CENTERS for MEDICARE & MEDICAID SERVICES

Payment Participant Guide

2011 Regional IT Technical Assistance

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INTRODUCTION AND OVERVIEW

Purpose

The purpose of this technical assistance session is to provide participants with the support needed to understand the reports used in reconciling payment. Plans receive monthly payments for the beneficiaries enrolled in their plans. The payments are communicated on the monthly reports provided by CMS. Plans should use the reports to reconcile payment received. The purpose of this guide is to provide participants with a high level understanding of monthly payments received by CMS.

Overview of the Session

This session is organized into three (3) modules which describe the fields communicated in each report and examples outlining how participants can use reports to reconcile their monthly payment. The session will introduce common terms and systems used to generate reports. This guide will highlight four monthly reports:

1. Plan Payment Report (PPR)
2. Monthly Membership Report (MMR)
3. Premium Withhold Report (PWR)
4. Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File

ICON KEY	
Definition	
Example	
Reminder	
Resource	

Participant Guide

This Participant Guide is designed to support the technical assistance program. The presentation slides complement the Participant Guide, and both are used extensively throughout this program to enhance the learning experience. Table A provides a description of the technical assistance tools used during the session.

TABLE A – TECHNICAL ASSISTANCE TOOLS

SECTION	DESCRIPTION
Participant Guide	Detailed description of relevant Payment information Examples
Slides	Organized by module
Resource Guide	Official CMS Notices List of Acronyms Website Links

Audience

This program is designed for plans new to the enrollment process, as well as new staff at existing plans and staff unable to attend previous sessions. The primary audiences for this session include:

- Staff of new
  - Medicare Advantage (MA) organizations
  - Medicare Advantage – Prescription Drug (MA-PD) organizations
  - Prescription Drug Plans (PDPs)
  - Employer Sponsored Group Health Plans (EGWPs)
  - Demonstration Plans
  - Program of All-Inclusive Care for the Elderly (PACE) organizations
- Existing staff unable to attend previous training sessions
- New staff at the existing organizations mentioned above

Learning Objectives

At the completion of this technical assistance session, participants will be able to:

- Define common terms.
- Understand how to reconcile plan payments using various payment reports.
- Review recent changes to reports and identify some common issues through scenarios.
- Provide basic payment formulas and map payment amounts to fields on the report.

Common Enrollment and Payment Terms

The modules throughout this guide will use common terms discussed during the session. Table B provides descriptions for common enrollment and payment system terminology.

TABLE B - PAYMENT COMMON SYSTEM TERMS

TERMS	DESCRIPTION
MARx	**Medicare Advantage Prescription Drug System** supports the enrollment and payment functions for plans approved by CMS to provide Part C and Part D benefits.
HPMS	The **Health Plan Management System** is a CMS information system that contains health plan-level data.
PWS	The **Premium Withholding System** receives information from MARx, the Social Security Administration (SSA), and Railroad Retirement Board (RRB) to record withheld premium amounts and periods as expected or actual. PWS notifies plans and APPS of withholdings.
APPS	The **Automated Plan Payment System** calculates payment using data provided by MARx, HPMS, and PWS, and disperses payment to the U.S. Treasury.

Reports Overview

CMS provides reports to plans communicating beneficiary demographic status, risk scores, and payment/adjustment amounts on a beneficiary-level. CMS also provides plans with plan-level reports that communicate a summary of payment/adjustment amounts. Plans must reconcile their internal records to ensure accuracy of payment for each beneficiary enrolled in the plan. This session will examine these reports used to reconcile the plans monthly payment.

Table C lists the reports and functions discussed in this session.

TABLE C –REPORT VERSIONS

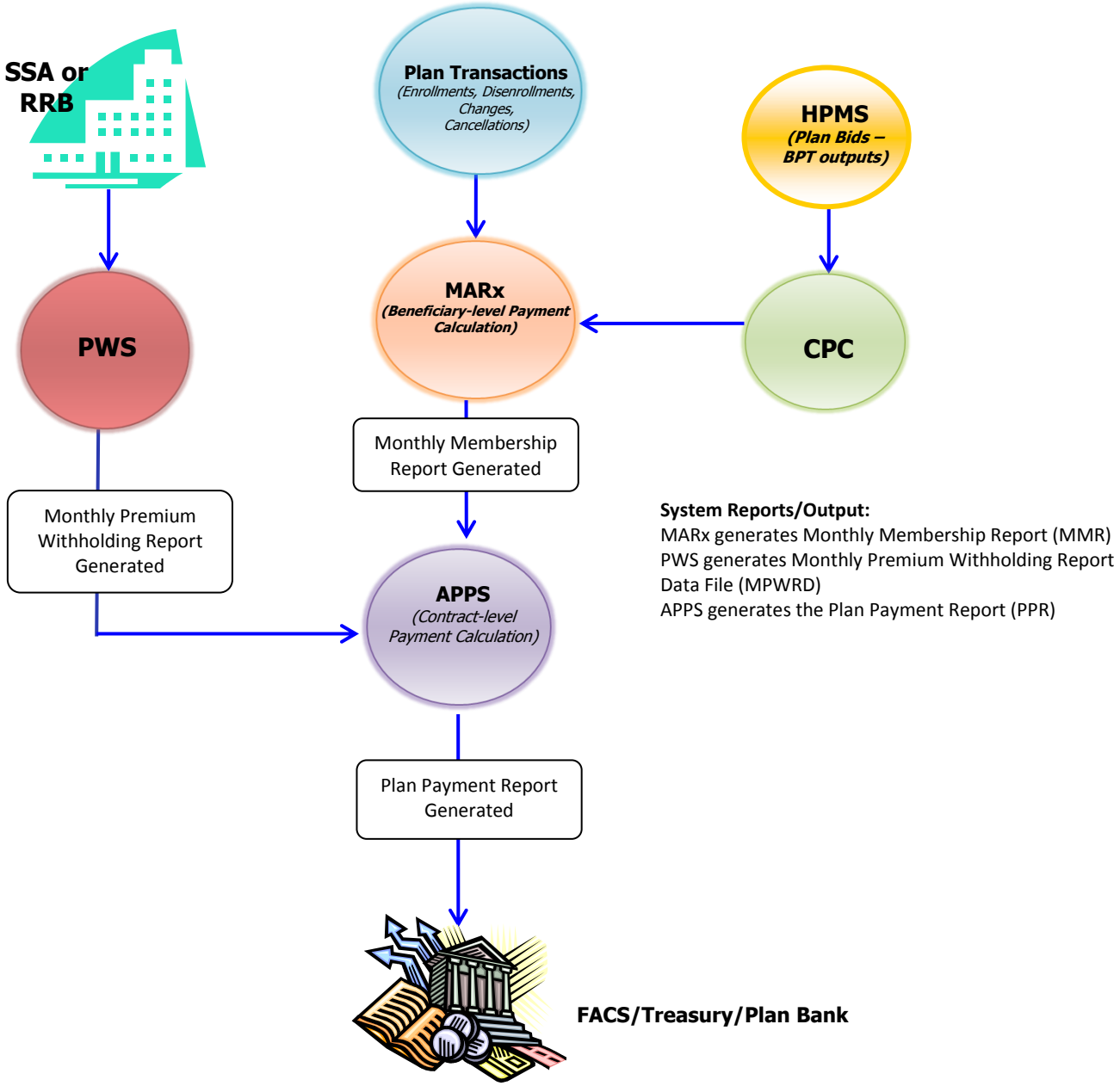
Report Name	Function	Layout
Plan Payment Report (PPR) / Interim Plan Payment Report (IPPR) Data File	Itemizes the final monthly payment to the plan	Report/ Data File
Part C Monthly Membership Detail Report - Non-Drug Report	Lists every Part C Medicare member of the contract and provides details about the payments and adjustments made for each	Report
Part D Monthly Membership Detail Report - Drug Report	Lists every Part D Medicare member of the contract and provides details about the payments and adjustments made for each	Report
Monthly Membership Detail Data File	Lists both Part C and D Medicare members of a contract and provides details about payments and adjustments for each	Data File
Monthly Membership Summary Report	Provides summary of payment and adjustments for Part C and D Medicare members of the contract This report summarizes payments to an MCO for the month, in several categories, and adjustments, by all adjustment categories. When the report is automatically generated as part of month-end processing, it covers one contract in one payment month.	Report
Monthly Membership Summary Data File	Lists both Part C and Part D members, summarizing payments made to a Plan for the month, in several categories; and the adjustments, by all adjustment categories	Data File
Monthly Premium Withholding Report Data File (MPWR)	Monthly reconciliation file of premiums withheld from SSA, RRB, or OPM checks. Includes Part C and Part D premiums and any Part D Late Enrollment Penalties	Data File
Low Income Subsidy/Late Enrollment Penalty Data File	This report provides information on low-income subsidized beneficiaries and on direct-billed beneficiaries with late enrollment penalties.	Data File

Plans continuously review CMS provided reports to reconcile and certify enrollments and payments. If there are discrepancies, then plans must submit retroactive transactions.

Payment Dataflow

Figure A provides an overview of the Payment data flow.

Figure A - Payment System Process Flow



Technical Assistance and Support

In an effort to ensure that participating plans have the necessary tools and information to be successful with the payment data process, CMS provides the following helpdesks for support and technical assistance, as described in Table D.

TABLE D – TECHNICAL ASSISTANCE AND SUPPORT

INITIATIVE	DESCRIPTION
HPMS Help Desk	The HPMS Help Desk is available to provide technical assistance to Plans on the use of HPMS and its software modules. The HPMS Help Desk also assists Plans on issues related to accessing and connecting to HPMS. HPMS does not have a designated website that provides technical assistance. Users may contact the HPMS Helpdesk via telephone or email at: 800-220-2028 or HPMS@cms.hhs.gov. For access and connectivity issues, plans should contact: Don Freeburger at 410-786-4586 or don.freeburger@cms.hhs.gov. For user access and user ID contact: Neetu Jhagwani at 410-786-2548 or neetu.jhagwani@cms.hhs.gov.
Customer Support for Medicare Modernization (CSMM) MAPD Help	The MAPD Helpdesk provides technical system support to CMS business partners for the implementation and operation of Medicare Parts C and D. This systems information is provided to assist external business partners with connectivity, testing, and data exchange with CMS. Users may contact the MAPD Helpdesk by calling 1-800-927-8069, emailing mapdhelp@cms.hhs.gov, or viewing the website at http://www.cms.gov/mapdhelpdesk/. The MAPD Helpdesk is available Monday – Friday 6:00 a.m. to 9:00 p.m. ET.

Roles and Contact Information

In addition to the technical support CMS provides, CMS supports Plans as it relates to policy, operations, and access to technical assistance documents. Table E provides the roles and contact information for important resources.

TABLE E – ENROLLMENT AND PAYMENT PROCESS POINTS OF CONTACT

ORGANIZATION	ROLE	CONTACT INFORMATION
Centers for Medicare & Medicaid (CMS) Division of Payment Operations	• Develops the payment and premium withhold guidelines, and validates payments to plans for the MMA program. Monitors plans to improve the quality of data in order to provide accurate payment. • Incorporates system releases into Plan Communications User Guide. • Approves plan users for MARx User Interface.	See the DPO Representatives list at the end of the Monthly Payment Letter and under the Contacts tab on www.pwsops.com.
A Reddix & Associates, Inc. (ARDX)	Technical Assistance Contractor responsible for Enrollment and Payment technical assistance initiatives (i.e., technical assistance registration, newsletter posting, technical assistance documents) and the payment premium portal.	www.tarsc.info TARegistrations@ardx.net www.pwsops.com
Customer Service and Support Center (CSSC)	CMS contractor that provides support to Plans on submission of data and provides a website with technical assistance documents.	www.csscoperations.com

MODULE 1 – PLAN PAYMENT REPORT

Purpose

CMS notifies Plans of their monthly payment on a summary level which is reflected in the Plan Payment Report. This module introduces the enhanced structure of the PPR and describes the steps to reconcile the report.

Learning Objectives

At the completion of this module, participants will be able to:
- Gain an understanding of the consolidated payment communicated on the PPR.
- Identify the five tables included in the new structure on the PPR.
- Determine the value and uses of the PPR Summary Section.
- Explain the data sources of each table on the PPR.
- Describe recent updates to Adjustment Reason Codes.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

1.1 CMS Plan Payment Report (PPR) Overview

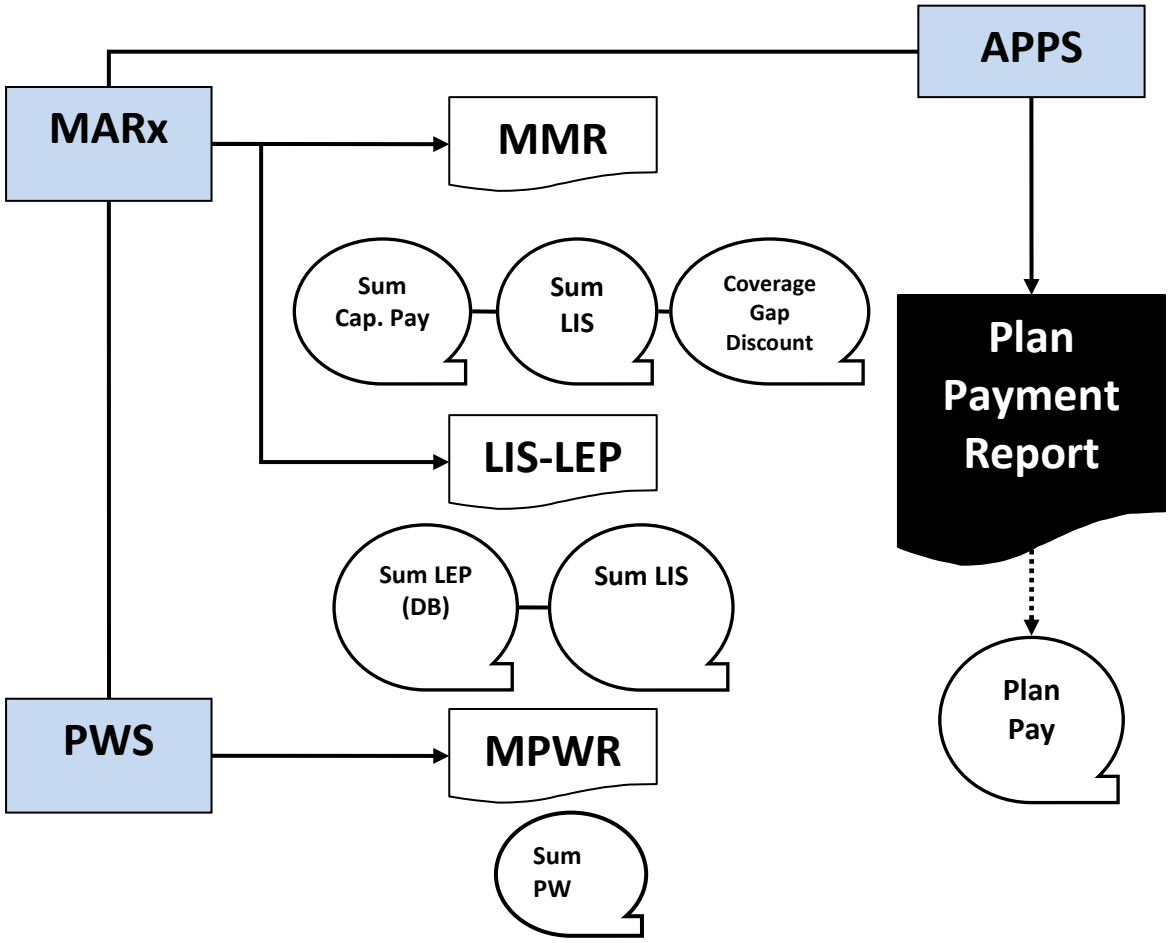
The PPR provides the consolidated view of the Plan payment once the final monthly payment is calculated by the Automated Plan Payment System (APPS). Available as both a data file and a formatted report, the PPR includes contract-level adjustments. The PPR displays the Plan's net payment, which is reflected on Table 5 and includes prospective, capitated, and adjusted payments. This amount is wired to the Plan's account by the Treasury Department, that includes Parts A/B and Part D payment amounts.

The Interim APPS Plan Payment Data File and Report are provided when a Plan is approved for an interim payment outside of the normal monthly process. The data file/report will contain the amount and reason for the interim payment to the Plan.

Effective January 1, 2011, CMS revised the Plan Payment Report format. The report format is expanded to a tabular layout for ease in processing. In addition, the report has been revised to accommodate the reporting of Coverage Gap Discount payment amounts, more descriptions of the CMS Adjustments included in the monthly payment, and a summary section to allow for tracking of balances carried over from the prior month to the current month and going forward.

The PPR provides a consolidated summary of the payment. When reconciling payments, Plans should first use the PPR to identify the total dollars and use the various reports identified in Table 1A to reconcile details of the total payment. Figure 1A illustrates the flow of payment data to the PPR.

Figure 1A – Monthly Plan Payment



The information included in the PPR formatted version is organized into five tables. Table 1A outlines each table of the report. Figures 1B-1F illustrates the pages of the report.

TABLE 1A – TABLES OF THE PPR

TABLE OF REPORT	SECTION WITHIN TABLE	DESCRIPTION	ASSOCIATED REPORTS
Table 1	Prospective Payments	• Provides the base payment amount • Summarized from MARx/MMR payment records	• Monthly Membership Report
	Adjusted Payments (3 Sections) • Prior Months Affecting A/B & D Payments • Prior Months Affecting A/B Payments • Prior Months Affecting D Payments	• Provides adjustments to prior months affecting Parts A, B and D payments • Provides a count of number of months or enrollees affected by payment • Defines adjustment with Adjustment Reason Codes (ARC) • Summarized from MARx/MMR adjustment records	
	Coverage Gap Discount	• Provides summary of prospective and adjusted CGD amounts included in the Part D payments in Table 1. These payments are based upon estimates using Bid data.	• Monthly Membership Report • Quarterly Coverage Gap Discount Program (CGDP) Invoice Reports
Table 2	Premium Settlement	• Provides different premium settlements • Part C premium withheld	• Monthly Premium Withhold Report (MPWR)
		• Part D premium withheld	• Monthly Premium Withhold Report
		• Prospective/Adjusted LIS	• Monthly Membership Report
		• LEP for direct bill members	• Low Income Subsidy/Late Enrollment Penalty (LIS/LEP)
Table 3	Fees	• Provides fee amounts on the Plan-level – Education User Fees collected for 9 months – Coordination of Benefits (COB) User collected for 9 months – Provided by Office of Actuary (OACT) on an annual basis	N/A
Table 4	Special Adjustments	• Resulting from CMS adjustments to Parts A, B and D payments CGD – Invoice for Coverage Gap Discount • Specific codes identify the type of adjustment	N/A
Table 5	Summary (New)	• Summarizes payments and adjustments from Tables 1-4 • Provides the Plan's net payment after subtracting and/or adding adjustments	• Tables 1-4 of the Plan Payment Report

1.2 PPR Formatted Report Version

The report version of the PPR provides Plans with a formatted version of the details regarding their consolidated payment and is organized into five tables. Plans can reconcile the payment by viewing each table of the report. This section outlines the data included in the formatted version.

1.2.1 PPR Table 1-Capitated Payment

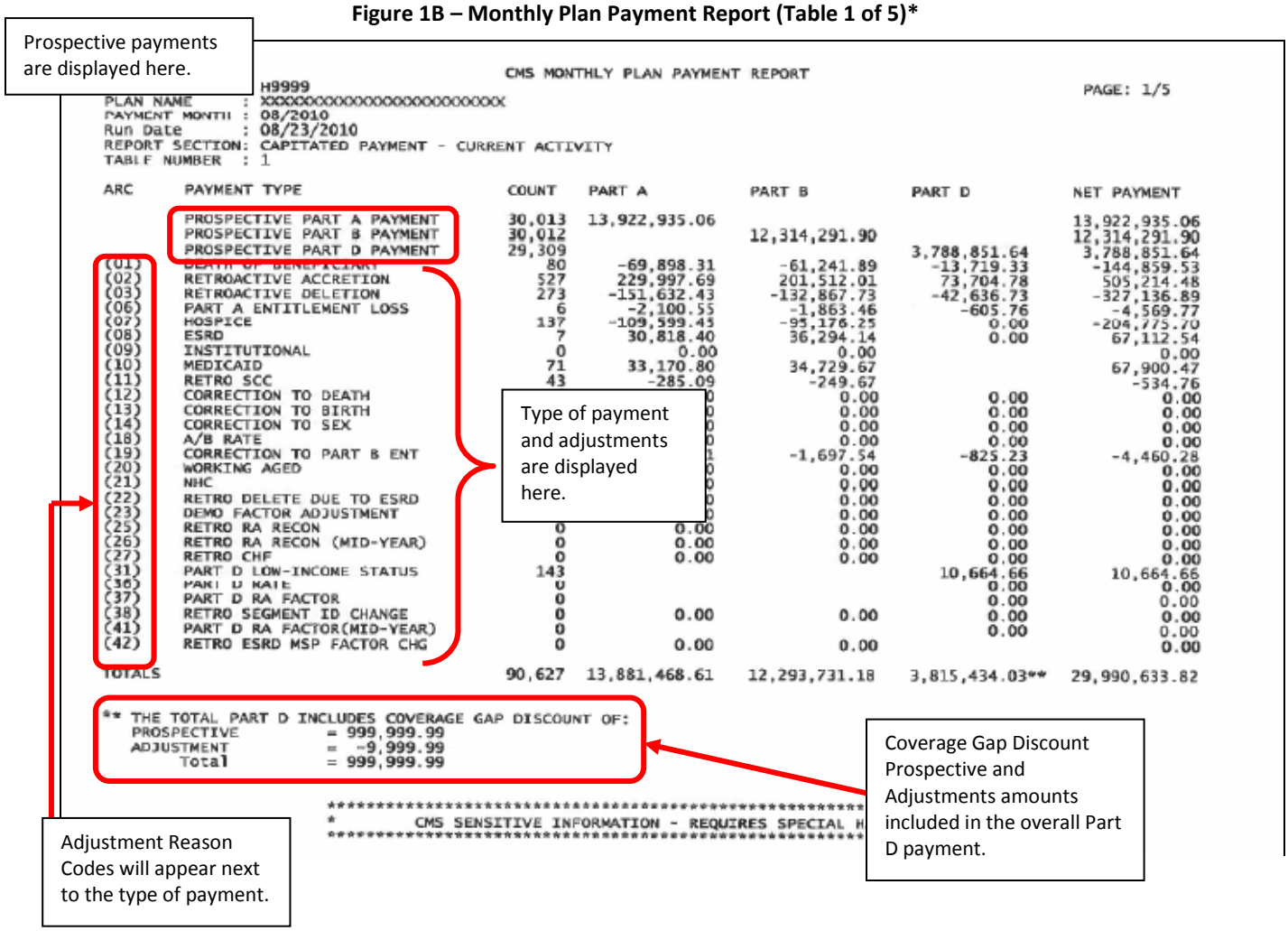
PPR Table 1 includes three components: prospective payments, beneficiary adjustments summarized by Adjustment Reason Code, and Coverage Gap Discount adjustment.

1.2.1.1 Prospective Payments

CMS calculates the prospective payment for each beneficiary's anticipated enrollment in a Plan, on the 1st day of the upcoming month. This includes ongoing enrollment or existing enrollees. In addition, Plan's new enrollees are included in those transactions submitted and accepted to enroll members by the Plan Data Due Date.

The payment amounts included in this section cover one month of the enrollment period. Figure 1B illustrates the prospective payment section of the report.

Figure 1B – Monthly Plan Payment Report (Table 1 of 5)*



CMS MONTHLY PLAN PAYMENT REPORT

H9999 PAGE: 1/5
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 08/2010
Run Date : 08/23/2010
REPORT SECTION: CAPITATED PAYMENT - CURRENT ACTIVITY
TABLE NUMBER : 1

ARC	PAYMENT TYPE	COUNT	PART A	PART B	PART D	NET PAYMENT
	PROSPECTIVE PART A PAYMENT	30,013	13,922,935.06			13,922,935.06
	PROSPECTIVE PART B PAYMENT	30,012		12,314,291.90		12,314,291.90
	PROSPECTIVE PART D PAYMENT	29,309			3,788,851.64	3,788,851.64
(01)	DEATH OF BENEFICIARY	80	-69,898.31	-61,241.89	-13,719.33	-144,859.53
(02)	RETROACTIVE ACCRETION	527	229,997.69	201,512.01	73,704.78	505,214.48
(03)	RETROACTIVE DELETION	273	-151,632.43	-132,867.73	-42,636.73	-327,136.89
(06)	PART A ENTITLEMENT LOSS	6	-2,100.55	-1,863.46	-605.76	-4,569.77
(07)	HOSPICE	137	-109,599.45	-95,176.25	0.00	-204,775.70
(08)	ESRD	7	30,818.40	36,294.14	0.00	67,112.54
(09)	INSTITUTIONAL	0	0.00	0.00		0.00
(10)	MEDICAID	71	33,170.80	34,729.67		67,900.47
(11)	RETRO SCC	43	-285.09	-249.67		-534.76
(12)	CORRECTION TO DEATH		0	0.00	0.00	0.00
(13)	CORRECTION TO BIRTH		0	0.00	0.00	0.00
(14)	CORRECTION TO SEX		0	0.00	0.00	0.00
(18)	A/B RATE		0	0.00	0.00	0.00
(19)	CORRECTION TO PART B ENT		1	-1,697.54	-825.23	-4,460.28
(20)	WORKING AGED		0	0.00	0.00	0.00
(21)	NHC		0	0.00	0.00	0.00
(22)	RETRO DELETE DUE TO ESRD		0	0.00	0.00	0.00
(23)	DEMO FACTOR ADJUSTMENT		0	0.00	0.00	0.00
(25)	RETRO RA RECON	0	0.00	0.00	0.00	0.00
(26)	RETRO RA RECON (MID-YEAR)	0	0.00	0.00	0.00	0.00
(27)	RETRO CHF	0	0.00	0.00	0.00	0.00
(31)	PART D LOW-INCOME STATUS	143			10,664.66	10,664.66
(36)	PART D RAIE	0			0.00	0.00
(37)	PART D RA FACTOR	0			0.00	0.00
(38)	RETRO SEGMENT ID CHANGE	0	0.00	0.00	0.00	0.00
(41)	PART D RA FACTOR(MID-YEAR)	0			0.00	0.00
(42)	RETRO ESRD MSP FACTOR CHG	0	0.00	0.00		0.00
TOTALS		90,627	13,881,468.61	12,293,731.18	3,815,434.03**	29,990,633.82

** THE TOTAL PART D INCLUDES COVERAGE GAP DISCOUNT OF:
PROSPECTIVE = 999,999.99
ADJUSTMENT = -9,999.99
Total = 999,999.99

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* CMS SENSITIVE INFORMATION - REQUIRES SPECIAL H
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Example 1

In the Sample Report Figure 1B, the PPR communicates that for the August 2010 Payment Month, CMS made an adjustment to Plan Heartwise's payment for 80 beneficiaries due to the death of the beneficiary, which is represented by an adjustment reason code of "01." This change resulted in a negative adjustment of $69,898.31. The Plan should verify the date of death of the beneficiaries and reconcile their internal records. In addition to date of death, the Plan must monitor all other payments and adjustments reported.

1.2.1.2 Adjustment Reason Codes (ARCs)

An adjustment payment is net payment calculated as the difference between the full monthly payment based upon the status change and the original or previous payment made for the month(s) adjusted.

The section includes the calculated adjustment payment for each beneficiary with a change affecting payment for prior month(s), for enrollment and status changes recorded after last month's payment. The adjustment amounts are summarized from the MARx/MMR adjustment records. Figure 1B above illustrates the adjustment payment section of the PPR by ARC.

The PPR displays all ARCs and associated dollar amounts, if adjustment not applicable for the given month the member count will be zero and the dollar amount will report zero dollars. Conversely, the MMR will only display ARCs that are applicable for the given month on the beneficiary level.

Table 1B outlines the enrollment and status changes that can result in an adjustment payment.

TABLE 1B - CHANGES RESULTING IN ADJUSTMENTS

CHANGE TO…	CHANGE DESCRIPTION
Enrollment	• Expansion, reduction or elimination of enrollment period • Voluntary disenrollments, examples include – Move out of Plan service area – Contract Violations (approved by CMS) • Involuntary disenrollments, examples include – Loss of Medicare eligibility – Plan termination – Death of beneficiary
Status	• Generally changes to a beneficiary status • Some Plan status changes may change an adjustment • Updates to beneficiary's risk factor • Changes to a beneficiary's health status • Beneficiary reclassified as having End-Stage Renal Disease (ESRD)

Plans can reconcile the ARCs on the PPR with the MMR to ensure the count of beneficiaries for each ARC and the associated adjustment amounts match the numbers on the MMR. Table 1C list the ARCs reported to Plans on the PPR.

TABLE 1C -ADJUSTMENT REASON CODES AND DESCRIPTION*

ADJUSTMENT REASON CODE (ARC)	ADJUSTMENT NAME
01	Death of beneficiary
02	Retroactive enrollment (appears as accretion on PPR)
03	Retroactive disenrollment
06	Correction to Part A entitlement
07	Retroactive hospice status
08	Retroactive ESRD status
09	Retroactive institutional status
10	Retroactive Medicaid status
11	Retroactive change to state county code
12	Date of death correction
13	Date of birth correction
14	Correction to sex code
18	Part C rate change
19	Correction to Part B entitlement
20	Retroactive working aged status
21	Retroactive NHC status
22	Disenrolled due to prior ESRD
23	Demo factor adjustment
25	Part C risk adjustment factor change/Recon
26	Part C risk adjustment factor change (mid-year)
27	Retroactive change to Congestive Heart Failure (CHF) payment
31	Retroactive change to Part D low-income status
36	Part D rate change, including change to Low Income Premium Subsidy Rate
37	Part D risk adjustment factor change
38	Retroactive segment ID change
41	Part D risk adjustment factor change (mid-year)
42	Retroactive MSP factor change
44 **(NEW)**	Retroactive Correction of Previously Failed Payment
50 **(NEW)**	Adjustment due to Beneficiary Merge
94 **(NEW)**	ARCs uniquely assigned to identify Payment Adjustments due to Cleanups

***CMS revisits descriptions of the adjustment reason codes and provides updates when available.**

Example 2

Plan Express is diligent in reconciling their monthly reports. Plan Express reviewed both the PPR and the MMR for ARCs and adjustment amounts for August 2010 (Figure 1B). Plan Express's PPR communicated a count of 535 members with a ARC of 03 (retroactive disenrollment). The dollars associated are reported on the PPR as (-) $750,000 to Part D payment adjustment amount. Plan Express understands the adjustment is on members receiving Part D benefit and to drill down to the specific amounts per affected beneficiary by accessing the MMR. Plan Express tabulated the beneficiaries on the MMR for each ARC and confirmed that the values matched the counts and associated adjustment amounts on the PPR.

1.2.1.2.1 New ARCs

CMS has added several new ARCs as indicated above in Table 1C. The following provides background explanations of these codes.

- **ARC 44 – Retroactive Correction of Previously Failed Payment**
  On December 2, 2010, CMS released the MARx Redesign and Modernization Handbook to Plans, which included a new *Failed Payment Reply Report*. If a payment fails to calculate by the end of the monthly payment process it will appear on the *Failed Payment Reply Report* with a reply code of 264 – Payment Not Yet Completed.

  Once the payment is successfully calculated it will appear on the Monthly Membership Report (MMR) with ARC 44. The adjustment start and end date(s) will be populated with the month(s) the payment(s) was missing. ARC 44 was not included in the Handbook as it was not finalized at the time the Handbook was released. **Note:** occurrences of this adjustment type are expected to be extremely rare.

- **ARC 50 – Adjustment due to Beneficiary Merge**
  As of the April 2011 Software Release, CMS implemented a change to improve the process CMS uses when the Social Security Administration (SSA) assigns a new Health Insurance Claim Number (HICN) to a beneficiary who already has a HICN. This process is called the Beneficiary Cross-Reference Merge (XREF). As a result of this change, ARC 50, and Transaction Reply Codes (TRC) 301 and 302 were instituted.

  In general, when a new HICN is received from SSA for an existing beneficiary, the new HICN is merged with the existing information from the previous HICN. This process creates the new XREF record with all the historical information attached. If the beneficiary is enrolled in a Plan, the current enrollment remains as is and the Plan is notified of the new HICN on the Transaction Reply Report (TRR). However, SSA periodically notifies CMS of HICN changes that impact two beneficiary records. In these cases, MARx must merge the enrollment and payment history under each of the separate HICNs into one set of records. Occasionally, there are conflicts that cause errors in processing. The software change that was implemented identifies these conflicts. Future enhancements will correct any remaining issues with the merge process. If data cleanup is necessary, Plans will be advised via the Week-At-A-Glance (WAAG) or Monthly Payment Letter notifications**.**

  This code will be displayed when MARx cancels an overlapping enrollment under the inactive HICN. The effective date(s) of the period(s) that was cancelled will be reported on the MMR. The ARC 50 is similar to a retroactive disenrollment (ARC 03), but the adjustment type is strictly associated with the cross-reference merge process.

  ARC 94 – Uniquely Identify Payment Adjustments due to Cleanups

  Payment adjustments due to cleanups developed by the MARx maintenance contractor currently are mixed together with routine payment adjustments using a common set of ARCs on the MMR. At times, Plans cannot reliably interpret why their payments were adjusted due to this mixing. This change, effective with the August 2011 Software Release will uniquely identify each payment adjustment appearing on the MMR (and UI) that resulted from a specific cleanup project. ARC 94 will go into effect beginning with the October 1, 2011 payment. Cleanup adjustments will be distinguishable from routine adjustments in two ways:

1. Cleanup Adjustments will be assigned a new ARC that will be reserved exclusively for cleanups.
2. A unique cleanup identifier will be created for each cleanup project. Payment adjustments created for that specific cleanup project will be tagged by adding the identifier as a new field in the MMR detail reports (and UI displays). This unique cleanup identifier will then be referred to in Plan communications to provide details about that specific cleanup.

The ARC for these cleanups will then be reported on the PPR so that Plans can reconcile the payments between the PPR and the MMR.

1.2.1.3 Coverage Gap Discount (CGD)

With the implementation of the Coverage Gap Discount, the PPR was revised to accommodate the new payment adjustment information. This table provides a summary of prospective and adjusted CGD amounts included in the Part D payments. These payments are based upon estimates using Bid data. The amounts are reported on MMR on beneficiary level. Figure 1B above illustrates the placement of the Coverage Gap Discount payment information on the PPR.

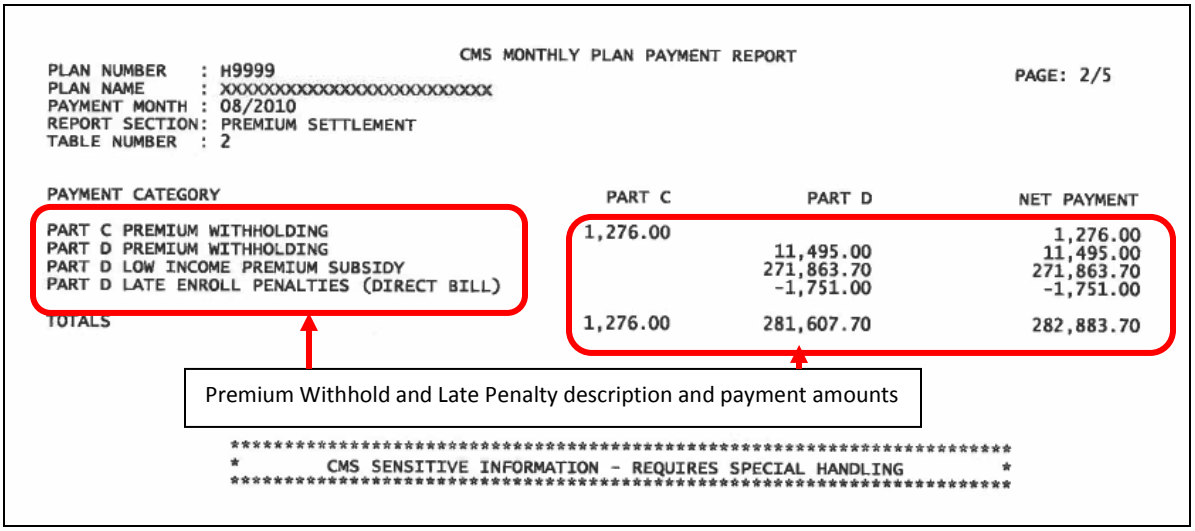
1.2.2 PPR Table 2-Premium Settlement

The PPR also details premiums paid to Plans. This information includes the following:

- Part C Premium received as a result of withholding from SSA, requested by beneficiary, and as reflected on the MPWR
- Part D Premium received as a result of withholding from SSA, requested by beneficiary, and as reflected on the MPWR
- Part D Low Income Premium Subsidy received from CMS based on Plan bid and Plan enrollment, and based on amount reflected on the MMR.
- Part D Late Enrollee Penalties (for Direct Bill) amount due from direct bill beneficiaries for LEP amounts that appear as an adjustment on the LIS/LEP report. The Part D Plan is responsible for collecting this amount from the beneficiary and paying this amount to CMS.

Figure 1C illustrates the premium settlement table of the PPR.

Figure 1C – PPR – Premium Settlement (Table 2 of 5)



CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : H9999
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 08/2010
REPORT SECTION: PREMIUM SETTLEMENT
TABLE NUMBER : 2

PAGE: 2/5

PAYMENT CATEGORY	PART C	PART D	NET PAYMENT
PART C PREMIUM WITHHOLDING	1,276.00		1,276.00
PART D PREMIUM WITHHOLDING		11,495.00	11,495.00
PART D LOW INCOME PREMIUM SUBSIDY		271,863.70	271,863.70
PART D LATE ENROLL PENALTIES (DIRECT BILL)		-1,751.00	-1,751.00
TOTALS	1,276.00	281,607.70	282,883.70

Premium Withhold and Late Penalty description and payment amounts

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* CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING *
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Example 3

Plan HealthyLife is reconciling the premium amounts reported on the PPR. They use the Premium Withhold Report to validate the premiums but continue to fail with reconciling the amounts.

Plan HealthyLife should use the Premium Withhold Report to validate Part C and D Premium amounts, but for members that choose direct bill to pay the late enrollee penalty, the Plan must use the LIS/LEP report. The MMR can be used to validate prospective/adjusted LIS premium amounts The use of the three reports will provide the plan with what is needed to validate amounts in this section.

1.2.3 PPR Table 3-Fees

CMS communicates the Plan-level adjustments for fees in Table 3 of the PPR, which are based on summarized data in APPS. There is no specific report the Plan can consult to reconcile fees. However, CMS releases annually through HPMS, the Annual Announcement communicating the fees and a payment letter that outlines the rates, and period of collection. The fees are provided annually by the Office of the Actuary (OACT) and CMS announces the fees annually in the announcements. The 2012 rates were announced in the 2012 Rate Announcement at http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf

In addition annually, CMS communicates in the Payment Letter prior to collection of fees, the rates by Plan type and period of collection. For example, the December 2010 Plan Payment Letter (Dated: November 22, 2010) announced the fees beginning January 2011.

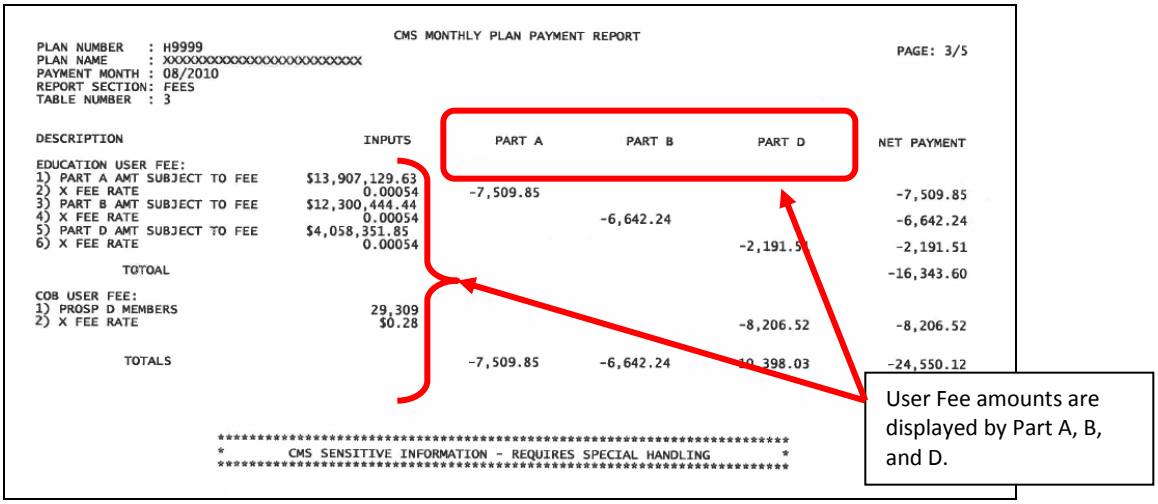
Table 1D outlines the possible fees and adjustments reported in this section.

TABLE 1D – FEES

PLAN-LEVEL ADJUSTMENT TYPE	DESCRIPTION
Education User Fees	• Different rates by Plan type • Applied the first 9 months of the year • Provided annually by the Office of the Actuary (OACT) • Fee is based on prospective payment • Part C and D
Coordination of Benefits (COB) User Fees	• Rates • Applied the first 9 months of the year • Enrollment count is the base for the calculation • Part D

Figure 1D illustrates the section of the PPR that reports user fee amounts.

Figure 1D – PPR – User Fee (Table 3 of 5)



Example 4

CMS collects user fees from January to September every year. Plan Express was able to see the COB user fee for Part D at a rate of $0.13 per Part D member per month. This adjustment will only appear on the PPR from January to September 2011. In addition, Plan Express could see the Education user fee adjustments broken out by Part A, B, and D. The rate for MA and MAPD plans is 0.047% and for PDPs is 0.050%. Plan Express had estimated what the Education User Fee adjustment would be in advance of receiving the January PPR and found that their estimate was higher than the actual reported fees. The reason Plan Express's estimate was more than the PPR, is that they forgot to subtract the MSP adjustments from the prospective payments.

1.2.4 PPR Table 4-Special Adjustments

CMS also provides Plans with amounts adjusted resulting from CMS adjustment actions. The payments and offsets Plans receive can result from the following:

- CMS advanced payments
- CMS offset of advanced payments

- CMS payments and offset
- Annual Part D Reconciliation
- Temporary advances against system problems
- Settlements of past payment issues
- Coverage Gap offsets

Once CMS has determined there is a need for a special adjustment, affected Plans will notice the adjustment in Table 4 of the PPR. CMS groups the special adjustments into six different types of adjustments outlined in Table 1E.

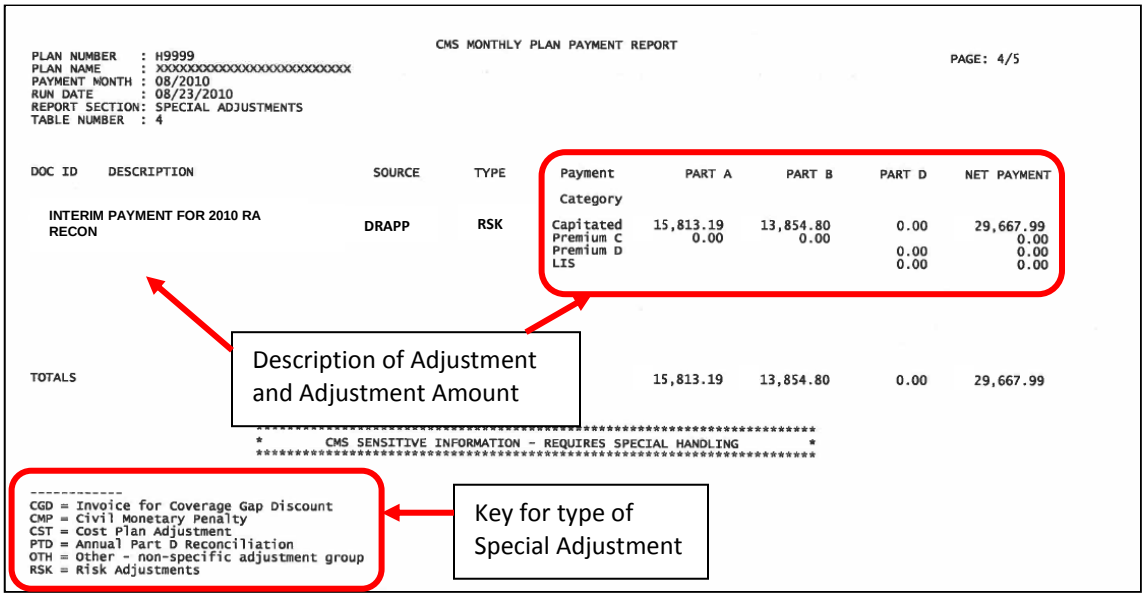
TABLE 1E – SPECIAL ADJUSTMENT REASON CODES/DESCRIPTIONS

Type	Description
CGD	Invoice for Coverage Gap Discount
CMP	Civil Monetary Penalty
CST	Cost Plan Adjustment
PTD	Annual Part D Reconciliation
OTH	Other – Non specific adjustment group
RSK	Risk Adjustment

In addition to the type of adjustment, CMS will provide the source that issued the adjustment (e.g., DPO for Division of Payment Operations), the payment category, and the adjustment amount.

Figure 1E illustrates the Special Adjustment Table.

Figure 1E – PPR – Special Adjustment (Table 4 of 5)



Example 5

CMS conducted a 2010 risk adjustment reconciliation and Plan Heartwise received an interim net adjustment payment of $29, 667.99. CMS reported the adjustment to Plan Heartwise on the Special Adjustments Table.

1.2.5 PPR Table 5-NEW FEATURE - Payment Summary

The summary table is a newly designed table that provides Plans with information collected from all other tables on the report. The summary table highlights the consolidated payment.

The PPR will sum all the payments from the PPR tables and report on the summary page. This page groups payments by type of payment, activity, net payment and balance forward. Figure 1F illustrates the payment table of the PPR.

Figure 1F – PPR – Payment Summary (Table 5 of 5)

CMS MONTHLY PLAN PAYMENT REPORT PAGE: 5/5

PLAN NUMBER : H9999
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 08/2011
RUN DATE : 08/23/20101
REPORT SECTION : CAPITATED PAYMENT – CURRENT ACTIVITY
TABLE NUMBER : 1

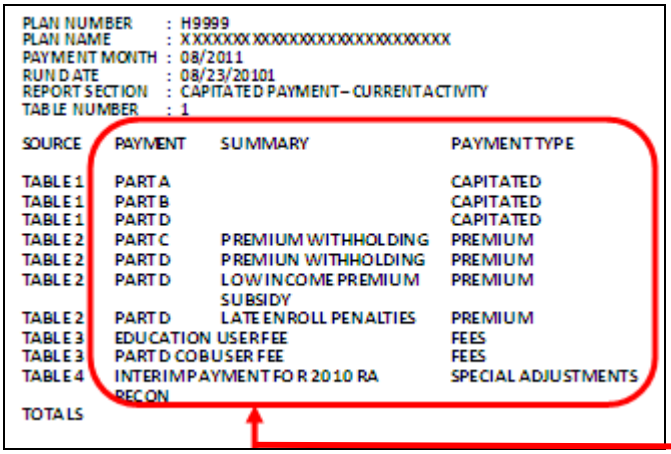
SOURCE	PAYMENT	SUMMARY	PAYMENT TYPE	PREVIOUS BALANCE	CURRENT ACTIVITY	NET PAYMENT	BALANCE FORWARD
TABLE 1	PART A		CAPITATED	0.00	13,881,468.61	13,881,468.61	0.00
TABLE 1	PART B		CAPITATED	0.00	12,293,731.18	12,293,731.18	0.00
TABLE 1	PART D		CAPITATED	0.00	3,815,434.03	3,815,434.03	0.00
TABLE 2	PART C	PREMIUM WITHHOLDING	PREMIUM	0.00	1,276.00	1,276.00	0.00
TABLE 2	PART D	PREMIUN WITHHOLDING	PREMIUM	0.00	11,495.00	11,495.00	0.00
TABLE 2	PART D	LOW INCOME PREMIUM SUBSIDY	PREMIUM	0.00	271,863.70	271,863.70	0.00
TABLE 2	PART D	LATE ENROLL PENALTIES	PREMIUM	0.00	-1,751.00	-1,751.00	0.00
TABLE 3	EDUCATION USER FEE		FEES	0.00	-16,343.60	-16,343.60	0.00
TABLE 3	PART D COB USER FEE		FEES	0.00	-8,206.52	-8,206.52	0.00
TABLE 4	INTERIM PAYMENT FO R 2010 RA RECON		SPECIAL ADJUSTMENTS	0.00	-29,667.99	-29,667.99	0.00
TOTALS				0.00	30,219,299.41	30,219,299.41	0.00

Payment Tables, Payment Summary Descriptions, Payment Type and Corresponding payment

NEW - Payment Summary Section of PPR

This section summarizes the consolidated payment that includes the capitated, premium, fees, and special adjustments. Plans may use this section to view a summary of the totals from all tables in the PPR. Figure 1G illustrates this section of the summary table.

Figure 1G – PPR – Payment Summary – Summary Highlights (Table 5 of 5)



PLAN NUMBER : H9999
PLAN NAME : XXXXXXX XXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 08/2011
RUN DATE : 08/23/20101
REPORT SECTION : CAPITATED PAYMENT– CURRENT ACTIVITY
TABLE NUMBER : 1

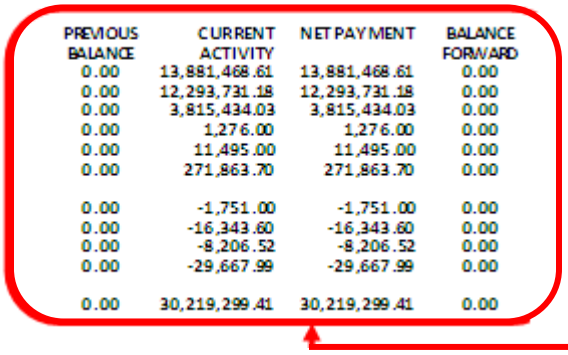
SOURCE	PAYMENT	SUMMARY	PAYMENT TYPE
TABLE 1	PART A		CAPITATED
TABLE 1	PART B		CAPITATED
TABLE 1	PART D		CAPITATED
TABLE 2	PART C	PREMIUM WITHHOLDING	PREMIUM
TABLE 2	PART D	PREMIUN WITHHOLDING	PREMIUM
TABLE 2	PART D	LOW INCOME PREMIUM SUBSIDY	PREMIUM
TABLE 2	PART D	LATE ENROLL PENALTIES	PREMIUM
TABLE 3	EDUCATION USER FEE		FEES
TABLE 3	PART D COB USER FEE		FEES
TABLE 4	INTERIM PAYMENT FOR 2010 RA RECON		SPECIAL ADJUSTMENTS
TOTALS			

The summary page now provides the total amounts of each payment and includes the payment type. Plans can determine the next steps in reconciling payment by understanding the type of payment received. See Table 1A in this guide for the source information of each payment type.

Previous/Current Activity

An addition to providing a summary of all payments, Table 5 also provides a view of your current and previous activity. This will allow plans to determine trends from month to month. The amount recorded in the previous balance field is the reported amount from the prior month's activity as a negative dollar amount. This amount is then adjusted against the current activity to provide the net payment. Figure 1H highlights this section of the Summary Table.

Figure 1H – PPR – Payment Summary – Payment Activity Highlights (Table 5 of 5)



PREVIOUS BALANCE	CURRENT ACTIVITY	NET PAYMENT	BALANCE FORWARD
0.00	13,881,468.61	13,881,468.61	0.00
0.00	12,293,731.18	12,293,731.18	0.00
0.00	3,815,434.03	3,815,434.03	0.00
0.00	1,276.00	1,276.00	0.00
0.00	11,495.00	11,495.00	0.00
0.00	271,863.70	271,863.70	0.00
0.00	-1,751.00	-1,751.00	0.00
0.00	-16,343.60	-16,343.60	0.00
0.00	-8,206.52	-8,206.52	0.00
0.00	-29,667.99	-29,667.99	0.00
0.00	30,219,299.41	30,219,299.41	0.00

This section of the summary page highlights payment activity. Plans can take a month to month view at the amounts that affect their monthly payment that were adjusted by a previous payment.

1.3 PPR Data File Version

In addition to the report version of the PPR, CMS provides a data file version of the report. The data file length is 200 bytes as of February 2011. The data file includes a Header Record that provides the contract information, payment cycle date, and the run date of the report. The data file then provides all the data that was illustrated above in the figures for the report layout version. Plans can export the data file into Excel or Access and develop

their own internal reports in order to reconcile the information on the PPR with other CMS provided reports like the MMR. Table 1F provides the data file layout of the PPR.

TABLE 1F - PPR DATA FILE RECORD LAYOUT

Item	Data Element	Position	Length	Type	Description
HEADER RECORD					
1	Contract Number	1-5	5	Character	Contract Number
2	Record Identification Code	6-6	1	Character	Record Type Identifier H = Header Record
3	Contract Name	7 – 56	50	Character	Name of the Contract
4	Payment Cycle Date	57 – 62	6	Character	Identified the month and year of payment: Format = YYYYMM
5	Run Date	63 – 70	8	Character	Identifies the date file was created: Format = YYYYMMDD
6	Filler	71 – 200	130	Character	Spaces

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD					
CAPITATED PAYMENT – CURRENT ACTIVITY					
7	Contract Number	1-5	5	Character	Contract Number
8	Record Identification Code	6-6	1	Character	Record Type Identifier C = Capitated Payment
9	Table ID Number	7-7	1	Character	1
10	Adjustment Reason Code	8-9	2	Numeric	Blank = for prospective pay For list of adjustment reason codes consult Section H.3 of the *Medicare Advantage and Prescription Drug Plan Communications User Guide*
11	Part A Total Members	10-17	8	Numeric	Number of beneficiaries Part A payments is being made prospectively. Format: ZZZZZZZ9
12	Part B Total Members	18-25	8	Numeric	Number of beneficiaries Part B payments is being made prospectively. Format: ZZZZZZZ9
13	Part D Total Members	26-33	8	Numeric	Number of beneficiaries Part D payments is being made prospectively. Format: ZZZZZZZ9
14	Part A Payment Amount	34-46	13	Numeric	Total Part A Amount Format: SSSSSSSS9.99
15	Part B Payment Amount	47-59	13	Numeric	Total Part B Amount Format: SSSSSSSS9.99
16	Part D Payment Amount	60-72	13	Numeric	Total Part D Amount Format: SSSSSSSS9.99
17	Coverage Gap Discount Amount	73 – 85	13	Numeric	The Coverage Gap Discount Amount included in Part D Payment. Format: SSSSSSSS9.99
18	Total Payment	86- 98	13	Numeric	Total Payment Format: SSSSSSSS9.99
19	Filler	99 – 200	102	Character	Spaces

TABLE 1F - PPR DATA FILE RECORD LAYOUT (CONTINUED)

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD (CONTINUED)					
PREMIUM SETTLEMENT					
20	Contract Number	1 – 5	5	Character	Contract Number
21	Record Identification Code	6 – 6	1	Character	Record Type Identifier P = Premium Settlement
22	Table ID Number	7 – 7	1	Character	2
23	Part C Premium Withholding Amount	8 – 20	13	Numeric	Total Part C Premium Amount Format: SSSSSSSSS9.99
24	Part D Premium Withholding Amount	21 – 33	13	Numeric	Total Part D Premium Amount Format: SSSSSSSSS9.99
25	Part D Low Income Premium Subsidy	34 – 46	13	Numeric	Total Low Income Premium Subsidy Format: SSSSSSSSS9.99
26	Part D Late Enrollment Penalty	47 – 59	13	Numeric	Total Late Enrollment Penalty Format: SSSSSSSSS9.99
27	Total Premium Settlement Amount	60 – 72	13	Numeric	Total Premium Settlement Format: SSSSSSSSS9.99
28	Filler	73 – 200	128	Character	Spaces
FEES					
29	Contract Number	1 – 5	5	Character	Contract Number
30	Record Identification Code	6 – 6	1	Character	Record Type Identifier F = FEES
31	Table ID Number	7 – 7	1	Character	3
32	NMEC Part A Subject to Fee	8 – 20	13	Numeric	Part A amount subject to National Medicare Educational Campaign fees. Format:ZZZZZZZZZ9.99
33	NMEC Part A Rate	21 – 27	7	Numeric	Rate used to calculate the fees for Part A. Format: 0.99999
34	Part A Fee Amount	28 – 40	13	Numeric	Fee Assessed for Part A Format:SSSSSS9.99
35	NMEC Part B Subject to Fee	41 – 53	13	Numeric	Part B amount subject to National Medicare Educational Campaign fees. Format: ZZZZZZZZZ9.99
36	NMEC Part B Rate	54 – 60	7	Numeric	Rate used to calculate the fees for Part B. Format: 0.99999
37	Part B Fee Amount	61 – 73	13	Numeric	Fee Assessed for Part B Format: SSSSSS9.99
38	NMEC Part D Subject to Fee	74 – 86	13	Numeric	Part D amount subject to National Medicare Educational Campaign fees. Format: ZZZZZZZZZ9.99
39	NMEC Part D Rate	87 – 93	7	Numeric	Rate used to calculate the fees for Part D. Format: 0.99999
40	Part D Fee Amount	94 – 106	13	Numeric	Fee Assessed for Part D Format: SSSSSS9.99
41	Total NMEC Fee Assessed	107 – 119	13	Numeric	Total NMEC Fee Assessed for Part A, B and D Format: SSSSSSS9.99
42	Total Prospective Part D Members	120 – 127	8	Numeric	Total members for Part D Format: ZZZZZZZ9
43	Rate for COB Fees	128 – 131	4	Numeric	Rate used to calculate the COB fees. Format: 0.99

TABLE 1F - PPR DATA FILE RECORD LAYOUT (CONTINUED)

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD (CONTINUED)					
44	Amount of COB Fees	132 – 144	13	Numeric	COB Fee Format: SSSSSS9.99
45	Total of Assessed Fees	145 – 157	13	Numeric	Total of all Fees Assessments Format: SSSSSS9.99
46	Filler	158 – 200	43	Character	Spaces
SPECIAL ADJUSTMENTS					
47	Contract Number	1 – 5	5	Character	Contract Number
48	Record Identification Code	6 – 6	1	Character	Record Type Identifier S = Special Adjustments
49	Table ID Number	7 – 7	1	Character	4
50	Document ID	8 – 15	8	Numeric	The document ID for identifying the adjustment.
51	Source	16 – 20	5	Character	The CMS division responsible for initiating the adjustments.
52	Description	21 – 70	50	Character	The reason the adjustment was made.
53	Type	71 – 90	20	Character	The payment component the adjustment is for. - Civil Monetary Penalty - Cost Plan Adjustment - Annual Part D Reconciliation - Risk Adjustment - Coverage Gap Invoice - Other – default non-specific group.
54	Adjustment to Part A	91 – 103	13	Numeric	Adjustment amount for Part A Format: SSSSSSSSS9.99
55	Adjustment to Part B	104 – 116	13	Numeric	Adjustment amount for Part B Format: SSSSSSSSS9.99
56	Adjustment to Part D	117 – 129	13	Numeric	Adjustment amount for Part D. Format: SSSSSSSSS9.99
57	Premium C Withholding Part A	130 – 142	13	Numeric	Adjustment amount for Premium Withholding Part A. Format: SSSSSSSSS9.99
58	Premium C Withholding Part B	143 – 155	13	Numeric	Adjustment amount for Premium Withholding Part B. Format: SSSSSSSSS9.99
59	Premium D Withholding	156 – 168	13	Numeric	Adjustment amount for Premium D Withholding. Format: SSSSSSSSS9.99
60	Part D Low Income Premium Subsidy	169 - 181	13	Numeric	Adjustment amount for Low Income Subsidy. Format: SSSSSSSSS9.99
61	Total Adjustment Amount	182 – 194	13	Numeric	Total Adjustments Format: SSSSSSSSS9.99
62	Filler	195 – 200	6	Character	Spaces

TABLE 1F - PPR DATA FILE RECORD LAYOUT (CONTINUED)

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD (CONTINUED)					
PAYMENT SUMMARY					
63	Contract Number	1 – 5	5	Character	Contract Number
64	Record Identification Code	6 – 6	1	Character	Record Type Identifier A = Payment Summary
65	Table ID Number	7 – 7	1	Character	5
66	Part A Amount	8 – 20	13	Numeric	Part A amount from Table 1 Format: ZZZZZZZZZ9.99
67	Part B Amount	21 – 33	13	Numeric	Part B amount from Table 1 Format: ZZZZZZZZZ9.99
68	Part D Amount	34 – 46	13	Numeric	Part D amount from Table 1 Format: ZZZZZZZZZ9.99
69	Part C Premium Withholding	47 – 59	13	Numeric	Part C Premium Amount from Table 2 Format: ZZZZZZZZZ9.99
70	Part D Premium Withholding	60 – 72	13	Numeric	Part D Premium amount from Table 2 Format: ZZZZZZZZZ9.99
71	Part D Low Income Premium Subsidy	73 – 85	13	Numeric	Part D Low Income Subsidy amount from Table 2 Format: ZZZZZZZZZ9.99
72	Part D Late Enrollment Penalty	86 – 98	13	Numeric	Part D Late Enrollment Penalty amount from Table 2 Format: SSSSSSSSS9.99
73	Education User Fee	99 – 111	13	Numeric	Total NMEC fee from Table 3 Format: SSSSSSS9.99
74	Part D COB User Fee	112 – 124	13	Numeric	Total COB fee from Table 3 Format:SSSSSSS9.99
75	CMS Special Adjustments	125 – 137	13	Numeric	Special CMS Adjustments from Table 4 Format: ZZZZZZZZZ9.99
76	Filler	138 – 200	63	Character	Spaces.

Example 6

Plan Express downloaded the PPR data file and exported the report into Excel. They extracted the total premium withholding amounts for Part C and D and compared the values to an Excel file summarizing their internal records of beneficiary premium withholding amounts for Part C and D.

MODULE 2 – PREMIUM WITHHOLD REPORT

Purpose

In addition to receiving payments from CMS, plans may also receive premium payments from their enrollees which is a component of the consolidated monthly payment. Section 1854 (d)(2) (A) of the Social Security Act mandates that beneficiaries have the option of paying their Part C and Part D premiums, through withholding the amount from benefit payments, electronic transfer, or other means, such as an employer. In addition to premiums, some Part D beneficiaries are accessed Late Enrollment Penalties. This module describes the components of the Monthly Premium Withholding Report (MPWR), the entities and systems involved in the process of communicating information provided on the report. The module will map premium fields on the PPR to those on the MPWR.

In addition, the module describes the Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) report and how to use the report to reconcile Table 2 of the PPR.

Learning Objectives

At the completion of this module, participants will be able to:

- Describe the premium withholding process
- Explain how the premium withhold amount is determined
- Describe how to reconcile Table 2 of the PPR using the (MPWR) and the Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Report
- Introduce the Premium Withhold and Payment Portal

ICON KEY	
Definition	
Example	
Reminder	
Resource	

2.1 Process Overview

Medicare beneficiaries can elect to have their Part C and Part D Plan premiums withheld by the Social Security Administration (SSA) and the Railroad Retirement Board (RRB) as a reduction in monthly benefit or request direct billing in which the beneficiary pays the Plan directly each month.

Each month SSA transfers withheld premium payments to CMS. After CMS screens the transferred amounts for accuracy, the premium withholding payments are included in the Plan's payment. The Payment Withhold System (PWS) reports the transferred premium withholding payment amounts on the Monthly Premium Withholding Report Data File (MPWR).

The premium withhold process relies on data reported by the plans and on an interface between the agency (SSA or RRB) and CMS. The process begins when plans submit premium information for new and current members on the appropriate transaction. Plans report the Part C and D premiums as applicable and the premium withhold option selected by the member. Currently the options are SSA Withholding, RRB, or Direct Bill (self-pay).

During processing, MARx will compare the submitted Part D premium to the amount assigned to the Plan Benefit Package (PBP) in the Plan bid information in the Health Plan Management System (HPMS).

If the beneficiary has elected the direct bill (self-pay) option, the Plan receives payment directly from the member. If the beneficiary has elected SSA or RRB premium withhold, CMS transmits this information to the SSA/RRB. On a monthly basis SSA/RRB withholds the premiums and sends them to CMS, where the premiums are verified and then passed (paid) to the plans. If SSA or RRB is unable to deduct a member's premium from their benefit check (due to insufficient funds or data issue), CMS notifies the Plan, instructing them to bill the member for the premiums. Plans may reconcile premium amounts using the MPWR.

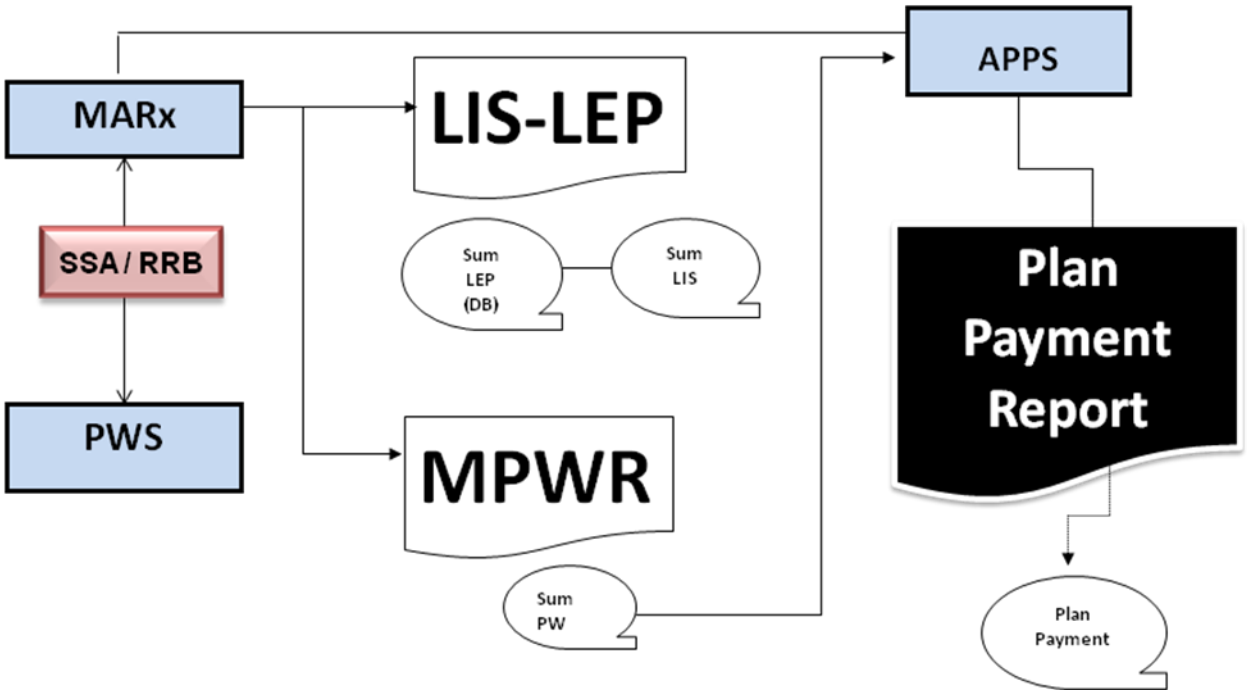
2.2 Premium Payment Flow

In understanding the information communicated on the MPWR, Plans should understand the data flow required for processing the premium withhold option.

- The premium withholding process begins during or after enrollment, when:
  - a beneficiary elects to pay the Plan premium from their SSA or RRB benefit.
  - a beneficiary enrolls with "uncovered months" and is required to pay a Late Enrollment Penalty (LEP).
    - The LEP is automatically deducted and retained by CMS by the Premium Withhold System (PWS) from the premium received from SSA/RRB.
- When a beneficiary chooses direct billing, then the payment is made directly to the Plan by the beneficiary.
- CMS notifies the SSA/RRB of the request to have premiums withheld from the SSA or RRB benefit. Because it can take one to three months to process the request at SSA/RRB, the beneficiary's request is considered to be pending until MARx notifies the Plan that SSA/RRB has processed and accepted it.
- The PWS uses premium withhold data from both MARx (expected premium withholding), SSA (actual premium withholding), and RRB (actual premiums withheld). This data is reconciled and reported to the Plan through the MPWR. If applicable, the LEP is also included in the MPWR but is retained by CMS.
- PWS also sends payment data to the Automated Plan Payment System (APPS) to be compiled with other Plan payment information, resulting in an aggregate Plan payment which includes the premium.
- The premium information reported on the MPWR is also reported on the PPR summarized on a contract-level.

Figure 2A illustrates the premium payment flow and the origin of information reported on the MPWR.

Figure 2A Premium Payment Data Flow



2.3 Premium Withholding System (PWS)

MARx provides the PWS with the expected premium withhold data. The PWS produces the MPWR data file. On a monthly basis, PWS notifies Plans of all beneficiary withholdings via the MPWR and provides premium withhold information to APPS. APPS then calculates payments to the Plan.

- **The Premium Withholding System (PWS)** receives information from MARx, SSA, and RRB to record withheld premium amounts and periods as expected or actual. PWS notifies plans and APPS of withholdings.

- **The Automated Plan Payment System (APPS)** calculates payment to plans using data provided by MARx, HPMS, and PWS, and disperses payment to the U.S. Treasury.

Table 2A provides the functions of the PWS.

TABLE 2A – PWS MONTHLY FUNCTIONS

Function	Purpose	Data Source
Receives the Monthly Premium Withhold Extract	Identifies beneficiaries electing Premium Withhold, the premium amounts, and the periods they apply to. These amounts are the ''expected'' premium payment to plans.	MARx
Receives the Monthly Premium Withhold File	Identifies premium amounts withheld and the periods they apply to. These amounts are the ''actual'' premium payment to plans.	SSA, RRB
Performs Monthly Reconciliation of "expected'' and "actual" premium payment amounts to plans	Reconciles ''expected'' and ''actual'' premium payment amounts to plans, identifies discrepancies and, if necessary, directs MARx to convert a beneficiary whose withholding is incorrect to direct bill status. The results of the reconciliation are reported to MARx for distribution to the plans.	MARx , SSA, RRB
Performs a reconciliation of the funds transferred to the actual transfer accomplished	Reconciles the report of funds transferred by SSA/RRB to the actual transfer accomplished via the Intergovernmental Payment and Collection (IPAC) files from SSA.	SSA, RRB and IPAC
Produces the Monthly Premium Withholding Report Data File (MPWR)	Provides a reconciliation file of premiums withheld from SSA, RRB, or the Office of Personnel Management (OPM).	SSA, RRB, OPM
Produces proper payment file	Creates a file that is sent to APPS indicating the proper payment of withheld funds to plans.	PWS

2.3.1 Reconciling the PPR with the MPWR

The premium information the PWS reports to the MPWR is also available on the PPR. However, the PPR reports the data to the Plan on a contract-level. The MPWR is a monthly reconciliation file of premiums withheld from SSA or RRB checks. The file includes Part C and Part D premiums and any Part D LEP. The Part D LEP on the MPWR is for information purposes only as the LEP dollars are retained by CMS.

MARx makes this report available to Plans as part of the month-end processing. The detail record of the data file contains:

- Contract/Plan Level Information
- Beneficiary Information
- Premium Payment Option
- Premium Withhold Start and End Dates
- Premiums Collected

When reconciling the PPR using the MMR, Plans can examine the premiums collected by beneficiary and sum the payments of all beneficiaries in the plan to obtain the contract-level premiums reported. The PPR contains the following premium relevant fields

- Part C Premiums
- Part D Premiums

Table 2B illustrates the fields on the MPWR that map to the PPR.

TABLE 2B – MPWR MAP TO PPR PREMIUM DATA FILE FIELDS

Field	MPWR		Field	PPR Data File
15	Part C Premiums Collected		23	Part C Premium Withholding Amount
16	Part D Premiums Collected		24	Part D Premium Withholding Amount

Plans must understand the information reported on the MPWR when reconciling premium payment. Sections 2.3.1.1 – 2.3.1.5 describe in more detail the fields on the MPWR.

2.3.1.1 Contract/Plan Level Information

The detail record provides specific Contract/Plan-level identifying information. The file contains the organization's five (5) character CMS provided contract number, the 3 character plan benefit package (PBP) number and, if applicable, the 3 character segment number. This is the plan that the beneficiary is enrolled in and owes premiums to on the premium start and end dates in the detail record.

2.3.1.2 Beneficiary Level Information

The report contains beneficiary information as described on Table 2C below. The report contains beneficiaries that elected Premium Withholding and those that previously had premiums withheld but either SSA/RRB, CMS or the plan has changed their status to direct bill. Note that in this latter case, there will be negative adjustments on the MPWR. If SSA had withheld premiums and they were paid to the plan for a period that is now defined as direct bill, they are recouped back from the plan and refunded to the beneficiary.

TABLE 2C - MPWR BENEFICIARY INFORMATION*

Field	Description
HIC Number	This identifies the beneficiary's HIC number
Surname	This field will report up to 7 letters of the beneficiary's surname
First Initial	The first initial of the beneficiary's first name is displayed
Sex	The gender of the beneficiary is reported as "M" for Male or "F" for Female
Date of Birth	The beneficiary date of birth is reported in this field

*The PPR does not contain beneficiary-level information, however, the MPWR allows the Plan to drill down to the individual beneficiary to validate amounts on the PPR.

2.3.1.2.1 HIC Number

A HIC number is a Medicare beneficiary's identification number. The SSA and the RRB issue Medicare HIC numbers. All HICNs issued by SSA are 9-digit numbers (Social Security number) with at least one letter suffix (beneficiary identification code or BIC) in the tenth position. If there is an eleventh position, it may be either a letter or number.

The HICN issued by the RRB, may contain either 6 or 9 digit numbers with up to a 3-position letter prefix. RRB numbers issued before 1964 contain 6-digit random numbers preceded by an alpha prefix. After 1964, the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha prefix.

If a beneficiary's entitlement changes, it is possible for the 9-digit number, the prefix, the suffix or all three to change. It is also possible to go from an SSA issued HICN to a RRB HICN or vice versa.

If the BIC is A, T, TA, M, M1, J1, J2, J3, J4 or the RRB prefix is an A or H the number is the beneficiary's own SSN. Otherwise, the SSN belongs to a wage earner and the beneficiary is entitled as an auxiliary or survivor on that SSN. Table 2D illustrate the characteristics for each HIC type.

TABLE 2D– STRUCTURE OF HIC NUMBERS

HIC TYPE	CHARACTERISTICS
CMS	9-Digit Social Security number followed by an alpha or alphanumerical suffix. Suffixes include but are not limited to: • "A" beneficiary • "B" spouse • "C" children* • "D" divorced spouse, widow, widower • "E" widowed parent • "F" parent (including step and adopting) • "HA" disabled claimant • "HB" spouse of disable claimant • "M" Uninsured – Premium Health Insurance Benefits • "TA" Medicare Qualified Government Employee (MQGE) • "TB" MQGE aged spouse • "W" disabled widow • "W1" Disabled Widower • "W6" Disabled Surviving Divorced Wife *Indicates number of children (e.g., "C1" first child)
RRB pre-1964	alpha prefix followed by 6-digit random numbers
RRB post-1964	alpha prefix followed by 9-digit Social Security number

2.3.1.3 Premium Payment Option Field

The report includes the premium payment option selected by the beneficiary or as changed to Direct Bill by CMS/SSA/RRB. The latter occurs if SSA or RRB rejects a withhold request due to insufficient funds or other data mismatch error. CMS will change the premium payment option to direct bill if the plan transaction is retroactive. Retroactive withhold requests are not allowed due to the impact of multiple months of premiums being withheld from one benefit check. SSA has a $200 limit on withholding from one benefit check.

Beneficiaries with premium payment options of Direct Bill appear on the report if premiums were withheld for a time period that now reflects the direct bill status. In these cases, the MPWR displays the premiums being recouped from the plan.

The MPWR communicates the premium payment option for the month in the "Premium Payment Option" field with the following descriptions:

- "SSA" - Withholding by SSA
- "RRB" - Withholding by RRB

Note: The option of premium withhold from RRB began in 2011 and CMS anticipates premium withholding option available for beneficiaries from OPM in the future.

2.3.1.3.1 Reasons Why Premium Withhold Requests Are Not Accepted

If the Plan submitted a MARx transaction requesting premium withholding and the beneficiary Premium Payment Option is not communicated on the data file the beneficiaries will remain in pending status until the SSA or RRB validates the transaction. Plans should continue to monitor the MPWR for updates to the status.

Once accepted, (via transaction reply code 186) the beneficiary's selected Premium Payment Option will display on the MPWR. Table 2E reports the reasons CMS may make changes to the premium withhold option.

TABLE 2E – REASONS WHY PREMIUM WITHHOLD REQUESTS ARE NOT ACCEPTED

REASONS CMS CHANGES PREMIUM WITHHOLD REQUESTS ARE NOT ACCEPTED
Retroactive premium withholding is not permitted.
The beneficiary's retirement system (SSA or RRB) was unable to withhold the entire premium amount from the beneficiary's monthly check because of insufficient funds.
The beneficiary has a BIC of M or T and chose "SSA" as the withhold option. SSA cannot withhold premiums for these beneficiaries (there is no benefit check to withhold from).
The Plan has submitted a Part C premium amount that exceeds the maximum Part C premium value provided by HPMS.

Example 1

On December 15, 2010, Summer Health Plan requested an SSA premium withhold status for a beneficiary to begin January 1, 2011. What will the January 2011 MPWR communicate? The report will not list the beneficiary since the SSA deduction will take approximately 2-3 months to validate.

2.3.1.3.2 Premium Withholding Details and Rules

SSA requires valid Social Security Numbers be submitted with each premium withhold request. Without this information, CMS will not pass the request along and the beneficiary will be left in direct bill status. Therefore, the beneficiary will not appear on the MPWR. Individuals who have requested premium withhold are considered to be in a pending status until either:

- CMS notifies the organization that the premium withhold request has been accepted or rejected.
- CMS notifies the Plan that member's request has been changed to direct bill.

2.3.1.4 Premium Start and End Date Fields

Once the premium withhold agency has begun deducting the premium from the beneficiary's benefit check this information is reported on the MPWR. The Premium Period Start Date will include the date(s) the premium payment covers.

The Premium End Date will report the ending period that the collected premium covers.

2.3.1.5 Premium Collected Fields

The actual amounts collected for each beneficiary is reported in the appropriate premium collected fields. The three fields that report collected amounts include:

- Part C Premiums Collected
- Part D Premium Collected
- Part D Late Enrollment Penalty

2.3.1.5.1 Part C Premiums Collected Field

The Part C premium amount is reported to CMS by the Plan and it may also include additional premium amounts for any optional supplemental benefits selected by the member.

If the beneficiary has elected the direct bill (self-pay) option, the Plan receives payment directly from the member. If the beneficiary has elected SSA premium withhold, CMS transmits this information to SSA. On a monthly basis, SSA withholds the premiums and sends them to CMS, where the premiums are verified and then passed (paid) to the plans. If SSA is unable to deduct a member's premium from their benefit check (due to insufficient funds or data issue), CMS notifies the Plan, instructing them to bill the member for the premiums.

The Part C Premium Collected field will report the Part C premiums collected by SSA/RRB. The amount reported can be a negative or positive value. A positive amount reports the amount being paid to the plan. A negative amount reports a recoupment from the plan that will be refunded to the beneficiary by SSSA/RRB.

⌦ Example 2

Spring Health Plan has reviewed the April PPR and is now reviewing the MPWR for a beneficiary enrolled in the Plan to validate the Part C premium amount collected. The Part C Premiums Collected field reported the following positive amounts: $90 for the April 2011 MPWR and $30 for the May 2010 MPWR. Spring Health Plan is reconciling the premium payments and noticed the difference in the two amounts collected.

Spring Health Plan reviewed the Premium Period Start and Premium Period End Dates to determine that the March amount collected on the April MPWR included the months of January-March 2011.

There can be a delay of up to two to three months before premium withhold amounts are deducted from the beneficiary's benefit check. Therefore, Plans must review the MPWR monthly to monitor the reports and status of premium withhold.

2.3.1.5.2 Part D Premiums Collected Field

The Part D premium amount reported is the base premium or the base plus enhanced premium, depending on the beneficiary's Plan election. During processing MARx will compare the Part D premium amount submitted by the plan to the amount assigned to the Plan Benefit Package (PBP) by the Plan bid information in the HPMS. If the amount is correct the withhold request is sent to SSA. If the amount submitted by the plan is incorrect, MARx changes it to the correct Part D premium amount and also changes the premium payment option to Direct Bill.

The Part D Premium Collected field will report the Part D premiums collected by SSA/RRB. The amount reported can be a negative or positive value. A positive amount reports the amount being paid to the plan. A negative amount reports a recoupment from the plan that will be refunded to the beneficiary by SSA/RRB.
This occurs when previously withheld premiums need to be refunded as the member is now in direct bill status.

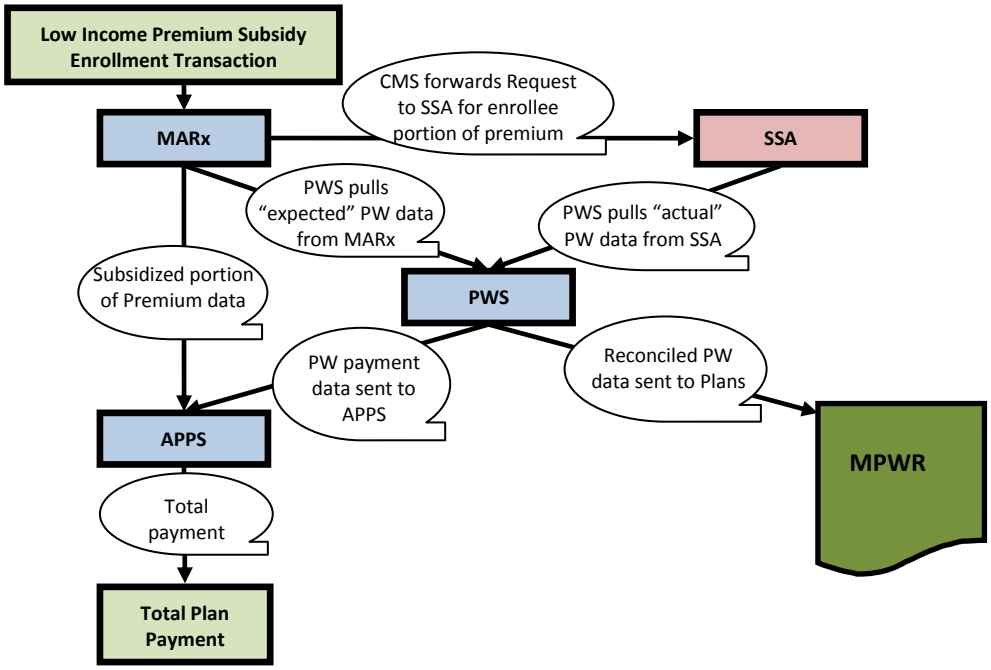
Also note that both the Part C and Part D premiums for a plan must be withheld if that is the option selected by the beneficiary. The beneficiary cannot elect to have the Part C premium withheld and the Part D premium directly billed.

The Part D premium amounts reported in this field do not include Late Enrollment Penalty amounts.

Low-Income Premium Subsidy
Beneficiaries eligible for the Low Income Premium Subsidy (LIPS) will receive a subsidy equal to a defined percentage amount; i.e., they will either not have to pay the basic Part D premium or they will only be liable for a portion of the basic Part D premium. (The LIPS does not apply to any enhanced Part D premiums that a beneficiary owes due to election of enhanced coverage.) If the LIPS eligible beneficiary selects the premium withhold option, only the amount not subsidized by CMS will be deducted. The agency (SSA or RRB) withholds the non-subsidized amount (if any) and CMS pays the Plan the remainder of the premium.

Figure 2B illustrates the LIPS withholding process.

Figure 2B – Low-Income Premium Subsidy Withholding Process



Example 3

Mr. January is eligible for a 75% Low Income Premium Subsidy (LIPS) and is responsible for the remainder of his premium. The premium for the Plan he is enrolled in is $40. The LIPS amount is $30; which CMS will pay to the plan. Mr. January is responsible for $10. He has elected to have the difference withheld from his SSA benefit. His Plan will receive the subsidized amount as a result of the LIPS ($30) from CMS and the remaining $10 from SSA as withheld from Mr. January's benefit. The premium deduction amount ($10) will appear in the Part D Premiums Collected field on the MPWR.

Premium Refunds

Refunds of withheld premiums will occur if a beneficiary disenrolls and their Medicare Part C/D premium is being deducted from their SSA or RRB benefit, they should allow up to three months for the refund to be processed by SSA or RRB. In addition, if a beneficiary changes their premium payment option from SSA/RRB Withhold to Direct Bill, three months should be allowed for this change to be processed. Plans may refer beneficiaries to contact 1-800-MEDICARE for questions on refunds.

Refunds are reported as negative amounts in the Part C/D Premiums Collected fields.

2.3.1.5.3 Part D Late Enrollment Penalties

Medicare beneficiaries may incur a Late Enrollment Penalty (LEP) if there is a continuous period of 63 days or more at any time after the end of the individual's Part D initial enrollment period during which the individual was eligible to enroll, but was not enrolled in a Medicare Part D Plan and was not covered under any creditable prescription drug coverage.

The LEP is an amount based on the number of uncovered months a beneficiary experienced. The LEP is considered a part of the Plan premium.

If a member is assessed a LEP, their premium will include the penalty amount. If the member elects the withholding option, SSA/RRB withholds the penalty amount and CMS retains it. Plans can see the amounts on the Monthly Premium Withhold Report or data file (MPWRD). If the member has elected the direct billing option, the Plan bills the premium amount that includes the LEP, and CMS deducts the LEP from the Plan payment.

🕮 Plans can also review the LEP amounts for directly billed beneficiaries on the Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) report. The file layout can be found in the Plan Communications User Guide Appendices, section E.17 at http://www.cms.gov/MAPDHelpDesk/downloads/PCUG_v5_3_111710_Appendices_With_Cover_Final.pdf

In addition to the information reported on the MPWR the LIS/LEP report displays more detailed information regarding the Late Enrollment Penalty.

2.3.2 Monthly Premium Withholding Report Data File Layout

The MPWR is comprised of three records that include the header, detail, and trailer. Each record contains 165 bytes in length. Table 2F provides a description of the information included in each of the records.

TABLE 2F – MWPRD FILE STRUCTURE

RECORD NAME	DESCRIPTION
Header Record	• Identifies the version of the data fie
Detail Record	• Provides Part C and D premium information D • Provides information on late enrollment penalties
Trailer	• Provides contract, PBP and segment totals of the premiums and penalties collected

Table 2G provides the specific data reported in the MPWR organized by file structure of header, detail, and trailer. The field represents the data reported, the size reports the length of data, the position reports the actual position in the data file where the data will appear and the description provides a description of how to interpret the data reported in the field.

TABLE 2G - MONTHLY PREMIUM WITHHOLDING REPORT DATA FILE (MPWR)

Header Record

ITEM	FIELD	SIZE	POSITION	DESCRIPTION
1	Record Type	2	1 – 2	H = Header Record PIC XX
2	MCO Contract Number	5	3 – 7	MCO Contract Number PIC X(5)
3	Payment Date	8	8 – 15	YYYYMMDD First 6 digits contain payment month PIC 9(8)
4	Report Date	8	16 – 23	YYYYMMDD Date this report created PIC 9(8)
5	Filler	142	24 – 165	Spaces

TABLE 2G - MONTHLY PREMIUM WITHHOLDING REPORT DATA FILE (MPWR) (CONTINUED)

Detail Record

ITEM	FIELD	SIZE	POSITION	DESCRIPTION
1	Record Type	2	1 – 2	D = Detail Record PIC XX
2	MCO Contract Number	5	3 – 7	MCO Contract Number PIC X(5)
3	Plan Benefit Package Id	3	8 – 10	Plan Benefit Package ID PIC X(3)
4	Plan Segment Id	3	11 – 13	Segment number PIC X(3)
5	HIC Number	12	14 – 25	Member's HIC # PIC X(12)
6	Surname	7	26 – 32	Member's last name PIC X(7)
7	First Initial	1	33	Member's first initial PIC X
8	Sex	1	34	Member's Gender M = Male, F = Female PIC X
9	Date of Birth	8	35 – 42	Member's Date of Birth YYYYMMDD PIC 9(8)
10	Premium Payment Option	3	43 – 45	Premium Payment Option in effect for the period defined below: "SSA" = Withholding by SSA "RRB" = Withholding by RRB "OPM" = Withholding by OPM PIC X(3)
11	Filler	1	46	Space
12	Premium Period Start Date	8	47 – 54	Starting Date of Period Premium Payment or Recoupment Covers YYYYMMDD PIC 9(8)
13	Premium Period End Date	8	55 – 62	Ending Date of Period Premium Payment or Recoupment Covers YYYYMMDD PIC 9(8)
14	Number of Months in Premium Period	2	63 – 64	The number of months covered by the payment or recoupment PIC 99
15	Part C Premiums Collected	8	65 – 72	Part C Premiums Collected for this beneficiary, Plan and premium period A negative amount indicates a recoupment by the period defined on this record. PIC -9999.99

TABLE 2G - MONTHLY PREMIUM WITHHOLDING REPORT DATA FILE (MPWR) (CONTINUED)

Detail Record (Continued)

ITEM	FIELD	SIZE	POSITION	DESCRIPTION
16	Part D Premiums Collected	8	73 – 80	Part D Premiums Collected (excluding LEP) for this beneficiary, Plan and premium period A negative amount indicates a recoupment by the withholding agency to refund a beneficiary for the period defined on this record PIC -9999.99
17	Part D Late Enrollment Penalties Collected	8	81 – 88	Part D Late Enrollment Penalties Collected for this beneficiary, Plan and premium period A negative amount indicates a recoupment by the withholding agency to refund a beneficiary for the period defined on this record PIC -9999.99
18	Filler	77	89 – 165	Spaces

Trailer Record

ITEM	FIELD	SIZE	POSITION	DESCRIPTION
1	Record Type	2	1 – 2	T1 = Trailer Record, withhold totals at the segment level T2 = Trailer Record, withhold totals at the PBP level T3 = Trailer Record, withhold totals at the contract level PIC XX
2	MCO Contract Number	5	3 – 7	MCO Contract Number PIC X(5)
3	Plan Benefit Package ID	3	8 – 10	Plan benefit package ID; not populated on T3 records PIC X (3)
4	Plan Segment ID	3	11 – 13	Plan segment ID; not populated on T2 or T3 records PIC x (3)
5	Total Part C Premiums Collected	14	14 – 27	The net Part C Premiums collected as specified by the trailer record type , field 1 PIC -9(10).99
6	Total Part D Premiums Collected	14	28 -41	The net Part D Premiums (LEP not included) collected as specified by the trailer record type , field 1 PIC -9(10).99
7	Total Part D Late Enrollment Penalties Collected	14	42 - 55	The net Part D LEP collected as specified by the trailer record type , field 1 PIC -9(10).99
8	Total Premiums Collected	14	56 – 69	Total Premiums Collected = +Total Part C Premiums Collected + Total Part D Premiums Collected + Total Part D LEPs Collected PIC -9(10).99
9	Filler	96	70 - 165	Spaces

Example 4

Beneficiaries enrolled in the Part D Summer Health Plan effective March 1 and are responsible for a Part D premium. After reconciling payment, Summer Health Plan concludes there is a deficit in payment due to uncollected premiums for 20 of their beneficiaries for the month of March. After closer review, the Plan determined these beneficiaries selected the SSA premium withhold option. Summer Health Plan reviews the MPWR to determine the amounts that are not reported on the March MPWR report. Summer Health Plan continued to monitor the Premium Start Date and Premium Part D Amount fields on the MPWR since SSA may take two to three months to deduct the beneficiary premium. In May, Summer Health Plan noticed the premium amounts for the beneficiaries reflected on the MPWR.

Note: Plans may also use the TRR to monitor premium withhold status.

2.3.3 Direct Billing Status

The Plan receives the payment directly from the beneficiary when the direct billing option is selected. Usually this takes the form of an automatic deduction from an account or payment with credit or debit card. Direct bill is the default position, meaning that during the enrollment process, if the enrollee does not actively select the premium withhold option, then they are billed directly. The MPWR does not report direct billing amounts.

2.3.3.1 Tracking and Reconciling Premiums

Plans have several resources available to assist with tracking and reconciling premium withholding and payment information. The reports in Table 2H are provided to Plans for the purpose of reviewing and reconciling current data on premium amounts, withheld amounts and other payment information.

TABLE 2H – RECONCILIATION REPORTS

Report Name	Purpose
Part C Monthly Membership Report (MMR)	List of every Part C Medicare member of the contract and providing details about the payments and adjustments made for each
Part D Monthly Membership Report (MMR)	List of every Part D Medicare member of the contract and providing details about the payments and adjustments made for each
Monthly Premium Withholding Report Data File (MPWR)	Monthly reconciliation file of premiums withheld from SSA checks, including Part C and Part D premiums and any Part D Late Enrollment Penalties
Plan Payment Report (PPR)	Itemized list of the final monthly payment to the Plan
LIS/LEP Report	List of LIS beneficiaries and direct bill beneficiaries that have incurred a LEP

Plans may create internal reports to reconcile premium withhold amounts collected, by extracting fields from the CMS provided reports and validating against other CMS reports.

In addition to the reports available, Plans may also track and reconcile premium amounts and premium withholdings via the Medicare Advantage and Part-D Inquiry System User Interface, often referred to as the User Interface (UI). The UI, a CMS user interface, provides plans with access to beneficiary information, payment information, and premiums charged by Plans. Plans may also request historical reports.

Note: The UI screen displays the term 'MCO' rather than 'Plan'. 'MCO' represents all types of Managed Care Plans (e.g., Cost Plans, Medicare Advantage (MA) plans, MAPD plans, and PDPs).

2.3.4 "No Premium Due" Status Notification

Enrollees who elect Part C optional supplemental benefits may also elect SSA premium withholding. In mid-November the MARx system begins preparing the premium records for the upcoming year. Since MARx cannot anticipate what optional premiums an enrollee may elect for next year, an enrollee only paying optional premiums may go from "SSA Premium Withholding" status in one year to "No Premium Due" status for the next year. Plans will be notified about enrollees in a "No Premium Due" status for the next year by a report called No Premium Due Data File.

2.4 Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Report

LIS and LEP are reported in detail on the LIS/LEP report. The report more specifically informs the plan if the premium amounts reported are part of an adjustment or prospective payment. Adjustment are indicated on the LIS/LEP report as "AD" and prospective payments are displayed as "PD" in the record type of the detail file, which is discussed in this section.

The report provides beneficiary-level information and includes demographic information that includes the HIC number, date of birth, and gender. In addition the report includes:

- PWS reports premium information
- Low Income Subsidy Amount
- Low Income Premium Subsidy Percentage
- Late Enrollment Penalty for Direct Bill

Reconciling PPR Using LIS/LEP Report
The PPR reports premium information in the Premium Settlement section of the PPR on a contract-level. Therefore, Plans should reconcile the amounts that display on the PPR using this beneficiary-level report. The PPR does not provide a count for the number of beneficiaries included in the Low Income Subsidy or Late Enrollment Penalty.

Plans will need to pull information from other reports to reconcile data on PPR by starting with the fields on the report. On the LIS/LEP report, Plans may reconcile the LIS amount using field 17 of the LIS/LEP report and field 25 of the PPR and reconcile the LEP using field 18 on the LIS/LEP report to reconcile with field 26 on the PPR.

Timing Reported on the LIS/LEP
The LIS/LEP report communicates the adjustment start date and end date. Plans can review this field to determine if the premium amounts reported are for the period intended. Applying the premium in the incorrect period could possibly cause inconsistencies when attempting to reconcile the PPR. The number of months reported indicates the coverage period for the subsidy.

For example, if a plan's premium is $20 monthly and the beneficiary elected premium withhold, which began 3 months later, the period may identify 3 months and the premium amount may reflect $60 instead of $20.

The net monthly Part D Basic premium for the period reported is displayed followed by the percentage of the subsidy the beneficiary is eligible for in this period.

Example 5

Summer Health Plan reviews the May 2011 PPR, which displays the total LIS premium amount of $200. The LIS/LEP reports $300. Summer Health Plan should consult the number of month's field since the payment can reflect more than one month for a beneficiary.

2.4.1 Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Report Structure

The LIS/LEP is comprised of three records that include the header, detail, and trailer. Each record contains 165 bytes in length. Table 2I provides a description of the information included in each of the records. And 2J displays the data file layout.

TABLE 2I – LIS/LEP FILE STRUCTURE

RECORD NAME	DESCRIPTION
Header Record	• Identifies the data field
Detail Record	• Provides information on late enrollment penalties • Provides Low Income Subsidy Premium percentages
Trailer	• Provides Total LIPS amount • Provides total late enrollment penalties amount

TABLE 2J – LIS/LEP DATA FILE LAYOUT

Header Record

Item	Field Name	Size	Position	Description
1	Record Type	3	1 - 3	H = Header Record PIC XXX
2	MCO Contract Number	5	4 - 8	MCO Contract Number PIC X(5)
3	Payment/Payment Adjustment Date	6	9 - 14	YYYYMM First 6 digits contain Current Payment Month PIC 9(6)
4	Data file Date	8	15 - 22	YYYYMMDD Date this data file created PIC 9(8)
5	Filler	143	23 - 165	Spaces

TABLE 2J – LIS/LEP FILE STRUCTURE (CONTINUED)

Detail Record

Item	Field Name	Size	Position	Description
1	Record Type	3	1 - 3	PD = Prospective Detail Record "Prospective" means Premium Period equals Payment Month reflected in Header Record AD = Adjustment Detail Record "Adjustment" means all premium periods other than Prospective PIC XXX
PLAN IDENTIFICATION				
2	MCO Contract Number	5	4 - 8	MCO Contract Number PIC X(5)
3	Plan Benefit Package Number	3	9-11	Plan Benefit Package Number PIC X(3)
4	Plan Segment Number	3	12 - 14	Plan Segment Number PIC X(3)
BENEFICIARY IDENTIFICATION & PREMIUM SETTINGS				
5	HIC Number	12	15 - 26	Member's HIC # PIC X(12)
6	Surname	7	27 - 33	PIC X(7)
7	First Initial	1	34	PIC X
8	Sex	1	35	M = Male, F = Female PIC X
9	Date of Birth	8	36 - 43	YYYYMMDD PIC 9(8)
10	Filler	1	44	Space
PREMIUM PERIOD				
11	Premium/Adjustment Period Start Date	6	45 - 50	PD: current processing month. AD: adjustment period. YYYYMM PIC 9(6)
12	Premium/Adjustment Period End Date	6	51 - 56	PD: current processing month. AD: adjustment period. YYYYMM PIC 9(6)
13	Number of Months in Premium/Adjustment Period	2	57 - 58	PIC 99
14	PD: Net Monthly Part D Basic Premium AD: Net Monthly Part D Basic Premium Amount	8	59 - 66	Plan's Part D Basic Rate in effect for this premium period Net is Monthly Part D Basic Premium (minus) DE MINIMIS DIFFERENTIAL **Note**: PD always equals AD for this field PIC -9999.99
15	Low Income Premium Subsidy Percentage	3	67 - 69	Low Income Premium Subsidy Percentage Subsidy percentage in effect for this premium period Valid values: 100, 075, 050, 025, Blank PIC 999

TABLE 2J – LIS/LEP FILE STRUCTURE (CONTINUED)

Detail Record (Continued)

Item	Field Name	Size	Position	Description
16	Premium Payment Option	1	70	Current view of Premium payment option. **Valid values:** D (direct bill) S (SSA withhold) R (RRB withhold) O (OPM withhold) N (no premium applicable) PIC X
ACTIVITY FOR PREMIUM PERIOD				
17	Premium Low Income Subsidy Amount	8	71 - 78	PD: Premium Low Income Subsidy Amount – the portion of the Part D basic premium paid by the Government on behalf of a low income individual AD: For adjustments, compute the adjustment for each month in the (affected) payment period if the payment has already been made. PIC -9999.99
18	Net Late Enrollment Penalty Amount for Direct Billed Members	8	79 - 86	PD: Late Enrollment Penalty Amount for Direct Billed Members owed by beneficiary for premium period. This amount is net of any subsidized amounts for eligible LIS members. Net Late Enrollment Penalty Amount for Direct Billed Members = Late Enrollment Penalty Amount (minus) LEP Subsidy Amount (minus) Part D Penalty Waived Amount AD: For adjustments, compute the adjustment for each month in the (affected) payment period if the payment has already been made. PIC -9999.99
19	Net Amount Payable to Plan	8	87 - 94	PD: Net Amount Payable to Plan = Premium Low Income Subsidy Amount (field 16) (minus) Net Late Enrollment Penalty Amount for Direct Billed Members (field 17) AD: For adjustments, compute the adjustment for each month in the (affected) payment period if the payment has already been made. PIC -9999.99
20	Filler	71	95 - 165	Spaces

TABLE 2J – LIS/LEP FILE STRUCTURE (CONTINUED)

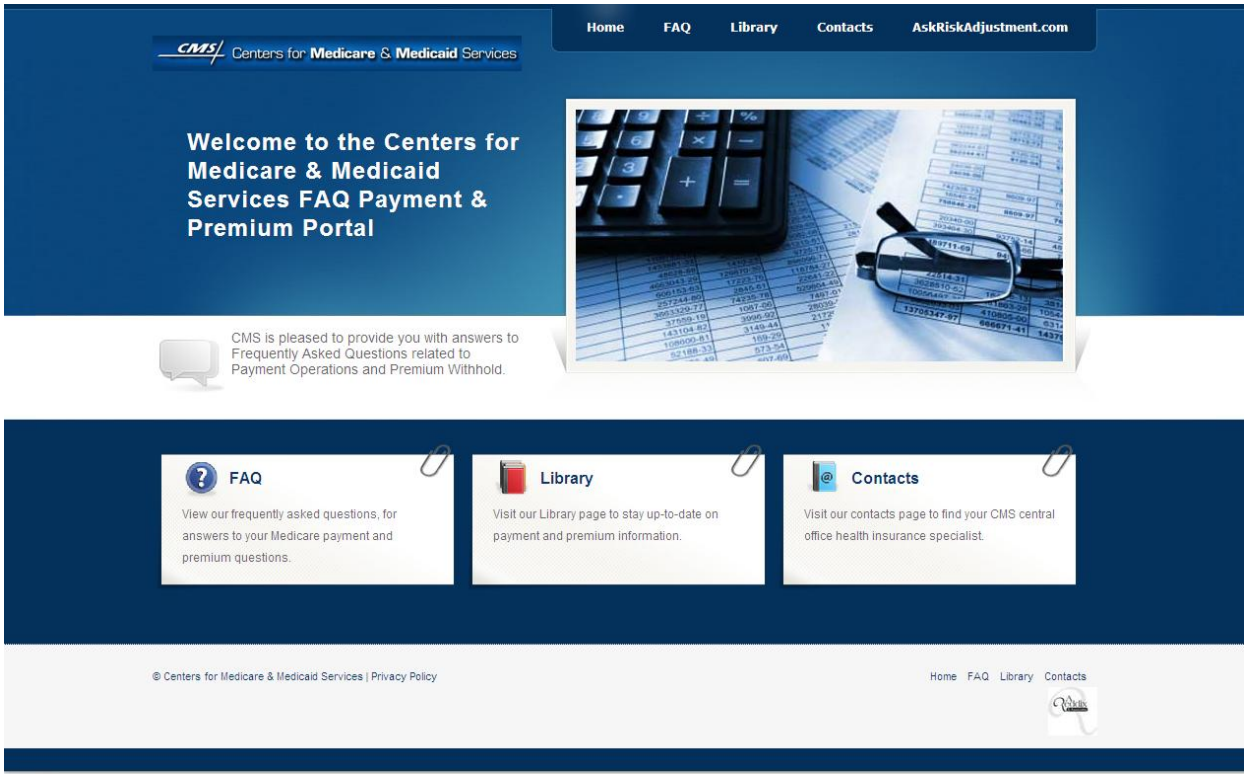
Trailer Record

Item	Field Name	Size	Position	Description
1	Record Type	3	1 - 3	PT1 = Trailer Record, Prospective Totals at Segment Level PT2 = Trailer Record, Prospective Totals at PBP Level PT3 = Trailer Record, Prospective Totals at Contract Level AT1 = Trailer Record, Adjustment Totals at Segment Level AT2 = Trailer Record, Adjustment Totals at PBP Level AT3 = Trailer Record, Adjustment Totals at Contract Level CT1 = Trailer Record, Combined Totals at Segment Level CT2 = Trailer Record, Combined Totals at PBP Level CT3 = Trailer Record, Combined Totals at Contract Level PIC XXX
PLAN IDENTIFICATION				
2	MCO Contract Number	5	4 - 8	MCO Contract Number PIC X(5)
3	Plan Benefit Package Number	3	9 - 11	Plan Benefit Package Number Not populated on T3 records PIC X(3)
4	Plan Segment Number	3	12 - 14	Plan Segment Number Not populated on T2 or T3 records PIC X(3)
5	Total Premium Low Income Subsidy Amount	14	15 - 28	Total of All Beneficiary Premium Low Income Subsidy Amounts At Level Indicated By Record Type PIC -9(10).99
6	Total Late Enrollment Penalty Amount (net of subsidized amounts for eligible LIS members.)	14	29 - 42	Total of All Beneficiary Late Enrollment Penalty Amounts At Level Indicated By Record Type PIC -9(10).99
7	Total Net Amount Payable to Plan for Direct Billed Beneficiaries	14	43 - 56	Total Net Amount Payable to Contract for Direct Billed Beneficiaries = Total Premium Low Income Subsidy Amount (field 5) (minus) Total Late Enrollment Penalty Amount Net of any Subsidy (field 6) PIC -9(10).99
8	Filler	109	57 - 165	Spaces

2.5 Premium Withhold and Payment Web Portal

CMS has developed the Premium Withhold and Payment Operations Web Portal to provide plans with a resource to questions concerning premium withhold and payment issues, a library of resource links and CMS contact information. Plans may access the web portal by entering www.pwsops.com web address in an internet search browser. Figure 2C illustrates the home screen of the pwsops web portal.

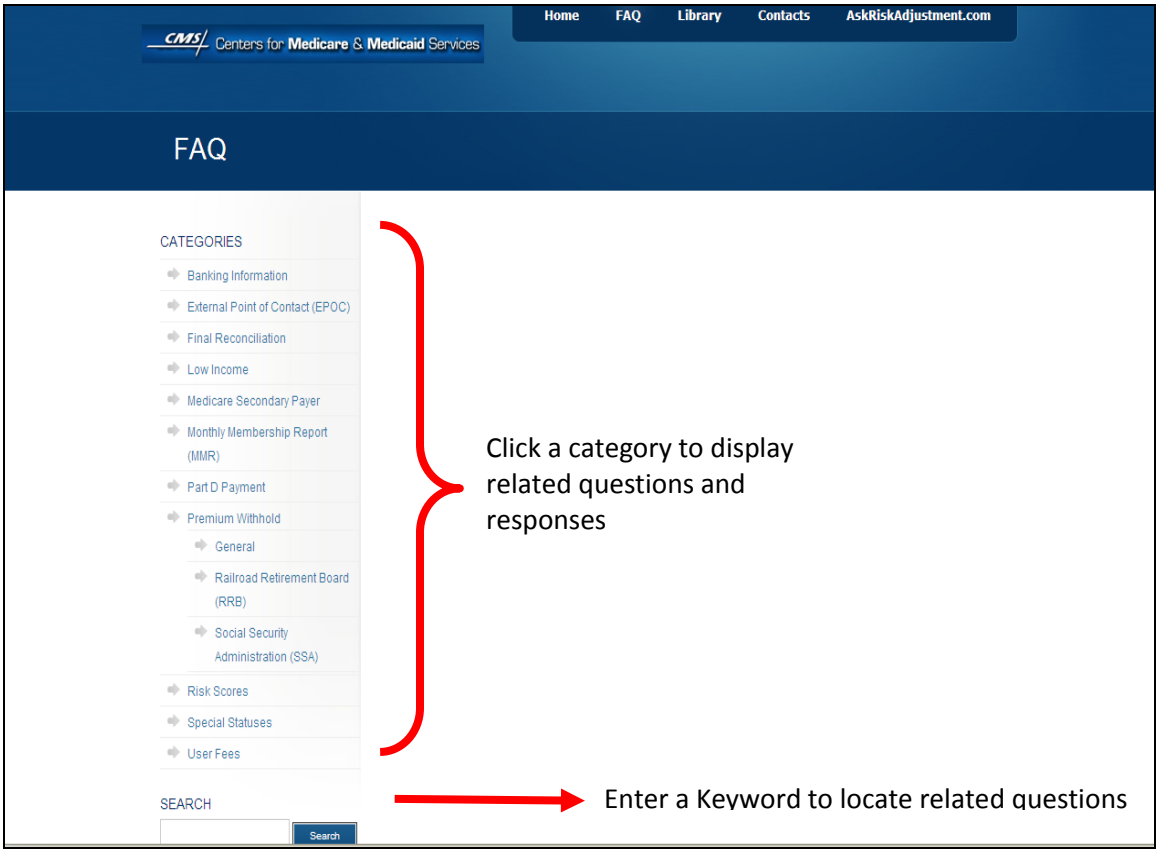
Figure 2C – Premium Withhold and Payment Operations (PWSOPS) Web Portal



2.5.1 PWSOPS – FAQs

CMS has developed a database of questions received from Plans regarding premium withhold. The web portal will provide access to the responses to the questions submitted. The web portal organized the questions by category and Figure 2D demonstrates the FAQ page.

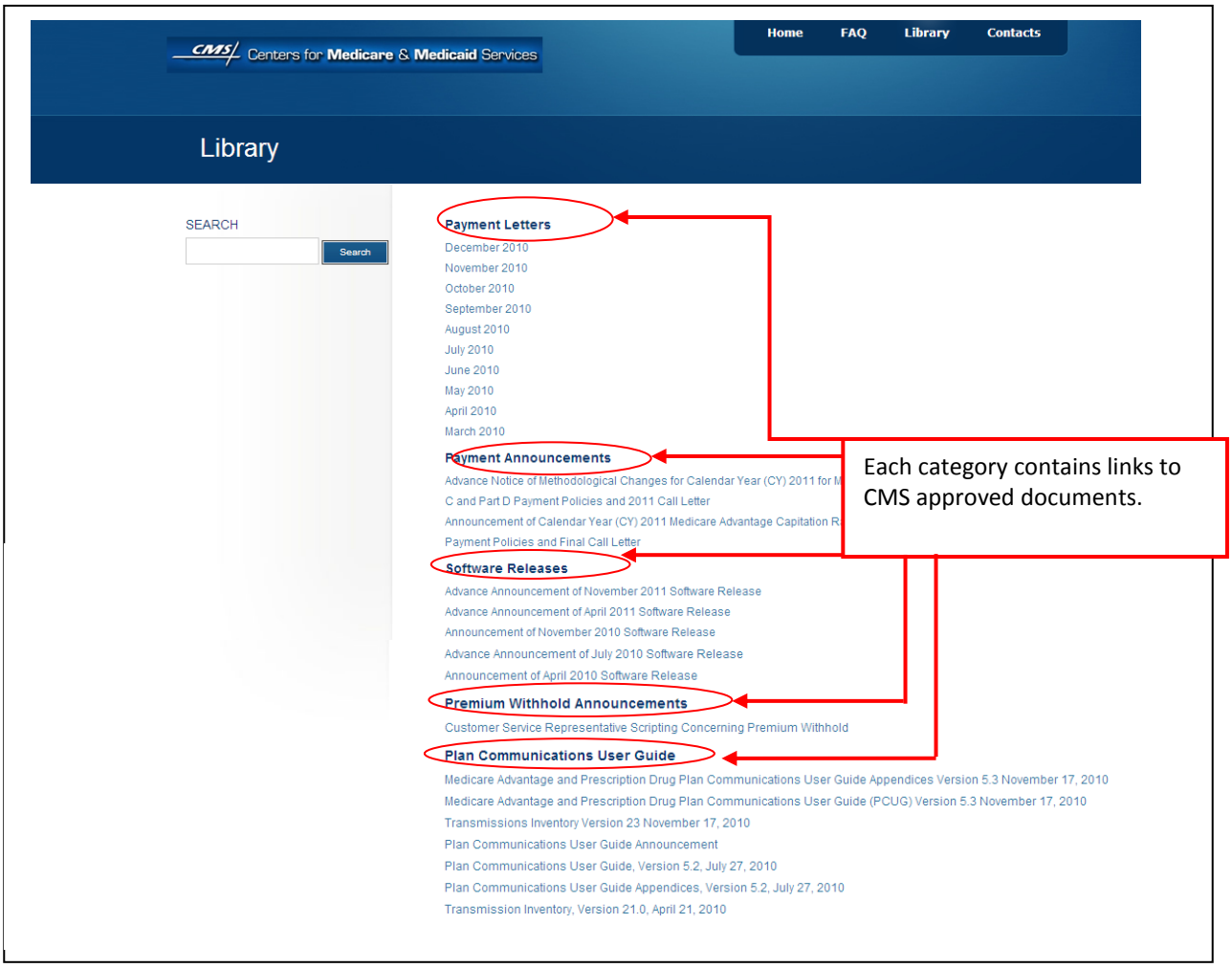
Figure 2D – PWSOPS FAQ



2.5.2 PWSOPS-Library

The portal also provides a quick link to access CMS approved documents. The links include quick access to Payment Notices, Announcements, and more. Figure 2E illustrates the library page.

Figure 2E – PWSOPS Library Page



2.5.3 PWSOPS-Contact Page

In addition to library resources, the portal provides a quick link to key CMS contact personnel. Figure 2F provides an illustration of the Contact Page.

Figure 2F - PWSOPS-Contact Page*

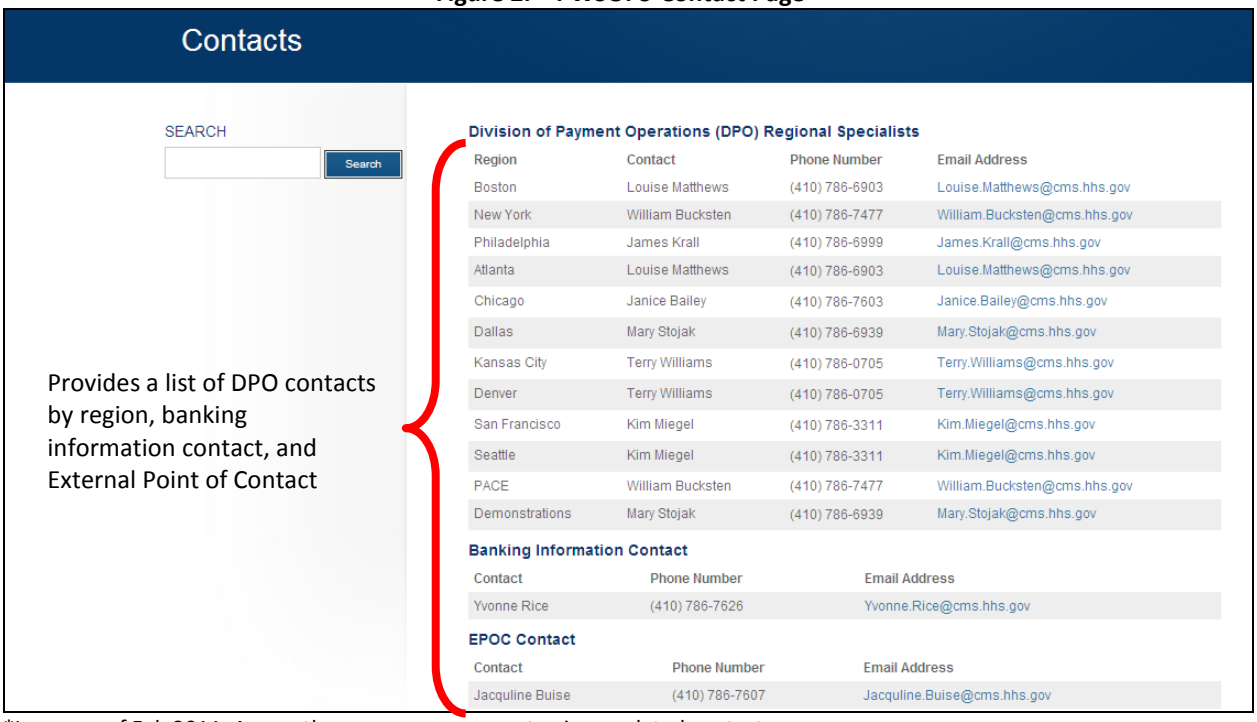


*Image as of Feb 2011. Access the www.pwsops.com to view updated contacts.

MODULE 3 – MONTHLY MEMBERSHIP REPORT

Purpose

CMS communicates beneficiary-level payments and adjustments on the Monthly Membership Report (MMR). This module will focus on the MMR and how it can be used to validate the capitated summary-level payment of the PPR and provide basic payment formulas.

Learning Objectives

At the completion of this module, participants will be able to:
- Describe the versions of the MMR
- Identify the payment-related fields on the MMR that map to the PPR
- Explain the fields and functions of report
- Identify most recent enhancements to MMR
- Describe how to submit updates to the Electronic Correspondence Referral System (ECRS)

ICON KEY	
Definition	
Example	
Reminder	
Resource	

3.1 Overview

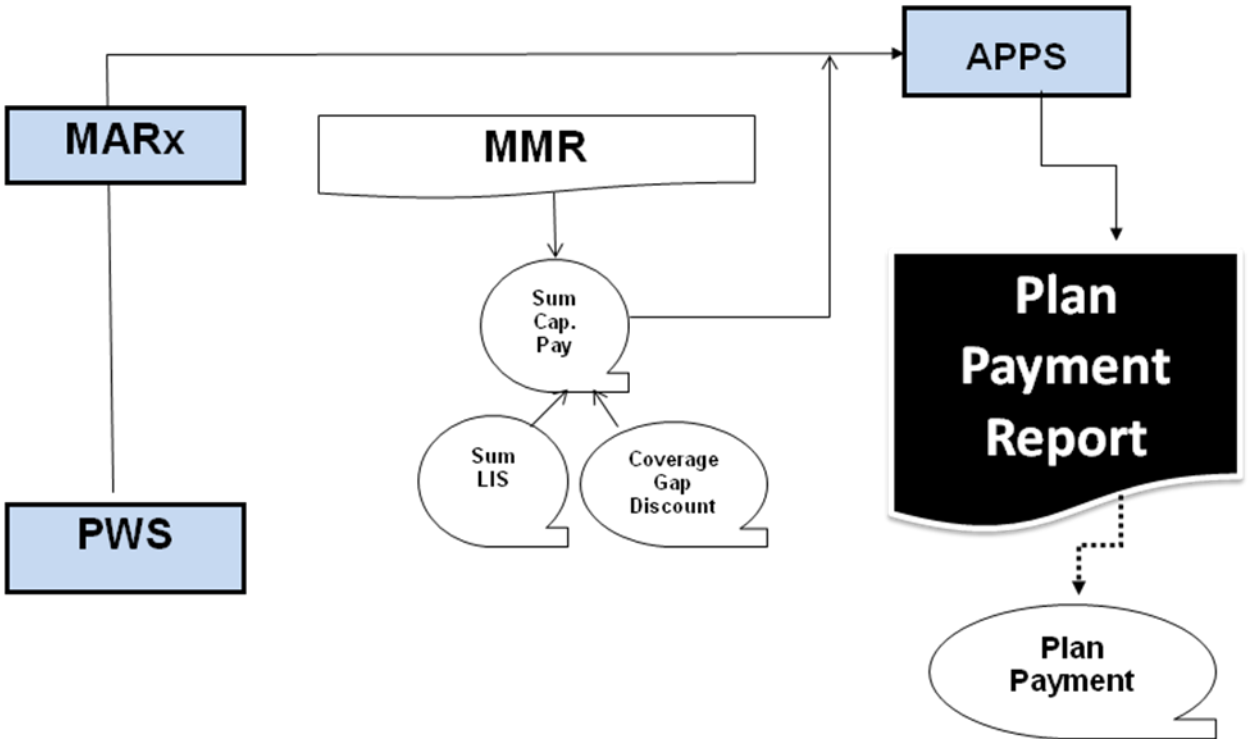
The MMR provides beneficiary-level information to Plans monthly and is available in both a report and detail format. The payment reported on the MMR is the capitated payment for each beneficiary enrolled in the Plan.

MARx receives information from other systems and calculates beneficiary-level payment based on the information received. MARx then produces the MMR, which contains beneficiary-level demographic and payment/adjustment related information.

Plans can use the data reported on the MMR to reconcile the monthly PPR. The capitated payments summarized to the plan level are forwarded to the APPS system for inclusion in the monthly plan payment along with premium information. Low Income Subsidy (LIS) and Coverage Gap Discount (CGD) are included in the capitated payment.

This information is then summed on the plan-level and reported on the PPR. The PPR will then report the capitated payment on plan-level. The payment, as indicated in Figure 3A, is calculated on the beneficiary-level, which can be reconciled with the plan-level capitated payment by reviewing the accuracy of the beneficiary-level data on the MMR. Figure 3A illustrates the flow of data.

Figure 3A – Flow of Data



There are some differences in the amount of information reported on the formatted report version versus the detail data file version of the MMR. The summary version of the MMR is also available in report and data file versions. Table 3A below provides a brief description of each version of the MMR available.

TABLE 3A – MMR REPORT VERSIONS

Report Name	Function	Layout
Part C Monthly Membership Detail Report - Non-Drug Report	Lists every Part C Medicare member of the Plan and provides details about the payments and adjustments made for each	Report
Part D Monthly Membership Detail Report - Drug Report	Lists every Part D Medicare member of the Plan and provides details about the payments and adjustments made for each	Report
Monthly Membership Detail Data File	Lists both Part C and D Medicare members of a Plan and provides details about payments and adjustments for each	Data File
Monthly Membership Summary Report	Provides summary of payment and adjustments for Part C and D Medicare members of the Plan. This report summarizes payments to an MCO for the month, in several categories, and adjustments, by all adjustment categories. When the report is automatically generated as part of month-end processing, it covers one Plan in one payment month.	Report
Monthly Membership Summary Data File	Lists both Part C and Part D members, summarizing payments made to a Plan for the month, in several categories; and the adjustments, by all adjustment categories	Data File

3.2 Monthly Membership Detail Report Layout

The Monthly Membership Detail Report (MMR) Drug and Non-Drug are beneficiary-level reports. CMS provides payment and adjustment information on each member enrolled in the Plan. The non-drug version list beneficiaries enrolled in the Plans offering Part C benefits and maps to the payments reported in the PPR as Part A and Part B payments. The drug version lists the beneficiaries enrolled in the Plan offering the Part D benefit and maps to the payments reported on the PPR listed as Part D payments.

Plans should use this report to reconcile plan-level capitated payments reported on the PPR. MA-PD Plans should review both the drug and non-drug version as CMS will list their members on both versions.

The information communicated on the report version of the MMR can be grouped into

- basic beneficiary information,
- flags/indicators, and
- payment and adjustments.

Basic beneficiary information includes the beneficiary's Health Insurance Claim Number (HICN), gender, date of birth, age, and state/county code. The flags communicate to Plans the factors that may affect payment. The Payments and Adjustments section provides detailed information regarding the payment and adjustment amounts for each enrollee listed.

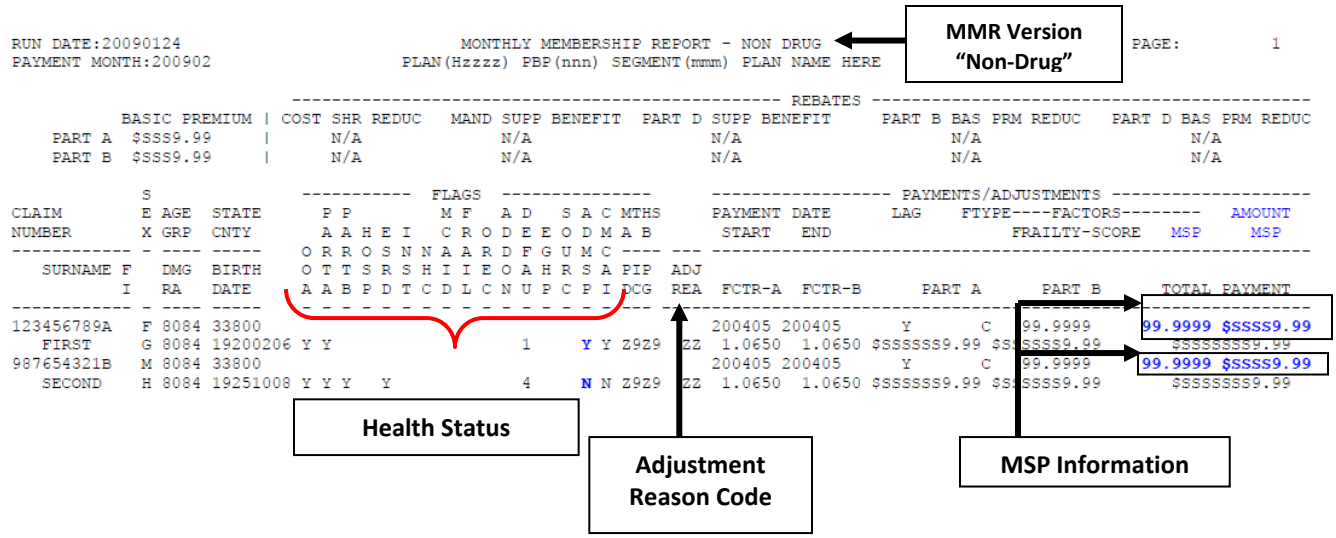
3.2.1 Monthly Membership Detail Report Layout – Non-Drug

The non-drug MMR report lists all beneficiaries enrolled in the Plan as of a specific month. The payment amounts listed on the report are displayed as Part A and Part B for each beneficiary. This is consistent with how the Plan's capitated payment is displayed in Table 1 of the PPR on the plan-level. Therefore, allowing Plans to reconcile the beneficiary-level MMR to the plan-level PPR (Table 1).

The beneficiary-level payments on the report includes rebate and basic premium information.

2011 Updates to the Non-Drug MMR
The updated MMR includes additional flags for Medicaid, updated MSP flag and MSP fields. Figure 3B illustrates a sample of the non-drug MMR report layout highlighting some of the updates to the report.

Figure 3B– Sample Non-Drug Monthly Membership Report



3.2.2 Monthly Membership Detail Report Layout – Drug

The Part D MMR Drug Report lists every Part D Medicare member of the Plan and provides details about the payments and adjustments made for each. The MMR Detail Drug Report follows the same format as the non-Drug version; however, it includes information specific to the Part D benefit.

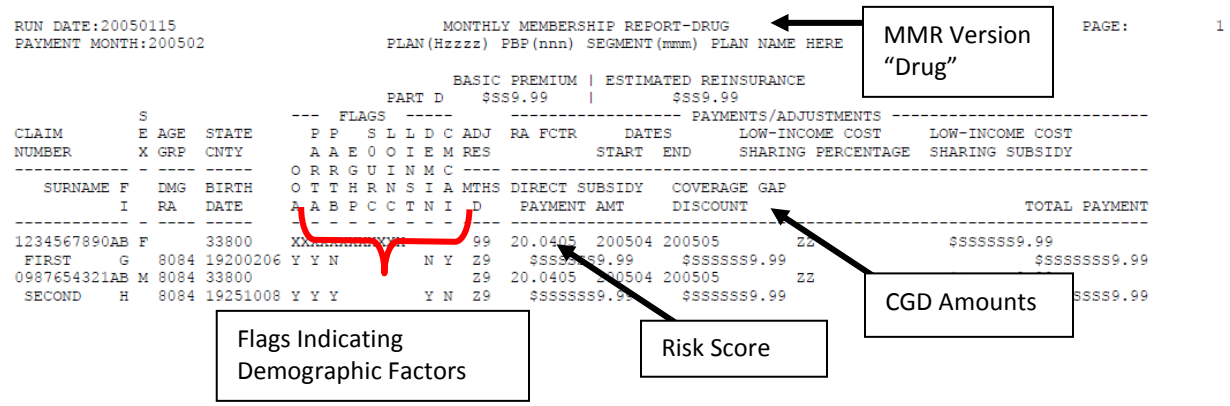
2011 Updates to the Drug MMR

The Affordable Care Act (ACA) established the Coverage Gap Discount (CGD) Program and CMS has adjusted the MMR to accommodate fields specific to the Coverage Gap. The CGD is a new Part D payment component, which is included in summaries of the Total Part D Payment in the MMR beginning with 2011 payments. Included are separate payment buckets for the CGD payment component, both at the detail and summary level versions of the MMR.

In addition, beginning in 2011, the MMR will include a "Part D Risk Adjustment Factor Type" CMS uses to calculate Part D Direct Subsidy.

Figure 3C provides a sample of the drug version of the MMR.

Figure 3C– Monthly Membership Report (Drug)



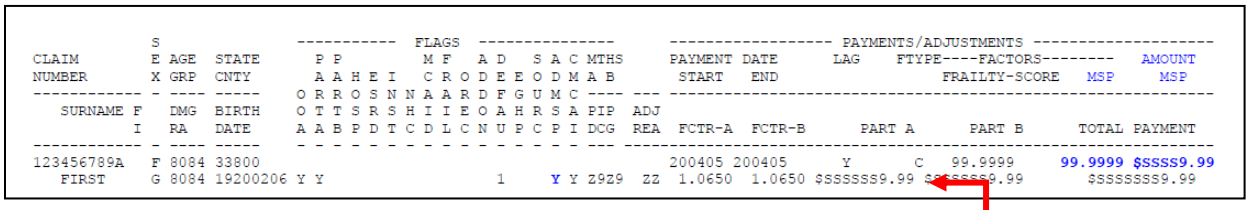
NOTE: PACE PLANS DO NOT RECEIVE CGD PAYMENTS AND CONTINUE TO RECEIVE "OLD" FORMAT OF THIS REPORT.

3.2.3 Reconciling the Capitated Payment Using the MMR

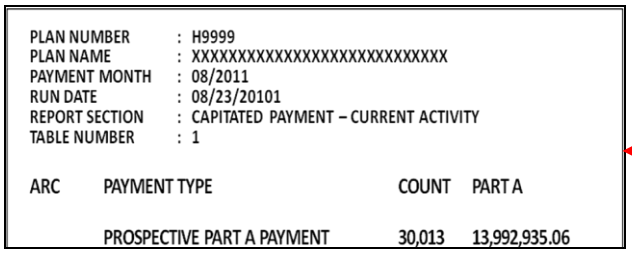
All capitated payments for each enrollee in the plan are summed and reported on Table 1 of the PPR. Plans can roll-up beneficiary-level payments reported on the MMR, to reconcile the capitated payment reported on the PPR. Figure 3D illustrates a snapshot of the MMR and a snapshot of Table 1 of the PPR illustrating the Plan-level (PPR) and beneficiary-level (MMR) Part A payment.

Figure 3D – Capitated Payment MMR - PPR

MMR Snapshot



PPR Snapshot



Beneficiary-level prospective payment for Part A on MMR maps to Plan-level prospective capitated payment on PPR.

In reconciling the full capitated payment reported on the PPR, the above process should be completed for the Part B and Part D (for Part D enrollees) payments. After determining the total payments, Plans can reconcile with the summed amount on the PPR. Plans can further define the total beneficiary payment to understand the elements that affect payment.

3.2.3.1 Beneficiary Information

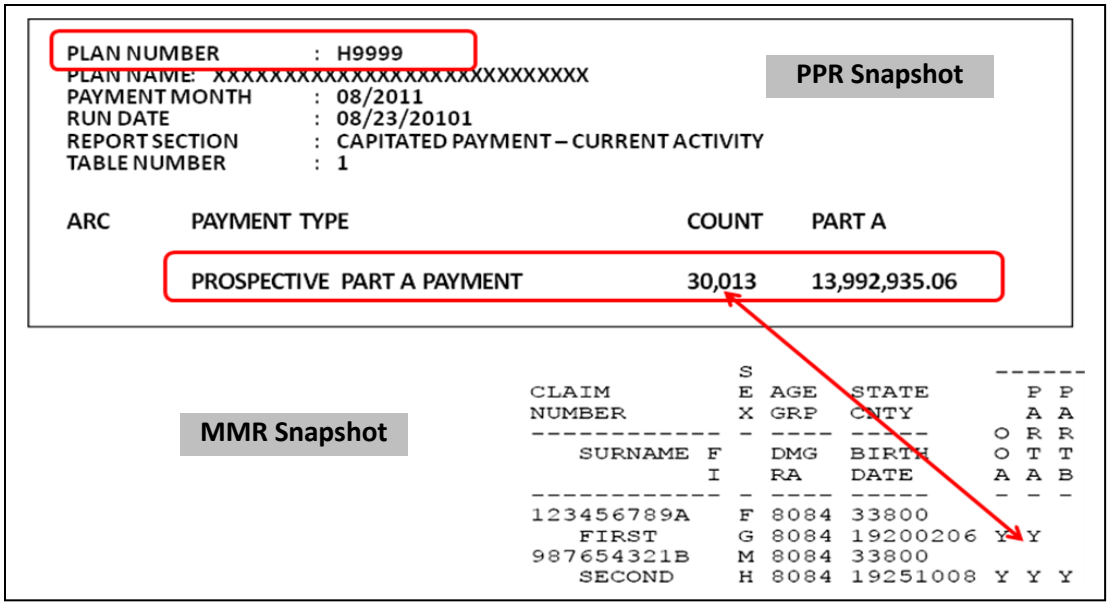
Beneficiary information and other factors make up the demographic factors that affect the capitated payment for an enrollee. Demographic data [i.e., sex of the beneficiary and Date of Birth (DOB)], received from the Common Tables can have a direct effect on the enrollee risk score, since it determines the factor coefficient based on age and sex. Payment benchmarks change from state to state and county to county and an incorrect state and county code (SCC) can result in incorrect payment. These factors should be considered as Plans reconcile beneficiary level capitated payments reported on the MMR and Plan–level payments on the PPR.

Beneficiary information in this section of the report includes:

- **Claim Number** – Reports HIC number of Beneficiary
- **Last Name First Initial** – Displays beneficiary last name and displays first initial of first name
- **Gender** – Report indicates if beneficiary is (M) male or (F) female
- **Age Group** – Displays the age group of the individual based on actual age
- **Risk Adjustment Age Group (RAAG)** – Displays applicable demographic age group of the beneficiary as of February 1 of the year used in RAS for determining risk score
- **Birth Date** – Reports the date of birth of beneficiary displayed in YYYYMMDD format
- **State/County Code** – List the applicable state/county code of beneficiary's residence

One of the first steps in reconciling the PPR with the MMR is to identify the actual beneficiaries included in the count for the specific payment type. Figure 3E illustrates the total number of beneficiaries included in the Part A payment reported and the MMR displaying a Part A eligible beneficiary.

Figure 3E –MMR Beneficiary Information/PPR Count Information



Once the beneficiary is identified the Plan may proceed in determining if beneficiary information reported on the MMR is accurate.

3.2.3.2 Flags/Indicators

In addition to beneficiary information, the MMR reports flags/indicators that further define payment. The flag/Indicator section of the MMR reports beneficiary's characteristics from Medicare entitlement to the frailty of the enrollee. Each of these flags indicates a characteristic that may affect the capitated payment calculated for the enrollee. Because CMS calculates payment on the beneficiary-level, understanding the sources of information for the flags and how they affect payment is essential when monitoring Plan records against CMS records. This section covers flags and indicators that may affect the Plan-level capitated payment reported on the PPR in Table 1- Capitated Payment.

Some flags and indicators are updated real-time as the change is received by CMS systems and are subsequently reported on the MMR. However, there are flags that are only updated following a risk adjustment model run.

Long Term Institutional Flag
The Minimum Data Set (MDS) reports the Long Term Institutional status, collected from institutional facilities such as skilled nursing facilities (SNFs) and this information is stored in the Minimum Data Set (MDS) and subsequently reported on the MMR.

Prior to 2011, the Part D payment included multipliers for low income and long term institutional status. Effective 2011, instead of a base model with multipliers for low income and long term institutional status, the 2011 RxHCC model will have 5 sets of coefficients: long term institutional, aged low income, aged non-low income, disabled low income, and disabled non-low income. CMS published the factors in the 2011 Advanced Notice at http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2011.pdf. LTI applies to both C and D payments.

⌦ Example 1

In May 2010, Plan sponsor Apple Health has an enrollee with a Low-Income (LI) Indicator. On the June MMR the enrollee has both the LI Indicator and the Long Term Institutional (LTI) Indicator. Under Part D, an enrollee cannot receive payment for both LI and LTI. When calculating the Part D risk score, only the LTI coefficients will be used in the calculation because when a beneficiary has both, LTI takes precedence over LI status.

Month of MMR	Institutional Flag	Low Income Subsidy Flag	LTI Multiplier or Part D RAFT Used to Determine Payment
June 2010	"Y"	"Y"	Multiplier
June 2011	"Y"	"Y"	Part D RAFT

Apple Health will calculate the 2010 Payment using the LTI multiplier, since both apply only the LTI is used. The June 2011 payment is calculated using the institutionalized factors from the recalibrated Rx-HCC model because the beneficiary-level RAFT code indicates institutional.

Note: In either case, payment is still based upon the LTI status. For the 2011 payment, refer to field #87, Part D RA Factor Type, to verify inclusion of the LTI status.

Risk Adjustment Factor Type
The MMR reports the factor type for Part C on the non-drug MMR (Field 47) and the Part D factor type (Field 87) on the drug MMR. The factor type informs Plans the model used in calculating payments. The models include new enrollee, institutionalized, community, low income, and various ESRD models. Each model applies different factors.

Therefore, awareness of the model used for each beneficiary is imperative in calculating accurate payment. Table 3B lists the Factor Type code and descriptions for Part C and Part D.

TABLE 3B – FACTOR TYPE/DESCRIPTIONS

Risk Adjustment Factor Types	Factor Code/Description
Part C Field 47	C = Community C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) E1 = New Enrollee Post-Graft I (ESRD) E2 = New Enrollee Post-Graft II (ESRD) G1 = Graft I (ESRD) G2 = Graft II (ESRD) I = Institutional I1 = Institutional Post-Graft I (ESRD) I2 = Institutional Post-Graft II (ESRD) SE = New Enrollee Chronic Care SNP
Part D* Field 87	D1 = Community Non-Low Income Continuing Enrollee, D2 = Community Low Income Continuing Enrollee, D3 = Institutional Continuing Enrollee, D4 = New Enrollee Community Non-Low Income Non-ESRD, D5 = New Enrollee Community Non-Low Income ESRD, D6 = New Enrollee Community Low Income Non-ESRD, D7 = New Enrollee Community Low Income ESRD, D8 = New Enrollee Institutional Non-ESRD, D9 = New Enrollee Institutional ESRD, Blank when it does not apply

*Prior to November 2010, the Part D Factor Type was not reported on the MMR.

ESRD Flag

CMS will activate the ESRD flag based on information received from the Renal Network. Providers complete the Form 2728 to indicate beneficiary status. The Renal Network subsequently submits this information to CMS. Payments for dialysis are triggered by this system. ESRD flag prompts the Plan to view the factor type. Plans with ESRD receive payment based on the CMS-ESRD Risk Adjustment Model. Updates to CMS systems are dependent on the timing of the information provided by the Renal Network.

There is no form needed to notify CMS of termination of ESRD benefits. CMS becomes aware of termination:

- 12 months after the last date of dialysis treatment
- 36 months after the month a member has a kidney transplant

For further information from the End Stage Renal Disease Network Coordinating Center or to locate the network for a plan's membership, plans may go to http://www.esrdncc.org/index.

For more detailed information regarding the United States Renal Data System (USRDS), plans may access the link http://www.usrds.org/default.asp

Example 2

Sunny Day Health Plan identified the ESRD flag on the February 2010 MMR indicates members are ESRD. The RA Factor Type Code on the MMR reflects ED (New Enrollee Dialysis). Sunny Day determines the payment received is the default payment. When will Sunny Day receive the payment calculated by the Risk Adjustment System?

Date of MMR	ESRD Flag	Default Payment	Next Model Run	Mid-Year Payment Adjustment Reported
February 2010	"Y"	Default Payment Calculated Based on Factor Type "ED"	March 2010	July 2010

CMS is notified of ESRD status, based on the form (CMS 2728), which identifies ESRD beneficiaries. CMS updated the ESRD flag on the MMR with the appropriate new enrollee RA Factor Type Code of ED = New Enrollee Dialysis. The payment system calculated the payment based on the "ED" RA Factor Type Code. While the beneficiary is identified as ESRD, the actual ESRD score is calculated by RAS during the Risk Adjustment System model run. The model runs three times for a payment year, all data for lagged period of July 1 through June 30 of year prior to payment year submitted by the first Friday of September is reflected in the Initial Payment (January), all data for period of January through December submitted by the first Friday of March is reflected in the Mid-Year Payment (July), the final run/reconciliation includes data submitted by January of the following year, and is reflected as a lump sum payment in August of the following year. During final reconciliation, ESRD status is reconciled to obtain the most precise month-by-month status. The ESRD actual risk score is based on whether the beneficiary is dialysis or transplant and that is dependent upon the notification. In the case of post graph beneficiaries, CMS applies the submitted diagnoses.

While status flags, such as for ESRD, are updated in real-time, meaning monthly, it is important to note that the risk adjustment factor type (RAFT) is updated on the Monthly Membership Report at the same time the risk score is updated. The impact to the risk score occurs when the risk score calculation occurs and both demographic and diagnostic data are pulled from the various databases for the calculation as mentioned above.

Example 3

Winter Health Plan offers a Part D benefit. When calculating payment in November 2010, the payment calculated did not reflect ESRD. Beginning in January 2011, the Plan is unable to reconcile the direct subsidy payment. The Plan has noticed an ARC 08 and was not sure how it applied to payment.

Effective with the January 2011 payment, the Part D risk adjustment model was updated to consider ESRD status. This change means it is now possible to receive Part D direct subsidy dollars associated with an ESRD adjustment (ARC 08). The direct subsidy dollars appear correctly on the Monthly Membership Report (MMR).

Medicare as Secondary Payer (MSP) Flag

Beneficiaries may have other insurance that must be applied before Medicare, i.e., Medicare is the Secondary Payer (MSP). Plans with beneficiaries who are working and covered under an employer's insurance policy or under a working spouse's policy, receive a reduced payment. MSP adjustments are taken when MSP coverage periods are on file for the beneficiary. The MSP coverage period records are established from a number of reporting sources including other Government agencies.

Payments for Working Aged/Disabled beneficiaries are flagged with a "Y" in Field 16, Aged/Disabled MSP. Payments for Working Aged/Disabled and ESRD beneficiaries where MSP status is applicable, show the MSP Reduction Amounts in Fields 83 (for Part A) and 84 (for Part B). The Part A and Part B payments are each multiplied

by the MSP factor shown in Field 82. The calculated amounts are then subtracted from the Part A and Part B payments. The Part A and Part B payments are then reduced by the result to determine the final payment.

Effective July 1, 2010, the field was modified to include the following valid values:

- 'Y' = Aged/Disabled factor applicable to Beneficiary;
- 'N' = Aged/Disabled factor not applicable to Beneficiary

The ESRD MSP amounts are populated in the MSP Reduction Amount fields on the Monthly Membership Detail Non-Drug report and the MMR data file. Beginning in 2010, the reductions will be taken on the beneficiary-level instead of the Plan-level. They are summarized on the Monthly Membership Summary Report. These amounts will also be shown on the M203, M215, M405 and M407 screens when the MSP period begins after 2010. MSP reduction amounts resulting from pre-2011 periods will not be displayed in these fields. The ESRD MSP flag on the MMR detail report will display separate values for transplant/dialysis and for post-graft.

Table 3C illustrates the basic calculation of the capitated payment including the MSP reduction, when calculating the Part A payment.

Table 3C – Payment Calculation Formula (MSP)

Part A Payment Calculation		
Field Number	**Field Name**	
	Part A	
33	Risk Adjuster Paymt/Adjustmt Rate A	+
54	Part C Basic Premium – Part A Amount	-
56	MA Rebate for Part A Cost Sharing Reduction	+
58	MA Rebate for Other Part A Mandatory Supplemental Benefits	+
62	MA Rebate for Part D Supplemental Benefits – Part A Amount	+
83	MSP Reduction/Reduction Adjustment Amount-Part A	-
	Total Part A Payment	

Note: The MSP reduction should also be deducted when calculating the Part B payment. The MSP reduction is already assumed in the total MA payment reported on the MMR. The calculation is provided for manual calculation purposes only.

Updates to MSP Records

Plans must request corrections to inaccurate MSP coverage through the Electronic Correspondence Referral System (ECRS). The ECRS is a Customer Information Control System (CICS) DB2 database stand-alone application that is used to notify the Coordination of Benefit Contractor (COBC) electronically of new and/or possible updates to existing Medicare Secondary Payer (MSP) occurrences and to delete invalid MSP-occurrences. An "MSP occurrence" is a period of time when a Medicare beneficiary has, or had, other insurance that is/was primary to Medicare. Health plans need to assist the COBC in maintaining accurate MSP Occurrence records.

Plans can submit MSP Inquiries through the ECRS Web, available 24 hours a day and seven (7) days a week. This option provides for electronic submission and tracking of request to add, change or delete MSP and other health insurance occurrence records.

ECRS Batch Submittal File

Plans can also submit an ECRS batch file with other healthcare information (OHI) to CMS *(rather than submittal through the ECRS on-line system).* The file can be submitted through Gentran or Connect:Direct.

We have provided a link to the ECRS user manual for instructions on accessing the system.

📖 ECRS User's Guide https://www.cms.gov/manuals/downloads/msp105c05_att1.pdf

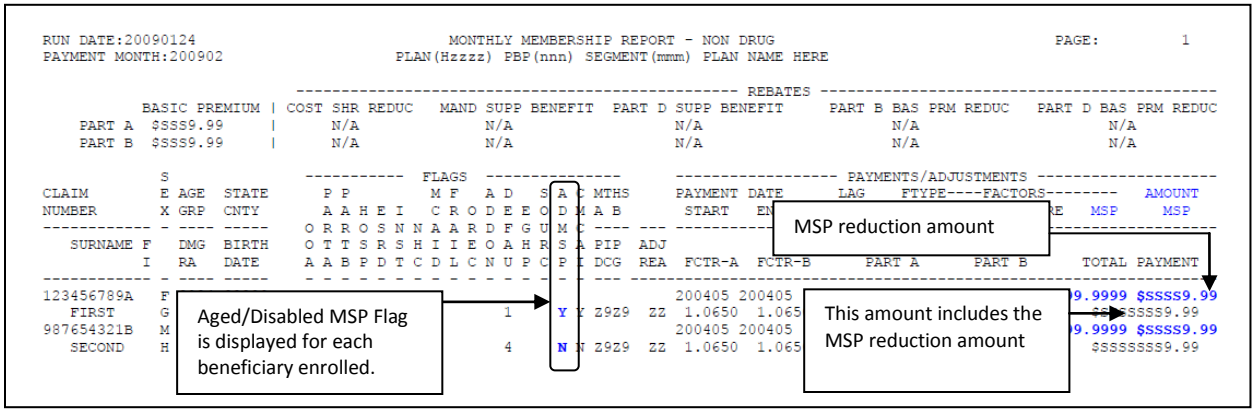
⌦ Example 4

Rainy Day Health Plan member John DoeRae indicated the Aged/Disabled MSP (Field 16) of "Y". Rainy Day Health Plan's Part A/B Bid was under the benchmark and therefore they also receive an MA Rebate. Rainy Day calculated the risk adjusted payment reported on the MMR in Fields 33 and 34 and added the MA Rebates found in Fields 56-59, and 62-63, but could not reconcile this sum to the amount reported in Field 66, Total MA Payment Amount.

Rainy Day must take the MSP reduction amounts into account when manually calculating the Total MA Payment Amount for John DoeRae. The total MA payment accounts for MSP on the MMR. But, when manually calculating, Plans must adjust the payment amount by subtracting the MSP reduction amount. See Fields 83 and 84.

Figure 3F depicts the fields on the print format MMR report.

Figure 3F – MMR - MSP Fields



Hospice Flag

A hospice flag populated on the MMR indicates the beneficary has entered hospice. Effective CY 2006, during the time the hospice election is in effect, CMS pays the MA organization the portion of the monthly payment attributable to the rebate, minus the amounts (if any) of rebate allocated to reduce the Part B premium and the Part D basic premium, plus the amount of the subsidy CMS pays the MA organization for a plan enrollee related to basic prescription drug coverage (if the enrollee is in an MA-PD plan).

The MMR may report more than one payment flag for a beneficiary. Plans must review the MMR for the accuracy of the flags determine payment based on the flags reported on the MMR. CMS applies a payment flag hierarchy, which indicates the order in which the payment flags should be calculated. The hierarchy is currently:

- Hospice
- ESRD
- All other beneficiaries

Example 5

Plan Capital Med receives a lower than expected payment for an enrollee. Upon examining the MMR, it is found that the enrollee has received a flag for Hospice, ESRD, Medicaid, and Institutional.

Flag	Hospice	ESRD	Medicaid	Institutional
Value Populated	"Y"	"Y"	"Y"	"Y"

In this case, the Plan is paid at the hospice rate. However, unless the plan is getting rebates, the payment for hospice is zero. Hospice benefits are paid by fee-for-service Medicare. Adjustments to hospice status are reported as (07) on the MMR as well as reported on the MMR.

Example 6

If MA Plan Sunny Day's bid is $400 and the benchmark is $450 and an enrollee has entered hospice. What is the Plan's payment if there is no Part B and Part D premiums.

Benchmark	$ 450
Plan's Bid	- $ 400
Difference between Bid and Benchmark	$ 50
75% Cost Savings for Rebate	X 0.75
Hospice Payment (Rebate Amount)	$ 37.50

The Plan's bid is subtracted from the benchmark, which results in a $50 difference. The 75 percent cost savings for rebate is then applied to obtain the hospice payment for the MA plan. If the Plan was a MA-PD plan, then the hospice payment will also include the Part D subsidy amounts CMS pays the Plan.

3.3 MMR Detail Data File

CMS generates a detailed data file in addition to the summary version of the report. The report versions communicate predefined fields pulled from the data file and provided to the Plan. However, with the data file, Plans have the flexibility to create internal reports to reconcile and monitor their enrollment and payment records. The fields in the data file can be downloaded into an application such as Microsoft Access or Excel and manipulated to create customized reports. The record layout for the MMR Detail Data file is located in the Appendix at the end of this module. Table 3D identifies the flags on the MMR detail data file.

TABLE 3D - BENEFICIARY FLAGS ON THE MMR DETAIL DATA FILE

Medicare	Record Layout Field Number	Flag Name	Name on Report
Part C and Part D	11	Out of Area Indicator	OOA
	12	Part A Entitlement	PART A
	13	Part B Entitlement	PART B
	19	New Medicare Beneficiary Medicaid Status Flag	ADDON
	21	Medicaid Indicator	MCAID
	40	Current Medicaid Status	CMCAI
	52	Enrollment Source	SOURC
	53	EGHP Flag	EGHP
	49	Original Reason for Entitlement Code	OREC
Part C	14	Hospice	HOSP
	15	ESRD	ESRD
	17	Institutional	INST
	16, 36	Age/Disabled MSP and ESRD MSP Flag	ADMSP
	18	NHC	NHC
	23	Default Risk Factor Code	DEFAUL
	47	RA Factor Type Code	FTYPE
	48	Frailty Indicator	FRAIL
Part D	43	De Minimis	DEMIN
	44	Beneficiary Dual and Part D Enrollment Status Flag	
	68	Part D Low-Income Indicator	LOINC
	70	Part D Long Term Institutional Indicator	INST
	85	Medicaid Dual Status Code	
	87	Part D RA Factor Type	
	88	Default Part D Risk Factor Code	DEFAUL

3.3.1 Reconciling PPR Table 1 Payments and Adjustments

Plans receive a prospective payment and a reconciliation payment. Prospective payment data includes demographic and risk adjustment information received monthly. The total monthly payment for each enrollees is communicated in the MMR, while the total monthly payment for all beneficiaries enrolled in the Plan is communicated on the PPR. The monthly payment for Part C (Total MA Payment) includes the total Part A and total Part B MA payment.

Table 3E identifies the fields on the MMR that specifically identify the monthly capitated amounts reported on the MMR and PPR paid to Plans prospectively.

TABLE 3E– MMR/PPR PROSPECTIVE DATA

MMR Field Number	Field Name	*PPR Field Number	Field Name
64	Total Part A MA Payment	66	Part A Payment Amount
65	Total Part B MA Payment	67	Part B Payment Amount
66	Total MA Payment Amount	**N/A	N/A
77	Total Part D Payment	69	Part D Payment Amount

*Fields from Table 5-Summary of the PPR

**PPR does not sum the total Part A and B payments only the full capitated payments including Parts A, B, and D.

Beneficiary information and special status flags are used to adjust the prospective payment amounts for each beneficiary.

3.3.2 Reconciling PPR Table 1 Adjustment Reason Codes (ARCs)

Adjustment Reason Codes (ARCs) are used to communicate corrections and retroactive changes to various enrollment, demographic, and risk adjustment factors, as well as payments. Only those MMRs that apply to the specific beneficiary for the month reported are communicated on the MMR. For example, if there is a change in the institutional status of a beneficiary the ARC of (09) will display on the MMR for the affected month..

While most of these adjustments are made as part of a change in status, the mid-year Risk Adjustment Factor Change (ARC 26) and mid-year Part D Risk Adjustment Factor Change (ARC 41) are updated each year to adjust for changes in enrollee risk factor from data collected over the first half of the Plan year. In addition, the Part C (ARC 25) and Part D (ARC 37) risk factors are updated again at Final Reconciliation. In reconciling Table 1-Capitated payment on the PPR, Plans can drill down to the specific beneficiaries by mapping the counts and dollar amounts on the PPR with the specific beneficiaries on the MMR affected by each ARC.

Refer to Module 1: Plan Payment Report for a list of the Adjustment Reason Codes (ARCs).

Refer to the Plan Communications User Guide (PCUG) Appendices , Appendix H.3 for the most current list of Adjustment Reason Codes located at https://www.cms.gov/MAPDHelpDesk/02_Plan_Communications_User_Guide.asp#TopOfPage

3.3.2.1 Part D Coverage Gap

Effective January 2011, payments include a Coverage Gap Discount amount. Calculation of Part D payments for each non-LIS enrollee in a Part D plan will include the new payment component. A per member monthly CGD rate will be developed in conjunction with the Part D bid.

CMS advances CGD payments to plans for 12 months and Plans can expect annual reconciliations of these CGD amounts after each payment year. CMS will include the CGD amount in each non-LIS enrollee's Part D monthly prospective payment. CGD prospective payments are adjusted for changes in enrollment and LIS statuses. Prospective CGD payments are included in summaries of the Total Part D Payment in the MMR.

The MMR includes a separate payment bucket for the CGD payment component, both at the detail and summary level versions of the MMR.

Note: The PACE MMR Detail Report print format will not include the CGD field.

3.3.3 MMR Payment Data Fields

Table 3F identifies the fields on the MMR Detail Data File that provide payment data or rebate accounting, or data providing key information to support payment calculation.

TABLE 3F – MMR DETAIL FILE DATA MAPPING

	Field Number	Field Name	Actual Payment Data	Key Information Mapping
Medicare Advantage Payment (Part C)		**Part A**		
	33	Risk Adjuster Paymt/Adjustmt Rate A		Field 64
	54	Part C Basic Premium – Part A Amount		Field 64
	56	Rebate for Part A Cost Sharing Reduction		Field 64
	58	Rebate for Other Part A Mandatory Supplemental Benefits		Field 64
	62	Rebate for Part D Supplemental Benefits – Part A Amount		Field 64
	83	MSP Reduction/Reduction Adjustment Amount-Part A		Field 64
	64	**Total Part A MA Payment**	**X**	
		Part B		
	34	Risk Adjuster Paymt/Adjustmt Rate B		Field 65
	55	Part C Basic Premium – Part B Amount		Field 65
	57	Rebate for Part B Cost Sharing Reduction		Field 65
	59	Rebate for Other Part B Mandatory Supplemental Benefits		Field-65
	63	Rebate for Part D Supplemental Benefits – Part B Amount		Field-65
	84	MSP Reduction/Reduction Adjustment Amount-Part B		Field 65
	65	**Total Part B MA Payment**	**X**	
	66	**Total MA Payment Amount**	**X**	
Prescription Drug Payment (Part D)		**Part D**		
	35	LIS Premium Subsidy		Field-77
	72	Rebate for Part D Basic Premium Reduction		Field-77
	73	Part D Basic Premium Amount – For Payment Purposes		Field-74
	74	Part D Direct Subsidy Payment Amount		Field-77
	75	Reinsurance Subsidy Amount		Field-77
	76	Low-Income Subsidy Cost-Sharing Amount		Field-77
	79	PACE Premium Add On		Field-77
	80	PACE Cost Sharing Add-on		Field-77
	86	Part D Coverage Gap Discount Amount		Field 74
	77	**Total Part D Payment**	**X**	
MA Rebate Accounting				
	56	Rebate for Part A Cost Sharing Reduction		
	57	Rebate for Part B Cost Sharing Reduction		
	58	Rebate for Other Part A Mandatory Supplemental Benefits		
	59	Rebate for Other Part B Mandatory Supplemental Benefits		
	60	Rebate for Part B Premium Reduction – Part A Amount		X
	61	Rebate for Part B Premium Reduction – Part B Amount		X
	62	Rebate for Part D Supplemental Benefits – Part A Amount		
	63	Rebate for Part D Supplemental Benefits – Part B Amount		
	72	Rebate for Part D Basic Premium Reduction		
		Total MA Rebate Amount		

TABLE 3F – MMR DETAIL FILE DATA MAPPING (CONTINUED)

	Field Number	Field Name	Actual Payment Data	Key Information Mapping
Factors and Multipliers	67	Part D RA Factor		Field-74
	68	Part D Low-Income Indicator		Field-74
	69	Part D Low-Income Multiplier (Prior to January 2011)*		Field-74
	70	Part D Long Term Institutional Indicator		Field-74
	71	Part D Long Term Institutional Multiplier (Prior to January 2011)*		Field-74

*Fields 69 the LI multiplier and field 71 the LTI multiplier will report zero effective January 2011, since the multipliers no longer apply to the Part D payment

3.3.4 Capitated Payments, Rebates, and Premiums

CMS makes capitated payments to health plans that provide Medicare Part A, B and D benefits for Medicare beneficiaries enrolled in their plans. For Medicare Parts A and B, beneficiaries can select traditional Medicare Fee-for-Service (FFS) or a Medicare Advantage (MA) plan. For Part D beneficiaries can choose to receive all three-benefit types (Medicare Part A, B, and D) by enrolling in a Medicare Advantage-Prescription Drug (MA-PD) plan. Alternatively, beneficiaries opting to enroll in FFS for Part A and B can enroll in a stand-alone Prescription Drug Plan (PDP) to obtain Part D benefits.

Note: There is no Part D FFS option. Beneficiaries can obtain Part D benefits only by enrolling in a MA-PD or PDP. CMS pays plans a capitated payment for providing coverage to a Medicare beneficiary each month. Unlike traditional Medicare FFS, capitated payments are for monthly coverage, even if the beneficiary does not use the benefits that month. Under FFS, payments are made only when benefits are actually used, one claim at a time.

Calculation of Part C Capitated Payments for non-Hospice, non-ESRD enrollees in Coordinated Care Plans and PFFS plans follows one of three rules depending upon the approved A/B Bid for each Plan Benefit Package, the bid's arithmetic relationship to a "Benchmark" rate and the resulting plan specific (and geographically adjusted) county rates, as illustrated in Table 3G.

TABLE 3G – PART C PAYMENT CALCULATIONS (REBATE, PREMIUM, OR ZERO RESULT)

RULE	PAYMENT CALCULATION CONDITION	NOTES
1	When Bid is below the Benchmark, the Part C Capitated Payment equals: (Plan Specific County Rate) x (Part C Enrollee Risk Score) + Rebate	• Rebate = 0.75 * (Benchmark – Bid) • Rebate (excluding Premium Reduction components) is added to the Risk Adjusted payment.
2	When Bid equals the Benchmark, the Part C Capitated Payment equals: (Plan Specific County Rate) x (Part C Enrollee Risk Score)	• No addition/subtraction to/from Risk Adjusted payment.
3	When Bid is above the Benchmark, the Part C Capitated Payment equals: (Plan Specific County Rate) x (Part C Enrollee Risk Score) – Part C Basic Premium	• Part C Basic Premium = Bid - Benchmark • Part C Basic Premium is paid by beneficiary not CMS.

Part D Direct Subsidy payments are the risk-adjusted component included in Part D Capitated Payments.

Direct Subsidy = (Plan Part D Standardized Bid) X (Part D Enrollee Risk Score) - Plan Part D Basic Premium

Example 7

Summer MA organization created an internal reports to reconcile beneficiary-level payment amounts for each of the following plan types offered:

- Rain MA-PD — Part A/B Bid < Benchmark
- Snow MA-PD — Part A/B Bid > Benchmark
- Storm MA Only — Part A/B Bid < Benchmark
- Winter PACE Plan — Dual Eligible Beneficiary
- Sunny Prescription Drug Plan (PDP)

Table 3H illustrates the five plans and payment amounts using sample data from an MMR Detail Data File. In addition, Table 3F above is a resource for this example.

Since the calculation is slightly different for each plan type based on the bid/benchmark relations or plan type the report displays the payment amounts received for five different beneficiaries enrolled in the five different plans listed above. Based on an April 2011 MMR, Summer MA Organization calculates the beneficiary level payment for Rain MA-PD plan, shown in Table 3H as "#1 Rain MA-PD, Part A/B Bid< BM".

The beneficiary is LIS eligible and has been identified as having health insurance secondary to Medicare. Summer MA organization uses five steps to calculate the payment

Step 1: Calculate Part A Payment

Obtain the risk adjuster payment/adjustment Amount A for this beneficiary is $455.00 as reported in field 33 of the MMR. In this example, the plan's bid is less than benchmark a rebate applies. Therefore, Summer MA Organization will apply the applicable rebates and subtract the MSP reduction amount from the risk adjuster payment/ adjustment amount.

Risk Adjuster Payment/Adjustment Amount Part A		$455.00
Part A Cost Sharing Reduction	+	$15.00
Other Part A Mandatory Supplemental Benefits	+	$7.00
Part D Supplemental Benefits	+	$6.00
MSP Reduction/Reduction Adjustment Amount	-	$375.83
Total Part A Payment	=	$107.17

Step 2: Calculate Part B Payment

Once the Part A payment is calculated, then the plan will obtain the risk adjuster payment/adjustment Amount B for this beneficiary is $427.00 as reported in field 34 of the MMR. Since this plan's bid is less than benchmark a rebate applies, to the Part B payment as well. Summer then applies the applicable rebates and subtracts the MSP reduction from the risk adjuster payment/adjustment amount

Risk Adjuster Payment/Adjustment Amount Part B		$427.00
Part B Cost Sharing Reduction	+	$14.00
Other Part B Mandatory Supplemental Benefit	+	$6.50
Part D Supplemental Benefits	+	$5.70
MSP Reduction/Reduction Adjustment Amount	-	$352.70
Total Part B Payment	=	$100.50

Step 3: Calculate Total MA Payment
Summer will then add the amounts of the Total Part A $107.17 plus the Total Part B $100.50 for this beneficiary that results in the Total MA payment amount of $207.67.

Step 4: Calculate Part D Payment
Since the beneficiary also receives Part D benefits and is enrolled as an LIS beneficiary. Summer Plan will also calculate the Part D portion of payment.

Rebate for Part D Basic Premium Reduction		$5.00
Reinsurance Subsidy Amount	+	$85.00
Low-Income Subsidy Payment Amount	+	$115.00
Part D Direct Subsidy Amount	+	$47.25
Part D Coverage Gap Discount Amount	+	$25.00
Total Part D Payment	=	$277.25

Step 5: Calculating the Total Payment
To obtain the final payment for the beneficiary, Summer will add all total amounts from steps 1, 2, and 4.

Step 1 - Total Part A Payment		$107.17
Step 2 - Total Part B Payment	+	$100.50
Step 4 - Total Part D Payment	+	$ 277.25
Total MA-PD Payment	=	$484.92

In addition to payment amounts, Summer can keep an accounting of the MA Rebates. The following is data reported for MA rebate Accounting.

Calculating MA Rebate Accounting
The MA Rebate Accounting section in the Table 3I provides Summer with a view of the rebates associated with the payment. The individual rebate amounts were extracted from fields as identified in the table and the report sums the rebate amounts. Rebate for part B Premium Reduction is not included in the Plan payment.

Rebate for Part A Cost Sharing Reduction		$15.00
Rebate for Part B Cost Sharing Reduction	+	$14.00
Rebate for Other Part A Mandatory Supplemental Benefits	+	$7.00
Rebate for Other Part B Mandatory Supplemental Benefits	+	$6.50
Rebate for Part B Premium Reduction - Part A Amount	+	$10.00
Rebate for Part B Premium Reduction - Part B Amount	+	$10.00
Rebate for Part D Supplemental Benefits - Part A Amount	+	$6.00
Rebate for Part D Supplemental Benefits - Part A Amount	+	$5.70
Rebate for Part D Basic Premium Reduction	+	$5.00
Total MA Rebate Amount	=	$79.20

TABLE 3H – SUMMER MA ORGANIZATION PLAN EXAMPLES (APRIL 2011)

MMR Field Number and Field Name Listed By Payment Type	#1. Rain MA-PD, Part A/B Bid < BM	#2. Snow MA-PD, Part A/B Bid > BM	#3. Storm MA Only, Part A/B Bid < BM	#3. Storm MA Only, Part A/B Bid = BM	#4. Winter PACE Plan, Dual Eligible Beneficiary	#5. Sunny Prescription Drug Plan (PDP)
Medicare Advantage Payment (Part C)						
33. Risk Adjuster Paymt/Adjustmt Rate A	$ 455.00	$ 508.00	$ 475.00	$ 475.00	$ 650.00	
54. Part C Basic Premium – Part A Amount		$ (-) 10.00				
56. Rebate for Part A Cost Sharing Reduction	$ 15.00		$ 10.00	$		
58. Rebate for Other Part A Mandatory Supplemental Benefits	$ 7.00		$ 16.00	$		
62. Rebate for Part D Supplemental Benefits – Part A Amount	$ 6.00					
83. MSP Reduction/Reduction Adjustment Amount –Part A	$ (-) 375.83	$ (-) 411.35	$ (-) 392.65	$ (-) 392.65	$ (-) 536.90	
64. Total Part A MA Payment	**$ 107.17**	**$ 86.65**	**$ 108.35**	**$ 82.35**	**$ 113.10**	
34. Risk Adjuster Paymt/Adjustmt Rate B	$ 427.00	$ 463.00	$ 375.00	$ 375.00	$ 635.00	
55. Part C Basic Premium – Part B Amount		$ (-) 10.00				
57. Rebate for Part B Cost Sharing Reduction	$ 14.00		$ 8.00	$		
59. Rebate for Other Part B Mandatory Supplemental Benefits	$ 6.50		$ 14.00	$		
63. Rebate for Part D Supplemental Benefits – Part B Amount	$ 5.70					
84. MSP Reduction/Reduction Adjustment Amount –Part B	$ (-) 352.70	$ (-) 374.18	$ (-) 309.75	$ (-) 309.75	$ (-) 524.51	
65. Total Part B MA Payment	**$ 100.50**	**$ 78.82**	**$ 87.25**	**$ 65.25**	**$ 110.49**	
66. Total MA Payment Amount	**$ 207.67**	**$ 165.47**	**$ 195.60**	**$ 147.60**	**$ 223.59**	

TABLE 3H – SUMMER MA ORGANIZATION PLAN EXAMPLES (CONTINUED)

MMR Field Number and Field Name Listed By Payment Type	#1. Rain MA-PD, Part A/B Bid < BM	#2. Snow MA-PD, Part A/B Bid > BM	#3. Storm MA Only, Part A/B Bid < BM	#3. Storm MA Only, Part A/B Bid = BM	#4. Winter PACE Plan, Dual Eligible Beneficiary	#5. Sunny Prescription Drug Plan (PDP)
Prescription Drug Payment (Part D)						
35. LIS Premium Subsidy		$ 26.00			$ 26.00	$ 26.00
72. Rebate for Part D Basic Premium Reduction						
75. Reinsurance Subsidy Amount	$ 85.00	$ 85.00			$ 85.00	$ 85.00
76. Low-Income Subsidy Cost-Sharing Amount	$ 115.00	$ 115.00			$ 115.00	$ 115.00
74. Part D Direct Subsidy Payment Amount	$ 47.25	$ 47.25			$ 47.25	$ 47.25
79. PACE Premium Add On					$ (+) 45.00	
80. PACE Cost Sharing Add-on					$ (+) 60.00	
86. Part D Coverage Gap Discount Amount	$ 25.00					
77. Total Part D Payment	**$ 277.25**	**$ 273.25**			**$ 378.25**	**$ 273.25**
MA Rebate Accounting						
56. Rebate for Part A Cost Sharing Reduction	$ 15.00	$ -	$ 10.00	$ -	$ -	$ -
57. Rebate for Part B Cost Sharing Reduction	$ 14.00	$ -	$ 8.00	$ -	$ -	$ -
58. Rebate for Other Part A Mandatory Supplemental Benefits	$ 7.00	$ -	$ 16.00	$ -	$ -	$ -
59. Rebate for Other Part B Mandatory Supplemental Benefits	$ 6.50	$ -	$ 14.00	$ -	$ -	$ -
60. Rebate for Part B Premium Reduction – Part A Amount	$ 10.00		$ 10.00			
61. Rebate for Part B Premium Reduction – Part B Amount	$ 10.00		$ 9.00			
62. Rebate for Part D Supplemental Benefits – Part A Amount	$ 6.00	$ -	$ -	$ -	$ -	$ -
63. Rebate for Part D Supplemental Benefits – Part B Amount	$ 5.70	$ -	$ -	$ -	$ -	$ -
72. Rebate for Part D Basic Premium Reduction	$ 5.00		$ -	$ -	$ -	$ -
XX. Total MA Rebate Amount	**$ 79.20**		**$ 67.00**	**$ -**	**$ -**	**$ -**
NOTES						
# 1: Rebate for Part B Premium Reduction not included in MA Payment (60/61), Provided for information purposes only. Rebate for Part D Basic Premium Reduction added to D Payment (72).						
# 2: Part C Basic Premium deducted from MA Payment, no MA Rebate (54/55).						
# 3: Rebates for Part D not available (62/63/72).						
# 4: No MA Rebate available, PACE Add-On payments for Dual Eligibles (79/80).						
# 5: No MA Rebate available, no MA payment (66).						

NOTE: Subtraction/Addition signs do not appear on the MMR. These are included on the worksheet for instruction purposes only.

3.3.4.1 Premium Settlement

Table 2-Premium Settlement of the PPR reports the premium amounts that affect the consolidated payment. The PPR reports settlements of the Part C and D premiums for beneficiaries that elected premium deductions from their Social Security and Railroad Retirement benefits, which can be reconciled with the Monthly Premium Withhold Report (MPWR).

Beneficiaries eligible for the Low Income Premium Subsidy receive premium assistance based on the level of eligibility. The MMR will report the beneficiary's LIS status and the Plan can reconcile the premium reported on the PPR. The MMR reports the LIS Premium Subsidy. Table 3I provides the MMR field number on the data file used to reconcile the Part D Low Income Premium Subsidy reported on the PPR.

Table 3I – MMR/PPR Reconcilng Part D Low Income Premium Subsidy

MMR Field Number	Field Name	PPR Field Number	Field Name
35	LIS Premium Subsidy	25	Part D Low Income Premium Subsidy

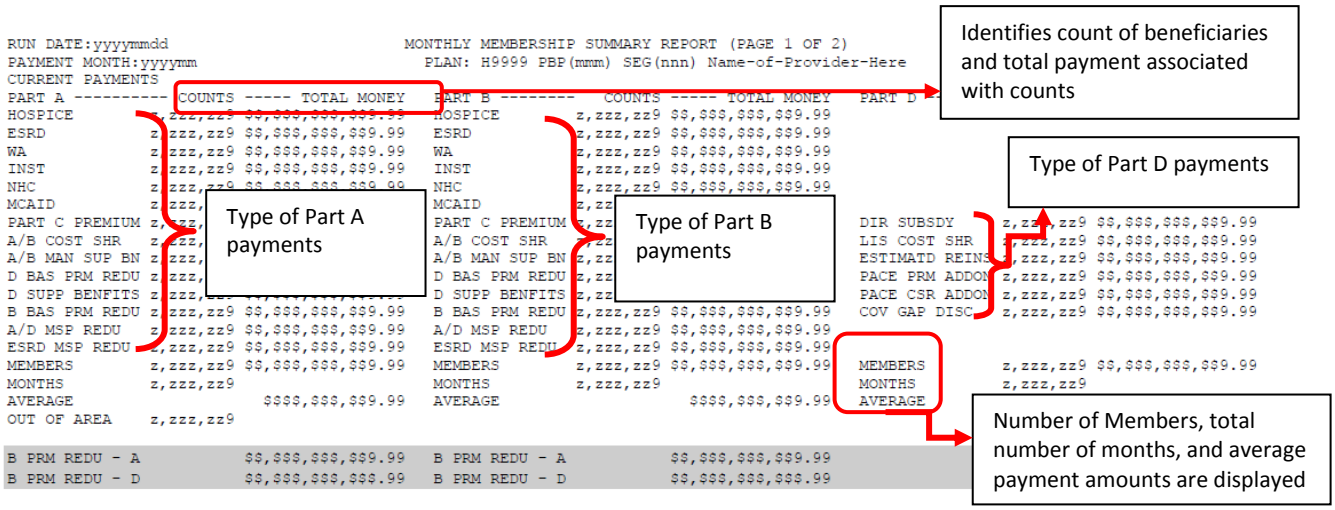
3.4 MMR Summary Report

In addition to the monthly detailed MMR reports CMS produces a summary MMR report. The summary report will roll-up the detail payment and adjustments communicated on the detail report in summary totals. The report groups payment and adjustment amount for the MMR Summary into payments for Part A, Part B, and if applicable Part D. Each payment and/or adjustment amount is further grouped by the type (i.e,. hospice, ESRD, Work Aged (WA, etc)

The summary report also provides a count of the number of members enrolled as of the report run date, the average dollar amount paid, and number of beneficiaries identified as out of area.

Figure 3G illustrates a sample of the first page of the MMR Summary, which provides payment information.

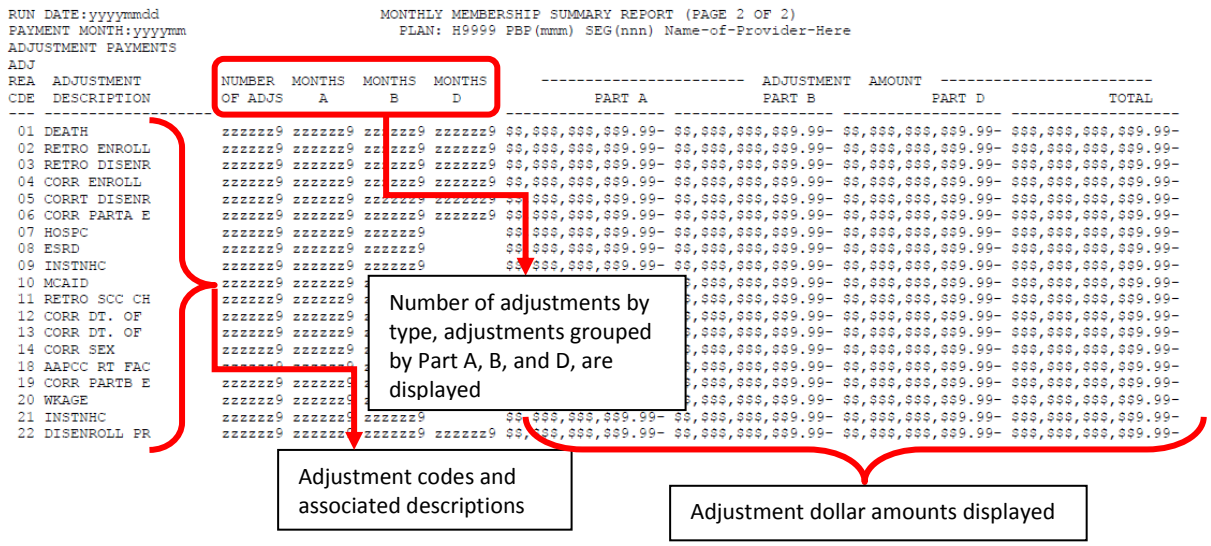
Figure 3G – MMR Summary Report (Payment)



In addition, to the payments reported on the summary report, the report also provides adjustment information. The detailed MMR reports provide the adjustment reason code and the adjustment amount applied to each beneficiary payment. The summary report summarizes the payments on the detailed report and displays the adjustment amounts by type of adjustment.

Figure 3H illustrates a sample of a second page of a Summary MMR Report, which provides the adjustment information.

Figure 3H – MMR Summary Report (Adjustment)



3.5 MMR Enhancements

CMS communicated changes to the MMR in the August 2011 Software Release. The MMR detailed and summary versions of the MMR are affected by the change effective August 2011. Table 3J provides the changes to the report.

TABLE 3J – CHANGES TO MMR EFFECTIVE AUGUST 2011

Report	Change
MMR Summary	Field Added: • Total Low Income Premium Subsidy Amount field – Summary amount at the appropriate rollup level (Segment, Plan or Plan).
MMR Detail	The affected monthly Part A, B, and D payment rates used in the payment calculations will be added to the MMR Detail Data File, for both prospective and adjusted payments.

Eliminate Display of Demographic/Blended Payments

Effective August 2011, the Monthly Membership Report (MMR), will no longer report data in fields 31-Demographic Payment/Adjustment Rate A and 32-Demographic Payment/Adjustment Rate B". The change will not affect the payment calculation. The Total Part A Payment, Total Part B Payment, and Total MA Payment will continue to report for all payments. If an adjusted payment should have an effective date prior to 2008, the correct blending will be applied to the calculation, but will not be displayed or reported on the MMR.

Appendix: Monthly Membership Report (MMR) Detail Data File (Effective October 1, 2011)

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (EFFECTIVE OCTOBER 1, 2011)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	HIC Number	12	20-31	Member's HIC #
5	Surname	7	32-38	
6	First Initial	1	39-39	
7	Sex	1	40-40	M = Male, F = Female
8	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10	State & County Code	5	53-57	
11	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12	Part A Entitlement	1	59-59	Y = Entitled to Part A
13	Part B Entitlement	1	60-60	Y = Entitled to Part B
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD
16	Aged/Disabled MSP	1	63-63	'Y' = aged/disabled factor applicable to beneficiary; 'N' = aged/disabled factor not applicable to beneficiary
17	Institutional	1	64-64	Y = Institutional (monthly)
18	NHC	1	65-65	Y = Nursing Home Certifiable

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (EFFECTIVE OCTOBER 1, 2011) (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
19	New Medicare Beneficiary Medicaid Status Flag	1	66-66	1. Prior to calendar 2008, payments and payment adjustments report as follows: • Y = Medicaid status, • blank = not Medicaid. 2. In calendar 2008, payments and payment adjustments were reported as follows: • Y = Beneficiary is Medicaid and a default risk factor was used, • N = Beneficiary is not Medicaid and a default risk factor was used, • blank = CMS is not using a default risk factor or the beneficiary is Part D only. 3. Beginning in calendar 2009: • Payment adjustments with effective dates in 2008 and after, and all prospective payments report as follows: • Y = Beneficiary is Medicaid and a default risk factor was used, • N = Beneficiary is not Medicaid and a default risk factor was used, • blank = CMS is not using a default risk factor or the beneficiary is Part D only. • Payment adjustments with effective dates in 2007 and earlier report as follows: • Y = A payment adjustment was made at a "Medicaid" rate to the demographic component of a blended payment. • N = A payment adjustment was made to the demographic payment component of a blended payment. The adjustment was not at a "Medicaid" rate. • Blank = Either the adjusted payment had no demographic component, or only the risk portion of a blended payment was adjusted.
20	LTI Flag	1	67-67	Y = Part C Long Term Institutional
21	Medicaid Indicator	1	68-68	When: • A RAS-supplied factor is used in the payment, and • The Part C Default Indicator in the Payment Profile is blank, and • The Medicaid Switch present in the RAS-supplied data that corresponds to the risk factor used in payment is not blank then value is Y = Medicaid Addon (RAS beneficiaries). Otherwise the value is blank.
22	PIP-DCG	2	69-70	PIP-DCG Category - Only on pre-2004 adjustments

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (EFFECTIVE OCTOBER 1, 2011) (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
23	Default Risk Factor Code	1	71-71	• Prior to 2004, 'Y' indicates a new enrollee risk adjustment (RA) factor was in use. • In the period 2004 through 2008, 'Y' indicates that a default factor was generated by the system due to lack of a RA factor. • For 2009 and after, for payments and payment adjustments and regardless of the effective date of the adjustment, the following applies: '1' = Default Enrollee- Aged/Disabled '2' = Default Enrollee- ESRD dialysis '3' = Default Enrollee- ESRD Transplant Kidney, Month 1 '4' = Default Enrollee- ESRD Transplant Kidney, Months 2-3 '5' = Default Enrollee- ESRD Post Graft, Months 4-9 '6' = Default Enrollee- ESRD Post Graft, 10+Months '7' = Default Enrollee Chronic Care SNP Blank = The beneficiary is not a default enrollee.
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28	Adjustment Reason Code	2	90-91	FORMAT: 99 Always Spaces on Payment and MSA Deposit or Recovery Records
29	Paymt/Adjustment/MSA Start Date	8	92-99	FORMAT: YYYYMMDD
30	Paymt/Adjustment/MSA End Date	8	100-107	FORMAT: YYYYMMDD
31	Demographic Paymt/Adjustmt Rate A	9	108-116	FORMAT: -99999.99 Prior to 2008, Demographic Paymt/Adjustmt Rate A is displayed. In 2008 and beyond, Demographic Paymt/Adjustmt Rate A is displayed as 0.00.
32	Demographic Paymt/Adjustmt Rate B	9	117-125	FORMAT: -99999.99 Prior to 2008, Demographic Paymt/Adjustmt Rate B is displayed. In 2008 and beyond, Demographic Paymt/Adjustmt Rate B is displayed as 0.00.
33	Monthly Paymt/Adjustmt Amount Rate A	9	126-134	Part A portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (EFFECTIVE OCTOBER 1, 2011) (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
34	Monthly Paymt/Adjustmt Amount Rate B	9	135-143	Part B portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
35	LIS Premium Subsidy	8	144-151	FORMAT: -9999.99
36	ESRD MSP Flag	1	152-152	As of January 2011: T = Transplant/Dialysis P = Post Graft Blank = ESRD MSP not applicable Prior to 2011: Format X. Values = 'Y' or 'N'(default) Indicates if Medicare is the Secondary Payer
37	MSA Part A Deposit/Recovery Amount	8	153-160	Medicare Savings Account (MSA) lump sum Part A dollars for deposit/recovery. Deposits are positive values; recoveries are negative. FORMAT: -9999.99
38	MSA Part B Deposit/Recovery Amount	8	161-168	Medicare Savings Account (MSA) lump sum Part B dollars for deposit/recovery. Deposits are positive values; recoveries are negative. FORMAT: -9999.99
39	MSA Deposit/Recovery Months	2	169-170	Number of months associated with MSA deposit or recovery dollars
40	Current Medicaid Status	1	171-171	Beginning in mid-2008, this field reports the beneficiary's current Medicaid status. (Prior to 11/07, Medicaid status was reported in field #19.) '1' = Beneficiary is determined as Medicaid as of current payment month minus two (CPM –2) or minus one (CPM – 1), '0' = Beneficiary was not determined as Medicaid as of current payment month minus two (CPM – 2) or minus one (CPM – 1), Blank = This is a retroactive transaction and Medicaid status is not reported. The four sources to determine Current Medicaid Status are: 1. MMA State files or Dual Medicare Table 2. Low Income Territory Table 3. Medicaid Eligibility Table (Only valid records with a Medicaid source code of "003U" and "003C" are used.) 4. Point of Sale Table
41	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age Beginning in 2011, if the risk adjuster factor is from RAS, the Risk Adjuster Age Group reported is the one used by RAS in calculating the risk factor

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (EFFECTIVE OCTOBER 1, 2011) (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
42	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – Only on pre-2004 adjustments
43	De Minimis	1	183-183	Prior to 2008, flag is spaces. Beginning 2008: 'N' = "de minimis" does not apply, 'Y' = "de minimis" applies.
44	Beneficiary Dual and Part D Enrollment Status Flag	1	184-184	'0' - Plan without drug benefit, beneficiary not dual enrolled '1' – Plan with drug benefit, beneficiary not dual enrolled '2' –Plan without drug benefit, beneficiary dual enrolled '3' Plan with drug benefit, beneficiary dual enrolled.
45	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999
46	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
47	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) E1 = New Enrollee Post-Graft I (ESRD) E2 = New Enrollee Post-Graft II (ESRD) G1 = Graft I (ESRD) G2 = Graft II (ESRD) I = Institutional I1 = Institutional Post-Graft I (ESRD) I2 = Institutional Post-Graft II (ESRD) SE=New Enrollee Chronic Care SNP
48	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
49	Original Reason for Entitlement Code (OREC)	1	192-192	0 = Beneficiary insured due to age 1 = Beneficiary insured due to disability 2 = Beneficiary insured due to ESRD 3 = Beneficiary insured due to disability and current ESRD 9=None of the above
50	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months
51	Segment ID	3	194-196	Identification number of the segment of the PBP. Blank if there are no segments.

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (EFFECTIVE OCTOBER 1, 2011) (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
52	Enrollment Source	1	197	The source of the enrollment. Values are: A = Auto-enrolled by CMS, B = Beneficiary election, C = Facilitated enrollment by CMS, D = Systematic enrollment by CMS (rollover)
53	EGHP Flag	1	198	Employer Group flag; Y = member of employer group, N = member is not in an employer group
54	Part C Basic Premium – Part A Amount	8	199-206	The premium amount for determining the MA payment attributable to Part A. It is subtracted from the MA Plan payment for Plans that bid above the benchmark. -9999.99
55	Part C Basic Premium – Part B Amount	8	207-214	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA Plan payment for Plans that bid above the benchmark. -9999.99
56	Rebate for Part A Cost Sharing Reduction	8	215-222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. This amount is added to the MA Plan payment for Plans that bid below the benchmark. -9999.99
57	Rebate for Part B Cost Sharing Reduction	8	223-230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. This amount is added to the MA Plan payment for Plans that bid below the benchmark. -9999.99
58	Rebate for Other Part A Mandatory Supplemental Benefits	8	231-238	The amount of the rebate allocated to providing Part A supplemental benefits. This amount is added to the MA Plan payment for Plans that bid below the benchmark. -9999.99
59	Rebate for Other Part B Mandatory Supplemental Benefits	8	239-246	The amount of the rebate allocated to providing Part B supplemental benefits. This amount is added to the MA Plan payment for Plans that bid below the benchmark. -9999.99
60	Rebate for Part B Premium Reduction – Part A Amount	8	247-254	The Part A amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -9999.99
61	Rebate for Part B Premium Reduction – Part B Amount	8	255-262	The Part B amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -9999.99
62	Rebate for Part D Supplemental Benefits – Part A Amount	8	263–270	Part A Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
63	Rebate for Part D Supplemental Benefits – Part B Amount	8	271–278	Part B Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
64	Total Part A MA Payment	10	279–288	The total Part A MA payment. -999999.99

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (EFFECTIVE OCTOBER 1, 2011) (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
65	Total Part B MA Payment	10	289–298	The total Part B MA payment. -999999.99
66	Total MA Payment Amount	11	299-309	The total MA A/B payment including MMA adjustments. This also includes the Rebate Amount for Part D Supplemental Benefits -9999999.99
67	Part D RA Factor	7	310-316	The member's Part D risk adjustment factor. NN.DDDD
68	Part D Low-Income Indicator	1	317	From 2006 through 2010, an indicator to identify if the Part D Low-Income multiplier is included in the Part D payment. Values are 1 (subset 1), 2 (subset 2) or blank. Beginning 2011, value 'Y' indicates the beneficiary is Low Income, value 'N' indicates the beneficiary is not Low Income for the payment/adjustment being made.
69	Part D Low-Income Multiplier	7	318-324	The member's Part D low-income multiplier. NN.DDDD For payment months 2011 and beyond, this field is zero.
70	Part D Long Term Institutional Indicator	1	325	From 2006 through 2010, an indicator to identify if the Part D Long-Term Institutional multiplier is included in the Part D payment. Values are A (aged), D (disabled) or blank. For payment months 2011 and beyond, this field is blank.
71	Part D Long Term Institutional Multiplier	7	326-332	The member's Part D institutional multiplier. NN.DDDD For payment months 2011 and beyond, this field is zero.
72	Rebate for Part D Basic Premium Reduction	8	333-340	Amount of the rebate allocated to reducing the member's basic Part D premium. -9999.99
73	Part D Basic Premium Amount	8	341-348	The Plan's Part D premium amount. -9999.99
74	Part D Direct Subsidy Monthly Payment Amount	10	349-358	The total Part D Direct subsidy payment for the member. When POS contract (X is first character of contract number), then it is total POS Direct Subsidy for the member. -999999.99
75	Reinsurance Subsidy Amount	10	359-368	The amount of the reinsurance subsidy included in the payment. -999999.99
76	Low-Income Subsidy Cost-Sharing Amount	10	369-378	The amount of the low-income subsidy cost-sharing amount included in the payment. -999999.99
77	Total Part D Payment	11	379-389	The total Part D payment for the member -9999999.99
78	Number of Paymt/Adjustmt Months Part D	2	390-391	99
79	PACE Premium Add On	10	392-401	Total Part D Pace Premium Addon amount -999999.99
80	PACE Cost Sharing Addon	10	402-411	Total Part D Pace Cost Sharing Addon amount -999999.99
81	Part C Frailty Score Factor	7	412-418	Beneficiary's Part C frailty score factor, NN.DDDD; otherwise, spaces
82	MSP Factor	7	419-425	Beneficiary's MSP secondary payor reduction factor, NN.DDDD; otherwise, spaces
83	MSP Reduction/Reduction Adjustment Amount – Part A	10	426-435	Net MSP reduction or reduction adjustment dollar amount–Part A, SSSSSS9.99

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (EFFECTIVE OCTOBER 1, 2011) (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
84	MSP Reduction/Reduction Adjustment Amount – Part B	10	436-445	Net MSP reduction or reduction adjustment dollar amount – Part B, SSSSSS9.99
85	Medicaid Dual Status Code	2	446-447	Entitlement status for the dual eligible beneficiary. The valid values when Field 40 = 1 are: 01 = Eligible is entitled to Medicare- QMB only 02 = Eligible is entitled to Medicare- QMB AND Medicaid coverage 03 = Eligible is entitled to Medicare- SLMB only 04 = Eligible is entitled to Medicare- SLMB AND Medicaid coverage 05 = Eligible is entitled to Medicare- QDWI 06 = Eligible is entitled to Medicare- Qualifying individuals 08 = Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB,QDWI or QI) with Medicaid coverage 09 = Eligible is entitled to Medicare – Other Dual Eligibles but without Medicaid coverage 99=Unknown The valid value when Field 40 = 0 is: 00 = No Medicaid Status The valid value when Field 40 is blank is: Blank
86	Part D Coverage Gap Discount Amount	8	448-455	The amount of the Coverage Gap Discount Amount included in the payment. -9999.99
87	Part D RA Factor Type	2	456-457	Beginning with January 2011 payment, type of factors in use (see Field 67): D1 = Community Non-Low Income Continuing Enrollee, D2 = Community Low Income Continuing Enrollee, D3 = Institutional Continuing Enrollee, D4 = New Enrollee Community Non-Low Income Non-ESRD, D5 = New Enrollee Community Non-Low Income ESRD, D6 = New Enrollee Community Low Income Non-ESRD, D7 = New Enrollee Community Low Income ESRD, D8 = New Enrollee Institutional Non-ESRD, D9 = New Enrollee Institutional ESRD, Blank when it does not apply.
88	Default Part D Risk Factor Code	1	458	Beginning with January 2011 payment : 1=Not ESRD, Not Low Income, Not Originally Disabled, 2=Not ESRD, Not Low Income, Originally Disabled, 3=Not ESRD, Low Income, Not Originally Disabled, 4=Not ESRD, Low Income, Originally Disabled, 5= ESRD, Not Low Income, Not Originally Disabled, 6= ESRD, Low Income, Not Originally Disabled, 7= ESRD, Not Low Income, Originally Disabled, 8= ESRD, Low Income, Originally Disabled, Blank when it does not apply.
89	Part A Monthly Payment Rate	9	459-467	Effective Part A Monthly Payment Rate Format: -99999.99

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (EFFECTIVE OCTOBER 1, 2011) (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
90	Part B Monthly Payment Rate	9	468-476	Effective Part B Monthly Payment Rate Format: -99999.99
91	Part D Monthly Payment Rate	9	477-485	Effective Part D Monthly Payment Rate Format: -99999.99
92	Cleanup ID	10	486-495	Cleanup Identifier, a reference linking to further documentation about a specific cleanup