuous quality improvement. Includes summarized data for payment error rates by state and nationally, provider certification and assessment data, provider compliance, provider deficiency, complaints about providers, enforcement actions against providers, survey tracking and scheduling activities, assessment collection activities, quality indicators and other quality and payment information, clinical data on patients in rehabilitation hospitals. Includes but is not limited to the following applications and information collection activities: Minimum Data Set and Outcome and Assessment Information Set, Data Management Systems, Quality Indicator Reporting, Inpatient Rehabilitation Facility Patient Assessment Instrument, Inpatient rehabilitation data from National Assessment Collection Database, Swing Bed Assessments and Data Processing System, Swing Bed Viewer, FI and RHHHI Extract Tools, QIES Metadata Application, Dashboard Reports, Survey and Certification Management Reporting, CASPER Reports

Survey and Certification Data

DISPOSITION: Temporary. Delete/destroy after 4 survey cycles or 10 years whichever is later. **(Disposition Authority: N1-440-09-03)**

Assessment Data

DISPOSITION: Temporary. Cutoff annually. Delete/destroy when 20 years old. **(Disposition Authority: N1-440-09-3)**

Physician Quality Reporting Initiative (PQRI) – Collects and maintain individually identifiable information for all eligible professionals who voluntarily participate in the PQRI. Eligible professionals report on a designated set of quality measures for services paid under the traditional fee-for-service program, may earn a bonus payment subject to a cap. Information is collected on eligible professionals voluntarily participating in PQRI. Information is collected on patients of participating providers from the CMS 1500 (Claim Form) and the 837-P electronic transaction claim. The information includes but not limited to name, address, phone number, social security number, taxpayer ID number, unique physician ID number, (UPIN) and National

Provider Identifier (NPI). Patient health information for provider patients will include, but is not limited to: Health Insurance Claims Number and social security number. Eligible professionals' NPI must be listed along with the Healthcare Common Procedure Coding System codes for services, procedures, and quality data on the claim. Eligible professionals must consistently use their NPIs to correctly identify their services, procedures and quality-data codes for an accurate determination of satisfactory reporting. The following functions are supported within the PQRI application: Measure Analytics, Measure Applicability Validation, payment Calculation, Feedback Reports, Web Application.

Standard Data Processing System (SDPS) - Consists of many data and reporting requirements that have been designed and developed in response to the ongoing ADP requirements of the various QIOs and other affiliated partners to fulfill its contractual requirements with CMS. Provides individual medical records, aggregate medical data, clinical data and financial data related to medical claims. Through the SDPS, the QIOs have a database of current Part A claims data, ad hoc capability to access Part B data, access to national data sets, software tools for data analysis, report generation tools and project information.

Quality Improvement Initiative (QII) – Assists Medicare beneficiaries and their caregivers by promoting the availability of quality measures, helping to ensure they understand what the measures mean, and encouraging them to use the measures as part of their health care decision making process. QIO will assist Medicare beneficiaries and their caregivers by promoting the availability of the quality measures, helping to ensure they understand what the measures mean, and encouraging them to use the measures as part of their health care decision making process.

End Stage Renal Disease (ESRD) Measures Development and Analytics System

ESRD QIP is a national value-based purchasing (VBP) program. The ESRD QIP complements existing ESRD quality initiatives, and adds a financial penalty when Medicare facilities do not deliver high quality patient care. Under the ESRD QIP, facilities or providers that cannot meet or exceed the QIP standards, face reductions up to 2% from their claims payments.

QualityNet

QualityNet provides healthcare quality improvement news, resources and data reporting tools and applications used by healthcare providers and others. QualityNet is the only CMS-approved website for secure communications and healthcare quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end stage renal disease (ESRD) networks and facilities, and data vendors. The goal of QualityNet is to help improve the quality of health care for Medicare beneficiaries by providing for the safe, efficient exchange of information regarding their care.

Financial Invoice Voucher System (FIVS)

FIVS contains financial data provided by Quality Improvement Organizations (QIOs) which is used to track the state's spending.

1a. Inputs – ESRD patient, claims, provider facility, facility personnel and events data; ESRD Medical Evidence Report, Medicare Entitlement and/or Patient Registration, ESRD Death Notifications, In-Center Hemodialysis Clinical Performance Measures; clinical performance measures; summarized data for payment error rates by state and nationally, provider certification and assessment data, clinical data on patients in rehabilitation hospitals, clinical information collected from residents in nursing homes and patients in home health agencies (HHA), MDS and OASIS assessment submissions from nursing homes and home health agency providers. QIOs enter a budget for each state contract for each statement of work and monthly vouchers into the system. A Statement of Work Budget Form is called a Best and Final Offer (BAFO). Monthly Voucher Forms include: F618B, F719A, F719, SF1034, 618ODC, 618IC, 618FB.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy when no longer needed for Agency business. (**Disposition Authority: NARA's GRS 20, item 2b**)

1b. Health Care Quality Improvement Systems - Master Files

ESRD patient, provider, facility, facility personnel and events data; ESRD Medical Evidence Report, Medicare Entitlement and/or Patient Registration, ESRD Death Notifications, In-Center Hemodialysis Clinical Performance Measures; clinical performance measures; summarized data for payment error rates by state and nationally, provider certification and assessment data, clinical data on patients in rehabilitation hospitals, clinical information collected from residents in nursing homes and patients in home health agencies (HHA), MDS and OASIS assessment submissions from nursing homes and home health agency providers; baseline and performance period calculations, achievement and improvement scores for each clinical measure, earned performance scores for all measures, performance rates or ratios for clinical measures, applied performance standards, performance scores and payment reduction percentages across facilities, and providers/facilities and corresponding payment reduction percentages. FIVS data is financial, not personal. The QIOs from all states and territories general submit annual budgets and vouchers on a monthly basis.

DISPOSITION: Temporary. Cutoff annually. Delete/destroy when 10 years old, or when no longer needed for Agency business, whichever is later. (**Disposition Authority: N1-440-09-3**)

1c. Outputs –Reports, Adhoc queries, Forms, (Includes but is not limited to: ESRD Facility/Patient information, Form CMS-2744, CMS Annual Report Tables, Quality Improvement Projects, Mortality Rate Reports, Population Trends Report, Report on Status of QIOs, Dialysis information, transplant information and ESRD coverage and patient status information, ESRD Renal Provider and Facility Survey Files, Statistics on Patient Measures, Quality Indicator Reports for use by nursing homes and surveyors, State Agency Performance Reports, Survey and Certification Reports, oversight management reports, summary and trend reports, facility reports, Home Health Quality Indicator Reports, Nursing Home and Home Health Agency reports, Data Accuracy and Verification Reports for nursing homes, Pre-review Reports for Nursing Home Quality Measures, Oversight Management Reports for nursing homes, Nursing Home management reports, standard survey reports for all provider types); reporting- and performance-rate analyses; payment calculations; payment data files; feedback reports, MDS QI reports, feedback reports, MDS and OASIS databases. There are 16 reports

that can be generated by FIVS. The reports are run on a monthly, quarterly, and yearly basis. They are used to track the state's spending throughout the SOW. The reports are administered by CMS.

DISPOSITION: Temporary. Adhoc Queries, Reports, Forms, etc. - Cutoff annually. Delete/destroy when no longer needed for Agency business. (**Disposition Authority: NARA's GRS 20, item 5**)

Q. AGENCY PILOTS

Pilot projects developed to test and evaluate the feasibility of new electronic systems before they are considered for conversion to CMS use. These pilots promote the effective, efficient and economical delivery of program-related services, the development of federally supported health-related programs, as well as the administrative functions of CMS.

Pilots may utilize data of pre-existing scheduled systems to test the effectiveness of delivery, uptake and/or use of CMS-sponsored information. CMS will revisit the retention for data within any pilot that leads to the full implementation of a new system.

1. Administrative pilots – Systems developed to streamline or to study the streamlining of administrative functions of CMS. Records/data may include but are not limited to forms, data input, applications, charts, reports, correspondence, etc.

DISPOSITION: Temporary. Cut off at end of year in which pilot project was completed. Destroy 5 years after cutoff. (**Disposition Authority: N1-440-11-2, Item 1**)

2. Program-related pilots – Systems developed to conduct research, streamline or to study the streamlining of program functions of CMS before they are considered for conversion to CMS-related programs. Records/data may include but are not limited to: data from Medicare contractors, beneficiaries, States, providers of services (physicians, hospitals, state agencies, etc.), applications, reports, correspondence, etc.

DISPOSITION: Temporary. Cut off at end of year in which pilot project was completed. Destroy 10 years after cutoff. (**Disposition Authority: N1-440-11-2, Item 2**)

R. RESERVED

S. MEDICARE UTILIZATION DATA COLLECTION AND ACCESS SYSTEM (MUDCAS) (Disposition Authority: N1-440-09-10)

A collection of automated systems that support the collection and analysis of Medicare and Medicaid program enrollment and utilization data on Medicare beneficiaries enrolled in hospital insurance (Part A) or medical insurance (Part B) of the Medicare program for statistical and research purposes related to evaluating and studying the operation and effectiveness of the Medicare program. Includes but is not limited to the following systems:

National Claims History (NCH) is the current System of Record for Medicare utilization data. It is a legacy tape database of sequential flat files that function as CMS' repository of paid Medicare claims data beginning with the service year 1991. The data from the NCH is used for statistical and research purposes related to evaluating/studying the operation and effectiveness of the Medicare program. Information sharing is provided via the enterprise access system, DESY, or via TAP files, which are user specific extracts provided to contractors for certain agency business functions.

National Medicare Utilization Database (NMUD) is the prime component of the MUDCAS. The data warehouse was implemented to take advantage of storing Medicare claims data beginning in the service year 1998. NMUD contains billing/utilization data on Medicare beneficiaries enrolled in hospital insurance (Part A) and/or medical insurance (Part B) under the fee-for-service program, which is used for statistical and research purposes related to evaluating/studying the operation and effectiveness of the Medicare program. NMUD also contains (as a separate collection under the NMUD umbrella) diagnoses data for beneficiaries enrolled in Medicare + Choice Medicare program in support of the new risk adjustment payment system.

Medicare Provider Analysis and Review Systems (MEDPAR) (a System of Record) function as CMS' repository of beneficiary data beginning with service year 1992. MEDPAR maintains information on inpatient and hospital and Skilled Nursing Facility (SNF) stays of Medicare beneficiaries. The primary purpose of the MEDPAR is to enable CMS and its contractors to facilitate research on the quality and effectiveness of care provided, update annual hospital Prospective Payment System (PPS) rates, and to recalculate Supplemental Security Income (SSI) ratios for hospitals that are paid under the increased reimbursement under Part A of the Medicare program.

Incurred But Not Reported (IBNR) contains summarized and individually identifiable claim level Medicare claims information. Data is based on the date the cost for Medicare services was incurred and the date the payment for those services was authorized.

Part B Extract and Summary System (BESS) is used by the CMS mainframe users to access data files and extracts Part B claims information. Data extraction programs are coded using batch COBOL, Interactive COBOL, SAS and CMS Data C enter mainframe system utilities.

Data Agreement and Data Shipping Tracking System (DADSS) allows Intranet and Extranet access to authorized CMS users from within the walls of CMS as well as from the MDCN. DADSS provides role-based access to all application resources.

Data Extract System (DESY) is CMS' web browser-to mainframe Enterprise data extract tool. DESY supports CMS and non-CMS business needs by providing a single data extraction tool that enables customers to define their data needs, extract required data from CMS enterprise data stores, and deliver this information to the user in a secure and HIPAA compliant manner. DESY provides customers with a data extract capability to the following CMS enterprise data stores: Medicare utilization claims data, Medicare Enrollment files, and Medicaid utilization and eligibility files.

Health Care Information Mod (HCISMod) is a client/server system which provides the ability to access summarized data for Home Health Agency (HHA), Skilled Nursing Facility (SNF), Hospice, Inpatient, Outpatient, Physician, Durable medical equipment (DME), Clinical Labs (CLab), Non-Physician Practitioner, Ambulance, and Enrollment. This ability aids in the investigation of claim payment trends for medical costs analysis and/or the investigation of fraud and abuse in the Medicare program. HCIS Mod users use this information in response to congressional requests to investigate payments for all, or specific Medicare claims types. There may also be a need to use this information to conduct reviews on setting claim payment rates based on trending analysis. This analysis is performed using individual claim type statistics summarized at various levels of reporting. HCISMod files are extracted from the Mainframe National Claims History file that is operated at the CMS Data Center and accessed by CMS employee and business partners.

Medicare Actuarial Data System (MADS) is a system application used by the Office of the Actuary (AOCT) to report Medicare financial expenditures from the Medicare Trust Fund. MADS provides OACT analysts and statistics with a representation of total Medicare expenditures by service provider and Medicare transaction claim type. This information is used for reporting current and projecting future Medicare expenditures. MADS data is comprised solely of Medicare Utilization claims data as stored in the National Claims History.

Medicare Beneficiary Payment Record Process (MBPRP) application is stored and batch job processing is performed on the Mainframe at the CMS Data Center. Only CMS personnel and internally managed contractors/subcontractors performing agency business functions can access MBPRP.

1. Master Files

1a. Primary Utilization Data (currently National Claims History) – Medicare utilization claims and utilization data. **(Disposition Authority: N1-440-09-10, item 2a)**

DISPOSITION: Cutoff at the end of the FY. Destroy/delete 75 years after cutoff.

1b. Derivative Systems (NMUD, MEDPAR, IBNR) – Medicare utilization claims data, Medicare Enrollment Files, Medicaid utilization and eligibility files; comprised of data from the NCH. **(Disposition Authority: N1-440-09-10, item 2b)**

DISPOSITION: Temporary. Cutoff at the end of the FY. Delete/destroy 30 years after cutoff.

1c. Special Purpose Programs - BESS, DADSS, DESY, HCISMod, MADS, MBPRP

DISPOSITION: Temporary. Delete when related master file or database has been deleted **(Disposition Authority: NARA's General Record Schedule 20, Item 10)**

2. Outputs

a) Standard Analytical Files (5% sampling), output files (currently in CSV format) created annually by CMS for claims closed that fiscal year. The 5% sample is created from the National Claims History (NCH) as well as the Common Working Files (CWF) based on selecting records with 05, 20, 45, 70 or 95 in positions 8 and 9 of the Health Insurance Claim (HIC) number. Files currently date back to 1999, and include the following individual files: (1) Durable Medical equipment; (2) Home Health Agency; (3) Hospice Care; (4) Inpatient Care; (5) Outpatient Care; (6) Physician/Supplier and (7) Skilled Nursing Facility.

DISPOSITION: PERMANENT. Cutoff annually. Pre-accession individual files to the National Archives 5 years after cutoff. Legally transfer individual files in an acceptable format (following current CFR guidelines) to the National Archives 20 years after cutoff. (**Disposition Authority: N1-440-09-10, item 3a**) Supersedes job N1-440-10-07, Item 3 (Common Working File, outputs).

b) Surveys/Final Financial Expenditure Reports (**Disposition Authority: GRS 20, Item 12**)

DISPOSITION: Temporary. Delete/destroy when no longer needed for administrative, legal, audit or other operational purposes.

3. System Documentation

a) Documentation relating to electronic records that are scheduled for permanent retention in the GRS or in a NARA-approved agency schedule (i.e., User manuals, data dictionaries, system plans, and other documentation required to operate the MUDCAS system and utilize the data within the National Claims History and Utilization Databases). (**Disposition Authority, GRS 20, Item 11a(2)**)

DISPOSITION: PERMANENT. Transfer to the National Archives and with the permanent electronic records to which the documentation relates.

b) Documentation relating to electronic records that are scheduled for destruction in the GRS or in a NARA-approved agency schedule (i.e., Surveys/Final Expenditure Reports, Ad Hoc Reports) (**Disposition Authority, GRS 20, Item 11a(1)**)

DISPOSITION: Temporary. Destroy or delete upon authorized deletion of the related electronic records or upon the destruction of the output of the system if the output is needed to protect legal rights, whichever is later.

T. MEDICARE ADVANTAGE AND Rx PLAN OPERATIONS (MARPO) (**Disposition Authority: N1-440-09-04**)

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

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

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

Drug Data Processing System (DDPS) – This system processes all Medicare covered and non-covered prescription drug events (PDEs) and related data, including non-Medicare drug events, as necessary to validate/authenticate Medicare payment of covered drugs made by plans for Medicare beneficiaries enrolled in Part. The DDPS performs validation and authentication of the drug event data in an operational database, and the extraction and loading of DDPS-related data into the integrated data repository (IDR).

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

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

Premium Withhold System (PWS) – The Agency’s system to reconcile premiums to be withheld by the Social Security Administration (SSA), Railroad Retirement Board (RRB), and office of the Personnel Management (OPM).

Risk Adjustment System (RAS) – Receives the demographic and diagnosis data feeds from Medicare Beneficiary Database/CME (beneficiary data for Risk Adjustment processing), National Medicare Utilization Database (beneficiary claims data, beneficiary claims adjustment

(final action) data and fee-for-service diagnosis data), Risk Adjustment Processing System (Medicare Advantage Organization diagnosis data), Health Plan Management System (information on the contract level data and stratification of the contracts).

State Phase Down Billing (SPDBS) – Calculates the “phased-down” amounts States must contribute, and to send each State a monthly bill. As part of the MMA, the States and the District of Columbia are required to make contributions to CMS towards the costs of drug benefits being assumed by Medicare.

Part D Transaction Facilitator (PDTransFac) (previously named True Out of Pocket (TrOOP)) – PDTransFac facilitates pharmacy transactions by forwarding data at point of sale. The system forwards to pharmacies Part A, B, and D eligibility information and forwards to Part D plans financial information for calculation of TrOOP balances; and, as necessary, TrOOP balances from other plans. Core Functions: (1) Part A, B, D Eligibility: Enables the pharmacy to submit a real-time transaction to determine if the patient is enrolled in Part A, B, or D. (2) TrOOP Reporting: Report to Part D plans when a supplemental plan to Part D has impacted the out-of-pocket expenses of a Part D beneficiary (3) TrOOP Balance Transfer: Determines when a beneficiary has been enrolled into a new plan and requests TrOOP balance information from the old plan(s) and delivers it to the new plan.

Payment Reconciliation System (PRS) – Compares Part D prospective payment information to actual cost in order to perform plan payment reconciliations (low income cost-sharing subsidy (LICS), reinsurance and risk sharing/risk corridor, final reconciliation payment adjustments). PRS provides year-end adjustments amounts (payments or recovery) for each contract for these reconciliations.

Medicare Plus Choice (MPC) - The primary purpose of this system is to determine the annual Medicare Advantage capitation rate for each Medicare Advantage payment area for year and to supply rate books and supporting data for publication on CMS’ web site.

Adjusted Average Per Capita Cost (AAPCC) System of Record - The primary purpose of this system is to support the determination of the annual Medicare Advantage capitation rate for each Medicare Advantage payment area for year and to supply rate books and supporting data for publication on CMS’ website

1a. Inputs – Health Insurance Claim Numbers, Plan Member IDs, Complaint IDs, health plan and package information, monthly counts of beneficiary enrollment for each plan package, National drug codes, national pharmacy information, secondary payer information, Part D drug plan information, Prescription Drug event data, beneficiary demographic and plan information, drug utilization costs at the beneficiary/plan level used in calculating Part D payment reconciliations; received and/or rejected PDE records and report files; out-of-pocket costs to the DDPS; plans submit transactions for enrollment, disenrollment and enrollment changes; withheld premiums; monthly state enrollment counts; state payments received; State monthly rates table; MBD Enrollment Counts File, FACS Payments Received File, OACT State Monthly Rates Table File; eligibility, enrollment, or other health insurance information enrollment and prospective payment information at the beneficiary/plan level, actual drug costs and plan level adjustments;

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

DISPOSITION: Temporary. Delete when data have been entered into the Master Files or database and verified, or when no longer required to support reconstruction of, or serves as a backup to, a master file or database, whichever is later. **(Disposition Authority: NARA's GRS 20, item 2b)**

1b. Master Files – Includes but not limited to: Health Insurance Claim Numbers, Plan Member IDs, Complaint IDs, health plan and package information, monthly counts of beneficiary enrollment for each plan package, National drug codes, national pharmacy information, secondary payer information, Part D drug plan information, Prescription Drug event data, beneficiary demographic and plan information, drug utilization costs at the beneficiary/plan level used in calculating Part D payment reconciliations; received and/or rejected PDE records and report files; out-of-pocket costs to the DDPS; plans submit transactions for enrollment, disenrollment and enrollment changes; withheld premiums; monthly state enrollment counts; state payments received; State monthly rates table; MBD Enrollment Counts File, FACS Payments Received File, Office of the Actuary State Monthly Rates Table File; eligibility, enrollment, or other health insurance information enrollment and prospective payment information at the beneficiary/plan level, actual drug costs and plan level adjustments; Medicaid data, buy-in data, institutional data, Medicare demographic data, Medicare fee-for-service enrollment & claims data, Managed Care enrollment data, age, gender, Census Bureau institutionalized counts and geographic location. The input data is summarized by nation, county, age and gender; data collected and maintained in the AAPCC system are Medicare Parts A, B, and C entitlement, enrollment, demographic, claims and risk score data.

DISPOSITION:

1b1. Beneficiary enrollment, premium and payment records – Temporary. Cutoff annually. Delete/destroy 6 years 3 months **(Disposition Authority: pending NARA approval)**

1b2. Medicare Advantage – Temporary. Cutoff annually. Delete/destroy 10 years after cutoff. **(Disposition Authority: N1-440-09-4, Item 1a)**

1b3. Prescription Drug Records – Temporary. Cutoff annually. Delete/destroy 10 years after cutoff. **(Disposition Authority: N1-440-09-4, Item 1b)**

1b4. Capitation Rate Records – Temporary. Cutoff annually. Delete/destroy 5 years after cutoff. **(Disposition Authority: N1-440-09-4, Item 1c)**

1b5. Prescription Drug Events (PDEs) and Related Data – Temporary. Cutoff annually. Delete/destroy 20 years after cutoff. **(Disposition Authority: N1-440-09-4, Item 1d)**

1c. Outputs

1c1. Prescription Drug Event (PDE) Reports – Outputs of the DDPS, which provide summary data of all annual prescription approvals. PDEs are summary reports of all Medicare Part D expenditures, and include information on the patient (date of birth, gender), provider (identifier) and statistical information on the prescribed drug (compound code, dispense type, quantity, supply, costs).

DISPOSITION: PERMANENT. Cut off annually. Pre-accession files to the National Archives 5 years after cutoff. Legally transfer individual files in acceptable format (following current CFR guidelines) to the National Archives annually, 20 years after cutoff. Include an electronic copy of the system documentation (i.e., codebooks, record layout, user guides and any other technical specifications) with the transfer. **(Disposition Authority: pending NARA approval)**

1c2. Other Outputs – Ad hoc reports (includes but not limited to: MCO-level payment amount, beneficiary complaints, prescription drug events, Medicare Advantage, Prescription Drug Costs, premium and payment reports, withheld drug premiums; monthly SPDBS reports to States, MBD, OACT, OFM; SPBDS billing activity; PRS Inputs to CPC & Plans; PRS Reconciliation Reports, PRS Reconciliation Results Report Detail & Beneficiary Detail, Data Anomalies Report); State Bills and Itemized Liability reports; payment requests to APPS; Beneficiary data at the part D plan level; Medicare Demographic Data, Medicare Fee-for-Service Reimbursements and Enrollments (summarized by nation, county, Medicare entitlement status, age and gender); Medicare Advantage Ratebook for payment to Medicare Advantage plans under Part C, Medicare Advantage Rate Calculation data showing details of the components of rate calculation, Medicare Demographic Data, Medicare United States Per Capita Costs, Medicare Advantage Regional Rates and Benchmarks, and Medicare Fee-for-Service Reimbursements and Enrollments. The output data is summarized by nation, county, age, and gender.

DISPOSITION: Temporary. Destroy when no longer needed for administrative, legal, audit or other operational purposes, provided the printouts do not contain substantive information, such as substantive annotations, that is not included in the electronic records. **(Disposition Authority: NARA's GRS 20, item 16)**

U. Medicaid State Children's Health Insurance Systems—Schedules pending.

V. Online Registration System (Disposition Authority: N1-440-10-8)

System CMS staff use to register for no-cost training, agency required classroom training (i.e., EEO, OSORA, OOM) and employee services (i.e., blood drive, flu shots, CPR, etc.)

1. Master Files – Consists of a list of CMS employees who registered for classes with the description of the class, dates and location of class.

DISPOSITION: Destroy 5 years after system is retired.

W. SUGGESTION PROGRAMS (Incentive /Performance Awards/Suggestion and Idea Exchange Information Files)

Suggestions submitted by CMS employees relative to internal operations and/or general policy. Includes entire suggestion program, whether paper or electronic. This currently includes the online “Idea Factory” blog, where employees can utilize an online forum to propose ideas, and get immediate comments from employees working throughout CMS, including regional offices. Employees can post comments and vote for their favorite ideas. If an idea is a top vote getter and shows promise, the person who proposed it gets to present it to senior leadership and/or work on a team to implement it.

1. Employee Suggestions

(a) Media-neutral collection of information (paper or electronic, including social media) that supports the exchange of information within the Agency documenting employee suggestions, awards, and onsite agency activities/awards ceremonies. Includes but not limited to: correspondence, pilots, electronic forums, electronic submissions, blogs, direct-key stroke entries into system screens maintained in the management of suggestions and forms designed to collect data about the respective programs.

DISPOSITION: Temporary. Cutoff annually. Destroy/delete 2 years after cutoff. **(NARA Disposition Authority: N1-440-11-1, Item 1)**

2. Employee Awards - General awards, records, EXCLUDING those relating to department level awards.

(a) Case files including recommendations, approved nominations, correspondence, reports and related handbooks pertaining to agency sponsored cash and noncash awards such as incentive awards, within grade merit increases, suggestions, and outstanding performance.

DISPOSITION: Temporary. Destroy 2 years after approval or disapproval **(NARA Disposition Authority: NC1-64-77-20, Item 12a1)**

(b) Correspondence pertaining to awards from other Federal agencies or non-Federal organizations.

DISPOSITION: Temporary. Destroy 2 years after approval or disapproval **(NARA Disposition Authority: NC1-64-77-20, Item 12a1)**

X. Continuity Assessment Record and Evaluation (CARE)

Internet-based application designed, developed and implemented to automate the CARE patient assessment instrument to uniformly measure and compare Medicare beneficiaries' health and functional status, across provider settings, over time and to test the instrument's usefulness in a 3-year Post Acute Care-Payment Reform Demonstration (PAC-PRD) starting in 2008, with a Report to Congress in 2011.

The CARE database contains Medicare patient assessment information which details information captured about a patient during admission, discharge, or major change in status (e.g., death). The information captured and stored includes administrative information, admission information, medical information, cognitive status information, impairments, functional status, plan of care information and discharge status.

DISPOSITION: Delete/destroy data and all related documentation 10 years after the final report to Congress is released, or when no longer needed for Agency business, whichever is longer. **(NARA Disposition Authority: N1-440-11-03)**

Y. HIPAA Eligibility Transaction System (HETS)

HETS is intended to allow the release of eligibility data to Medicare providers, suppliers or their authorized billing agents for the purpose of preparing an accurate Medicare claims, determining beneficiary liability to determine eligibility for specific services. This application allows providers or clearinghouses to submit HIPAA compliant 270 eligibility request files over a secure connection. Also includes phone logs of questions from Clearing House and providers and CMS' answers regarding a beneficiary's eligibility.

DISPOSITION: Cut off at the close of the calendar year. Destroy/delete 6 years and 3 months after cutoff. **(NARA Disposition Authority: N1-440-04-3, Item 1a)**

Z. Surveyor Learning Management System (TotalLMS)

The Total LMS documents the federal training provided to surveyors for the survey and certification process of all health facilities that provide care to Medicare or Medicaid beneficiaries. This is accomplished through the CMS (SumTotal) Learning Management System, an externally hosted database.

1. Inputs – Auto file transfers from CMS Blackboard Learn:

<http://cms.scg.blackboard.com/index.html>; Auto file transfers from Surveyor Training site: <http://surveyortraining.cms.hhs.gov/index.aspx>; Manual input from Central Office Training Coordinators; Manual input from Central Office LMS Administrators Manual input from TSI contractors for LMS and Editorial Support; Manual input from SA Training Coordinators.

DISPOSITION: Destroy/delete data when entered into the master file or database and verified, or when no longer required to support reconstruction of, or serve as backup to, a master file or

database, whichever is later (**NARA Disposition Authority: GRS 20, item 2(4)b, Input Source Records**).

2. Master Files – Contains training transcripts of 56 state agency surveyors and Regional Office surveyors. System-captured data dates back to 2002 at the inception of the first LMS. Other entries were manually entered in mass data entry sessions by Central Office. Data is used in reports viewed by State, ROs and CO to track and assign training, verify training and eligibility for classes. Although no PII is maintained, transcripts data must be available for prolonged periods as these have been subpoenaed during legal actions and under FOIA where the surveyor (student) or State Agency has been sued by a provider and needs to protect the integrity of their expertise.

DISPOSITION: Destroy/delete data 30 years from the date of entry. (**NARA Disposition Authority: DAA-0440-2012-0006**)

3. Outputs – Outputs are primarily electronic (diploma, activity summary, transcripts, evaluations) but may be printed. Tables may be exported. Training activity can be exported in PDF. Screen shots for learner training schedule; self-reported training, instructor schedule, manager dashboard (exception reports tracks activities of managed users).

DISPOSITION: Destroy/delete when no longer needed for Agency business. (**NARA Disposition Authority: GRS 20, Item 16**)

3b. Adhoc Reports - Reports – may vary depending on user role, as well as ability to create custom reports. Reports at the CO level are controlled by the CO Database Administrator. Frequency is on demand.

DISPOSITION: Destroy/delete when no longer needed for Agency business. (**NARA Disposition Authority: GRS 20, Item 16**)

4. System Documentation: Data Dictionary, User Guides and Reference Materials

DISPOSITION: Destroy/delete when upon authorized deletion of the related electronic records or upon destruction of the output of the system. (**NARA Disposition Authority: GRS 20, Item 11(a)(1)**)

AA. Payment Recovery Information System (PRIS)

PRIS provides services over Multi-protocol Label Switching (MPLS) lines for CMS to request approval of New Audit Issues and to enter Improper Payments results identified in Medicare Parts C & D. PRIS will support the Lifecycle of the Parts C & D Recovery Audit Contractors (RACs) program. Features of the lifecycle will include activities from the RACs, DVC, & Appeals contractor along with activities associated with the improper payment recoupment process. PRIS will interface with APPS to send requests to offset improper payments to adjust plans' monthly payments. The payment process will include functionality to document wire transfers and receipts of checks. PRIS will capture and store total improper payment amounts

and contingency amounts owed to the RAC. The data warehouse will store the all activities associated with identified improper payments. Data stored in the data warehouse will be used for reporting. The reporting feature will allow CMS policy personnel to review the issues for interpretation of CMS policy. PRIS allows the secure transfer of imaged documentation from the RAC to CMS over MPLS lines. These images are stored in Enterprise Content Manager (ECM).

1. Inputs - The primary data source will be identified Improper PDE records & Part C claims (imaged documentation) provided by the Recovery Audit Contractor (RAC). Improper Payment validation findings will be input by the Data Validation Contractor (DVC). Improper Payment Notification Letters will be input by the RAC.

Appeals notifications and appeals results will be input by the Appeals contractor. There are no agency forms used as input sources. PRIS will receive data from inside the agency; system name "APPS". PRIS will validate Prescription Drug Event (PDE) records and Part C claims to ensure that an improper payment was not previously identified and the improper payment was not previously recouped. The data warehouse will store PDE records and Part C claims when it was a result of an improper payment and a PRIS Payment Monthly Adjustment file was sent to APPS to adjust the contract's monthly payment.

DISPOSITION: CMS contractors - Destroy/delete source data when data have been entered into the Master File or database and verified, or when no longer needed to support construction of, or serve as backup to, the master file or database, whichever is later. **(Disposition Authority: GRS 20, Item 2b)**

2. Master Files – Metadata associated with the collection of claims and supporting documentation submitted by a Medicare Part C or Part D Recovery Audit Contractor (RAC) in support of their analysis to identify and recover improper claim payments made to a Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), or a Prescription Drug (PDP) plan/sponsor.

DISPOSITION: Cut off at the end of the calendar year of an improper payment recoupment or final appeals results. Destroy 10 years after cutoff. **(Disposition Authority: DAA-0440-2012-0007)**

3. Outputs - Reports illustrating the number of identified improper payments, the number of contracts that were impacted by improper payments along with the dollar amount that will be recouped and applied to the Medicare Trust Fund. The reports will be made available monthly.

DISPOSITION: Destroy/delete when no longer needed for administrative, legal, audit, or other operational purposes. **(Disposition Authority: GRS 20, Item 4)**

4. Documentation - PRIS Logical/Physical Data Model (LDM/PDM) and corresponding data dictionary which details the data elements captured in ECM (see attachment). Data-related documentation: IDR SAF PDE Layout, PRIS/APPS ICD, HPMS Contract Data Sample.

DISPOSITION: Destroy/delete when system is no longer operational. (**Disposition Authority: GRS 20, Item 11a1**)

BB. Patient Protection and Affordable Care Act - Private Health Insurance Systems

The Private Health Insurance Systems support the implementation of the Patient Protection and Affordable Care Act. Includes but not limited to the following systems related to private health insurance.

1. Health Insurance Oversight System (HIOS) (Disposition Authority: DAA-0440-2012-0005-0001)

Input –

Master Files – Product level information from health insurance issuers across states and US territories for display on consumer website, such as Healthcare.gov; oversight data in key financial areas, including annual limits waivers, rate review, medical loss ratio (MLR), and grants. HIPS provides caseworkers and State agencies which are recipients of the Consumer Assistance Program (CAP) grant, with a CAP tool to document and address consumer issues related to health insurance. HIOS also provides reporting capabilities on data captured in the system.

DISPOSITION: Cutoff at the end of the year in which record was created and transfer to inactive storage at the end of the year in which the record was created. Destroy 7 years after cutoff.

NOTE: When fraud or overutilization of services is involved, the recordkeeping copy shall be retained until the resolution of the investigation plus 3 months or revert to normal disposition, whichever is longer.

Output -

2. Health Insurance Assistance Database (HIAD) (Disposition Authority: DAA-0440-2012-0005-0002)

Master Files - Case files created from telephone calls received by CMS that address consumer issues related to health insurance. For states not covered by the Consumer Assistance Program (CAP) grant, see HIOS. CAP tool is used to create data capture in HIAD.

DISPOSITION: Cut off at the end of each calendar year. Destroy 3 years after cutoff.

3. Pre-Existing Condition Insurance Plan (PCIP)

a. Federally-Administered Program

Collects and maintains information on individuals who apply for enrollment in the program. This information will enable HHS acting through NFC, OPM, and any third-party administrator(s) to determine applicants eligibility, enroll eligible individuals into the program, adjudicate appeals of eligibility and coverage determinations, bill and collect premium payments, and process and pay claims for covered health care items and services furnished to eligible individuals. The PCIP program began accepting applications for enrollment July 2010 and will end in December 2013. Beginning January 2014, all enrollees will be transitioned over to a health insurance exchange program.

DISPOSITION

a. Inputs

1. Paper Applications- Cutoff after verifying all images are captured and legible and verifying plans and procedures are in place to migrate records to accessible hardware and software as necessary throughout their retention period. Destroy immediately after cutoff. **(Disposition Authority: NARA's GRS 20, Item 2a4)**

2. Imaged Applications – Cutoff at the end of the calendar year of the disenrollment effective date. Destroy 7 years after cutoff.

b. Master Files - Information on individuals who apply for enrollment in the program. This information will enable HHS acting through NCF, OPM and any third party administrator(s) to determine applicants' eligibility, enroll eligible individuals into the program, adjudicate appeals of eligibility and coverage determinations, bill and collect premium payments, and process and pay claims for covered health items and services furnished to eligible individuals.

DISPOSITION: PERMANENT. Cut off at the end of the program. Transfer electronic records from the years 2010 to 2013 to the National Archives for pre-accessioning immediately after cutoff. Transfer to the National Archives 15 years after cutoff. **(Disposition Authority: DAA-0440-2012-0005-0004).**

c. Outputs – Statistical reports including state-by-state enrollment data and quarterly expenditure data.

DISPOSITION: PERMANENT. Cut off at the end of the program. Transfer electronic records from the years 2010 to 2013 to the National Archives for pre-accessioning immediately after cutoff. Transfer to the National Archives 15 years after cutoff. **(Disposition Authority: DAA-0440-2012-0005-0005).**

b. State-Based Programs (Disposition Authority: DAA-0440-2013-0007 pending NARA Approval)

(1) Technical Approach Proposals – Formal technical approach proposals submitted to CMS by States and State-Designated Nonprofit Entities. These records document the method each State and State-Designated Nonprofit Entity proposed to establish and administer PCIP in accordance with the PPAC. These records provide substantial informational, including but not limited to administrative processes related to eligibility determinations and enrollment procedures, coverage and benefits, premium administration and billing, appeals customer service, case management, payment of health and prescription drug claims, marketing and outreach, anti-dumping procedures, and fraud, waste and abuse. Records include all versions approved by CMS.

DISPOSITION: PERMANENT. Cut off at the end of the program. One-time transfer to the National Archives 5 years after cutoff.

(2) Contracts - Formal fully executed contract documents between the Department of Health and Human Services (HHS)/CMS and States and State-designated entities to establish and operate PCIP to provide coverage for eligible individuals beginning in 2010 and ending on December 31, 2013. These records include the terms and conditions of the contract, including but not limited to specific service and delivery tasks, program requirements, data use agreements and contractor/HHS responsibility.

DISPOSITION: PERMANENT. Cutoff at contract termination. One-time transfer to the National Archives 5 years after cutoff.

(3) Data Reports and Statistical Models - Formal data and financial audit reports submitted to CMS by States and State-Designated Nonprofit Entities and statistical models used by CMS for data analysis and other reports. These records document metrics related to the administration of PCIP, including application and enrollment, plan premiums billed and collected, administrative expenses, and incurred and paid claims. Records include monthly data reports along with “Guide for States on Reporting” documentation, financial audit reports, annual PCIP report, and statistical models.

DISPOSITION: PERMANENT. Official recordkeeping copy is electronic. Cutoff at contract termination. One time transfer to the National Archives 5 years after cutoff.

(4) States and State-Designated Nonprofit Entities Records - Records created and maintained by States and State-Designated Nonprofit Entities operating PCIP under contract with CMS. These records include application and supporting documentation for enrollment, eligibility and benefit appeals, claims and payment data, and program financial information.

DISPOSITION: Cutoff at contract termination. Destroy 6 years after cutoff.

4. Rate and Benefit System (RBIS)

Data submissions from health insurance issuers in the individual and small group markets regarding benefit and cost sharing information on their products and plans. RBIS is comprised

of a collection portal, databases, a rules engine, and a set of web services supporting HealthCare.gov “PlanFinder.”

DISPOSITION: Cutoff annually. Destroy 7 years after cutoff. **(Disposition Authority: DAA-0440-2012-0005-0006)**

5. Collaborative Application Lifecycle Tool (CALT)

Repository for all documentation artifacts related to the state and federal health insurance exchange implementation life cycle. Within each stage of the methodology artifacts are collected and reviewed collaboratively using the CALT system.

DISPOSITION: Cutoff annually. Destroy 7 years after cutoff. **(Disposition Authority: DAA-0440-2012-0005-0007)**

6. Early Retiree Reinsurance Program (ERRP)

Facilitates the tracking and completion of all work activities including the review and processing of application packages, processing of payment requests to determine the appropriate subsidy amounts, initiative electronic payments and remittances; and tracking all correspondence with the Plan Sponsors and other stakeholders. The ERRP Secure Web Site allows Plan Sponsors the ability to register and submit payment requests via the Internet in a secure manner.

DISPOSITION: Cutoff at the end of the calendar year in which payment/final actin occurred. Destroy 7 years after cutoff. **(Disposition Authority: DAA-0440-2012-0005-0008)**

7. Case Management/ERDE System

Master Files – provides functionality that will allow program offices to track cases and interactions with external stakeholders, citizens, and insurance providers in a secure, hosted environment. ERDE will provide the capability to collect, evaluate and manage insurance plan information and display it in a format that meets regulatory requirements and consumer expectations.

DISPOSITION: Cutoff annually. Destroy 7 years after cutoff. **(Disposition Authority: DAA-0440-2012-0005-0010)**

8. All Other items not covered in item BB. above but are related to the Affordable Care Act – Private Health Insurance Systems

DISPOSITION: Cutoff annually. Destroy 7 years after cutoff. **(Disposition Authority: DAA-0440-2012-0005-0013)**

9. Reserved for: Health Care Insurance Exchange IT Investment (HIX)

a. HIX activities are organized around two key systems: the Exchange Systems and the Data Services Hub. Exchange Systems support the core business functions of an exchange including administration, health plan management, eligibility and enrollment, risk adjustment, premium tax credit administration, program integrity, and portal for customers. The Data Services Hub acts as a broker of information and will facilitate accessing and management of complex set of data from a variety of sources, including multiple Federal agencies, with exchanges, and Medicaid systems, The IT investment also includes activities aimed at coordinating integration with state exchanges.

b. Essential Health benefits (EHB)

Application component of the Federally-facilitated Exchange (HIX) designed to collect templates for the HIX system from the issuer's community.

10. Reserved for: Multidimensional Insurance Data Analytic System (MIDAS)

Central and historical collection for data from all Affordable Care Act (ACA) systems used for reporting, analysis, trending and measurement of the ACA programs.

11. Reserved for: Opportunity to Network and Engage (zONE)

Collaborative space for internal and external CMS projects so that project teams have virtual community space to communicate and share discussions, ideas, and documents that further the goals and objectives of CMS programs.

12. Reserved for: State Exchange Resource and Tracking System (SERTS)

Performs content management, relationship management, case management, and information-sharing activities for State Exchange grantees. Interacts with Grant Solutions for data intake, CSP for data dissemination, integration between the CRM and Resource Center layers; tracks State readiness milestones, grant usage, interactions, questions, relationship management; and provides information sharing area for state users.

CC. Enterprise Identity Management (EIDM)

EIDM is an information security system that allows the assignment of a single electronic credential to an individual to enable their access to CMS systems while meeting the appropriate federal security requirements. Services available from EIDM have been grouped into four main services areas (registration service, authorization service, ID lifecycle management service, and access management service). CMS will make remote electronic services available in a reliable and secure manner to providers of services and suppliers to support their efforts to better manage and coordinate care furnished to beneficiaries and Exchange applicants of CMS programs. Identify and Access Management services will provide identity and credential services for millions of partners, providers, insurance exchanges enrollees, beneficiaries and other CMS non-organizational users; and thousands of CMS employees, contractors and other CMS

organizational users. EIDM accepts other federal agency credentials provided to CMS from the Federated Cloud Credential Exchange and provides secure access to the CMS Enterprise Portal.

1. Master Files

a. Registration - username/password and challenge question/answers, allows users to prove their identity by associating federate credentials as well as use these credentials for subsequent authentication

DISPOSITION: Destroy/delete when 7 years 6 months, 10 years 6 months, or 20 years 6 months old, based on the maximum level of operation of the Certification Authority, or when no longer needed for business, whichever is later. **(Disposition Authority, GRS 24, item 13a1)**

b. Authorization - manages applications as well as entitlements within applications as requested items to end users; integration of CMS applications into EIDM; connects with application stores specific to Federal Exchange using the database connector

DISPOSITION: Destroy/delete when 7 years 6 months, 10 years 6 months, or 20 years 6 months old, based on the maximum level of operation of the Certification Authority, or when no longer needed for business, whichever is later. **(Disposition Authority, GRS 24, item 13a1)**

c. ID Management – Self-service for forgotten user Ids and passwords to enable temporarily disabled accounts, to reset passwords, to update user profiles, to allow for step up authentication, for Federated user ID matching, and allow helpdesk service to view users, enable/disable users, unlock user Ids and reset passwords.

DISPOSITION: Delete/destroy when agency determines they are no longer needed for administrative, legal, audit or other operational purposes. **(Disposition Authority: GRS 20, Item 1)**

d. Access Management - can extract relevant identify attributes; users enter credentials (e.g., one-time password); native integration point to call an external web service for validation of collected multi-factor credentials.

DISPOSITION: Delete/destroy when agency determines they are no longer needed for administrative, legal, audit or other operational purposes. **(Disposition Authority: GRS 20, Item 1)**

2. Inputs

DISPOSITION: Destroy/delete data when entered into the master file or database and verified, or when no longer required to support reconstruction of, or serve as backup to, a master file or database, whichever is later **(NARA Disposition Authority: GRS 20, item 2(4)b, Input Source Records).**

5. Outputs

DISPOSITION: Destroy/delete when no longer needed for Agency business. (NARA Disposition Authority: GRS 20, Item 16)

DD. The National Database Services Tracking Analysis and Reporting System (NDB STARS)

Provides the claims, provider, and beneficiary information needed to detect fraud, waste, and abuse in the Medicare fee-for-service program. Data is extracted from various CMS systems: National Claims History, Medicare Enrollment Database, Provider Enrollment & Chain Ownership System), transformed and loaded monthly into the National Database Services Tracking Analysis and Reporting System (NDB STARS) and maintained in various tables in the Oracle database. Data includes but is not limited to: Medicare claims (Inpatient/skilled nursing facility, outpatient home health, hospital carrier and durable medical equipment); Medicare Enrollment Database (monthly report of new Medicare enrollees), Certification and Survey Provider Reports (certification information for Part A institutions, clinical laboratory provider certifications); demographic and eligibility information for suppliers of durable medical equipment (DME), prosthetics, orthotics and supplies; Part B provider data; original and adjustment records for Pharmacy events; relationship information, taxonomy codes, Medicaid, payment center, parent organization and other provider information, Railroad Retirement Board and Drug Enforcement Agency provider data; provider trading partner information on DME supplies.

DISPOSITION: Destroy 10 year(s) after cutoff or when agency determines they are no longer needed for administrative, legal, audit or other operational purposes occurs, whichever is later

1. Master Files - National Claims and Pharmacy data maintained in partitioned tables.

DISPOSITION: Cut off annually. Destroy 10 year(s) after cutoff. (**Disposition Authority: DAA-0440-2012-0004-0001**)

2. All other "ancillary data" - A full replacement on a monthly basis maintained in tables in the Oracle database and covers information for providers and enrollees for the entire nation. Data is separate from master file, and used to understand the data on the claim records within the master file.

DISPOSITION: Cut off annually. Destroy 10 year(s) after cutoff or when agency determines they are no longer needed for administrative, legal, audit or other operational purposes occurs, whichever is later. (**Disposition Authority: DAA-0440-2012-0004-0004**)

3. Inputs – The input data listed below is extracted, transformed and loaded into the NDB STARS on a monthly basis and is maintained in various tables in the Oracle database.

- Inpatient/SNF, Outpatient, Home Health, Hospital, Carrier and Durable Medical Equipment (DME)).
- Medicare Enrollment Database produces each month new Medicare enrollee files to load

- Certification and Survey Provider Enhanced Reports (CASPER) – the CASPER/Clinical Laboratory Improvement Amendments (CLIA) files provides identification, location, participation, bed count, and certification information for Part A institutions, including hospitals, SNFs, ESRD facilities, CORFs, ASCs, FQHCs, CMHCs, hospices, home health agencies and others; CLIA88 certification information on all the country’s laboratories, including those operated by Part B providers
- Provider Enrollment & Chain Ownership System (demographic and eligibility information for suppliers of durable medical equipment, prosthetics, orthotics, and supplies)
- Records pulled from provider enrollment files in each instance of MCS
- National Provider Identification information (Part B provider data)
- Medicare Exclusion Database
- Original and adjustment records for Pharmacy events
- Pharmacy Provider Data (relationship information, taxonomy codes, Medicaid, payment center, parent organization and other provider information)
- Railroad Retirement Board & Drug Enforcement Agency provider data
- Provider Trading Partner information on Durable Medical Equipment (DME) suppliers for the entire country. This data is used for DME claims processing to determine who processes and receives payment and notices on behalf of the suppliers.

4. Outputs – monthly report showing summarized claims information for specific HEAT cities for each newly loaded month; quarterly workload counts from NDB based on a rolling 12-month period and are grouped by Provider State; monthly mainframe extract files for the latest National Claims History claims data, provider and enrollee data; National Provider Identifier (NPI) Crosswalk files that includes Provider Tax ID, Provider SSN and Provider Date of Birth; Part B Provider Enrollment and Demographic data; monthly report of claims processed by beneficiary HICNs.

DISPOSITION: Temporary. Destroy when agency determines that they are no longer needed for administrative, legal, audit or other operational purposes. **(Disposition Authority: GRS 20, Item 16)**

EE. OIG Hotline Database

The OIG Hotline database is a repository for allegations of per se fraud, waste, and abuse (FWA) of the Medicare program received by the Office of Inspector General (OIG) from beneficiaries, providers, suppliers, and CMS employees throughout the United States and its territories. CMS and its contractors access the OIG Hotline database to address these complaints for the purpose of making a determination whether said complaints offer credible evidence of per se FWA; if so, these complaints are referred to CMS Medicare Program Integrity Contractors for further development, which may result in administrative action or a referral to Law Enforcement for investigation and possible prosecution. Where there is no credible evidence of per se FWA, CMS contractors may take an administrative action, such as issuing an overpayment, or closing the complaint for lack of actionable evidence.

DISPOSITION: Temporary. Cutoff annually in the year the investigation is closed. Destroy 7 year(s) after cutoff. **(Disposition Authority: DAA-0440-2012-0011)**

FF. State Health Insurance and Assistance Program National Performance Reporting System (SHIP-NPR) (Disposition Authority: DAA-0440-2012-0012)

SHIP-NPR is a performance measurement system used to manage the State Health Insurance Assistance Program (SHIP) National Performance Report (NPR) to monitor and assess customer service information efforts and develop outcome measures to assess CMS' progress in improving overall communications with beneficiaries.

1. Master Files - Client Contact Form (CMS-10028A) – Medicare and Medicaid beneficiary name, telephone number, age group, gender, race/ethnicity, beneficiary zip code, counselor zip code, counselor user ID, date of contact, counselor and agency, beneficiary primary language, beneficiary social security disability of Medicare disability status, beneficiary dual eligible with mental illness/mental disability status, monthly income category, client asset category Public and Media Form (CMS-10028B)– Event or activity, agency code, name of presenter(s), type of activity or event, date of activity, event or group name, event address, topics discussed, target audiences Resource Report Form (CMS-10028B)- Counselors and volunteers, number of active counselors and hours, number of local coordinators/sponsors and hours, number of other paid and, volunteer staff, number of counselor training, number of active counselors with the following characteristics: counselor age, counselor gender, years of SHIP service, counselor, race/ethnicity, counselor disability, counselor speaks another language.

DISPOSITION: Cutoff annually. Destroy 7 years after cutoff.

FF. Medicaid Drug Rebate System

The Medicaid Drug Rebate (MDR) System (previously known as Medicaid Drug Rebate Initiative) supports the MDR program, which enables states to receive Federal funding for outpatient drugs dispensed to Medicaid patients. Drug manufacturer product and pricing information is used by the system to calculate Unit Rebate Amounts (URAs) for drugs on a quarterly basis. Rebate information is sent to the states, who invoice drug manufacturers for the appropriate rebate amounts. Drug manufacturers submit updated product and pricing information (average manufacturer price, Best Price, Customary Prompt Pay Discount, Nominal Price) via the Drug Data Reporting System.

1. Master Files (Disposition Authority Number DAA-0440-2012-0018-0001)

Drug manufacturer product and pricing (i.e., Average Manufacturer Price (AMP), Best Price (BP), Customary Prompt Pay (CPP) Discount, and Nominal Price (NP) information; state utilization and adjustment data.

DISPOSITION: Cutoff annually. Destroy 10 years after cutoff, or when no longer needed for Agency business, whichever is later.

2. One Time Disposal of Two Medicaid Drug Rebate (MDRI) Initiative Components (Disposition Authority Number DAA-0440-2012-0018-0002)

The MDRI has migrated from the Model 204 system and was replaced by the Medicaid Drug Rebate (MDR) system. The plan is to retire the MDRI by disposing of two limited MDRI components. The records consist of the M204 Database files, and the M204 User Language code contained in one of the files.

DISPOSITION: Destroy immediately after approval of records schedule.

XV. AUDIOVISUAL RECORDS

Records on this schedule are to cover those created solely by the Office of External Affairs/Visual & Multimedia Communications Group and Broadcast & Video Production Group, or those placed in the digital asset management system (e.g., Media Mine). Final printed versions are the responsibility of the Center/Office for which they were developed and should be scheduled on a separate SF115 and submitted to NARA for approval.

1. Recordings/Productions – Audio, video, sound, filmstrip and power point productions produced by CMS or CMS contractors.

a. Official speeches, press conferences, meetings, interviews, and panel discussions of the Administrator, Deputy Administrator, or other CMS officials, and associated finding aids.

DISPOSITION: PERMANENT. Transfer to the National Archives and Records Administration (NARA) in 5 year blocks, when no longer needed for administrative purposes, or when the oldest item is 10 years old, whichever is earlier in accordance with 36 CFR 1235.40. **(Disposition Authority: N1-440-05-1, Item 1a)**

b. Agency Video Productions (television commercials, broadcasts, advertisements, news releases, public service announcements, satellite broadcasts, CMS-sponsored training/seminars, etc.) and associated finding aids.

DISPOSITION: PERMANENT. Transfer to the National Archives and Records Administration (NARA) in 5 year blocks, when no longer needed for administrative purposes, or when the oldest item is 10 years old, whichever is earlier in accordance with 36 CFR 1235.40. **(Disposition Authority: N1-440-05-1, Item 1b)**

c. All Other Recordings – Recordings/productions that do not reflect the mission of the agency (e.g., programs acquired from outside sources, internal training programs, personnel and management training, routine staff meetings, award presentations, video news releases, and clips that do not represent the complete file, etc.) and associated finding aids.

DISPOSITION: Temporary. Destroy when 2 years old. **(Disposition Authority: NARA's GRS 21, Item 20)**

d. Sound Recordings not described in "c." above (recordings of meetings for note taking or transcription, routine staff meetings, etc.) and associated finding aids.

DISPOSITION: Temporary. Destroy immediately after use. **(Disposition Authority: NARA's GRS 21, Item 22)**

2. Still Photography - Electronic, negatives and photographs.

a. Senior agency officials conducting activities related to the mission of the Agency including documentary photographs shot during the construction process (in 1995) of the agency's new facility and all associated finding aids.

DISPOSITION: PERMANENT. Transfer to the National Archives and Records Administration (NARA) in 5 year blocks when no longer needed for administrative purposes, or when oldest item is 10 years old, whichever is earlier in accordance with 36 CFR 1235.40 (**Disposition Authority: N1-440-05-1, Item 2a**)

b. Digital or electronic images of senior agency officials conducting activities related to the mission of the Agency including documentary photographs shot during the construction process (in 1995) of the agency's new facility and all associated electronic or hard copy finding aids.

DISPOSITION: PERMANENT. Transfer to the National Archives and Records Administration all digital images in 2 year blocks immediately after the second year of the block (Example - digital images taken in 2005-2006 should be transferred at the end of 2006). All digital images dated prior to 2005 should be sent immediately and in accordance with the transfer instructions outlined in NARA's current guidance - Transfer Instructions for Permanent Electronic Images - Digital Photographs. (**Disposition Authority: N1-440-05-1, Item 2b**)

c. Routine award ceremonies, social events, and activities not related to the mission of the agency and all associated finding aids.

DISPOSITION: Temporary. Destroy when 1 year old. (**Disposition Authority: NARA's GRS 21, Item 1**)

3. Graphic Arts

a. Posters, Forms, CMS Program-Related Publications, CMS identity, brand and program marks, advertisements and marketing materials, and other final products distributed agency-wide or to the public and including associated finding aids.

DISPOSITION: PERMANENT. Transfer to the National Archives and Records Administration (NARA) in 5 year blocks when no longer needed for administrative purposes, or when oldest item is 10 years old, whichever is earlier in accordance with 36 CFR 1228.266 (c), (d) and (e). (Supersedes: NC1-440-79-2, Items 6 and 7). (**Disposition Authority: N1-440-05-1, Item 3a**)

b. Posters distributed agency wide or to the public and that are relevant to the agency's mission, along with associated finding aids.

DISPOSITION: - PERMANENT. Place NARA on the agency distribution list and send 2 copies upon printing. If no distribution list exists, the office responsible for the creation and printing should send 2 copies to NARA immediately after printing. (**Disposition Authority: N1-440-05-1, Item 3b**)

c. Exhibits

DISPOSITION: Temporary. Destroy when no longer needed for administrative purposes.
(Disposition Authority: N1-440-05-1, Item 3c)

d. Routine artwork for handbills, flyers, posters, letterhead and other graphics and all associated finding aids.

DISPOSITION: Temporary. Destroy when no longer needed for publication or reprinting.
(Disposition Authority: N1-440-05-1, Item 3d)

4. Documentation. Records required to plan, develop, operate or maintain electronic records (Items 1a & b, 2a & b, and 3a & b). Included are system specifications, file specifications, code books, record layout, user guides and/or output specifications.

DISPOSITION: PERMANENT. Transfer to the National Archives with associated collection (Items 1a, 2a or 3a). Transfer in format and media according to NARA guidance and regulations applicable at the time. **(Disposition Authority: N1-440-05-1, Item 4)**

5. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

DISPOSITION: Temporary. Delete when 180 days after the recordkeeping copy has been produced. **(Disposition Authority: NARA's GRS 20, Item 13)**

b. Copies used for dissemination, revision, or updating that are maintained in addition to the recordkeeping copy.

DISPOSITION: Temporary. Delete when dissemination, revision or updating is completed.
(Disposition Authority: NARA's GRS 20, Item 14)

XVI. ADMINISTRATOR'S OFFICE

1. Calendars and Daily Schedules (Disposition Authority: N1-440-07-1, Item 1)

Calendars, appointment books, schedules, logs, diaries, and other records documenting meetings, appointments, telephone calls, trips, visits, and other activities by the Administrator, Deputy Administrator, Chief of Staff and Chief Operating Officer, confidential associates, special assistants and political appointees, while serving in an official capacity.

DISPOSITION: PERMANENT. Cut off annually and retire to the Washington National Records Center in 5 year blocks or when volume warrants. Transfer to the National Archives when 20 years old.

2. Telephone Logs (Disposition Authority: N1-440-07-1, Item 2)

Files consist of lists of incoming telephone messages to the Administrator, Deputy Administrator and Chief Operating Officer. Include date of call, caller's name and phone number and a brief message.

DISPOSITION: PERMANENT. Cutoff annually. Transfer to the Washington National Records Center in 5-year blocks or when volume warrants. Transfer to the National Archives 20 years after cutoff.

3. Public Appearance and Meeting Requests

Invitations received by the Administrator, Deputy Administrator, and Chief Operating Officer to make a public appearance and attend meetings.

DISPOSITION:

- a. Accepted** – Destroy 3 years after the close of the official's tenure in office. (**Disposition Authority: N1-440-07-1, Item 3a**)
- b. Unaccepted** – Destroy when 2 years old. (**Disposition Authority: N1-440-07-1, Item 3b**)

4. Speech Files (Disposition Authority: N1-440-07-1, Item 4)

Official speeches of the Administrator, Deputy Administrator and Chief Operating Officer. Arranged by date of speech.

DISPOSITION: PERMANENT. Cut off files at the close of the CY. Transfer to the Washington National Records Center in 5-year blocks or when volume warrants. Offer to the National Archives 20 years after cutoff.

5. Biographies (Disposition Authority: N1-440-07-1, Item 5)

Files contain personal data sketches, photographs, newspaper clippings, copies of press releases and similar materials pertaining to major CMS officials. Arranged by name of individual.

DISPOSITION: PERMANENT. Cutoff at the close of the CY. Hold for 3 years or when volume warrants, then transfer to the Washington National Records Center. Transfer to the National Archives 20 years after cutoff.

6. Conference and Public Hearing Files (Disposition Authority: N1-440-07-1, Item 6)

Files contain information about conferences or hearings. Included are agendas, announcement of the conference and press releases.

DISPOSITION: PERMANENT. Cut off at the close of the calendar year. Hold for 5 years or when volume warrants, then transfer to the Washington National Records Center. Transfer to the National Archives 20 years after cutoff.

7. Itineraries of Visits (Disposition Authority: N1-440-07-1, Item 7)

Files pertaining to speaking engagements and visits of the Administrator, Deputy Administrator, and Chief Operating Officer with other major Department officials, town hall meetings, colleges/university officials, officials from health organizations, law firms and other private organizations.

DISPOSITION: Temporary. Destroy 3 years after tenure in office.

8. Briefing Books for Senior Staff within the Office of the Administrator

Briefing books prepared daily for the Administrator, Administrator, Chief of Staff, Chief Operating Officer and their Deputies, that may contain handwritten annotations. Consists of sensitive information from the White House, daily memoranda for meetings scheduled for that day/week, copy of decision memoranda to be done, long term schedule, meeting agenda, follow-up action items from previous meetings, weekly compilation of highlights and significant activities focusing mostly on upcoming issues from CMS offices and Regional Offices.

a. Briefing Books

DISPOSITION: PERMANENT. Cut off at the end of the calendar year, then transfer to the Washington National Records Center. Transfer to the National Archives 20 years after cutoff. **(Disposition Authority: DAA-0440-2013-0004-0001, pending NARA approval)**

b. Materials provided by CMS Offices for Inclusion in the Briefing Books for the Administrator's Office.

DISPOSITION:. Temporary. Destroy when 3 years old. (**Disposition Authority: N1-440-07-1, Item 8b**)

9. Correspondence (Disposition Authority: N1-440-07-1, Item 9)

Correspondence, decision memoranda, IG Reports, Reports to Congress, GAO Reports, National Coverage Decisions, etc. for signature by the Office of the Administrator.

DISPOSITION: PERMANENT. Cut off at the close of the calendar year. Hold for 5 years or when volume warrants, then transfer to the Washington National Records Center. Transfer to the National Archives 20 years after cutoff. Produce a hardcopy report from SWIFT of the closed and/or inactive jobs and include a copy during the transfer of the textual records the report corresponds to.

XVII. EQUAL EMPLOYMENT OPPORTUNITY (EEO) FILES

1. Official Discrimination Complaint Case Files (Disposition Authority: N1-440-09-1, Item 1a)

a. Originating agency's file containing complaints with related correspondence, reports, exhibits, withdrawal notices, copies of decisions, records of hearings and meetings, and other records as described in 29 CFR 1613.222. Cases resolved within the agency, by Equal Employment Opportunity Commission, or by a U.S. Court.

DISPOSITION: Destroy 7 years after resolution of case.

b. Copies of Complaint Case Files (**Disposition Authority: NARA's GRS 1, Item 25b**) Duplicate case files or documents pertaining to case files retained in Official Discrimination Complaint Case Files.

DISPOSITION: Destroy 1 year after resolution of case.

c. Preliminary and Background Files

(1) Background records not filed in the Official Discrimination Complaint Case Files. (**Disposition Authority: NARA's GRS 1, Item 25c1**)

DISPOSITION: Destroy 2 years after final resolution of case.

(2) Records documenting complaints that do not develop into Official Discrimination Complaint Cases. (**Disposition Authority: NARA's GRS 1, Item 25c2**)

DISPOSITION: Destroy when 2 years old.

d. Compliance Records

(1) Compliance Review Files (**Disposition Authority: NARA's GRS 1, Item 25d1**) Reviews, background documents, and correspondence relating to contractor employment practices.

DISPOSITION: Destroy when 7 years old.

(2) EEO Compliance Reports (**Disposition Authority: NARA's GRS 1, Item 25d2**)

DISPOSITION: Destroy when 3 years old.

e. Employee Housing Requests (**Disposition Authority: NARA's GRS 1, Item 25e**) Forms requesting agency assistance in housing matters, such as rental or purchase.

DISPOSITION: Destroy when 1 year old.

f. Employment Statistics Files (employment statistics relating to race and sex). (**Disposition Authority: NARA's GRS 1, Item 25f**) [See note after this item.]

DISPOSITION: Destroy when 5 years old.

[NOTE: Electronic master files and databases created to supplement or replace the records covered by this sub item are not authorized for disposal under the NARA GRS. Such files must be scheduled on an SF 115.]

g. EEO General Files (**Disposition Authority: NARA's GRS 1, Item 25g**)

General correspondence and copies of regulations with related records pertaining to the Civil Rights Act of 1964, the EEO Act of 1972, and any pertinent later legislation, and agency EEO Committee meeting records, including minutes and reports.

DISPOSITION: Destroy when 3 years old, or when superseded or obsolete, whichever is applicable.

h. EEO Affirmative Action Plans (AAP)

(1) Agency copy of consolidated AAP(s) (**Disposition Authority: N1-440-09-1, Item 1b1**)

DISPOSITION: Destroy 7 years from date of plan

(2) Agency feeder plan to consolidated AAP(s) (**Disposition Authority: N1-440-09-1, Item 1b2**)

DISPOSITION: Destroy 7 years from date of feeder plan or when administrative purposes have been served, whichever is sooner.

(3) Report of on-site reviews of Affirmative Action Programs (**Disposition Authority: N1-440-09-1, Item 1b3**)

DISPOSITION: Destroy 7 years from date of report

(4) Agency copy of annual report of Affirmative Action accomplishments (**Disposition Authority: N1-440-09-1, Item 1b4**)

DISPOSITION: Destroy 7 years from date of report.

XVIII. CMS Leadership Records (Consortium Administrators, Regional Administrators, Center/Office Directors, Chief Technology Officer and their Deputies)

1. Calendars and Daily Schedules

Calendars, appointment books, schedules, logs, diaries, and other records documenting meetings, appointments, telephone calls, trips, visits, and other activities while in official capacity.

a. Substantive information relating to official activities not incorporated into the files.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Save as a .pst file or print out. Destroy when 5 years old. **(Disposition Authority: N1-440-10-5, Item 1a)**

b. Routine activities containing no substantive information.

DISPOSITION: TEMPORARY. Destroy/delete when no longer needed for convenience of reference. **(Disposition Authority: NARA's GRS 23, Item 5b).**

2. Telephone Logs (do not create a log if one is not maintained)

Files consist of lists of incoming telephone messages. May include date of call, caller's name and phone number and a brief message.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy when 5 years old. **(Disposition Authority: N1-440-10-5, Item 2)**

3. Public Appearance and Meeting Requests

Accepted invitations received to make a public appearance and meetings.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy when 5 years old. **(Disposition Authority: N1-440-10-5, Item 3)**

4. Speech Files

Official speeches arranged by date of speech.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy when 5 years old. **(Disposition Authority: N1-440-10-5, Item 4)**

5. CMS Sponsored/Organized Conference and Public Hearing Files

Files contain information about conferences or hearings. Included are agendas, announcement of the conference and press releases.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy when 5 years old. **(Disposition Authority: N1-440-10-5, Item 5)**

6. Itineraries of Visits

Files pertaining to speaking engagements and visits that CMS Leadership has with other Department officials, town hall meetings, officials from health organizations, law firms and other private organizations.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy 5 years after cutoff. **(Disposition Authority: N1-440-10-5, Item 6)**

7. Briefing Books

Consists of weekly compilation of highlights and significant activities focusing mostly on upcoming issues from CMS offices and Regional Offices.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy 5 years after cutoff. **(Disposition Authority: N1-440-10-5, Item 7)**

8. Correspondence

a. Decision documents, final reports, policy determinations, etc., for signature by the Consortium Administrators, Regional Administrators, Center/Office Directors, Chief Technology Officer, and their Deputies.

DISPOSITION: PERMANENT. Cut off at the end of the calendar year. Hold for 5 years then transfer to the Washington National Records Center. Transfer to the National Archives 20 years after cutoff. **(Disposition Authority: N1-440-10-5, Item 8a)**

b. Incoming/outgoing correspondence that pertains to substantive policy issues and program functions (e.g., plans, objective, or responsibilities). **(Disposition Authority: N1-440-10-5)**

DISPOSITION: PERMANENT. Cut off at the end of each calendar year. Transfer to the Washington National Records Center 5 years after cutoff. Transfer to the National Archives 20 years after cutoff. **(Disposition Authority: N1-440-10-5, Item 8b)**

c. Incoming/outgoing correspondence of a routine nature (e.g., request for reference services, general information about the Agency, etc.).

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy 5 years after cutoff. **(Disposition Authority: N1-440-10-5, Item 8c)**

XIX. Health, Safety, Occupational, Emergency and Environmental

1. Safety and Occupational Health Complaints

Complaint files relating to safety and health factors in CMS facilities. Files include the complaint, papers involving the processing of the complaint, the official responses to the complaint, and related materials.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy 5 years old after cutoff. (**Disposition Authority: DAA-0440-2013-0012-0001.**)

2. Emergency/Disaster Planning Reports

- a. Agency reports of operations and tests, consisting of consolidated or comprehensive reports reflecting agency-wide results of tests conducted under emergency/disaster plans.

DISPOSITION: TEMPORARY. Destroy 5 years old after cutoff. Cutoff when superseded or obsolete. Retire to CMS Records Holding Area if volume warrants. (**Disposition Authority: DAA-0440-2013-0012-0002.**)

- b. Copies not maintained by the office of primary responsibility.

DISPOSITION: TEMPORARY. Cutoff when superseded or obsolete. (**Disposition Authority: DAA-0440-2013-0012-0003.**)

3. Preliminary Energy Audit Reports

Annual reports outlining energy use and conservation measures in CMS facilities. This report is submitted annually to the Department of Energy.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy 5 years old after cutoff. (**Disposition Authority: DAA-0440-2013-0012-0004.**)

4. Environmental Impact Statements (EIS) Prepared by CMS

EISs assess the environmental impact of an action taken by CMS. The EISs are distributed to other Federal agencies, public and private groups for review and comment. Final EISs must address written comments on the draft EIS submitted by reviewers.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy 6 years old after cutoff. (**Disposition Authority: DAA-0440-2013-0012-0005.**)

5. Limited Impact Statements Prepared by CMS

Limited Impact Statements assess the environmental impacts that are not considered to be “significant” and therefore do not require preparation of an EIS. The documents must be available for the public upon request, but they do not require distribution.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy 6 years old after cutoff. **(Disposition Authority: DAA-0440-2013-0012-0006.)**

6. Environmental Analyses Prepared by CMS

Environmental analyses are the documents used to support the decision to prepare either an EIS or limited impact statement. Environmental analyses are retained either was the EIS or limited impact statements in the project file of the agency which prepares the EIS or limited impact statement.

DISPOSITION: TEMPORARY. Cutoff at the end of the calendar year. Destroy 6 years after cutoff. **(Disposition Authority: DAA-0440-2013-0012-0007.)**

7. Categorical Exclusions

Categorical exclusions are analyses that are prepared by CMS program staff which may determine that program actions are not capable of creating significant environmental impact, and therefore, exclude that program activity from any further consideration of the need for an environmental analyses or environmental impact.

DISPOSITION: TEMPORARY. Destroy on expiration of the authority for the activity covered by the analyses, or 2 years after supersession by a revised analysis, whichever is earlier. **(Disposition Authority: DAA-0440-2013-0012-0008.)**

ALPHABETICAL INDEX

To search on a topic, please click on the first letter of the subject in bold text. Topics that do not have a Section or Item listed can be found in the National Archives & Records Administration's General Record Schedules.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

	<u>Section</u>	<u>Item</u>
A		
Accountable		
<u>Expenditures and Estimates of Account Files (Medicaid)</u>	V	V
<u>Accountable Officers' Accounts</u> (See NARA's General Records Schedule 6)		
http://www.archives.gov/records-mgmt/grs		
Accountable Officers' Files		1
Administrative Claims		10
Administrative Files		5
Certificates Settlement		3
E-Mail and Word Processing Copies (NARA's General Records Schedule 20)		13,14
Federal Personnel Surety Bond Files		6
Gasoline Sales Tickets		7
GAO Exceptions		2
General Fund		4
Telephone		8
Telegrams		9
Waiver of Claim		11
<u>Accounting</u> (See NARA's General Records Schedule 7, Items 1-5)		
http://www.archives.gov/records-mgmt/grs		
Appropriation Allotments		3
Correspondence & Subject Files		1
E-Mail & Word Processing Copies (NARA's General Records Schedule 20)		13,14
Expenditure Accounting Posting & Control Files		4
Ledgers		2
<u>Adjusted Community Rate Proposal</u>	VII	E
<u>Administrative Accounts (CLIA)</u>	XI	C4
<u>Administrative/Management Files</u>		
<u>Administrative Office Files</u>	I	M
<u>Agency Agreements</u>	I	A

	<u>Section</u>	<u>Item</u>
<u>Clearance and Vetting</u>	I	Q
<u>Committees/Task Forces</u>	I	B
<u>Delegation of Authority</u>	I	J
<u>Finding Aids</u>	I	W
<u>Forms Management Case Files</u>	I	F
<u>Instructions</u>	I	G
<u>Instructions/Background Files</u>	I	H
<u>Management Surveys</u>	I	E
<u>Office Files</u>	I	M
<u>Organizational Planning</u>	I	D
<u>Policy/Precedent</u>	I	I
<u>Posters</u>	I	P
<u>Rulemaking Record for Regulations</u>	I	N
<u>Rulemaking Support File</u>	I	N2
<u>Staff Visits</u>	I	C
<u>Suggestions</u>	XIV	W
<u>Suspense Files</u>	I	T
<u>Task Force</u>	I	K
<u>Tracking & Control Records</u>	I	V
<u>Training Publications</u>	I	L
<u>Transitory Records</u>	I	U
<u>Y2K Project Files</u>	I	R
<u>Administrator's Office Files</u>		
<u>Biographies</u>	XVI	5
<u>Briefing Books</u>	XVI	8
<u>Calendars and Daily Schedules</u>	XVI	1
<u>Conference and Public Hearing Files</u>	XVI	6
<u>Correspondence</u>	XVI	9
<u>Itineraries of Visits</u>	XVI	7
<u>Public Appearance and Meeting Requests</u>	XVI	3
<u>Speech Files</u>	XVI	4
<u>Telephone Logs</u>	XVI	2
<u>ADP Systems Plan Files</u>		
<u>IEDS or MMIS</u>	V	CC
<u>Agreements</u>		
<u>CMS</u>	I	A
<u>State Agency</u>	IV	E
<u>All State Letters (Medicaid)</u>	V	C
<u>Ambulance Services Certification (Medicare)</u>	III	L

	<u>Section</u>	<u>Item</u>
<u>Ambulatory Surgical Centers Survey Responses (Medicare)</u>	III	Y
<u>Annual Approval Letters (CLIA)</u>	XI	D
<u>Approved/Discontinued PT Programs - (CLIA)</u>	XI	D
Applications		
<u>CLIA</u>	XI	B
<u>HMO</u>	VII	A
<u>Provider/Supplier /DME Enrollment</u>	IV	T
<u>Appointee Clearance and Vetting</u>	I	Q
<u>ASET (Electronic System)</u>	XIV	D
<u>Assistance from DO, Request for</u>	III	M
<u>Assessments, Medicaid State</u>	V	DD
Audiovisual Records		
<u>Documentation</u>	XV	4
<u>Graphic Arts</u>	XV	3
<u>Recordings/Productions</u>	XV	1
<u>Still Photography</u>	XV	2
<u>Audio/Video Tapes of Interviews with Medicare Beneficiaries</u>	III	LL2
<u>Audit - HHS Agency Reports (Medicaid)</u>	V	X
<u>Audit - Teaching Hospital Medical Records (Provider)</u>	IV	Q
<u>Audited Financial Reports (HMO)</u>	VII	B1
B		
<u>Background Records, Other - Consumer Research</u>	III	LL3
<u>Bank Media (CLIA)</u>	XI	CI
<u>Bank Statements/Financial Documents, Medicare Premium</u>	III	KK
<u>Bankruptcy Case File</u>	IV	O

	<u>Section</u>	<u>Item</u>
Beneficiary		
<u>Overpayment Report (Medicare)</u>	III	P
<u>Benefit Check Records (Medicare)</u>	III	C
<u>Biographies</u> - Administrator's office	XVI	5
<u>Briefing Books</u> - Administrator's office	XVI	8
Budget		
<u>and Financial Reports (State Agency)</u>	IV	D
<u>Estimate and Cost Report, Administrative (Medicare)</u>	III	H
<u>Requests (Medicare)</u>	III	H1
<u>Budget Preparation, Presentation and Apportionment Records (SEE NARA's GENERAL RECORDS SCHEDULE 5, Items 1 -3)</u> http://www.archives.gov/records-mgmt/grs		
Apportionment		3
Background		2
Correspondence		1
<u>Buy-In Agreements (State Agency-Medicare)</u>	IV	G
<u>Cancelled Payments (CLIA)</u>	XI	C2
C		
Calendars		
<u>Calendars and Daily Schedules</u> - Administrator's office	XVI	1
<u>All Others (See NARA's GENERAL RECORDS SCHEDULE 23, Item 5)</u> http://www.archives.gov/records-mgmt/grs		
Senior Executives (Center/Office Directors, Deputies, Assistants)PENDING	XVIII	
<u>Card Files (PRRB)</u>	VIII	2
Carrier		
<u>Beneficiary Overpayment Report</u>	III	P
<u>Budget Estimates and Cost Report</u>	III	H
<u>Closing Agreements (Medicare)</u>	III	V
<u>Computer Printouts (Medicare Part B Claims)</u>	III	W
<u>Contracts</u>	III	R
<u>Letter of Credit</u>	III	I

	Section	Item
<u>Monthly Financial Reports</u>	III	K
<u>Payment Vouchers and Transmittals</u>	III	J
<u>Performance Reports (Medicare)</u>	III	O
<u>Requests for Assistance from District Offices</u>	III	M
<u>Review & Fair Hearing Cases (SMI)</u>	III	F
<u>Subcontracts</u>	III	S
<u>Certification Files (Provider-Medicare)</u>	IV	A
<u>Certifications Enrollment (HMO)</u>	VII	B6
<u>Check Listing (Medicare)</u>	III	W2
<u>Chief Information Officer Records</u> (See NARA's GENERAL RECORDS SCHEDULE 27, Items 1 - 6) http://www.archives.gov/records-mgmt/grs		
CIO Committee Records		5
CIO Subject and Office Records		6
Enterprise Architecture		2
Information Technology		
Capital Investment		3
Planning		1
Legal & Regulatory Compliance		4
<u>Civil Litigation/Bankruptcy Case Files (Provider)</u>	IV	O
<u>Claims</u>		
<u>Medicare, Part A & B</u>	III	A&B
<u>Processing Files</u>	IV	M
<u>Medicaid</u>	V	J & K
<u>CLIA (Clinical Laboratory Improvement Amendments)</u>		
<u>Accreditation Organization/Exempt State Approval Files</u>	XI	H
<u>Clinical Laboratory Applications</u>	XI	A
<u>Electronic Mail and WP System Copies</u>	XI	G
<u>Laboratory Personnel Report</u>	XI	B
<u>Post Clinical Laboratory Survey Questionnaire (Form CMS-668B)</u>	XI	I
<u>PT Participant Summary Reports</u>	XI	E
<u>Proficiency Testing Program Files</u>	XI	D
<u>User Fee Related Files</u>	XI	C1
<u>Validation Reviews</u>	XI	F
<u>Closing Agreements (Medicare)</u>	III	V
<u>Committees</u>		

	Section	Item
Copies of Committee Records	I	B3
Federal Advisory Committee Act (FACA)		
Advisory Committee Records	I	B2
FACA Management Records	I	B4
Internal Agency Committees	I	B1a & B1b
Communications (See NARA's General Record Schedule 12) http://www.archives.gov/records-mgmt/grs		
General Files		2
Messenger Service Files		1
Telecommunications Operational Files		3
Telephone Use (Call Detail) Records		4
Compliance Files		
<u>Official (HMO)</u>	VII	B
<u>Records (Medicaid)</u>	V	I
<u>State Compliance Hearings (Research & Demonstration)</u>	X	E
Computer Printouts		
<u>Medicaid</u>	V	T
<u>Medicare, Intermediary/Carrier</u>	III	W
<u>Conference and Public Hearing Files</u> - Administrator's office	XVI	6
Congressional Study Files (Medicare)	III	Z2
Consent Forms - Consumer Research	III	LL1
Consumer Research Records	III	LL
<u>Audio/Video Tapes of Interviews w/Beneficiaries</u>	III	LL2
<u>Consent Forms</u>	III	LL1
<u>Other Background Records</u>	III	LL3
<u>Results/Final Report</u>	III	LL4
Contact Reports (Medicaid)	V	B3
Contract Files		
<u>Medicaid, State Contractors</u>	V	U
<u>Medicare (Intermediary/Carrier)</u>	III	R
Contractor		
<u>Pension Cost Questionnaire (Medicare)</u>	III	AA
<u>Performance Review Visits (Medicare)</u>	III	T

	<u>Section</u>	<u>Item</u>
<u>Control Records (Research & Demonstrations)</u>	X	J4
<u>Correction Payment Action Summary Report (Provider)</u>	IV	N
<u>Corrective Plans, State (Medicaid)</u>	V	AA
Correspondence		
<u>Administrator's Office</u>	XVI	9
HMO	VII	A2
<u>Leadership (CMS)</u>	XVIII	5
<u>Routine Inquiries (Medicare Beneficiary/Provider)</u>	III	Q
Cost Reports		
<u>Demonstration</u>	X	K
<u>End Stage Renal Disease</u>	III	CC
<u>Intermediary (Medicare)</u>	III	X
D		
<u>Data Match, (Medicare)</u>	III	FF
<u>Data Use Agreements</u>	I	S
<u>Delegation of Authority</u>	I	J
<u>Detailed Printouts (Depots)</u>	IV	I
<u>Demonstration Cost Reports</u>	X	K
<u>Demonstrations</u> – Project Files	X	L
<u>Disallowance Cases (Medicaid)</u>	V	W
<u>Discontinued PT Programs (CLIA)</u>	XI	D2
<u>Distribution</u> (See NARA's GENERAL RECORDS SCHEDULE 13) http://www.archives.gov/records-mgmt/grs		
Administrative Correspondence		1
Control Files		3
Internal Management		6
JCP Reports		5
Mailing Lists		4

	Section	Item
Project Files		2
<u>Dockets (State Grant)</u>	X	F
Documentation (System/File Specs, Code Books, Record Layout, etc.)		
<u>Audiovisual</u>	XV	4
<u>HCPCS</u>	XIV	B3d
<u>Matrix</u>	XIV	A
<u>Duplication (See GENERAL RECORDS SCHEDULE 13)</u> http://www.archives.gov/records-mgmt/grs		
Project Files		2
E		
E-Mail and Word Processing System Copies (Applicable for all CMS Records) (See NARA's GENERAL RECORDS SCHEDULE 20) http://www.archives.gov/records-mgmt/grs		13,14
Electronic Records (See NARA's GENERAL RECORDS SCHEDULE 20) http://www.archives.gov/records-mgmt/grs		
Backups of Files		8
Creation, Use & Maintenance of Computer Systems		1
Data Files Consisting of Summarized Information		4
Documentation		11
Downloaded Data (and copied)		12
E-Mail Records		14
Electronic Records that Replace Temporary Hard Copy Records		3
Electronic Records that Replace Permanent Hard Copy Records		3.1
Electronic Spreadsheets		15
Electronic Versions of Records Scheduled for Disposal		3b
Extracted Information		5
Finding Aids or Indexes		9
Hard Copy Printouts Created to Meet Ad Hoc Business Needs		16
Input/Source Records		2
Print File		6
Special Purpose Programs		10
Technical Reformat File		7
Word Processing Files		13

	Section	Item
<u>Electronic Systems (CMS)</u>		
<u>Administrative Simplification Enforcement Tool (ASET)</u>	XIV	D
<u>Continuity Assessment Record and Evaluation (CARE)</u>	XIV	X
<u>Common Working File</u>	XIV	R
<u>Health Care Common Procedures Codes (HCPCS)</u>	XIV	B
<u>Health Care Quality Improvement System Family (ASPEN, CROWN, QIES, PQRI, SDPS, QIL, ESRD MAS, ESRD-QIP, QualityNet)</u>	XIV	P
<u>Healthcare Integrated General Ledger Accounting System (HIGLAS)</u>	XIV	J
<u>Idea & Information Exchange System</u>	XIV	W
<u>Integrated Data Repository (PENDING)</u>	IX	G
<u>Matrix (National Health Accounts Estimates)</u>	XIV	A
Medicaid & Children's Health Insurance System Family (EPSDT, FULS, SPW, MDR, MBES/CBES, CHIP/SEDS, SC/CLIA, MSIS, MAX, CARTIS, IBNRS, DDR) (PENDING)	XIV	U
Medicare Advantage and Rx Plan Operations System Family (APPS, HPMS, DDPS, MARx, PWS, RAS, SPDBS, PDTransFac (aka TrOOP), PRS, MPC, AAPCC (SOR))	XIV	T
<u>Medicare Appeals System (MAS)</u>	XIV	H
<u>Medicare Beneficiary Enrollment System Family (MBES, EDB, MDB)</u>	XIV	F
<u>Medicare Financial Management and Payment System Family (CAFM, CAFMII, CASR, CERT, CMIS, CMS-ART, CROWD, DPS, HCRSI, PIMR, PULSE, STAR, COB, RAC, PS&R)</u>	XIV	G
<u>Medicare Pricing System Family (HCPCS, CLSF, DMEFS, IDE, MQSA, PPS, PRICER, PPRICE, SGR, WI)</u>	XIV	I
<u>Medicare Utilization Data Collection and Access System (NCH, NMUD, MEDPAR, IBNR)</u>	XIV	S
<u>National Database Services Tracking Analysis & Reporting System (NDB-STARS)</u>	XIV	DD
<u>Online Registration System</u>	XIV	V
<u>Payment Quality Review System Family (FID, MPARTS, POR, PSOR, ReMAS, SMART, MARTI, PERM)</u>	XIV	O
<u>Payment Recovery Information System (PRIS)</u>	XIV	AA
<u>Personal Health Record (PHR) Pilots</u>	XIV	E
<u>PPCIS (Physician Practice Cost and Income Survey)</u>	XIV	C
<u>Pilots (Administrative and Program-Related)</u>	XIV	Q
<u>Provider Enrollment System Family (NPPEs, PECOS, IRIS, MED, UPIN, NPI, DBids)</u>	XIV	K
<u>Retiree Drug Subsidy</u>	XIV	L
State Health Insurance & Assistance Program National Performance Reporting System (SHIP-NPR)	XIV	FF
<u>Strategic Work Information Folder Transfer (SWIFT)</u>	XIV	M
<u>Suggestion and Idea Information Exchange Files</u>	XIV	W
<u>Surveyor Learning Management System (TotalLMS)</u>	XIV	Z
<u>Website Records</u>	XIV	N

	Section	Item
Emergency/Disaster Planning Reports	XIX	2
Energy Audit Reports	XIX	3
End Stage Renal Disease		
<u>Cost Reports (Medicare)</u>	III	CC
<u>Exception Requests (Medicare)</u>	III	GG
Enrollment Applications (Provider/Supplier)	IV	T
<u>Enrollment Certifications - MHPO</u>	VII	B6
Enrollment Database	IX	A
Environmental		
Categorical Exclusion	XIX	7
Environmental Analyses Prepared by CMS	XIX	6
Impact Statements	XIX	4
Limited Impact Statement	XIX	5
Equal Employment Opportunity	<u>XVII</u>	A-H
Ethics Program Records (See GENERAL RECORD SCHEDULE 25)		
<u>http://www.archives.gov/records-mgmt/grs</u>		
Agreement Records		2
Annual Agency Ethics Program Questionnaire		7
Employee Program Transcript & Education Files		3
Program Implementation, Interpretation, Counseling & Development Files		4
Program Procedures Files		5
Program Review Files		6
Financial Disclosure		7
Non-Federally Funded Travel Files		8
Violations, Referrals and Notifications		9
Exception Requests (ESRD)	III	GG
Exclusion and Termination Actions	III	PP
Executive Officer Hearing Record Cases (PRRB)	VIII	B2
Extra Copy		
<u>Convenience Files (Medicaid)</u>	V	B
Explanation of Benefit (Medicare)	III	D

	<u>Section</u>	<u>Item</u>
F		
<u>Federal Advisory Committee Act Records</u>	I	B2 & B4
<u>Federal Monitoring Re-Review Schedule (Medicaid)</u>		
<u>Active</u>	V	O
<u>Negative</u>	V	P
<u>Finding Aids</u>	I	W
Final		
<u>Administrative Cost Proposal (Medicare)</u>	III	H5
<u>Product (Grants)</u>	VI	B
<u>Financial Reports, Monthly (Medicare)</u>	III	K
<u>Financial Documents, Medicare Premium</u>	III	KK
Forms		
<u>Case History</u>	I	F2
<u>Consent - Consumer Research</u>	III	LL1
<u>Record Copy</u>	I	F1
Fraud and Abuse (See Program Integrity Case Files)	III	G
<u>Freedom of Information (See NARA's GENERAL RECORD SCHEDULE 14)</u> http://www.archives.gov/records-mgmt/grs		
Administrative Files	GRS 14	15
Appeals	GRS 14	12
Control Files	GRS 14	13
Reports Files	GRS 14	14
Requests	GRS 14	11
G		
<u>General Enrollment Period</u>		
<u>SMI (Provider)</u>	IV	L
<u>HI Provider Master File (Machine Readable)</u>	IX	B
<u>Geographic Classification Reviews (Medicare)</u>	VIII	3
Grant Records		
<u>Final Products</u>	VI	B
<u>Grants</u>	VI	A

	Section	Item
Loan/Loan Guarantee Files	VII	C1,C2
Performance Measurement Reports	VII	G
Plan Submissions	VII	F
Service Area Expansion Files	VII	E
Hearings		
<u>Provider (Medicare)</u>	IV	K
Hearings, Office of		
<u>Database</u>	VIII	1C
<u>Decisions/Proposed Decisions</u>	VIII	4
<u>Instruction Background Files</u>	VIII	1B
<u>Instruction Files</u>	VIII	1A
<u>Medicare Geographic Reviews Board Files</u>	VIII	3
<u>Provider Reimbursement Review Board Files</u>		
<u>Closed Case Files</u>	VIII	2B
<u>Hearing Decisions</u>	VIII	2A
<u>HHS Audit Reports (Medicaid)</u>	V	X
<u>Hospital Mortality, Publication (HSQB)</u>	III	BB
I		
<u>Information Technology Operations & Management Records</u>		
(See NARA's GENERAL RECORD SCHEDULE 24)		
http://www.archives.gov/records-mgmt/grs		
Asset and Configuration Management Files	GRS 24	3
Computer Security Incident Handling, Reporting and Follow-up Records	GRS 24	7
Customer Service Files	GRS 24	10
Financial of IT Resources and Services	GRS 24	9
Infrastructure Design and Implementation	GRS 24	11
Maintaining Security of Systems and Data	GRS 24	4
Operations Records	GRS 24	8
Oversight and Compliance	GRS 24	1
Public Key Infrastructure Records	GRS 24	13
System Backups and Tape Library Records	GRS 24	3
IT Site Facility, Site Mgmt., & Equipment Support Services Records	GRS 24	2
User ID, Profiles, Authorizations and Password Files	GRS 24	6
<u>Initial Enrollment Questionnaire</u>	III	II

	Section	Item
Instructions		
<u>CMS (Administrative/Management)</u>	I	G
<u>Medicare</u>	II	1A
<u>PRRB</u>	VIII	1A
Instructions/Background		
<u>CMS (Administrative/Management)</u>	I	H
<u>Medicare</u>	II	2
<u>Medigap</u>	XII	B
<u>PRRB</u>	VIII	1b
Interchange of Research Experts	X	A
Interim		
<u>Expenditure Reports (Medicare)</u>	III	H4
<u>Rate Listings</u>	IV	J
Intermediary (Medicare)		
<u>Administrative Budget Estimate & Cost Report</u>	III	H
<u>Closing Agreements</u>	III	V
<u>Computer Printouts</u>	III	W
<u>Cost Reports</u>	III	X
<u>Workload Reports</u>	III	N
<u>Letter of Credit</u>	III	I
Internal Control Review (See GENERAL RECORD SCHEDULE 16)		
http://www.archives.gov/records-mgmt/grs		
Management Control Records (See GRS 16, Item 14)		
Interviews with Medicare Beneficiaries, Audio/Video Tapes	III	LL2
<u>Itineraries of Visits - Administrator's office</u>	XVI	7
<u>Itineraries of Visits - CMS Leadership</u>	XVIII	6
J		
K		
L		
<u>Leadership Records (CMS)</u>	XVIII	

	Section	Item
Briefing Books	XVIII	7
Calendars and Daily Schedules	XVIII	1
Conference and Public Hearing Files	XVIII	5
Correspondence	XVIII	8
Itineraries of Visits	XVIII	6
Public Appearance and Meeting Requests	XVIII	3
Speech Files	XVIII	4
Telephone Logs	XVIII	2
<u>Ledgers and Cash Tables (State Grant)</u>	X	G
<u>Letter of Credit, Intermediary/Carrier</u>	III	I
<u>Loan/Loan Guarantee (HMO)</u>	VII	C
<u>Loans Paid in Full (HMO)</u>	VII	C1
M		
<u>Mail and Delivery Service (See GENERAL RECORD SCHEDULE 12, Item 6)</u> http://www.archives.gov/records-mgmt/grs		
Mail and Delivery Service Control Files	GRS 12	6
<u>Mailing Lists (See GENERAL RECORD SCHEDULE 13)</u> http://www.archives.gov/records-mgmt/grs	GRS 13	4
<u>Management (CMS)</u>		
Forms	I	F
Surveys	I	E
<u>Mammography Facilities</u>	IV	A1b4
<u>Marketing Materials - HMO</u>	VII	B7
<u>Master Data Files (Machine Readable)</u>	IX	C
<u>Mechanized Claims Processing Information Systems</u>		
State ADP Contract Cases (MMIS-Medicaid)	V	K
State ADP Systems Plans (MMIS-Medicaid)	V	J
State ADP Systems Plans (IEDS-Medicaid)	V	CC

	<u>Section</u>	<u>Item</u>
Medicaid - See also: State		
<u>Administrative Subject Files</u>	V	D
<u>All State Letters</u>	V	C
<u>Compliance Records</u>	V	I
<u>Computer Printouts</u>	V	T
<u>Corrective Action Plans, State</u>	V	AA
<u>Disallowance Case File</u>	V	W
Federal Monitoring Re-Review Schedule Case Files		
<u>Active</u>	V	O
<u>Negative</u>	V	P
<u>HHS Audit Agency Reports</u>	V	X
Program		
<u>General Subject File</u>	V	E
<u>Reports from States</u>	V	L
<u>Review Files</u>	V	S
<u>State Annual Budget Projections</u>	V	EE
<u>State Subject Files</u>	V	F
<u>SPR Files on Mechanized Claims Processing</u>	V	Z
State		
<u>Accountable Expenditures and Estimates of Accounts</u>	V	V
<u>Assessments</u>	V	DD
ADP		
<u>Contract Case Files</u>	V	K
Systems Plans Files		
<u>MMIS</u>	V	J
<u>IEDS or M-RAS</u>	V	CC
<u>Contracts for Administration of Medicaid Program</u>	V	U
<u>Corrective Plans</u>	V	AA
<u>Plans and Amendments</u>	V	G
<u>Re-approval Review Files</u>	V	Y
<u>Review Files</u>	V	S
<u>Review Schedules</u>	V	Q
<u>Sampling Plans (Active and Negative)</u>	V	R
<u>Technical Reference Material</u>	V	A
Utilization Control		
<u>Quarterly Reports</u>	V	M
<u>Onsite Validation Surveys</u>	V	N
<u>Waiver Programs</u>	V	BB
Medical Records		
Fraud & Abuse (Program Integrity Case Files)	III	G
Payment Quality Review Systems	XIV	O1b
Teaching Hospital Medical Records (Audit & Recoupment Files)	IV	Q & R

	<u>Section</u>	<u>Item</u>
Medicare		
Administrative		
<u>Budget Estimate & Cost Reports (Inter/Carrier)</u>	III	H
<u>Instructions Files</u>	II	A1a
<u>Ambulance Services Certification</u>	III	L
<u>Ambulatory Surgical Center Survey Responses</u>	III	Y
<u>Bank Statements/Financial Documents</u>	III	KK
Beneficiary		
<u>Correspondence</u>	III	Q
<u>Enrollment System (MBES)</u>	XIV	F
<u>Overpayment Report</u>	III	P
<u>Benefit Check Records</u>	III	C
Budget		
<u>Estimate and Cost Report and Financial Reports (State Agency)</u>	III IV	H D
<u>Requests</u>	III	H1
<u>Buy-In Agreements (State)</u>	IV	G
<u>Carrier Performance Report</u>	III	O
<u>Certifications, Provider</u>	IV	A
<u>Civil Litigation/Bankruptcy Cases</u>	IV	O
Claims		
<u>Part A</u>	III	A
<u>Part B</u>	III	B
<u>Claims Processing Files, Provider (previously Quality Assurance)</u>	IV	M
<u>Claims Processing Systems (Medicare)</u>	III	MM
<u>Closing Agreements, Intermediary & Carrier</u>	III	V
<u>Computer Printout Records, Intermediary & Carrier</u>	III	W
<u>Contract Files</u>	III	R
Contractor		
<u>Pension Cost Questionnaire</u>	III	AA
<u>Performance Review Visits</u>	III	T
<u>Correction Payment Action Summary Report</u>	IV	N
Cost Reports		
<u>End Stage Renal Disease Provider to Intermediary</u>	III III	CC X
<u>Data Match (Medicare)</u>	III	FF
<u>Detailed Printouts (Provider)</u>	IV	I
<u>Exclusion and Termination Actions</u>	III	PP
<u>Explanation of Medicare Benefit Records</u>	III	D
<u>Financial Reports (Monthly)</u>	III	K
<u>Financial Documents, Medicare Premium</u>	III	KK
<u>Financial Management and Payment Systems (MFMPS)</u>	XIV	G
<u>Fraud and Abuse (Program Integrity)</u>	III	G
<u>General Enrollment Period (Provider)</u>	IV	L

	Section	Item
<u>Geographic Classification Review Board Files</u>	VIII	3
<u>Graduate Medical Agreements</u>	III	SS
<u>HHS Audit Agency Report</u>	V	X
<u>Hospital Mortality (Publication)</u>	III	BB
<u>Initial Enrollment Questionnaire</u>	III	II
<u>Instructions/Instructions Background</u>	II	2a
Interim		
<u>Expenditure Report</u>	III	H4
<u>Rate Listings</u>	IV	J
<u>Intermediary Workload Reports</u>	III	N
<u>Letter of Credit Files</u>	III	I
<u>Medical Facilities Directory</u>	IV	C
<u>Medicare Secondary Payer</u>	III	HH
<u>Notice of Budget Approval</u>	III	H3
<u>Overpayments-Part A</u>	III	JJ
<u>Program Operational Studies</u>	III	Z1
<u>Payment Vouchers and Transmittals</u>	III	J
<u>Pension Actuarial Analysis</u>	III	EE
<u>Pension Cost Questionnaire</u>	III	AA
<u>Performance Reports, Carrier</u>	III	O
<u>Professional Qualifications</u>	IV	P
<u>Professional Standards Review Organization Files</u>	III	NN
Program		
<u>Integrity Case Files</u>	III	G
<u>Review Team (PRT) Files</u>	III	OO
<u>Validation Reviews</u>	IV	H
Provider		
<u>Certifications</u>	IV	A
<u>Claims Processing (Carrier)</u>	IV	M
<u>Corrective Action Payment (Part B)</u>	IV	N
<u>Enrollment Applications</u>	IV	T
<u>Hearing Files</u>	IV	K
<u>Nominations</u>	III	U
<u>Quality Assurance, Claims Processing (Part B)</u>	IV	M & N
<u>Statistical & Reimbursement Reports</u>	IV	B
<u>Questionnaire, Initial Enrollment</u>	III	II
<u>Reconsideration and Hearing Cases</u>	III	E
<u>Requests for Assistance from DO</u>	III	M
<u>Review & Fair Hearing Case Files</u>	III	F
Studies		
<u>Congressional</u>	III	Z2
<u>Program Operational</u>	III	Z1
<u>Subcontract Files</u>	III	S

	Section	Item
<u>Summary Notices, Medicare</u>	III	D
<u>Supplemental Budget Request</u>	III	H2
<u>Supplementary Medical Insurance</u>	IV	L
<u>Survey and Certification (Provider)</u>	IV	A
<u>Survey Report Form</u>	IV	A1b2
Teaching Hospital Medical Records		
<u>Audit Files</u>	IV	Q
<u>Recoupment Audits</u>	IV	R
<u>Utilization Reviews</u>	IV	S
<u>Waivers for Hospital Payment (Medicare)</u>	III	DD
<u>Workload Reports (Intermediary)</u>	III	N
<u>Medicare Secondary Payer</u>	III	HH
<u>Medigap</u>		
<u>Instructions/Background Files</u>	XII	B
<u>Program Files</u>	XII	C
<u>State Reviews</u>	XII	A
<u>Monthly Financial Report (Medicare)</u>	III	K
<u>Motor Vehicle Maintenance and Operation (See GENERAL RECORD SCHEDULE 10) http://www.archives.gov/records-mgmt/grs</u>		
Accidents	GRS 10	5
Correspondence	GRS 10	1
Cost Files	GRS 10	3
Operating & Maintenance	GRS 10	2
Operator Files	GRS 10	7
Vehicle Release Files	GRS 10	6
Vehicle Report Files	GRS 10	4
N		
<u>NDRR Reports (HMO)</u>	VII	B3&4
<u>Notice of Budget Approval (Medicare)</u>	III	H3
O		
<u>OIG Hotline Database</u>	XIV	EE
<u>Onsite Validation Surveys (Utilization Control-Medicaid)</u>	V	N
<u>Organizational Planning</u>	I	D

	Section	Item
<u>Other Committees</u>	I	B2
<u>Overpayments-Part A</u>	III	JJ
P		
<u>Part A & B Claims (Medicare)</u>	III	A&B
<u>Participant Summary Report PT (CLIA)</u>	XI	E
<u>Payment Vouchers & Transmittals (Medicare)</u>	III	J
<u>Payroll (See GENERAL RECORD SCHEDULE 2)</u> http://www.archives.gov/records-mgmt/grs		
Allotment Authorizations	GRS 2	15, 16
Bonds	GRS 2	14
Direct Deposit	GRS 2	24
Reports	GRS 2	13, 22
Retirement	GRS 2	28
Time & Attendance	GRS 2	7
<u>Pension</u>		
<u>Pension & Employee Benefits Actuarial Analysis</u>	III	EE
<u>Cost Questionnaire, Medicare Contractor</u>	III	AA
<u>Performance Reports-Carrier (Medicare)</u>	III	O
<u>Personal Health Record (PHR) Pilots System</u>	XIV	E
<u>Personnel (See GENERAL RECORD SCHEDULE 1)</u> http://www.archives.gov/records-mgmt/grs		
Adverse Actions/Performance Based Actions	GRS 1	30
Administrative Grievance	GRS 1	30
Alternate Worksite Records (Flexi place)	GRS 1	42
Correspondence	GRS 1	3
Drug Testing Program	GRS 1	35
Donated Leave Program	GRS 1	6
Employee Awards Files	GRS 1	7
Employment Offers	GRS 1	4
Health Unit Control Files	GRS 1	20
Medical Folders	GRS 1	21
Merit Promotions Case Files	GRS 1	32
Non-Occupational Health Record Files	GRS 1	19
Occupational Injury/Illness Files	GRS 1	34

	Section	Item
Official Personnel Files (OPFs)	GRS 1	1
Performance File System Records	GRS 1	23
Reasonable Accommodation Requests	GRS 1	24
Supervisory Personnel Files & Duplicate OPF Documents	GRS 1	18
Training Records	GRS 1	29
<u>Physician Practice Costs & Income, Survey Data File (Electronic System)</u>	XIV	C
Pilot Systems (Agency's Administrative and Program-Related)	XIV	Q
<u>Policy/Precedent Files (CMS)</u>	I	I
<u>Posters</u>	I	P
<u>Press Office Files</u>		
<u>Daily Press Service (News Clips)</u>	XIII	2
<u>E-Mail and Word Processing Copies</u>	XIII	5
<u>News Conferences</u>	XIII	3
<u>Press Releases</u>	XIII	1
<u>Publication Planning & Clearance Request Form</u>	XIII	4
<u>Printing (See NARA's GENERAL RECORD SCHEDULE 13)</u> http://www.archives.gov/records-mgmt/grs		
Administrative Correspondence	GRS 13	1
Control Files	GRS 13	3
Internal Management	GRS 13	6
Joint Committee on Printing Reports	GRS 13	5
Mailing Lists	GRS 13	4
Project Files	GRS 13	2
<u>Privacy (See GENERAL RECORD SCHEDULE 14)</u> http://www.archives.gov/records-mgmt/grs		
Amendments	GRS 14	22
Accounting of Disclosure	GRS 14	23
Erroneous Release Files	GRS 14	36
General Administrative Files	GRS 14	26
Reports	GRS 14	25
Requests	GRS 14	21
<u>Procurement and Supply (See GENERAL RECORD SCHEDULE 3)</u> http://www.archives.gov/records-mgmt/grs		
Bids & Proposals		

	Section	Item
Solicited	GRS 3	
Unsolicited	GRS 3	
Cancelled Solicitations	GRS 3	
Contractor' Payroll Files	GRS 3	
General Correspondence	GRS 3	
Inventory Files	GRS 3	
Inventory Requisitions	GRS 3	
Nonpersonal Requisitions	GRS 3	
Public Printer Files	GRS 3	
Routine Procurements	GRS 3	
Supply Management	GRS 3	
Tax Exemptions	GRS 3	
Telephone Records	GRS 3	
<u>Professional Qualifications (Provider)</u>	IV	P
<u>Professional Standards Review Organization Files</u>	III	NN
<u>Proficiency Testing (CLIA)</u>	XI	D
Program		
<u>Integrity Cases (Medicare)</u>	III	G
<u>Medigap Files</u>	XII	C
<u>Operational Studies (Medicare)</u>	III	Z1
<u>Review Team Files</u>	III	OO
<u>Reports from States (Medicaid)</u>	V	L
<u>Validation Reviews</u>	IV	H
<u>Property, Disposal/Surplus/Excess (See GENERAL RECORD SCHEDULE 4)</u> http://www.archives.gov/records-mgmt/grs	GRS 4	
Provider Records		
<u>Certification Files (Medicare)</u>	IV	A
<u>Civil Litigation/Bankruptcy</u>	IV	O
<u>Claims Processing (previously Quality Assurance File)</u>	IV	M
<u>Corrective Action Payment Summary</u>	IV	N
<u>Detailed Printouts</u>	IV	I
<u>Hearing Files (Medicare)</u>	IV	K
<u>Interim Rate Listings</u>	IV	J
<u>Medical Facilities Directory</u>	IV	C
<u>Nominations (Medicare)</u>	III	U
<u>Professional Qualifications</u>	IV	P
<u>Program Validation Reviews</u>	IV	H
State Agency		

	<u>Section</u>	<u>Item</u>
<u>Agreement</u>	IV	E
<u>Budget and Financial Report</u>	IV	D
<u>Buy-In Agreements</u>	IV	G
<u>Review Files</u>	IV	F
<u>Statistical and Reimbursement Reports</u>	IV	B
<u>Supplementary Medical Insurance - GEP</u>	IV	L
Teaching Hospital Medical Record		
<u>Audit Files</u>	IV	Q
<u>Medical Recoupment (Audit)</u>	IV	R
<u>Utilization Reviews</u>	IV	S
<u>Provider Nominations</u>	III	U
<u>Provider Reimbursement Review Board</u>		
<u>Closed Case Files</u>	VIII	2b
<u>Hearing/Decisions</u>	VIII	2a
<u>Public Appearance and Meeting Requests - Administrator's office</u>	XVI	3
<u>Publications</u>		
<u>Hospital Mortality</u>	III	BB
<u>Program-Related (see Instruction Files)</u>	I	G
<u>Training</u>	I	L
Q		
<u>Quality Assurance (Part B Claims)</u>	IV	M
<u>Quality Control Schedule, Eligibility Review (Medicaid)</u>		
<u>Active</u>	V	O
<u>Negative</u>	V	P
<u>Questionnaires</u>		
<u>Data Match (MSP, Medicare)</u>	III	FF
<u>Medicare Contractor Pension Cost (OACT)</u>	III	AA
R		
<u>Research & Demonstration Project Case Files</u>	X	M

	Section	Item
<u>Re-approval Review Files (Medicaid)</u>	V	Y
<u>Reconsideration and Hearing (HI Program-Medicare)</u>	III	E
<u>Recordings/Productions (Audiovisual)</u>	XV	1
<u>Records Common to Most Offices (See GENERAL RECORD SCHEDULE 23)</u> http://www.archives.gov/records-mgmt/grs		
<u>Records Management (See GENERAL RECORD SCHEDULE 16)</u> http://www.archives.gov/records-mgmt/grs		
<u>Refund Reports (CLIA)</u>	XI	C3
<u>Regulations, Rulemaking Record</u>	I	N
<u>Requests for Assistance, from DOs (Medicare)</u>	III	M
Reports		
<u>Administrative Budget Estimate (Intermediary/Carrier)</u>	III	H
<u>Audited Financial (HMO)</u>	VII	B1
<u>Carrier Performance</u>	III	O
<u>Contact (Medicaid)</u>	V	B3
<u>Correction Payment Action Summary</u>	IV	N
<u>Cost Report</u>		
<u>By provider to intermediary (Medicare)</u>	III	X
<u>Demonstration</u>	X	K
<u>End Stage Renal Disease</u>	III	CC
<u>Federal Advisory Committee Act (FACA,)/Committee Management Records</u>	I	B4
<u>Financial Reports, Intermediary & Carrier</u>	III	K
<u>HHS Audit Agency (State Agency)</u>	V	X
<u>Intermediary Workload</u>	III	N
<u>Interim Expenditure</u>	III	H4
<u>Laboratory Personnel (CLIA)</u>	XI	A
<u>Medicaid Program, from States</u>	V	L
<u>NDRR (HMO)</u>	VII	B3
<u>Performance Measurement Reports</u>	VII	G
<u>Refunds (CLIA)</u>	XI	C3
<u>Revoked Audited Financial (HMO)</u>	VII	B2
<u>State Agency Budget & Financial</u>	IV	D
<u>Survey Report-Access Hospitals</u>	IV	A1b3
<u>Trip (Medicaid)</u>	V	B2

	Section	Item
<u>Utilization Control, Quarterly (Medicaid)</u>	V	M
<u>Workload (Intermediary)</u>	III	N
Research		
<u>Demonstration Project Files</u>	X	L
Results/Final Report		
<u>Consumer Research</u>	III	LL4
Review		
<u>and Fair Hearing Files -SMI (Medicare)</u>	III	F
<u>Medicare-State Agency</u>	IV	F
<u>Medicaid</u>	V	S
<u>State Re-approval</u>	V	Y
Review Schedules, State (Medicaid)	V	Q
Revoked Audited Financial Reports (HMO)	VII	B1
Rulemaking Record		
<u>for Regulations</u>	I	N
S		
<u>Safety and Occupational Health Complaints</u>	XIX	1
<u>Security & Protective Services</u> (See GENERAL RECORD SCHEDULE 18) http://www.archives.gov/records-mgmt/grs		
<u>Source Documents (MCPS)</u>	III	MM1b
<u>Space and Maintenance</u> (See GENERAL RECORD SCHEDULE 11) http://www.archives.gov/records-mgmt/grs		
<u>Speech Files - Administrator's office</u>	XVI	4
<u>SPR Mechanized Claims Processing MMIS (Medicaid)</u>	V	Z
<u>Staff Visits (Administrative/Management)</u>	I	C
<u>Still Photography, Audiovisual</u>	XV	2
State - See also: Medicaid		

	Section	Item
<u>Accountable Expenditures & Estimates of Accounts (Medicaid)</u>	V	V
<u>Annual Budget Projections</u>	V	EE
<u>Assessments</u>	V	DD
ADP Systems Plans Files		
<u>IEDS</u>	V	CC
<u>MMIS</u>	V	J
<u>ADP Contract Cases (Medicaid) MMIS</u>	V	K
<u>Buy-In Agreements</u>	IV	G
<u>Contractor Contracts (Medicaid)</u>	V	U
<u>Corrective Action Plans (Medicaid)</u>	V	AA
<u>Disallowance Cases (Medicaid)</u>	V	W
Program		
<u>Reports from States (Medicaid)</u>	V	L
<u>Reviews (Medicaid)</u>	V	S
<u>Re-approval Reviews (Medicaid)</u>	V	Y
<u>Review Schedules (Medicaid)</u>	V	Q
<u>Reviews State (Medigap)</u>	XII	A
<u>Sampling Plans, Active & Negative (Medicaid)</u>	V	R
<u>SPR Files on Mechanized Claims Processing</u>	V	Z
State Agency (Provider)		
<u>Agreements</u>	IV	E
<u>Budget and Financial Reports</u>	IV	D
<u>Buy-In Agreements</u>	IV	G
<u>Program Validation Reviews</u>	IV	H
<u>Review Files</u>	IV	F
State Plans		
<u>and Amendments (Medicaid)</u>	V	G
<u>Correspondence (Medicaid)</u>	V	H
Statistical		
<u>and Reimbursement Reports (Provider-Medicare)</u>	IV	B
Studies		
<u>Congressional</u>	III	Z2
<u>Program Operational</u>	III	Z1

	Section	Item
<u>Subcontract Files, Carrier/Inter. (Medicare)</u>	III	S
<u>Supplemental Budget Request (Medicare)</u>	III	H2
<u>Supplementary Medical Insurance GEP (Medicare)</u>	IV	L
Survey		
<u>Ambulatory Surgical Center Responses</u>	III	Y
<u>and Certification (Provider Certifications)</u>	IV	A
<u>Management Case Files (CMS)</u>	I	E
<u>Utilization Control Onsite Validation (Medicaid)</u>	V	N
Suspense Files	I	T
System of Records		
<u>Common Working File</u>	IX	H
<u>Data Collection Secondary to Coverage Decision (DCSCD) System</u>	IX	I
<u>Enrollment Database</u>	IX	A
<u>Group Health Plan System</u>	IX	C
<u>Health Insurance Provider</u>	IX	B
<u>Health Insurance General Enrollment Period</u>	IX	E
<u>Integrated Data Repository</u>	IX	G
<u>Medicaid Integrity System</u>	IX	F
<u>Third Party</u>	IX	D
Systems, State ADP Electronic Records, Plans Files, State ADP		
<u>IEDS</u>	V	CC
<u>MMIS</u>	V	J
T		
Task Force	I	K
<u>Internal Control Review</u>	I	K1
<u>Regulatory Reform</u>	I	K2
Teaching Hospital Medical Record (Provider)		
<u>Audit Files</u>	IV	Q
<u>Recoupment Files</u>	IV	R
<u>Technical Reference Material (Medicaid)</u>	V	A
<u>Telephone Logs - Administrator's office</u>		
Administrator's Office	XVI	2

	Section	Item
<u>All Others</u> (See GENERAL RECORDS SCHEDULE 23) http://www.archives.gov/records-mgmt/grs	GRS 23	5a
<u>Third-Party HI Master File, (Machine Readable)</u>	IX	D
<u>Telecommunications</u> (See NARA's GENERAL RECORDS SCHEDULE 12)	GRS 12	
<u>Training Publications</u>	I	L
<u>Training Records</u> (See NARA's GENERAL RECORDS SCHEDULE 1)	GRS 1	29
<u>Tracking & Control Records</u>	I	V
<u>Transitory Records</u>	I	U
<u>Travel and Transportation</u> (See GENERAL RECORDS SCHEDULE 9) http://www.archives.gov/records-mgmt/grs	GRS 9	
U		
<u>Uncollected Loans (HMO)</u>	VII	C2
<u>User Fees (CLIA)</u>	XI	C
Utilization		
<u>Control (Medicaid)</u>	V	M
<u>Onsite Validation Surveys</u>	V	N
<u>Quarterly Reports</u>	V	M
<u>Reviews (Provider)</u>	IV	S
V		
<u>Validation Reviews (CLIA)</u>	XI	F
<u>Videotapes – Agency</u>	XV	1a
<u>Video/Audio Tapes of Interviews with Medicare Beneficiaries</u>	III	LL2
<u>Y2K</u>	I	R
W		
<u>Waiver Programs (Medicaid)</u>	V	BB
<u>Waivers for Hospital Payment (Medicare)</u>	III	DD

	<u>Section</u>	<u>Item</u>
<u>Workload Reports (Intermediary)</u>	III	N
X		
Y		
<u>Y2K Project Files</u>	I	R
Z		