2008 Regional Technical Assistance
ENROLLMENT & PAYMENT

CMS Centers for Medicare & Medicaid Services

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INTRODUCTION AND OVERVIEW

Purpose (Slide 3)

The purpose of this technical assistance session is to provide participants with the support needed to understand the connection between Enrollment and Payment. This information will enable participants to collect and submit enrollment data and reconcile payments in accordance with Centers for Medicare & Medicaid Services (CMS) requirements. This module introduces participants to important terms and key resources that provide a foundation for the Enrollment and Payment technical assistance program.

About This Technical Assistance Session

This session is organized into 4 modules:

1. **Enrollment Process Summary**
   Provides an overview and summary of enrollment processing activities.
2. **Enrollment Processing and MARx Overview**
   Describes various enrollment transaction types and provides a basic understanding of the features of the MARx system.
3. **Payment Overview**
   Provides a summary of the components of monthly plan payments.
4. **Reports and Reconciliation**
   Identifies various reports that organizations may use to reconcile the enrollment and payment data.

ICON KEY	
Example	
Reminder	
Resource	

Participant Guide (Slide 4)

This Participant Guide is designed as the foundation of the technical assistance program. The presentation slides complement the Participant Guide, and both are used extensively throughout this program. The participant binder includes the Participant Guide, Presentation Slides, a Resource Guide, and Job Aids. Collectively, these tools enhance the learning experience. Sections of the binder are described in Table A.

TABLE A – TECHNICAL ASSISTANCE TOOLS

SECTION	DESCRIPTION
Participant Guide	• Detailed description of relevant Enrollment and Payment information • Examples
Slides	• Organized by module • Printed two slides per page

Audience (Slide 5)

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) and 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 (Slide 7)

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

- Summarize enrollment processing activities
- Explain enrollment transactions and processing
- Describe the monthly plan payment
- Reconcile enrollment and payment using reports

Common Enrollment and Payment Terms (Slide 8)

Table 2A provides descriptions for common enrollment and payment system terminology.

TABLE B - ENROLLMENT AND 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.
Common UI	**Part D Eligibility and Inquiry System** enables access to enrollment, eligibility, and 4Rx information for beneficiaries.
MAPD IUI	**Medicare Advantage Prescription Drug Integrated User Interface** is the *new* interface that enables access to enrollment, eligibility, and 4Rx information for beneficiaries.
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.

Enrollment and Payment Process Overview (Slides 9-12)

Each time a beneficiary submits an enrollment application, plans must verify the beneficiary's eligibility to enroll in Medicare Parts C and/or D by submitting a transaction in a MARx Batch Input Transaction Data File. Once enrolled, the plan must monitor the enrollee membership and payment adjustments for the beneficiary to ensure appropriate payments for providing services.

Beneficiaries enroll using one of five enrollment periods:
- Annual Election Period (AEP)
- Initial Coverage Election Period (ICEP)
- Initial Enrollment Period (IEP)
- Special Election Periods (SEP)
- Open Enrollment Period (OEP)

There are six types of transactions plans can submit to update a beneficiary's enrollment status:
- Enrollment Transaction
- Disenrollment Transaction
- Plan Elections (PBP Change) Transaction
- Plan Change Transaction
- Correction
- Part D Opt-Out

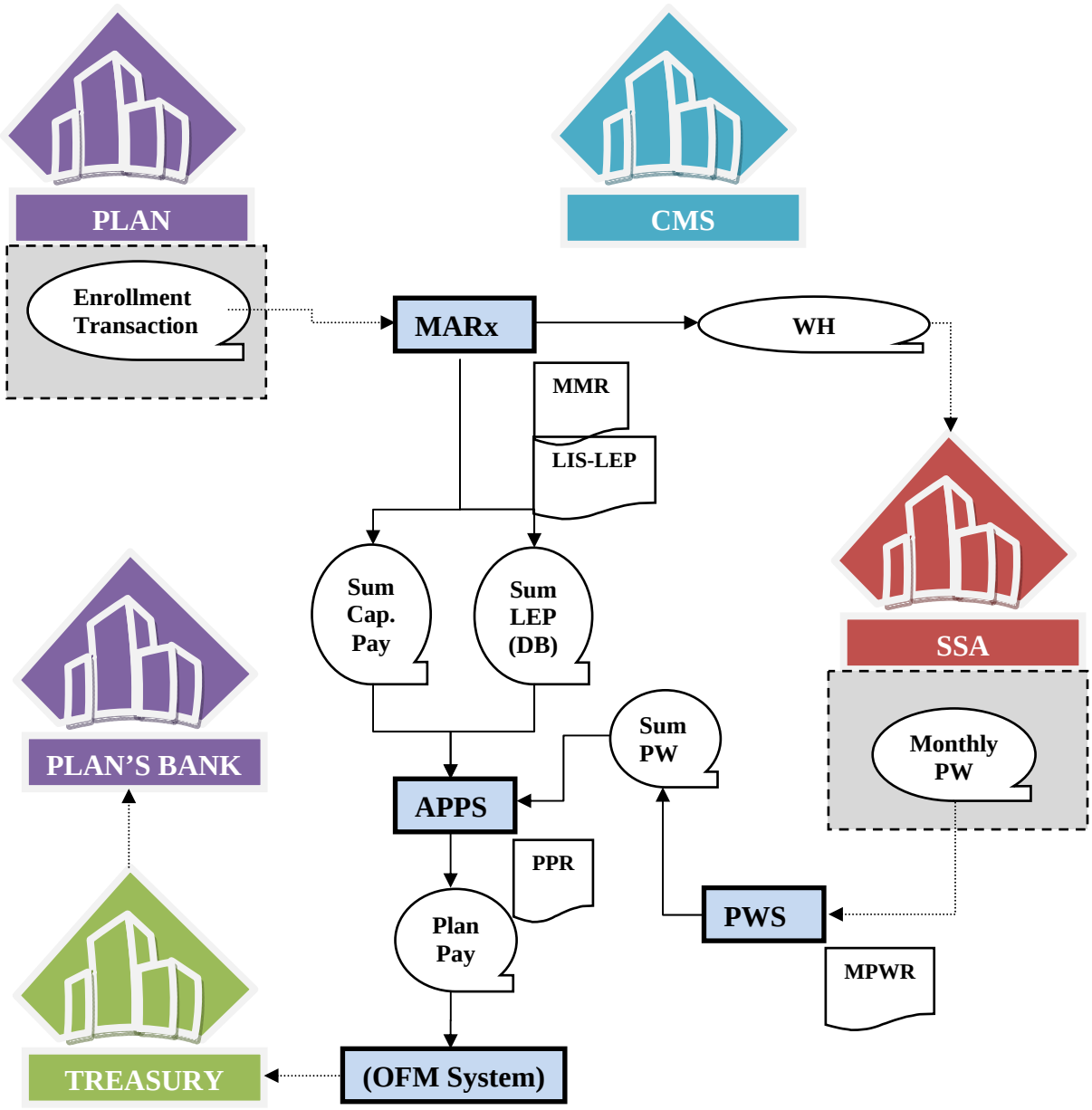
There are three main sources of payment data contributing to a plans monthly payment:
- MARx
- PWS
- APPS

Plans are required to reconcile and certify enrollments and payments. If there are discrepancies, then plans must submit retroactive transactions.

Enrollment and Payment Dataflow (Slide 13)

Figure A provides an overview of the Monthly Plan Payment process flow.

Figure A – Payment Systems Flow



Technical Assistance and Support (Slide 14)

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

TABLE C – 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, such as the Complaints Tracking Module (CTM). 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.freebruger@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) MMA Help	The MMA 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 MMA Helpdesk by calling 1-800-927-8069, emailing mmahelp@cms.hhs.gov, or viewing the website at www.cms.hhs.gov/mmahelp. The MMA Helpdesk is available Monday – Friday 6:00 a.m. to 9:00 p.m. ET.

MODULE 1– ENROLLMENT PROCESS SUMMARY

Purpose (Slide 2)

This document provides an overview and summary of enrollment processing activity. Plans must refer and adhere to the Centers for Medicare & Medicaid Services (CMS) policy when enrolling and disenrolling a beneficiary. This module provides enrollment and disenrollment guidelines, ultimately ensuring accurate processing.

Enrollment policy is provided via the CMS Enrollment and Disenrollment Guidance for Medicare Advantage Plans (Chapter 2 of the *Medicare Managed Care Manual (MMCM)*), the CMS *PDP Guidance for Eligibility, Enrollment and Disenrollment*, and the *CMS Cost Plan Enrollment and Disenrollment Instructions* (Chapter 17-D of the MMCM). Additional information regarding systems processes is provided in the CMS Plan Communications User Guide.

This overview and summary does not replace, enhance, change or otherwise impact published official CMS guidance documents.

Learning Objectives (Slide 4)

At the completion of this module, participants will:

- Identify enrollment requirements
- Describe enrollment mechanisms
- Identify enrollment periods
- Define plan communication

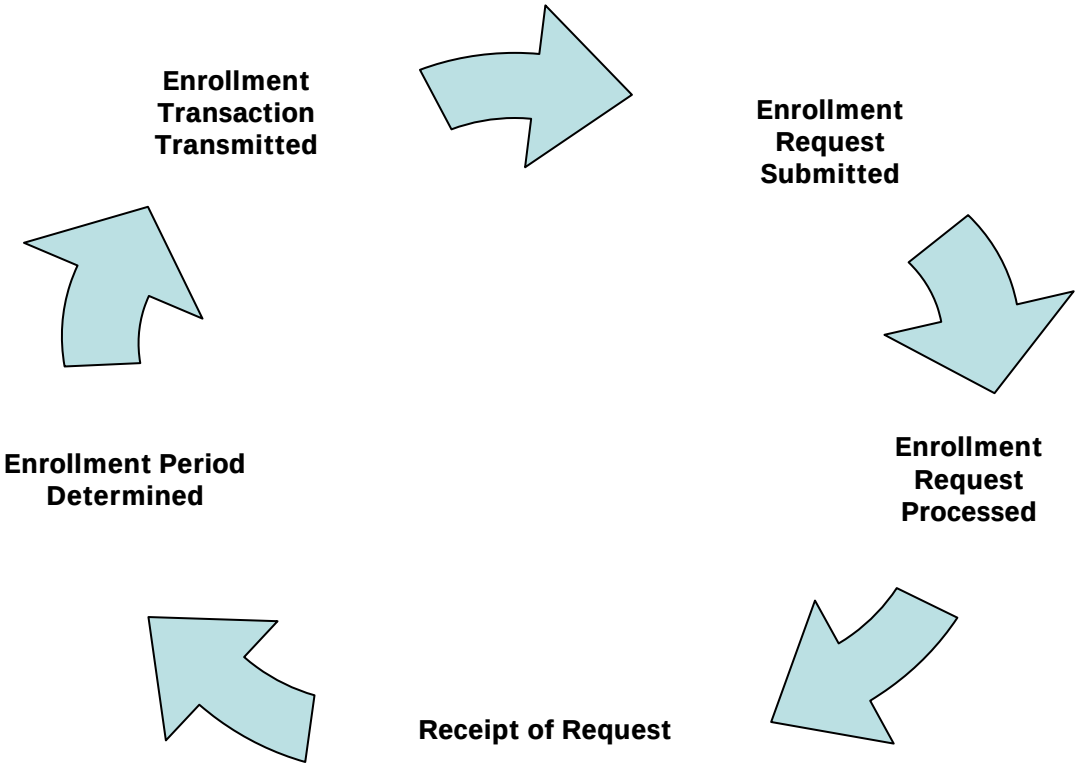
ICON KEY	
Example	
Reminder	
Resource	
Definitions	

The term “enrollment” used throughout this guide describes both enrollment and disenrollment.

1.1 Overview of Enrollment/Disenrollment Process (Slide 6)

Generally, an eligible individual enrolls in a PDP or MA plan by completing and submitting an enrollment request to the organization. The enrollment process begins with the eligible individual completing and submitting an enrollment request within the required timeframes. The process continues with the communication between the plan and CMS. Figure 1A outlines this process.

Figure 1A – Enrollment / Disenrollment Process Overview



- Beneficiary submits an enrollment request to the plan.
- Plan processes the enrollment request by reviewing the enrollment and determining if the request submitted contains all required information, as directed in CMS guidance.
- Plan verifies beneficiary eligibility using CMS systems and verifies if the request is complete
- Plan determines if beneficiary submitted the enrollment request within a valid enrollment period and determines the effective date of enrollment or disenrollment.
- Plan communicates with beneficiary to accept, deny, or request additional information regarding the enrollment request
- Plan submits appropriate transaction to CMS within 7 calendar days.
- CMS communicates disposition of the enrollment to the plan via the Batch Completion Summary Status report and on the Weekly Transaction Reply Report
- Plan communicates the disposition of the request to the beneficiary within timeframes established by CMS.

1.2 Eligibility for Enrollment

In general, an individual is eligible to enroll provided the beneficiary meets the MA, PDP, or other Medicare health plan eligibility requirements.

1.2.1 Eligibility Requirements for Enrollment in a PDP (Slide 7)

A PDP provides prescription drug coverage offered under a policy, contract, or plan offered by a PDP sponsor that has a contract with CMS that meets the contract requirements. An individual is eligible to enroll in a PDP provided the individual meets all requirements described in the CMS PDP Enrollment and Disenrollment Guidance. A summary is provided in Table 1A below; please refer to the current, appropriate CMS guidance for complete information.

TABLE 1A – SUMMARY OF PDP ELIGIBILITY REQUIREMENTS

SUMMARY OF PDP ELIGIBILITY REQUIREMENTS
Entitled to Medicare Part A **or** enrolled in Part B
Permanently resides in the plan's service area

1.2.2 Basic Eligibility Requirements for Enrollment in an MA (Slide 8)

An MA Plan (including an MA-PD plan) provides health benefit coverage offered under a policy or contract by an MA organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area (or segment of the service area) of the MA plan. An individual is eligible to enroll in an MA Plan provided the individual meets all requirements provided in the CMS Enrollment and Disenrollment guidance for MA plans. A summary of the basic MA eligibility is listed in Table 1B; please refer to the current, appropriate CMS guidance for information. Note that some MA plan types have additional eligibility requirements, such as Special Needs Plans (SNP) or Medicare Savings Account (MSA) plans.

TABLE 1B – SUMMARY OF BASIC MA ELIGIBILITY REQUIREMENTS

SUMMARY OF BASIC MA ELIGIBILITY REQUIREMENTS
Entitled to Medicare Part A **and** enrolled in Part B
Not medically determined to have ESRD prior to completing the enrollment election; EXCEPTIONS APPLY
Permanently resides in the plan's service area (some exceptions apply)
Completes an enrollment request and includes all the information required to process the enrollment
Is fully informed of and agrees to abide by the rules of the MA organization
Makes a valid election during an election period
Additional eligibility requirements apply to certain MA plan types, such as SNP or MSA. Refer to CMS Enrollment and Disenrollment Guidance for MA plans for complete information.

1.3 Low Income Subsidy (LIS) Eligible Individuals (Slide 9)

The MMA provides LIS to assist with prescription drug costs for individuals with limited income and resources. The federal government pays a subsidy for the Medicare beneficiary the drug plan enrolls, which provides the beneficiary with assistance with premium, deductible and co-payments of the program.

Beneficiaries may apply for the LIS with the SSA or the State Medicaid agency. Certain groups of Medicare beneficiaries automatically qualify and do not have to apply. CMS will automatically award this group the subsidy based on information received from the States and SSA. Table 1C lists the LIS groups methods for qualifying for LIS.

TABLE 1C - METHODS TO QUALIFY FOR LIS BY GROUP

LIS GROUPS	MEDICAID ELIGIBLE	DEEMED	APPLY
Full Benefit Dual Eligible	X	X	
Medicare Savings Program Qualified Medicare Beneficiary (QMB) Specified Low Medicare Beneficiary (SLMB) Qualified Individuals (QI)	X	X	
SSI		X	
LIS Applicants			X

1.3.1 Full-Benefit Dual Eligible Individuals

Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit. FBDE are individuals eligible for full Medicaid benefits and Medicare Part D. This includes those who are eligible for comprehensive Medicaid payment of Medicare Part B premiums and/or cost-sharing (sometimes known as QMB-plus or SLMB-plus).

FBDE do not include those individuals eligible for Medicare Secondary Payor (MSP).

1.3.2 Other LIS Eligible Individuals

Other LIS Eligible Individuals include the MSP individuals and SSI-only (those eligible for SSI payments but receive no Medicaid benefits) and LIS applicants. CMS deems MSP and SSI-only individuals eligible for the subsidy. State Medicaid agencies determine individuals eligible for MSP based on limited income and resources guidelines.

1.4 Enrollment Mechanisms (Slide 10)

Generally, an eligible individual or the individual's legal representative must complete an enrollment request to enroll in a plan, even if that individual is electing a plan in the same organization in which currently enrolled. Unless otherwise specified by CMS, an eligible individual can elect a plan only if the

eligible individual or the individual's legal representative submits a completed enrollment election and provides required information to the organization within the required timeframes. CMS provides for auto and facilitated enrollment processes for individuals who receive LIS; these processes are defined in the CMS PDP Plan Enrollment and Disenrollment Guidance.

All plans must, at a minimum, offer a paper enrollment form that complies with CMS' guidelines in format and content. CMS has provided short enrollment forms for both MA and PDPs for use when a beneficiary is requesting enrollment into another plan within the same organization (following all the enrollment requirements, including having a valid enrollment period in which to make the request).

In addition to the paper form, MA and PDP plans may offer beneficiaries various methods to request enrollment. The additional options include:

- Internet, including the CMS Online Enrollment Center
- Telephonic
- Other Mechanisms as provided in CMS enrollment guidance applicable to the plan type.

1.4.1 Paper Enrollment Form Requests

At a minimum, all plans must provide the paper enrollment request. CMS provides model enrollment forms for MAs and PDPs. All required fields on the enrollment request must be completed. The plan must determine if the request submitted by the beneficiary is complete by verifying each request.

1.4.1.1 MA Paper Enrollment Form Request

Beneficiaries can request enrollment in an MA or MA-PD plan by completing and submitting an MA Paper Enrollment Request form to the MA or MA-PD plan. Figure 1B provides a sample MA enrollment request.

Figure 1B – 2008 Sample MA Enrollment Request

To Enroll in <plan>, Please Provide the Following Information:			
[Optional Field: **Please check which plan you want to enroll in:** _ Product ABC $XX per month _ Product XYZ $XX per month]			
LAST name: FIRST Name: Middle Initial			☐Mr. ☐ Mrs. ☐Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐M ☐F	[Optional field: Social Security Number: (providing this information is optional)]	Home Phone Number: ( )
Permanent Residence Street Address:			
City:	State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[Optional field: **Emergency contact:** _____ **Phone Number**:_____ **Relationship to You:** _____]			
[Optional field: **E-mail Address:** _____]			
Please Provide Your Medicare Insurance Information			
Please take out your Medicare Card to complete this section. ▪ Please fill in these blanks so they match your red, white and blue Medicare card - OR ▪ Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.			MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ ___-___-____ ___ Is Entitled To Effective Date HOSPITAL (Part A) _____ MEDICAL (Part B) _____

Figure 1B – 2008 Sample MA Enrollment Request (Continued)

[**Zero premium MA plans omit this section**: **Paying Your Plan Premium**

You can pay your monthly plan premium by mail <insert optional methods: **"Electronic Funds Transfer (EFT)", "credit card"> each month <**insert optional intervals, if applicable, for example **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.**

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month <optional language in place of "bill each month": "coupon book" or "payment book">.

Please select a premium payment option:

☐Receive a bill <option: "coupon", "payment" book, etc>
<option to include other billing intervals e.g. bi-monthly, quarterly>
<Include other optional methods, such as EFT & credit card as follows:
☐Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
Account holder name: _____
Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _

Account type: ☐Checking ☐Saving

☐ Credit Card. Please provide the following information:

Type of Card:
Name of Account holder as it appears on card:
Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Expiration Date: _ _/_ _ _ _ (MM/YYYY)>

☐Automatic deduction from your monthly SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <MA plan>? ☐Yes ☐No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ID # for this coverage: Group # for this coverage

Figure 1B – 2008 Sample MA Enrollment Request (Continued)

3. Are you a resident in a long-term care facility, such as a nursing home? ☐Yes ☐ No

If "yes" please provide the following information:

Name of Institution:
Address & Phone Number of Institution (number and street):_____

4. Are you enrolled in your State Medicaid program? ☐Yes ☐No

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ☐Yes ☐No

[*Optional field:* **Please choose the name of a Primary Care Physician (PCP), clinic or health center:**]

[*Optional field:* **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**

_____ Language A (e.g., Spanish)

_____ Language B (e.g., Chinese)]

[Following box required only for MA-PD plans:

Please Read This Important Information

If you currently have health coverage from an employer or union, joining <MA-PD Name> could affect your employer or union health benefits. If you have health coverage from an employer or union, joining <MA-PD Name> may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.]

Figure 1B – 2008 Sample MA Enrollment Request (Continued)

Please Read and Sign Below
By completing this enrollment application, I agree to the following: <Plan Name> is a Medicare Advantage plan and I will need to keep my Parts A and B. I can be in only one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. *[**MA-only plans insert:** I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.]* Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by /sending a request to <Name> or by calling 1-800-Medicare. TTY users should call 1-877-486-2048. *24 hours a day/7days a week.*

<Plan name> serves a specific service area. If I move out of the area that <plan name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <plan name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

[***MA PFFS do not include the following paragraph:*** I understand that beginning on the date [plan name] coverage begins, I must get all of my health care from <plan name>, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <PLAN NAME> WILL PAY FOR THE SERVICES.**]

[***Insert the following for MA-PD Part D payment demonstration plan:*** By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare drug plan.]

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. *I also acknowledge that <plan name> will release my information [**MA-PD plans insert:** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.* The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Figure 1B – 2008 Sample MA Enrollment Request (Continued)

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <plan name> or by Medicare.

Your Signature:	**Today's Date:**
If you are the authorized representative, you must provide the following information: **Name:** _____ **Address:** _____ **Phone Number:** (___) ___- _____ **Relationship to Enrollee** _____	

Office Use Only:
Name of staff member (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

1.4.1.1.1 MA Data Elements Required to Complete Enrollment Election

MA and MA-PD plans must verify that each request received is complete. CMS provides a tool to assist plans as Appendix 2 of the CMS Enrollment and Disenrollment Guidance for MA Plans. Table 1D below provides an example of this tool; refer to the CMS enrollment guidance document for the current appendix.

TABLE 1D – EXAMPLE OF MA DATA ELEMENTS REQUIRED TO COMPLETE ENROLLMENT ELECTION (SEE CMS GUIDANCE)

	DATA ELEMENT	REQUIRED BEFORE ENROLLMENT COMPLETE
1	MA Plan name	Yes
2	MA Plan/Product/premium choice (if applicable)	Yes
3	Beneficiary name	Yes
4	Beneficiary Date of Birth	Yes
5	Beneficiary Sex	Yes
6	Social Security Number (optional field)	No
7	Beneficiary Telephone Number	No
8	Permanent Residence Address	Yes
9	Mailing Address	No
10	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No
11	E-mail Address (Optional Field)	No
12	Beneficiary Medicare number	Yes
13	Additional Medicare information contained on sample Medicare card, or copy of card	No
14	Plan Premium Payment Option	No
15	Response to ESRD Question	Yes
16	Response to long term care question	No
17	Response to other insurance COB information	No
18	Response to Medicaid question	No
19	Language preference (Optional Field)	No
20	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No
21	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	No
22	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No
23	Name of chosen Primary Care Physician, clinic or health center (Optional Field)	No
24	Beneficiary signature and/or Authorized Representative Signature	Yes
25	Date of signature	No
26	Authorized representative contact information	Yes
27	Employer or Union Name and Group Number	Yes
28	Question of which MA plan the beneficiary is currently a member of and to which MA plan the beneficiary is changing	Yes
29	For enrollments into a Part D Payment Demonstration MA-PD plan, attestation regarding financial support for purchase of prescription drugs	Yes
30	For Special Needs Plans, verification of SNP eligibility	Yes
31	For MSA plans, proof that MSA bank account has been established	Yes

1.4.1.2 MA Short Paper Enrollment Request

CMS also provides an optional short Enrollment Request paper form for beneficiaries to request enrollment in another MA plan within the same MA organization. This optional enrollment form is reviewed and processed in the same manner as any other enrollment request received by the plan.

Example 2

Mr. Harold Smith submits an enrollment request to enroll in Spring MA Health Plan. Spring MA Health Plan reviews the request. Mr. Smith completed all fields on the enrollment request with the exception of the permanent address. The permanent address is required; therefore, Spring MA Health plan determines Mr. Smith's submitted request is incomplete. Spring MA Health Plan follows the appropriate procedures, as provided in the CMS enrollment guidance, to request the necessary additional information to complete the enrollment request from Mr. Smith within the timeframes CMS requires.

1.4.1.3 PDP Paper Enrollment Request Form

Beneficiaries can request enrollment in a PDP by completing and submitting a PDP Paper Enrollment Request Form to the PDP during a valid enrollment period.

1.4.1.3.1 PDP Data Elements Required to Complete Enrollment Election

PDPs receive enrollment request forms from individuals requesting enrollment and must verify the request received is complete. CMS provides a tool to assist PDP plans as Appendix 2 of the CMS PDP Plan Enrollment and Disenrollment Guidance. Table 1E below provides an example of this tool; refer to the CMS enrollment guidance document for the current appendix.

TABLE 1E – PDP DATA ELEMENTS REQUIRED TO COMPLETE ENROLLMENT ELECTION

DATA ELEMENT		REQUIRED BEFORE ENROLLMENT COMPLETE
1	PDP Plan Name	Yes
2	PDP Plan/Product	Yes
3	Beneficiary Name	Yes
4	Beneficiary Birth Date	Yes
5	Beneficiary Sex	Yes
6	Social Security Number	No
7	Beneficiary Telephone Number	No
8	Permanent Residence Address	Yes
9	Mailing Address	No
10	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No
11	E-mail address	No
12	Beneficiary Medicare number	Yes
13	Additional Medicare information contained on sample Medicare card, or copy of card	No. *CMS recognizes PDPs need at a minimum, the Medicare number in order to verify entitlement to Part A and/or enrollment in Part B; and have accounted for the need for this data under the Beneficiary Birth Date data element*
14	Plan Premium Payment Option	No
15	Response to other insurance COB information	No
16	Response to long term care question	No
17	Beneficiary signature and/or Beneficiary Representative Signature	Yes
18	Date of signature	No
19	Authorized Representative contact information (if not signed by beneficiary)	Yes

Example 3

Mr. Brian Blue submits an enrollment request to enroll in Autumn PDP. Autumn PDP reviews the request and notices that Mr. Blue completed all fields on the enrollment request with the exception of his social security number. Since the social security number is not a required field, and may not be required by the plan, Autumn PDP determines that Mr. Blue's enrollment request is a completed request.

1.4.1.4 PDP Short Paper Enrollment Form

CMS also provides an optional short paper Enrollment Request form for beneficiaries to request enrollment in another PDP plan within the same PDP sponsor during a valid enrollment period. This optional enrollment form is reviewed and processed in the same manner as any other enrollment request received by the plan.

1.4.2 Enrollment via Internet

When choosing to offer beneficiaries the internet option to submit enrollments, Plans must submit all materials and web pages related to the online enrollment process for CMS approval in accordance with the Marketing Guidance and provide beneficiaries with the information required by all applicable CMS guidelines.

Plans must also comply with CMS' internet security policies and advise each individual at the beginning of the online enrollment process that the individual is submitting an actual enrollment request.
Plans must capture the same data required on the model enrollment form and include a separate screen or page that includes an "enroll now" or "I agree" button that the individual must click to indicate the beneficiary's intention to enroll.

Beneficiary must agree to the release and authorization language and attest to the truthfulness of the data provided. Plans must notify beneficiaries of consequences of completing the internet enrollment (i.e., CMS may approve and grant enrollment and the plan will send a notice of acceptance or denial following the submission of the enrollment to CMS.)

The website must include a tracking mechanism. The plan must maintain securely stored and readily reproducible electronic records. Other requirements apply.

CMS also provides the online enrollment center (OEC) via the Medicare.gov web site.

Please refer to the CMS Enrollment and Disenrollment Guidance applicable to the plan type for complete information regarding internet enrollment mechanisms.

1.4.3 Enrollment via Telephone

Plans may accept enrollment requests into one or more of its plans via incoming (inbound) telephone calls provided plans adhere to the guidelines provided by CMS which include:

- Enrollment request may only be accepted from/during an incoming (inbound) call from the beneficiary
- Individuals must be advised that they are completing an enrollment
- Each telephonic enrollment request must be recorded (audio record) and must be easily reproducible

- Collection of financial information is prohibited at any time during the call
- Notice of acknowledgement and other required information must be provided to the individual
- Scripts for completing the enrollment requirements must be developed by the plan following the requirements provided in the CMS Enrollment and Disenrollment Guidance applicable to the plan type, and must be reviewed and approved through the CMS Marketing Materials approval process.

1.5 Enrollment via Auto/Facilitated Enrollment (Slides 12-15)

All LIS eligible individuals who elect an MA plan without Medicare prescription drug benefits (MA-only plan) effective 2006 or later, are auto or facilitated enrolled into an MA-PD plan in the same organization. The auto/facilitated enrollment processes will occur monthly.

The term "auto-enrollment" denotes the process that applies to FBDE individuals, and "facilitated enrollment" to others with LIS.

CMS will identify FBDE and Other LIS individuals to be auto and facilitated enrolled in PDPs. CMS will assign beneficiaries to a plan in a two-step process. The first level of assignment is at the PDP Sponsors level and the second level is assignment of individual PDPs.

MA organizations will identify MA-PD plans in the same service area and MA organization with the lowest combined Part C and Part D premium amount. If more than one MA-PD plan exists, the MA must assign enrollment randomly.

1.5.1 Enrollment via Auto-Enrollment

FBDE not enrolled in a Part D plan are auto-enrolled in a MA-PD plan by the MA organization and auto enrolled in a PDP by CMS, with the exception of those individuals that meet the exclusion conditions listed in Table 1F.

TABLE 1F – AUTO-ENROLLMENT EXCLUSIONS

EXCLUSIONS	MA FBDE	PDP FBDE
Live in any of the five U.S. territories	X	X
Live in another country	X	X
Are inmates in a correctional facility	X	X
Have opted out of auto-enrollment into Part D benefits	X	X
For MA-PFFS only – are already enrolled in a stand-alone PDP	X	
Are already enrolled in a Part D plan		X

1.5.2 Enrollment via Facilitated Enrollment

Other LIS individuals not enrolled in a Part D plan are facilitated enrolled in an MA-PD plan by the MA organization and facilitated enrolled in a PDP by CMS, with the exception of those individuals that meet the exclusion conditions listed in Table 1G.

TABLE 1G – FACILITATED ENROLLMENT EXCLUSIONS

EXCLUSIONS	MA LIS	PDP LIS
Live in any of the five U.S. territories	X	X
Live in another country	X	X
Are inmates in a correctional facility	X	X
Have opted out of auto-enrollment into Part D benefits	X	X
For MA-PFFS only – are already enrolled in a stand-alone PDP	X	
Are already enrolled in a Part D plan		X
Individuals the employer or union is claiming for retiree drug subsidy	X	X
Individuals enrolled in an employer-sponsored MA-only plan, including "800" series plans	X	
Enrolled in an MA-PD		X

1.5.3 Auto/Facilitated Opt Out (Slide 16)

Both Dual and other LIS eligibles may opt out or affirmatively decline the Part D benefit. The beneficiary may opt out of auto/facilitated enrollment verbally or in writing. The primary means for declining auto or facilitated enrollment from a PDP is by calling 1-800-Medicare. The beneficiary may also call the PDP to opt out of the auto or facilitated enrollment.

For an MA only plan enrollee, this primarily means declining auto/facilitated enrollment into an MA-PD plan in the same organization and maintaining enrollment in the MA-only plan.

1.6 Enrollment via Employer Group Enrollment

CMS provides an optional process for group enrollment into an employer/union sponsored plan. The group enrollment process must include notification and materials to each beneficiary as provided in the CMS Enrollment and Disenrollment guidance documents. Individuals must be provided with this information within the timeframes established by CMS, prior to the effective date of enrollment. The information provided must include, among other things, clear instruction regarding the individual's right to decline the enrollment (opt-out). Please refer to the CMS enrollment guidance applicable to the plan type for complete information.

1.7 Beneficiary Selections

Beneficiaries may also choose how they wish to pay any plan premiums in the "Paying Your Plan Premium" section of the enrollment request. Beneficiaries can select one of the several options for paying monthly premiums, which include direct bill, Electronic Funds Transfer, Credit Card, or SSA benefit deduction ("premium withhold"). If the beneficiary leaves the option for paying premium blank on the enrollment request, the plan must default the option to direct bill.

1.8 Enrollment Periods (Slides 17-18)

In order for an MA organization or PDP sponsor to accept an enrollment or disenrollment request, a valid request must be made during an enrollment period. It is the responsibility of the organization or sponsor to determine the correct period for each request.

Table 1H provides an overview of enrollment periods by plan type. Complete information is provided in CMS enrollment and disenrollment guidance.

TABLE 1H – ENROLLMENT PERIODS OVERVIEW

ENROLLMENT PERIODS	MA	MA-PD	PDP
Annual Election Period (AEP)	X	X	X
Initial Coverage Election Period (ICEP)	X	X	
Initial Enrollment Period (IEP)		X	X
Special Election Periods (SEP)	X	X	X
Open Enrollment Period (OEP)	X	X	

1.8.1 AEP – Annual Enrollment Period

During the AEP, eligible individuals may enroll in or disenroll from an MA or PDP. The last election made, determined by the application date, will be the election that takes effect.

The AEP occurs November 15 through December 31 of every year.

An employer/union sponsored MA plan may have an "open season" as determined by the employer. This may or may not correspond with the MA annual election period. Therefore, organizations are not required to accept enrollment requests into employer/union plans during the AEP (unless the AEP and open season occur simultaneously); however, organizations must accept valid requests for disenrollment.

1.8.2 ICEP – Initial Coverage Election Period

The ICEP is the period during which an individual newly eligible for MA may make an initial election to enroll in an MA plan. This period begins three months immediately before the individual's first entitlement to **both** Medicare Part A and Part B and ends on the later of the last day of the:

1. Month preceding entitlement to both Part A and Part B
or
2. Individual's Part B initial enrollment period

The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility.

Once the beneficiary makes an ICEP election and enrollment takes effect, the beneficiary has used the ICEP election.

1.8.3 IEP - Initial Enrollment Period for Part D

The IEP for Part D is the period during which an individual is first eligible to enroll in a Part D plan. In general, an individual is eligible to enroll in a Part D plan when entitled to Part A and/or enrolled in Part B, AND permanently resides in the service area of a Part D plan.

Individuals who are becoming eligible for Medicare will have an Initial Enrollment Period for Part D that is the 7-month period surrounding the date of Part D eligibility that begins 3 months prior to the month of Part D eligibility and ends 3 months after the month of Part D eligibility.

Individuals eligible for Medicare prior to age 65 will have another IEP for Part D based upon attaining age 65.

Enrollment requests made prior to the month of eligibility are effective the first day of the month of eligibility. Requests made during or after the first month of eligibility are effective the 1st of the month following the month the request was made.

1.8.4 SEP - Special Enrollment Periods

An SEP may apply to an individual under the circumstances described for each SEP in the CMS enrollment guidance documents. During an SEP, an individual may request enrollment or disenrollment as permitted by the specific SEP that applies. Certain SEPs are limited to an enrollment or disenrollment election. For most SEPs, once the individual has used the SEP opportunity the SEP ends for that individual even if the timeframe for the SEP is still in effect, unless specified otherwise within an SEP.

Other SEPs are "continuous" and do not end when an enrollment or disenrollment request is made, such as the SEP for individuals who are dually eligible for both Medicare and Medicaid, or the SEP for individuals who have Part D LIS. Refer to the current CMS enrollment and disenrollment guidance for complete information on SEPs.

An individual's eligibility for an SEP does not convey eligibility to enroll in the plan; in addition to having a valid enrollment period, an individual must also meet all applicable MA or PDP eligibility criteria; whichever is applicable.

It is the responsibility of the organization to determine whether the individual is eligible for an SEP. To make this determination, the organization may need to contact the individual to obtain the information. Unless otherwise required by CMS, the organization MUST accept verbal confirmation from the individual regarding the eligibility conditions for the SEP. The organization may obtain this information at the time of the enrollment request.

1.8.5 OEP – Open Election Period

During the OEP, MA eligible individuals may make one MA OEP enrollment request from January 1st through March 31st. However, MA organizations are not required to open enrollment during an OEP. If an MA organization has more than one MA plan, the MA organization is not required to open each plan for enrollment during the same timeframes.

MA organizations must accept valid requests for disenrollment from MA-only plans during the OEP since Original Medicare is always open during an OEP.

Beneficiaries can enroll or disenroll during the OEP, but cannot add or drop Part D drug coverage. The OEP is in addition to the enrollment request opportunities during the AEP, SEP, or ICEP.

1.8.6 Summary of Enrollment Periods by Plan Type

Individuals enrolling in a plan may use the following enrollment periods, if applicable, to request enrollment or disenrollment from an MA, MA-PD or PDP. Table 1I Summary of Enrollment Periods outlines the enrollment periods applicable to specific plan types. Refer to the appropriate CMS enrollment and disenrollment guidance for complete information.

TABLE 1I – SUMMARY OF ENROLLMENT PERIODS BY PLAN TYPE

PLAN TYPE	ELIGIBLE ENROLLMENT PERIODS	ENROLLMENT DATES	EFFECTIVE DATES
PDP	IEP	• 3 months prior to month Part D eligibility begins • Month Part D eligibility begins and • 3 months after the month Part D eligibility began	• Requests made prior to the month Part D eligibility began are effective the month of eligibility • Requests made during or after the month Part D eligibility began are effective the following month
	AEP	November 15 – December 31	January 1 of the following year
	SEP (Situational) depending on circumstance		
MA	ICEP	Begins 3 months before entitlement to both Medicare Part A and Part B and ends on the later of: • Last day of month before entitlement to both Part A and Part B or • Last day of individual's Part B initial enrollment period	1st day of month entitlement to Medicare Part A and B
	AEP	November 15 – December 31	January 1 of the following year
	OEP (including OEPI and OEPNEW)	• Plans are not required to open their MA Plans for the OEP, OEPI or OEPNEW periods • If an organization has more than one MA Plan, the MA Plan is not required to open each Plan for enrollment during the same time • If an MA Plan is open for enrollment during the OEP, it must accept all valid enrollments during the OEP • Regardless of whether or not the plan is open for enrollment, it must accept disenrollment (within the limitations) • During the MA OEP an individual may not add or drop drug coverage Enrollment Dates: January 1 – March 31	1st date of month after month the MA receives a completed enrollment election
	SEP (Situational)	• SEP (Situational)	SEP (Situational)

TABLE 1I – ENROLLMENT PERIODS BY PLAN TYPE (CONTINUED)

PLAN TYPE	ELIGIBLE ENROLLMENT PERIODS	ENROLLMENT DATES	EFFECTIVE DATES
MA-PD	IEP	• 3 months prior to entitlement month • Entitlement month and • 3 months after the entitlement month	• Requests made prior to the entitlement month become effective the month of entitlement • Requests made during or after the entitlement month become effective the following month
	ICEP	Begins 3 months before entitlement to both Medicare Part A and Part B and ends on the later of: • Last day of month before entitlement to both Part A and Part B or • Last day of individual's Part B initial enrollment period	1st day of month entitlement to Medicare Part A and B
	AEP	November 15 – December 31	January 1 of the following year
	OEP	• Plans are not required to open their MA Plans for open enrollment • If an organization has more than one MA Plan, the MA Plan is not required to open each Plan for enrollment during the same time • If an MA Plan is open for enrollment during the OEP, it must accept all valid enrollments during the OEP Enrollment Dates: January 1 – March 31	1st date of month after month the MA receives a completed enrollment election
	SEP (Situational)	• SEP (Situational)	SEP (Situational)
Employer/Union Direct Contract PDP	IEP	• 3 months prior to entitlement month • Entitlement month and • 3 months after the entitlement month	• Requests made prior to the entitlement month become effective the month of entitlement • Requests made during or after the entitlement month become effective the following month
	AEP	November 15 – December 31	January 1 of the following year
	SEP (Situational)	SEP (Situational)	SEP (Situational)

1.9 Late Enrollment Penalty/Creditable Coverage (Slide 19)

Beneficiaries enrolling in a Prescription Drug Plan may be subject to a late enrollment penalty (LEP) if the beneficiary did not enroll in the plan offering the Part D benefit during the beneficiaries IEP or ICEP and did not have creditable coverage during this period.

Part D plans must determine if the beneficiary will be accessed the LEP by reviewing CMS files. If it is determined the beneficiary has a period of uncovered months, the plan must contact the beneficiary to verify the absence of creditable coverage. The beneficiary can attest to creditable coverage during the period in question by completing the appropriate Attestation Form. If the beneficiary confirms the absence of creditable coverage during the period in question, the plan must calculate the period and report to CMS as uncovered months.

CMS will assess the amount of the LEP and the plan will inform the beneficiary within 10 calendar days using the appropriate Model Notice. CMS can bill the beneficiary for the LEP or the beneficiary can request the amount as a SSA deduction.

1.10 Incomplete Application Determinations (Slide 20)

When the enrollment election is incomplete, the plan must document all efforts to obtain additional documentation to complete the enrollment election and have an audit trail to document why the enrollment election needed additional documentation before the plan could consider it complete. The plan must make this determination and notify the individual within 10 calendar days of receipt of the request that the plan requires additional information for the completion of the enrollment request.

For AEP elections, additional documentation to make the request complete must be received by December 31 or within 21 calendar days (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received or within 21 calendar days (whichever is later).

1.11 Retroactive Determinations (Slide 21)

If an Individual has fulfilled all enrollment requirements but the plan or CMS is unable to process the enrollment for the required effective date, CMS or its designee will process a retroactive enrollment.

In other limited cases, CMS may determine that an individual is eligible for an SEP due to an extraordinary circumstance beyond control and may permit a retroactive enrollment in a plan as necessary to prevent a gap in coverage or liability for the late enrollment penalty.

The Plan must request the retroactive enrollment request within 45 calendar days of the availability of the first Transaction Reply Report.

Reports module includes details about the Transaction Reply Report.

1.12 Cancellations

Cancellations may be necessary in cases of mistaken enrollment made by an individual and/or mistaken disenrollment made by a member. Unless otherwise directed by CMS, an individual may cancel enrollment only by contacting the organization prior to the effective date of the enrollment.

Plans can cancel an individual's enrollment only if the beneficiary makes the request prior to the effective date of enrollment, unless otherwise directed by CMS.

1.13 Disenrollments from Plan (Slides 22-23)

Plans may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. The plan may contact members to determine the reason for disenrollment but not discourage members from disenrolling after member's request to disenroll. Voluntary disenrollments are disenrollments requested by the beneficiary.

In addition to beneficiary request for disenrollments, plans are required to disenroll members in certain cases, which are referred to as Involuntary Disenrollments. The plan must disenroll a member from the plan in the following cases:

- Change of Residence, for MA-PD plans, includes incarceration, makes the individual ineligible to remain enrolled in the plan
- Member loses entitlement to Medicare
- The member of a Special Needs Plan that exclusively serves special needs individuals loses special needs status
- The member dies
- The Plan contract terminates or the plan discontinues offering the plan in any portion of the area where the plan had previously been available
- Failure to pay premiums

1.13.1 Disenrollment

- All of the basic PDP requirements for voluntary and involuntary disenrollment procedures apply to dual-eligibles as appropriate with one exception. A PDP sponsor may disenroll a member who fails to pay premiums after a grace period and proper notice.

- For dual-eligibles, PDP sponsors have the option to retain dual eligible members when they fail to pay premiums even if the PDP sponsor has a policy to disenroll members for non-payment of premiums. The PDP sponsor has the discretion to offer this option to dual eligible individuals within each of its PDPs. If the PDP offers this option in one of its PDPs, it must apply the policy to all dual eligible individuals in that PDP.

- Also, if a Plan institutes a policy change, they must inform members of the change at least 30 days before the policy change occurs. Policy changes must be documented and available for CMS to review.

1.14 Plan to Beneficiary Communication (Slide 24)

Once the plan receives a Transaction Reply Report from CMS indicating whether CMS has accepted or rejected the individual's enrollment the plan must notify the individual in writing of CMS' rejection or acceptance of the enrollment within 10 calendar days of the availability of the weekly or monthly TRR, whichever contains the earliest notification.

1.15 Certification of Monthly Enrollment and Payment Data (Slides 25-26)

Plans must attest that the plan reported accurate enrollment and status information the Plan reported accurate information to CMS. Plans must report any discrepancies between its records and CMS' Monthly Membership Report (MMR), Weekly/Monthly Transaction Reply Reports (TRR) and Plan Payment Report (PPR).
Plans must certify enrollment records within 45 days of the date the monthly payment reports become available.

Example 6

Plan receives reports on Feb 22, 2008 – Certification is due by April 7, 2008.

The plan's Chief Executive Officer or Chief Financial Officer must sign the Certification document. CMS uses the certification data to ensure the plan is compliant in reconciling its membership records with CMS' records. CMS Regional Office (RO) receives certification reports monthly.

1.16 Notice Timeframes

Plans must adhere to timeframes when communicating with beneficiaries. The MA and PDP notifications that Plans send to beneficiaries and the timeframes in which Plans must send the notices are detailed in the CMS plan enrollment and disenrollment guidance applicable to the plan type. Table 1J and 1K provide the MA and PDP notice timeframes.

TABLE 1J – MA NOTICE TIMEFRAMES

NOTICE	REQUIRED?	TIMEFRAME
Model Enrollment Form	Yes	NA
Information to include on or with Enrollment Form -- Information to Determine Enrollment Periods	No	NA
MA MSA Enrollment Form	*Yes*	*NA*
EGHP Enrollment Form	No	NA
Short Enrollment Forms	No	NA
Acknowledgment of Receipt of Completed Enrollment Election	Yes	*10 calendar* days of receipt of completed enrollment election
Combination Acknowledgement and Confirmation Notice	Yes	*7 calendar* days of *receipt of* reply listing
L-OEP Enrollment Requests Into MA-Only Plans (other than PFFS)	*Yes*	*10 calendar days of receipt of enrollment request*
Acknowledge Receipt of Completed PFFS Enrollment Election	*Yes*	*10 calendar days of receipt of completed enrollment request*
Request for Information	No	*10 calendar days of receipt of enrollment request*
Medicare Prescription Drug Plan Individual Enrollment Form	Yes	NA
Optional information to include on or with Enrollment Form -- Information to Determine Enrollment Periods	No	NA
Acknowledge Receipt of Enrollment Request	Yes	10 calendar days of receipt of enrollment request
Acknowledge Receipt of Enrollment Request – Enrollment in another Plan Within the Same PDP Organization	Yes	10 calendar days of receipt of completed enrollment election
Acknowledge Receipt of Enrollment and Confirmation of Enrollment	Yes	7 calendar days of receipt of reply listing
Request for Information	No	NA
Confirmation of Enrollment	Yes	10 calendar days of monthly reply listing
Individuals Identified on CMS Records As Members of Employer/Union Receiving Employer Subsidy	Yes	10 calendar days of monthly reply listing
PDP Organization Denial of Enrollment	Yes	10 calendar days of denial determination

TABLE 1K – PDP NOTICE TIMEFRAMES

NOTICE	REQUIRED?	TIMEFRAME
Medicare Prescription Drug Plan Individual Enrollment Form	Yes	NA
Optional information to include on or with Enrollment Form -- Information to Determine Enrollment Periods	No	NA
Acknowledge Receipt of Enrollment Request	Yes	10 calendar days of receipt of enrollment request
Acknowledge Receipt of Enrollment Request – Enrollment in another Plan Within the Same PDP Organization	Yes	10 calendar days of receipt of completed enrollment election
Acknowledge Receipt of Enrollment and Confirmation of Enrollment	Yes	7 calendar days of receipt of reply listing
Request for Information	No	NA
Confirmation of Enrollment	Yes	10 calendar days of monthly reply listing
Individuals Identified on CMS Records As Members of Employer/Union Receiving Employer Subsidy	Yes	10 calendar days of monthly reply listing
PDP Organization Denial of Enrollment	Yes	10 calendar days of denial determination
CMS Rejection of Enrollment	Yes	10 calendar days of reply listing
Send Out Disenrollment Form/ Disenrollment Form	No	NA
Acknowledgement of Receipt of Voluntary Disenrollment Request from Member	Yes	10 calendar days of receipt of request to disenroll
Final Confirmation of Voluntary Disenrollment Identified Through Reply Listing	Yes	10 calendar days of reply listing
PDP Denial of Disenrollment	Yes	10 calendar days of denial determination
CMS Rejection of Disenrollment	Yes	10 calendar of reply listing
Disenrollment Due to Permanent Move (no exhibit)		Within 10 calendar days of learning of the permanent move and no later than before the disenrollment transaction is submitted to CMS
Disenrollment Due to Death	Yes	10 calendar days of reply listing
PDP Model Notice for auto-enrollments provided by CMS with recent deceased code	Yes	10 calendar days of reply listing
Disenrollment Due to Loss of Medicare Part A and/or Part B	Yes	10 calendar days of reply listing
Notices on Terminations/Nonrenewals	Yes	Follow requirements in 42 CFR 423.506 - 423.512
Advanced Warning of Potential Disenrollment Due to Disruptive Behavior	Yes	
Intent to request CMS' permission to disenroll the member	Yes	

TABLE 1K – PDP NOTICE TIMEFRAMES (CONTINUED)

NOTICE	REQUIRED?	TIMEFRAME
Confirmation of Disenrollment for Disruptive Behavior	Yes	Before disenrollment transaction submitted to CMS
Disenrollment for Fraud & Abuse	Yes	Before disenrollment transaction submitted to CMS
Offering Beneficiary Services,	Yes	10 calendar days of initial
Pending Correction of Erroneous Death Status		contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination	Yes	10 calendar days of initial contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination	Yes	10 calendar days of initial contact with member
Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another PDP Organization	Yes	10 calendar days of initial contact with member
Closing Out Request for Reinstatement	Yes	10 calendar days after information was due to organization
Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage	Yes	Within 10 calendar days after the 1st of the month for which delinquent premiums due
Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment	Yes	Before disenrollment transaction submitted to CMS
Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment	Yes	10 calendar days of reply listing
Acknowledgement of Request to Cancel Enrollment	Yes	10 calendar days of request
Acknowledgement of Request to Cancel Disenrollment	Yes	10 calendar days of request
Inform member of Auto-enrollment	Yes	10 calendar days of reply listing or address report, whichever is later
Inform member of Facilitated Enrollment	Yes	10 calendar days of reply listing or address report, whichever is later
Request to Decline Part D	Yes	10 calendar days of request
Auto-and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor Offers another PDP at or below the Low-Income Premium Subsidy Amount for that Region	No	10 calendar days of reply listing

TABLE 1K – PDP NOTICE TIMEFRAMES (CONTINUED)

NOTICE	REQUIRED?	TIMEFRAME
Auto and Facilitated Enrollees Who Permanently Reside in another Region Where PDP Sponsor Does Not offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region	Yes	10 calendar days of reply listing
Reassignment Confirmation	Yes	
Optional Notice for "Losing Plan" to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC)	No	
Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes	As necessary	10 calendar days of receipt of reply listing

MODULE 2 – ENROLLMENT PROCESSING AND MARx OVERVIEW

Purpose (Slide 2)

Plans must submit accurate and timely enrollment transactions to CMS for processing. This module describes the file layout for formatting enrollment transactions and how to submit those transactions to CMS. In addition, the module provides a basic understanding of the features of the current and future MARx systems.

Learning Objectives (Slide 3)

At the completion of this module, participants will:

- Explain steps to connect to CMS and transmit data
- Define the fields and functions of enrollment transactions
- Identify enrollment transaction processing requirements
- Describe characteristics of enrollment and eligibility User Interfaces

ICON KEY	
Example	
Reminder	
Resource	

2.1 Overview (Slide 4)

Plans begin the Enrollment Process by establishing an electronic connection with CMS through which to transmit enrollment data to and from CMS. A component of establishing connectivity is security. Security involves receiving approval to view or transmit enrollment data and obtaining the appropriate permissions for the user role and passwords to gain access to the systems. Once these tasks are complete, plans can process beneficiary applications for enrollment, disenrollment, and changes by verifying eligibility and submitting transactions using the appropriate naming conventions for the data files. Plans can then check the status of transactions or view beneficiary information related to enrollment and payment using the various screens in the User Interface.

2.2 Connectivity (Slide 5)

Connectivity refers to the electronic connection between the plan and CMS. Plans use the electronic connection to transmit enrollment information to CMS and receive information in return. Exchanging information with CMS can be accomplished using different tools and procedures and is dependant on a Plan's current capabilities and the volume of data to be exchanged.

Large Plans are identified as having 100,000 or more Plan members and must use a T1 line to the Medicare Data Communications Network (MDCN) and Connect:Direct software to facilitate the exchange of data. Information transmitted using this connection is transferred from mainframe to mainframe.

Small Plans are Plans with less than 100,000 Plan members and can connect using the same connectivity as large plans (typically cost-prohibitive). Small plans can also connect using the Internet Gentran Server and Connect:Enterprise client from Sterling Commerce or a secure Web page (HTTPS – HyperTextTransfer Protocol Secure) to exchange data with CMS. The Connect:Enterprise client implements the secure file transfer protocol (SFTP) to accomplish the file transfer.

The process of connecting plans to CMS data systems involves five stages. Table 2A defines the five stages.

TABLE 2A – STAGES FOR CONNECTING TO CMS SYSTEMS

STAGE OF CONNECTION	DESCRIPTION
1. Getting Started	• Obtain a Contract Number • Enter connectivity data into HPMS Plan Connectivity Data Module
2. Security and Access	• Submit External Point of Contact (EPOC) designation letter • Register EPOC in Individual Access to CMS Systems (IACS) • Register user/submitters and user/representatives for enrollment, 4Rx, BEQ, and Electronic Correspondence Referral System (ECRS) • Register user/submitters for PDE/RAPS
3. Connectivity Set-up	• Select connection option and set up - Set up T1/Connect:Direct to CMS - Set up Gentran Access
4. Connectivity Testing	• Test selected connection option - Test T1/Connect:Direct to CMS - Test Gentran
5. Application Testing	• MMA Help Desk initiates contact with contracts to schedule transmission of test files.

There are several tools or resources available from CMS and the Medicare Modernization Act Help Desk (www.cms.hhs.gov/mmahelp) to assist plans in working through the five stages to establish and gain user access to the Individual Access to CMS Systems (IACS).

📖 MMA Help Desk New Medicare Advantage and Prescription Drug Plan Connectivity and Access Configuration Process, Version 1.3 (April 24, 2008) available at http://www.cms.hhs.gov/MMAHelp/downloads/connectivity_access_configuration%20_04242008.pdf

📖 MMA Help Desk New Medicare Advantage and Prescription Drug Plan Connectivity and Access Configuration Process, Version 1.3 (April 24, 2008), Appendix B Plan Connectivity Checklist available at http://www.cms.hhs.gov/MMAHelp/downloads/connectivity_access_configuration%20_04242008.pdf

📖 Individuals Authorized Access to CMS Computer Services (IACS) User Guide, Version 8.1 (April 2007) http://www.cms.hhs.gov/MMAHelp/downloads/IACS_UserGuide_8.1.pdf

2.2.1 Security (Slide 6)

Anyone with access to CMS Computer Systems containing sensitive information **must** abide by the Rules of Behavior or the individual will lose access to the account.

It is imperative that users review the IACS User Guide to get a clear understanding of the security requirements and expectations of CMS regarding access to CMS systems.

http://www.cms.hhs.gov/MMAHelp/downloads/IACS_UserGuide_8.1.pdf

Below are reminders of the security requirements. However, this list is not all-inclusive. CMS does not permit:

- Disclosure or lending of identification numbers (UserID) and passwords to another individual. UserIDs are for an individual's use only and serves as that individual's electronic signature. This means that CMS can hold the individual responsible for the consequences of unauthorized or illegal transactions.
- Browsing or use of CMS data files for unauthorized or illegal purposes
- CMS data files for private gain
- Misrepresentation of oneself or CMS
- Disclosure of CMS data that is not specifically authorized
- Duplication of CMS data files, creation of sub-files of such records, removal, or transmission of data unless specifically authorized

2.3 Enrollment Transaction Processing (Slides 7-8)

Enrollment transaction processing records each individual beneficiary's plan enrollment and calculates the payments to plans for providing coverage to beneficiaries who are enrolled in the contracts including Part C, Part D, Cost plans, and other Medicare Health Plans. Part C contracts are Medicare Advantage Managed Care Plans that provide Part A and B benefits for beneficiaries. Part D contracts provide drug coverage for beneficiaries who may also enroll in either fee-for-service (Original Medicare) or in some health plans. A contract may provide services under both Parts C and D. A contract may offer several Plan Benefit Packages (PBPs) with different levels of coverage.

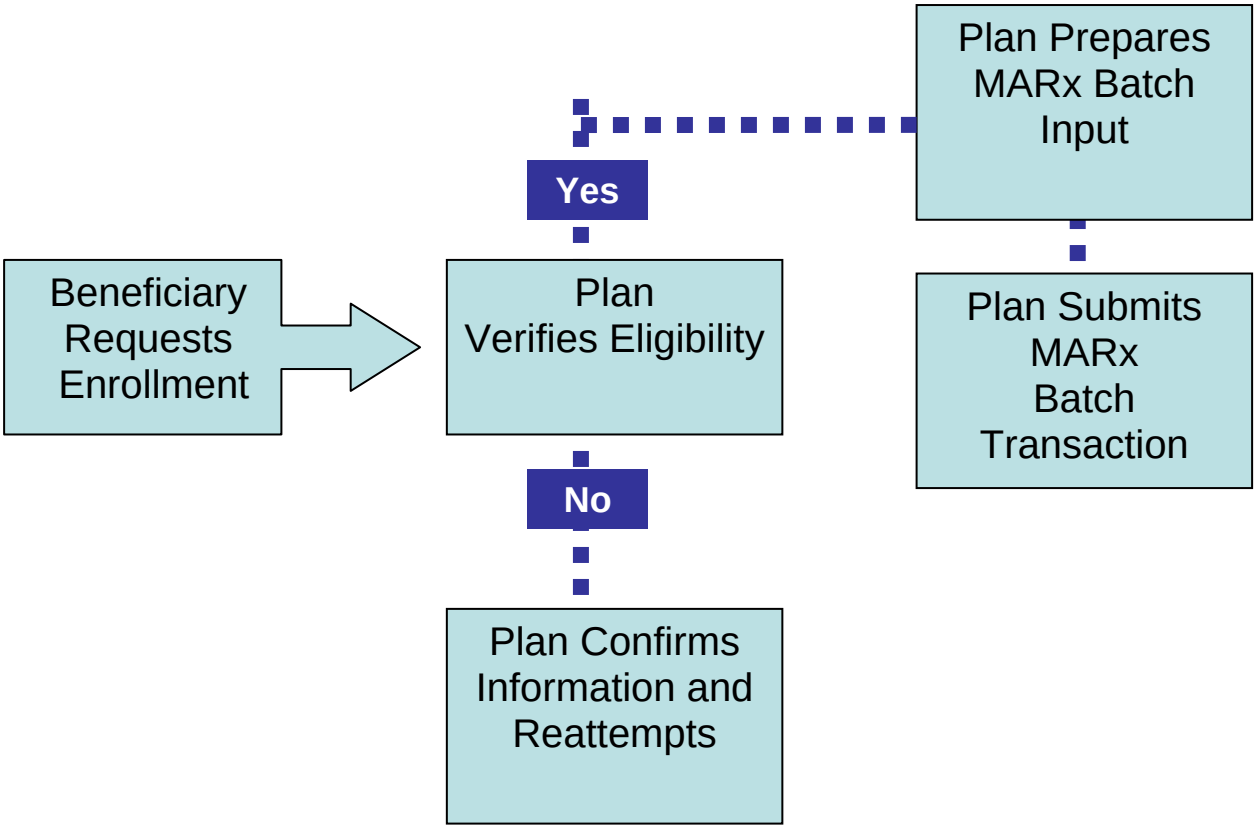
Plan interactions with the enrollment processing system fall into the following two categories:

1. Exchanging of files in which plans submit transactions in batch files to MARx. In response, MARx generates transaction reports to provide the plan with details concerning the processing status of the transactions.

2. Online access through a Web-based user interface in which plans query the enrollment processing system via an entry point called the CMS Applications Portal at: https://applications.cms.hhs.gov. The CMS Applications Portal allows the user to view enrollment, payment, premium, and beneficiary information from the Common User Interface (UI) system.

Figure 2A illustrates the sequence of events on the part of the plan in enrolling a beneficiary.

Figure 2A – Plan Process for Enrollments



CMS established standard naming conventions for data files and reports for communicating electronically. These naming conventions are for communication both to and from CMS. Table 2B identifies the naming conventions required for the Eligibility and Enrollment Transactions and the key to the naming convention components. The key defines each character, number, or file type in the naming conventions.

TABLE 2B – ELIGIBILITY AND ENROLLMENT TRANSACTION NAMING CONVENTIONS

TRANSACTION NAME	NAMING CONVENTION
BEQ Request File	**Gentran mailbox:** [GUID].[RACFID].MBD.D.xxxxx.BEQ.[P/T][.ZIP] **Connect:Direct:** P#EFT.IN.PLxxxxx.BEQ4RX.DYYMMDD.THHMMSST Note: DYYMMDD.THHMMSST must be coded as shown, as it is a literal
BEQ Response File	**Gentran mailbox:** P.Rxxxxx.#BQN4.Dyymmdd.Thhmmsst.pn **Connect:Direct [Mainframe]:** zzzzzzzz.Rxxxxx.#BQN4.Dyymmdd.Thhmmsst **Connect:Direct [Non-mainframe]:** [directory]Rxxxxx.#BQN4.Dyymmdd.Thhmmsst
MARx Batch Input Transaction Data File • Enrollment Transaction (60/61/62) • Disenrollment Transaction (51/54) • Plan Elections (PBP Change) Transaction (71) • Plan Change Transaction (72) • Correction (01) • Part D Opt-Out (41)	**Gentran mailbox:** [GUID].[RACFID].MARX.D.xxxxx.FUTURE.[P/T][.ZIP] Note: FUTURE is part of the filename and does not change. **Connect:Direct:** P#EFT.IN.uuuuuuu.MARXTR.DYYMMDD.THHMMSST Note: DYYMMDD.THHMMSST must be coded as shown, as it is a literal

DATASET NAMING CONVENTIONS KEY	
[GUID]	7 character IACS User ID P = Production Data
[RACFID]	Four-character RACF user ID. **Note**: If a RACF ID was not assigned, insert NONE.
[.ZIP]	Appended if the file is compressed
[directory]	Optional directory specification from non-mainframe C:D clients (if present, may consist of up to 60 characters). If none exists, directory defaults to the constant "EFTO." for Production files and "EFTT." for Test files.
pn	Processing number of varying length assigned to the file by Gentran
ccccc	Contract number
Pccccc	Plan Contract Number for C:D
Uuuu-uuuuuuu	4-7 character transmitter RACF ID
xxxxx	5 character Contract ID
yyyymmdd	Calendar year, month & day
yymmdd	Two digit year, month, day
zzzzzzzz	Plan-provided high level qualifier
eeee	Year for which final yearly RAS file was produced
vvvvv	Sequence counter for final yearly RAS files
Annnnn & Bnnnnn	MARx batch transaction ID, nnnnnnnnnn split into two nodes A…and B …with leading zeroes as necessary to complete ten-character batch ID
hhmm	Hour and minute
ssssss	Sequentially assigned number
mmyyyy	Calendar month & year hlq = High Level Qualifier or Directory per VSAM File freq = Frequency code of file

Plan Communications User' Guide, Version 3.1 (April 18, 2008), Appendix J - All Transmission Overview available at http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp#TopOfPage

CMS MMA Transmissions to and from Medicare Advantage and Prescription Drug Plans, Version 15 (April 18, 2008) available at http://www.cms.hhs.gov/mmahelp/downloads/Transmissions_Inventory_v15_20080418.pdf

Using the naming conventions, plans can transmit the appropriate data files based on the phase of the process.

2.3.1 Beneficiary Eligibility Verification (Slide 9)

Plans receive an enrollment request via phone, mail, or internet. Plans then inform the beneficiary that they are in receipt of the request.

The plan submits a Batch Eligibility Query (BEQ) to CMS to determine the beneficiary's eligibility. The BEQ provides a vehicle for plans, regardless of type or size, to submit batches of queries for individuals in order to obtain verification of eligibility, timely prescription drug program eligibility determination, Low Income Subsidy (LIS) information, and past drug coverage period information.

Each Detail Record on the BEQ Request file should identify a **prospective** or **current** plan enrollee. Plans **may not submit** a BEQ for individuals who have not requested consideration for enrollment.

Plans may submit multiple BEQ request files to CMS during any CMS business day (Monday-Friday) via Connect: Direct (NDM) or the Sterling Electronic Mailbox (Gentran).

MARx processes plan transactions as they are received and there is no minimum or maximum limit to the number of BEQ Request Transactions that may be submitted in a day. CMS Systems recognize BEQ Request Files by the information supplied in the Header and Trailer Records of the data file.

BEQ Response Files are not time-stamped; therefore, plans should process these files immediately upon receipt.

The plan receives an email notification informing them if the request is accepted or rejected. Figures 2B and 2C illustrate examples of email notifications for acceptance and rejection of BEQ requests.

Figure 2B – Example of BEQ Request File "Pass" Acknowledgment

TO: Jim.Doe@xxs.net

TO: Chris.Doe@dxxx.org

TO: Falcon.Doe@xxxx.org

TO: eevs.helpdesk@ngc.com

FROM: MBD#BQ94.HCFJES@cms.hhs.gov

Subject: CMS MMA DATA EXCHANGE FOR MMABTCH

MMABTCH file has been received and passed surface edits by CMS.

QUESTIONS? Contact 1-800-927-8069 or Email mmahelp@cms.hhs.gov

INPUT HEADER RECORD

MMABEQRHS0094 20070306F20070306

INPUT TRAILER RECORD
MMABEQRTS0094 20070306F200703060000074

Figure 2C – Example of BEQ Request File "Fail" Acknowledgment

TO: Jim.Doe@xxs.net

TO: Chris.Doe@dxxx.org

TO: Falcon.Doe@xxxx.org

TO: eevs.helpdesk@ngc.com

FROM: MBD#BQ30.HCFJES@cms.hhs.gov

Subject: CMS MMA DATA EXCHANGE FOR MMABTCH

MMABTCH file has been received and failed surface edits by CMS.

QUESTIONS? Contact 1-800-927-8069 or Email mmahelp@cms.hhs.gov

INPUT HEADER RECORD

MMABEQRHH0030 20070228 84433346

INPUT TRAILER RECORD

MMABEQRTH0030 20070221 844333460074065

THE TRAILER RECORD IS INVALID THE TRAILER RECORD IS INVALID

If accepted, plans receive a BEQ Response File. If the email notification indicates the BEQ rejected, the plan will not receive a BEQ Response File.

Once the plan receives, the BEQ Response file indicating the beneficiary's eligibility to enroll, the plan can then submit the enrollment transaction to CMS. If the enrollment transaction fails, the plan receives a Failed Transaction Data File (FTR) detailing transactions that cannot load into MARx for processing due to formatting errors and did not meet basic file validation.

Accepted, rejected, and pending enrollment transactions are reported to the plan on the Batch Completion Status Summary (BCSS) Report and the Weekly Transaction Reply Report (TRR). MARx updates enrollments and payments on a daily basis. MARx notifies plans of enrollment and payment information on reports as part of the month-end processing.

The format for each record layout is organized into three levels:

- Header level information, which identifies the submitter
- Detail level information, which identifies the beneficiary and describes the transaction type
- Trailer level information, which identifies the submitter and tracking information for the data file

Each record in the file is 750 bytes in length.

2.3.1.1 Beneficiary Eligibility Query (BEQ) Request File

2.3.1.1.1 Header Record

The header record is the first record in the file.

The file header contains four fields and one filler field. Table 2C provides an overview of the header fields. The four fields are critical for the submission of this file.

TABLE 2C – FILE HEADER INFORMATION

FIELD NAME	VALUE
File ID Name	'MMABEQRH' This field should always be set to this value. The RH in the File ID stands for Record Header.
Sending Entity (CMS)	Sending Organization Left justified and space filled
File Creation Date	YYYYMMDD The date on which the BEQ Request File was created by the Sending Entity.
File Control Number	Assigned by Sending Entity CMS will pass this information back to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File, which allows the plan to track the detail records within the data file.

2.3.1.1.2 Detail Record Fields

There is no limit to the number of transactions within the file and plans can submit multiple files in a business day. This section reviews data elements within the detail records. Fields may be populated with dates, alpha or alpha-numeric values, or intentionally left blank. However, a blank field has meaning to the system when it is processing the transactions.

The first field in the detail record is the Record Type. Plans must populate this field with 'DTL01'. This informs the system that this is a Batch Eligibility Query Transaction

2.3.1.1.2.1 Beneficiary Identifiers

After the Record Type, several fields identify the beneficiary that the plan wishes to obtain enrollment verification for. The following data elements identify the beneficiary:

- HICN or RRB Number
- Social Security Number
- Patient Birth Date (YYYYMMDD)
- Patient Gender

The HICN is a Medicare beneficiary's identification number. Both Social Security Administration (SSA) and the Railroad Retirement Board (RRB) issue Medicare HICNs. The format of a HICN issued by SSA is a Social Security number followed by an alpha or alpha-numeric Beneficiary Identification Code (BIC). RRB numbers issued before 1964 are 6-digit numbers preceded with an alpha prefix. After 1964, the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha prefix. Table 2D illustrates the HIC# structure.

TABLE 2D – HIC# STRUCTURE

HICN TYPE	CHARACTERISTICS
CMS	• 9-digit Social Security number • alpha suffix - "A" beneficiary - "B" spouse - "C" children - "D" divorced spouse, widow, widower • alpha-numeric suffix - indicates type of dependent
RRB pre-1964	• alpha prefix • 6-digit random numbers
RRB post-1964	• alpha prefix • 9-digit Social Security number

The BIC indicates the type of benefits that a beneficiary is entitled. These letter codes may appear on correspondence that individuals receive from Social Security or on a Medicare card. The BIC will never appear on a Social Security number card. Table 2E provides a list of common BICs from the SSA website.

TABLE 2E – COMMON BENEFICIARY IDENTIFICATION CODES

CODE	IDENTFICATION	CODE	IDENTIFICATION
A	Primary claimant (wage earner)	E5	Surviving Divorced Father
B	Aged wife, age 62 or over	F1	Father
B1	Aged husband, age 62 or over	F2	Mother
B2	Young wife, with a child in her care	F3	Stepfather
B3	Aged wife, age 62 or over, second claimant	F4	Stepmother
B5	Young wife, with a child in her care, second claimant	F5	Adopting Father
B6	Divorced wife, age 62 or over	F6	Adopting Mother
BY	Young husband, with a child in his care	HA	Disabled claimant (wage earner)
C1-C9	Child - Includes minor, student or disabled child	M	Uninsured – Premium Health Insurance Benefits (Part A)
D	Aged Widow, age 60 or over	M1	Uninsured - Qualified for but refused Health Insurance Benefits (Part A)
D1	Aged widower, age 60 or over	T	Uninsured - Entitled to HIB (Part A) under deemed or renal provisions; or Fully insured who have elected entitlement only to HIB
D2	Aged widow (2nd claimant)	TA	Medicare Qualified Government Employment (MQGE)
D3	Aged widower (2nd claimant)	TB	MQGE aged spouse
D6	Surviving Divorced Wife	W	Disabled Widow
E	Widowed Mother	W1	Disabled Widower
E1	Surviving Divorced Mother	W6	Disabled Surviving Divorced Wife
E4	Widowed Father		

NOTE: This list is not complete, but shows the most common beneficiary identification codes.

📖 Social Security Administration website provides Beneficiary Identification Codes www.ssa.gov.

2.3.1.1.2.2 Detail Record Sequence Number

The Detail Record Sequence Number is a seven digit number unique within the request file. The sending entity assigns a number to each record to track the progress of the processing of the record.

2.3.1.1.3 Trailer Record

The trailer record is similar to the header record for the BEQ Request File. There is one additional field, which is the Record Count. The Record Count indicates how many detail records are within the file and must be a numeric value greater than zero.

In addition, the File ID Name ends, in 'RT' for Record Trailer instead of 'RH'.

Table 2F provides the record layout for the BEQ Request File.

TABLE 2F – BATCH ELIGIBILITY QUERY (BEQ) REQUEST FILE

Header Record

Data Field	Size	Position	Format	Valid Values	Field Definition
File ID Name	8	1 …. 8	X(8)	'MMABEQRH'	Critical Field This field should always be set to the value 'MMABEQRH'. This code identifies the file as a Batch Eligibility Query (BEQ) Request File and this record as the Header Record of the file.
Sending Entity (CMS)	8	9 … 16	X(8)	Sending Organization (left justified space filled) Acceptable Values: 5-position Contract Identifier +3 Spaces (3 Spaces are for Future Use)	Critical Field This field provides CMS with the Identification of the entity that is sending the BEQ Request File. The value for this field will be provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Trailer Record. The Sending Entity may be a Part D Organization.
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	Critical Field The date on which the BEQ Request File was created by the Sending Entity. This value should be formulated as YYYYMMDD. For example, January 3, 2010 would be the value 2010003. This value should agree with the corresponding value in the Trailer Record. CMS will pass this information back to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity	Critical Field The specific Control Number assigned by the Sending Entity to the BEQ Request File. CMS will pass this information back to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Trailer Record.
Filler	717	34 … 750	X(717)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.

TABLE 2F – BATCH ELIGIBILITY QUERY (BEQ) REQUEST FILE (CONTINUED)

Detail Record (Transaction)

Data Field	Size	Position	Format	Valid Values	Field Definition
Record Type	5	1 … 5	X(5)	"DTL01" = Batch Eligibility Query Transaction Note: The value above is DTL-zero-one.	Critical Field This field should be set to the value "DTL01", which indicates that this detail record is a Batch Eligibility Query Transaction. This code identifies the record as a detail record to be processed specifically for Batch Eligibility Query Service.
HICN/RRB Number	12	6 … 17	X(12)	Health Insurance Claim Number or Railroad Retirement Board Number	Critical Field: This is a required field, if the SSN is not provided. This field provides either the Health Insurance Claim Number or the Railroad Retirement Board Number for identification of the individual. The Plan should provide either the HICN or the RRB Number, whichever the Plan has available and active for the individual. The value should be left justified in the field. The value should not include dashes, decimals or commas.
SSN	9	18 … 26	X(9)	Social Security Number. Nine-Byte Numeric	Critical Field: This is a required field, if the HICN/RRB is not provided. The Social Security Number for the individual. The value should include only numbers. The value should not include dashes, decimals or commas.
Date of Birth (DOB)	8	27 … 34	X(8)	YYYYMMDD	Critical Field The date of birth of the individual. The value should be formatted as YYYYMMDD. The value should not include dashes, decimals or commas. The value should include only numbers.
Gender Code	1	35 … 35	X(1)	0 (Zero) = Unknown; 1 = Male 2 = Female	Not Critical Field The gender of the individual. The acceptable values include 0 (Zero) = Unknown, 1 = Male, 2 = Female
Detail Record Sequence Number	7	36 … 42	9(7)	Seven-byte number unique within the Batch Eligibility Query Request File	Critical Field A unique number assigned by the Sending Entry to the Transaction (Detail Record). This number should uniquely identify the Transactions (Detail Record) within the Batch Eligibility Query Request File.
Filler	708	43 … 750	X(708)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.

TABLE 2F – BATCH ELIGIBILITY QUERY (BEQ) REQUEST FILE (CONTINUED)

Trailer Record

Data Field	Size	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"MMABEQRT"	Critical Field This field should always be set to the value "MMABEQRT". This code identifies the record as the Trailer Record of a BEQ Request File.
Sending Entity (CMS)	8	9 … 16	X(8)	Sending Organization (left justified space filled) Acceptable Values: 5-position Contract Identifier +3 Spaces (3 Spaces are for Future Use)	Critical Field This field provides CMS with the identification of the entity that is sending the BEQ Request File. The value for this field will be provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Header Record. The Sending Entity may be a Part D Organization.
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	Critical Field The date on which the BEQ Request File was created by the Sending Entity. This value should be formulated as YYYYMMDD. For example, January 3 2010 would be the value 20100103. This value should agree with the corresponding value in the Header Record. CMS will pass this information back to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity	Critical Field The specific Control Number assigned by the Sending Entity to the BEQ Request File. CMS will pass this information back to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Header Record.
Record Count	7	34 … 40	9(7)	Numeric value greater than Zero.	Critical Field The total number of Transactions (Detail Records) supplied on the BEQ Request File. This value should be right justified in the field, with leading zeros. This value should not include non-numeric characters, such as commas, spaces, dashes, decimals.
Filler	710	41 … 750	X(710)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.

2.3.1.2 Beneficiary Eligibility Query (BEQ) Response File

The BEQ Response File, like the Request file, is 750 bites and comprised of three levels: header record, detail record, and trailer record.

2.3.1.2.1 Header Record

The header record is the first record in the file.

The Sending Entity in the header record is CMS instead of the organization and the File ID Name is 'CMSBEQRH' instead of 'MMABEQRH'. The Creation Date changes to the date that CMS generates the Response File instead of the date of the Request File.

2.3.1.2.2 Detail Record

In the Response File, the complete Detail Record that was submitted in the Request File is included as part of the Response transaction. This allows the sequence number to be included for the plan to track the response to each request transaction.

2.3.1.2.2.1 Flags

The detail record contains flags about the status of the transaction and the beneficiary. Table 2G describes these flags.

TABLE 2G – FLAGS

FIELD NAME	DESCRIPTION
Processed Flag	Indicates if the Transaction (Detail Record) was accepted for processing. A Transaction will be accepted for processing if all critical fields contain valid values.
Beneficiary Match Flag	A flag that indicates whether the beneficiary in the Transaction (Detail Record) was successfully matched (located) to a beneficiary on the CMS Medicare Beneficiary Database (MBD).

2.3.1.2.2.2 Medicare Entitlement and Medicaid

The detail record contains start and end dates for Medicare Entitlement for Part A and Part B, and enrollment and disenrollment dates for Part D. In addition, there is the Medicaid Indicator for beneficiaries if applicable.

2.3.1.2.2.3 Part D Fields

There are several Part D fields in the detail record in which CMS provides information about the beneficiary to the plan. The detail record is designed to allow for multiple occurrences of the data that populates these fields. Table 2H identifies these fields.

TABLE 2H – PART D FIELDS

FIELD NAME	NUMBER OF OCCURANCES
Part D Enrollment Effective Date/Employer Subsidy Enrollment Start Date	10
Disenrollment Date/Employer Subsidy End Date	10
Part D Eligibility Start Date	1
Deemed LIS Effective Date	2
Deemed LIS End Date	2
Co-Payment Level Identifier	2
Part D Premium Subsidy Percent	2
Retiree Drug Subsidy (RDS)/Part D Indicator	10
Start Date	20
Number of Uncovered Months	20
Number of Uncovered Months Status Indicator	20
Total Number of Uncovered Months	20

2.3.1.2.3 Trailer Record

The trailer record is similar to the trailer record in the Request File. The File ID Name changes slightly to indicate the file is from CMS instead of the plan, the majority of the fields contain the same data as in the header. However, the Record Count is of the number of records returned in the Response File. This number may differ from the Trailer Record count in the BEQ Request File. Table 2I provides the record layout for the BEQ Response File.

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE

Header Record

Data Field	Size	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	'CMSBEQRH'	This field will always be set to the value 'CMSBEQRH'. This code identifies the record as the header Record of a BEQ Response File.
Sending Entity (MBD)	8	9 … 16	X(8)	'MBD ' (MBD + 5 spaces)	This field will always be set to the value "MBD ". The value specifically is MBD + 5 following Spaces. This value will agree with the corresponding value in the Trailer Record.
File Creation Date	8	17 … 24	X(8)	CCYYMMDD	The date on which the BEQ Response File was created by CMS. This value will be in the format of CCYYMMDD. For example, January 3, 2010 would be the value 20100103. This value will agree with the corresponding value in the Trailer Record.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity (MBD)	The specific Control Number assigned by CMS to the BEQ Response File. CMS will utilize this value to track the BEQ Response File through CMS processing and archive. This value will agree with the corresponding value in the Trailer Record.
Filler	717	34 … 750	X(717)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Detail Record (Transaction)

Data Field	Size	Position	Format	Valid Values	Field Definition
Record Type	3	1 … 3	X(3)	"DTL"	This field will be set to the value "DTL", which indicates that this is a detail record.
Original Detail Record	42	4 … 45	X(42)	The first 42 positions of the original Transaction (Detail Record)	This field provides the meaningfully populated area of the BEQ Request File Transaction (Detail Record) provided by the Sending Entity. Here is the breakdown. • Record Type X(95) position 4 … 8 • Bene, HICN / RRB # X(12) position 9 … 20 • Beneficiary SSN X(9) position 21 … 29 • Beneficiary DOB X(8) position 30 … 37 • Beneficiary Gender Code X(1) position 38 … 38 • Detail Record Sequence #9(7) position 39 … 45
Processed Flag	1	46 … 46	X(1)	"Y" = The detail record was accepted for processing "N" = The detail record was not accepted for processing	A flag that indicates if the Transaction (Detail Record) was accepted for processing. A Transaction will be accepted for processing if all critical fields contain valid values.
Beneficiary Match Flag	1	47 … 47	X(1)	"Y" = The beneficiary was matched (located) successfully. "N" = The beneficiary was not matched (located) successfully. " " (SPACE) = Beneficiary Match was not attempted due to an invalid condition in the Transaction (Detail Record)	A flag that indicates whether the beneficiary in the Transaction (Detail Record) was successfully matched (located) to a beneficiary on the CMS Medicare Beneficiary Database (MBD).
Medicare Part A Entitlement Start Date	8	48 … 55	X(8)	CCYYMMDD Spaces = Not currently enrolled or Data Not Found.	The Entitlement Start Date of the beneficiary's most recent or active Medicare Part A entitlement period.
Medicare Part A Entitlement End Date	8	56 … 63	X(8)	CCYYMMDD Spaces = Not currently Enrolled or Data Not Found	The Entitlement End Date of the beneficiary's most recent or active Medicare Part A entitlement period.
Medicare Part B Entitlement Start Date	8	64 … 71	X(8)	CCYYMMDD Spaces = Not currently enrolled or Data Not Found	The Entitlement Start Date of the beneficiary's most recent or active Medicare Part B entitlement period.

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Medicare Part B Entitlement End Date	8	72 … 79	X(8)	CCYYMMDD Spaces = Not currently enrolled or Data Not Found.	The Entitlement End Date of the beneficiary's most recent or active Medicare Part B entitlement period.
Medicaid Indicator	1	80 … 80	X(1)	"0" = The beneficiary has no current or active Medicaid coverage; "1" = The beneficiary has current or active Medicaid coverage.	An indicator of the presence of current Medicaid coverage for the beneficiary. The value for this field is based upon the presence of Medicaid reported for the beneficiary by states in the previous calendar month via the MMA State Files.
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 1)	8	81 … 88	X(8)	CCYYMMDD Spaces = No Drug coverage period for this occurrence or Data Not found.	Effective start date of the Part D Plan or the Start Date of the Employer Subsidy coverage for the beneficiary (most recent or presently active).
Part D disenrollment Date/Employer subsidy End Date (Occurrence 1)	8	89 … 96	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (most recent or presently active).
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 2)	8	97 … 104	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (second most recent).
Part D Disenrollment Date/Employer Subsidy End Date (Occurrence 2)	8	105 … 112	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (second most recent).
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 2)	8	113 … 120	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (third most recent).
Part D Disenrollment Date/Employer Subsidy End Date (Occurrence 3)	8	121 … 128	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (third most recent).

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 4)	8	129 … 136	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (fourth most recent).
Part D Disenrollment Date/Employer Subsidy End Date (Occurrence 4)	8	137 … 144	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (fourth most recent).
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 5)	8	145 … 152	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (fifth most recent).
Part D Disenrollment Effective Date/Employer Subsidy Start Date (Occurrence 5)	8	153 … 160	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment start date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (fifth most recent).
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 6)	8	161 … 168	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (sixth most recent).
Part D Disenrollment Effective Date/Employer Subsidy Start Date (Occurrence 6)	8	169 … 176	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (sixth most recent).
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 7)	8	177 … 184	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (seventh most recent).
Part D Disenrollment Effective Date/Employer Subsidy Start Date (Occurrence 7)	8	185 … 192	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (seventh most recent).

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 8)	8	193 … 200	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (eighth most recent).
Part D Disenrollment Effective Date/Employer Subsidy Start Date (Occurrence 8)	8	201 … 208	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (eighth most recent).
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 9)	8	209 … 216	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (ninth most recent).
Part D Disenrollment Effective Date/Employer Subsidy Start Date (Occurrence 9)	8	217 … 224	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (ninth most recent).
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 10)	8	225 … 232	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (tenth most recent).
Part D Disenrollment Effective Date/Employer Subsidy Start Date (Occurrence 10)	8	233 … 240	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (tenth most recent).
Sending Entity	8	241 … 248	X(8)	Sending Part D Organization (left justified space filled) Acceptable Values: 5-position Contract Identifier + 3 Spaces (3 Spaces are for Future Use)	The Sending Entity provided on the Header Record of the BEQ Request File in which the Transaction (Detail Record was found. The Sending Entity may be a Part D Organization.

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
File Control Number	9	249 … 257	X(9)	Assigned by Sending Entity	The File Control Number provided by the Sending Entity on the Header record of the BEQ Request File in which the Transaction (Detail Record) was found.
File Creation Date	8	258 … 265	X(8)	CCYYMMDD	The File Creation Date provided on the Header Record of the BEQ Request File in which the Transaction (Detail Record) was found.
Part D Eligibility Start Date	8	266 … 273	X(8)	CCYYMMDD	This field identifies the date the beneficiary became eligible for Part D benefits.
Deemed / Low Income Subsidy Effective Date (Occurrence 1)	8	274 … 281	X(8)	CCYYMMDD	Effective start date of the deeming period or Low Income Subsidy. This will be the first day of the month in which the deeming was made or the start date of the Low Income Subsidy (most recent or presently active).
Deemed / Low Income Subsidy End Date (Occurrence 1)	8	282 … 289	X(8)	CCYYMMDD	The end date of the Deemed period or Low Income Subsidy (most recent or presently active.
Co-payment Level Identifier (Occurrence 1)	1	290 … 290	X(1)	Deemed: 2006 Values 1 – High ($2/$5) 2 – Low ($1/$3) 3 – Zero (no co-pay) 5 – Unknown LIS 2006 Values: 1 – High ($2/$5) 4 – 15%	This field indicates the co-payment level for the beneficiary.
Part D Premium Subsidy Percent (Occurrence 1)	3	291 … 293	X(3)	‘100’, ‘075’, ‘050’, ‘025’, or ‘000’	If beneficiary is Deemed, subsidy is 100 percent. If beneficiary is LIS, this field identifies the portion of Part D premium subsidized.
Deemed / Low Income subsidy Effective Date (Occurrence 2)	8	294 … 301	X(8)	CCYYMMDD	Effective start date of the deeming period or Low Income Subsidy. This will be the first day of the month in which the deeming was made or the start date of the Low Income Subsidy (second most recent).
Deemed / Low Income Subsidy End Date (Occurrence 2)	8	302 … 309	X(8)	CCYYMMDD	The end date of the Deemed period or Low Income Subsidy (second most recent).

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Co-payment Level Identifier (Occurrence 2)	1	310 … 310	X(1)	Deemed: 2006 Values 1 – High ($2/$5) 2 – Low ($1/$3) 3 – Zero (no co-pay) 5 – Unknown LIS 2006 Values: 1 – High ($2/$5) 4 – 15%	This field indicates the Co-payment level for the beneficiary.
Part D Premium Subsidy Percent (Occurrence 2)	3	311 … 313	X(3)	'100', '075', '050', '025', or '000'	If beneficiary is Deemed, subsidy is 100 percent. If beneficiary is LIS, this field identifies the portion of Part D Premium subsidized.
RDS/Part D Indicator (Occurrence 1 for date fields beginning in position 81)	1	314 … 314	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 2 for date fields beginning in position 97)	1	315 … 315	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 3 for date fields beginning in position 113)	1	316 … 316	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 4 for date fields beginning in position 129)	1	317 … 317	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 5 for date fields beginning in position 145)	1	318 … 318	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 6 for date fields beginning in position 161)	1	319 … 319	X(1)	R = RDS D = Part D	

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
RDS/Part D Indicator (Occurrence 7 for date fields beginning in position 177)	1	320 … 320	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 8 for date fields beginning in position 193)	1	321 … 321	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 9 for date fields beginning in position 209)	1	322 … 322	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 10 for date fields beginning in position 225)	1	323 … 323	X(1)	R = RDS D = Part D	
Start Date (Occurrence 1)	8	324 … 331	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 1)	3	332 … 334	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 1)	1	335 … 335	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 1)	3	336… 338	9(3)		Right justified with leading zeros.
Start Date (Occurrence 2)	8	339 … 346	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 2)	3	347 … 349	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 2)	1	350 … 350	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 2)	3	351 … 353	9(3)		Right justified with leading zeros.

TABLE 2I– BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Start Date (Occurrence 3)	8	354 … 361	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 3)	3	362 … 364	9(3)		Right justified with leading zeros
Number of Uncovered Months Status Indicator (Occurrence 3)	1	365 … 365	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 3)	3	366 … 368	9(3)		Right justified with leading zeros.
Start Date (Occurrence 4)	8	369 … 376	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 4)	3	377 … 379	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 4)	1	380 …380	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 4)	3	381 … 383	9(3)		Right justified with leading zeros.
Start Date (Occurrence 5)	8	384 … 391	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 5)	3	392 … 394	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 5)	1	395 … 395	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 5)	3	396 … 398	9(3)		Right justified with leading zeros.
Start Date (Occurrence 6)	8	399 … 406	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 6)	3	407 … 409	9(3)		Right justified with leading zeros.

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Number of Uncovered Months Status Indicator (Occurrence 6)	1	410 … 410	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 6	3	411 … 413	9(3)		Right justified with leading zeros.
Start Date (Occurrence 7)	8	414 … 421	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 7)	3	422 … 424	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 7)	1	425 … 425	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 7)	3	426 … 428	9(3)		Right justified with leading zeros.
Start Date (Occurrence 8)	8	429 … 436	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 8)	3	437 … 439	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 8)	1	440 … 440	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 8)	3	441 … 443	9(3)		Right justified with leading zeros.
Start Date (Occurrence 9)	8	444 … 451	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 9)	3	452 … 454	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 9)	1	455 … 455	X(1)		Right justified with leading zeros.

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Total Number of Uncovered Months (Occurrence 9)	3	456 … 458	9(3)		Right justified with leading zeros.
Start Date (Occurrence 10	8	459 … 466	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 10)	3	467 … 469	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 10)	1	470 … 470	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 10)	3	471 … 473	9(3)		Right justified with leading zeros.
Start Date (Occurrence 11)	8	474 … 481	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 11)	3	482 … 484	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 11)	1	485 … 485	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 12)	3	486 … 488	9(3)		Right justified with leading zeros.
Start Date (Occurrence 12)	8	489 … 496	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 12)	3	497 … 499	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 12)	1	500 … 500	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 12)	3	501 … 503	9(3)		Right justified with leading zeros.
Start Date (Occurrence 13)	8	504 … 511	X(8)	CCYYMMDD	

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Number of Uncovered Months (Occurrence 13)	3	512 … 514	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 13)	1	515 … 515	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 13)	3	516 … 518	9(3)		Right justified with leading zeros.
Start Date (Occurrence 14)	8	519 … 526	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 14)	3	527 … 529	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 14)	1	530 … 530	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 14)	3	531 … 533	9(3)		Right justified with leading zeros.
Start Date (Occurrence 15)	8	534 … 541	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 15)	3	542 … 544	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 15)	1	545 … 545	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 15)	3	546 … 548	9(3)		Right justified with leading zeros.
Start Date (Occurrence 16)	8	549 … 556	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 16)	3	557 … 559	9(3)		Right justified with leading zeros.

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Number of Uncovered Months Status Indicator (Occurrence 16)	1	560 … 560	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 16)	3	561 … 563	9(3)		Right justified with leading zeros.
Start Date (Occurrence 17)	8	564 … 571	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 17)	3	572 … 574	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 17)	1	575 … 575	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 17)	3	576 … 578	9(3)		Right justified with leading zeros.
Start Date (Occurrence 18)	8	579 … 586	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 18)	3	587 … 589	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 18)	1	590 … 590	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 18)	3	591 … 593	9(3)		Right justified with leading zeros.
Start Date (Occurrence 19)	8	594 … 601	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 19)	3	602 … 604	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 19)	1	605 … 605	X(1)		Right justified with leading zeros.

TABLE 2I – BATCH ELIGIBILITY QUERY (BEQ) RESPONSE FILE (CONTINUED)

Data Field	Size	Position	Format	Valid Values	Field Definition
Total Number of Uncovered Months (Occurrence 19)	3	606 … 608	9(3)		Right justified with leading zeros.
Start Date (Occurrence 20)	8	609 … 616	X(8)	CCYYMMDD	
Number of Uncovered Months (Occurrence 20)	3	617 … 619	9(3)		Right justified with leading zeros.
Number of Uncovered Months Status Indicator (Occurrence 20)	1	620 … 620	X(1)		Right justified with leading zeros.
Total Number of Uncovered Months (Occurrence 20)	3	621 … 623	9(3)		Right justified with leading zeros.
Filler	127	624 … 750	X(127)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.

Trailer Record

Data Field	Size	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	'CMSBEQRT'	This field will always be set to the value 'CMSBEQRT'. This code identifies the record as the Trailer Record of a Batch Eligibility Query (BEQ) Response File
Sending Entity (MBD)	8	9 … 16	X(8)	'MBD ' (MBD + 5 spaces)	This field will always be set to the value "MBD ". The value specifically is MBD + 5 following Spaces. This value will agree with the corresponding value in the Header Record.
File Creation Date	8	17 … 24	X(8)	CCYYMMDD	The date on which the BEQ Response File was created by CMS. This value will be formatted as CCYYMMDD. For example, January 3, 2010 would be the value 20100103. This value will agree with the corresponding value in the Header Record.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity (MBD)	The specific Control Number assigned by CMS to the BEQ Response File. CMS will utilize this value to track the BEQ Response File through CMS processing and archive. This value will agree with the corresponding value in the Header Record.
Record Count	7	34 … 40	9(7)	Numeric value greater than Zero.	The total number of Transactions (Detail Records) on the BEQ Response File. This value will be right justified in the field, with leading zeros. This value will not include non-numeric characters, such as commas, spaces, dashes, decimals.
Filler	710	41 … 750	X(710)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.

Following receipt of the BEQ Response file and confirmation that the prospective beneficiary is eligible to enroll, plans can then complete the MARx Batch Input Transaction and submit the transaction to CMS for processing.

2.3.2 Transaction Submission (Slide 10)

Plans process enrollment transactions. There are several possible enrollment transactions. Each transaction is an individual record or refers to an individual beneficiary. The collective data file format used for enrollment, disenrollment, change, and correction transactions is MARx Batch Input Transaction Data File.

The term "enrollment" describes enrollment, disenrollment, plan and PBP changes, and correction transactions.

Within the transaction file is a transaction code that identifies the transaction type. Table 2J lists the possible codes for each transaction type.

TABLE 2J – TRANSACTION TYPE CODES

TRANSACTION TYPE	CODE	CODE DESCRIPTION
Enrollment	60	Enrollment into an Employer Group when effective dates is 1-3 months prior to Current Payment Month (CPM)
	61	All other enrollments
	62	Retroactive enrollments for the Current Payment Month minus 2 months (CPM-2)
Disenrollment	51	Disenrollment from the managed care organizations submitted in a batch
	*54	Disenrollment through the Medicare Customer Service Center
Plan Benefit Package (PBP) Change	71	Plan Benefit Package Changes
Plan Changes	72	Reporting of 4RX data, Non-4Rx changes, premium withholding amounts, and reporting of the Number of Uncovered Months (NUNCMO)
Part D Opt-Out	*41	• Reporting of Opt-Out status of beneficiary submitted by CMS. • CMS uses Transaction Code 41 to provide the plans with information about the opt-out. • Plans are not to use this code when submitting transactions.
Correction	01	Reporting of a health status change or correction (such as Medicaid and institutional)

2.4 MARx Batch Input Transaction Data File (Slide 11)

The Plans are required to submit the transactions identified in Table 2J (above) based on the beneficiary request or enrollment information. CMS requires plans to submit these transactions using a designated

data file format. Plans may submit multiple files per month. MARx processes the plan's transactions upon receipt.

The format is organized into two levels:

- Header level information, which identifies the submitter.
- Detail level information, which identifies the beneficiary and describes the transaction type.

The header record is the same for all the transaction types. Plans can combine the different transactions into one data file with one header record.

2.4.1 Header Record

The header record is the first record in the file. The header record is 300 bytes. The naming convention for the header record is "AAAAAAHEADER". This naming convention identifies this file as the MARx Batch Input Transaction Data File for processing.

The file header contains two fields and two filler fields. Table 2K provides an overview of those fields.

TABLE 2K – FILE HEADER INFORMATION

FIELD NAME	VALUE
Header Message	'AAAAAAHEADER'
Filler	Spaces
Payment Month	MMYYYY Date should be one month after the processing date (e.g., input 022002 for data submitted before the January 2002 cutoff)
Filler	Spaces

2.4.2 Detail Record Fields

Like the header record, each detail record within the MARx Batch Input Transaction Data File equals 300 bytes.

There are two formats for the detail record. Five of the transaction types use the same detail record format and contains 42 fields. Five of the 42 fields are filler fields. The second format is the correction transaction.

While the header record is the same for correction transactions, the correction uses a different detail record format and only contains 10 fields.

There is no limit to the number of transactions within the file. This section reviews data elements within the detail records. Populating the individual fields depends on the transaction type. How the fields are populated is often based on the plan type (i.e., Medicare Advantage, Prescription Drug Plan, Cost, Medicare Savings Account, etc.). Fields may be populated with dates, alpha or alpha-numeric values, or intentionally left blank. However, a blank field has meaning to the system when it is processing the transactions.

2.4.2.1 Beneficiary Identifiers

The following data elements identify the beneficiary:

- HIC#
- Surname
- First Name
- M. Initial
- Patient Gender
- Patient Birth Date (YYYYMMDD)

With the exception of the middle initial, these fields are required for all "enrollment" transactions.

HIC#'s can be in several formats depending on whether the Social Security Administration or the Railroad Retirement Board generated the number.

2.4.2.2 Enrollment Identifiers

Nine fields describe the enrollment, disenrollment, or change regarding the beneficiary and the plan.

- EGHP Flag
- Plan Benefit Package (PBP)
- Election Type
- Contract#
- Application Date
- Transaction Code
- Disenrollment Reason
- Effective Date (YYYYMMDD)
- Segment ID
- Prior Commercial Override

Table 2L provides descriptions of the enrollment identifiers.

TABLE 2L – ENROLLMENT IDENTIFIERS

FIELD #	FIELD NAME	DESCRIPTION
7	EGHP Flag	Identifies whether the beneficiary is enrolled in a Employer Group Health Plan
8	Plan Benefit Package (PBP)	Identifies the plan benefit package in which to enroll the beneficiary
9	Election Type	Identifies the election period for the enrollment
10	Contract#	Identifies the plan as local, regional, PDP, fallback, or employer sponsored
11	Application Date	Identifies the date the plan received the beneficiary's completed enrollment application
12	Transaction Code	Identifies the transaction type as enrollment, disenrollment, change, etc.
13	Disenrollment Reason	Required for involuntary disenrollments
14	Effective Date	Identifies the effective date of the enrollment
15	Segment ID	Identifies the geographic segment of a plan, if applicable
16	Prior Commercial Override	Required if beneficiary is ESRD and wants to enroll in a non-PDP, not required if plan is special needs plan (SNP)

2.4.2.3 Premium Withhold and Amounts

There are three fields related to beneficiary premiums. These fields identify the method for withholding or paying premiums and the premium amounts for Part C and D. Table 2M lists the premium withhold and amount fields.

TABLE 2M – PREMIUM WITHHOLD AND AMOUNTS

FIELD #	FIELD NAME	DESCRIPTION
18	Premium Withhold Option/Parts C-D	Identifies the option the beneficiary selected for paying premiums
19	Part C Premium Amount	Amount of the beneficiary's premium for Part C
20	Part D Premium Amount	Amount of the beneficiary's premium for Part D

2.4.2.4 Secondary Insurance

The secondary insurance fields are populated with information provided by the beneficiary on the enrollment application regarding secondary insurance coverage. Table 2N describes the secondary insurance fields.

TABLE 2N – SECONDARY INSURANCE

FIELD #	FIELD NAME	DESCRIPTION
27	Secondary Drug Insurance Flag	Identifies a beneficiary with secondary insurance coverage
28	Secondary Rx ID	Secondary insurance plan's ID number for a beneficiary
29	Secondary Rx Group	Secondary insurance plan's group ID

2.4.2.5 Banking Information

There are three banking information fields for routing payment information:

- Trustee Routing Number
- Bank Account Number
- Bank Account Type

Populate these fields with filler.

2.4.2.6 Part D Insurance Fields

The 4Rx data are identifying data required for prescription drug insurance claims routing and are submitted by plans to MARx. If MARx accepts these 4Rx data, the data are sent to the TrOOP Facilitation Contractor to support eligibility transactions from pharmacies. These transactions are needed when a beneficiary visits the pharmacy for the first time and does not have a plan-issued card for drug benefits.

So that supplemental payers can also communicate information to support point-of-sale, two fields are for supplemental payers to establish unique RxBIN and RxPCN for claims where Part D is the primary payer.

Table 2O describes the 4Rx and supplemental Rx fields for Part D insurance.

TABLE 2O – PART D INSURANCE FIELDS

FIELD #	FIELD NAME	DESCRIPTION
36	Part D Rx BIN	Identifies the Prescription Bank Identification Number (BIN)
37	Part D Rx PCN	Identifies the Prescription Processor Control Number (RxPCN)
38	Part D Rx Group	Identifies the Prescription Member Identification Number or Cardholder ID (RxID)
39	Part D Rx ID	Identifies the Prescription Group Number (RxGroup)
40	Secondary Drug BIN	Identifies the Prescription Bank Identification Number (BIN) for the secondary insurer
41	Secondary Drug PCN	Identifies the Prescription Processor Control Number (RxPCN) for the secondary insurer

2.4.2.7 Additional Detail Record Fields

Table 2P identifies additional detail fields and provides a description of the fields.

TABLE 2P – ADDITIONAL DETAIL RECORD FIELDS

FIELD #	FIELD NAME	DESCRIPTION
21	Creditable Coverage Flag	Valid for drug plans
22	Number of Uncovered Months	Identifies the count of months without creditable drug coverage
23	Employer Subsidy Enrollment Override Flag	Applies when a beneficiary is in a plan receiving employer subsidy and wants to enroll in a Part D plan
24	Part D Opt-Out Flag	Applies to full benefit dual eligible and facilitated enrolled beneficiaries and indicates when the beneficiary wants to opt-out of a plan and select another plan.
30	Enrollment Source	Identifies the source of the enrollment submission
31	SSN	Social Security Number

2.4.2.8 Correction Detail Record Fields

The correction detail record contains 10 fields, of which 3 fields are filler. Like the main detail record, there are fields identifying the beneficiary and the contract. The only transaction type or code to use for this transaction is "01" for correction.

The one remaining field in this record is the Action Code. The correction transaction is used for special statuses: turn on institutional status, turn on or off Medicaid status, or turn on Nursing Home Certifiable (NHC) status.

2.4.3 MARx Batch Input Transaction Record Layout

Table 2Q describes each field of the MARx Batch Input Transaction Record, including header and detail level. The table references the field number and provides the field name, position, and an explanation of the data element for each transaction type. The record layout is organized on the following pages as follows:

- Header Record
- Detail Record for Enrollment Transactions (60/61/62), Disenrollment (51/54), PBP Change (71)
- Detail Record for 4Rx Plan Change (72), Non-4Rx Plan Change (72), NUNCMO Plan Change (72), Part D Opt-Out (41)
- Correction Record
- Notes for All Transaction Types

TABLE 2Q – MARX BATCH INPUT TRANSACTION DATA FILE

Header Record

Item	Fields	Size	Position	Header	Description
1	Header Message	12	1 – 12	R	'AAAAAAHEADER'
2	Filler	21	13 – 33	N/A	Spaces
3	Payment Month	6	34 – 39	R	MMYYYY (Note that the date should be one month after the processing date, e.g. input 022002 for data submitted before the January 2002 cutoff.
4	Filler	261	40 – 300	N/A	Spaces

Enrollment/Disenrollment/PBP Change Detail Record

Item	Fields	Size	Position	Enrollment (60/61/62) [Note 1]	Disenrollment (51/54)	PBP Change (71) [Note 1 & Note 2]
1	HIC#	12	1 – 12	R	R	R
2	Surname	12	13 – 24	R	R	R
3	First Name	7	25 – 31	R	R	R
4	M. Initial	1	32			
5	Sex	1	33	R	R	R
6	Birth Date (YYYYMMDD)	8	34 – 41	R	R	R
7	EGHP Flag	1	42	Blank field has a meaning	N/A	Blank field has a meaning
8	PBP	3	43 – 45	R	N/A	R (change-to value)
9	Election Type	1	46	R (for all plan types when [Note 1] is true; otherwise not required for HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MDHO demo, MSHO demo, and PACE National plans	R (for all plan types except HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MDHO demo, MSHO demo, and PACE National plans	R (for all plan types when [Note 1 is true; otherwise not required for HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MDHO demo, MSHO demo, and PACE National plans)
10	Contract #	5	47 – 51	R	R	R
11	Application Date	8	52 – 59	R	N/A	R
12	Transaction Code	2	60 – 61	R	R	R
13	Disenrollment Reason (Required for Involuntary Disenrollments)	2	62 – 63	N/A	Required for Involuntary Disenrollments. Optional for Voluntary Disenrollments	N/A
14	Effective Date (YYYYMMDD)	8	64 – 71	R	R	R
15	Segment ID	3	72 – 74	R, blank for non-segmented organizations; otherwise, 3-digits	N/A	R, blank for non-segmented organizations; otherwise, 3-digits
16	Filler	5	75 – 79	N/A	N/A	N/A

TABLE 2Q – MARX BATCH INPUT TRANSACTION DATA FILE (CONTINUED)

Item	Fields	Size	Position	Enrollment (60/61/62) [Note 1]	Disenrollment (51/54)	PBP Change (71) [Note 1 & Note 2]
17	Prior Commercial Override	1	80	If applies; otherwise, zero or blank	N/A	If applies; otherwise, zero or blank
18	Premium Withhold Option/Parts C-D	1	81	R (required for all plan types except HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MSA/MA and MSA/demo plans)	N/A	R (required for all plan types except HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MSA/MA and MSA/demo plans
19	Part C Premium Amount (XXXXvXX)	6	82 – 87	R (required for all plan types except HCPP, COST 1, COST 2, CCIP/FFS demo, MSA/MA and MSA/demo plans	N/A	R (required for all plan types except HCPP, COST 1, COST 2, CCIP/FFS demo, MSA/MA and MSA/demo plans)
20	Part D Premium Amount (XXXXvXX)	6	88 – 93	R (for all Part D plans); otherwise blank	N/A	R (for all Part D plans); otherwise blank
21	Creditable Coverage Flag	1	94	R (for all Part D plans); otherwise blank	N/A	R (for all Part D plans); otherwise blank
22	Number of Uncovered Months	3	95 – 97	R (for all Part D plans); otherwise blank. Blank = zero, meaning no uncovered months	N/A	R (for all Part D plans); otherwise blank. Blank = zero, meaning no uncovered months
23	Employer Subsidy Enrollment Override Flag	1	98	R if beneficiary has Employer Subsidy status for Part D; otherwise blank	N/A	R if beneficiary has Employer Subsidy status for Part D; otherwise blank
24	Part D Opt-Out Flag	1	99	N/A	Optional (for all Part D plans); otherwise blank	R (Y when Opting Out for Part D; N when Opting in for Part D); otherwise blank)
25	Filler	20	100 – 119	N/A	N/A	N/A
26	Filler	15	120 – 134	N/A	N/A	N/A
27	Secondary Drug Insurance Flag	1	135	R (for all Part D plans, value is Y or N or Blank; for auto/facilitated enrollments and rollovers value should be blank); for non Part D plans, value should be blank.	N/A	R (for all Part D plans, value is Y or N or Blank; for auto/facilitated enrollments and rollovers value should be blank); for non Part D plans, value should be blank.
28	Secondary Rx ID	20	136 – 155	R if secondary insurance; otherwise blank	N/A	R if secondary insurance; otherwise blank
29	Secondary Rx Group	15	156 – 170	R if secondary insurance; otherwise blank	N/A	R if secondary insurance; otherwise blank
30	Enrollment Source	1	171	R (for POS submitted enrollment transactions); otherwise optional	FILLER	R (for plan submitted auto-enrollments and facilitated enrollment transactions includes [Note 2]; otherwise optional.
31	SSN	9	172 – 180	FILLER	FILLER	FILLER
32	Trustee Routing Number	9	181 – 189	FILLER	FILLER	FILLER

TABLE 2Q – MARX BATCH INPUT TRANSACTION DATA FILE (CONTINUED)

Item	Fields	Size	Position	Enrollment (60/61/62) [Note 1]	Disenrollment (51/54)	PBP Change (71) [Note 1 & Note 2]
33	Bank Account Number	17	190 – 206	FILLER	FILLER	FILLER
34	Bank Account Type	1	207	FILLER	FILLER	FILLER
35	Filler	17	208 – 224	N/A	N/A	N/A
36	Part D Rx BIN	6	225 – 230	R (for all Part D plans except PACE National); otherwise blank	N/A	R (for all Part D plans except PACE National); otherwise blank
37	Part D Rx PCN	10	231 – 240	Change-to value (for all Part D plans except PACE National); otherwise blank	N/A	Change-to value (for all Part D plans except PACE National); otherwise blank
38	Part D Rx Group	15	241 – 255	Change-to value (for all Part D plans except PACE National); otherwise blank	N/A	Change-to value (for all Part D plans except PACE National); otherwise blank
39	Part D Rx ID	20	256 – 275	R (for all Part D plans except PACE National); otherwise blank	N/A	R (for all Part D plans except PACE National); otherwise blank
40	Secondary Drug BIN	6	276 – 281	R if secondary insurance; otherwise blank	N/A	R if secondary insurance; otherwise blank
41	Secondary Drug PCN	10	282 – 291	R if secondary insurance; otherwise blank	N/A	R if secondary insurance; otherwise blank
42	Filler	9	292 – 300	FILLER	FILLER	FILLER

Plan Change/Part D Opt-Out Detail Record

Item	Fields	Size	Position	4Rx Plan Change (72) [Note 1]	Non-4Rx Plan Change (72) [Note 2]	NUNCMO Plan Change (72) [Note 3]	Part D Opt-Out (41)
1	HIC#	12	1 – 12	R	R	R	R
2	Surname	12	13 – 24	R	R	R	R
3	First Name	7	25 – 31	R	R	R	R
4	M. Initial	1	32	Optional	Optional	Optional	Optional
5	Sex	1	33	R	Optional	R	R
6	Birth Date (YYYYMMDD)	8	34 – 41	R	R	R	R
7	EGHP Flag	1	42	N/A	Blank or change to value	N/A	N/A
8	PBP #	3	43 45	R	R	R	N/A
9	Election Type	1	46	N/A	R for premium withhold option changes; otherwise, N/A	N/A	N/A
10	Contract #	5	47 – 51	R	R	R	R (transaction for type 41 when beneficiary is enrolled in Medicare); otherwise, N/A

TABLE 2Q – MARX BATCH INPUT TRANSACTION DATA FILE (CONTINUED)

Item	Fields	Size	Position	4Rx Plan Change (72) [Note 1]	Non-4Rx Plan Change (72) [Note 2]	NUNCMO Plan Change (72) [Note 3]	Part D Opt-Out (41)
11	Application Date	8	52 – 59	N/A	N/A	N/A	N/A
12	Transaction Code	2	60 – 61	R	R	R	R
13	Disenrollment Reason (Required for Involuntary Disenrollments	2	62 – 63	N/A	N/A	N/A	N/A
14	Effective Date (YYYYMMDD)	8	64 – 71	R	R	R	N/A
15	Segment ID	3	72 – 74	N/A	Blank or change-to value for local plans; otherwise, N/A	N/A	N/A
16	Filler	5	75 – 79	N/A	N/A	N/A	N/A
17	Prior Commercial Override	1	80	N/A	N/A	N/A	N/A
18	Premium Withhold Option/Parts C-D	1	81	N/A	Blank or change-to value	N/A	N/A
19	Part C Premium Amount (XXXXvXX)	6	82 – 87	N/A	Blank or change-to value	N/A	N/A
20	Part D Premium Amount (XXXXvXX)	6	88 – 93	N/A	Blank or change-to value	N/A	N/A
21	Creditable Coverage Flag	1	94	N/A	N/A	'Y' or Blank when Number of uncovered months = o, or 'N' when Number of uncovered months > 0 OR 'R' (Reset, Number or uncovered months = 0) OR 'U' (Reset, Number of uncovered months undone)	N/A
22	Number of uncovered months	3	95 – 97	N/A	N/A	Blank or change-to value	N/A
23	Employer Subsidy Enrollment Override Flag	1	98	N/A	N/A	N/A	N/A
24	Part D Opt-Out Flag	1	99	N/A	Blank or change-to value	N/A	N/A
25	Filler	20	100 – 119	N/A	N/A	N/A	N/A
26	Filler	15	120 – 134	N/A	N/A	N/A	N/A
27	Secondary Drug Insurance Flag	1	135	Blank or new value. Blank does not remove or replace existing data.	N/A	N/A	N/A

TABLE 2Q – MARX BATCH INPUT TRANSACTION DATA FILE (CONTINUED)

Item	Fields	Size	Position	4Rx Plan Change (72) [Note 1]	Non-4Rx Plan Change (72) [Note 2]	NUNCMO Plan Change (72) [Note 3]	Part D Opt-Out (41)
28	Secondary Rx ID	20	136 – 155	Blank or new additional value. Blank does not remove or replace existing data.	N/A	N/A	N/A
29	Secondary Rx Group	15	156 – 170	Blank or new additional value. Blank does not remove or replace existing data.	N/A	N/A	N/A
30	Enrollment Source	1	171	N/A	N/A	N/A	N/A
31	SSN	9	172 – 180	N/A	N/A	N/A	N/A
32	Trustee Routing Number	9	181 – 189	N/A	N/A	N/A	N/A
33	Bank Account Number	17	190 – 206	N/A	N/A	N/A	N/A
34	Bank Account Type	1	207	N/A	N/A	N/A	N/A
35	Filler	17	208 – 224	N/A	N/A	N/A	N/A
36	Part D Rx BIN	6	225 – 230	Required together with Part D Rx ID when changing 4Rx primary insurance information. Must either be the beneficiary's current field value or the change-to value. Can only be blank when not changing a beneficiary's 4Rx primary insurance information.	N/A	N/A	N/A
37	Part D Rx PCN	10	231 – 240	Change-to value, either a new value or a blank. Blank will remove the beneficiary's existing value.	N/A	N/A	N/A
38	Part D Rx Group	15	241 – 255	Change-to value, either a new value or a blank. Blank will remove the beneficiary's existing value.	N/A	N/A	N/A

TABLE 2Q – MARX BATCH INPUT TRANSACTION DATA FILE (CONTINUED)

Item	Fields	Size	Position	4Rx Plan Change (72) [Note 1]	Non-4Rx Plan Change (72) [Note 2]	NUNCMO Plan Change (72) [Note 3]	Part D Opt-Out (41)
39	Part D Rx ID	20	256 – 275	Required together with Part D Rx BIN when changing 4Rx primary insurance information. Must either be the beneficiary's current field value or the change-to value. Can only be blank when not changing a beneficiary's 4Rx primary insurance information.	N/A	N/A	N/A
40	Secondary Drug BIN	6	276 – 281	Blank or new additional value. Blank does not remove or replace existing data.	N/A	N/A	N/A
41	Secondary Drug PCN	10	282 – 291	Blank or new additional value. Blank does not remove or replace existing data.	N/A	N/A	N/A
42	Filler	9	292 – 300	FILLER	FILLER	FILLER	FILLER

Note 1: 4Rx (Type 72) Plan Change transactions can be retroactive as well as prospective. Any effective date will be accepted as long as it matches a Part D enrollment effective date. When primary 4Rx values are specified on a 72 transaction, MARx replaces the current Primary 4Rx values for the enrollment (if any) with the Primary 4Rx values from the 72 transaction. When Secondary 4Rx values are specified on a 72 transaction, MARx adds the Secondary 4Rx values from the 72 transaction as a new instance of Secondary 4Rx coverage. There is no mechanism for plans to delete or replace an instance of Secondary 4Rx coverage via MARx transactions.

Note 2: Non-4Rx (Type 72) Plan Change transactions excluding Creditable Coverage information are prospective, meaning the current processing month plus three months. Said another way, plan change effective date between current payment month minus one month and current payment month plus two months.

Note 3: Creditable Coverage Plan change transaction (Type 72) information can be retroactive (not prior to June 2006) as well as prospective (not past CPM plus 2 months). Effective date on the transaction should match Part D enrollment dates if the creditable coverage flag is Y, N and blank. Effective date on the transaction can be within a Part D enrollment period if the creditable coverage flag is R. Effective date must match the effective date of an existing Reset if the creditable coverage flag is U.

TABLE 2Q – MARx BATCH INPUT TRANSACTION DATA FILE (CONTINUED)

Correction Record

Item	Field	Size	Position	Correction	Description
1	HIC#	12	1 – 12	R	Nine-byte SSN of primary beneficiary (Beneficiary Claim Account Number); two-byte BIC (Beneficiary Identification Code); one-byte filler (except RRB)
2	Surname	12	13 – 24	R	Beneficiary's last name
3	First Name	7	25 – 31	R	Beneficiary's first name
4	M. Initial	1	32		Beneficiary's middle initial
5	Action Code	1	33	R	D = Institutional ON E = Medicaid ON F = Medicaid OFF G = Nursing Home Certifiable (NHC) ON
6	Filler	13	34 – 46	N/A	Spaces
7	Contract #	5	47 – 51	R	Contact Number
8	Filler	8	52 – 59	N/A	Spaces
9	Transaction Code	2	60 – 61	R	'01' = Correction
10	Filler	239	62 – 300	N/A	Spaces

Notes for All Transaction Types

Item	Fields	Description
1	HIC#	Claim Account Number (CAN) plus Beneficiary Identification Code (BIC)
2	Surname	No comment
3	First Name	No comment
4	M. Initial	No comment
5	Sex	1 = male, 2 = female, 0 = unknown
6	Birth Date (YYYYMMDD)	YYYYMMDD
7	EGHP Flag	Y if EGHP; otherwise, blank = not EGHP for type 60, 61, 62 and 71 transactions. For type 72 transactions, Y if EGHP, N if not EGHP, and blank indicates no change.
8	PBP #	3 blanks = non EGHP organizations (HCP, CCIP/FFS Demos); 3-character numeric = PBP number, zero-padded, 001- 999 valid for organizations except HCPP and CCIP/FFS demos.
9	Election Type	A=AEP; E=IEP; I=ICEP; S=Other SEP; O=OEP; N=OEPNEW; T=OEPI; U=Dual/LIS SEP; V =Permanent Change in Residence SEP; W=EGHP SEP; X=Administrative SEP; Y=CMS/Case Worker SEP; MAs have I, A, O, S, N U, V, W, X, Y and T. MAPDs have I, A, O, S U, V, W, X, Y, T and E, N and T. PDPs have A, S, U, V , W, X, Y and E.
10	Contract #	Hxxxx = identifies local plans. Rxxxx = identifies regional plans. Sxxxx = identifies PDPs. Fxxxx = identifies fallback plans, Exxxx = identifies employer sponsored MA/MA-PD and PDP plans.
11	Application Date	YYYYMMDD – The date the plan received the beneficiary's completed enrollment application.
12	Transaction Code	51/54 = disenrollment; 60/61 = enrollment; 62 = retroactive batch enrollments for CPM-2; 71 = plan election (PBP change); 72 = plan change; 41 = 1-800-MEDICARE or CMS Contractors submitted.
13	Disenrollment Reason	Required for Involuntary Disenrollments

TABLE 2Q – MARX BATCH INPUT TRANSACTION DATA FILE (CONTINUED)

Item	Fields	Description
14	Effective Date (YYYYMMDD)	YYYYMMDD
15	Segment ID	3-blanks = non-segmented organization transaction; for segmented organization transactions, 3-character numeric = segment number, zero-padded, 001-999 valid plan Segment ID range. Only local MA/MA-PD plans (Hxxxx) may have segments.
16	Filler	N/A
17	Prior Commercial Override	Required if beneficiary is ESRD and wants to enroll in a non-PDP plan. Not required if plan is special-needs-plan (SNP). Alpha-numeric, 0-9 and A-F. Zero (0) and blank = no override
18	Premium Withhold Option/Parts C-D	D = direct self-pay; S = deduct from SSA benefits; R = deduct from RRB benefits; O = deduct from OPM benefits; N = No Premium. The option applies to both Part C and D premiums.
19	Part C Premium Amount (XXXXvXX)	6-digits with leading zeroes, or blank if premium does not apply. Decimal point assumed 2-digits from right, XXXXvXX. Any value other than a blank on a type 72 transaction indicates a change-to value. That is, 000000 is an acceptable change-to value meaning $0.00.
20	Part D Premium Amount (XXXXvXX)	6-digits with leading zeroes, or blank if premium does not apply. Decimal point assumed 2-digits from right, XXXXvXX. Any value other than a blank on a type 72 transaction indicates a change-to value. That is, 000000 is an acceptable change-to value meaning $0.00.
21	Creditable Coverage Flag	Valid for drug plans. For enrollment (type 60/61/62/71) transactions valid values are Y, N, R and blank. For plan change (type 72) transaction, valid values are Y, N, R, U and blank. Y if covered, N if not covered, R if resetting uncovered months to zero due to a new IEP and U for resetting uncovered months to the value prior to using R.
22	Number of Uncovered Months	Count of months without creditable drug coverage. When creditable coverage flag is blank, value must be zero. When creditable coverage flag is Y, R or U, the value should be zero. When creditable coverage flag is N, value should be greater than zero. When submitted on an enrollment (60/61/71) transaction, this represents the number of months without creditable drug coverage during any break in Part D enrollment immediately preceding the effective date of this new enrollment. That is, the period of time between the effective date of this enrollment and the end of the previous Part D enrollment if there is one, otherwise from the end of the individual's Part D IEP. Refer to CMS CC/LEP policy for information on determining the number of uncovered months to report including corrections and resets. When submitted on a plan change (72) transaction to update an existing number of uncovered months, this is the new number of uncovered months that will replace the number of uncovered months currently associated with an effective date. This value when submitted on an enrollment (60/61/71) or plan change (72) transaction must be formatted as right justified with leading zeros. Example: 2 uncovered months should be submitted as 002. Leading spaces(__2) will not be accepted by MARx.
23	Employer Subsidy Override Flag	If the beneficiary is in a plan receiving an employer subsidy, but still wants to enroll in a Part D plan, submit the enrollment with the override = Y; otherwise blank.

TABLE 2Q – MARX BATCH INPUT TRANSACTION DATA FILE (CONTINUED)

Item	Fields	Description
24	Part D Opt-Out Flag	Applies to full benefit dual eligible and facilitated enrolled beneficiaries. Y=opt-out of Part D; blank=no change to opt-out status. For 71 type of transaction, applies when a beneficiary wants to opt out from MA-PD plan and desires to enroll in MA only PBP of the same contract. For 71 type of transaction, also applies when a beneficiary wants to change from MA plan and desires to enroll in MA-PD only PBP of the same contract. For 41 type of transactions, Y= Opt-Out of Part D; N=Not to Opt-Out of Part D. Part D Opt-Out Flag will be used to allow (when value is N) or reject (when value is Y) auto-enrollment (full benefit dual eligible) or facilitated enrollment (partial benefit dual eligible) beneficiaries.
25	Filler	N/A
26	Filler	N/A
27	Secondary Drug Insurance Flag	For types 60, 61, 71 and 72 transactions, Y = beneficiary has secondary drug insurance; N = beneficiary does not have secondary drug insurance available; blank = do not know whether beneficiary has secondary drug insurance.
28	Secondary Rx ID	Secondary insurance plan's ID number for a beneficiary. Alpha-numeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces. Applicable for transaction types 60, 61, 62, 71 and 72.
29	Secondary RX Group	Secondary insurance plan's group ID number for a beneficiary. Alpha-numeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces. Applicable for transaction types 60, 61, 62, 71 and 72.
30	Enrollment Source	A = auto-enrolled by CMS; B = beneficiary election; C = facilitated enrollment by CMS; D = System generated rollovers; E = Plan submitted auto-enrollments; F = Plan submitted facilitated enrollments. G = Point of Sale (POS) submitted enrollments and H = Re-assignments submitted by CMS or Plans. Plan submitted enrollments are defaulted to enrollment source of B when submitted with a blank enrollment source.
31	SSN	N/A
32	Trustee Routing Number	N/A
33	Bank Account Number	N/A
34	Bank Account Type	N/A
35	Filler	N/A
36	Part D Rx BIN	Part D insurance plan's BIN number for a beneficiary. Numeric; right justified (for example, if BIN if five position numeric (12345), plan should set BIN to six position numeric with zero added in the first position (012345). Applicable for transaction types 60, 61, 62, 71 and 72.
37	Part D Rx PCN	Part D insurance plan's PCN number for a beneficiary. Alphanumeric, upper case when alpha; left justified. Limited to upper case characters (A-Z) and/or numeric (0-9) and default value of spaces. Applicable for transaction types 60, 61, 62, 71 and 72.

TABLE 2Q – MARX BATCH INPUT TRANSACTION DATA FILE (CONTINUED)

Item	Fields	Description
38	Part D Rx Group	Part D insurance plan's group ID number for a beneficiary. Alphanumeric, upper case when alpha; left justified. Limited to uppercase characters (A-Z) and/or numeric (0-9) and default value of spaces. Applicable for transaction types 60, 61, 62, 71 and 72.
39	Part D Rx ID	Part D insurance plan's ID number for a beneficiary. Alphanumeric, uppercase when alpha; left justified. Limited to upper case characters (A-Z) and/or numeric (0-9) and default value of spaces. Applicable for transaction types 60, 61, 71 and 72.
40	Secondary Rx BIN	Secondary insurance plan's BIN number for a beneficiary. Numeric. Applicable for transaction types 60, 61, 62, 71 and 72.
41	Secondary Rx PCN	Secondary insurance plan's PCN number for a beneficiary. Alphanumeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces. Applicable for transaction types 60, 61, 62, 71 and 72.
42	Filler	N/A

2.5 Retroactive Enrollment (62) Transaction (Slide 12-13)

CMS guidance provides flexibility to Plans completing beneficiary enrollment requests for up to 21 calendar days following the receipt of the enrollment request.

At times, the processing of enrollment requests result in transactions retroactive to the current payment month (CPM), where plans were unable to submit the transactions directly to CMS.

CMS implemented a retroactive enrollment transaction, transaction code 62 to assist in the facilitation of this process. For this retroactive transaction, the effective date of the enrollment must equal the Current Payment Month minus 2 months (CPM-2).

Example: 1

> **Scenario**: The current calendar date is January 17, 2008. The Current Payment month is March 2008, which will include data submitted January 12, (which is the day following the Plan Data Due date of January 11) through February 8 (plan data due date for February 2008).
>
> **Results:** The CPM-2 will equal January 1 (March minus 2 months equals January). If an enrollment was completed on January 10, for a request of an effective date of January 1, the transaction type code is 62. This is a CPM-2 Retroactive Transaction.

The format of the 62 enrollment transactions is the same as the transaction format for 60 and 61 enrollment transactions.

MARx will reject 62 enrollment transactions for enrollment requests with valid retroactive effective dates other than the CPM-2. IntegriGuard and/or CMS will process retroactive enrollment transactions under the existing processes for requests other than those that meet the criteria of the 62 transaction. The Reports module discusses the options and requirements for processing general retroactive transactions.

2.6 User Interface (Slides 14-17)

The eligibility system provides CMS and its external business partners with a centralized database to exchange beneficiary-specific information. CMS considers this eligibility system the authoritative source for Medicare beneficiary entitlement and eligibility status for Parts C and D.

CMS created the enrollment system to accommodate changes for the implementation of the Medicare Modernization Act (MMA) legislative provisions. This system interacts with transmissions submitted to CMS from MA Plans, MA-PDs and PDPs, including the enrollment/disenrollment of beneficiaries and the calculation of payments.

MA plans and PDPs may query these eligibility and enrollment systems using the web-based Beneficiary Eligibility Portal through the Medicare Advantage & Part D Inquiry System User Interface, commonly referred to as the Common UI. This portal allows authorized users access to the entitlement and eligibility information for the plan's Medicare beneficiaries to review enrollment and payment data stored at CMS.

CMS is in the process of transitioning from the Common UI to the Medicare Advantage Prescription Drug Integrated User Interface (MAPD IUI). This section describes and illustrates the key features for navigating the UI screens for both the Common UI and the MAPD IUI. While the features are similar, the screen layouts are slightly different. **Note:** The figures include grayed areas to cover Private Health Information (PHI).

2.6.1 Part D Eligibility and Inquiry System (Common UI)

The Common UI enables access to enrollment, eligibility, and 4Rx information for beneficiaries. CMS has combined this data into a single user interface. The Common UI accommodates online and batch processing. Individuals with access can use the online capabilities to view beneficiary or contract information. Plans can use batch capabilities to submit data, such as enrollment and disenrollment transactions (see Section 2.4).

Common UI online operations support the following capabilities:
- Log on and view messages
- View beneficiary information
- View payment information
- View premiums charged by Plans
- Request historical reports

Information is available for enrollments starting from the start of the program.

2.6.1.1 Common UI Roles and Privileges

The Common UI is a role-based system, which provides a secure environment for data. A role describes a user's job by the tasks that a user may perform. To fulfill the security goals, the system provides functionality and data filtering based on the needs of users and security considerations.

Table 2R describes the roles and permissions of plan users.

TABLE 2R – COMMON UI PLAN ROLES

PLAN ROLES	DESCRIPTIONS
MCO Representative	• Works for a Plan managing beneficiaries in the Medicare program via MARx. • Can access detailed enrollment data only for their own membership and minimal current enrollment data for other beneficiaries. • Cannot transmit batch files containing membership changes and health status corrections.
MCO Representative Transmitter	• Works for a Plan managing beneficiaries in the Medicare program via MARx. • Can access detailed enrollment data only for their own membership and minimal current enrollment data for other beneficiaries. • Cannot transmit batch files containing membership changes and health status corrections. • Ability to transmit batch files containing membership changes and health status corrections.

2.6.1.2 Common UI Screen Features

Many screens within the Common UI contain forms that users fill out and buttons to click to carry out an action. Some fields are required, and others are optional. A **red asterisk (*)** appears next to a field label to indicate that it is a required field. A **red plus sign (+)** appears next to field labels to indicate that one or more of those fields must be entered**.**

Since the Common UI is role-based, screens are customized so that not all screens are available to each role or so that some menus, submenus, links, fields, etc. may not appear depending on the user's privileges.

Sometimes there are additional rules regarding what combination of fields is acceptable, and the instructions on the screen indicate those rules.

There are different ways to enter information into a field and Table 2S describes the ways.

TABLE 2S – COMMON UI SCREEN CHARACTERISTICS

METHODS FOR ENTERING INFORMATION	DESCRIPTION
Text entry	• Most fields (such as claim number or contract) allow Plans to type in the information.
Dropdown list	• Some fields (such as state or disenrollment reason) provide a list of values from which you can select. • Click on the down arrow next to the field to display the list, and then click on a value to select it. • To delete a selection, select the blank value, which is at the top of the dropdown list for an optional field.
Radio buttons	• Choose one of the items in a group by clicking on the circle next to that item.
Check boxes	• Select any number of the items in a group by clicking on the box next to each item to be selected.

The Common UI validates information entered on a form to ensure that the request is valid, and displays an error message to let the user know when something is wrong. The validation occurs when exiting the field after entering the information (this is done when the user clicks tab or clicks elsewhere on the screen). The field is color coded — **yellow** for a valid field and **pink** for an invalid field. When a field is invalid, it is selected (i.e., highlighted), and an error message is displayed in "red" below the title line.

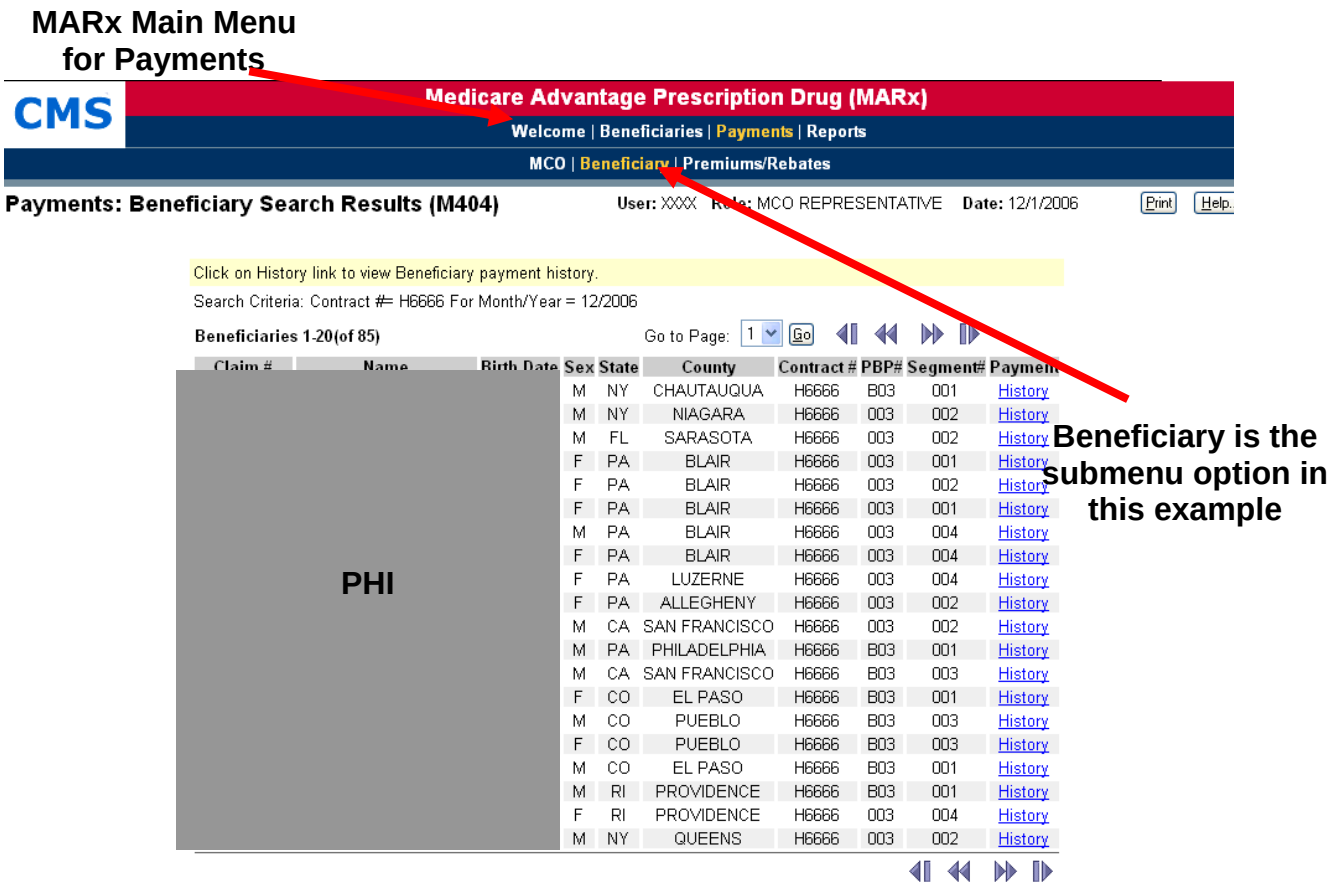
Some validations do not occur when exiting the field, but rather when clicking on a button. Generally, this happens when the validation involves the relationship between fields, such as checking that a start date is not after an end date. When the Common UI detects an error upon clicking a button, the screen displays an error message and does not carry out the button's action.

After validation is complete, the user's action is submitted. The buttons on the screen (except for the [Print], [Help], [Close], and [Cancel] buttons) are disabled (grayed out) until the action is complete, to prevent a button from being clicked multiple times. In addition, the screen displays a message, asking the user to wait until the requested action is completed. If the validation is successful, a message

displays on the screen in **green** indicating that the action was successful. If the processing encountered an error, a message displays in **red** explaining the problem, and then displays the user's inputs on the screen again.

The heading of each primary screen displays the Common UI main menu. The display options are Welcome, Beneficiaries, Payments, and Reports. CMS users can also see enrollment and group enrollments as a submenu option. Figure 2D illustrates the Common UI Main Menu.

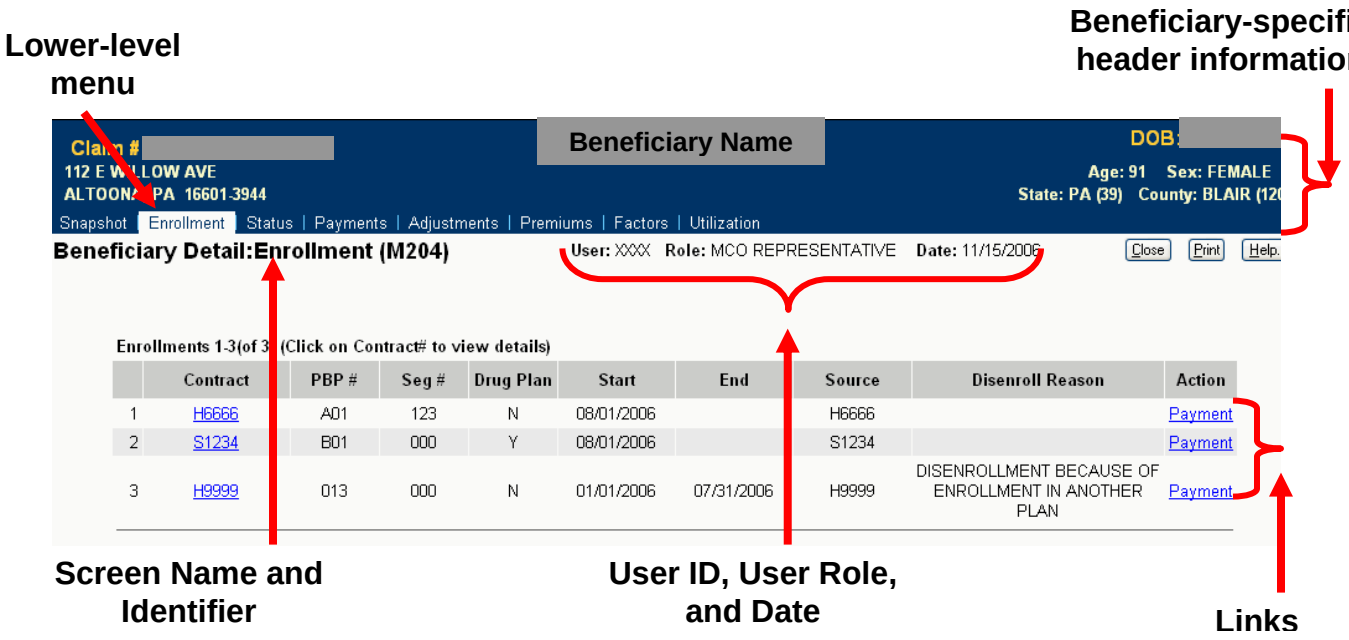
Figure 2D – Common UI Main Menu



In most cases, a submenu is located below the main menu and provides options based on the menu item chosen. The screen highlights in **yellow** selected menu and submenu items on the system.

The system displays secondary screens with additional detail in new, pop-up windows. Multiple pop-up windows may be open at a time. When switching primary screens, any open secondary screens associated with that primary screen will close automatically. Figure 2E illustrates the Common UI Secondary Pop-Up Menu.

Figure 2E – Common UI Secondary Menu (Pop-Up)



On the Beneficiary Detail Screen, notice the header information on the right side of Figure 2E (bracket) is specific to the selected beneficiary. The Beneficiary level header includes such information as the beneficiary's name; claim number; date of birth, date of death when applicable; street address; age; sex; state; and county.

On the left side of the screen is a lower-level menu system for this secondary screen. This lower-level screen provides information regarding *Snapshot, Enrollment, Status, Payments, Adjustments, Premiums, and Factors*. User's can move among these screens by clicking the appropriate menu item.

Figure 2E identifies the *Screen Name as "Beneficiary Detail: Enrollment (M204),"* which describes the screen's purpose. On the primary screen, the name also reflects how the user reached the screen using the menu and submenu. The *Screen Identifier* starts with a "M" and is useful when asking for help or reporting a problem to the MMA helpdesk.

Each screen always displays the *User ID* and *User* role along with the current date.

Some windows display additional features to access other windows and messages. If there is an error, the screen displays the error message in **red**. Messages indicating success display in **green**. If there are no messages, the area is **blank**.

Many of the screens display instructions or users can obtain additional information by clicking on the Help button. Links take users to other screens or tables with additional or more detailed information.

2.6.2 Medicare Advantage Prescription Drug Integrated User Interface (MAPD IUI)

The MAPD IUI is an enhancement that replaces the existing Common UI application, which CMS designed as a single integrated system. The MAPD IUI enhances quality and accuracy of the information displayed when viewing beneficiary information. The new IUI provides plans the opportunity to function in a timelier, efficient, and cost-effective manner because of the availability of the beneficiary information.

The MAPD IUI allows plans to conduct beneficiary searches pre- and post-enrollment, check on batch file status, and order reports. Table 2T categorizes the information contained in the MAPD IUI for post-enrollment.

TABLE 2T – POST-ENROLLMENT DATA CATEGORIES IN MAPD IUI

CATEGORY	SUB-CATEGORY
Demographics	• Basic Demographics • Extended Demographics
Eligibility & Entitlement	• Entitlement & Eligibility Summary • Low Income Subsidy
Enrollment	• Enrollment Summary • Additional Insurance Information • Supplemental Insurance • Status
Payments & Premiums	• Beneficiary Snapshot • Payments • Adjustments • Premiums • Factors

2.6.2.1 MAPD IUI Role-Based User Access (RBAC)

Similar to the Common UI, the MAPD IUI permits access based on roles, referred to as Role-Based User Access (RBAC). As with the Common UI, the role describes a users "job" by the tasks that a user performs and the functionality or permissions granted in the system. These permissions depend on the needs of the users as well as any security considerations.

The roles permitted access to MAPD IUI include the following:

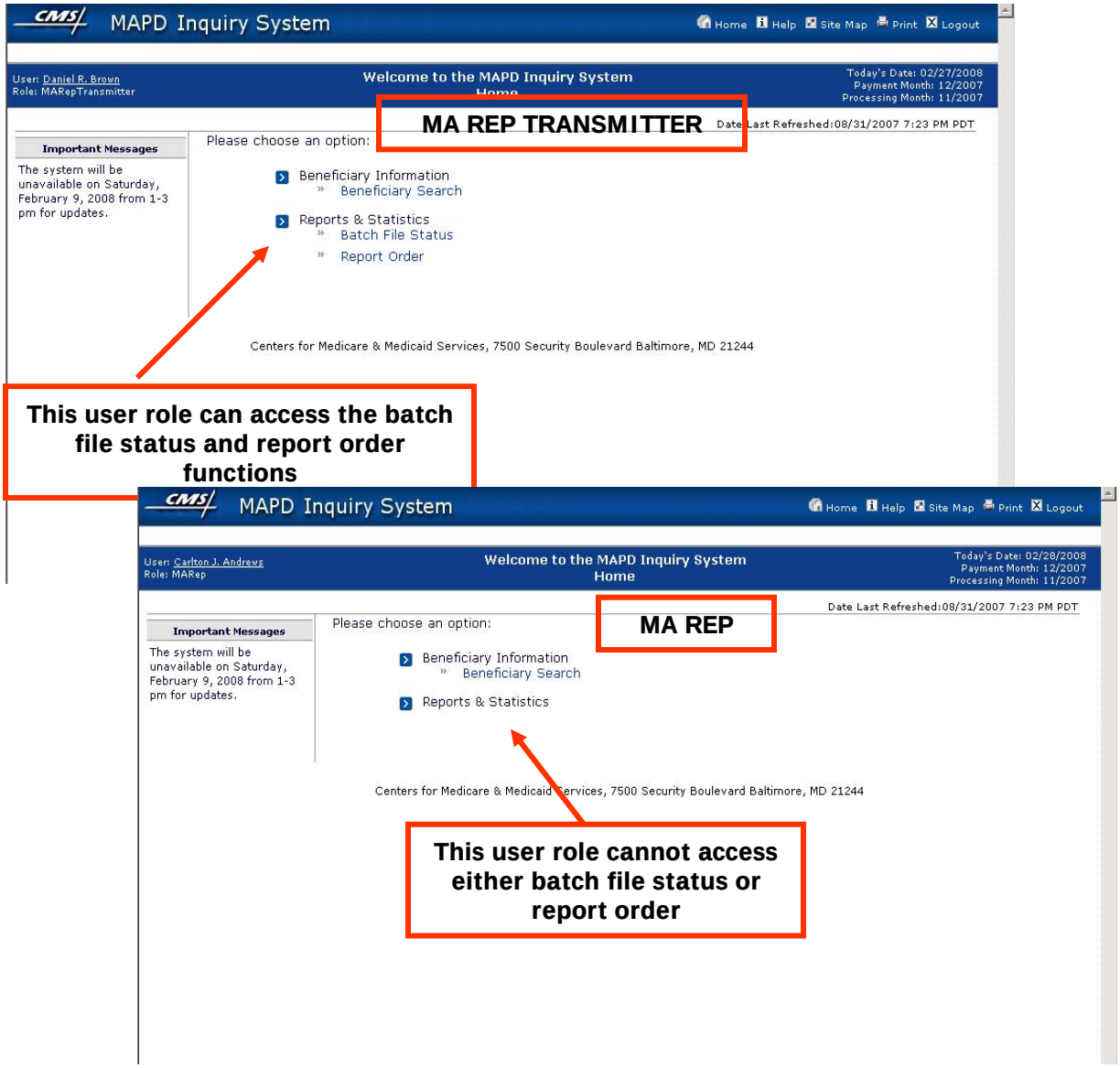
- Medicare Advantage (MA) Representative
- MA Representative Transmitter (Submitter)
- Prescription Drug Plan (PDP) Representative
- PDP Representative Transmitter (Submitter)
- Point-of-Sale Facilitated Enrollment (POSFE) Contractor
- Helpdesk
- Administrator
- State Role

2.6.2.2 MAPD IUI System Features

Similar to the Common UI, the MAPD IUI includes features on the various screens that allow the user to navigate among the screens to obtain information on the plan's membership. As indicated in the previous section, a user's role determines screen or user access. Depending on the role, certain information may or may not appear on a given screen. For example, Figure 2F highlights the section of an MAPD IUI screen where a user chooses an option. As seen in the figure, a MA Representative does not have the same access granted to a MA Representative Transmitter.

The Home screen in the MAPD IUI highlights important dates and messages, and identifies the role of the user accessing the system.

Figure 2F – Choosing an Option in MAPD IUI



When navigating among the screens in the MAPD IUI, key features to be aware of include the Main Domains and the Sub-Domains. These are similar to tabs and categorize the information for user navigation. Some of the Sub-Domain screens have a "Display All" feature that allows the user to display all the information on one screen. Figure 2G illustrates the MAPD IUI domains.

Figure 2G – Domains in MAPD IUI

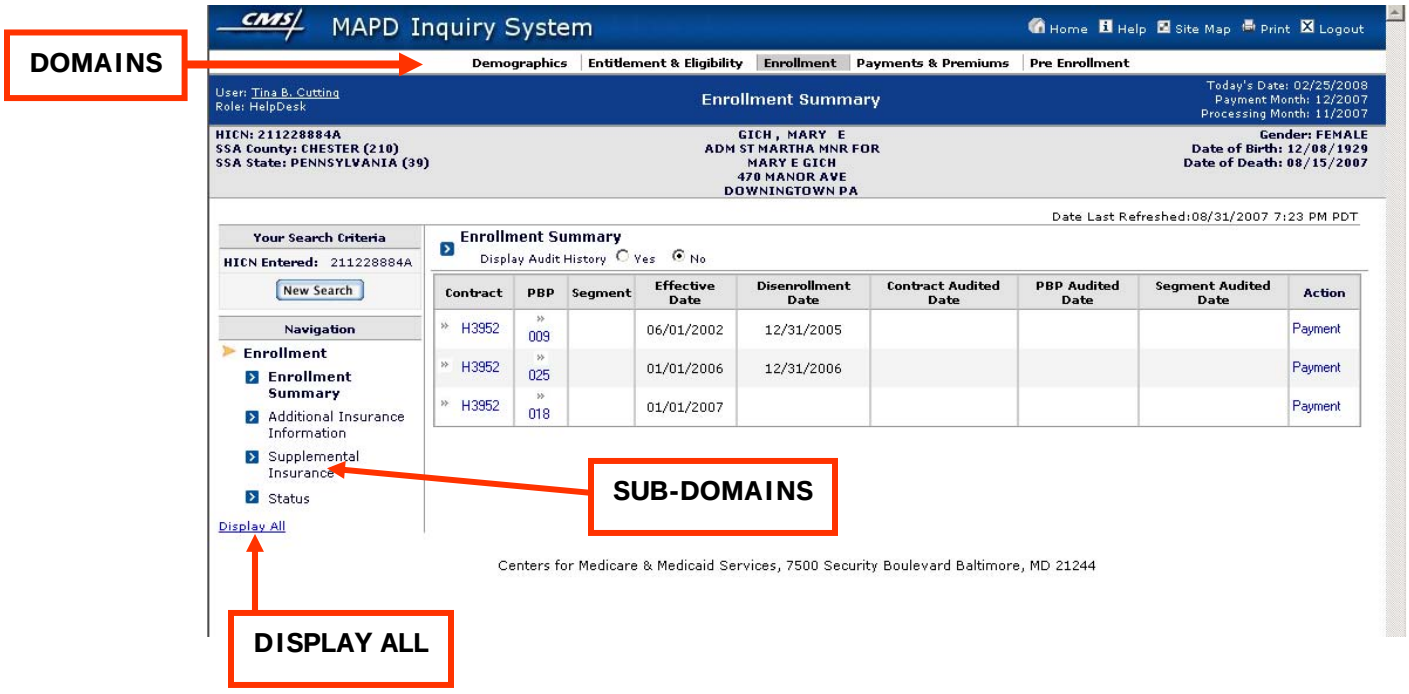
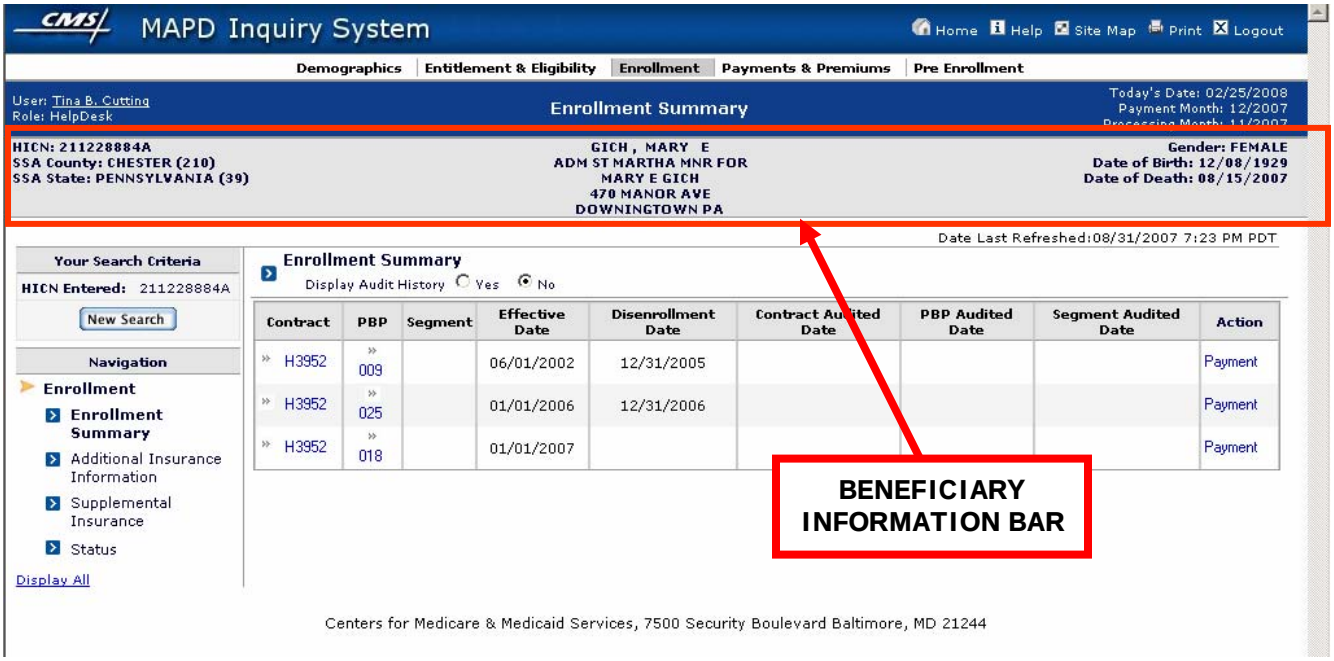


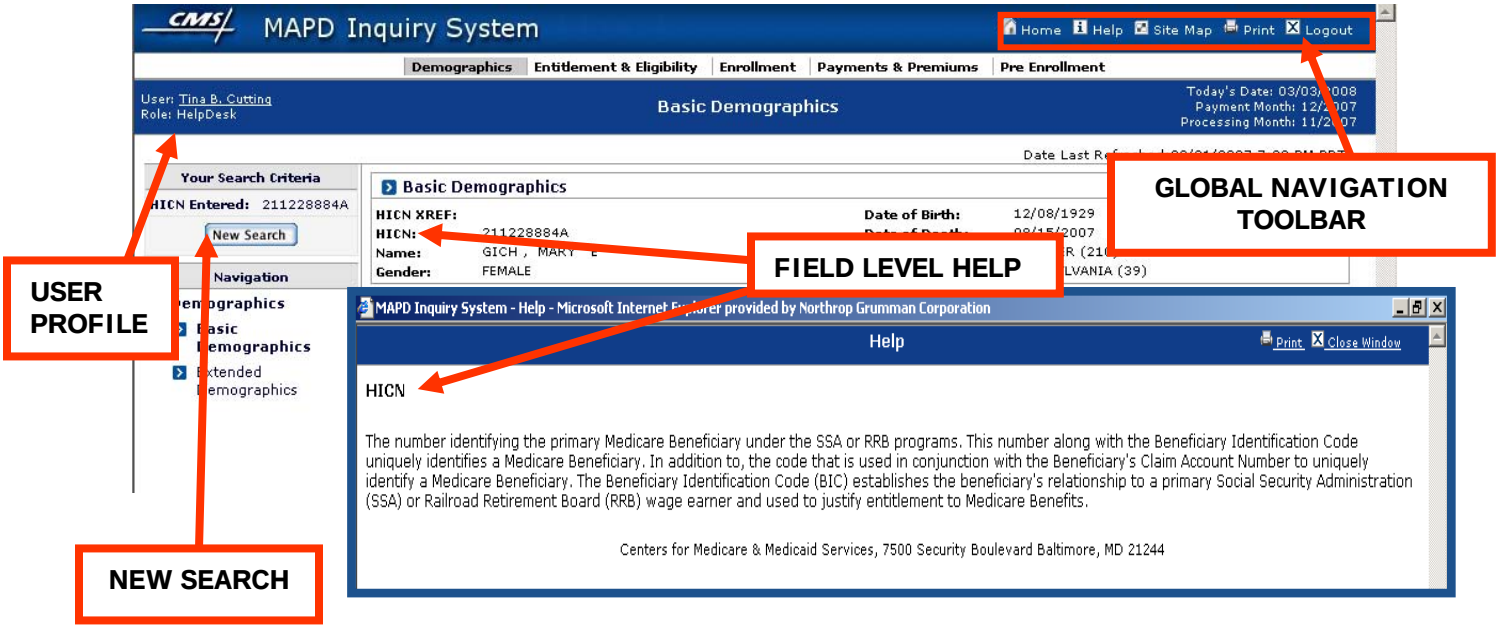
Figure 2H illustrates the Beneficiary Information Bar. The Beneficiary Information Bar provides an easy reference bar to beneficiary overview information.

Figure 2H – MAPD IUI Beneficiary Information Bar



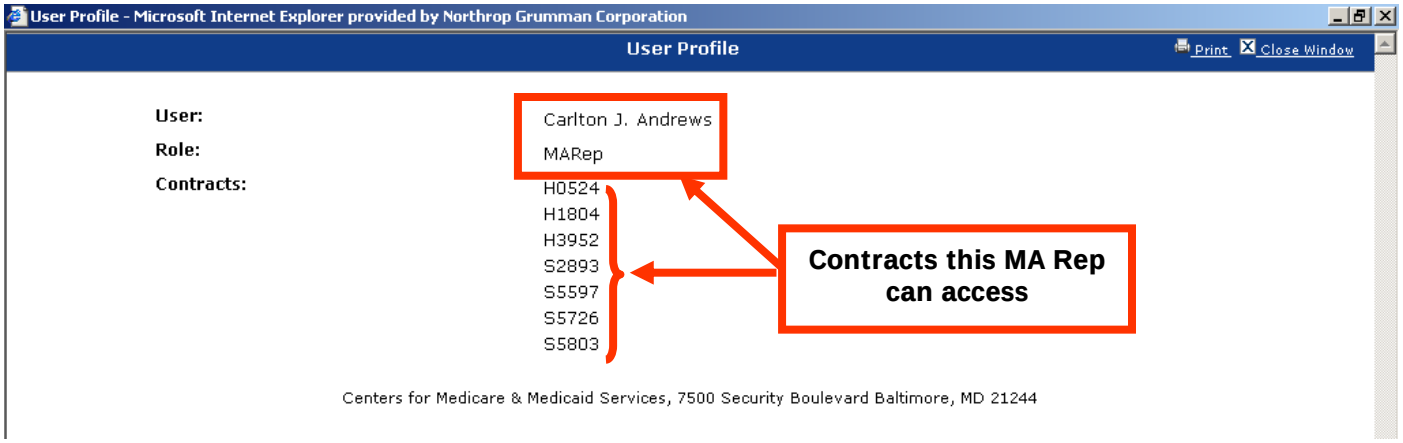
Some features on the IUI screen include the User Profile section, the global navigation toolbar, the New Search function, and Field Level Help. Figure 2I illustrate the global access features.

Figure 2I – MAPD IUI Global Access



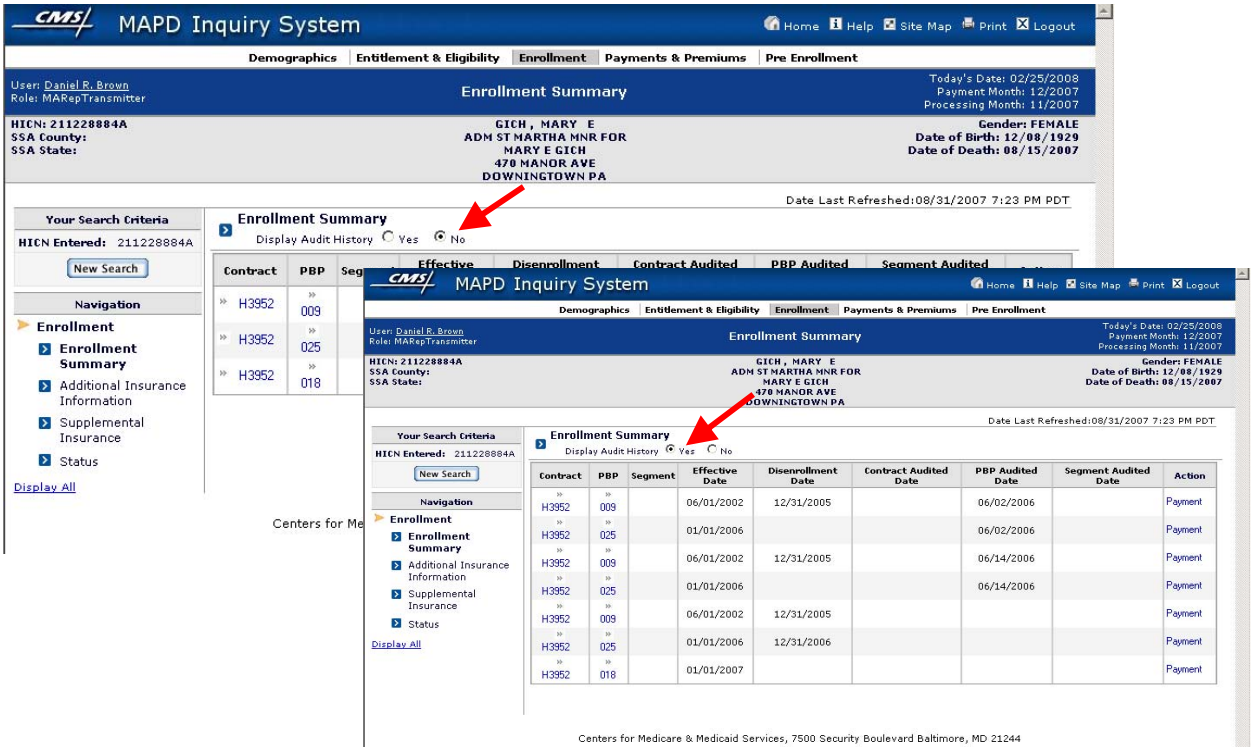
The User Profile screen allows users to view their full name, user role, and contracts for which they can view beneficiary information. Figure 2J illustrates the User Profile screen.

Figure 2J – MAPD IUI User Profile



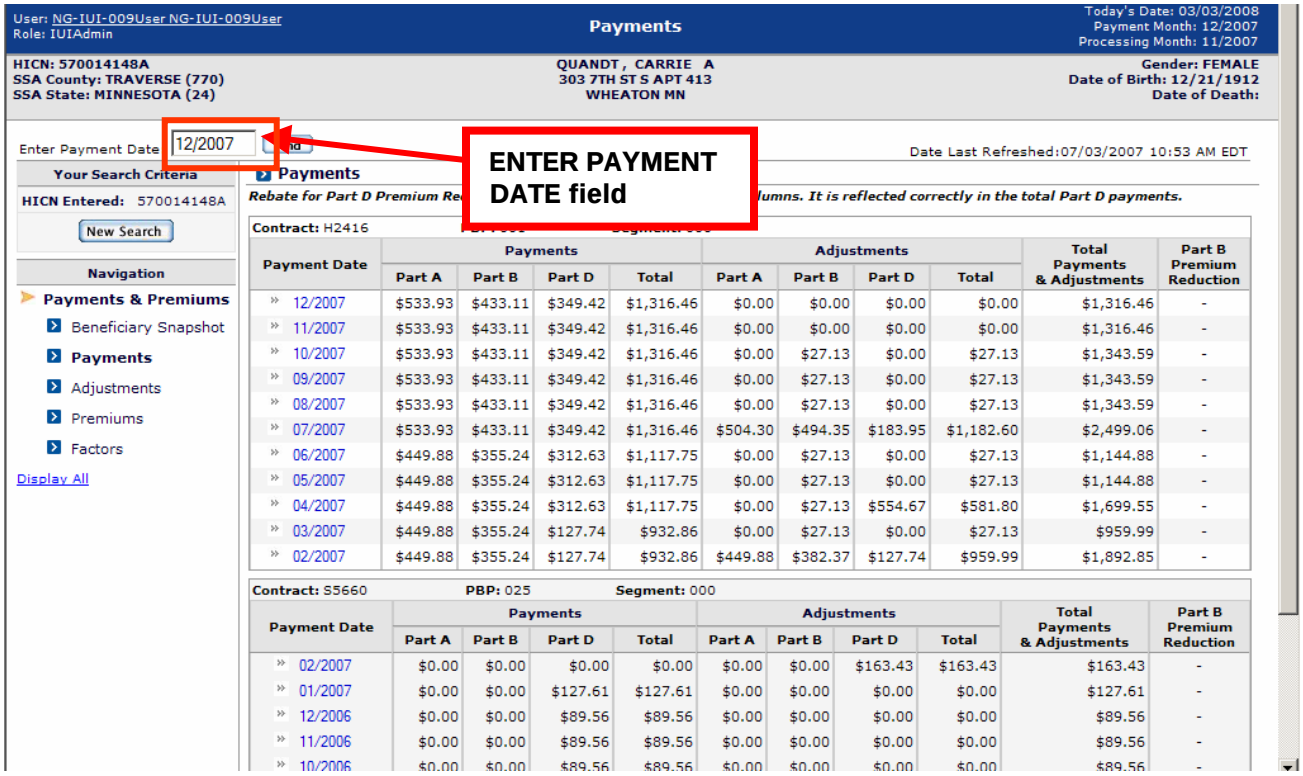
Many screens allow users to select additional (Audit) history. Simply click **Yes** to display Audit history for a beneficiary. Figure 2K illustrates the Audit History.

Figure 2K – MAPD IUI Audit History



The Enter Payment Date field on the Payments & Premiums screens allows users to change the payment month and year. Figure 2L illustrates a Payment and Premium screen.

Figure 2L – MAPD IUI Payment and Premium



User: NG-IUI-009User NG-IUI-009User
Role: IUIAdmin

Payments

Today's Date: 03/03/2008
Payment Month: 12/2007
Processing Month: 11/2007

HICN: 570014148A
SSA County: TRAVERSE (770)
SSA State: MINNESOTA (24)

QUANDT, CARRIE A
303 7TH ST S APT 413
WHEATON MN

Gender: FEMALE
Date of Birth: 12/21/1912
Date of Death:

Enter Payment Date 12/2007

Date Last Refreshed:07/03/2007 10:53 AM EDT

Your Search Criteria
HICN Entered: 570014148A
New Search

Navigation
Payments & Premiums
Beneficiary Snapshot
Payments
Adjustments
Premiums
Factors
Display All

Payments

Rebate for Part D Premium Re... lumns. It is reflected correctly in the total Part D payments.

Contract: H2416

Payment Date	Payments				Adjustments				Total Payments & Adjustments	Part B Premium Reduction
	Part A	Part B	Part D	Total	Part A	Part B	Part D	Total		
12/2007	$533.93	$433.11	$349.42	$1,316.46	$0.00	$0.00	$0.00	$0.00	$1,316.46	-
11/2007	$533.93	$433.11	$349.42	$1,316.46	$0.00	$0.00	$0.00	$0.00	$1,316.46	-
10/2007	$533.93	$433.11	$349.42	$1,316.46	$0.00	$27.13	$0.00	$27.13	$1,343.59	-
09/2007	$533.93	$433.11	$349.42	$1,316.46	$0.00	$27.13	$0.00	$27.13	$1,343.59	-
08/2007	$533.93	$433.11	$349.42	$1,316.46	$0.00	$27.13	$0.00	$27.13	$1,343.59	-
07/2007	$533.93	$433.11	$349.42	$1,316.46	$504.30	$494.35	$183.95	$1,182.60	$2,499.06	-
06/2007	$449.88	$355.24	$312.63	$1,117.75	$0.00	$27.13	$0.00	$27.13	$1,144.88	-
05/2007	$449.88	$355.24	$312.63	$1,117.75	$0.00	$27.13	$0.00	$27.13	$1,144.88	-
04/2007	$449.88	$355.24	$312.63	$1,117.75	$0.00	$27.13	$554.67	$581.80	$1,699.55	-
03/2007	$449.88	$355.24	$127.74	$932.86	$0.00	$27.13	$0.00	$27.13	$959.99	-
02/2007	$449.88	$355.24	$127.74	$932.86	$449.88	$382.37	$127.74	$959.99	$1,892.85	-

Contract: S5660 **PBP:** 025 **Segment:** 000

Payment Date	Payments				Adjustments				Total Payments & Adjustments	Part B Premium Reduction
	Part A	Part B	Part D	Total	Part A	Part B	Part D	Total		
02/2007	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$163.43	$163.43	$163.43	-
01/2007	$0.00	$0.00	$127.61	$127.61	$0.00	$0.00	$0.00	$0.00	$127.61	-
12/2006	$0.00	$0.00	$89.56	$89.56	$0.00	$0.00	$0.00	$0.00	$89.56	-
11/2006	$0.00	$0.00	$89.56	$89.56	$0.00	$0.00	$0.00	$0.00	$89.56	-
10/2006	$0.00	$0.00	$89.56	$89.56	$0.00	$0.00	$0.00	$0.00	$89.56	-

2.6.2.3 MAPD IUI System Screens

MAPD IUI includes a variety of system screens, which relate to the Pre and Post-Enrollment Categories and the Subcategories within Post-Enrollment. There is a Home screen where users start once logged into the system. From the Home screen, users can perform beneficiary searches, check batch file status or order reports if the role permits. Table 2U describes the various screens.

TABLE 2U – SYSTEM SCREENS

SCREEN	SCREEN DESCRIPTION
Beneficiary Search	The Beneficiary Search screen allows users to search for Pre- or Post-Enrollment beneficiaries.
Pre-Enrollment Beneficiary Eligibility Query Information	The Pre-Enrollment screen displays beneficiary's Demographics, Entitlement and Eligibility, Creditable Coverage, and Low Income Subsidy information.
Beneficiary Search – Pre and Post Enrollment	To perform a Post-Enrollment search, users only need to enter a beneficiary's HICN.
Basic Demographics	After a Post-Enrollment search, the Basic Demographics screen displays as the default view in Demographics, and provides information identifying the beneficiary.
Extended Demographics	The Extended Demographics screen displays beneficiary details, including mailing address, SSA county and state, and Federal Information Processing Standard (FIPS).
Entitlement & Eligibility Summary	The Entitlement & Eligibility Summary screen displays information about a beneficiary's Medicare entitlement, specifically the periods of Part A and Part B entitlement coverage.
Low Income Subsidy	The Low Income Subsidy screen shows subsidy and co-pay information for a beneficiary approved to receive help by the state or SSA, or otherwise deemed eligible.
Enrollment Summary	The Enrollment Summary screen displays enrollment information by Contract, Plan Benefit Package (PBP), and Segment (if applicable) for a beneficiary.
Enrollment Summary – Contract Details	Users can access the contract detail information by clicking the contract number when needing more detail.
Enrollment Summary – Enrollment Details	Users can view Enrollment Details for a PBP, including Segment (if applicable), by clicking on the PBP hyperlink. The Payment hyperlink in the Action column opens the Payments screen.
Additional Insurance Information	The Additional Insurance Information screen provides a summary of primary and secondary insurance responsibility for a beneficiary's medical and drug claims.
Additional Insurance Information – COB Detail	By clicking on an insurance hyperlink under Medical Coverage Type, users can view the insurer details about additional beneficiary coverage for Medical or Drug charges.
Supplemental Insurance	The Supplemental Insurance screen displays information about other insurances that pay secondary on a claim for Drug coverage: Medicare, Medicaid, or other.
Status	The Status screen displays a list of health statuses for an enrollment period, sorted by Contract, PBP, and Segment, listing one row for each status during that period. Clicking on a status hyperlink takes the user to a specific status screen.
Beneficiary Snapshot - Payments and Premiums	For Payments & Premiums, the Beneficiary Snapshot screen shows contract, demographic, risk, payment, and adjustment information.
Payment – Payment Detail	The Payments screen displays payment and adjustment information for a beneficiary's CPM by Contract, PBP, and Segment in descending date order. The Payments screen displays payment and adjustment details when a user selects a specific Payment Date hyperlink.
Adjustments	The Adjustments screen displays the payment adjustment information by Contract, PBP, and Segment, in descending order by Payment Date.
Premiums	The Premiums screen displays detailed premium information to users, showing the active premium profiles of the beneficiary up to the date specified.
Factors	The Factors screen displays factor types and details about factors that apply to the beneficiary. Next, we will look at the Batch File Status option on the Home screen.

Users can check the status of batch files by selecting Batch File Status from the Home screen and specifying a date range to view. Similarly, users can select the Report Order option from the Home screen and then complete the search fields for ordering the desired report(s).

2.7 Monthly Schedule (Slide 18)

CMS provides the Monthly Schedule to assist Plans with identifying key due dates and timelines on a monthly basis. When considering enrollment transactions, plans must take into account Payment Due dates, Certification for Enrollment, Plan Data Due, when monthly reports are available, MARx Down Days and MARx Dark Days. Government holidays are also a consideration.

In general, transaction processing occurs during the first two weeks of the month until a cut-off date. This date changes each month. After the cutoff date, the system suspends the processing of new transactions. The month-end process performs final summarization of beneficiary level payment to plan level payments. Monthly payments are reviewed by CMS before they are approved. Once approved, the enrollment processing system closes the current month and resumes the processing of transactions for the next month.

The calendar also lists MARx Down Days. MARx Down Days mean that MARx is no longer processing any new data. Plans may still submit files, but the data will not process, and the plan will have read only access to the UI.

Although not all months have them, it is important to note that the Monthly Schedule also includes MARx Dark Days. MARx Dark Days are days that the system is not processing data at all, there is no UI access, and no MARx processing.

MODULE 3 – PAYMENT OVERVIEW

Purpose (Slide 2)

Legislation mandates that CMS pay applicable Parts C and D plans in a manner that is accurate and fair. This requires the coordination of data from various sources. This module introduces the components of monthly payments, the systems involved in capturing the data, and the reporting of payment to plans.

Learning Objectives (Slide 3)

At the completion of this module, participants will:

- Identify the three main sources of monthly payment
- Explain the Social Security Administration's role in premium withhold
- Describe the relationship between the Medicare Advantage Prescription Drug System (MARx), Premium Withhold System (PWS), and the Automated Plan Payment System (APPS)
- Interpret the nine sections of the Plan Payment Report (PPR)

ICON KEY

Example

Reminder

Resource

3.1 Overview of Payment (Slide 4)

CMS makes a monthly payment to contracting health plans that provide Medicare benefits for beneficiaries enrolled in their plans. Payments to plans occur at the contract-level, while enrollments occur at the plan benefit package level (PBP). Table 3A identifies the three main sources contributing to a plan's monthly payment.

TABLE 3A – MONTHLY PAYMENT SOURCES

SOURCE	PAYMENT CONTRIBUTION
Medicare Advantage Prescription Drug System (MARx)	• Capitated Payments • Late Enrollment Penalties (LEP)
Premium Withhold System (PWS)	• Premium Withhold Payments
Automated Plan Payment System (APPS)	• Other Payments • Fees • Charges

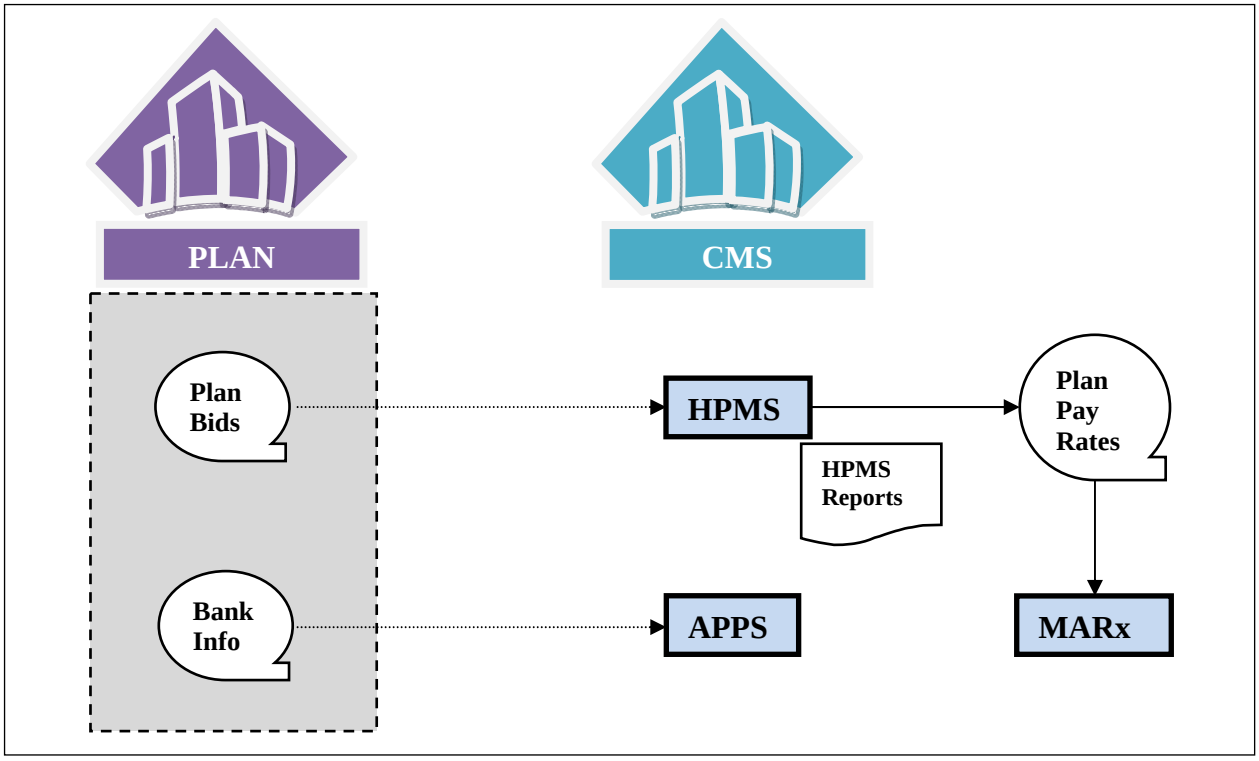
APPS is not only a source of payments, but acts as the **consolidator** for all payment sources. APPS reports the consolidated payment on the CMS Plan Payment Report (PPR), also referred to as the Plan Payment Letter.

3.1.1 Payment Prerequisites (Slide 5)

Figure 3A provides a high-level illustration of the payment setup required for plans to receive monthly payments.

- Plans submit bid data to CMS in June each year using the Bid Pricing Tool (BPT).
- Approved bids determine plan payment rates. The Health Plan Management System (HPMS) releases the approved rates and other plan information to MARx and other CMS systems.
- Organizations new to CMS must submit banking information for each contract.

Figure 3A – Payment Prerequisites

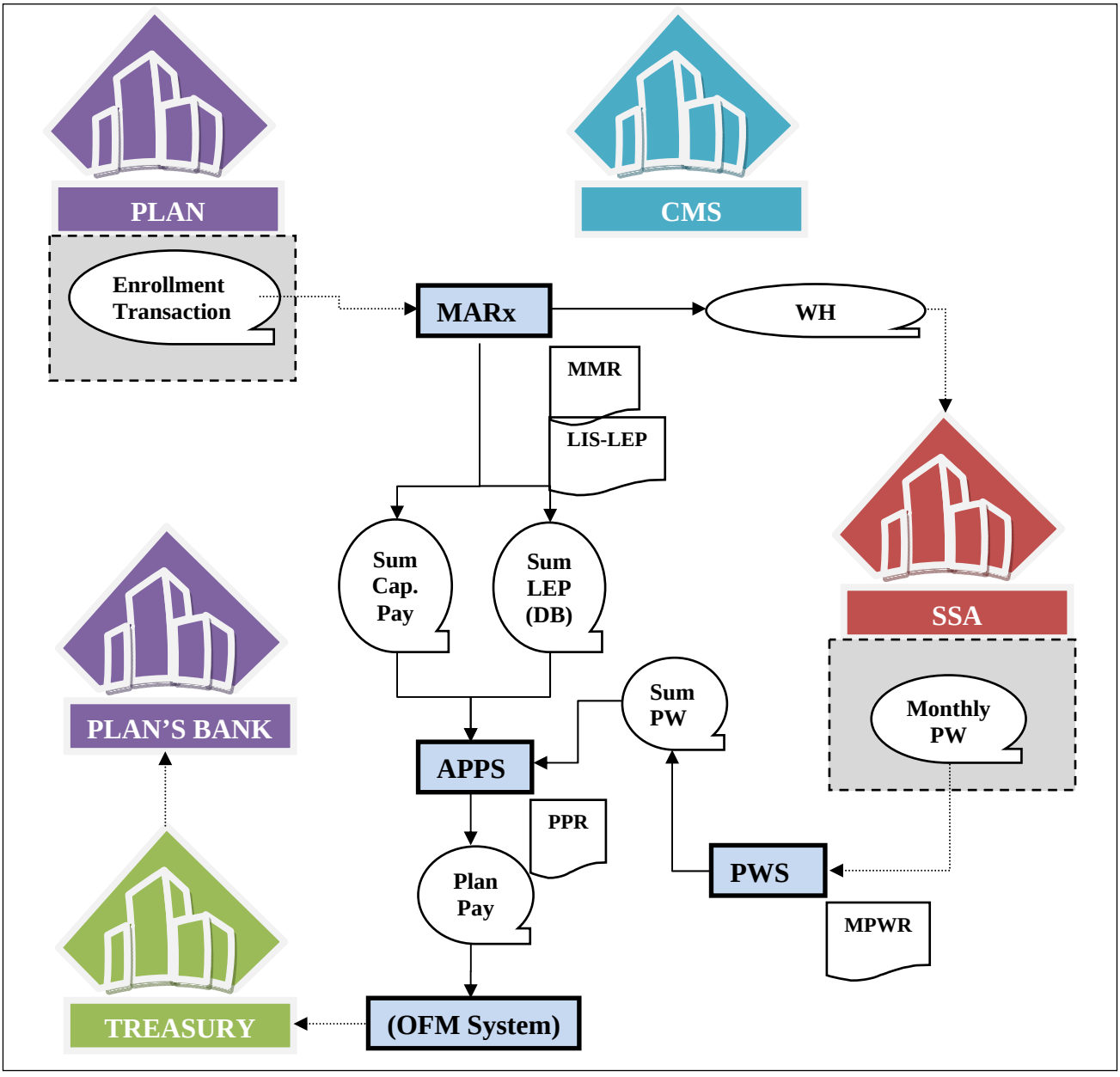


3.1.2 Monthly Plan Payment (Slide 6)

Figure 3B provides a high-level illustration of monthly plan payment.

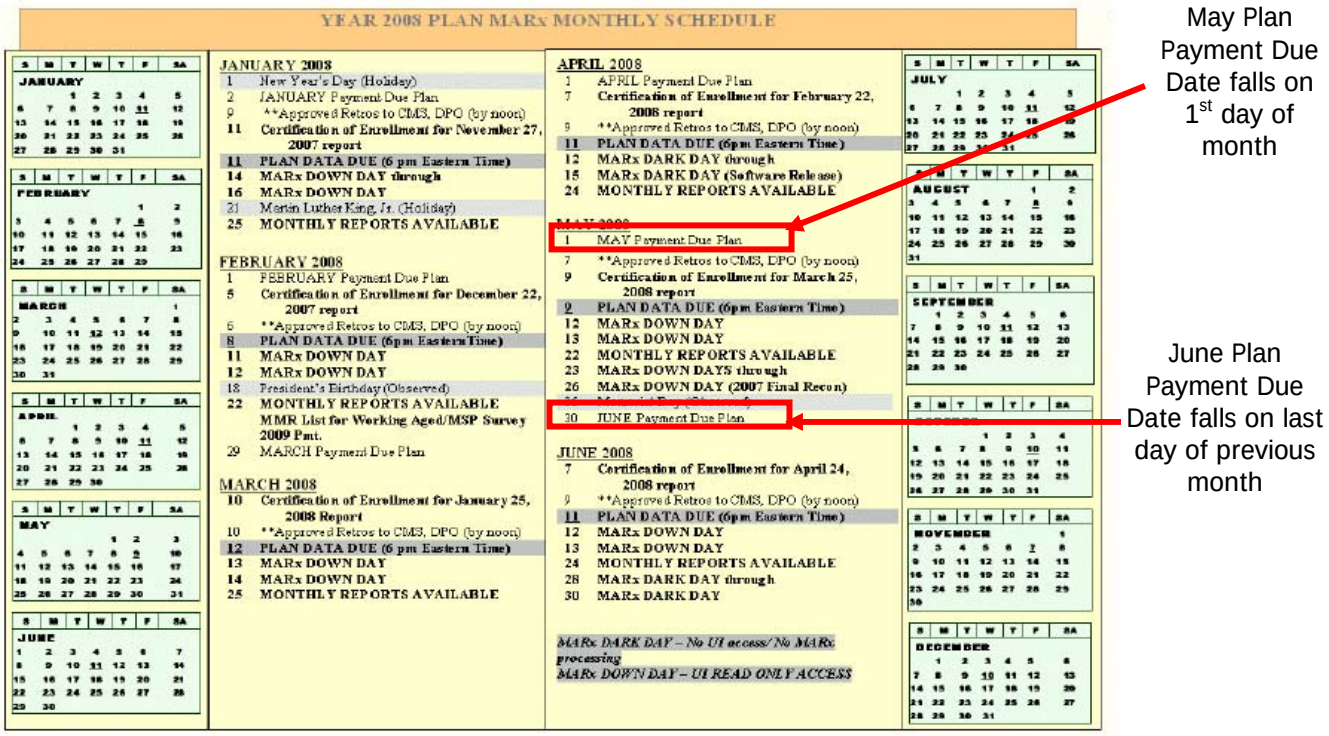
- Plans continually submit enrollments. Established enrollments result in the calculation of monthly capitation payments in MARx for each enrollee.
  - The MARx reports monthly capitation payments for each enrollee on the Monthly Membership Report (MMR).
  - The capitated payments summarized to the plan level are forwarded to the APPS system for inclusion in the monthly plan payment.
- Enrollees in Part D plans enrolling "late," with the exception of LIS are required to pay CMS a Late Enrollment Penalty (LEP).
  - The LEP is calculated as 1% of the National Base Beneficiary Premium multiplied by the number of uncovered months (NUNCMO) indicated on the enrollment transaction.
  - MARx reports monthly LEPs on the LIS-LEP Report. Only enrollees owing LEP who also pay premiums directly ("direct billing") are listed on the report since these amounts require a plan payment adjustment. Specifically these amounts are subtracted from the monthly plan payments.
  - The Direct Bill LEP amounts summarized to the plan level are forwarded to the APPS system for inclusion in the monthly plan payment.
- For enrollees electing to pay plan premiums via premium withholding CMS forwards premium withholding (PW) requests to SSA.
  - Typically, there is a lag of two months before withholding payments begin.
  - The PWS reports monthly premium withholding payments for each enrollee on the Monthly Premium Withholding Report (MPWR).
  - PWS reports monthly LEPs on the MPWR Report for applicable enrollees who pay premiums via withholding. These amounts are reported for information only since these amounts do not require a plan payment adjustment.
- APPS consolidates payments from all sources including APPS itself and calculates a net payment for each plan.
  - The APPS system reports the net payment on the PPR.
  - The net payment listed on the PPR is sent to the plan's bank via CMS's Office of Financial Management's (OFM) system and the United States Treasury.

Figure 3B – Monthly Plan Payment



CMS distributes the monthly payment according to the schedule identified on Year 2008 Plan MARx Monthly Schedule. Figure 3C illustrates the payment schedule and how payments may occur on either the first day of the month or the last day of the previous month.

Figure 3C – Payment Schedule



3.2 MARx System

3.2.1 Capitated Payments (Slide 7-8)

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 have two options. Beneficiaries can select traditional Medicare Fee-for-Service (FFS) or a Medicare Advantage (MA) plan. For Part D, which is coverage for prescription drug benefits, beneficiaries can choose to receive all three-benefit types (Medicare Part A, B, and D) by enrolling in a 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 3B.

TABLE 3B – 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

In addition to the Direct Subsidy payments Part D Capitated Payments also includes the following non-risk-adjusted components:

- LIS Cost Sharing Subsidy (Low Income enrollees)
- LIS Premium Subsidy (Low Income enrollees)
- Reinsurance Subsidy
- PACE Premium Add On (PACE Plans dual eligible enrollees)
- PACE Cost Sharing Add On (PACE Plans dual eligible enrollees)
- Rebate for Part D Basic Premium Reduction (MA-PD Plans only)

3.2.1.1 Monthly Membership Report (MMR) (Slide 9)

The MARx System calculates capitated payments and reports the results on the MMR. Plans receive capitated payments for each calendar month in a beneficiary's enrollment period with the plan.

MARx generates the MMR as part of the month-end processing. Table 3C lists the fields on the MMR that identify the amounts paid to plans prospectively.

TABLE 3C – MMR PROSPECTIVE DATA

FIELD NUMBER	FIELD NAME
64	Total Part A MA Payment
65	Total Part B MA Payment
66	Total MA Payment Amount
77	Total Part D Payment*

*While the Part D summary payment field on the MMR may be inaccurate, the actual payment calculated in APPS is unaffected.

Table 3D 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 3D – MMR DETAIL FILE DATA FOR MMR ARITHMETIC-FIELD 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
	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
	65	**Total Part B MA Payment**	**X**	
	66	**Total MA Payment Amount**	**X**	
Prescription Drug Payment (Part D)				
	35	LIS Premium Subsidy		Field-77
	72	Rebate for Part D Basic Premium Reduction		Field-77
	75	Reinsurance Subsidy Amount		Field-77
	76	Low-Income Subsidy Cost-Sharing Amount		Field-77
	74	Part D Direct Subsidy Payment Amount		Field-77
	79	PACE Premium Add On		Field-77
	80	PACE Cost Sharing Add-on		Field-77
	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		
Factors and Multipliers	67	Part D RA Factor		Field-74
	68	Part D Low-Income Indicator		Field-74
	69	Part D Low-Income Multiplier		Field-74
	70	Part D Long Term Institutional Indicator		Field-74
	71	Part D Long Term Institutional Multiplier		Field-74
	73	Part D Basic Premium Amount – For Payment Purposes		Field-74

Example 1 (Slide 10)

Table 3E illustrates MMR Arithmetic for five plan payments using sample data from an MMR Detail Data File.

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

TABLE 3E – MMR ARITHMETIC EXAMPLES

MMR "Arithmetic" Examples April 2008	#1. MA-PD, Part A/B Bid < BM	#2. MA-PD, Part A/B Bid > BM	#3. MA Only, Part A/B Bid < BM	#4. PACE Plan, Dual Eligible Beneficiary	#5. Prescription Drug Plan (PDP)
Medicare Advantage Payment (Part C)					
33. Risk Adjuster Paymt/Adjustmt Rate A	$ 455.00	$ 508.00	$ 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				
64. Total Part A MA Payment	**$ 483.00**	**$ 498.00**	**$ 501.00**	**$ 650.00**	
34. Risk Adjuster Paymt/Adjustmt Rate B	$ 427.00	$ 463.00	$ 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				
65. Total Part B MA Payment	**$ 453.20**	**$ 453.00**	**$ 397.00**	**$ 635.00**	
66. Total MA Payment Amount	**$ 936.20**	**$ 951.00**	**$ 898.00**	**$ 1,285.00**	
Prescription Drug Payment (Part D)					
35. LIS Premium Subsidy	$ 26.00	$ 26.00		$ 26.00	$ 26.00
72. Rebate for Part D Basic Premium Reduction	$ (+) 5.00				
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	
77. Total Part D Payment	**$ 278.25**	**$ 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.

3.2.2 Summarization of Capitated Payments

MARx will generate summary payment/adjustment data and maintain the plan summary totals in the MARx database. Table 3F describes the organization of summary totals for prospective payment amounts and adjustments.

TABLE 3F – ORGANIZATION OF SUMMARY PROSPECTIVE PAYMENT AMOUNTS AND ADJUSTMENTS

SUMMARY PROSPECTIVE PAYMENT AMOUNTS/ADJUSTMENTS	ORGANIZED BY
Number of beneficiaries currently enrolled in managed care	• Contract number • PBP • Segment • Payment month
MA Rebate Data including Part B Premium Reduction Amounts	• Contract number • PBP • Segment
Monthly Part A, Part B, and Part D prospective payment amounts	• Contract number • PBP • Segment
Monthly Part A, Part B, and Part D retroactive adjustment amounts and adjustment reason codes	• Contract number • PBP • Segment

Each month MARx computes beneficiary prospective payment and retroactive adjustment amounts summarized, by contract, plan, and segment levels. The MMR provides a summary of the capitated payments included in this month's payment. MARx also forwards the summarized capitated payments to the APPS system.

3.2.3 Late Enrollment Penalties (Slide 11)

CMS reports LEP data for Part D beneficiaries on a beneficiary-level, which the Plan Payment Report reflects as an adjustment. The Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Report informs plans of the net amount of LEP for direct billed beneficiaries (Field 18) and the net amount payable to the plan (Field 19).

LIS eligible beneficiaries are exempt from LEP. Therefore, beneficiaries paying LEP that become LIS eligible have the penalty removed from direct billing.

3.2.3.1 LIS-LEP Report

Table 3G provides the data file for the LIS/LEP Report for Part D beneficiaries. The data file includes three records and are 165 bytes in length:

- Header
- Detail
- Trailer

TABLE 3G – LIS/LEP DATA FILE RECORD LAYOUT

Header Record

#	Field Name	Len	Pos	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

Detail Record

#	Field Name	Len	Pos	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
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

TABLE 3G – LIS/LEP DATA FILE RECORD LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
***** PREMIUM PERIOD**				
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
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

TABLE 3G – LIS/LEP DATA FILE RECORD LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
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

Trailer Record

#	Field Name	Len	Pos	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

3.3 Premium Withholding Payments (Slide 12)

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Medicare beneficiaries can elect to have plan premiums withheld by Social Security as a reduction in monthly benefit checks 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 PWS reports the transferred premium withholding payment amounts on the Monthly Premium Withholding Report (MPWRD).

3.3.1 Monthly Premium Withhold Report Data File (MPWRD) (Slide 13)

The Monthly Premium Withhold Report Data File (MPWRD) is a monthly file of premiums withheld from SSA checks. In the future, the file will include premiums withheld from the Railroad Retirement Board (RRB) or the Office of Personnel Management (OPM). The file includes Part C and Part D premiums and any Part D LEP for information. The Part D LEP is for information purposes only and does not impact payment.

The PWS produces the data file, which includes three records types. Each record is 165 bytes in length. Table 3H identifies the file structure and Table 3I provides the data file format.

TABLE 3H – MWPRD FILE STRUCTURE

RECORD NAME	DESCRIPTION
Header Record	• Identifies the data fie
Detail Record	• Provides the premium information for each plan enrollee for Part C and D • Provides information on late enrollment penalties
Trailer	• Provides individual and summary totals of the premiums collected • Provides total late enrollment penalties collected

TABLE 3I – MPWRD REPORT DATA FILE

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 3I – MPWRD REPORT DATA FILE (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	PIC X(3)
5	HIC Number	12	14 – 25	Member's HIC # PIC X(12)
6	Surname	7	26 – 32	PIC X(7)
7	First Initial	1	33	PIC X
8	Sex	1	34	M = Male, F = Female PIC X
9	Date of Birth	8	35 – 42	YYYYMMDD PIC 9(8)
10	Premium Payment Option	3	43 – 45	Premium Payment Option in effect for this Pay Month "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 Covers YYYYMMDD PIC 9(8)
13	Premium Period End Date	8	55 – 62	Ending Date of Period Premium Payment Covers YYYYMMDD PIC 9(8)
14	Number of Months in Premium Period	2	63 – 64	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 refund by withholding agency to beneficiary of premiums paid in a prior premium period PIC -9999.99
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 refund by withholding agency to beneficiary of premiums paid in a prior premium period 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 refund by withholding agency to beneficiary of penalties paid in a prior premium period PIC -9999.99
18	Filler	77	89 – 165	Spaces

TABLE 31 – MPWRD REPORT DATA FILE (CONTINUED)

Trailer Record

Item	Field	Size	Position	Description
1	Record Type	2	1 – 2	T1 = Trailer Record, withheld totals at segment level T2 = Trailer Record, withheld totals at PBP level T3 = Trailer record, withheld totals at 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	Not populated on T2 or T3 records PIC X(3)
5	Total Part C Premiums Collected	14	14 – 27	Total withholding collections as specified by Trailer Record type, field (1) PIC -9(10).99
6	Total Part D Premiums Collected	14	28 – 41	Total withholding collections as specified by Trailer Record type, field (1) PIC -9(10).99
7	Total Part D Late Enrollment Penalties Collected	14	42 – 55	Total withholding collections as specified by 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 Penalties Collected PIC -9(10).99
9	Filler	96	70 – 165	Spaces

3.4 APPS System Payments, Fees, and Charges (Slide 14)

The APPS system is an additional source of plan payments, fees, and charges. These additional amounts include:

- contract-level payment adjustments authorized by CMS and entered into APPS for a specific purpose or issue
- authorized collection of user fees for both National Medicare Education Campaign (NMEC) and Coordination Of Benefit (COB)
- contract-level Medicare Secondary Payer (MSP) adjustments

An example of a contract-level payment adjustment is the annual Part D Reconciliation amount.

APPS then consolidates the payment for each contract from all three system sources (MARx, PWS and APPS).

The APPS System reports the consolidated plan payment on the CMS PPR. The PPR is available in both print file and data file formats. Also made available is a separate Health Information Portability and Accountability Act (HIPAA) compliant version of the PPR, known as the 820 Format Payment Advice.

3.4.1 CMS Plan Payment Report (PPR) (Slide 15)

The PPR itemizes the final monthly payments to plans. The APPS System produces this report following calculation of the final monthly payment. This report includes contract-level adjustments. CMS makes this report available to plans through the Common User Interface (CUI) as part of the month-end processing.

The PPR displays the summarized amounts wired to plan's accounts by the Treasury Department, including Parts A/B and Part D payment amounts.

CMS includes nine sections on the report defining the payment plan receives. Table 3J outlines each section of the report. Figure 3D is a sample of the PPR.

TABLE 3J – SECTIONS OF THE PPR

SECTION OF REPORT	DESCRIPTION
Prospective Payments	• Provides the base payment amount • Summarized from MARx/MMR payment records
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
Plan-Level Adjustments	• Provides payment amounts on a plan-level - National Medicare Education Campaign (NMEC) - Coordination of Benefits (COB) User Fees - Medicare Secondary Payer (MSP) for MAs only • Summarized from MARx Factors in APPS
CMS Adjustments	• CMS adjustments to Parts A, B and D payments
Subtotals	• Provides subtotals prior to premium settlements
Premium Settlement	• Provides different premium settlements - Part C premium withheld - Part D premium withheld - Prospective/Adjusted LIS - LEP for direct bill members
Net Payment	• Provides the plan's payment after subtracting and/or adding adjustments

Figure 3D describes the PPR data file structure includes eight records that are all 735 bytes in length.

Figure 3D – PPR

```
|---------1---------2---------3---------4---------5---------6---------7---------8---------9---------0---------1---------2-------
  CMS PLAN PAYMENT REPORT                                                                              PAGE 1 OF 2
  PLAN NUMBER: H9999                                                                          PAYMENT MONTH: MM/YYYY
  PLAN NAME: ABC HEALTH PLANS INC                                                               RUN DATE: MM/DD/YYYY

  PAYMENT TYPE:                                                    A/B PAYMENT              D PAYMENT              NET PAYMENT


  1. PROSPECTIVE PAYMENT:
     A/B PAYMENT                          MEMBERS: ZZ,ZZZ,ZZ9     $  Z,ZZZ,ZZZ,ZZ9.99
     D PAYMENT                            MEMBERS: ZZ,ZZZ,ZZ9                              $  Z,ZZZ,ZZZ,ZZ9.99

  2. ADJUSTMENTS TO PRIOR MONTHS AFFECTING A/B & D PAYMENTS:
     (01) DEATH OF BENEFICIARY..........COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     (02) RETROACTIVE ACCRETION.........COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     (03) RETROACTIVE DELETION..........COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     (04) CORRECTION TO ACCRETION.......COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     (05) CORRECTION TO DELETION........COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     (06) PART A ENTITLEMENT LOSS.......COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     (12) CORRECTION TO DEATH...........COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     (19) CORRECTION TO PART B ENT......COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     (22) RETRO DELETE DUE TO ESRD......COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     (35) RETRO CHANGE TO REBATE........COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99

  3. ADJUSTMENTS TO PRIOR MONTHS AFFECTING A/B PAYMENTS:
     (07) HOSPICE.......................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (08) ESRD..........................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (09) INSTITUTIONAL.................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (10) MEDICAID......................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (11) RETRO SCC.....................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (13) CORRECTION TO BIRTH...........COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (14) CORRECTION TO SEX.............COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (18) A/B RATE......................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (20) WORKING AGED..................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (21) NHC...........................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (23) DEMO FACTOR ADJUSTMENT........COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (25) RETRO RA RECON ...............COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (26) RETRO RA ONGOING..............COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (27) RETRO CHF.....................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (29) HOSPICE RATE..................COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99
     (34) PART C BASIC PREMIUM..........COUNT: ZZ,ZZZ,ZZ9     $ -Z,ZZZ,ZZZ,ZZ9.99

  4. ADJUSTMENTS TO PRIOR MONTHS AFFECTING D PAYMENTS:
     (30) PART D PREMIUM................COUNT: ZZ,ZZZ,ZZ9                              $ -Z,ZZZ,ZZZ,ZZ9.99
     (32) ESTIMATED LICS................COUNT: ZZ,ZZZ,ZZ9                              $ -Z,ZZZ,ZZZ,ZZ9.99
     (33) ESTIMATED REINSURANCE.........COUNT: ZZ,ZZZ,ZZ9                              $ -Z,ZZZ,ZZZ,ZZ9.99
     (36) PART D RATE...................COUNT: ZZ,ZZZ,ZZ9                              $ -Z,ZZZ,ZZZ,ZZ9.99
     (37) PART D RA FACTOR..............COUNT: ZZ,ZZZ,ZZ9                              $ -Z,ZZZ,ZZZ,ZZ9.99

  CMS PLAN PAYMENT REPORT                                                                              PAGE 2 OF 2
  PLAN NUMBER: H9999                                                                          PAYMENT MONTH: MM/YYYY
  PLAN NAME: ABC HEALTH PLANS INC                                                               RUN DATE: MM/DD/YYYY

  PAYMENT TYPE:                                                    A/B PAYMENT              D PAYMENT              NET PAYMENT

  5. PLAN LEVEL ADJUSTMENTS:
     A. EDUCATION USER FEE
        1) AMOUNT SUBJECT TO FEE      $  Z,ZZZ,ZZZ,ZZ9.99
        2) X FEE RATE                          -0.9999%     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     B. COB USER FEE
        1) PROSP D MEMBERS                  ZZ,ZZZ,ZZ9
        2) X FEE RATE                          $ -0.99                              $ -Z,ZZZ,ZZZ,ZZ9.99
     C. WORKING AGED/DISABLED ADJUSTMENT
        1) ADJUSTED DEMOG PMT         $  Z,ZZZ,ZZZ,ZZ9.99
        2) X PLAN DEMOG RATE                   -0.9999%     $ -Z,ZZZ,ZZZ,ZZ9.99
        3) ADJUSTED RA PMT            $  Z,ZZZ,ZZZ,ZZ9.99
        4) X PLAN RA RATE                      -0.9999%     $ -Z,ZZZ,ZZZ,ZZ9.99
     D. BIPA 606 PAYMENT REDUCTION
        1) ADJUSTMENTS PRIOR TO 2006                        $ -Z,ZZZ,ZZZ,ZZ9.99
     E. BBRA BONUS PAYMENTS
        1) ADJUSTMENTS PRIOR TO 2004                        $ -Z,ZZZ,ZZZ,ZZ9.99

  6. CMS ADJUSTMENTS:
     <== DESCRIPTION TEXT FOR MANUAL ADJUSTMENTS ======>    $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99
     <== DESCRIPTION TEXT (OPTIONAL LINES) ============>    $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99

  7. SUBTOTALS BEFORE PREMIUM SETTLEMENT:                   $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99     $ -Z,ZZZ,ZZZ,ZZ9.99

  8. PREMIUM SETTLEMENT:
     A. PREMIUM WITHHOLDING
        1) PART C PREMIUMS                                                                                $ -Z,ZZZ,ZZZ,ZZ9.99
        2) PART D PREMIUMS                                                                                $ -Z,ZZZ,ZZZ,ZZ9.99
     B. LOW INCOME SUBSIDY
        1) PROSPECTIVE LIS                                                                                $  Z,ZZZ,ZZZ,ZZ9.99
        2) ADJUSTMENTS TO LIS                                                                             $ -Z,ZZZ,ZZZ,ZZ9.99
     C. LATE ENROLLMENT PENALTY (DIRECT BILL ONLY)                                                        $ -Z,ZZZ,ZZZ,ZZ9.99

  9. NET PAYMENT:                                                                                         $  Z,ZZZ,ZZZ,ZZ9.99

---------1---------2---------3---------4---------5---------6---------7---------8---------9---------0---------1---------2---------3
OTE: THE NEGATIVE SIGN SHOULD FLOAT BUT THE DOLLAR SIGN ("$") CAN REMAIN IN A FIXED POSITION.
```

3.4.1.1 PPR Prospective Payment Section (Slide 16)

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, plans 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 will cover one month of the enrollment period. Figure 3E illustrates the prospective payment section of the report.

Figure 3E - PPR Prospective Payment Section

```
CMS PLAN PAYMENT REPORT                                                    PAGE 1 OF 2
PLAN NUMBER: H9999                                                PAYMENT MONTH: MM/YYYY
PLAN NAME: ABC HEALTH PLANS INC                                     RUN DATE: MM/DD/YYYY

PAYMENT TYPE:                                    A/B PAYMENT          D PAYMENT          NET PAYMENT


1. PROSPECTIVE PAYMENT:
   A/B PAYMENT                 MEMBERS: ZZ,ZZZ,ZZ9    $  Z,ZZZ,ZZZ,ZZ9.99
   D PAYMENT                   MEMBERS: ZZ,ZZZ,ZZ9                      $  Z,ZZZ,ZZZ,ZZ9.99
```

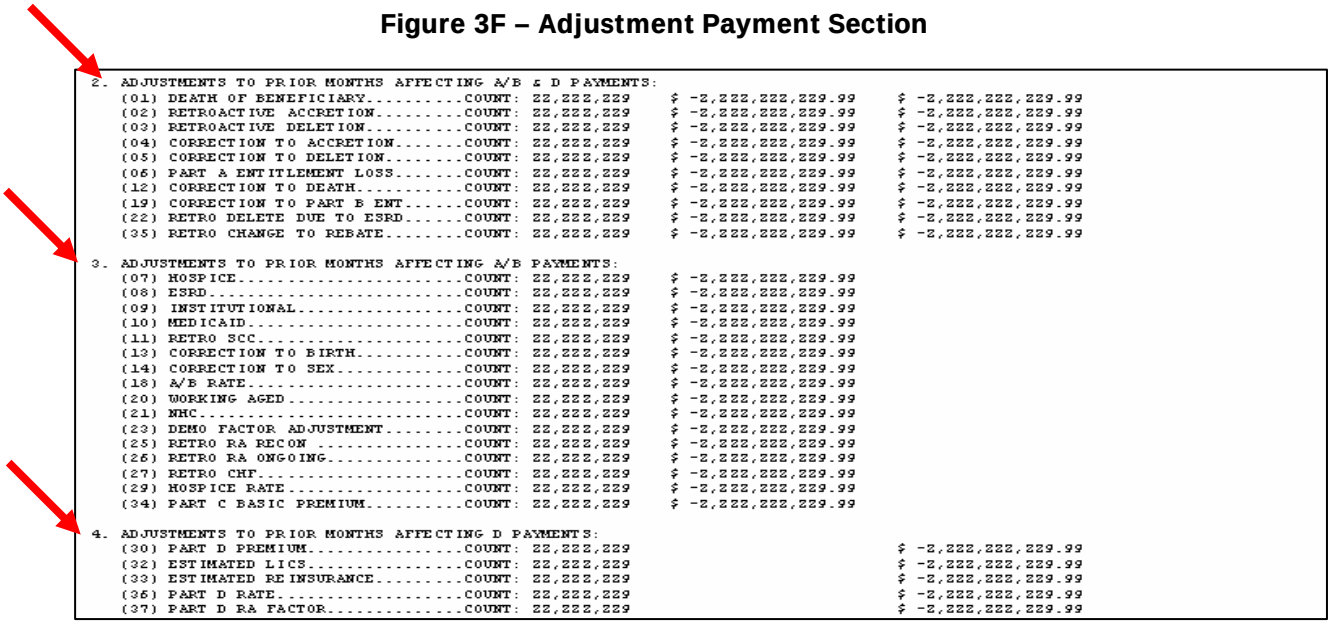
3.4.1.2 PPR Adjusted Payment Sections (Slide 17)

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 PPR categories the adjusted payments into three sections by payment type

- Adjustments affecting Parts A, B and D
- Adjustments affecting Parts A and B
- Adjustments affecting Part D

Each section provides 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 3F illustrates the adjustment payment section of the PPR and Table 3K outlines the enrollment and status changes that can result in adjustment payment.

Figure 3F – Adjustment Payment Section



```
2. ADJUSTMENTS TO PRIOR MONTHS AFFECTING A/B & D PAYMENTS:
   (01) DEATH OF BENEFICIARY..........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
   (02) RETROACTIVE ACCRETION.........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
   (03) RETROACTIVE DELETION..........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
   (04) CORRECTION TO ACCRETION.......COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
   (05) CORRECTION TO DELETION........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
   (06) PART A ENTITLEMENT LOSS.......COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
   (12) CORRECTION TO DEATH...........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
   (19) CORRECTION TO PART B ENT......COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
   (22) RETRO DELETE DUE TO ESRD......COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
   (35) RETRO CHANGE TO REBATE........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99

3. ADJUSTMENTS TO PRIOR MONTHS AFFECTING A/B PAYMENTS:
   (07) HOSPICE.......................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (08) ESRD..........................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (09) INSTITUTIONAL.................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (10) MEDICAID......................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (11) RETRO SCC.....................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (13) CORRECTION TO BIRTH...........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (14) CORRECTION TO SEX.............COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (18) A/B RATE......................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (20) WORKING AGED..................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (21) WHC...........................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (23) DEMO FACTOR ADJUSTMENT........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (25) RETRO RA RECON ...............COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (26) RETRO RA ONGOING..............COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (27) RETRO CHF.....................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (29) HOSPICE RATE..................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
   (34) PART C BASIC PREMIUM..........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99

4. ADJUSTMENTS TO PRIOR MONTHS AFFECTING D PAYMENTS:
   (30) PART D PREMIUM................COUNT: ZZ,ZZZ,ZZ9                            $ -Z,ZZZ,ZZZ,ZZ9.99
   (32) ESTIMATED LICS................COUNT: ZZ,ZZZ,ZZ9                            $ -Z,ZZZ,ZZZ,ZZ9.99
   (33) ESTIMATED REINSURANCE.........COUNT: ZZ,ZZZ,ZZ9                            $ -Z,ZZZ,ZZZ,ZZ9.99
   (36) PART D RATE...................COUNT: ZZ,ZZZ,ZZ9                            $ -Z,ZZZ,ZZZ,ZZ9.99
   (37) PART D RA FACTOR..............COUNT: ZZ,ZZZ,ZZ9                            $ -Z,ZZZ,ZZZ,ZZ9.99
```

TABLE 3K - 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)

Table 3L list the ARCs reported to plans on the PPR by payment type.

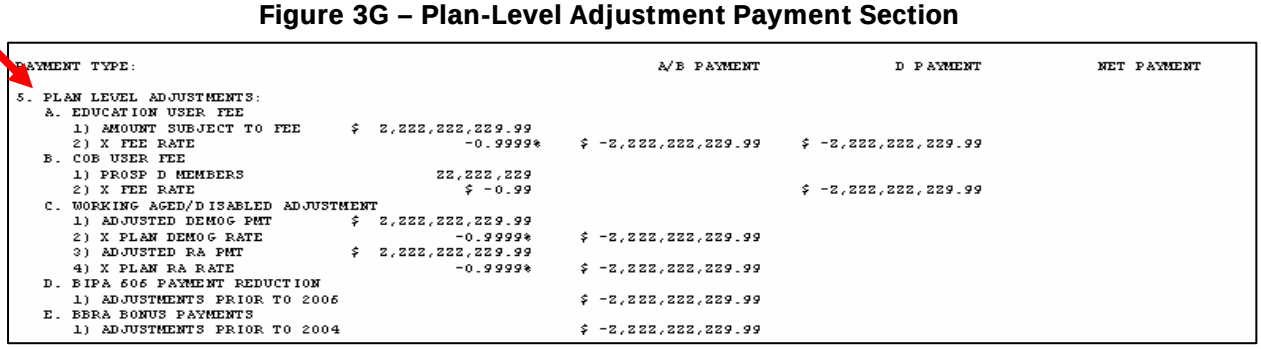
TABLE 3L -ADJUSTMENT REASON CODES AND DESCRIPTION

	ADJUSTMENT CODE	ADJUSTMENT NAME
Adjustments to Prior Months Affecting A/B and D Payment	01	Death of beneficiary
	02	Retroactive enrollment
	03	Retroactive disenrollment
	06	Correction to Part A entitlement
	12	Date of death correction
	19	Correction to Part B entitlement
	22	Disenroll due to prior ESRD
	42	Retroactive ESRD MSP factor change
Adjustments to Prior Months Affecting A/B Payment	07	Retroactive hospice status
	08	Retroactive ESRD status
	09	Retroactive institutional status
	10	Retroactive Medicaid status
	11	Retroactive change to state county code
	13	Date of birth correction
	14	Correction to sex code
	18	Part C rate change
	20	Retroactive working aged status
	21	Retroactive NHC status
	23	Demo factor adjustment
	25	Part C risk adjustment factor change
	26	Part C risk adjustment factor change (mid-year)
	27	Retroactive change to Congestive Heart Failure (CHF) payment
Adjustments to Prior Months Affecting D 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)

3.4.1.3 PPR Plan-Level Adjustment Section (Slide 18)

CMS communicates the plan-level adjustments in Section 5 of the PPR, which are based on summarized data from MARx/Factors in APPS. Figure 3G illustrates the plan-level adjustment payment section and Table 3M outlines the possible fees and adjustments reported in this section.

Figure 3G – Plan-Level Adjustment Payment Section



PAYMENT TYPE:		A/B PAYMENT	D PAYMENT	NET PAYMENT
5. PLAN LEVEL ADJUSTMENTS:				
A. EDUCATION USER FEE				
1) AMOUNT SUBJECT TO FEE	$ 2,222,222,229.99			
2) X FEE RATE	-0.9999%	$ -2,222,222,229.99	$ -2,222,222,229.99	
B. COB USER FEE				
1) PROSP D MEMBERS	22,222,229			
2) X FEE RATE	$ -0.99		$ -2,222,222,229.99	
C. WORKING AGED/DISABLED ADJUSTMENT				
1) ADJUSTED DEMOG PMT	$ 2,222,222,229.99			
2) X PLAN DEMOG RATE	-0.9999%	$ -2,222,222,229.99		
3) ADJUSTED RA PMT	$ 2,222,222,229.99			
4) X PLAN RA RATE	-0.9999%	$ -2,222,222,229.99		
D. BIPA 606 PAYMENT REDUCTION				
1) ADJUSTMENTS PRIOR TO 2006		$ -2,222,222,229.99		
E. BBRA BONUS PAYMENTS				
1) ADJUSTMENTS PRIOR TO 2004		$ -2,222,222,229.99		

TABLE 3M- PLAN-LEVEL ADJUSTMENTS

PLAN-LEVEL ADJUSTMENT TYPE	DESCRIPTION
NMEC	National Medicare Educational User Fees • Different rates by plan type • Applied the first 9 months of the year • Fee is based on prospective payment minus MSP adjustment
COB User Fees	Coordination of Benefits • Rates • Applied the first 9 months of the year • Enrollment count is the base for the calculation
MSP Adjustment	Medicare as Secondary Payer • Excludes Hospice and ESRD • Annual Survey Process • MSP plan-level adjustment calculation

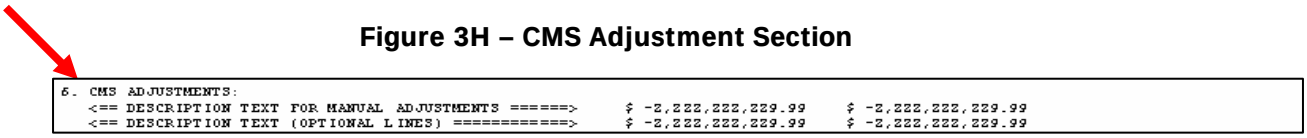
3.4.1.4 PPR CMS Adjustment Section (Slide 19)

CMS also provides plans with amounts adjusted resulting from CMS adjustment actions. The payments and offsets plans view in this section are not based on the MARx/MMR; however, the report provides a free form section CMS will use to document the cause for the adjustment. The adjustment can result from one of the following:

- Prior month carryover (if prior payment was wiped out due to a large negative adjustment)
- 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

Figure 3H illustrates the CMS adjustment section.

Figure 3H – CMS Adjustment Section



6. CMS ADJUSTMENTS:		
<== DESCRIPTION TEXT FOR MANUAL ADJUSTMENTS ======>	$ -2,222,222,229.99	$ -2,222,222,229.99
<== DESCRIPTION TEXT (OPTIONAL LINES) ============>	$ -2,222,222,229.99	$ -2,222,222,229.99

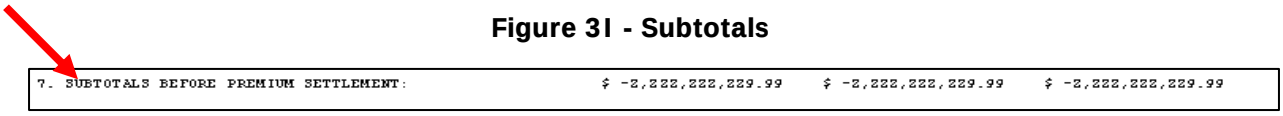
3.4.1.5 PPR Subtotals Section

Section 7 of the report subtotals the following from Sections 1 through 6:

- A/B payment
- D Payment
- Net Payment subtotals the A/B payment and D Payment

Figure 3I illustrates the subtotals for A/B and D payments.

Figure 3I - Subtotals



7. SUBTOTALS BEFORE PREMIUM SETTLEMENT:	$ -2,222,222,229.99	$ -2,222,222,229.99	$ -2,222,222,229.99

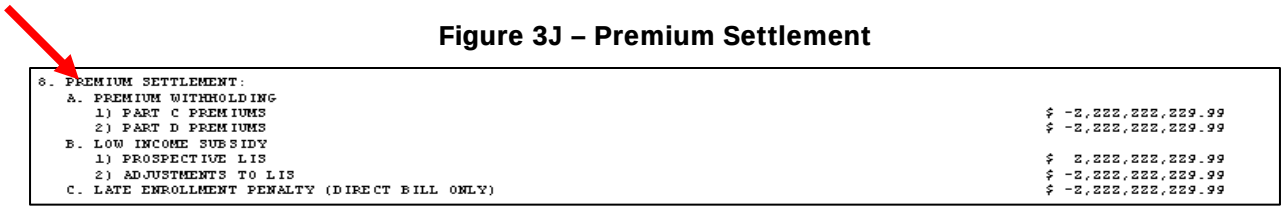
3.4.1.6 PPR Premium Settlement Section (Slide 20)

The three sections in the PPR Premium Settlement Section provide summary level premium information based on various CMS reports.

- Section 8A, Monthly Premium Witholding, identifies the total Part C and Part D premiums withheld as reflected on the MPWRD.
- Section 8B, Low Income Subsidy, identifies the Prospective and Adjustments to LIS amounts for Part D based on amount reflected on the MMR.
- Section 8C, Late Enrollment Penalty (Direct Bill Only), includes the LEP that appears 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 3J illustrates the premium settlement section of the PPR.

Figure 3J – Premium Settlement

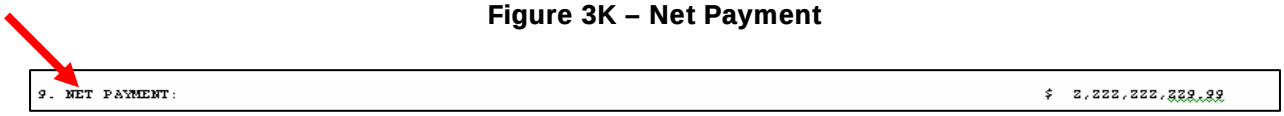


8. PREMIUM SETTLEMENT:	
A. PREMIUM WITHHOLDING	
1) PART C PREMIUMS	$ -2,222,222,229.99
2) PART D PREMIUMS	$ -2,222,222,229.99
B. LOW INCOME SUBSIDY	
1) PROSPECTIVE LIS	$ 2,222,222,229.99
2) ADJUSTMENTS TO LIS	$ -2,222,222,229.99
C. LATE ENROLLMENT PENALTY (DIRECT BILL ONLY)	$ -2,222,222,229.99

3.4.1.7 PPR Net Payment Section (Slide 21)

The Net Payment section of the report Provides totals the plan's final monthly payment after subtracting all of the adjustments. The US Treasury deposits this net amount into the plans account. Figure 3K illustrates the net payment on the PPR.

Figure 3K – Net Payment



9. NET PAYMENT:	$ 2,222,222,229.99

Table 3N contains an example of payment timing and what plans can anticipate as reported by the PPR.

TABLE 3N - TIMING OF PAYMENTS/PREMIUM PAYMENTS

PAYMENT #	PAYMENT DATE	PPR REPORT and PAYMENT CONTAINS....
1	January 1, 2008	• January Part D capitated and LIS payments from CMS
2	February 1, 2008	• February Part D capitated and LIS payments from CMS + January Withheld premiums from SSA
3	March 1, 2008	• March Part D capitated and LIS payments from CMS + February Withheld premiums from SSA
4	April 1, 2008	• April Part D capitated and LIS payments from CMS + March Withheld premiums from SSA

MODULE 4– REPORTS AND RECONCILIATION

Purpose (Slide 2)

The Centers for Medicare & Medicaid Services (CMS) provides reports to plans communicating the status of enrollment including payment amounts. Plans must submit attestations regarding enrollment and payment each month. Therefore, it is important to reconcile plan records against CMS records. The purpose of this module is to examine reports that assist plans in reconciling and certifying enrollment in an effort to receive accurate payment and to use reports to determine if adjustments are required.

Learning Objectives (Slide 3)

At the completion of this module, participants will:

- Verify enrollment and payment using reports
- Describe the reports reconciliation process
- Define the certification process
- Identify three retroactive submission processes
- Explain the fields and functions of reports

ICON KEY	
Example	
Reminder	
Resource	
Definitions	

4.1 Reports Overview

As plans submit transactions, CMS communicates the status of enrollment using various reports transmitted to plans. This module describes how plans validate enrollment and payment using reports. The report reconciliation process is a method plans must use to reconcile, certify, and submit retroactive adjustments to CMS. Table 4A describes the three reports used to verify enrollment and payment.

TABLE 4A – REPORTS OVERVIEW

REPORT	DESCRIPTION
Transaction Reply Report (TRR)	• The Transaction Reply Report provides the plans with details of the rejected and accepted transactions that have been processed for members within its contracts for the time period specified. There are two types of TRRs: • The Weekly TRR covers the processing week (typically Sunday through Saturday). The Weekly TRR provides details of notifications involving contract members, for example, notification that a beneficiary has died • The Monthly TRR covers the payment processing month • Failed transactions do not appear on the Weekly TRR; the failed transaction is provided only on the Failed Transaction Data File • Available in data file and report format
Monthly Membership Detail Report	• Provides beneficiary-level payment information to plans for the month • Provides beneficiary-level adjustment information by category • Generated as part of month-end processing • Available in data file and report format
Plan Payment Report	• The Plan Payment Report (PPR), also known as the Plan Payment Letter (PPL), itemizes the final monthly payments to plans • Automated Plan Payment System produces this report following calculation of the final monthly payment • This report includes plan-level adjustments • This report includes Part A/B and Part D payments and adjustments, National Medicare Education Campaign (NMEC), Coordination of Benefits (COB) User Fees, and premium settlement information • Available as a data file and report format

4.2 Enrollment and Payment Verification Process (Slide 5)

After enrollments are submitted and processed, plans receive reports communicating the status of the enrollment and payment on the monthly enrollment and payment reports. The Enrollment and Payment Verification process includes three steps:

1. Reconciliation
2. Certification
3. Retroactive Submission

4.2.1 Step 1: Reconciliation (Slide 6)

The purpose of the reconciliation step is for plans to determine accuracy of data by reconciling CMS' records with plan's records. Plans review the Transaction Reply Report (TRR) and the Monthly Membership Report (MMR) ensuring the accuracy of:

- Beneficiary-level payment
- Enrollment
- Disenrollment

- Applicable health status
- Other beneficiary information

Plans may identify discrepancies during this step.

4.2.2 Step 2: Certification (Slides 7-8)

Following the reconciliation of the plan's enrollment and payment, plans must attest to this data by submitting certifications. Organizations must submit monthly attestations of enrollment information related to payment. CMS uses certification data to ensure the plan is compliant in reconciling its membership records with CMS' records. IntegriGuard submits certification data reports to each CMS Regional Office (RO) on a monthly basis. Certification allows plans to attest to and report:

- Incorrect beneficiary-level payments
- System problems
- Beneficiaries, promptly, who must be retroactively processed
- Justifications for retro requests

Plans must notify CMS of requests for corrections within 45 days of the date the reports become available for that month's data. Requests based on identified discrepancies are reported via the normal "retroactive request" process to satisfy the certification requirements of reporting discrepancies to CMS.

Plans submit their certifications using the Certification of Monthly Enrollment and Payment Data Certification form. Table 4B illustrates the appropriate person to sign the form and the form requirements. CMS will not process retroactive adjustments submitted with the certification forms. They must be submitted in the required process.

TABLE 4B – CERTIFICATION FORM

FORM	WHO SIGNS	REQUIREMENTS
Certification of Monthly Enrollment and Payment Data	• Chief Executive Officer (CEO), • Chief Financial Officer (CFO), or • Delegated Individual, on behalf of CEO or CFO	Certify the accuracy of new data submitted to CMS. This includes new enrollments, disenrollments, including changes in plan Benefit Packages, as well as beneficiaries who have met the qualifying institutional period or Medicaid periods as appropriate Certify the accuracy of MMR and TRR. Plans must review the MMR and TRR and document discrepancies between the report and the organization's records

Example 1

Plan receives reports on February 22, 2008, Certification is due by April 7, 2008.

http://www.cms.hhs.gov/mmahelp/downloads/PCUG_v3_1_041808_Appendices_with_Cover_Final.pdf

4.2.3 Step 3: Retroactive Adjustments (Slide 9)

Plans reviewing reports for certification are required to forward discrepancies to CMS or IntegriGuard within 45 days of receipt of the final monthly reports using the retroactive adjustment process. Retroactive adjustments can be categorized into three basic categories as illustrated in Table 4C and are the result of transactions submitted outside of current processing month for reasons including:

- Rejections for a technical or format error that could not be corrected during the current month process
- Transactions not submitted or erroroneously omitted during the current processing month

TABLE 4C – RETROACTIVE ADJUSTMENT REQUEST REASONS

CATEGORY	REASON FOR RETROACTIVE ADJUSTMENT REQUEST	DESCRIPTION	ACTION
1	Plan submitted batch files not successfully processed in the most recent cutoff	Organizations encounter issues submitting files by established cutoff	Organizations must immediately contact the MMA helpdesk for assistance to correct issue for files not processed successfully prior to cut-off
2	CMS system issues prevented successful processing of transaction during a recent cut-off	Transactions involving problems that prevented the system from successfully processing transactions. These transactions can be identified by the transaction type used in the submission and/or the transaction reply code received for the transaction	Organizations must contact the Division of Payment Operations (DPO) Representative to discuss details and determine the appropriate action
3	Other (Non-system Issues)	Normal process for requesting retroactive adjustments based on a current payment or enrollment reconciliation results	Submit to IntegriGuard

4.2.3.1 Retroactive Adjustment Batch Submissions

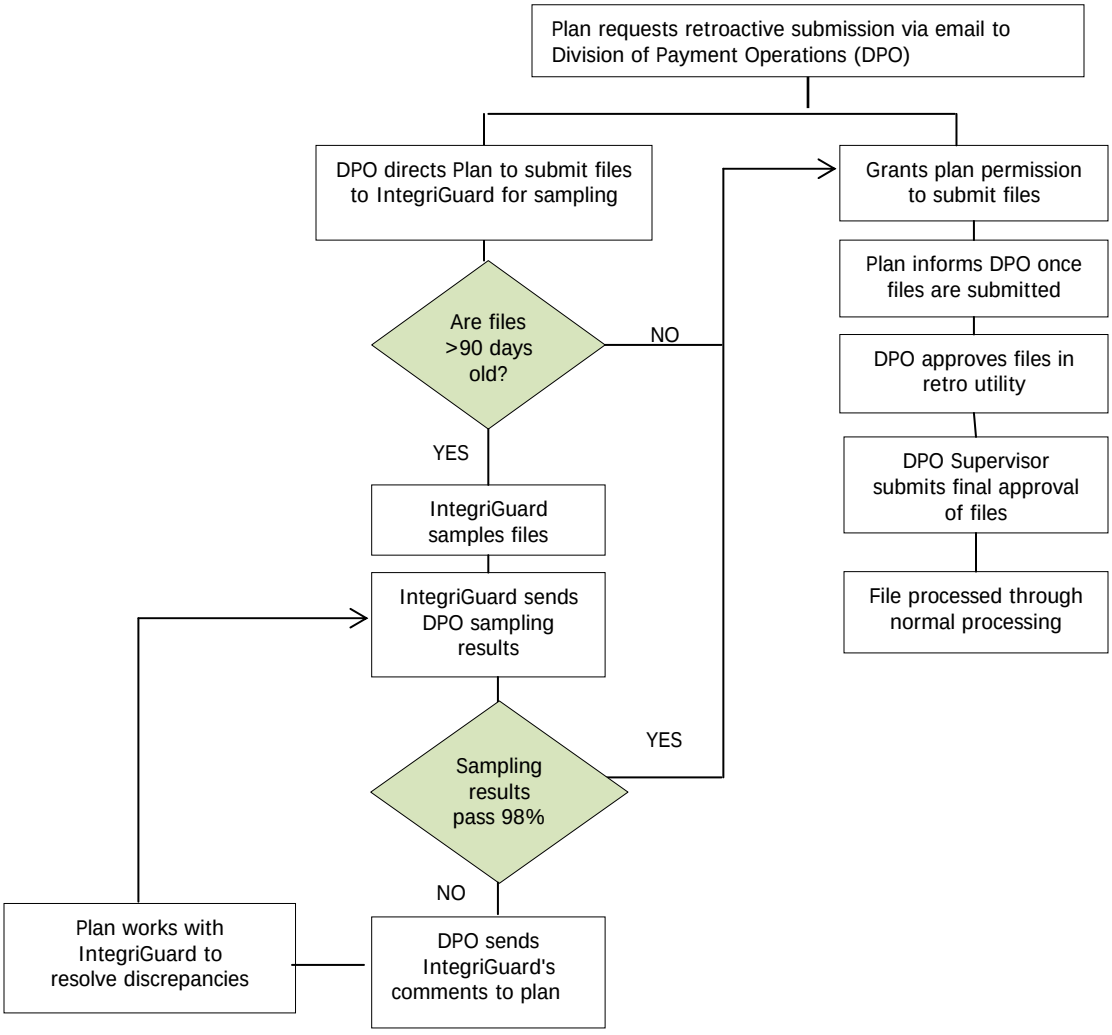
There are three processes for submitting retroactive adjustment requests depending on the reason for the retroactive adjustment request:

- Streamline Process
- IntegriGuard Submissions (Normal Processing)
- CMS Submissions

Retroactive Streamline Process (Slides 10-11)

The streamline process is reserved for large numbers of retroactive adjustments with effective dates of more than 2 months from the current payment month. Plans must have at least 100 transactions caused by the same issue and with the same effective date. Plans must submit a request to the DPO representative for approval to submit files using the streamline process. Figure 4A outlines the Retroactive Streamline process.

Figure 4A – Retroactive Streamline Process



IntegriGuard Retroactive Submissions (Normal Process) (Slides 12)

IntegriGuard processes manual updates including:

- Enrollments
- Disenrollments
- PBP changes
- State/County code changes
- LIS changes

IntegriGuard processes transactions in accordance with the policies outlined in the Medicare Managed Care Manual, Chapter 19.

Plans submit valid requests for retroactive plan enrollment adjustments to IntegriGuard. The request must include required information in the specific order as listed in Table 4D and supporting documentation as outlined in Table 4E. Plans can locate information about supporting documentation on the IntegriGuard website at www.integriGuard.org. IntegriGuard will acknowledge receipt of the requested retroactive enrollment adjustment request within 10 days of receipt via mail, e-mail, or telephone and will process the requested retroactive enrollment adjustments within 45 days of receipt.

TABLE 4D – RETROACTIVE REQUEST SPREADSHEET

Organization Name:					Contact Name:			
Mailing Address:					Phone #:			
City, State, Zip Code:					E-Mail Address:			
H#	PBP #	CMS Region #	Action Requested	HIC #	Beneficiary's Last Name	Beneficiary's First Name	Beginning Date mm/dd/yyyy	Ending Date mm/dd/yyyy

TABLE 4E – ENROLLMENT/DISENROLLMENT SUPPORTING DOCUMENTATION

ENROLLMENT	DISENROLLMENT
• Copy of the completed request • Reason for retroactive enrollment	• Copy of valid disenrollment request
• Correct application date for transaction • Copy of reply listing indicating plan's attempt to enroll • Copy of acknowledgement/acceptance letter sent to beneficiary within specified timeframes	• CMS reply listing indicating attempt to disenroll was timely
• Copy of CMS reply listing showing erroneous termination • Member documentation indicating desire to continue enrollment and letter from plan advising member to continue with use of plan's services	• Other relevant documentation
• Confirmation beneficiary cancelled from employer's drug plan when organization-submitted transaction was erroneously rejected • For ESRD erroneous rejections - Letter from physician documenting beneficiary not ESRD during period requested - Proof member enrolled in plan prior to converting to Medicare status - Proof application completed prior to ESRD diagnosis	• Evidence timely request to disenroll from Employer/Union sponsored plan made directly to employer

Table 4F lists the CMS and IntegriGuard submission addresses.

TABLE 4F – SUBMISSION ADDRESSES

CMS	**IntegriGuard**
Div. of Payment Operations Mail Stop C1-05-17 7500 Security Boulevard Baltimore, Maryland 21244-1850 Phone: Contact the DPO representative assigned to the plan's region	MMC Enrollment Project 2121 North 117 Avenue Suite 200 Omaha, Nebraska 68164 Phone: 402.955.2781

IntegriGuard will adjust enrollments retroactively to the appropriate effective date and associated payment adjustments will be created. IntegriGuard provides the plan with a report detailing the disposition of the requests, including an explanation of reasons for not entering the change as submitted into the system.

The organization should never submit duplicate information unless the Retro-Contractor specifically requests.

Incomplete Retroactive Requests

IntegriGuard will return requests without actions if documentation received is incomplete and include the reason for non-action. The plan may resubmit the request including adequate and appropriate documentation.

CMS Retroactive Submissions

CMS DPO representatives and Regional Office (RO) caseworkers may also perform retroactive processing on a case-by-case basis.

4.3 Transaction Reply Report (TRR) (Slides 13-15)

The TRR summarizes the disposition of transactions received for the week. This report allows plans to reconcile plan's membership records with those maintained by CMS. Plans may use this report to correct and submit failed and rejected transactions. The TRR is available in report format or as a data file. To ensure accurate enrollment and payment, plans must validate information provided on the TRR with the organization's database. Discrepancies in enrollment data can result in your payment discrepancies. MARx generates a weekly and monthly TRR.

The monthly TRR includes the last week prior to month-end, plus all transactions processed for the upcoming payment. CMS does not produce a separate weekly TRR for the last week prior to month-end.

Plans can view the results of CMS' maintenance actions related to their members in the TRR. The TRR also identifies if CMS approved or rejected plan-submitted transactions. Beneficiaries disenrolling from one plan into another plan will display on the TRR as a disenrolled member for the losing plan and as an enrolled member for the gaining plan.

CMS groups the TRR report format into sections to assist plans in identifying the source of the transaction. Table 4G lists the sections of the TRR.

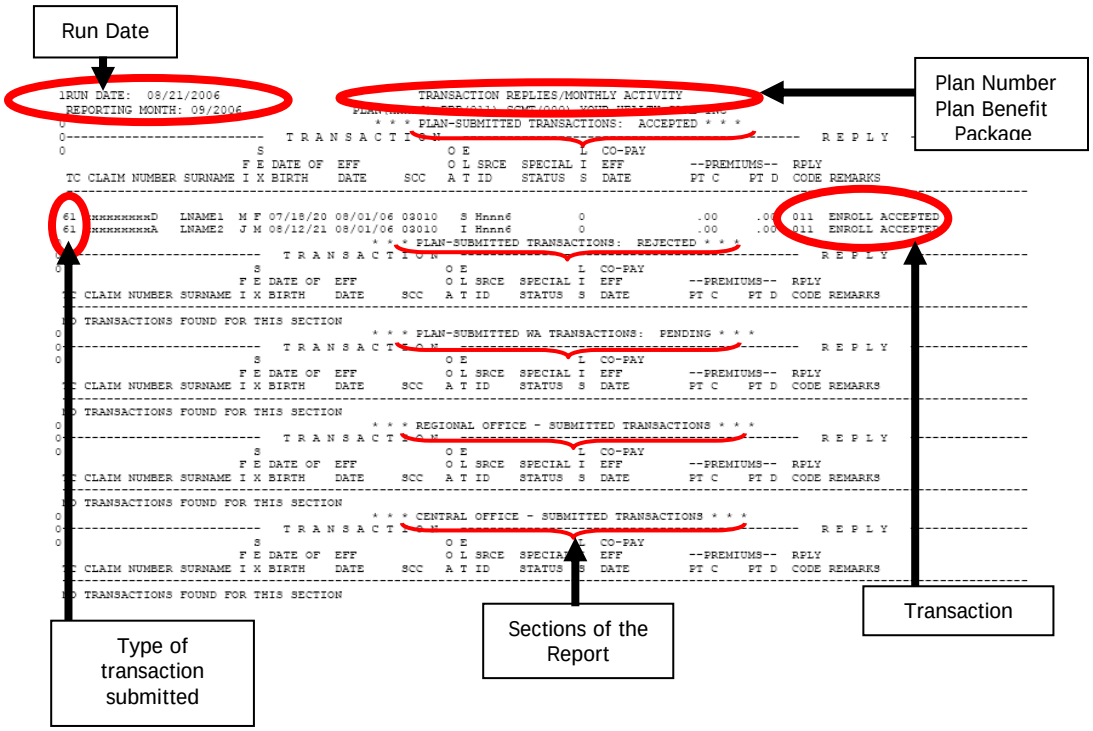
TABLE 4G – TRR SECTIONS

TRR SECTIONS	DESCRIPTIONS
Plan Accepted/Rejected	• Includes a response to plan-submitted transactions. • CMS replies indicate if the transaction was accepted or rejected. • CMS groups replies in two sections, Plan Submitted "Accepted" and "Rejected".
Regional Office	• Identifies transactions submitted by Regional Office representatives.
Central Office	• Identifies updates or changes as a result of Central Office submissions.
CMS District Offices Accepted/Rejected	• Obsolete since January 2006
Medicare Customer Service Accepted/Rejected	• This includes a response to Medicare Customer Service transactions. • CMS replies indicate if the transaction was accepted or rejected. • CMS groups these replies in two sections, Medicare Customer Service "Accepted" and "Rejected".
Automatic Disenrollments	• Identifies beneficiaries whom selected enrollment in a different plan, which automatically disenrolls them from the previous plan. Also includes disenrollment due to death or loss of Medicare entitlement.
Beneficiary Factor Transactions - Accepted/Rejected	• Only relates to one demonstration plan at this point • Does not include premium related information. • CMS groups the information into two sections "Rejected" and "Accepted" transactions.
Maintenance Actions	• Reports updates or changes to a beneficiary's demographic information that may impact enrollment information.

Figure 4B highlights the location of key information on a sample formatted TRR for Your Health Care Inc. The TRR indicates the reporting month and run date in the upper left corner. For this report, the reporting month is September 2006 and the run date is August 21, 2006. Your Health Care Inc. reviews the sections of the report. The report displays one plan-submitted transaction that CMS accepted. The report displays a Transaction code of 61, representing a plan-submitted enrollment. The Transaction Reply Code for this accepted transaction is 011 indicating CMS accepted this enrollment. Your Health Plan, Inc. reviews the plans internal records and validates the submission.

The data file of the TRR communicates all information reported on the Report layout along with additional information to assist plans with validating enrollments. The record layout for the data file is located at the end of the module.

Figure 4B – Sample TRR (Your Health Care, Inc.)



Example 2

Center Insurance received a TRR (Figure 4C) reflecting Enrollment Activity for March 2007. Center Insurance's internal database reflects two new enrollment submissions. As illustrated in Table 4H, Center Insurance membership includes five members, prior to reconciliation of the TRR. Center Insurance submitted no other transactions, therefore expecting the TRR to reflect the two new enrollments only.

TABLE 4H – CENTER INSURANCE DATABASE PRIOR TO RECONCILIATION

Beneficiary	Leroy, L	Smith, J	Day, G	Lewis, L	Blue, S	Brown, S	Doolittle, H	Totals
Enrollment Submissions	X	X						2
Previous Enrolled			X	X	X	X	X	5
Disenrollment Submissions								
Plan Benefit Package Change								
Premium Withhold Changes								

Figure 4C – Center Insurance Sample TRR

```
1RUN DATE:  04/15/2007                          TRANSACTION REPLIES/MONTHLY ACTIVITY                                  REPORT ID:  10
 REPORTING MONTH: 03/2007                PLAN(H9999) PBP(001) SGMT(000) CENTER INSURANCE                          PAGE:   1
0                                    * * * PLAN-SUBMITTED TRANSACTIONS:  ACCEPTED * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                            S                       O E                L  CO-PAY
                           F E DATE OF  EFF          O L SRCE  SPECIAL I  EFF         --PREMIUMS--  RPLY
TC CLAIM NUMBER SURNAME    I X BIRTH    DATE    SCC  A T ID    STATUS  S  DATE        PT C    PT D  CODE REMARKS
-------------------------------------------------------------------------------------------------------------------------------
61 123456789A   LEROY      L M 12/28/33 04/01/07 21110    I H9999             04/01/07                  011  ENROLL ACCEPTED
0                                    * * * PLAN-SUBMITTED TRANSACTIONS:  REJECTED * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                            S                       O E                L  CO-PAY
                           F E DATE OF  EFF          O L SRCE  SPECIAL I  EFF         --PREMIUMS--  RPLY
TC CLAIM NUMBER SURNAME    I X BIRTH    DATE    SCC  A T ID    STATUS  S  DATE        PT C    PT D  CODE REMARKS
-------------------------------------------------------------------------------------------------------------------------------
NO TRANSACTIONS FOUND FOR THIS SECTION
0                                    * * * PLAN-SUBMITTED WA TRANSACTIONS:  PENDING * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                            S                       O E                L  CO-PAY
                           F E DATE OF  EFF          O L SRCE  SPECIAL I  EFF         --PREMIUMS--  RPLY
TC CLAIM NUMBER SURNAME    I X BIRTH    DATE    SCC  A T ID    STATUS  S  DATE        PT C    PT D  CODE REMARKS
-------------------------------------------------------------------------------------------------------------------------------
NO TRANSACTIONS FOUND FOR THIS SECTION
0                                    * * * REGIONAL OFFICE - SUBMITTED TRANSACTIONS * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                            S                       O E                L  CO-PAY
                           F E DATE OF  EFF          O L SRCE  SPECIAL I  EFF         --PREMIUMS--  RPLY
TC CLAIM NUMBER SURNAME    I X BIRTH    DATE    SCC  A T ID    STATUS  S  DATE        PT C    PT D  CODE REMARKS
-------------------------------------------------------------------------------------------------------------------------------
51 444455552A   DAY        G M 01/14/07 01/01/06 21090 Y S AUTOD          3  01/01/06    1.00-   1.00- 154  OUT OF AREA
0                                    * * * CENTRAL OFFICE - SUBMITTED TRANSACTIONS * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                            S                       O E                L  CO-PAY
                           F E DATE OF  EFF          O L SRCE  SPECIAL I  EFF         --PREMIUMS--  RPLY
TC CLAIM NUMBER SURNAME    I X BIRTH    DATE    SCC  A T ID    STATUS  S  DATE        PT C    PT D  CODE REMARKS
-------------------------------------------------------------------------------------------------------------------------------
51 918273645A   LEWIS      L M 12/25/24 01/01/06 21090    S AUTOD       M  2 01/01/06     0.00    0.00   014  DISENROLL-NEW MCO
0                                    * * * DISTRICT OFFICE - SUBMITTED TRANSACTIONS:  ACCEPTED * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                            S
                           F E DATE OF  EFF       DISTRICT OFFICE  SPECIAL  RPLY
TC CLAIM NUMBER SURNAME    I X BIRTH    DATE         NUMBER        STATUS   CODE  REMARKS
-------------------------------------------------------------- ----------------------------------------------------------------
NO TRANSACTIONS FOUND FOR THIS SECTION
```

Figure 4C – Center Insurance Sample TRR (Continued)

```
1RUN DATE:  04/15/2007                          TRANSACTION REPLIES/MONTHLY ACTIVITY                                    REPORT ID:  10
 REPORTING MONTH: 03/2007                 PLAN(H9999) PBP(001) SGMT(000) CENTER INSURANCE                            PAGE:   2
0                                          * * * DISTRICT OFFICE - SUBMITTED TRANSACTIONS:  REJECTED * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                          S
                         F E DATE OF  EFF       DISTRICT OFFICE  SPECIAL  RPLY
TC CLAIM NUMBER SURNAME  I X BIRTH    DATE          NUMBER       STATUS   CODE  REMARKS
-------------------------------------------------------------- ------------------------------------------------------------------------
NO TRANSACTIONS FOUND FOR THIS SECTION
0                                          * * * MEDICARE CUSTOMER SERVICE SUBMITTED TRANSACTIONS:  ACCEPTED * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                          S                       O E                L  CO-PAY
                         F E DATE OF  EFF          O L SRCE  SPECIAL  I  EFF          --PREMIUMS--  RPLY
TC CLAIM NUMBER SURNAME  I X BIRTH    DATE     SCC  A T ID    STATUS  S  DATE         PT C    PT D  CODE REMARKS
-------------------------------------------------------------------------------------------------------------------------------------
72 212121212B   BLUE     S F 02/25/37 04/01/07 21000  I H9999           4/01/07      .00     .00  144  PREM WH OPT CHG
0                                          * * * MEDICARE CUSTOMER SERVICE SUBMITTED TRANSACTIONS:  REJECTED * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                          S                       O E                L  CO-PAY
                         F E DATE OF  EFF          O L SRCE  SPECIAL  I  EFF          --PREMIUMS--  RPLY
TC CLAIM NUMBER SURNAME  I X BIRTH    DATE     SCC  A T ID    STATUS  S  DATE         PT C    PT D  CODE REMARKS
-------------------------------------------------------------------------------------------------------------------------------------
NO TRANSACTIONS FOUND FOR THIS SECTION
0                                          * * * AUTOMATIC DISENROLLMENTS * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                          S                          L  CO-PAY
                         F E DATE OF  EFF       SPECIAL  I  EFF       RPLY
TC CLAIM NUMBER SURNAME  I X BIRTH    DATE      STATUS   S  DATE      CODE  REMARKS
-------------------------------------------------------------------------------------------------------------------------------
NO TRANSACTIONS FOUND FOR THIS SECTION
0                                          * * * BENEFICIARY FACTOR TRANSACTIONS:  ACCEPTED * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                          S                          L  CO-PAY
                         F E DATE OF  EFF       SPECIAL  I  EFF       RPLY
TC CLAIM NUMBER SURNAME  I X BIRTH    DATE      STATUS   S  DATE      CODE  REMARKS
-------------------------------------------------------------------------------------------------------------------------------
NO TRANSACTIONS FOUND FOR THIS SECTION
0                                          * * * BENEFICIARY FACTOR TRANSACTIONS:  REJECTED * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                          S                          L  CO-PAY
                         F E DATE OF  EFF       SPECIAL  I  EFF       RPLY
TC CLAIM NUMBER SURNAME  I X BIRTH    DATE      STATUS   S  DATE      CODE  REMARKS
-------------------------------------------------------------------------------------------------------------------------------
NO TRANSACTIONS FOUND FOR THIS SECTION
0                                          * * * MAINTENANCE ACTIONS * * *
0--------------------------   T R A N S A C T I O N   ----------------------------------------------   R E P L Y   ----------------
0                           S                         L  CO-PAY
                          F E DATE OF  EFF       SPECIAL  I  EFF       RPLY
TC CLAIM NUMBER SURNAME  I X BIRTH    DATE      STATUS   S  DATE      CODE  REMARKS
-------------------------------------------------------------------------------------------------------------------------------
01 333333333A   BROWN    S F 10/18/34 04/01/07      M   2  04/01/07  077   MEDICAID STATUS SET
51 999999999A   DOOLITT  H F 09/21/05 01/01/06      S   3  01/01/06  090   REPORT OF DEATH
```

Figure 4C – Center Insurance Sample TRR (Continued)

1RUN DATE: 04/15/2007 TRANSACTION REPLIES/MONTHLY ACTIVITY REPORT ID: 10
REPORTING MONTH: 03/2007 PLAN(H9999) PBP(001) SGMT(000) CENTER INSURANCE PAGE: 3
0 * * * TRANSACTION REPLY SUMMARY * * *

0	TC 72	TC 71	TC 60	TC 61	TC 51	TC 53	TC 54	TC 30	TC 31	TC 01	ALL
+											
ACCEPTED ACTN	0	0	0	1	0	0	0	0	0	0	1
0REJECTED ACTN	0	0	0	0	0	0	0	0	0	0	0
0REGION ACTNS	0	0	0	0	1	0	0	0	0	0	1
0CNTRL OFFICE ACT	0	0	0	0	1	0	0	0	0	0	1
0DISTR OFFICE ACT	0	0	0	0	0	0	0	0	0	0	0
ACCEPTED:	0	0	0	0	0	0	0	0	0	0	0
REJECTED:	0	0	0	0	0	0	0	0	0	0	0
DUPLICATES:	0	0	0	0	0	0	0	0	0	0	0
0MCARE CUST SRVC	1	0	0	0	0	0	0	0	0	0	1
ACCEPTED:	1	0	0	0	0	0	0	0	0	0	1
REJECTED:	0	0	0	0	0	0	0	0	0	0	0
0BENE FACT ACTN	0	0	0	0	0	0	0	0	0	0	0
ACCEPTED:	0	0	0	0	0	0	0	0	0	0	0
REJECTED:	0	0	0	0	0	0	0	0	0	0	0
0AUTO-DISENROLL	0	0	0	0	0	0	0	0	0	0	0
0MAINTENANCE	0	0	0	0	1	0	0	0	0	1	2
0** TOTAL ACTNS*	1	0	0	1	3	0	0	0	0	1	6
ACCEPTED:	1	0	0	1	3	0	0	0	0	1	6
REJECTED:	0	0	0	0	0	0	0	0	0	0	0
0* ORBIT/PENDING *	0	0	0	0	0	0	0	0	0	0	0

Step 1: (Review the TRR)

Center Insurance reviews the TRR in Figure 4C and finds discrepancies in the internal database and the information communicated on the TRR. Center Insurance identified discrepancies prior to submitting certification to CMS (Step 2); therefore, additional investigation of the TRR is required. Table 4I illustrates the changes to the internal database following the review of the TRR and the internal records.

TABLE 4I – CENTER INSURANCE ENROLLMENT DATABASE FOLLOWING RECONCILIATION

Beneficiary	Leroy, L	Smith, J	Day, G	Lewis, L	Blue, S	Brown, S	Doolittle, H	Totals
Enrollment Submissions	X	X						1
Previous Enrolled					X			1
Disenrollment Submissions			X	X		X	X	4
Plan Benefit Package Change								
Premium Withhold Changes					X			1

The TRR does not reflect the enrollment for Ms. J. Smith. Following additional verification, Center Insurance listed Ms. Smith's enrollment request as an "enrollment submission"; however, the enrollment request was not transmitted. Center Insurance certifies the enrollment including the discrepancies reported to CMS. Center Insurance updates its internal database to reflect:

- 4 Disenrollments
- 2 New Enrollments
  - 1 Reported on TRR
  - 1 not reported on TRR, however plan has a completed enrollment request, they failed to submit in error
- 1 Premium withhold change

Step 2: (Certification of Enrollment)

Center Insurance certifies using the Certification of Monthly Enrollment and Payment Data form indicating the plan submitted the retroactive adjustment to reflect the enrollment of Ms. Jones' enrollment request.

Note: A review of the TRR only does not satisfy certification. Plans must also review the MMR prior to submitting certification of enrollment.

Step 3: (Retroactive Submission)

The investigation in Step 1 determined this month's enrollment transactions included a discrepancy on the TRR. The discrepant record included one file and was not the result of system error. Therefore, Center Insurance used the Normal Retroactive processing to submit the discrepancy to IntegriGuard. This includes the submission of the RETRO spreadsheet and supporting documentation required to process the retroactive enrollment.

4.4 Monthly Membership Report (MMR) (Slides 17-18)

There are two Monthly Membership Detail Report formats available: report and data file. There are 2 formatted report versions available: one for drug plans and one for non-drug plans. The non-drug report would be used by any plan that is not offering a drug plan (i.e., MA only). The MMR Drug report is used by plans offering a drug program such as an MA-PD, or a stand-alone PDP.

The Monthly Membership Summary Reports summarize the information on the MMR detail reports and contain the total number of beneficiaries paid to your organization by CMS for that month. You can use this report to compare CMS' totals to your plan's totals.

The MMR provides information that allows plans to reconcile its Medicare membership and payment records with the records maintained by CMS. Therefore, plans would compare the information on the MMR with the plan's enrollment and payment data on a monthly basis along with the beneficiary data received on the TRR.

Summary: This format presents a summary of the payments and adjustments applicable to the MA organization's Medicare membership. This format shows the total number of beneficiaries for whom a hospice, ESRD, or institutionalized payment was received.

Detail: This format lists every Medicare member of the contract and provides details about payments and adjustments for each beneficiary. Plans use this report to reconcile what is being paid to the plan according to the plan enrollees.

Plans should direct questions regarding accessing and understanding the MMR to the plan's regional contact at CMS Central Office.

The MMR Reports communicate information on a beneficiary level. The MMR Summary is available in both data file and report layout format. Both the data file and the report include summaries of drug and non-drug data.

4.4.1 Monthly Membership Detail Reports

The MMR Detail is available in a data file that includes both drug and non-drug data. CMS extracts data from the data file and generates two formatted reports; one for drug data, and one for non-drug data. The reports display payment information as it relates to the appropriate payment model. Table 4J highlights the contents of the non-drug and drug MMRs.

TABLE 4J – MMR DETAIL REPORT DESCRIPTIONS

Non-Drug Monthly Membership Report	contains information on: • Rebates • Basic Part C premium • payments and adjustments • Part A and Part B information • risk adjustment factors for Part A and Part B • health status flags • other detailed beneficiary information
Drug Monthly Membership Report	contains information on: • basic Part D premium • estimated reinsurance • payments and adjustments • low-income cost sharing percentage • low-income cost sharing subsidy • Part D risk adjustment factors • other detailed beneficiary information • LTI or LIS multiplier

Figure 4D highlights the location of key information on the formatted MMRs for reconciling reports with enrollee information.

At the top of the report, the name of the report appears along with whether the report is for drug or non-drug data. The plan number, PBP, and Segment along with the plan name appear under the report name.

At the top left of the report is the group number and contract number. The run date appears as year/month/date with the payment month in the top left of the report. The page number is to the right.

There are two lines of information for each beneficiary in the detail report and that information is staggered. For example, the Claim Number appears on one line and beneath that line appears the surname of the beneficiary.

The MMR for Non-Drugs reports on flags for Health Status and the Drug reports on the LIS or LTI multiplier for calculation in the beneficiary risk factor.

If a beneficiary has one of the flags for a Health Status, which is sometimes called “special status”, this is identified with a “Y” on the report.

There is a hierarchy for how plans receive payments for beneficiaries with special statuses.

Figure 4D – Sample Drug and Non-Drug MMRs

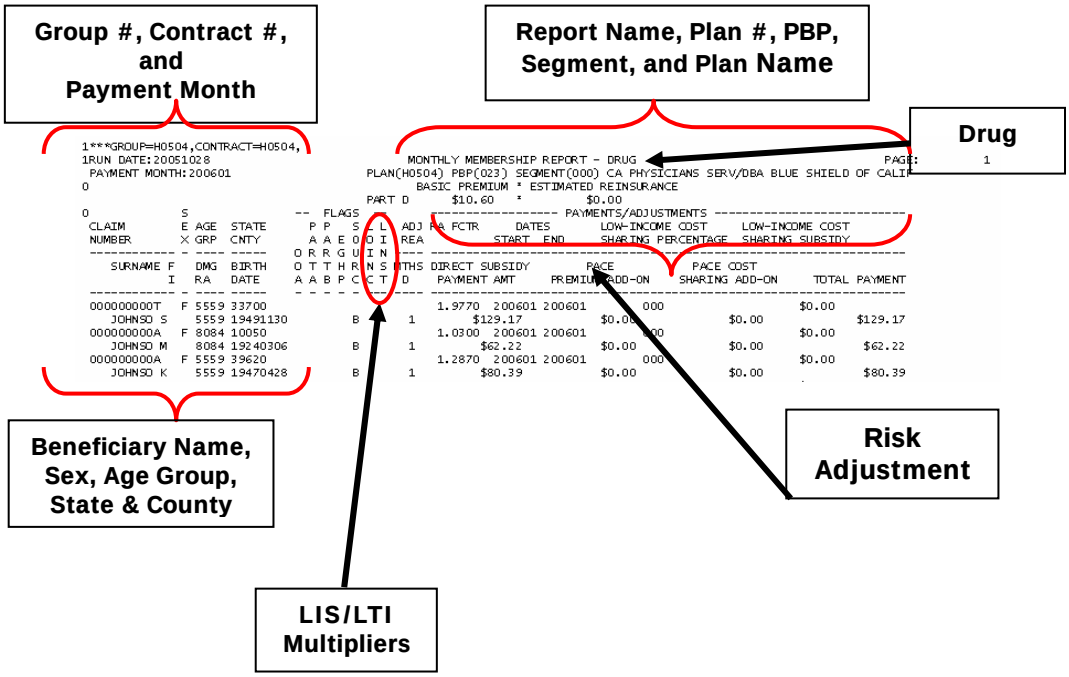
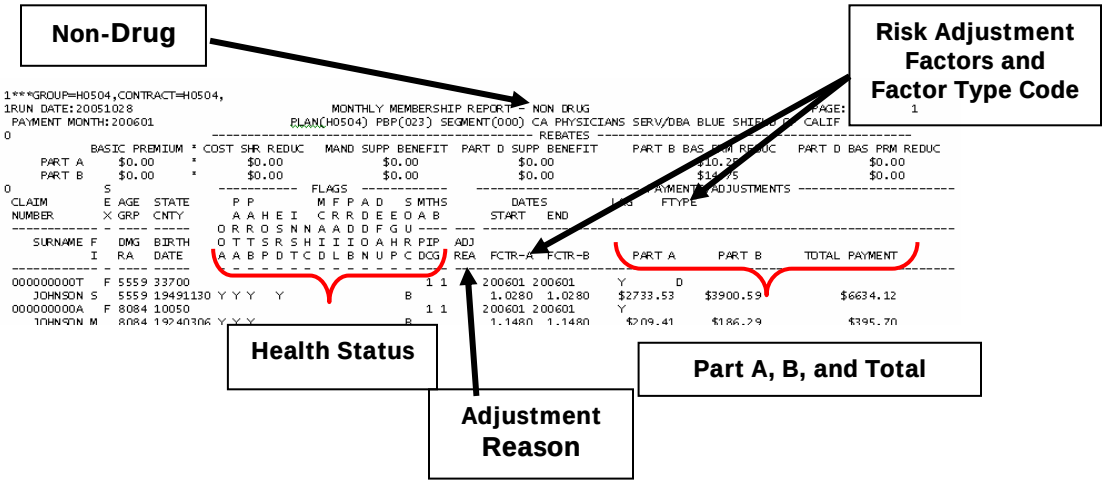


Figure 4D – Sample MMR Drug and Non-Drug (Continued)



The MMR is also available as a data file. Table 4K describes the MMR field ranges. The record layout for the data file is located at the end of the module.

TABLE 4K – SUMMARY OF THE MMR DETAIL RECORD LAYOUT FIELD RANGES

FIELD RANGE	GENERAL DESCRIPTION OF FIELD RANGE
1-3	Managed Care Organization Information
4-11	Beneficiary Identification
12-13	Entitlement
14-21	Health Status
22-34	Risk Adjustment/Demographic Payment Adjustment Information
35	Low Income Subsidy Premium Amount
36	ESRD MSP Flag
37-46	Additional Indicators
47	Risk Adjustment Factor Type Code
48	Frailty Indicator
49	Original Reason for Entitlement Code (OREC)
51	Segment ID
52	Enrollment Source
53	EGHP Flag
54-66	Risk Adjustment Premium/Rebate/Payment Information
67	Part D Risk Factor
68-78	Fields supporting the Part D Benefit
79-80	PACE related fields

Example 3

Beneficiary #1
Mrs. Sally Blue is 67 years old and lives in an apartment in Allegany County, Maryland. She originally enrolled in Medicare Part A and Part B in January 2005. Mrs. Blue enrolled with Center Insurance, an MA Plan, in August 2006. Mrs. Blue was diagnosed in February 2006 with diabetes with acute complications and pneumococcal pneumonia when she visited her doctor.

Beneficiary #2
Mrs. Susie Brown has been a member of Center Insurance's MA Plan since August 1, 2006. Mrs. Brown is 72 years old and lives with her daughter in Baltimore County, Maryland. Mrs. Brown was originally disabled upon entering Medicare. Mrs. Brown is a Medicaid beneficiary. When Mrs. Brown visited the doctor on February 15, 2006, she was diagnosed with Chronic Obstructive Pulmonary Disease along with Congestive Heart Failure. At that time, she was also diagnosed with Opportunistic Infections.

Beneficiary #3
Mr. Loyal Leroy is 73 years old. Mr. Leroy has End Stage Renal Disease (ESRD), post-graft, and it has been 4 months since his transplant. When he entered Medicare, he was disabled and had ESRD at that time. He has been at Green Garden Nursing Home since October 15, 2006, with no expectations of going home soon. Mr. Leroy has a home in Garrett County, Maryland and is not eligible for Medicaid. Mr. Leroy was diagnosed with diabetes with acute complications.

Step1: (Review the MMR)

When Center Insurance reviews the MMR (Figure 4E) to ensure that CMS records match their enrollment records they discover a discrepancy. As indicated in the scenario, Susie Brown is eligible for Medicaid. However, the MMR is not reflecting this status, which impacts the payment Center Insurance receives for providing services to Ms. Brown. Center Insurance confirms that their records show Ms. Brown as having Medicaid status.

Step 2: (Certification of Enrollment)

The health status as reflected on the MMR is inaccurate, which means that Center Insurance can certify the enrollment information, but report the discrepancy.

Step 3: (Retroactive Submission)

Center Insurance submits a 01 RETRO Correction transaction to IntegriGuard to retroactively turn on the Medicaid status for Susie Brown. Once IntegriGuard processes the RETRO transaction, Center Insurance will receive an adjustment to their payment for Ms. Brown.

Figure 4E – Center Insurance's Monthly Membership Report

```
 RUN DATE:20070418                                        MONTHLY MEMBERSHIP REPORT - NON DRUG                               PAGE: 1
  PAYMENT MONTH:200705                               PLAN(H9999) PBP(001) SEGMENT(000) CENTER INSURANCE
                                    -------------------------------------------- REBATES --------------------------------------------
  BASIC PREMIUM | COST SHR REDUC   MAND SUPP BENEFIT  PART D SUPP BENEFIT   PART B BAS PRM REDUC   PART D BAS PRM REDUC
PART A    $0.00     |   $19.44            $4.91              $0.00                     $0.00                  $0.00
PART B    $0.00     |   $17.71            $4.48              $0.00                     $0.00                  $0.00

               S    -----------  FLAGS  ------------    ----------------------- PAYMENTS/ADJUSTMENTS ----------------------
  CLAIM        E AGE  STATE      P P         M F    A D   S A MTHS         DATES         LAG     FTYPE
  NUMBER       X GRP  CNTY       A A H E I   C R O  D E E O D A B       START   END
  ------------ - ---- -----    O R R O S N N A A R  D F G U M ---- --- -----------------------------------------------------
     SURNAME F    DMG  BIRTH    O T T S R S H I I E  O A H R S PIP  ADJ
             I    RA   DATE     A A B P D T C D L C  N U P C P DCG  REA   FCTR-A  FCTR-B      PART A      PART B   TOTAL PAYMENT
  ------------ - ---- -----    - - - - - - - - - -  - - - - - ---- -----------------------------------------------------
 212121212A    F 6569 21000                                             200509  200705  Y            C
     BLUE    S    6569 19370225   Y Y              0                      1.143   1.143      $479.17      $432.15        $911.32
 333333333A    F 7074 21020                                              200505  200705 Y            C
     BROWN   S    7074 19350115   Y Y              1                      2.963   2.963     $1375.31     $1240.31       $2615.62
 123456789A    M 7074 21110                                             200705  200705  Y           I1
     LEROY   L    7074 19331228   Y Y   Y          3                      5.275    5.275   $17716.57    $17716.57      $35433.13
```

4.5 Plan Payment Report (PPR) (Slide 19)

The PPR itemizes the final monthly payments to plans for all enrolled beneficiaries. This includes base level prospective payments for each beneficiary, any beneficiary or plan level adjustments, and premiums.

Plans can reconcile enrollment numbers with the numbers identified on the PPR for the base prospective payment. In addition, plans can reconcile the number of adjustments on the TRR and MMR with the number of adjustments identified on the PPR. Then, the plan can reconcile the PPR with the numbers maintained in Independent Blue Cross' internal databases.

Example 4

Independence Blue Cross receives its Plan Payment Report as part of the month-end processing. Independence Blue Cross reviews the PPR along with the TRR and MMR to ensure that the prospective payments, enrollment numbers, and adjustments are correct.

Step 1: (Review the PPR)

When Independence Blue Cross reviews the PPR for November 2007 (Figure 4F) to ensure that CMS records match their enrollment records, they determine that the enrollee numbers are correct. However, several adjustments do not match Independence Blue Cross' records for this month. According to Independence Blue Cross' records for adjustments affecting prior months for Parts A/B and D, there were:

- 121 enrollments
- 104 disenrollments
- 3 ESRD

The remainder of the report matched their records and the other reports.

Independence Blue Cross further reviewed their internal database records and determined that there were several transactions that did not process on their end as well as the ESRD status not reflected in CMS records for two enrollees.

Step 2: (Certification of Enrollment)

Independence Blue Cross certifies the enrollment and payment and reports the discrepancies identified while reconciling reports.

Step 3: (Retroactive Submission)

Independence Blue Cross submits RETRO spreadsheet and supporting documentation required to process the retroactive transactions.

Figure 4F – Independence Blue Cross Payment Report

CMS MONTHLY PLAN PAYMENT REPORT — PAGE 1 OF 2
PLAN NUMBER: H3909 — PAYMENT MONTH: 11/2007
PLAN NAME: INDEPENDENCE BLUE CROSS — RUN DATE: 11/02/2007

PAYMENT TYPE:		A PAYMENT	B PAYMENT	D PAYMENT	NET PAYMENT
1. PROSPECTIVE PAYMENT:					
PARTA MEMBERS:	21,764	$ 8,629,358.13			$ 8,629,358.13
PARTB MEMBERS:	21,764		$ 8,099,793.20		$ 8,099,793.20
PARTD MEMBERS:	19,005			$ 1,426,422.97	$ 1,426,422.97
2. ADJUSTMENTS TO PRIOR MONTHS AFFECTING A/B & D PAYMENTS:					
(01) DEATH OF BENEFICIARY.....COUNT:	48	$ -49,083.46	$ -46,925.48	$ -5,565.81	$ -101,574.75
(02) RETROACTIVE ACCRETION.....COUNT:	124	$ 60,092.54	$ 57,288.74	$ 8,850.96	$ 126,232.24
(03) RETROACTIVE DELETION.....COUNT:	101	$ -95,943.62	$ -91,744.84	$ -10,672.43	$ -198,360.89
(04) CORRECTION TO ACCRETION...COUNT:	0	$ 0.00	$ 0.00	$ 0.00	$ 0.00
(05) CORRECTION TO DELETION....COUNT:	0	$ 0.00	$ 0.00	$ 0.00	$ 0.00
(06) PART A ENTITLEMENT LOSS...COUNT:	0	$ 0.00	$ 0.00	$ 0.00	$ 0.00
(08) ESRD.....COUNT:	1	$ 4,979.28	$ 7,031.34	$ 0.00	$ 12,010.62
(12) CORRECTION TO DEATH.....COUNT:	0	$ 0.00	$ 0.00	$ 0.00	$ 0.00
(19) CORRECTION TO PART B ENT..COUNT:	0	$ 0.00	$ 0.00	$ 0.00	$ 0.00
(22) RETRO DELETE DUE TO ESRD..COUNT:	0	$ 0.00	$ 0.00	$ 0.00	$ 0.00
(35) RETRO CHANGE TO REBATE....COUNT:	0	$ 0.00	$ 0.00	$ 0.00	$ 0.00
(38) RETRO SEGMENT ID CHANGE...COUNT:	0	$ 0.00	$ 0.00	$ 0.00	$ 0.00
3. ADJUSTMENTS TO PRIOR MONTHS AFFECTING A/B PAYMENTS:					
(07) HOSPICE.....COUNT:	49	$ -67,341.61	$ -68,592.19		$ -135,933.80
(09) INSTITUTIONAL.....COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(10) MEDICAID.....COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(11) RETRO SCC.....COUNT:	17	$ -642.03	$ -594.90		$ -1,236.93
(13) CORRECTION TO BIRTH.....COUNT:	1	$ -48.67	$ 0.00		$ -48.67
(14) CORRECTION TO SEX.....COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(18) A/B RATE.....COUNT:	11	$ 3,850.19	$ 1,938.13		$ 5,788.32
(20) WORKING AGED.....COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(21) NHC.....COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(23) DEMO FACTOR ADJUSTMENT....COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(25) RETRO RA RECON.....COUNT:	1	$ -143.44	$ -130.60		$ -274.04
(26) RETRO RA RECON (MID-YEAR).COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(27) RETRO CHF.....COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(29) HOSPICE RATE.....COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(34) PART C BASIC PREMIUM.....COUNT:	0	$ 0.00	$ 0.00		$ 0.00
(42) RETRO ESRD MSP FACTOR CHG.COUNT:	2	$ -1,940.93	$ -2,555.35		$ -4,496.28

Figure 4F – Independence Blue Cross Plan Payment Report (Continued)

CMS MONTHLY PLAN PAYMENT REPORT — PAGE 2 OF 2
PLAN NUMBER: H3909 — PAYMENT MONTH: 11/2007
PLAN NAME: INDEPENDENCE BLUE CROSS — RUN DATE: 11/02/2007

PAYMENT TYPE:	A PAYMENT	B PAYMENT	D PAYMENT	NET PAYMENT
4. ADJUSTMENTS TO PRIOR MONTHS AFFECTING D PAYMENTS:				
(30) PART D PREMIUM.....COUNT: 0			$ 0.00	$ 0.00
(31) PART D LOW-INCOME STATUS..COUNT: 26			$ 7,917.94	$ 7,917.94
(32) ESTIMATED LICS.....COUNT: 0			$ 0.00	$ 0.00
(33) ESTIMATED REINSURANCE.....COUNT: 0			$ 0.00	$ 0.00
(36) PART D RATE.....COUNT: 0			$ 0.00	$ 0.00
(37) PART D RA FACTOR.....COUNT: 10			$ 58.97	$ 58.97
(41) PART D RA FACTOR(MID-YEAR)COUNT: 0			$ 0.00	$ 0.00
5. PLAN LEVEL ADJUSTMENTS:				
A. EDUCATION USER FEE:				
1) AMT SUBJECT TO FEE $ 18,095,609.44				
2) X FEE RATE $ 0%	$ 0.00	$ 0.00	$ 0.00	$ 0.00
B. COB USER FEE:				
1) PROSP D MEMBERS 19,005				
2) X FEE RATE $ 0			$ 0.00	$ 0.00
C. WORKING AGED/DISABLED ADJUSTMENT:				
1) ADJUSTED DEMOG PMT $ 0.00				
2) X PLAN DEMOG RATE 0	$ 0.00	$ 0.00		$ 0.00
3) ADJUSTED RA PMT $ 18,095,315.39				
4) X PLAN RA RATE 0.00402	$ -37,760.74	$ -34,982.42		$ -72,743.16
D. BIPA 606 PAYMENT REDUCTION:				
1) ADJUSTMENTS PRIOR TO 2006		$ 0.00		$ 0.00
E. BBRA BONUS PAYMENTS:				
1) ADJUSTMENTS PRIOR TO 2004	$ 0.00	$ 0.00		$ 0.00
6. CMS ADJUSTMENTS:				
A. 2006 PART D PAYMENT RECONCILIATION	$ 0.00	$ 0.00	$ -5,000,142.06	$ -5,000,142.06
B. PREMIUM RECONCILIATION PART 3	$ 0.00	$ 0.00	$ 1,087.90	$ 1,087.90
7. SUBTOTALS BEFORE PREMIUM SETTLEMENT:	$ 8,445,375.64	$ 7,920,525.63	$ -3,572,041.56	$ 12,793,859.71
8. PREMIUM SETTLEMENT:				
A. PREMIUM WITHHOLDING				
1) PART C PREMIUMS			$ 22,385.00	$ 22,385.00
2) PART D PREMIUMS			$ 5,108.50	$ 5,108.50
B. LOW INCOME SUBSIDY				
1) PROSPECTIVE LIS			$ 12,778.30	$ 12,778.30
2) ADJUSTMENTS TO LIS			$ 1,802.73	$ 1,802.73
C. LATE ENROLLMENT PENALTY (DIRECT BILL ONLY)			$ 0.00	$ 0.00
9. NET PAYMENT:	$ 8,445,375.64	$ 7,920,525.63	$ -3,529,967.03	$ 12,835,934.24

4.6 Ordering Reports (Slide 20)

Reports that plans can order are those that CMS generated in previous months. When small plans order these reports, CMS places the reports in the plan's Gentran Mailbox server for retrieval. Large plans will receive their reports directly from MARx through Connect:Direct. The only individuals who can order reports from MARx are those users identified as MCO Representative Transmitters. Plans are allowed a maximum of four Representative Transmitters per plan.

Plans can order copies of reports and data files generated for previous months. CMS delivers the ordered reports via Connect:Direct or Gentran.

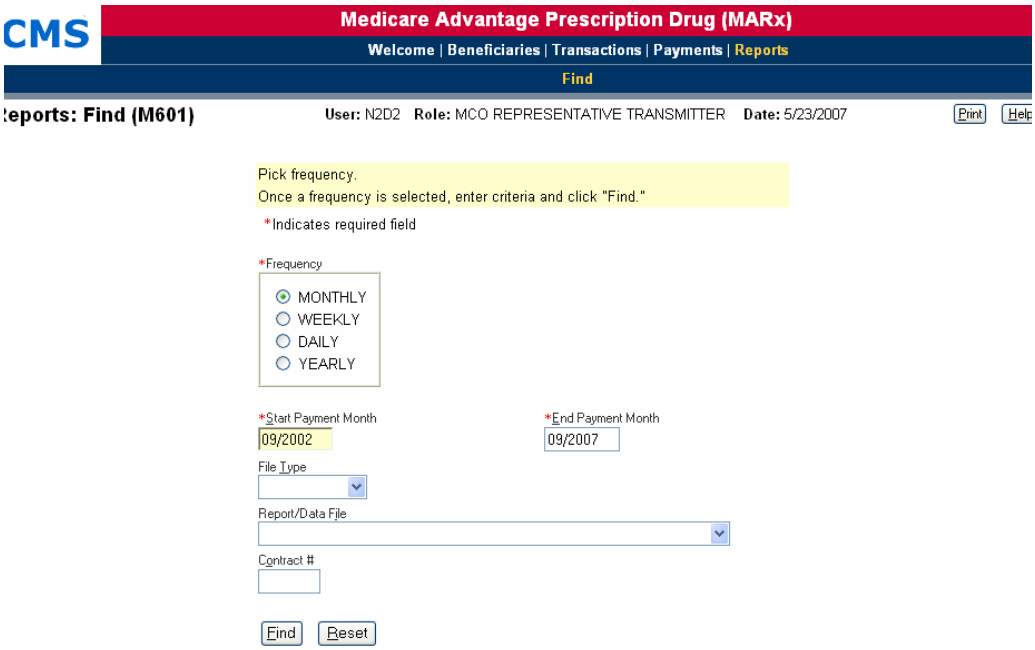
CMS offers four types of reports in the enrollment processing system. Table 4L describes the types of reports available for ordering.

TABLE 4L – TYPES OF REPORTS AVAILABLE FOR ORDERING

TYPE OF REPORTS/DATA FILES	DESCRIPTION
Daily (based on transaction)	• generated each day for events that occurred that day, including: - processing of a batch transaction file - receipt of a report
Weekly	• scheduled and automatically generated • reflect transactions that were processed that week for a contract
Month-end	• scheduled and automatically generated • part of monthly payment processing

Figure 4G provides a screenshot of the screen for ordering reports in MARx.

Figure 4G – Common UI - Ordering Reports Screen



Plan Communications User Guide, Version 3.1, Section 4.6 (April 18, 2008).

DATA FILE RECORD LAYOUTS

TABLE 4M – TRR FLAT FILE LAYOUT

Field	Size	Position	Description
1. Claim Number	12	1 – 12	Claim Account Number
2. Surname	12	13 – 24	Beneficiary Surname
3. First Name	7	25 – 31	Beneficiary Given Name
4. Middle Name	1	32	Beneficiary Middle Initial
5. Sex Code	1	33	Beneficiary Sex Identification Code '0' = Unknown '1' = Male '2' = Female
6. Date of Birth	8	34 – 41	YYYYMMDD Format
7. Filler	1	42	Space
8. Contract Number	5	43 – 47	Plan Contract Number
9. State Code	2	48 – 49	Beneficiary Residence State Code
10. County Code	3	50 – 52	Beneficiary Residence County Code
11. Disability Indicator	1	53	'1' = Disabled '0' = No Disability
12. Hospice Indicator	1	54	'1' = Hospice '0' = No Hospice
13. Institutional/NHC Indicator	1	55	'1' = Institutional '2' = NHC '0' = No Institutional
14. ESRD Indicator	1	56	'1' = End-Stage Renal Disease '0' = No End-Stage Renal Disease
15. Transaction Reply Code	3	57 – 59	Transaction Reply Code
16. Transaction Type Code	2	60 – 61	Transaction Type Code
17. Entitlement Type Code	1	62	Beneficiary Entitlement Type Code: 'Y' = Entitled to Part A and B Blank = Entitled to Part A or B
18. Effective Date	8	63 – 70	YYYYMMDD Format; Effective date is present for all Transaction Reply Codes. However, for UI Transaction Reply Codes (TRC), field content is TRC dependent: 701 – New enrollment period start date, 702 – Fill-in enrollment period start date, 703 – Start date of cancelled enrollment period, 704 – Start date of enrollment period cancelled for PBP correction, 705 – Start date of enrollment period for corrected PBP, 706 – Start date of enrollment period cancelled for segment correction, 707 – Start date of enrollment period for corrected segment, 708 – Enrollment period end date assigned to existing opened ended enrollment, 709 & 710 – New start date resulting from update, 711 & 712 – New end date resulting from update, 713 – "00000000" – End date removed. Original end date can be found in field 24.X.

TABLE 4M – TRR FLAT FILE LAYOUT (CONTINUED)

Field	Size	Position	Description
19. WA Indicator	1	71	'1' = Working Aged '0' = No Working Aged
20. Plan Benefit Package ID	3	72 – 74	PBP number
21. Filler	1	75	Spaces
22. Transaction Date	8	76 – 83	YYYYMMDD Format; Present for all transaction reply codes
23 UI Initiated Change Flag	1	84	'1' = transaction created through user interface '0' = transaction from source other than user interface
24. Positions 85 – 96 are dependent upon the value of the TRANSACTION REPLY CODE. There are spaces for all codes except where indicated below.			
a. Effective Date of the Disenrollment	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 13, 14, 18, 84
b. New Enrollment Effective Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 17, 83
c. Claim Number (new)	12	85 – 96	Present only when Transaction Reply Code is one of the following: 22, 25, 86
d. Date of Death	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 90 (with transaction type 01), 92
e. Hospice Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 71
f. Hospice End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 72
g. ESRD Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 73
h. ESRD End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 74
i. Institutional/ NHC Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 48, 75, 158, 159
j. Medicaid Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 77
k. Medicaid End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 78
l. Part A End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 79
m. WA Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 66

TABLE 4M – TRR FLAT FILE LAYOUT (CONTINUED)

Field	Size	Position	Description
n. WA End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 67
o. Part A Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 80
p. Part B End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 81
q. Part B Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 82
r. New SCC	5	85 – 89	Beneficiary Residence State and County Code; Present only when Transaction Reply Code is 85
s. Attempted Enroll Effective Date	8	85 - 92	The effective date of an enrollment transaction that was submitted but rejected. Present only when Transaction Reply code is the following: 35, 36, 45, 56
t. New Low-Income Premium Subsidy	12	85 – 96	ZZZZZZZZ9.99 Format; Part D low-income premium subsidy amount. Present only when Transaction Reply Code is 167.
u. New Low-income Cost Sharing Subsidy	1	85 – 85	The beneficiary's Part D low-income subsidy status has changed, resulting in a co-pay level change. The new co-pay level is: '1' = (High) '2' = (Low) '3' = (0) '4' = 15% Present only when Transaction Reply Code is 168.
v. PBP Effective Date	8	85 – 92	YYYYMMDD Format. Effective date of a beneficiary's PBP change. Present only when Transaction Reply Code is 100.
w. Correct Part D Premium Rate	12	85 – 96	ZZZZZZZZ9.99 Format; Part D premium amount reported by HPMS for the Plan. Present only when the Transaction Reply Code is 181.
x. Date Identifying Information Changed by UI User	8	85 – 92	YYYYMMDD Format; Field content is dependent on Transaction Reply Code: 702 – Fill-in enrollment period end date, 705 – End date of enrollment period for corrected PBP, blank when end date not provided by user, 707 – End date of enrollment period for corrected segment, blank when end date not provided by user, 709 & 710 – Enrollment period start date prior to start date change, 711, 712, & 713 – Enrollment period end date prior to end date change.
y. Modified Part C Premium Amount	12	85 - 96	ZZZZZZZZ9.99 Format; Part C premium amount reported by HPMS for the Plan. Present only when the Transaction Reply Code is 182.

TABLE 4M – TRR FLAT FILE LAYOUT (CONTINUED)

Field	Size	Position	Description
25. District Office Code	3	97 – 99	Code of the originating district office; Present only when Transaction Type Code is 53
26. Previous Part D Contract/PBP for TrOOP Transfer.	8	100 – 107	CCCCCPPP Format; Present only if previous enrollment exists within reporting year in Part D Contract. Otherwise, field will be blank. CCCCC = Contract Number PPP = Plan Benefit Package (PBP) Number
27. Filler	8	108 – 115	Spaces
28. Source ID	5	116 – 120	Transaction Source Identifier
29. Prior Plan Benefit Package ID	3	121 – 123	Prior PBP number; present only when transaction type code is 71
30. Application Date	8	124 – 131	The date the plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper). Format: YYYYMMDD
31. UI User Organization Designation	2	132 – 133	'02' = Regional Office, '03' = Central Office, Blank if not UI transaction
32. Out of Area Flag	1	134 – 134	Out of Area Indicator
33. Segment Number	3	135 – 137	Further definition of PBP by geographic boundaries

TABLE 4N - MONTHLY MEMBERSHIP REPORT (MMR) (DRUG AND NON-DRUG FIELDS)

[Plan Communications User's Guide Appendices, Version 3.1 (April 18, 2008). Centers for Medicare & Medicaid Services]

#	Field Name	Len	Pos	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	First 7 letters of the member's surname
6	First Initial	1	39-39	First initial of the member's first name
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 = Working Aged
17	Institutional	1	64-64	Y = Institutional (monthly)
18	NHC	1	65-65	Y = Nursing Home Certifiable
19	Medicaid Beneficiary Medicaid Status Flag	1	66-66	Y = Default Part C risk factor used, Medicaid Beneficiary N = Default Part C risk factor used, non-Medicaid beneficiary Blank = No Part C default factor used or the beneficiary is Part D only
20	LTI Flag	1	67-67	Y = Part C Long Term Institutional
21	Medicaid Indicator	1	68-68	Y = Medicaid Add-on to beneficiary RAS factor Blank = No Medicaid Add-on
22	PIP-DCG	2	69-70	PIP-DCG Category - Only on pre-2004 adjustments
23	Default Indicator	1	71-71	Y = default RA factor in use • For pre-2004 adjustments, a 'Y' indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a 'Y' indicates that a default factor was generated by the system due to lack of a RA factor.
24	Risk Adjuster Factor A	7	72-78	NN.DDDD

TABLE 4N – MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
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/Adjustmt Start Date	8	92-99	FORMAT: YYYYMMDD
30	Paymt/Adjustmt End Date	8	100-107	FORMAT: YYYYMMDD
31	Demographic Paymt/ Adjustmt Rate A	9	108-116	FORMAT: -99999.99
32	Demographic Paymt/ Adjustmt Rate B	9	117-125	FORMAT: -99999.99
33	Risk Adjuster Paymt/ Adjustmt 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
34	Risk Adjuster Paymt/ Adjustmt 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	Format X. Values = 'Y' or 'N'(default) Indicates if Medicare is the Secondary Payer for an ESRD member
37	MSA Part A Deposit/ Recovery Amount	8	153-160	Medicare Savings Account (MSA) lump sum Part A dollars to be deposited/recovered. Deposits are positive values and 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 to be deposited/recovered. Deposits are positive values and 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	FILLER	1	171-171	SPACES

TABLE 4N – MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
41	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
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	'N' = "de minimis" does not apply 'Y' = "de minimis" applies
44	FILLER	2	184-184	SPACES
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)
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
50	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months.

TABLE 4N – MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
51	Segment ID	3	194-196	Identification number of the segment of the PBP. Blank if there are no segments.
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) , E = Auto-enrolled by Plans, F = Facilitated enrollment by Plans, G = POS submitted enrollment, H = Re-assignment enrollment by CMS or Plans and I = Enrollments submitted by Plans with enrollment source other that B, E, F, G, H and blank.
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

TABLE 4N – MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
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
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	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.
69	Part D Low-Income Multiplier	7	318-324	The member's Part D low-income multiplier. NN.DDDD
70	Part D Long Term Institutional Indicator	1	325	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.
71	Part D Long Term Institutional Multiplier	7	326-332	The member's Part D institutional multiplier. NN.DDDD
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

TABLE 4N – MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
73	Part D Basic Premium Amount	8	341-348	The plan's Part D premium amount. -9999.99
74	Part D Direct Subsidy Payment Amount	10	349-358	The total Part D Direct subsidy payment 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 -999999.99.
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 Add-on amount -999999.99
80	PACE Cost Sharing Add on	10	402-411	Total Part D PACE Cost Sharing Add-on amount -999999.99

2008 Regional Technical Assistance
Enrollment & Payment

CMS Centers for Medicare & Medicaid Services

Introduction and Overview

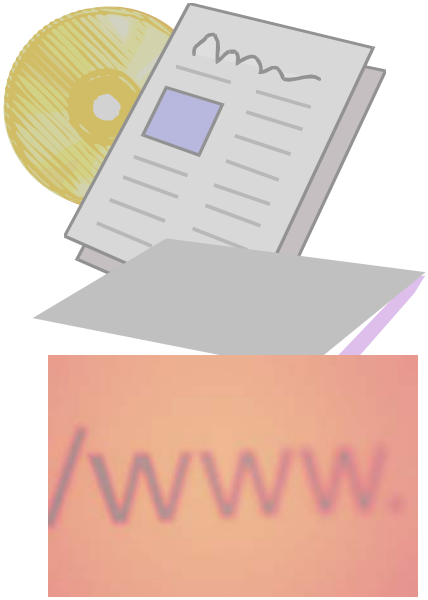
2008 ENROLLMENT & PAYMENT

Purpose

- To introduce participants to important terms and key resources that provide a foundation for the Enrollment and Payment technical assistance program

Technical Assistance Session Tools

- Participant Guide
  - CD with slides
- www.tarsc.info



Audience

- New staff of:
  - Medicare Advantage (MA) and Medicare Advantage – Prescription Drug (MA-PD) organizations
  - Prescription Drug Plan (PDP) organizations
  - Employer Sponsored Group Health plans
  - Demonstration Plans, Program of All-Inclusive Care for the Elderly (PACE) organizations
- Existing staff unable to attend previous training sessions
- New staff at existing organizations

Agenda Topics

Introduction and Overview
Enrollment Process Summary
Q&A Session 1
Enrollment Processing and MARx Overview
Payment Overview
Reports and Reconciliation
Q&A Session 2

The session includes two 15-minute breaks and 1 hour and 15 minutes for lunch.

Learning Objectives

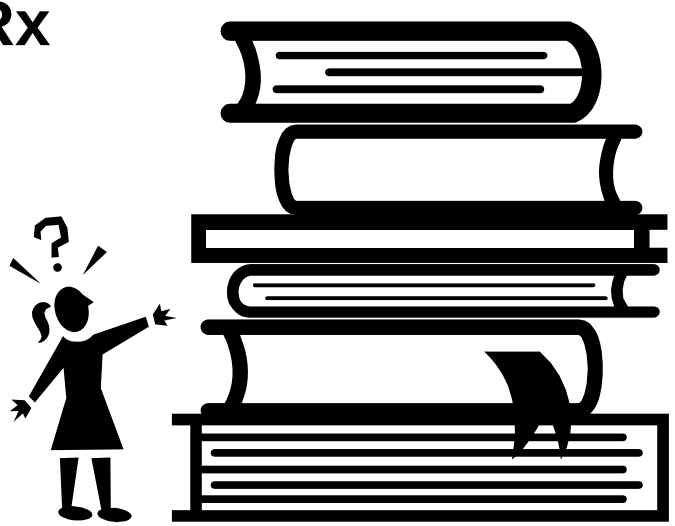
- Summarize enrollment processing activities
- Explain enrollment transactions and processing
- Describe the monthly plan payment
- Reconcile enrollment and payment using reports

Common Enrollment and Payment System Terms

MARx

APPS

HPMS



PWS

Common UI

MAPD IUI

Enrollment Periods

- Annual Election Period (AEP)
- Initial Coverage Election Period (ICEP)
- Initial Enrollment Period (IEP)
- Special Election Periods (SEP)
- Open Enrollment Period (OEP)

Enrollment Processing

- Enrollment Transaction
- Disenrollment Transaction
- Plan Elections (PBP Change) Transaction
- Plan Change Transaction
- Correction
- Part D Opt-Out

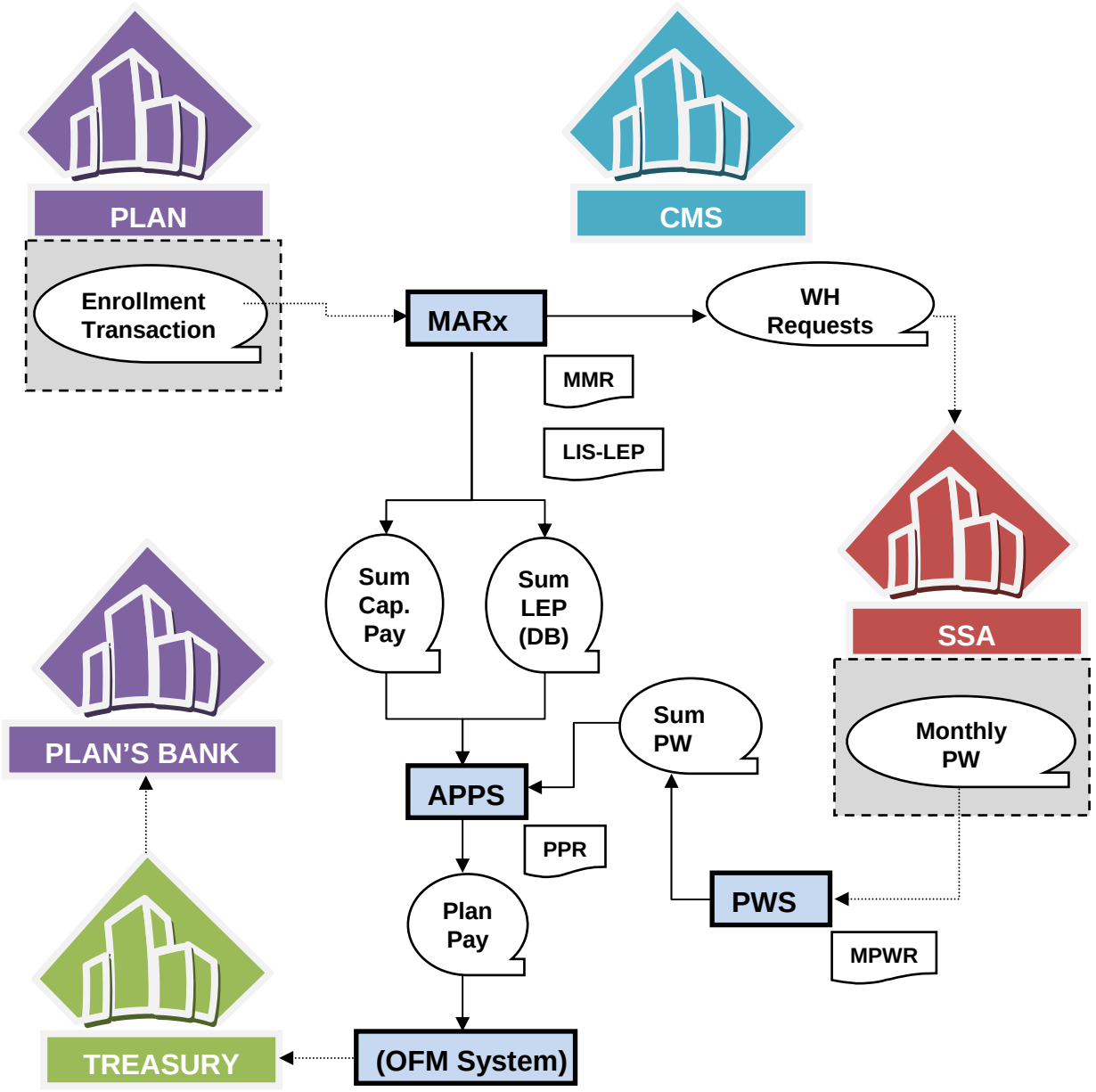
Monthly Plan Payment

- Three main sources of monthly plan payment data:
  - MARx
  - Premium Withhold System (PWS)
  - Automated Plan Payment System (APPS)

Enrollment and Payment Verification Process

Step 1	Reconciliation
Step 2	Certification
Step 3	Retroactive Submission

Monthly Plan Payment Process



Technical Assistance and Support

- **Customer Support for Medicare Modernization (CSMM) Helpdesk**
  - **www.cms.hhs.gov/mmahelp**
- **Health Plan Management System (HPMS) Helpdesk**
- **Technical Assistance and Registration Service Center (TARSC)**
  - **www.tarsc.info**

Enrollment Process Summary

Purpose

- Provide plans with an overview and summary of enrollment processing activity

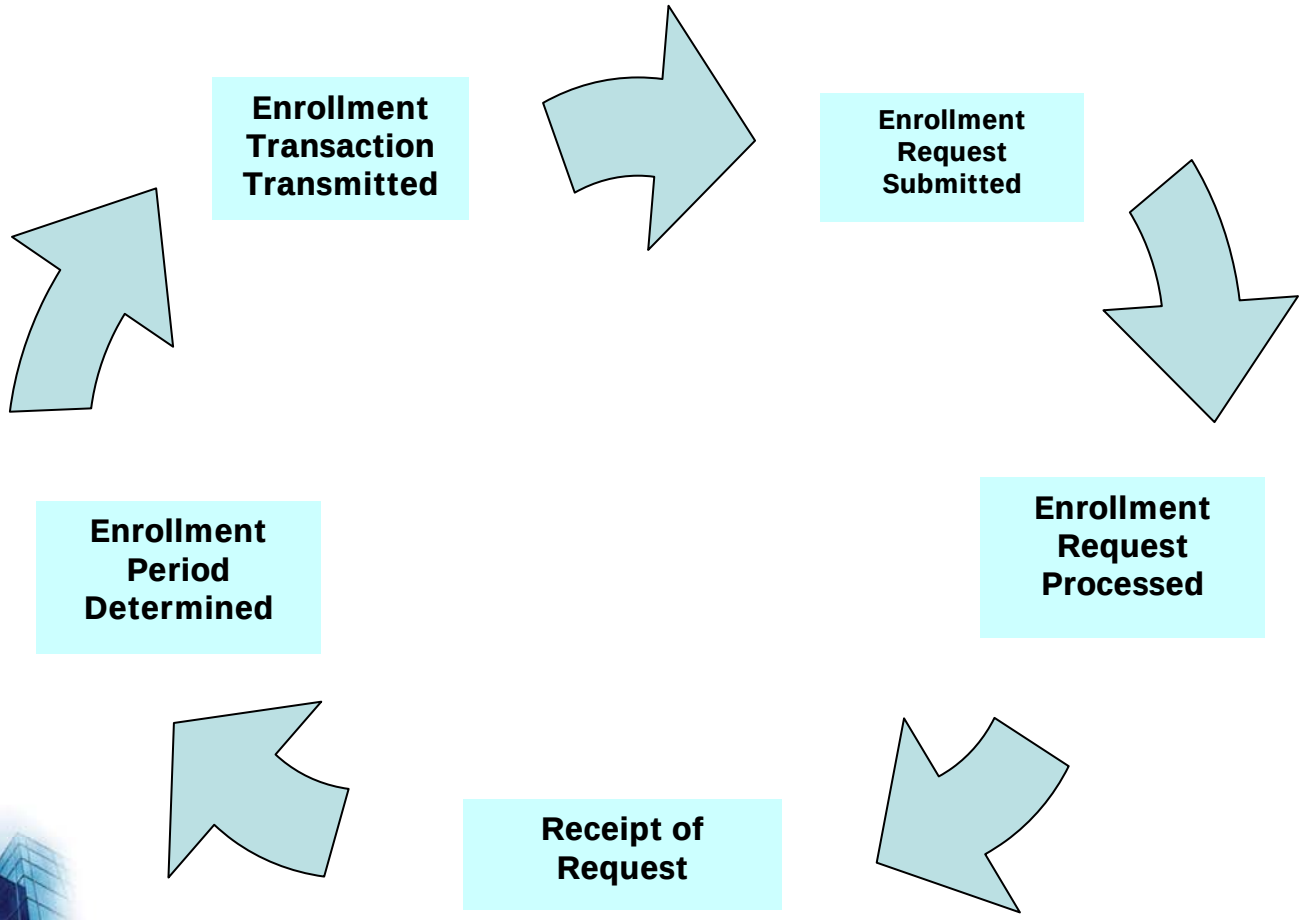
This overview and summary does NOT replace, enhance, change, or otherwise impact published official CMS guidance documents.

Objectives

- Identify enrollment requirements
- Describe enrollment mechanisms
- Identify enrollment periods
- Define plan communication

“enrollment” used throughout this module refers to all enrollment and disenrollment requests, unless otherwise specified

Enrollment Process Overview



Summary of PDP Eligibility Requirements

PDP Eligibility Enrollment Requirements*
• Entitled to Medicare Part A **or** enrolled in Part B
• Permanently resides in the plan's service area

*All eligibility requirements are described in the CMS PDP Enrollment and Disenrollment Guidance.

Summary of Basic MA and MA-PD Eligibility Requirements

Eligibility Enrollment Requirements*
• Entitled to Medicare Part A **and** enrolled in Part B
• Not medically determined to have ESRD prior to completing the enrollment election; Exceptions Apply
• Permanently resides in the plan's service area
• Completes an enrollment request and includes all the information required to process the enrollment
• Is fully informed of and agrees to abide by the rules of the MA organization
• Makes a valid election during an election period

*Additional eligibility requirements apply to certain MA plan types, such as SNP or MSA. Refer to CMS Enrollment and Disenrollment Guidance for MA plans for complete information.

Low Income Subsidy Eligible

LIS GROUPS	MEDICAID ELIGIBLE	DEEMED	APPLY
Full Benefit Dual Eligible	x	x	
Medicare Savings Program • Qualified Medicare Beneficiary (QMB) • Specified Low Medicare Beneficiary (SLMB) • Qualified Individuals (QI)	x	x	
Supplemental Security Income (SSI)		x	
LIS Applicants			X

Enrollment Mechanisms

Paper Application

Internet

Phone

CMS Online Enrollment Center
(or 1-800-MEDICARE)

Enrollment Request Scenario

Scenario	Question
Mr. Harold Smith submits an enrollment request to enroll in Spring MA Health Plan. Spring Health Plan reviews the request. Mr. Smith completed all fields on the enrollment request with the exception of the permanent address.	Did Spring Health Plan receive a completed enrollment request?

Enrollment via Auto/Facilitated Enrollment

The term ***auto-enrollment*** denotes the process that applies to FBDE individuals and ***facilitated enrollment*** to others with LIS

Part C – Auto-/Facilitated Enrollment Process for Dual and Other LIS Eligibles

- CMS monthly MA dual eligible file
- MA organizations use MA dual eligible file to identify beneficiaries to
  - Auto-enroll in MA-PD plan with lowest combined Part C and D premium
  - Randomly assign to plan if more than one MA-PD plan has the lowest premium

Part D – Auto-/Facilitated Enrollment Process for Dual and Other LIS Eligibles

1. **Step 1:** CMS identifies individuals for auto/facilitated enrollment
   - Full-benefit dual eligible – auto-enrollment
   - Other LIS eligible – facilitated enrollment
2. **Step 2:** CMS assigns beneficiaries to a stand-alone PDP plan via a two step process:
   - First level of assignment is at the Sponsor's level
   - Second level is to an individual PDP

Part D – Auto-/Facilitated Enrollment Process for Dual and Other LIS Eligibles **(continued)**

There are 4 PDP Sponsoring organizations in a region that offer one or more plans with premiums at or below the low income premium subsidy amount. The numbers of PDPs with an appropriate premium are as follows:

Sponsoring Organization	**Step 1** *Each org. assigned 25% of avail. population*	**Step 2** *Assignment to each plan*		
Organization A – 1 PDP	25,000	100%		
Organization B – 1 PDP	25,000	100%		
Organization C – 2 PDPs	25,000	50% Plan A	50% Plan B	
Organization D – 3 PDPs	25,000	33.3% Plan A	33.3% Plan B	33.3% Plan C

Example based on 100,000 beneficiaries

Part D Opt Out

Both Dual and Other LIS eligibles may opt out or affirmatively decline the Part D benefit. The beneficiary may opt out of auto/facilitated enrollment verbally or in writing.

Enrollment Periods

Enrollment Period	Plan Types	Enrollment Dates	Effective Dates
Initial Enrollment Period (IEP)	• PDP • MA-PD	• Three months prior to entitlement month, the entitlement month, and three months after the entitlement month	• Requests made prior to the entitlement month become effective the month of entitlement Requests made during or after the entitlement month become effective the following month
Annual Coordinated Election Period (AEP)	• PDP • MA-PD • MA	• November 15 – December 31	• January 1 of the following year

Enrollment Periods (continued)

Enrollment Period	Plan Types	Enrollment Dates`	Effective Dates
Initial Coverage Election Period (ICEP)	• MA • MA-PD	• Begins 3 months before entitlement to both Medicare Part A and Part B and ends on the later of: • Last day of month before entitlement to both Part A and Part B • The last day of individual's Part B initial enrollment period	• First day of month of entitlement to Medicare Part A and Part B • First of month following month of election after entitlement has occurred
Special Enrollment Period (SEP)	• MA • MA-PD • PDP	• Situational	• Situational
Open Enrollment Period (OEP)	• MA-PD • MA	• January 1 – March 31	• 1st date of month after month the MA receives a completed enrollment election

Note: While IEP and ICEP are both available to MA-PD plans, the IEP is used for beneficiaries.

Late Enrollment Penalty

- Did not enroll during IEP or ICEP
- No Creditable Coverage
- Number of Uncovered Months

Incomplete Application

- Request does not include all required fields
- Check CMS files
- Notice to beneficiary
- Application must be made complete within 21 calendar days

Retroactive Determinations

Definition - A Retroactive Enrollment is an enrollment with an effective date prior to the Current Processing Month.

Plan must request the retroactive enrollment request **within 45 calendar days** of the availability of the first transaction reply report.

Disenrollment from Plan

Plans may not either orally or in writing or by any other action or inaction request or encourage any member to disenroll.

Types of Disenrollments

- Voluntary
  - Misrepresentation of benefits
- Involuntary
  - Individual no longer resides in the Plan' service area
  - Individual loses entitlement to Medicare
  - Death of the beneficiary
  - Plan termination
  - Material misrepresentation of third-party reimbursement

Plan to Beneficiary Communications

Notice	Timeframe
Acknowledgement of Receipt of Completed Enrollment Election	10 calendar days of receipt of completed enrollment election
Acknowledge Receipt of Enrollment Request	10 calendar days of receipt of enrollment request
Failure to Pay Plan Premiums – Advance Notification of Disenrollment or Reduction in Coverage	Within 10 calendar days after the 1st of the month for which delinquent premiums due

Certification

- Attest to Enrollment
- Plans must report accurate information to CMS
- Report Discrepancies
- Use of Monthly Reports
  - Monthly Membership Report
  - Transaction Reply Report
  - Plan Payment Report

Certification (continued)

Scenario	Process
• Plan receives reports on February 22, 2008 • Certification is due by April 7, 2008	• CEO or CFO signs Certification document. • CMS uses certification data to ensure compliance with CMS records • CMS RO receives certification reports monthly

Where To Obtain More Information

- *Prescription Drug Plan (PDP) Guidance*
- Updates on the www.cms.hhs.gov website
- Chapter 2 of the *Medicare Managed Care Manual*
- Chapter 19 of the *Medicare Managed Care Manual*

Summary

- Identified enrollment requirements
- Described enrollment mechanisms
- Identified enrollment periods
- Defined plan communication

EVALUATION

Please take a moment to complete the evaluation form for the Enrollment Process Summary Module.

THANK YOU!

Enrollment Processing and MARx Overview

2008 ENROLLMENT & PAYMENT

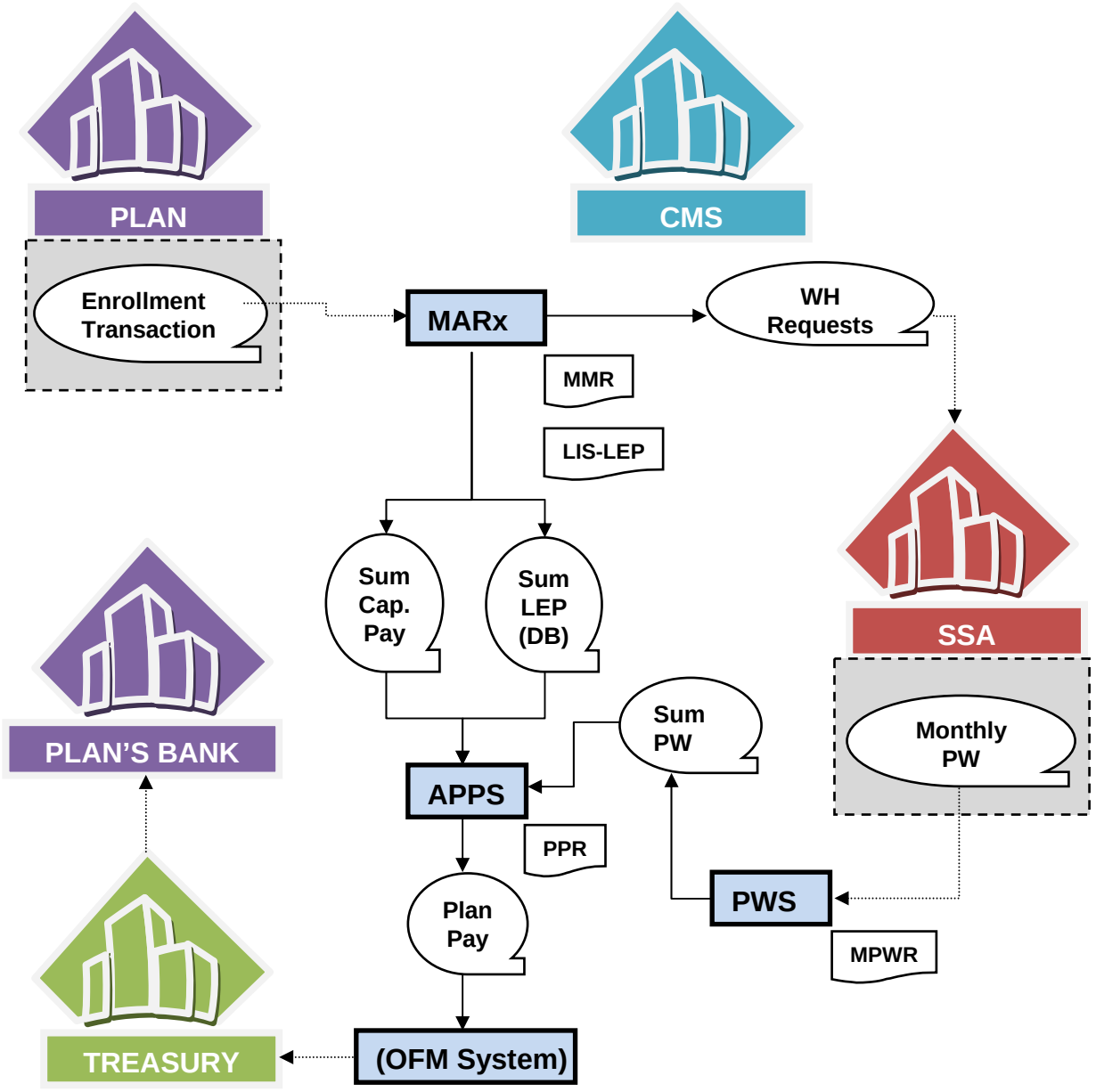
Purpose

- Participants will learn about the latest information regarding enrollment file layouts and the process of submitting enrollment transactions

Objectives

- Explain steps to connect to CMS and transmit data
- Define the fields and functions of enrollment transactions
- Identify enrollment transaction processing requirements
- Describe characteristics of enrollment and eligibility User Interfaces

Monthly Plan Payment Process



Connecting to CMS Systems

STAGE OF CONNECTION	DESCRIPTION
Getting Started	• Obtain a Contract Number • Enter connectivity data into HPMS Plan Connectivity Data Module
Security and Access	• Submit External Point of Contact (EPOC) designation letter • Register EPOC in Individual Access to CMS Systems (IACS) • Register user/submitters and user/representatives for enrollment, 4RX, BEQ, and ECRS • Register user/submitters for PDE/RAPS
Connectivity Set-up	• Select connection option and set up -Set up T1/Connect:Direct to CMS -Set up Gentran Access
Connectivity Testing	• Test selected connection option -Test T1/Connect:Direct to CMS -Test Gentran
Application Testing	• MMA Help Desk initiates contact with contracts to schedule transmission of test files.

Security Requirements

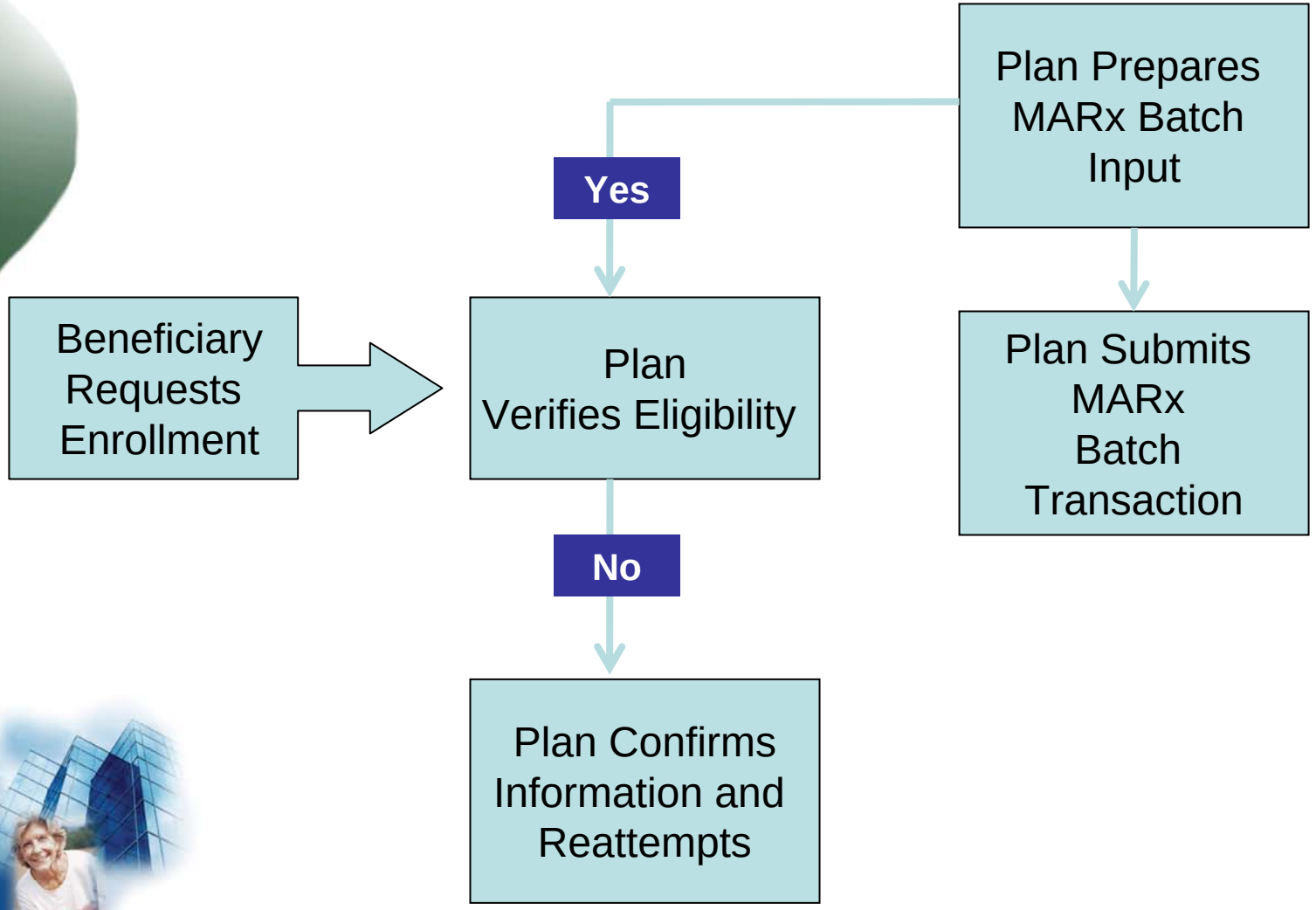
Users are prohibited from

- Disclosing or lending User IDs and passwords
- Browsing/Using CMS data files for unauthorized or illegal purposes
- Using CMS data files for private gain or misrepresentation
- Disclosing CMS data not specifically authorized
- Duplicating/Removing/Transmitting data unless authorized

Enrollment Transaction Processing

- Exchanging of files
  - Plan's submit transaction files to MARx
  - MARx generates reports detailing submission status
- Online access
  - Authorized users query enrollment processing system
  - User views enrollment, payment, premium and beneficiary information from the Common UI

Plan Enrollment Process



Batch Eligibility Query (BEQ)

- BEQ Request
  - Accepted, rejected and pending enrollment transactions
  - CMS provides notification reporting the disposition of all BEQ Request
- BEQ Response File
  - Confirms enrollment eligibility and other pertinent information
  - Plans complete MARx Batch Input Transaction and submit to CMS for processing

Multiple BEQ Request Files can be submitted to CMS during any CMS business day

Transaction Types Codes

Transaction Type	Code
Enrollment	60, 61, 62
Disenrollment	51, *54
PBP Change	71
4RX, Non-4RX, and NUNCMO	72
Part D Opt-Out	*41
Correction	01

***Submitted by CMS only**

Batch Transactions

- Plans submit transaction files to CMS defined by transaction codes
- Consists of header record followed by transaction records
  - Enrollment/Disenrollment/PBP Change record
  - Plan Change/Part D Opt-Out
  - Correction
- Contains 300 Bytes

Retro Enrollment (62) Transaction

- Transaction code “62” used for retroactive transactions only if
  - Incomplete enrollment application is received prior to the end of an election period
  - Application made complete within 21 calendar days of receipt and
  - Enrollment effective date equals Current Payment Month -2 months (CPM-2)

Scenario

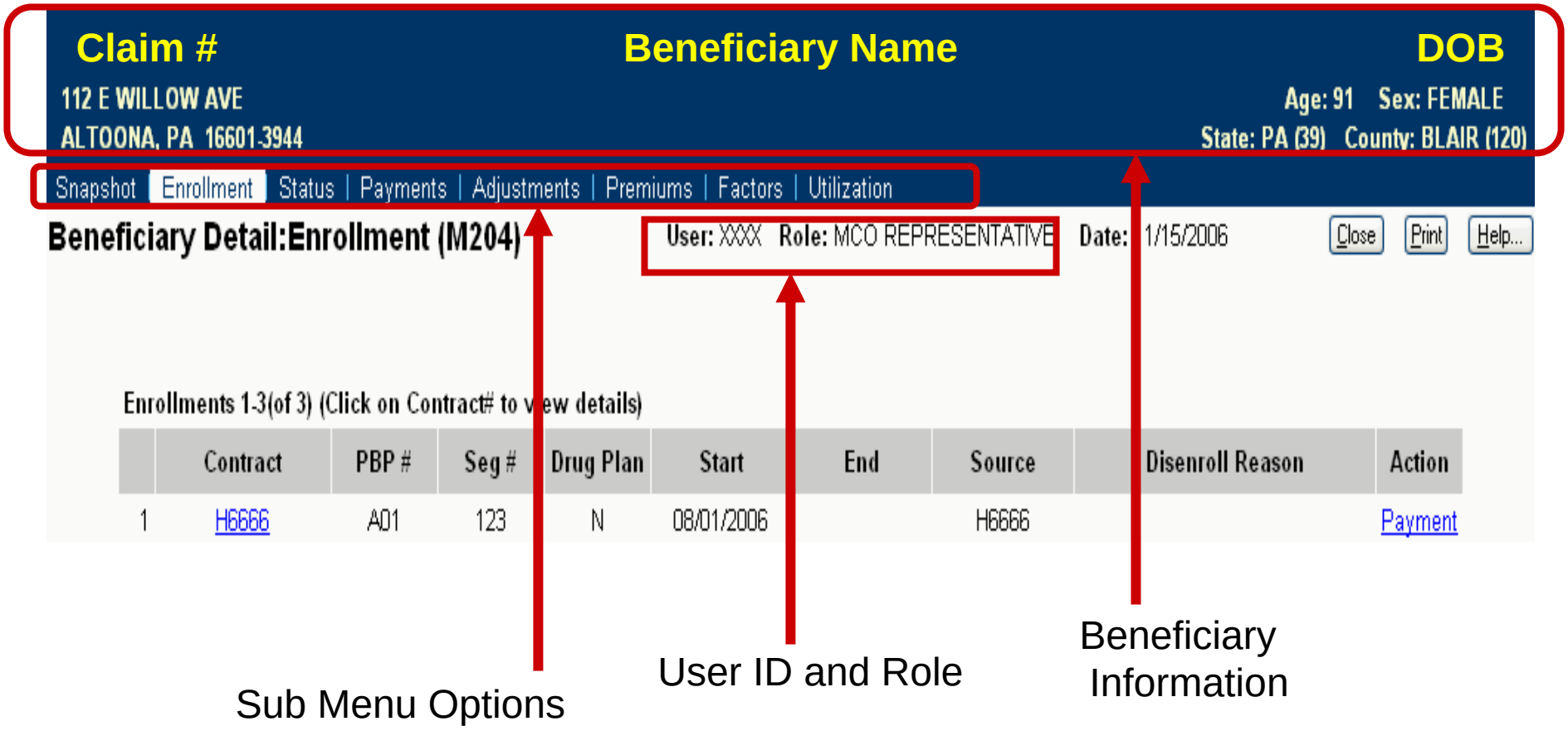
Scenario	Question
The current calendar date is January 17, 2008. The current payment month is March 2008, which will include data submitted January 12 through February 8 (plan data due date for February 2008).	When would the retroactive transaction become effective?

User Interface

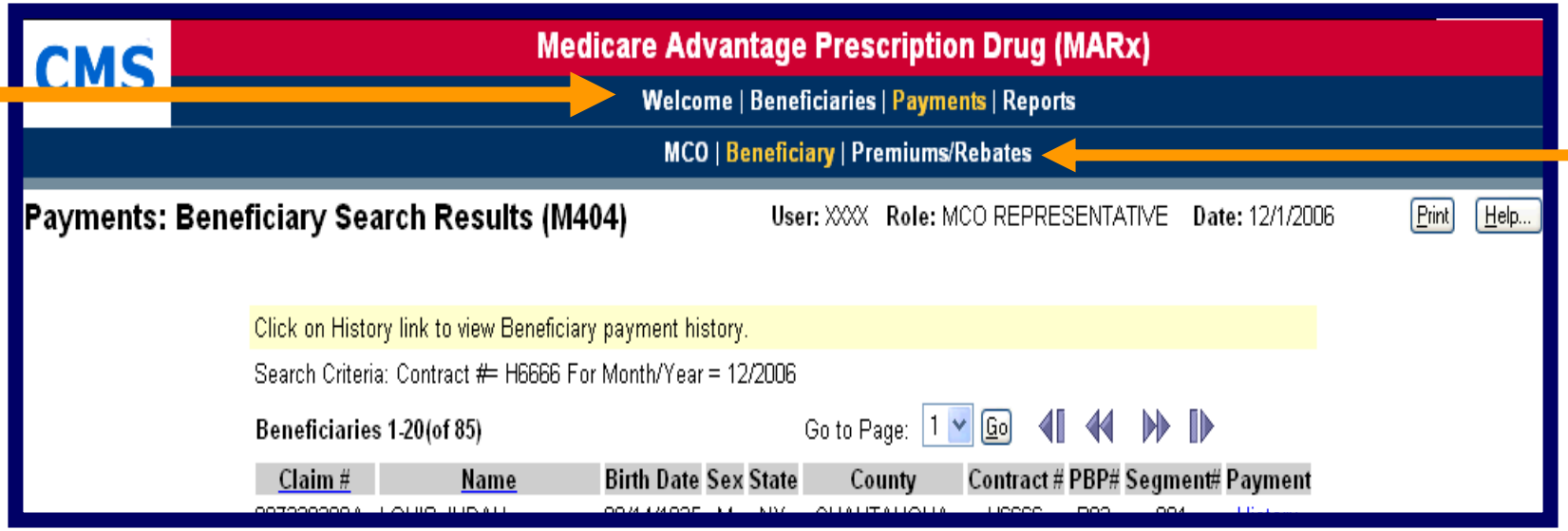
- Serves as centralized database to exchange beneficiary-specific information
- Authoritative source for Medicare beneficiary entitlement and eligibility status Parts C and D
- Accommodates changes regarding MMA
- Interacts with transmissions submitted to CMS from MA Plans, MA-PDs and PDPs
- Allows MA plans and PDPs to query eligibility and enrollment systems via web

MARx Common UI transitioning to MAPD IUI

Common UI


Claim #
Beneficiary Name
DOB
112 E WILLOW AVE
ALTOONA, PA 16601-3944
Age: 91 Sex: FEMALE
State: PA (39) County: BLAIR (120)
Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | Factors | Utilization
Beneficiary Detail:Enrollment (M204)
User: XXXX Role: MCO REPRESENTATIVE
Date: 1/15/2006
Close
Print
Help...
Enrollments 1-3(of 3) (Click on Contract# to view details)
Contract
PBP #
Seg #
Drug Plan
Start
End
Source
Disenroll Reason
Action
1
H6666
A01
123
N
08/01/2006
H6666
Payment
Sub Menu Options
User ID and Role
Beneficiary Information

Common UI



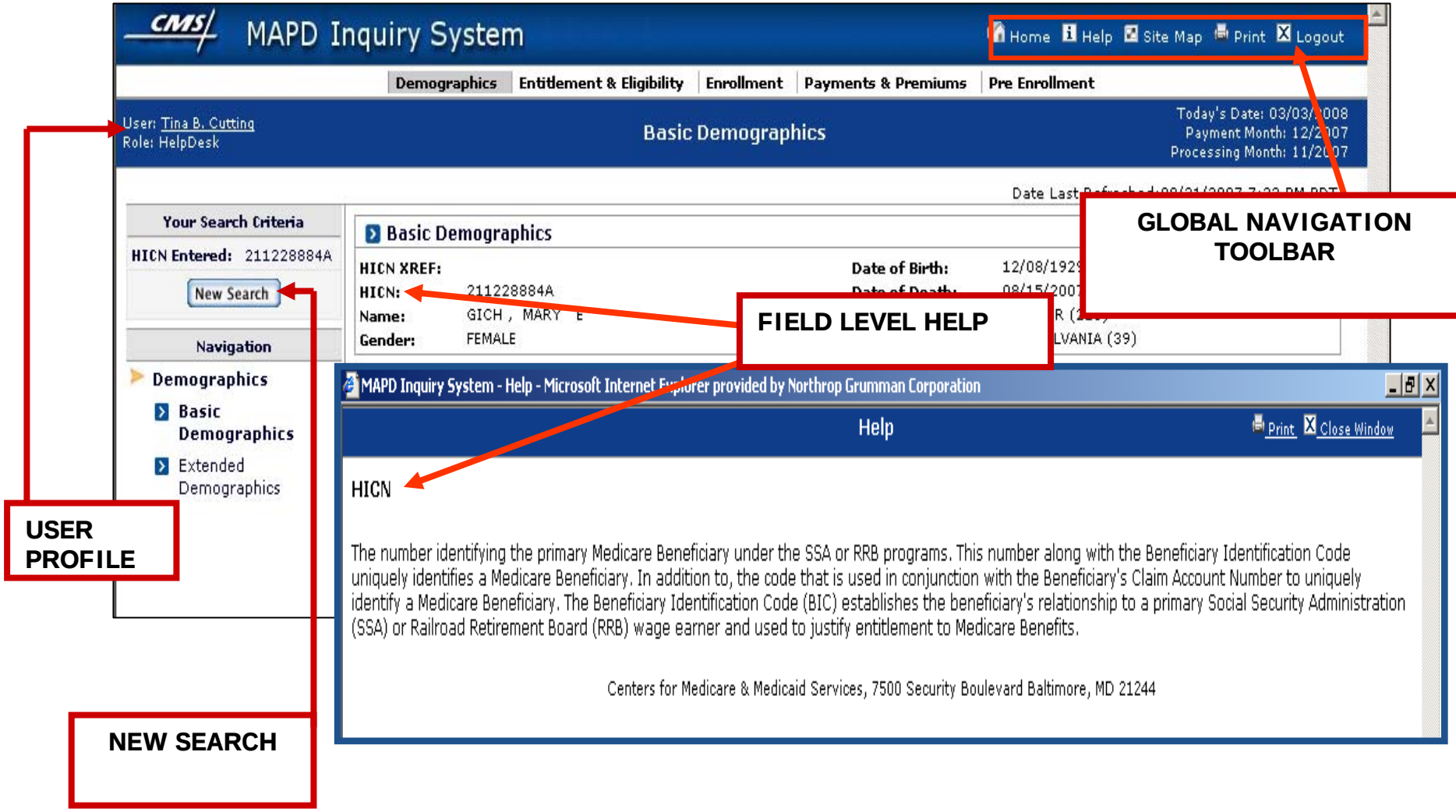
Main Menu Options

- Beneficiaries
- **Payment** (Selected)
- Reports

Payments Submenu Options

- MCO
- **Beneficiary** (Selected)
- Premiums/Rebates

MAPD IUI

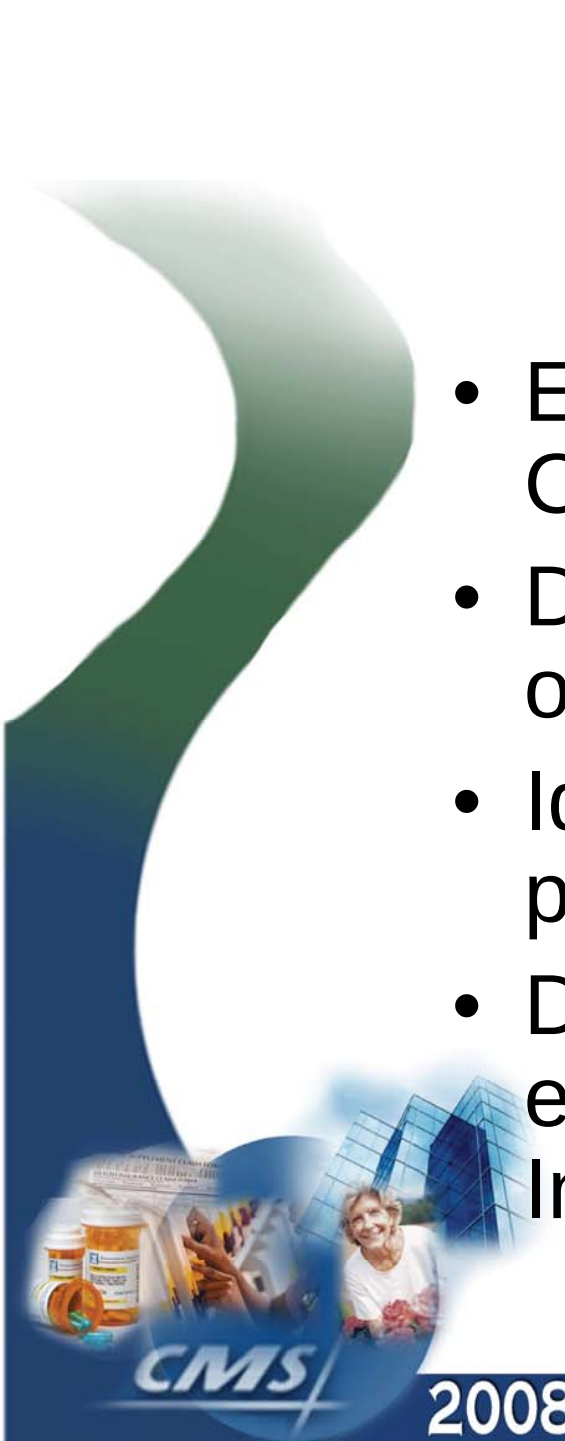

MAPD Inquiry System
Home
Help
Site Map
Print
Logout
Demographics
Entitlement & Eligibility
Enrollment
Payments & Premiums
Pre Enrollment
User: Tina B. Cutting
Role: HelpDesk
Basic Demographics
Your Search Criteria
HICN Entered: 211228884A
New Search
Navigation
Demographics
Basic Demographics
Extended Demographics
HICN XREF:
HICN:
211228884A
Name:
GICH , MARY E
Gender:
FEMALE
Date of Birth:
12/08/192
GLOBAL NAVIGATION TOOLBAR
FIELD LEVEL HELP
USER PROFILE
NEW SEARCH
MAPD Inquiry System - Help - Microsoft Internet Explorer provided by Northrop Grumman Corporation
Help
Print
Close Window
HICN
The number identifying the primary Medicare Beneficiary under the SSA or RRB programs. This number along with the Beneficiary Identification Code uniquely identifies a Medicare Beneficiary. In addition to, the code that is used in conjunction with the Beneficiary's Claim Account Number to uniquely identify a Medicare Beneficiary. The Beneficiary Identification Code (BIC) establishes the beneficiary's relationship to a primary Social Security Administration (SSA) or Railroad Retirement Board (RRB) wage earner and used to justify entitlement to Medicare Benefits.
Centers for Medicare & Medicaid Services, 7500 Security Boulevard Baltimore, MD 21244

Monthly Schedule

- Payment Due Dates
- Certification
- Plan Data Due Dates
- MARx Down and Dark Days

Summary

- Explained steps to connect to CMS and transmit data
- Defined the fields and functions of enrollment transactions
- Identified enrollment transaction processing requirements
- Described characteristics of enrollment and eligibility User Interfaces



EVALUATION

Please take a moment to complete the evaluation form for the Enrollment Processing and MARx Overview Module.

THANK YOU!

Payment Overview

Purpose

- To introduce the components of the monthly payments, the systems involved in capturing the data, and the reporting of payment to plans

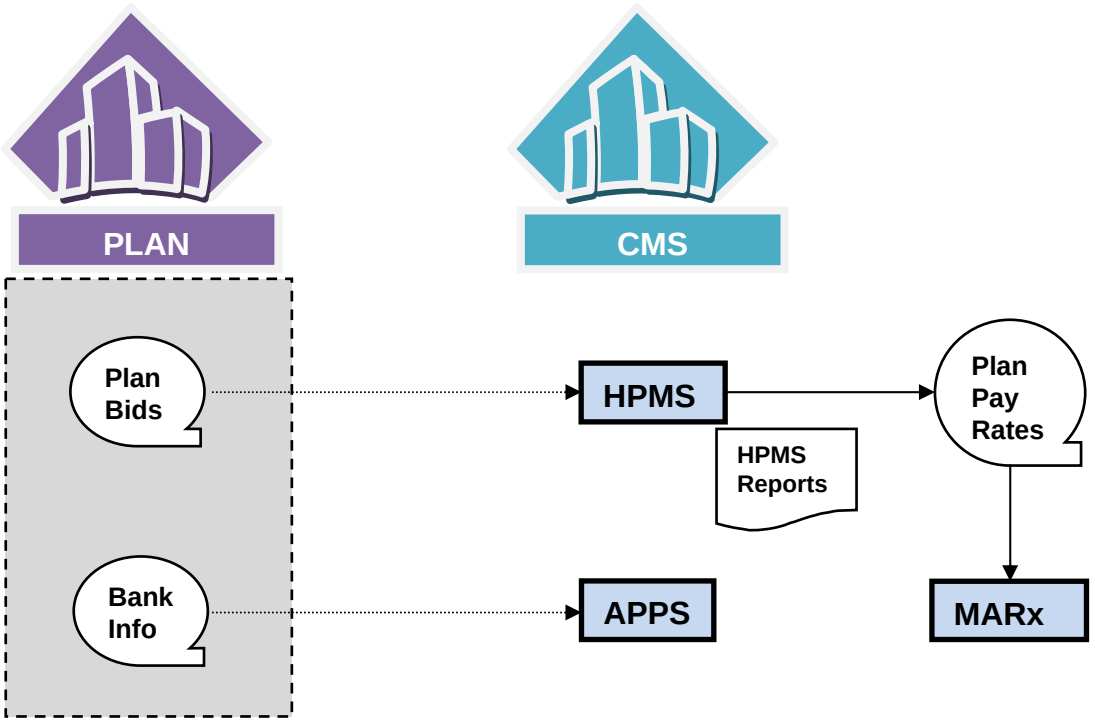
Objectives

- Identify the three main sources of monthly payment
- Explain SSA's role in premium withhold
- Describe the relationship between MARx, PWS, and APPS
- Interpret the nine sections of the PPR

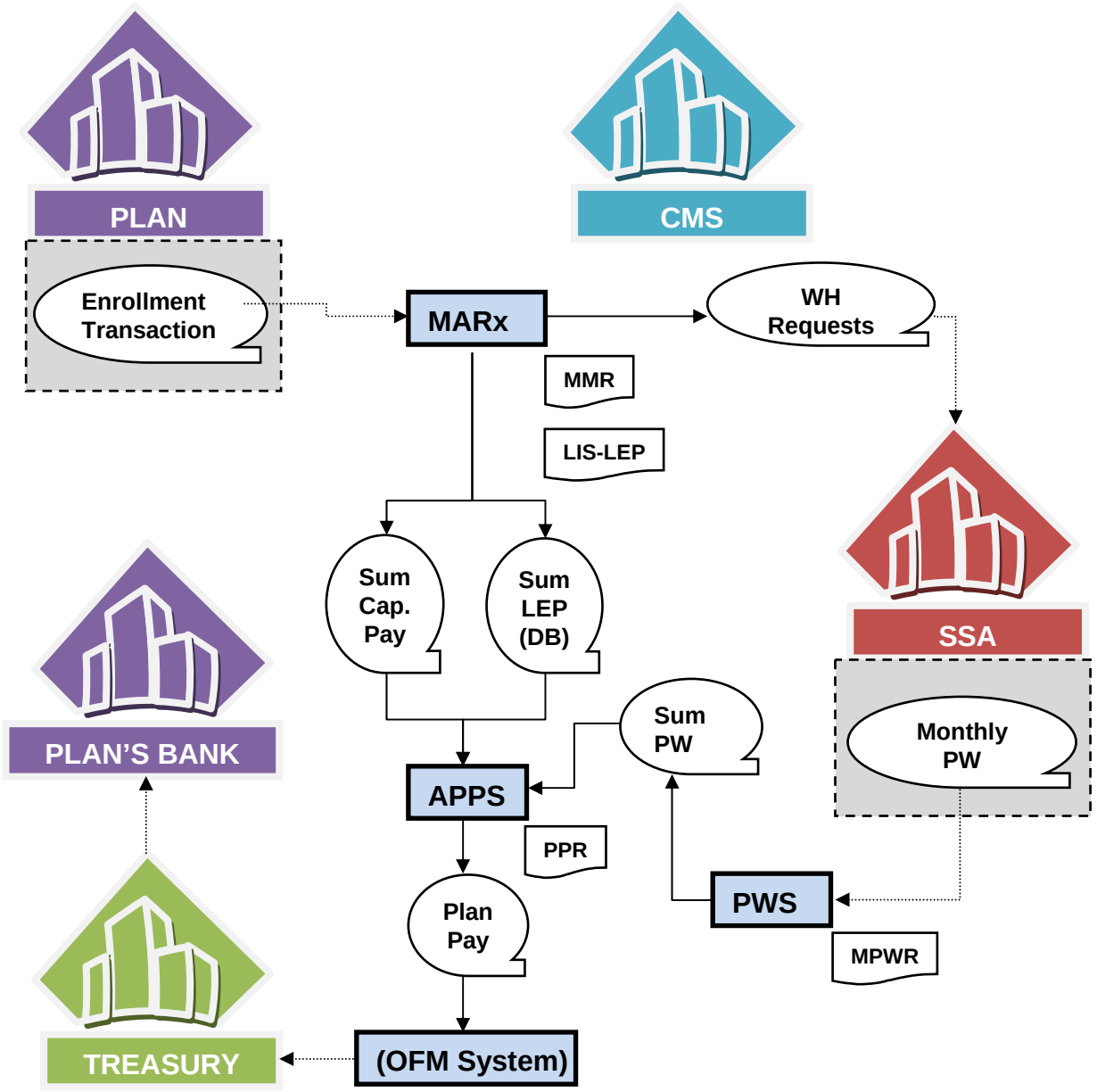
Monthly Payment Sources

SOURCE	PAYMENT CONTRIBUTION
Medicare Advantage Prescription Drug System (MARx)	• Capitated Payments • LEP
Payment Withhold System (PWS)	• Premium Withhold Payments
Automated Plan Payment System (APPS)	• Other payments • Fees • Charges

Payment Prerequisites



Monthly Plan Payment Process



Capitated Payment-Part C

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.

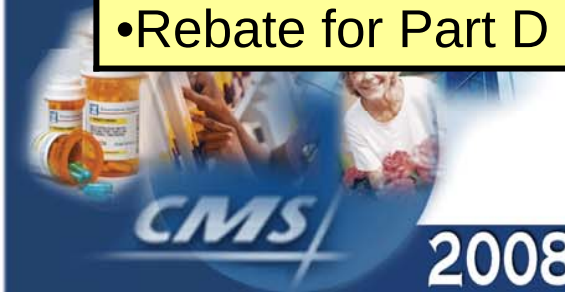
Capitated Payment-Part D

Direct Subsidy =

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

In addition to the Direct Subsidy payments Part D Capitated Payments also includes the following non-risk-adjusted components:

- LIS Cost Sharing Subsidy (Low Income enrollees)
- LIS Premium Subsidy (Low Income enrollees)
- Reinsurance Subsidy
- PACE Premium Add On (PACE Plans dual eligible enrollees)
- PACE Cost Sharing Add On (PACE Plans dual eligible enrollees)
- Rebate for Part D Basic Premium Reduction (MA-PD Plans only)



Monthly Membership Report (MMR)

- Generated by MARx
- Available in two formats:
  - Detail
    - Non-Drug MMR
    - Drug MMR
  - Summary
- Beneficiary-level information
  - Actual payment data
  - Key payment calculation information

Non-Drug	Drug
• Rebates, payments, and adjustments • Part A & B information • Risk Adjustment factors • Other detailed beneficiary information	• Rebates, payments, and adjustments • Part A & B information • Risk Adjustment factors • Other detailed beneficiary information • LICS percentages • LICS Subsidy

MMR ARITHMETIC

Example: 1

MA-PD	Part A/B Bid < Benchmark
MA-PD	Part A/B Bid > Benchmark
MA Only	Part A/B Bid < Benchmark
PACE Plan	Dual Eligible Beneficiary
Prescription Drug Plan (PDP)	

Late Enrollment Penalties (LEP)

- Reported on a beneficiary-level
- PPR reflects LEP as adjustments
- LIS/LEP Report informs plans of:
  - Net amount of LEP for direct billed beneficiaries
  - Net amount payable to the plan
- LIS beneficiaries exempt from LEP

Premium Withholding Payments

SOURCE	PAYMENT CONTRIBUTION
Medicare Advantage Prescription Drug System (MARx)	•Capitated Payments •LEP
Payment Withhold System (PWS)	•Premium Withhold Payments
Automated Plan Payment System (APPS)	•Other payments •Fees •Charges

Monthly Premium Withhold Report Data File

- Displays monthly premiums withheld from SSA checks
- Include Part C and Part D premiums and any Part D LEP information
- 165 bytes in length

Note: Part D LEP for information purposes only. Does not impact payment.

APPS System

SOURCE	PAYMENT CONTRIBUTION
Medicare Advantage Prescription Drug System (MARx)	•Capitated Payments •LEP
Payment Withhold System (PWS)	•Premium Withhold Payments
Automated Plan Payment System (APPS)	•Other payments •Fees •Charges

Plan Payment Report (PPR)

- Referred to as the Plan Payment Letter (PPL)
- Provides:
  - amount paid (prospectively) to plans
  - adjustments to prior months
  - adjustments affecting Part D payments
- Generated monthly

PPR
Prospective Payment Section

- Displays the prospective payment for each beneficiary enrolled as of the 1st day of the upcoming month
- Relates to:
  - existing enrollees
  - new enrollees
- Covers 1-month of the enrollment period

PPR
Adjusted Payment Section

- Adjustments
  - Parts A, B, and D
  - Parts A and B
  - Part D

PPR
Plan-Level Adjustments Section

- National Medicare Educational User Fees (NMEC)
- Coordination of Benefits (COB)
- Medicare as Secondary Payer (MSP)

PPR
CMS Adjustments Section

- Prior month carryover (if prior payment was wiped out due to a large negative adjustment)
- 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

PPR
Premium Settlement Section

- Premium Withholding
- Low Income Subsidy
- Late Enrollment Penalty

PPR
Net Payment Section

- Provides totals for final monthly payment minus adjustments

Summary

- Identified the three main sources of monthly payment
- Explained the SSA role in premium withhold
- Described the relationship between the MARx, PWS, and APPS
- Interpreted the nine sections of the PPR

EVALUATION

Please take a moment to complete the evaluation form for the Payment Overview Module.

THANK YOU!

Reports and Reconciliation

2008 ENROLLMENT & PAYMENT

Purpose

- To examine reports that assist plans in reconciliation, certification and adjustments to ensure accurate enrollment and payment

Objectives

- Verify enrollment and payment using reports
- Describe the report reconciliation process
- Define the certification process
- Identify three retroactive submission processes
- Explain the fields and functions of reports

Reports Overview

Report Name	Acronym
Transaction Reply Report	TRR
Monthly Membership Report	MMR
Plan Payment Report	PPR

Reports Reconciliation Process

Step	Process
1	Reconciliation
2	Certification
3	Retroactive Requests

Step 1 – Reports Reconciliation

- Determine accuracy of data by reconciling CMS' record with Plan's records
- Plan's review reports to ensure accuracy of
  - Beneficiary-level payment
  - Enrollment
  - Disenrollment
  - Applicable health status
  - Other beneficiary information

Step 2 - Certification

- Plans attest to the accuracy of data by submitting signed Certification Form
- Monthly attestations of enrollment are required
- Ensures plans are compliant
- Plans must report discrepancies

Step 2 – Certification (continued)

- Certification allows plans to attest to and report
  - Incorrect beneficiary payments
  - System problems
  - Beneficiaries requiring retroactive processing
  - Justifications for retroactive requests

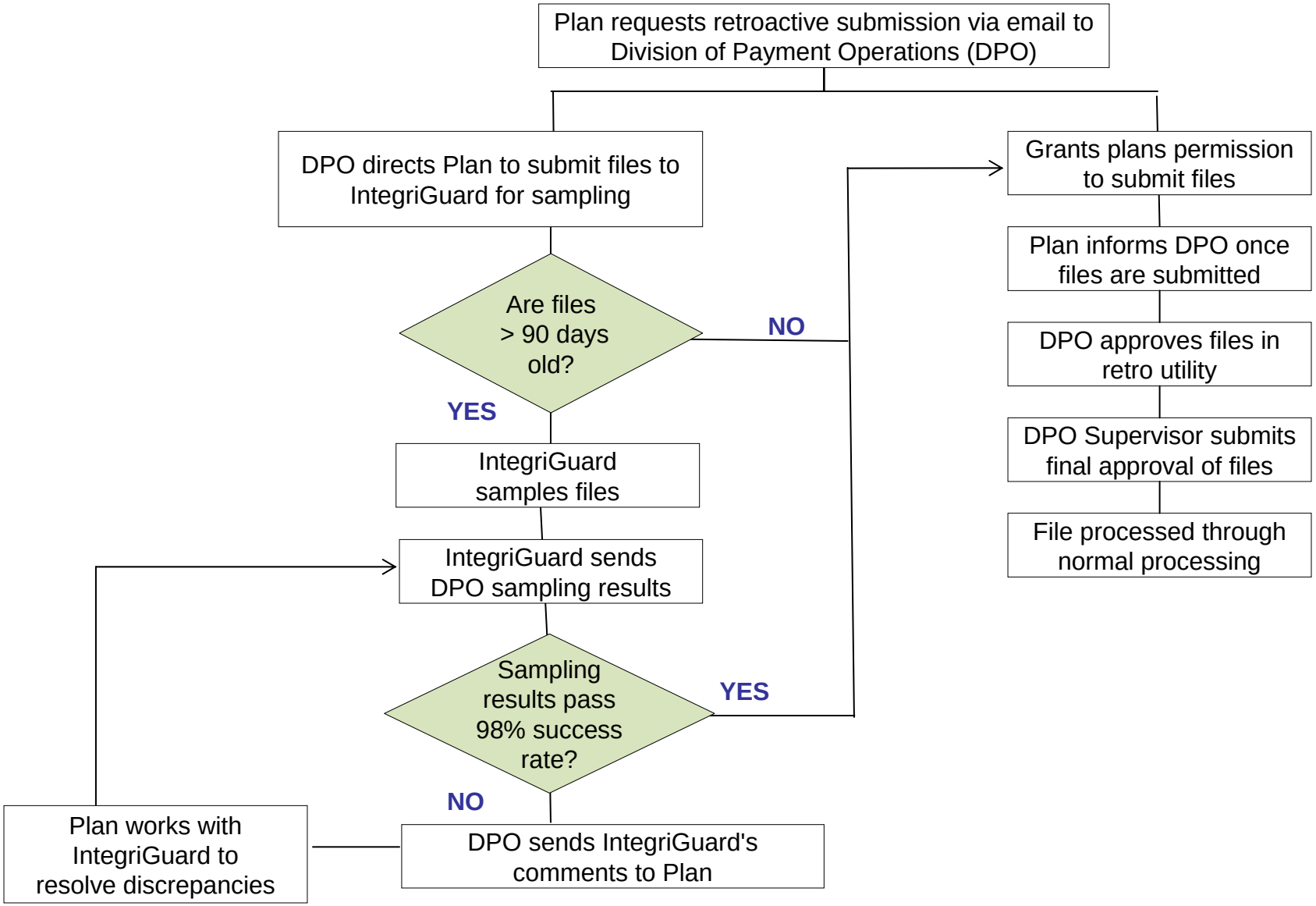
Step 3 – Retroactive Adjustments

- Plans must submit valid retroactive requests within 45 days of receipt of monthly reports
- Retroactive Adjustment Processes
  - Streamline
  - IntegriGuard “Normal Processing”
  - CMS

Streamline Retroactive Process

- CMS must approve request to submit streamline process
- Retroactive Adjustment Request >100 transactions caused by the same issue with same effective date

Streamline Retroactive Process (continued)



IntegriGuard “Normal Process”

- “Normal Processing” IntegriGuard processes manual updates
- Plans must include
  - Required spreadsheet
    - Listing all requested changes
  - Supporting documentation
    - www.integriguard.org

Transaction Reply Report (TRR)

- What is its purpose?
  - Reconciles Plan's membership records with CMS' records
  - Identifies changes not initiated by Plans
- How often is it generated?
  - Weekly
  - Monthly

Provided as a Data File and in Report Format

Transaction Reply Report (continued)

- Report includes:
  - CMS processing of transactions submitted
  - CMS maintenance actions related to a Plan's members
  - Disenrolled members that enrolled in other Plans

TRR Sections

Sections of TRR	Description
Plan Accepted/Rejected	• Response to Plan-submitted transactions • Two sections “Accepted” and “Rejected”
Regional Office	• Regional Office representatives transactions
Central Office	• Changes or updates by Central Office
CMS District Offices Accepted/Rejected	• Obsolete since January 2006
Medicare Customer Service Accepted/Rejected	• Reply to Medicare Customer Service Center transactions • Two sections “Accepted” and “Rejected”
Automatic Disenrollments	• Beneficiaries electing new plan and disenrolled from prior plan, due to death or loss of Medicare
Beneficiary Factor Transactions - Accepted/ Rejected	• Only relates to one Demonstration Plan
Maintenance Actions	• Reports updates or changes to a beneficiary’s demographic information

TRR Report Example

Step 1: Reconcile Reports	Are there discrepancies in Center Insurance Data?
Step 2: Certification	Should Center Insurance certify data?
Step 3: Retroactive Adjustments	Will Center Insurance submit Retroactive Adjustments? –Streamline –Normal Processing of –CMS submission

Monthly Membership Report (MMR)

Two Formats Available

Detail

Detailed list of **every** beneficiary in the Plan, provides payments and adjustments for each beneficiary in the Plan

- Drugs
- Non-Drugs

Summary

Summarizes data from the MMR detail and contains the total number of beneficiaries already paid for that month

Compare Plan totals to CMS' totals

MMR (continued)

Non-Drug MMR contains information on:	Drug MMR contains information on:
• Rebates • Basic Part C Premium • payments and adjustments • Part A and Part B information • Risk adjustment factors for Part A and Part B • Health status flags • Other detailed beneficiary information	• Basic Part D premiums • Estimated reinsurance • Payments and adjustments • LICS percentage/ subsidy • Risk adjustment factors • other detailed Beneficiary information • LTI or LIS multiplier

Plan Payment Report

- Itemizes:
  - Enrollee counts
  - Prospective payments
  - Adjustments
  - Premiums
  - Net payment

Ordering Reports

TYPE OF REPORTS/ DATA FILES	DESCRIPTION
Daily (based on transactions)	• generated each day for events that occurred that day, including: - processing of a batch transaction file - receipt of a report
Weekly	• scheduled and automatically generated • reflect transactions that were processed that week for a contract
Month-end	• scheduled and automatically generated • part of monthly payment processing

Summary

- Validated enrollment and payment using reports
- Described reconciliation process
- Defined the certification process
- Identified the three retroactive submission processes
- Explained the fields and functions of reports

EVALUATION

Please take a moment to complete the evaluation form for the Reports and Reconciliation Module.

THANK YOU!

RESOURCE GUIDE

About this Guide

This Resource Guide is intended to help prescription drug plans, providers, and third party submitters locate information specific to enrollment and payment.

The information listed in the Resource Guide is arranged in five sections:

- ENROLLMENT AND PAYMENT ACRONYMS AND TERMS
- CMS RESOURCES
- CMS WEB RESOURCES
- CMS REFERENCE DOCUMENTS
- REPORTS SUMMARY

GENERAL CONTACT INFORMATION

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) - http://cms.hhs.gov

CMS Contacts for Technical Issues
Marla Kilbourne: marla.kilbourne@cms.hhs.gov

MMA HELP DESK - http://www.cms.hhs.gov/mmahelp/
The MMA Help Desk 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.

Contact Information
Phone: 1-800-927-8069
Email: mmahelp@cms.hhs.gov
Hours of Operation: M-F 6 a.m. to 9 p.m. EST

IntegriGuard, LLC – http://www.integriguard.org
IntegriGuard provides support to CMS by processing retroactive enrollment transactions. In addition, attestations are submitted to IntegriGuard for the certification of enrollment and payment data.

Contact Information
2121 North 117th Avenue, Suite 200
Omaha, NE 68114.

LEADING THROUGH CHANGE, INC. (LTC)
For general questions about training, please email LTC at EPRegistration@ltcinc.net.

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ENROLLMENT AND PAYMENT ACRONYMS AND TERMS

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ACRONYM	TERM
AAPCC	Adjusted Average Per Capita Cost
AARCC	Allowable Adjusted Risk Corridor Costs
ACR	Adjusted Community Rate
ADLs	Activities of Daily Living
AE	Automated Enrollment
AEP	Annual Coordinated Election Period
AEP	Annual Enrollment Period
APPS	Automated Plan Payment System
ASUF	Age Sex Underwriting Factor
BAE	Best Available Evidence
BBA	Balanced Budget Act of 1997
BCSS	Batch Completion Status Report
BEQ	Batch Eligibility Query
BIC	Beneficiary Identification Code
BIPA	Benefits Improvement & Protection Act of 2000
BPT	Bid Pricing Tool
BSF	Benefit Stabilization Fund
CAN	Claim Account Number
CAP	Corrective Action Plan
CBC	Center for Beneficiary Choices
CCB	Change Control Board [now called Change Management Board (CMB)]
CCP	Coordinated Care Plan
C:D	Connect:Direct
CHF	Congestive Heart Failure
CHPP	Center for Health Plans and Providers
CMB	Change Management Board (formerly Change Control Board)
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	CMS-Hierarchical Condition Category
CO	Central Office
COB	Close of Business
COB	Coordination of Benefits
COBA	Coordination of Benefits Agreement
CPM	Current Payment Month
CPP	Covered D Plan Paid Amount
CR	Change Request
CSMM	Customer Support for Medicare Modernization
CTM	Complaint Tracking Module
CUI	Common User Interface
CWF	Common Working File database (CMS' beneficiary database)
DBC	Drug Benefit Calculator
DCG	Diagnostic Cost Group
DDPS	Drug Data Processing Systems
DEPO	Division of Enrollment and Payment Operations
DIR	Direct and Indirect Remuneration
DO	District Office
DOB	Date of Birth
DOD	Date of Death
DOE	Date of Entitlement
DOS	Date of Service
DPO	Division of Payment Operations

ACRONYM	TERM
DSN	Data Set Name
ECRS	Electronic Correspondence Referral System
EDB	Enrollment Database
EGHP	Employer Group Health Plan
ESRD	End Stage Renal Disease
EOB	Explanation of Benefit
EOM	End of Month
EOY	End of Year
EPOC	External Point of Contact
ERC	Error Return Codes
FAQ	Frequently Asked Questions
FE	Facilitated Enrollment
FERAS	Front-End Risk Adjustment System
FFS	Fee-for-Service
FIPS	Federal Information Processing Standard
FIR	Financial Information Reporting
FOIA	Freedom of Information Act
FPL	Federal Poverty Level
FTR	Failed Transaction Report
FTP	File Transfer Protocol
GDCA	Gross Drug Cost Above the Out-of-Pocket Threshold
GDCB	Gross Drug Cost Below the Out-of-Pocket Threshold
GHP	Group Health Plan
GROUCH	GHP Report Output User Communication Help System
Guide	Medicare Advantage and Prescription Drug System Plan Communications User's Guide
HCFA	Health Care Financing Administration (renamed to CMS)
HCPP	Health Care Prepayment Plan
HCC	Hierarchical Condition Category
HIC	Health Insurance Claim
HICN	Health Insurance Claim Number
HMO	Health Maintenance Organization
HPMS	Health Plan Management System
HTML	Hypertext Markup Language
HTTPS	Hypertext Transfer Protocol Secure
IACS	Individuals Authorized Access to CMS Computer Services
ICEP	Initial Coverage Election Period
ID	Identification
IEP	Initial Enrollment Period
IPPR	Interim Plan Payment Report
IRC	Information Request Code
IRE	Independent Review Entity
ISAR	Intra-Service Area Rate
IT	Information Technology
IUI	Integrated User Interface
LEP	Late Enrollment Penalty
LICS	Low Income Cost-sharing Subsidy
LIS	Low Income Subsidy
LISHIST	Monthly Low Income Subsidy History Data File
LISPRM	Low Income Subsidy Premium Data File

ACRONYM	TERM
LTC	Long Term Care
LTI	Long-Term Institutionalized
M+C	Medicare+Choice (now known as MA)
M+CO	Medicare+Choice Organization
MA	Medicare Advantage (formerly known as M+C)
MA BSF	Medicare Advantage Benefit Stabilization Fund
MA-PD	Medicare Advantage – Prescription Drug
MAPD IUI	Medicare Advantage Prescription Drug Integrated User Interface
MA-PFFS	Medicare Advantage – Private Fee-for-Service
MARx	Medicare Advantage and Prescription Drug System
MBD	Medicare Beneficiary Database
MCO	Managed Care Organization
MCSC	Medicare Customer Service Center (1-800-MEDICARE)
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Modernization Act)
MMCM	Medicare Managed Care Manual
MMCS	Medicare Managed Care System
MMR	Monthly Membership Report
MMRD	Monthly Membership Detail Report
MMSR	Monthly Membership Summary Report
MPAG	Medicare Plan Accountability Group
MPWR	Monthly Premium Withholding Report Data File
MSA	Medical Savings Account
MSP	Medicare Secondary Payer
NCDP	National Council of Prescription Drug Programs
NDM	Network Data Mover
NHC	Nursing Home Certifiable
NUNCMO	Number of Uncovered Months
OEP	Open Election Period
OEP	Open Enrollment Period
OEPI	Open Enrollment Period for Institutionalized Individuals
OEPNEW	Open Enrollment Period for Newly Eligible Individuals
OMB	Office of Management and Budget
OOP	Out-of-Pocket
OPM	Office of Personnel Management
PACE	Program for All-Inclusive Care for the Elderly
PAP	Patient Assistance Program
PBO	Payment Bill Option
PBM	Pharmacy Benefit Manager
PBP	Plan Benefit Package
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PFFS	Private Fee-for-Service
PHI	Personal Health Information
PIP-DCG	Principal Inpatient Diagnostic Cost Group
PM	Processing Month
PMPM	Per Member Per Month
POS	Point of Sale
PPO	Preferred Provider Organization
PPR	Plan Payment Report

ACRONYM	TERM
PRS	Payment Reconciliation System
PRM	Primary
PSO	Provider Sponsored Organization
PWS	Premium Withhold System
QI	Qualified Individuals
QMB	Qualified Medicare Beneficiaries
RACF	Resource Access Control Facility
RAF	Risk Adjustment Factor
RAPS	Risk Adjustment Processing System
RAS	Risk Adjustment System
RDS	Retiree Drug Subsidy
RTG	Return to Government
Rx BIN	Prescription Beneficiary Identification Number
Rx GRP	Prescription Group Number
Rx ID	Prescription Identification Number
Rx PCN	Prescription Patient Control Number
RxHCCs	Prescription Drug Hierarchical Condition Categories
RO	CMS Regional Office
RRB	Railroad Retirement Board
SA	Service Area
SCC	State and Country Code (Service Area)
SEP	Special Election Period
SEP	Special Enrollment Period
SFTP	Secure Shell File Transfer Protocol
SGMT	Segment Number
SHMO	Social Health Maintenance Organization
SLMB	Specified Low Income Medicare Beneficiary
SMS	Shared Maintenance System
SNP	Special Needs Plan
SOP	Standard Operation Procedure
SSA	Social Security Administration
SSA DO	Social Security Administration District Office
SSA FO	Social Security Administration Field Office
SSI	Supplemental Security Income
SSN	Social Security Number
SUP	Supplemental
TBT	TrOOP Balance Transfer
TC	Transaction Code
TPA	Third Party Administrator
TRC	Transaction Reply Code
TrOOP	True Out-of-Pocket Costs
TRR	Transaction Reply Report
TSO	Time Sharing Option
UI	User Interface
URL	Universal Resource Locator (worldwide web address)
USPCC	United States Per Capita Cost
VA	Veteran's Administration
VDSA	Voluntary Data Sharing Agreement