2012 Regional Technical Assistance Participant Guide

Thursday, August 9, 2012

Payment

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INTRODUCTION AND OVERVIEW

Purpose

Plans receive monthly payments for the beneficiaries enrolled in their plans. The payments are communicated on the monthly reports provided by CMS. Plans should use the reports to reconcile received payments. The purpose of this guide is to provide participants with a high-level understanding of monthly payments received by CMS. The purpose of this technical assistance session is to provide participants with updates, resources, and instruction in utilizing the reports for reconciling payment.

Overview of the Session

This technical assistance session is organized into two modules, one describing CMS updates and payment resources and a second module that provides the opportunity for application of calculations in report reconciliation. This overview will introduce common terms and systems used to generate reports.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

Materials

This **Participant Guide** has been updated from the 2011 Technical Assistance session to include current information. It supports the 2012 Technical Assistance session as a resource document. This guide highlights four monthly reports:

- Plan Payment Report (PPR)
- Premium Withhold Report (PWR)
- Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File
- Monthly Membership Report (MMR)

The **presentation slides** will focus on providing current information and resources, highlight basic material from the Participant Guide, and illustrate components of report reconciliation.

The **Workbook** includes report examples for participant use during the session to apply payment calculations and reconcile values among the various reports, which are described in detail in this Participant Guide.

Audience

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

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

Learning Objectives

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

- Describe recent payment operations updates.
- Apply payment calculations and reconcile plan payments using various payment reports.
- Identify payment resources.

Common Payment System Terms

The modules throughout this guide use common system terms discussed during the session. Table A provides descriptions of the system terminology.

TABLE A - COMMON PAYMENT SYSTEM TERMS

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

Reports Overview

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

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

TABLE B – REPORT VERSIONS

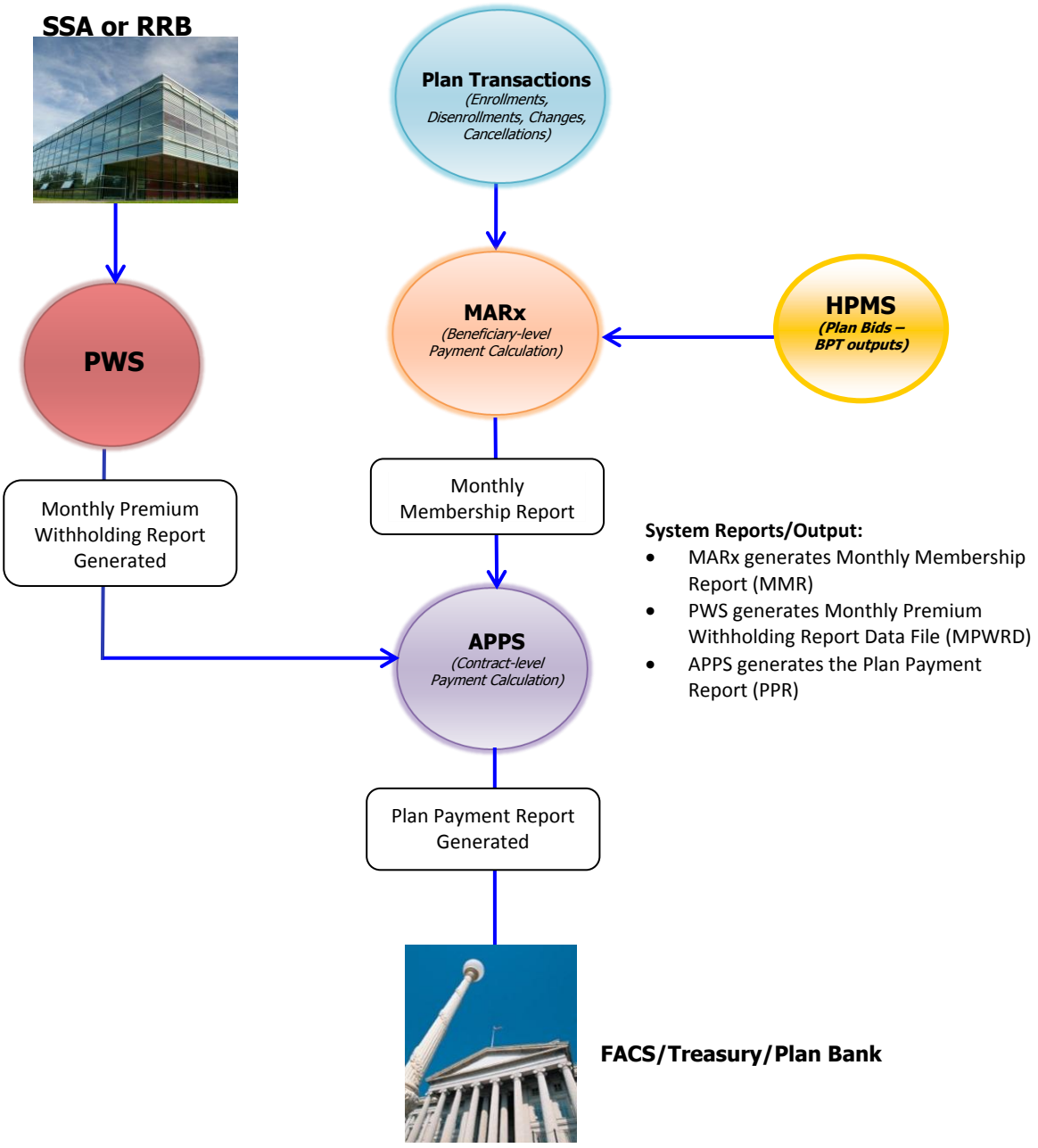
Report Name	Function	Layout
Plan Payment Report (PPR)/ Interim Plan Payment Report (IPPR) Data File	Itemizes the final monthly payment to the plan.	Report/ Data File
Part C Monthly Membership Detail Report - Non-Drug Report	Lists every Part C Medicare member of the contract and provides details about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

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

Payment Dataflow

Figure A provides an overview of the Payment data flow.

Figure A - Payment System Process Flow



Technical Assistance and Support

CMS provides the following helpdesks in an effort to ensure participating plans have the necessary tools and information to be successful with the payment data process. Table C provides descriptions and contact information for the helpdesks available for technical assistance and support.

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. The HPMS Help Desk also assists Plans on issues related to accessing and connecting to HPMS. HPMS does not have a designated website that provides technical assistance. Users may contact the HPMS Helpdesk via telephone or email at: 800-220-2028 or HPMS@cms.hhs.gov. For access and connectivity issues, plans should contact: Don Freeburger at 410-786-4586 or don.freeburger@cms.hhs.gov. For user access and user ID contact: Neetu Jhagwani at 410-786-2548 or neetu.jhagwani@cms.hhs.gov.
Customer Support for Medicare Modernization (CSMM) MAPD Help Desk	The MAPD 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. Users may contact the MAPD Help Desk by calling 1-800-927-8069, emailing mapdhelp@cms.hhs.gov, or viewing the website at http://www.cms.gov/mapdhelpdesk/. The MAPD Helpdesk is available Monday – Friday, 6:00 a.m. to 9:00 p.m. ET.

Roles and Contact Information

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

TABLE D – PAYMENT PROCESS POINTS OF CONTACT

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

MODULE 1 – PLAN PAYMENT REPORT

Purpose

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

Learning Objectives

At the completion of this module, participants will be able to:
- Gain an understanding of the consolidated payment communicated on the PPR.
- Identify the five tables included on the PPR.
- Explain the data sources of each table on the PPR.

ICON KEY	
Definition	
Example	
Reminder	
Resource	

1.1 CMS Plan Payment Report (PPR) Overview

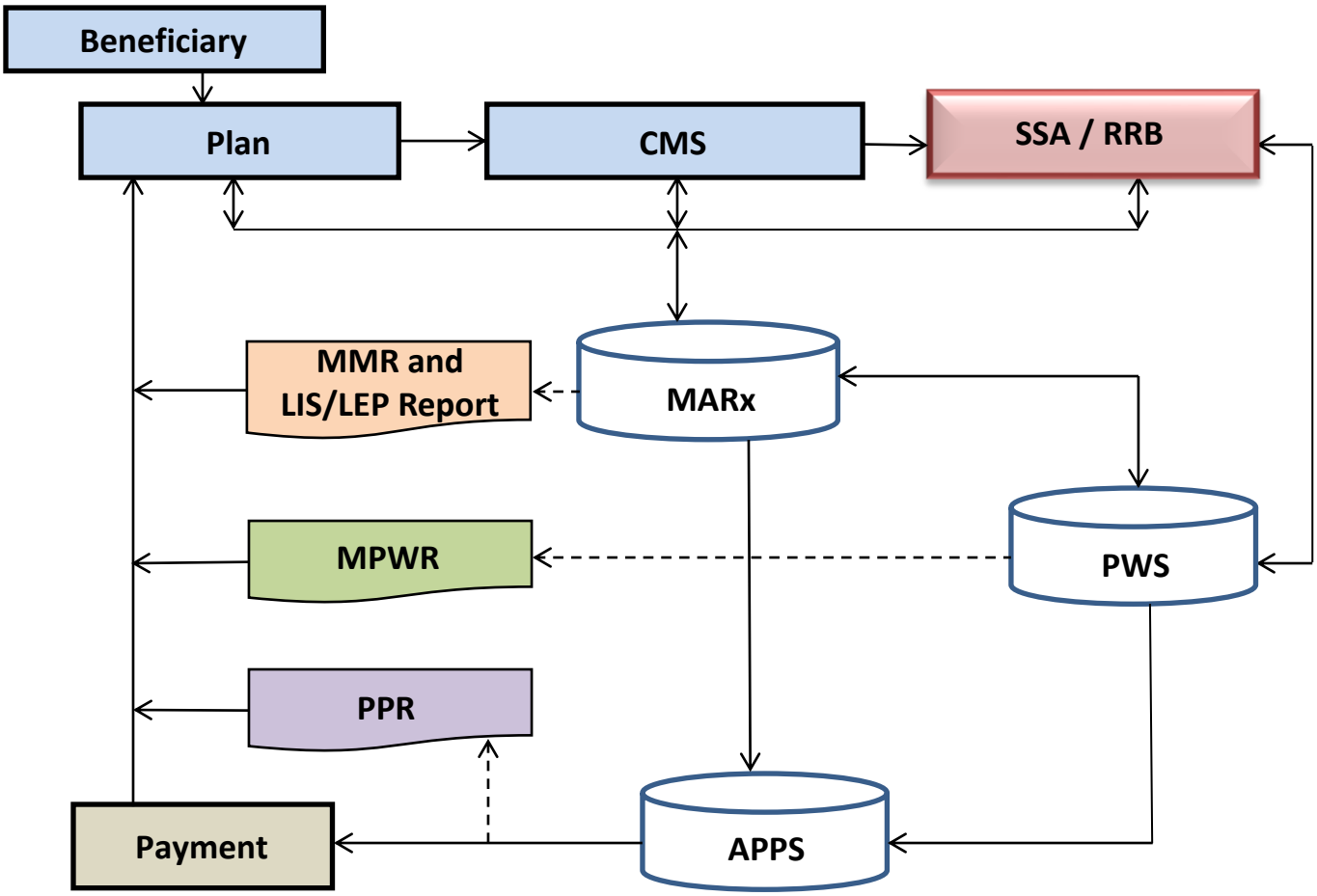
The PPR provides the consolidated view of the plan payment once the final monthly payment is calculated by the Automated Plan Payment System (APPS). Available as both a data file and a formatted report, the PPR includes contract-level adjustments. The PPR displays the Plan's net payment, which is reflected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

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

Effective January 1, 2011, CMS revised the Plan Payment Report format. The report format was expanded to a tabular layout for ease in processing. In addition, the report was revised to accommodate the reporting of Coverage Gap Discount payment amounts, more descriptions of the CMS Adjustments included in the monthly payment, and a summary section to allow for tracking of balances carried over from the prior month to the current month and going forward. In 2012, the report has been expanded to accommodate the Health Information Technology for Economic & Clinical Health Act (HITECH) incentive payments.

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

Figure 1A – Monthly Plan Payment



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

TABLE 1A – TABLES OF THE PPR

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

1.2 PPR Formatted Report Version

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

1.2.1 PPR Table 1-Capitated Payment

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

1.2.1.1 Prospective Payments

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

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

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

Prospective payments are displayed here.

CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : H9999 PAGE: 1/5
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 02/2012
RUN DATE : 01/25/2012
REPORT SECTION: CAPITATED PAYMENT - CURRENT ACTIVITY
TABLE NUMBER : 1

ARC	PAYMENT TYPE	COUNT	PART A	PART B	PART D	NET PAYMENT
	PROSPECTIVE PART A PAYMENT	4,339	1,736,181.09			1,736,181.09
	PROSPECTIVE PART B PAYMENT	4,339		1,591,270.07		1,591,270.07
	PROSPECTIVE PART D PAYMENT	4,336			270,961.16	270,961.16
(01)	DEATH OF BENEFICIARY	13	-15,444.77	-15,883.89	-1,367.53	-32,696.19
(02)	RETROACTIVE ENROLLMENT	149	50,768.14	47,504.32	7,916.85	106,189.31
(03)	RETROACTIVE DISENROLLMENT	361	-144,524.67	-134,366.75	-27,862.87	-306,754.29
(06)	CORRECT PART A ENT	0	0.00	0.00	0.00	0.00
(07)	RETRO HOSPICE STATUS	27	-25,322.85	-22,658.93	0.00	-47,981.78
(08)	RETRO ESRD STATUS	0	0.00	0.00	0.00	0.00
(09)	RETRO INST STATUS	0	0.00	0.00	0.00	0.00
(10)	RETRO MEDICAID STATUS	0	0.00	0.00	0.00	0.00
(11)	RETRO STATE COUNTY CHANGE	2	39.58	35.74	0.00	75.32
(12)	DATE OF DEATH CORRECTION	3	-5,658.47	-5,113.01	-425.49	-11,196.97
(13)	DATE OF BIRTH CORRECTION	0	0.00	0.00	0.00	0.00
(14)	SEX CODE CORRECTION	0	0.00	0.00	0.00	0.00
(18)	PART C RATE CHANGE	0	0.00	0.00	0.00	0.00
(19)	CORRECT PART B ENT	0	0.00	0.00	0.00	0.00
(20)	RETRO WORKING AGED STATUS	0	0.00	0.00	0.00	0.00
(21)	RETRO NHC STATUS	0	0.00	0.00	0.00	0.00
(22)	DISENROLL FOR PRIOR ESRD	0	0.00	0.00	0.00	0.00
(23)	DEMO FACTOR ADJUSTMENT	0	0.00	0.00	0.00	0.00
(25)	RETRO RA RECON ANNUAL	0	0.00	0.00	0.00	0.00
(26)	RETRO RA RECON MID-YEAR	0	0.00	0.00	0.00	0.00
(27)	RETRO CHF	0	0.00	0.00	0.00	0.00
(31)	RETRO LIS STATUS	4	0.00	0.00	524.06	524.06
(36)	PART D RATE CHANGE	0	0.00	0.00	0.00	0.00
(37)	PART D RA RECON ANNUAL	0	0.00	0.00	0.00	0.00
(38)	RETRO SEGMENT ID CHANGE	0	0.00	0.00	0.00	0.00
(41)	PART D RA RECON MID-YEAR	0	0.00	0.00	0.00	0.00
(42)	RETRO MSP FACTOR CHG	9	22,518.27	19,939.94	0.00	42,458.21
(44)	RETRO CORRECT FAILD PAY	0	0.00	0.00	0.00	0.00
(50)	BENE MERGE ADJUSTMNT	0	0.00	0.00	0.00	0.00
(94)	PMT ADJ DUE TO CLEANUP	0	0.00	0.00	0.00	0.00
TOTAL		13,582	1,617,556.32	1,480,727.49	249,746.18	3,349,029.99

** THE TOTAL PART D INCLUDES COVERAGE GAP DISCOUNT OF:
PROSPECTIVE = 9,892.53
ADJUSTMENT = -1,362.66
TOTAL = 8,529.87

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* CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDL
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Type of payment and adjustments are displayed here.

Adjustment Reason Codes will appear next to the type of payment.

Coverage Gap Discount Prospective and Adjustments amounts included in the overall Part D payment are displayed here.

Example 1: In the Sample Report Figure 1B, the PPR communicates that for the February 2012 Payment Month, CMS made an adjustment to the Plan Heartwise's payment for 13 beneficiaries due to the death of the beneficiary, which is represented by an adjustment reason code of "01." This change resulted in a negative adjustment of (-)$32,696.19 (Part A+PartB+Part D). The Plan should verify the date of death of the beneficiaries and reconcile their internal records. In addition to date of death, the Plan must monitor all other payments and adjustments reported.

1.2.1.2 Adjustment Reason Codes (ARCs)

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

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

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

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

TABLE 1B – CHANGES RESULTING IN ADJUSTMENTS

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

Plans can reconcile the ARCs on the PPR with the MMR to ensure the count of beneficiaries for each ARC and the associated adjustment amounts match the numbers on the MMR. Table 1C lists the complete list of ARCs as of February 2012. The PPR does not include all ARC codes every month. The majority of ARCs are displayed, but ARCs that are used infrequently only appear on the PPR when applicable.

TABLE 1C – ADJUSTMENT REASON CODES AND DESCRIPTION*

ADJUSTMENT REASON CODE (ARC)	ADJUSTMENT NAME
01	Notification of Death of Beneficiary
02	Retroactive Enrollment
03	Retroactive Disenrollment
04 **	Correction to Enrollment Date
05 **	Correction to Disenrollment Date
06	Correction to Part A Entitlement
07	Retroactive Hospice Status
08	Retroactive ESRD Status
09	Retroactive Institutional Status
10	Retroactive Medicaid Status
11	Retroactive Change to State County Code
12	Date of Death Correction
13	Date of Birth Correction
14	Correction to Sex Code
17	For APPS use only
18	Part C Rate Change
19	Correction to Part B Entitlement
20	Retroactive Working Aged Status
21	Retroactive NHC Status
22	Disenrolled Due to Prior ESRD
23	Demo Factor Adjustment
24 **	Retroactive Change to Bonus Payment
25	Part C Risk Adj Factor Change/Recon
26	Mid-year Part C Risk Adj Factor Change
27	Retroactive Change to Congestive Heart Failure (CHF) Payment
28 **	Retroactive Change to BIPA Part B Premium Reduction Amount
29 **	Retroactive Change to Hospice Rate
30 **	Retroactive Change to Basic Part D Premium
31	Retroactive Change to Part D Low Income Premium Subsidy Change
32 **	Retroactive Change to Estimated Cost-Sharing Amount
33 **	Retroactive Change to Estimated Reinsurance Amount
34 **	Retroactive Change Basic Part C Premium
35 **	Retroactive Change to Rebate Amount
36	Part D Rate Change
37	Part D Risk Adjustment Factor Change
38	Part C Segment ID Change
41	Part D Risk Adjustment Factor Change (ongoing)
42	Retroactive MSP Status
43 **	Retroactive Plan Premium Waiver Update
44	Retroactive correction of previously failed Payment (affects Parts C and D)
45 (New)	Disenroll for Failure to Pay Part D IRMAA Premium – Reported for Pt C and Pt D

TABLE 1C – ADJUSTMENT REASON CODES AND DESCRIPTION (CONTINUED)*

ADJUSTMENT REASON CODE (ARC)	ADJUSTMENT NAME
46 (New)	Correction of Part D Eligibility – Reported for Pt D
50	Payment adjustment due to Beneficiary Merge
90 **	System of Record History Alignment
94	Special Payment Adjustment Due to Clean-Up

*CMS revisits descriptions of the adjustment reason codes and provides updates when available.
**These ARC codes only appear on the PPR when applicable

Example 2: Plan Express is diligent in reconciling their monthly reports. Plan Express reviewed both the PPR and the MMR for ARCs and adjustment amounts for February 2012 (Figure 1B). Plan Express' PPR communicated a count of 361 members with an ARC of 03 (retroactive disenrollment). The dollars associated are reported on the PPR as (-)$27,862.87 to the Part D payment adjustment amount. The Plan understands the adjustment affects members receiving Part D benefits only and therefore, drills down to the specific amounts per affected beneficiary by accessing the MMR. Plan Express tabulated the beneficiaries on the MMR for each ARC and confirmed that the values matched the counts and associated adjustment amounts on the PPR.

1.2.1.2.1 New ARCs

CMS communicated additional ARC codes in the February 2012 Software Release.

- **ARC 45 – Disenroll for Failure to Pay Part D IRMAA Premium**
  As of the February 2012 Software Release, CMS notified plans that they would begin disenrolling individuals in direct bill status enrolled in a Medicare Part D plan who failed to pay their Part D Income-Related Monthly Adjustment Amount (IRMAA) in full by the end of the initial grace period (i.e., three months). The first disenrollment action, which was effective April 1, 2012, included individuals who failed to pay their Part D IRMAA for more than three months, but retained their Part D coverage.

  CMS does provide the opportunity for reinstatement of these individuals into their Medicare Part D Plan for good cause situations. These situations include when an individual:
  - Requests reinstatement within 60 days of the disenrollment effective date via 1-800-MEDICARE.
  - Receives a favorable determination by CMS regarding the untimely payment of Part D IRMAA.
  - Pays in full the Part D IRMAA and any Plan premium amounts due within three months of the Part D IRMAA disenrollment effective date.

  ARC 45 identifies the adjustments for these disenrollments.

- **ARC 46 – Correction of Part D Eligibility – Reported for Part D**
  Prior to February 2012, MARx enrollment edits required Part D eligibility in order to enroll in a PACE Plan. Effective with the February 2012 Software Release, MARx began to accept PACE enrollment without Part D eligibility. Monthly payments will be calculated (prospectively and retroactively) according to the combination of the enrollee's Parts A, B, and D entitlements in effect for each payment month. The timeframe for submitting enrollment transactions is not affected by this change.

  ARC 46 identifies the adjustments for these transactions.

1.2.1.3 Coverage Gap Discount (CGD)

The PPR identifies the Coverage Gap Discount adjustment information at the bottom of Table 1. This table provides a summary of prospective and adjusted CGD amounts included in the Part D payments. These payments are based upon estimates using Bid data. The amounts are reported on the MMR on a beneficiary level. Figure 1B above illustrates the placement of the Coverage Gap Discount payment information on the PPR.

1.2.2 PPR Table 2-Premium Settlement

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

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

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

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

CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : H9999 PAGE: 2/5
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 02/2012
RUN DATE : 01/25/2012
REPORT SECTION: PREMIUM SETTLEMENT
TABLE NUMBER : 2
PAYMENT CATEGORY

	PART C	PART D	NET PAYMENT
PART C PREMIUM WITHOLDING	65,720.40		65,720.40
PART D PREMIUM WITHOLDING		14,110.50	14,110.50
PART D LOW INCOME PREMIUM SUBSIDY		2,901.90	2,901.90
PART D LATE ENROLL PENALTIES (DIRECT BILL)		-1.20	-1.20
TOTAL	65,720.40	17,011.20	82,731.60

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* CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING *
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Premium Withhold and Late Enrollment Penalty description and payment amounts

Example 3: Plan HealthyLife is reconciling the premium amounts reported on the PPR and use the Premium Withhold Report to validate the premiums. However, they are unable to reconcile the amounts.

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

1.2.3 PPR Table 3-Fees

CMS communicates the Plan-level adjustments for fees in Table 3 of the PPR, which are based on summarized data in APPS. There is no specific report the Plan can consult to reconcile fees. However, CMS releases annually through HPMS, the Annual Payment Announcement communicating the fees and a payment letter that outlines the rates and period of collection. The fees are provided annually by the Office of the Actuary (OACT) and CMS announces the fees annually in the announcements. The 2013 rates were announced in the 2013 Payment Announcement at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2013.pdf.

In addition, CMS annually communicates in the Payment Letter prior to collection of fees, the rates by Plan type and period of collection. For example, the December 2011 Plan Payment Letter (Dated November 23, 2011) announced the fees beginning January 2012.

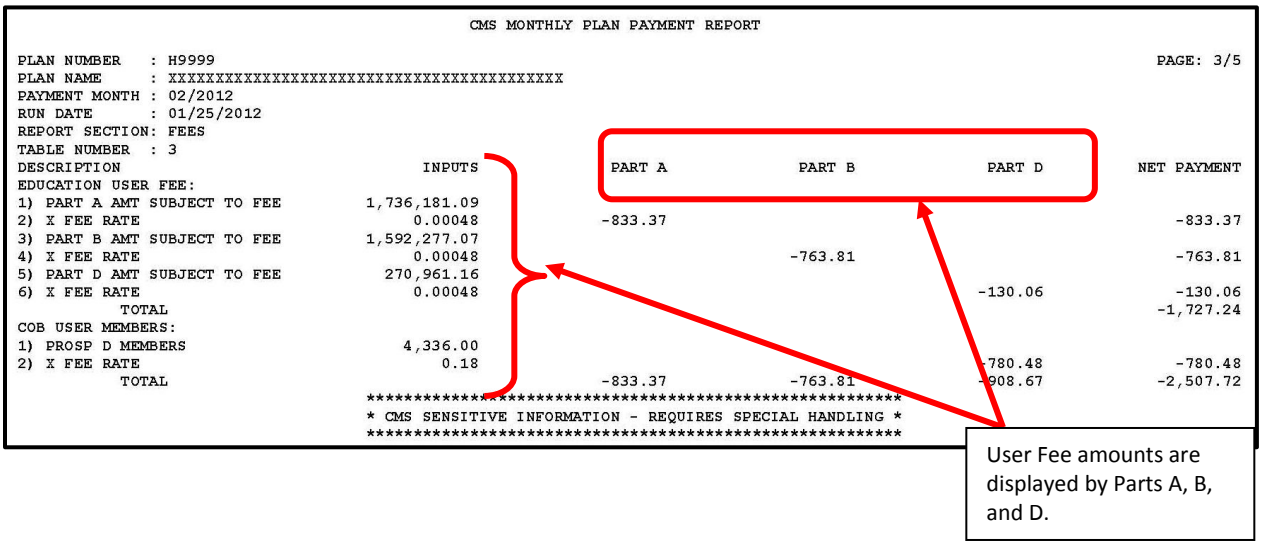
Table 1D outlines the possible fees and adjustments reported in this section.

TABLE 1D – FEES

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

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

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



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                                CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER    : H9999                                                          PAGE: 3/5
PLAN NAME      : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH  : 02/2012
RUN DATE       : 01/25/2012
REPORT SECTION: FEES
TABLE NUMBER   : 3
DESCRIPTION                              INPUTS      PART A      PART B      PART D      NET PAYMENT
EDUCATION USER FEE:
1) PART A AMT SUBJECT TO FEE          1,736,181.09
2) X FEE RATE                             0.00048     -833.37                                 -833.37
3) PART B AMT SUBJECT TO FEE          1,592,277.07
4) X FEE RATE                             0.00048                 -763.81                     -763.81
5) PART D AMT SUBJECT TO FEE            270,961.16
6) X FEE RATE                             0.00048                             -130.06         -130.06
           TOTAL                                                                            -1,727.24
COB USER MEMBERS:
1) PROSP D MEMBERS                        4,336.00
2) X FEE RATE                                0.18                             -780.48         -780.48
           TOTAL                                        -833.37     -763.81    -908.67       -2,507.72
                                ************************************************************
                                * CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING *
                                ************************************************************
```

Example 4: CMS collects user fees from January to September every year. Plan Express was able to see the COB User Fee for Part D at a rate of $0.18 per Part D member per month. This adjustment will only appear on the PPR from January to September 2012. In addition, Plan Express could see the Education User Fee adjustments broken out by Parts A, B, and D. The rate for MA and MAPD plans is 0.048% and for stand-alone PDPs is 0.049%. Plan Express had estimated what the Education User Fee adjustment would be in advance of receiving the January PPR and found that their estimate was higher than the actual reported fees. The reason Plan Express's estimate was more than the PPR is that they forgot to subtract the Medicare Secondary Payer (MSP) adjustments reported on the MMR from the prospective payments. (Refer to Module 3 Monthly Membership Report for more on MSP.)

1.2.4 PPR Table 4-Special Adjustment

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

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

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

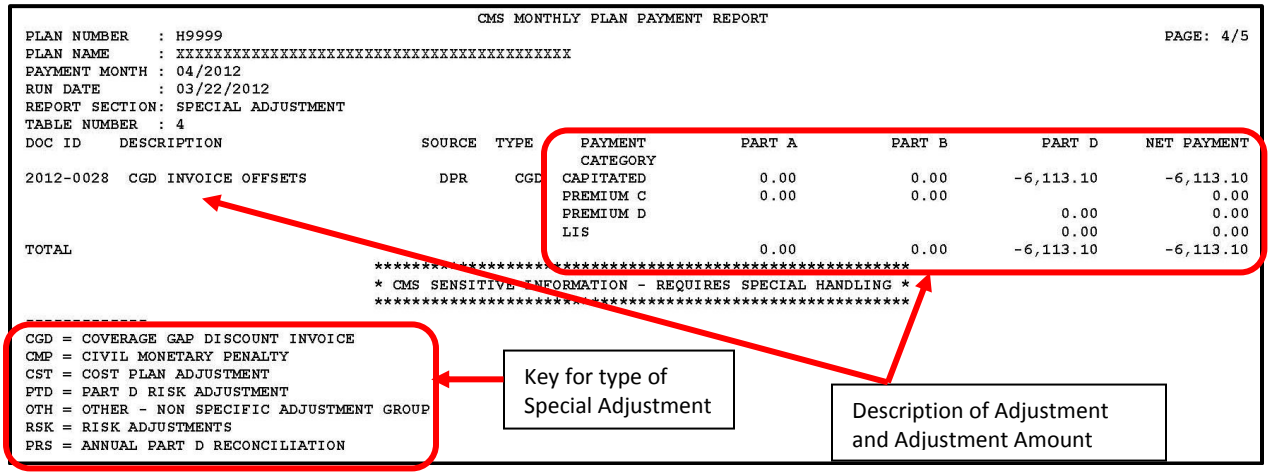
TABLE 1E – SPECIAL ADJUSTMENT REASON CODES/DESCRIPTIONS

Type	Description
CGD	Invoice for Coverage Gap Discount
CMP	Civil Monetary Penalty
CST	Cost Plan Adjustment
PTD	Part D Risk Adjustment
PRS	Annual Part D Reconciliation
RSK	Risk Adjustment
HTC	HITECH Incentive Payment
RAC	Recovery Audit Contract Adjustment
OTH	Other – Non specific adjustment group

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

Figure 1E illustrates the Special Adjustment Table.

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



CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : H9999 PAGE: 4/5
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 04/2012
RUN DATE : 03/22/2012
REPORT SECTION: SPECIAL ADJUSTMENT
TABLE NUMBER : 4

DOC ID	DESCRIPTION	SOURCE	TYPE	PAYMENT CATEGORY	PART A	PART B	PART D	NET PAYMENT
2012-0028	CGD INVOICE OFFSETS	DPR	CGD	CAPITATED	0.00	0.00	-6,113.10	-6,113.10
				PREMIUM C	0.00	0.00		0.00
				PREMIUM D			0.00	0.00
				LIS			0.00	0.00
TOTAL					0.00	0.00	-6,113.10	-6,113.10

****
* CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING *
****

CGD = COVERAGE GAP DISCOUNT INVOICE
CMP = CIVIL MONETARY PENALTY
CST = COST PLAN ADJUSTMENT
PTD = PART D RISK ADJUSTMENT
OTH = OTHER - NON SPECIFIC ADJUSTMENT GROUP
RSK = RISK ADJUSTMENTS
PRS = ANNUAL PART D RECONCILIATION

Key for type of Special Adjustment

Description of Adjustment and Adjustment Amount

Example 5: CMS conducted a 2012 Coverage Gap Discount Invoice Offset and on Plan Park's report they received a negative net adjustment payment of (-)$6, 113.10. CMS reported the adjustment to Plan Park on the Special Adjustments Table.

1.2.4.1 HITECH Incentive Payment

Plans participating in the Electronic Health Records (EHR) Incentive Program under the HITECH Act receive annual incentive payments. The incentive payment is included for the Plan's qualifying MA eligible professionals and not for any incentive payments due to qualifying MA eligible hospitals under this program. For payment year 2011, the incentive payment was included in the May 2012 payment.

This payment appears in the Special Adjustment section of the PPR with the Adjustment Type "HTC" for HITECH. For reporting purposes, the PPR formatted version is using the Part D column to report the adjustment payment. As of May 2012, the column heading reads "Part D/HITECH". When the payment adjustment is a Part D payment, the Adjustment Type code will display "PTD" for Part D Risk Adjustment and if the payment adjustment is an EHR incentive payment, the Adjustment Type code of "HTC" for HITECH will display in the field. In the data file, the code will be in Field 53 and the dollars are reported in Field 56.

CMS may recoup all or a portion of a payment made to an MA organization or on behalf of an MA organization, if the payment is made based on an incorrect or fraudulent attestation, incorrect or fraudulent cost data, or any other submission required to establish eligibility or to qualify for such payment, or if the submission is incorrect or fraudulent.

1.2.4.2 Coverage Gap Discount Program (CGDP) Quarterly Invoicing

Plans are paid an estimated Coverage Gap Discount amount each month for their current Part D members. CMS offsets the upfront payments by invoicing participating prescription drug manufacturers after completion of the CGD payment cycle, and subsequently recovers the invoiced amounts. These offsets appear as a CMS Special Adjustment on Table 4 of the PPR with the Adjustment Type code of "CGD". The CGD offsets occur quarterly.

1.2.4.3 CGDP Annual Reconciliation

For each benefit year (January to December), CMS will conduct a cost-based reconciliation for the CGDP. Prospective payments are an estimate and Part D sponsors may experience actual CGDP costs greater than or less than the prospective payments. If the total CGDP prospective payments received are greater than or less than the actual gap discount amounts documented in Prescription Drug Event (PDE) records (meaning prescription drug claims), then CMS will reconcile the differences. This reconciliation process will ensure that Part D sponsors are fully reimbursed for the manufacturer discounts amounts made available to their enrollees as reported on accepted PDE records.

The schedule is different for determining the CGDP reconciliation payments from the existing Part D payment reconciliation. CGDP reconciliation begins after the sixth invoicing and payment processing cycle has been completed for a benefit year. After the CGDP reconciliation, CMS will discontinue additional offsets for the benefit year. After CGDP reconciliation, Plans may continue to report discounts to CMS for 37 months following the end of the benefit year. The sponsor will receive payment through the Manufacturer Invoice Process.

CGDP Reconciliation payments will appear as Special Adjustments on the PPR.

1.2.5 PPR Table 5-Payment Summary

The summary table provides Plans with information collected from all other tables on the report. The summary table highlights the consolidated payment.

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

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

CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : H9999 PAGE: 5/5
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 02/2012
RUN DATE : 01/25/2012
REPORT SECTION: PAYMENT SUMMARY
TABLE NUMBER : 5

SOURCE	PAYMENT SUMMARY	PAYMENT TYPE	PREVIOUS BALANCE	CURRENT ACTIVITY	NET PAYMENT	BALANCE FORWARD
TABLE 1	PART A	CAPITATED	0.00	1,617,556.32	1,617,556.32	0.00
TABLE 1	PART B	CAPITATED	0.00	1,480,727.49	1,480,727.49	0.00
TABLE 1	PART D	CAPITATED	0.00	249,746.18	249,746.18	0.00
TABLE 2	PART C PREMIUM WITHHOLDING	PREMIUM	0.00	65,720.40	65,720.40	0.00
TABLE 2	PART D PREMIUM WITHHOLDING	PREMIUM	0.00	14,110.50	14,110.50	0.00
TABLE 2	PART D LOW INCOME PREMIUM SUBSIDY	PREMIUM	0.00	2,901.90	2,901.90	0.00
TABLE 2	PART D LATE ENROL PENALTIES	PREMIUM	0.00	-1.20	-1.20	0.00
TABLE 3	EDUCATION USER FEE	FEES	0.00	-1,727.24	-1,727.24	0.00
TABLE 3	PART D COB USER FEE	FEES	0.00	-780.48	-780.48	0.00
TABLE 4	CMS ADJUSTMENTS	SPEC ADJ	0.00	0.00	0.00	0.00
TOTAL			0.00	3,416,027.67	3,416,027.67	0.00

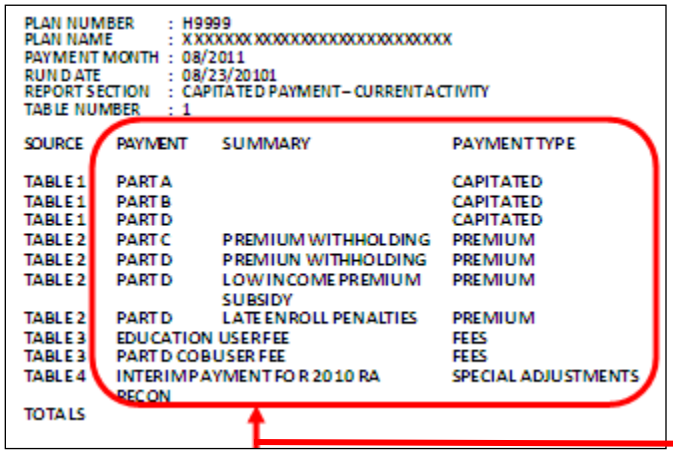
* CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING *

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

Payment Summary Section of PPR

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

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



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

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

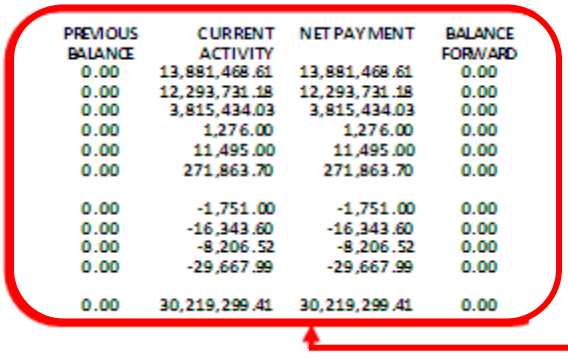
The summary page now provides the total amounts of each payment and includes the payment type. Plans can determine the next steps in reconciling payment by understanding the type of payment received. See Table 1A in this guide for the source information of each payment type.

Previous/Current/Balance Forward Activity

In addition to providing a summary of all payments, Table 5 also provides a view of current, previous, and balance forward activity. This allows plans to determine trends from month to month. The amount recorded in the Previous Balance column is the reported amount from the prior month's activity and is reported as a negative dollar amount. This amount is then adjusted against the current activity to provide the net payment. The Balance Forward column identifies the current net payment that is negative and that is carried over to the next month.

As of January 2012, CMS implemented a format change to the PPR data file to expand the information provided and to more closely align the data file version with the report version. The update to the data file included the addition of the data associated with the Previous Balance and Balance Forward. Figure 1H highlights this section of the Summary Table.

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



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

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

1.3 PPR Data File Version

In addition to the report version of the PPR, CMS provides a data file version of the report. As of February 2011, the data file length is 200 bytes. The data file includes a Header Record that provides the contract information, payment cycle date, and the run date of the report. The data file then provides all the data that was illustrated above in the figures for the report layout version. Plans can export the data file into Excel or Access and develop their own internal reports in order to reconcile the information on the PPR with other CMS provided reports like the MMR. Table 1F provides the data file layout of the PPR.

TABLE 1F – PPR DATA FILE RECORD LAYOUT

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

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

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD					
CAPITATED PAYMENT – CURRENT ACTIVITY					
7	Contract Number	1 – 5	5	Character	Contract Number
8	Record Identification Code	6 – 6	1	Character	Record Type Identifier C = Capitated Payment
9	Table ID Number	7 – 7	1	Character	1
10	Adjustment Reason Code	8 – 9	2	Numeric	Blank = for prospective pay For list of adjustment reason codes consult Section H.3 of the *Medicare Advantage and Prescription Drug Plan Communications User Guide*
11	Part A Total Members	10 – 17	8	Numeric	Number of beneficiaries Part A payments is being made prospectively Format: ZZZZZZZ9
12	Part B Total Members	18 – 25	8	Numeric	Number of beneficiaries Part B payments is being made prospectively Format: ZZZZZZZ9
13	Part D Total Members	26 – 33	8	Numeric	Number of beneficiaries Part D payments is being made prospectively Format: ZZZZZZZ9
14	Part A Payment Amount	34 – 46	13	Numeric	Total Part A Amount Format: SSSSSSSSS9.99
15	Part B Payment Amount	47 – 59	13	Numeric	Total Part B Amount Format: SSSSSSSSS9.99
16	Part D Payment Amount	60 – 72	13	Numeric	Total Part D Amount Format: SSSSSSSSS9.99
17	Coverage Gap Discount Amount	73 – 85	13	Numeric	The Coverage Gap Discount Amount included in Part D Payment Format: SSSSSSSSS9.99
18	Total Payment	86 – 98	13	Numeric	Total Payment Format: SSSSSSSSS9.99
19	Filler	99 – 200	102	Character	Spaces
PREMIUM SETTLEMENT					
20	Contract Number	1 – 5	5	Character	Contract Number
21	Record Identification Code	6 – 6	1	Character	Record Type Identifier P = Premium Settlement
22	Table ID Number	7 – 7	1	Character	2
23	Part C Premium Withholding Amount	8 – 20	13	Numeric	Total Part C Premium Amount Format: SSSSSSSSS9.99
24	Part D Premium Withholding Amount	21 – 33	13	Numeric	Total Part D Premium Amount Format: SSSSSSSSS9.99
25	Part D Low Income Premium Subsidy	34 – 46	13	Numeric	Total Low Income Premium Subsidy Format: SSSSSSSSS9.99
26	Part D Late Enrollment Penalty	47 – 59	13	Numeric	Total Late Enrollment Penalty Format: SSSSSSSSS9.99
27	Total Premium Settlement Amount	60 – 72	13	Numeric	Total Premium Settlement Format: SSSSSSSSS9.99
28	Filler	73 – 200	128	Character	Spaces

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

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD (CONTINUED)					
FEES					
29	Contract Number	1 – 5	5	Character	Contract Number
30	Record Identification Code	6 – 6	1	Character	Record Type Identifier F = Fees
31	Table ID Number	7 – 7	1	Character	3
32	NMEC Part A Subject to Fee	8 – 20	13	Numeric	Part A amount subject to National Medicare Educational Campaign Fees Format:ZZZZZZZZZ9.99
33	NMEC Part A Rate	21 – 27	7	Numeric	Rate used to calculate the fees for Part A Format: 0.99999
34	Part A Fee Amount	28 – 40	13	Numeric	Fee assessed for Part A Format:SSSSSS9.99
35	NMEC Part B Subject to Fee	41 – 53	13	Numeric	Part B amount subject to National Medicare Educational Campaign Fees Format: ZZZZZZZZZ9.99
36	NMEC Part B Rate	54 – 60	7	Numeric	Rate used to calculate the fees for Part B Format: 0.99999
37	Part B Fee Amount	61 – 73	13	Numeric	Fee assessed for Part B Format: SSSSSS9.99
38	NMEC Part D Subject to Fee	74 – 86	13	Numeric	Part D amount subject to National Medicare Educational Campaign Fees Format: ZZZZZZZZZ9.99
39	NMEC Part D Rate	87 – 93	7	Numeric	Rate used to calculate the fees for Part D Format: 0.99999
40	Part D Fee Amount	94 – 106	13	Numeric	Fee assessed for Part D Format: SSSSSS9.99
41	Total NMEC Fee Assessed	107 – 119	13	Numeric	Total NMEC Fee assessed for Part A, B and D Format: SSSSSSS9.99
42	Total Prospective Part D Members	120 – 127	8	Numeric	Total members for Part D Format: ZZZZZZZ9
43	Rate for COB Fees	128 – 131	4	Numeric	Rate used to calculate the COB Fees Format: 0.99
44	Amount of COB Fees	132 – 144	13	Numeric	COB Fees Format: SSSSSS9.99
45	Total of Assessed Fees	145 – 157	13	Numeric	Total of all fees assessments Format: SSSSSS9.99
46	Filler	158 – 200	43	Character	Spaces
SPECIAL ADJUSTMENTS					
47	Contract Number	1 – 5	5	Character	Contract Number
48	Record Identification Code	6 – 6	1	Character	Record Type Identifier S = Special Adjustments
49	Table ID Number	7 – 7	1	Character	4
50	Document ID	8 – 15	8	Numeric	The document ID for identifying the adjustment
51	Source	16 – 20	5	Character	The CMS division responsible for initiating the adjustments
52	Description	21 – 70	50	Character	The reason the adjustment was made

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

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD (CONTINUED)					
53	Type	71 – 90	20	Character	The payment component the adjustment is for • CGD – Coverage Gap Discount Invoice • CMP – Civil Monetary Penalty • CST – Cost Plan Adjustment • PTD – Part D Risk Adjustment • PRS – Annual Part D Reconciliation • RSK – Risk Adjustment • HTC – HITECH Incentive Payment • RAC – Recovery Audit Contract • OTH – Other – default non-specific group
54	Adjustment to Part A	91 – 103	13	Numeric	Adjustment amount for Part A Format: SSSSSSSSS9.99
55	Adjustment to Part B	104 – 116	13	Numeric	Adjustment amount for Part B Format: SSSSSSSSS9.99
56	Adjustment to Part D or Adjustment to HITECH Incentive Payment	117 – 129	13	Numeric	Adjustment amount for HITECH Incentive Payment when the adjustment type is "HTC" The adjustment amount is for Part D for the rest of the types Format: SSSSSSSSS9.99
57	Premium C Withholding Part A	130 – 142	13	Numeric	Adjustment amount for Premium Withholding Part A Format: SSSSSSSSS9.99
58	Premium C Withholding Part B	143 – 155	13	Numeric	Adjustment amount for Premium Withholding Part B Format: SSSSSSSSS9.99
59	Premium D Withholding	156 – 168	13	Numeric	Adjustment amount for Premium D Withholding Format: SSSSSSSSS9.99
60	Part D Low Income Premium Subsidy	169 - 181	13	Numeric	Adjustment amount for Low Income Subsidy Format: SSSSSSSSS9.99
61	Total Adjustment Amount	182 – 194	13	Numeric	Total Adjustments Format: SSSSSSSSS9.99
62	Filler	195 – 200	6	Character	Spaces
PREVIOUS CYCLE BALANCE SUMMARY					
63	Contract Number	1 – 5	5	Character	Contract Number
64	Record Identification Code	6 – 6	1	Character	Record Type Identifier L = Last Period Carry Over Amounts carried over to this month from previous months
65	Table ID Number	7 – 7	1	Character	5
66	Part A Carry Over Amount	8 – 20	13	Numeric	Part A Carry Over Amount from Table 5** - Previous Balance Column Format: SSSSSSSSS9.99

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

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD (CONTINUED)					
67	Part B Carry Over Amount t	21 – 33	13	Numeric	Part B Carry Over Amount from Table 5** - Previous Balance Column Format: SSSSSSSS9.99
68	Part D Carry Over Amount	34 – 46	13	Numeric	Part D Carry Over Amount from Table 5** - Previous Balance Column Format: SSSSSSSS9.99
69	Part C Premium Withholding Carry Over Amount	47 – 59	13	Numeric	Part C Premium Withholding Carry Over Amount from Table 5** - Previous Balance Column Format: SSSSSSSS9.99
70	Part D Premium Withholding Carry Over Amount	60 – 72	13	Numeric	Part D Premium Withholding Carry Over Amount from Table 5** - Previous Balance Column Format: SSSSSSSS9.99
71	Part D Low Income Premium Subsidy Carry Over Amount	73 – 85	13	Numeric	Part D Low Income Premium Subsidy Carry Over Amount from Table 5** - Previous Balance Column Format: SSSSSSSS9.99
72	Part D Late Enrollment Penalty Carry Over Amount	86 – 98	13	Numeric	Part D Late Enrollment Penalty Carry Over Amount from Table 5** - Previous Balance Column Format: SSSSSSSS9.99
73	Education User Fee Carry Over Amount	99 – 111	13	Numeric	Education User Fee Carry Over Amount from Table 5** - Previous Balance Column Format: SSSSSSSS9.99
74	Part D COB User Fee Carry Over Amount	112 – 124	13	Numeric	Part D COB User Fee from Table 5** - Previous Balance Column Format: SSSSSSSS9.99
75	CMS Special Adjustments Carry Over Amount	125 – 137	13	Numeric	CMS Special Adjustments Carry Over Amount from Table 5** - Previous Balance Column Format: SSSSSSSS9.99
76	Total Carry Over Amount	138-150	13	Numeric	Sum of amounts in Previous Balance Column Format: SSSSSSSS9.99
77	Filler	151 – 200	50	Character	Spaces
PAYMENT SUMMARY					
78	Contract Number	1 – 5	5	Character	Contract Number
79	Record Identification Code	6 – 6	1	Character	Record Type Identifier A = Payment Summary Amounts included in this month's payment from Tables 1 thru 4 plus Carry Over (from Previous Balance Column)
80	Table ID Number	7 – 7	1	Character	5
81	Part A Amount	8 – 20	13	Numeric	Part A Amount from Table 5** - Net Payment Column Format: ZZZZZZZZZ9.99
82	Part B Amount	21 – 33	13	Numeric	Part B Amount from Table 5** - Net Payment Column Format: ZZZZZZZZZ9.99

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

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD (CONTINUED)					
83	Part D Amount	34 – 46	13	Numeric	Part D Amount from Table 5** - Net Payment Column Format: ZZZZZZZZZ9.99
84	Part C Premium Withholding Amount	47 – 59	13	Numeric	Part C Premium Withholding Amount from Table 5** - Net Payment Column Format: ZZZZZZZZZ9.99
85	Part D Premium Withholding Amount	60 – 72	13	Numeric	Part D Premium Withholding Amount from Table 5** - Net Payment Column Format: ZZZZZZZZZ9.99
86	Part D Low Income Premium Subsidy Amount	73 – 85	13	Numeric	Part D Low Income Subsidy Amount from Table 5** - Net Payment Column Format: ZZZZZZZZZ9.99
87	Part D Late Enrollment Penalty Amount	86 – 98	13	Numeric	Part D Late Enrollment Penalty Amount from Table 5** - Net Payment Column Format: SSSSSSSSS9.99
88	Education User Fee Amount	99 – 111	13	Numeric	Education User Fee Amount from Table 5** - Net Payment Column Format: SSSSSSSSS9.99
89	Part D COB User Fee Amount	112 – 124	13	Numeric	Part D COB User Fee Amount from Table 5** - Net Payment Column Format: SSSSSSSSS9.99
90	CMS Special Adjustments Amount	125 – 137	13	Numeric	CMS Special Adjustments Amount from Table 5** - Net Payment Column Format: SSSSSSSSS9.99
91	Total Net Payment	138 – 150	13	Numeric	Sum of amounts in Net Payment Column This is the plan's Net Payment Amount for the month. If the amount is negative, the payment will be carried forward Format: SSSSSSSSS9.99
92	Filler	151 – 200	50	Character	Spaces.
PAYMENT BALANCE CARRIED FORWARD					
93	Contract Number	1 – 5	5	Character	Contract Number
94	Record Identification Code	6 – 6	1	Character	Record Type Identifier N = Balance Carried Forward to Next Cycle. Amounts carried forward (and not paid) to next month from this month
95	Table ID Number	7 – 7	1	Character	5
96	Part A Amount	8 – 20	13	Numeric	Part A Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99
97	Part B Amount	21 – 33	13	Numeric	Part B Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99
98	Part D Amount	34 – 46	13	Numeric	Part D Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99

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

Item	Data Element	Position	Length	Type	Description
DETAIL RECORD (CONTINUED)					
99	Part C Premium Withholding Amount	47 – 59	13	Numeric	Part C Premium Withholding Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99
100	Part D Premium Withholding Amount	60 – 72	13	Numeric	Part D Premium Withholding Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99
101	Part D Low Income Premium Subsidy Amount	73 – 85	13	Numeric	Part D Low Income Subsidy Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99
102	Part D Late Enrollment Penalty Amount	86 – 98	13	Numeric	Part D Late Enrollment Penalty Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99
103	Education User Fee Amount	99 – 111	13	Numeric	Education User Fee Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99
104	Part D COB User Fee Amount	112 – 124	13	Numeric	Part D COB User Fee Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99
105	CMS Special Adjustments Amount	125 – 137	13	Numeric	CMS Special Adjustments Amount Carry Forward from Table 5** - Balance Forward Column Format: SSSSSSSSS9.99
106	Total Carry Forward Amount	138 – 150	13	Numeric	Sum of amounts in Balance Forward Column Format: SSSSSSSSS9.99
107	Filler	151 – 200	50	Character	Spaces

**Table 5 refers to the Plan Payment Report (print format)

1.4 Future Updates to the PPR

In January 2013, newly integrated capitated plans will become available for Medicare-Medicaid enrollees (full-benefit dual eligible beneficiaries) under the new Financial Alignment Demonstration plans in select states. The demonstration plans will provide a full array of Medicare and Medicaid services to beneficiaries enrolled in them. The demonstrations are not bid-based payments and do not have rebates, but are risk adjusted for Part C and Part D payment. While the demonstration is in development, CMS is assessing the impact to reporting. When updates are determined for the PPR, CMS will provide that information through HPMS notices and software releases.

MODULE 2 – PREMIUM WITHHOLD REPORT

Purpose

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

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

Learning Objectives

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

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

ICON KEY	
Definition	
Example	
Reminder	
Resource	

2.1 Process Overview

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

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

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

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

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

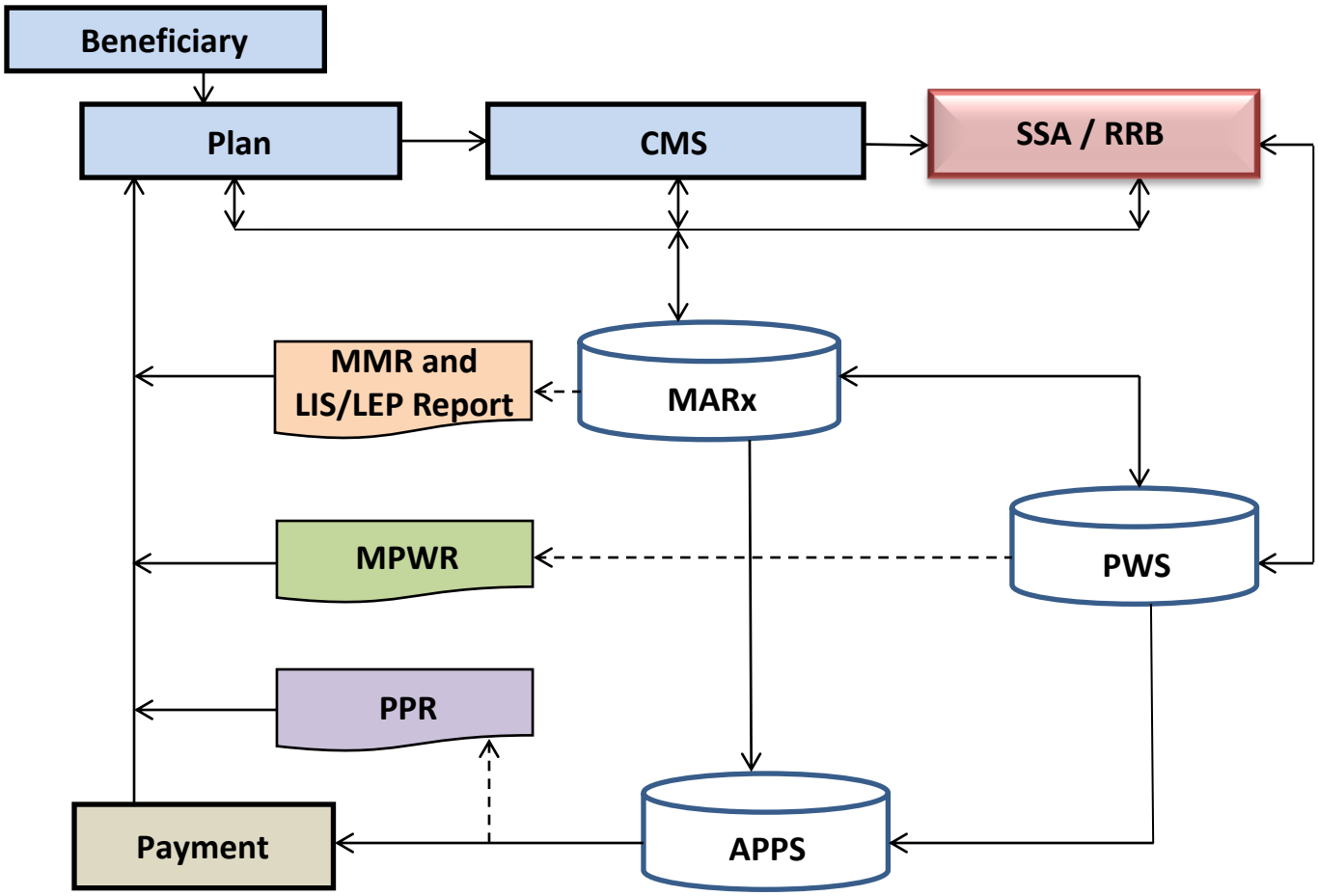
2.2 Premium Payment Flow

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

- The premium withholding process begins during or after enrollment when:
  - A beneficiary elects to pay the Plan premium from their SSA or RRB benefit.
  - A beneficiary enrolls with "uncovered months" and is required to pay a Late Enrollment Penalty (LEP).
    - The LEP is automatically deducted and retained by CMS by the Premium Withhold System (PWS) from the premium received from SSA/RRB.
- Beneficiaries have two options for paying their plan premiums or late enrollment penalties. They can choose either premium withhold or direct bill. This means that they can:
  - Elect to have their Part C and Part D Plan premiums withheld by the Social Security Administration (SSA) or the Railroad Retirement Board (RRB) as a reduction in their monthly benefit, or
  - Rrequest direct billing in which they pay the Plan directly each month.
    - It is important to note that direct bill is the default position, which means that during the enrollment process, if the enrollee does not **actively** select the premium withhold option, they are then billed directly.
- CMS notifies the SSA/RRB of the request to have premiums withheld from the SSA or RRB benefit. Because it can take one to three months to process the request at SSA/RRB, the beneficiary's request is considered to be pending until MARx notifies the Plan that SSA/RRB has processed and accepted it.
- The PWS uses premium withhold data from MARx (expected premium withholding), SSA (actual premium withholding), and RRB (actual premium withheld). This data is reconciled and reported to the Plan through the Monthly Premium Withholding Report (MPWR). If applicable, the LEP is also included in the MPWR, but is retained by CMS. Late Enrollment Penalty payments are included on the LIS/LEP report.
- PWS sends payment data to the Automated Plan Payment System (APPS) to be compiled with other Plan payment information, resulting in an aggregate Plan payment, which includes the premium.
- The premium information reported on the MPWR is also reported on the PPR and summarized on a contract-level.

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

Figure 2A – Premium Payment Data Flow



2.3 Premium Withholding System (PWS)

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

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

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

Table 2A provides the functions of the PWS.

TABLE 2A – PWS MONTHLY FUNCTIONS

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

2.3.1 Reconciling the PPR with the MPWR

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

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

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

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

- Part C Premiums
- Part D Premiums

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

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

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

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

2.3.1.1 Contract/Plan-Level Information

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

2.3.1.2 Beneficiary-Level Information

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

TABLE 2C – MPWR BENEFICIARY INFORMATION*

Field	Description
HIC Number	This identifies the beneficiary's HIC number.
Surname	This field will report up to seven (7) letters of the beneficiary's surname.
First Initial	This field displays the first letter of the beneficiary's first name.
Sex	This field displays the gender of the beneficiary as "M" for Male or "F" for Female.
Date of Birth	This field identifies the beneficiary's date of birth.

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

2.3.1.2.1 Health Insurance Claim (HIC) Number

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

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

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

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

Table 2D illustrate the characteristics for each HIC type.

TABLE 2D – STRUCTURE OF HIC NUMBERS

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

2.3.1.3 Premium Payment Option Field

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

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

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

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

2.3.1.3.1 Reasons Why Premium Withhold Requests Are Not Accepted

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

Once accepted (via transaction reply code 186), the beneficiary's selected Premium Payment Option will display on the MPWR. CMS may make changes to the premium withhold option and not accept premium withhold requests for the following reasons:

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

Example 1: On December 15, 2011, Summer Health Plan requested an SSA premium withhold status for a beneficiary to begin January 1, 2012. What will the January 2012 MPWR communicate? The report will not list the beneficiary since the SSA deduction will take approximately two to three months to validate.

2.3.1.3.2 Premium Withholding Details and Rules

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

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

2.3.1.4 Premium Start and End Date Fields

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

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

2.3.1.5 Premium Collected Fields

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

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

2.3.1.5.1 Part C Premiums Collected Field

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

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

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

Example 2: Spring Health Plan has reviewed the April PPR and is now reviewing the MPWR for a beneficiary enrolled in the Plan to validate the Part C premium amount collected. The Part C Premiums Collected field reported the following positive amounts: $90 for the April 2012 MPWR and $30 for the May 2012 MPWR. Spring Health Plan is reconciling the premium payments and noticed the difference in the two amounts collected.

Spring Health Plan reviewed the Premium Period Start and Premium Period End Dates to determine that the March amount collected on the April MPWR included the months of January-March 2012.

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

2.3.1.5.2 Part D Premiums Collected Field

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

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

Also note that both the Part C and Part D premiums for a Plan must be withheld if a beneficiary selects the premium withhold option. Beneficiaries cannot elect to have the Part C premium withheld and the Part D premium directly billed, or vice versa.

The Part D premium amounts reported in this field do not include LEP amounts.

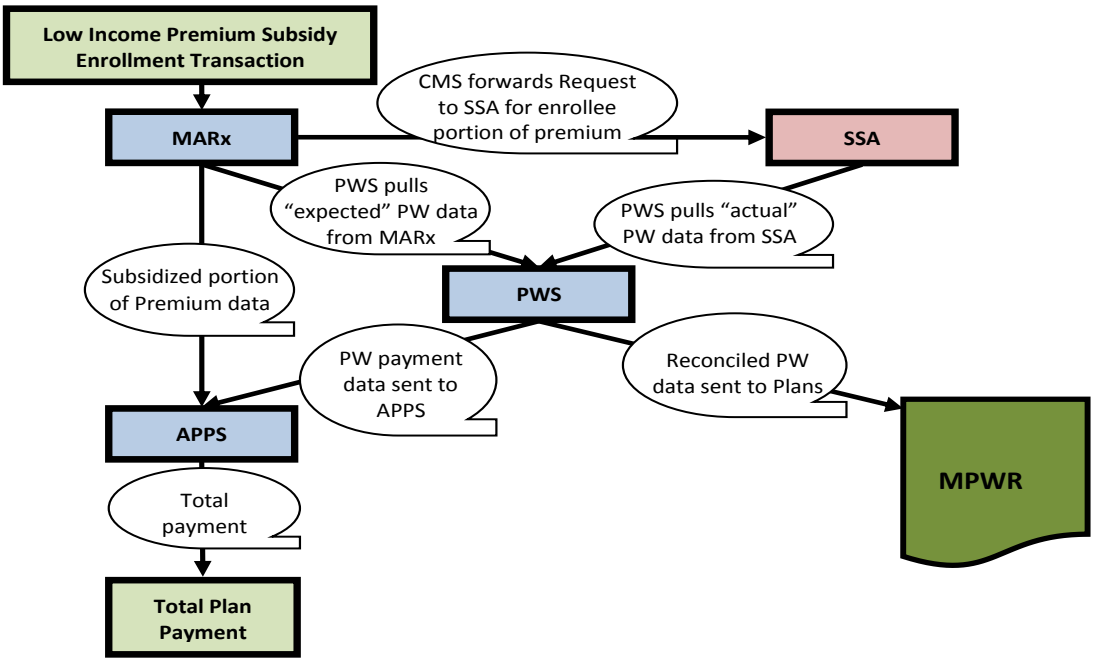
Low-Income Premium Subsidy

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

Note: The LIPS does not apply to any enhanced Part D premiums that a beneficiary owes due to election of enhanced coverage.

Figure 2B illustrates the LIPS withholding process.

Figure 2B – Low-Income Premium Subsidy Withholding Process



Example 3: Mr. January is eligible for a 75% LIPS and is responsible for the remainder of his premium. The premium for the Plan he is enrolled in is $40. The LIPS amount is $30, which CMS will pay to the Plan. Mr. January is responsible for $10. He has elected to have the difference withheld from his SSA benefit. His Plan will receive the subsidized amount as a result of the LIPS ($30) from CMS and the remaining $10 from SSA is withheld from Mr. January's benefit. The premium deduction amount ($10) will appear in the Part D Premiums Collected field on the MPWR.

Premium Refunds

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

Refunds are reported as negative amounts in the Parts C and D Premiums Collected fields.

2.3.1.5.3 Part D Late Enrollment Penalties

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

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

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

Beneficiaries receiving LIS are not subject to a LEP.

Plans are responsible for ensuring timely processing of LEP changes, refunds due to error, or LIS redetermination.

Plans can also review the LEP amounts for directly billed beneficiaries on the LIS/LEP report. The file layout can be found in the Plan Communications User Guide Appendices at http://cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html.

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

2.3.2 Monthly Premium Withholding Report Data File Layout

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

TABLE 2E – MPWRD FILE STRUCTURE

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

Table 2F provides the specific data reported in the MPWR organized by file structure of header, detail, and trailer.

The field represents the data reported, the size reports the length of data, the position reports the actual position in the data file where the data will appear, and the description explains how to interpret the data reported in the field.

TABLE 2F – MONTHLY PREMIUM WITHHOLDING REPORT DATA FILE (MPWR)

Header Record

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

Detail Record

ITEM	FIELD	SIZE	POSITION	DESCRIPTION
1	Record Type	2	1 – 2	D = Detail Record PIC XX
2	MCO Contract Number	5	3 – 7	MCO Contract Number PIC X(5)
3	Plan Benefit Package ID	3	8 – 10	Plan Benefit Package ID PIC X(3)
4	Plan Segment ID	3	11 – 13	Segment number PIC X(3)
5	HIC Number	12	14 – 25	Member's HIC number PIC X(12)
6	Surname	7	26 – 32	Member's last name PIC X(7)
7	First Initial	1	33 – 33	Member's first initial PIC X
8	Sex	1	34 – 34	Member's gender M = Male, F = Female PIC X
9	Date of Birth	8	35 – 42	Member's Date of Birth YYYYMMDD PIC 9(8)
10	Premium Payment Option (PPO)	3	43 – 45	PPO 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 – 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)

TABLE 2F – MONTHLY PREMIUM WITHHOLDING REPORT DATA FILE (MPWR) (CONTINUED)

ITEM	FIELD	SIZE	POSITION	DESCRIPTION
14	Number of Months in Premium Period	2	63 – 64	The number of months covered by the payment 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 penalties 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

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 (PBP) ID	3	8 – 10	PBP ID, not populated on T3 records PIC X (3)
4	Plan Segment ID	3	11 – 13	Plan segment ID, not populated on T2 or T3 records PIC X (3)
5	Total Part C Premiums Collected	14	14 – 27	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	The net Part D LEP Collected as specified by the trailer record type , Field 1 PIC -9(10).99
8	Total Premiums Collected	14	56 – 69	Total Premiums Collected = +Total Part C Premiums Collected + Total Part D Premiums Collected + Total Part D LEPs Collected PIC -9(10).99
9	Filler	96	70 – 165	Spaces

Example 4: Beneficiaries enrolled in the Part D Summer Health Plan effective March 1 and are responsible for a Part D premium. After reconciling payment, Summer Health Plan concludes there is a deficit in payment due to uncollected premiums for 20 of their beneficiaries for the month of March. After closer review, the Plan determined these beneficiaries selected the SSA premium withhold option. Summer Health Plan reviews the MPWR to determine the amounts that are not reported on the March MPWR report. Summer Health Plan continued to monitor the Premium Start Date and Premium Part D Amount fields on the MPWR, since SSA may take two to three months to deduct the beneficiary premium. In May, Summer Health Plan noticed the premium amounts for the beneficiaries reflected on the MPWR.

Note: Plans may also use the Transaction Reply Report (TRR) to monitor premium withhold status.

2.3.3 Direct Billing Status

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

2.3.3.1 Tracking and Reconciling Premiums

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

TABLE 2G – RECONCILIATION REPORTS

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

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

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

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

2.3.4 "No Premium Due" Status Notification

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

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

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

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

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

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

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

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

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

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

Example 5: Summer Health Plan reviews the May 2012 PPR, which displays the total LIS premium amount of $200. The LIS/LEP reports $300. Summer Health Plan should consult the number of months field since the payment can reflect more than one month for a beneficiary.

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

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

TABLE 2H – LIS/LEP FILE STRUCTURE

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

TABLE 2I – LIS/LEP DATA FILE LAYOUT

Header Record

Item	Field Name	Size	Position	Description
1	Record Type	3	1 - 3	H = Header Record PIC XXX
2	MCO Contract Number	5	4 - 8	MCO Contract Number PIC X(5)
3	Payment/Payment Adjustment Date	6	9 - 14	YYYYMM First 6 digits contain Current Payment Month (CPM) 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

Item	Field Name	Size	Position	Description
1	Record Type	3	1 - 3	PD = Prospective Detail Record “Prospective” means Premium Period equals Payment Month reflected in Header Record AD = Adjustment Detail Record “Adjustment” means all Premium Periods other than Prospective PIC XXX
PLAN IDENTIFICATION				
2	MCO Contract Number	5	4 - 8	MCO Contract Number PIC X(5)
3	Plan Benefit Package (PBP) Number	3	9-11	PBP Number PIC X(3)
4	Plan Segment Number	3	12 - 14	Plan Segment Number PIC X(3)

TABLE 2I – LIS/LEP DATA FILE LAYOUT (CONTINUED)

Item	Field Name	Size	Position	Description
BENEFICIARY IDENTIFICATION & PREMIUM SETTINGS				
5	HIC Number	12	15 - 26	Member's HIC number PIC X(12)
6	Surname	7	27 - 33	PIC X(7)
7	First Initial	1	34 - 34	PIC X
8	Sex	1	35 - 35	M = Male, F = Female PIC X
9	Date of Birth	8	36 - 43	YYYYMMDD PIC 9(8)
10	Filler	1	44 - 44	Space
PREMIUM PERIOD				
11	Premium/Adjustment Period Start Date	6	45 - 50	PD: current processing month AD: adjustment period YYYYMM PIC 9(6)
12	Premium/Adjustment Period End Date	6	51 - 56	PD: current processing month AD: adjustment period YYYYMM PIC 9(6)
13	Number of Months in Premium/Adjustment Period	2	57 - 58	PIC 99
14	PD: Net Monthly Part D Basic Premium AD: Net Monthly Part D Basic Premium Amount	8	59 - 66	Plan's Part D Basic Rate in effect for this premium period Net is Monthly Part D Basic Premium (minus) DE MINIMIS DIFFERENTIAL **Note**: PD always equals AD for this field PIC -9999.99
15	Low Income Premium Subsidy Percentage	3	67 - 69	Low Income Premium Subsidy Percentage Subsidy percentage in effect for this premium period Valid values: 100, 075, 050, 025, and Blank PIC 999
16	Premium Payment Option	1	70 - 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

TABLE 2I – LIS/LEP DATA FILE LAYOUT (CONTINUED)

Item	Field Name	Size	Position	Description
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 equals (=) Late Enrollment Penalty Amount (minus) LEP Subsidy Amount (minus) Part D Penalty Waived Amount AD: For adjustments, compute the adjustment for each month in the (affected) payment period if the payment has already been made. PIC -9999.99
19	Net Amount Payable to Plan	8	87 - 94	PD: Net Amount Payable to Plan equals (=) 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

Item	Field Name	Size	Position	Description
1	Record Type	3	1 - 3	PT1 = Trailer Record, Prospective Totals at Segment Level PT2 = Trailer Record, Prospective Totals at PBP Level PT3 = Trailer Record, Prospective Totals at Contract Level AT1 = Trailer Record, Adjustment Totals at Segment Level AT2 = Trailer Record, Adjustment Totals at PBP Level AT3 = Trailer Record, Adjustment Totals at Contract Level CT1 = Trailer Record, Combined Totals at Segment Level CT2 = Trailer Record, Combined Totals at PBP Level CT3 = Trailer Record, Combined Totals at Contract Level PIC XXX
PLAN IDENTIFICATION				
2	MCO Contract Number	5	4 - 8	MCO Contract Number PIC X(5)
3	Plan Benefit Package Number	3	9 - 11	Plan Benefit Package Number Not populated on T3 records PIC X(3)
4	Plan Segment Number	3	12 - 14	Plan Segment Number Not populated on T2 or T3 records PIC X(3)

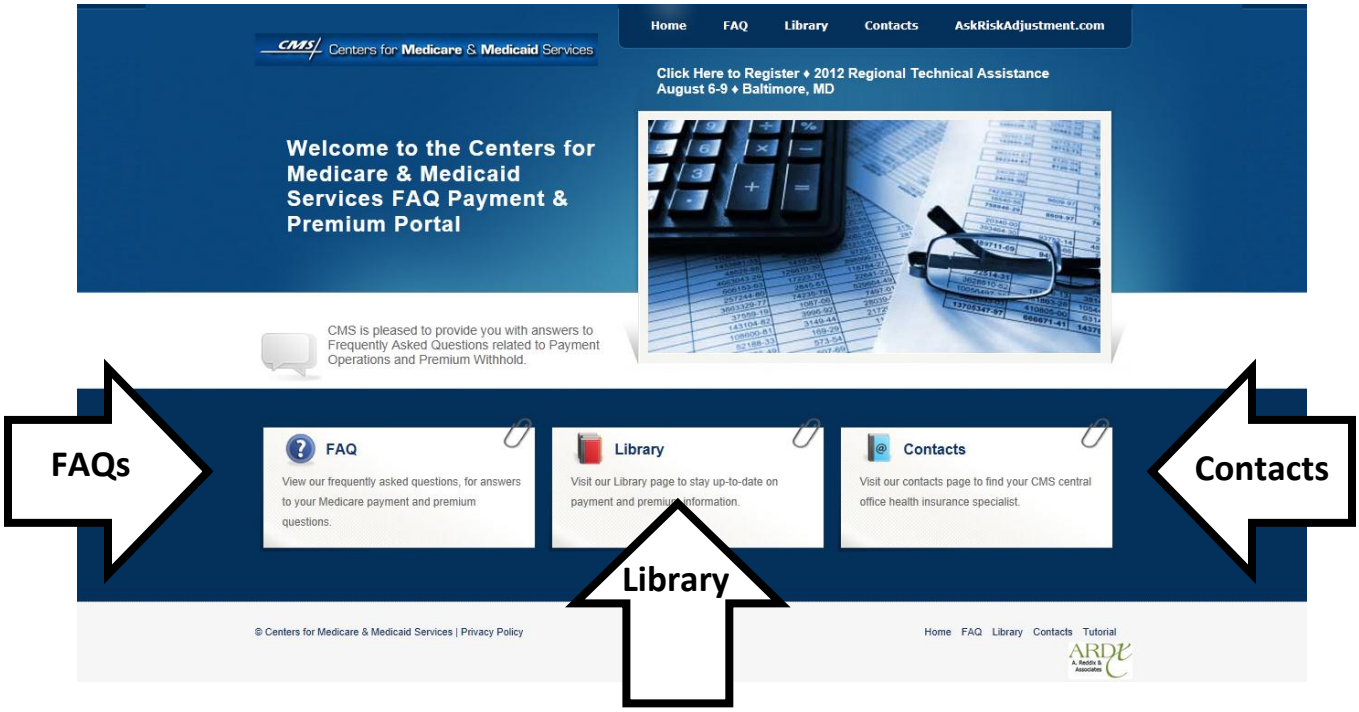
TABLE 2I – LIS/LEP DATA FILE LAYOUT (CONTINUED)

Item	Field Name	Size	Position	Description
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 equals (=) Total Premium Low Income Subsidy Amount (Field 5) (minus) Total Late Enrollment Penalty Amount Net of any Subsidy (Field 6) PIC -9(10).99
8	Filler	109	57 - 165	Spaces

2.5 Premium Withhold and Payment Web Portal

CMS developed the Premium Withhold and Payment Operations Web Portal to provide Plans with a resource for questions concerning premium withhold and payment issues, a library of resource links, and CMS contact information**.** Plans may access the web portal at www.pwsops.com**.** Figure 2C illustrates the home screen of the PWSOPS web portal.

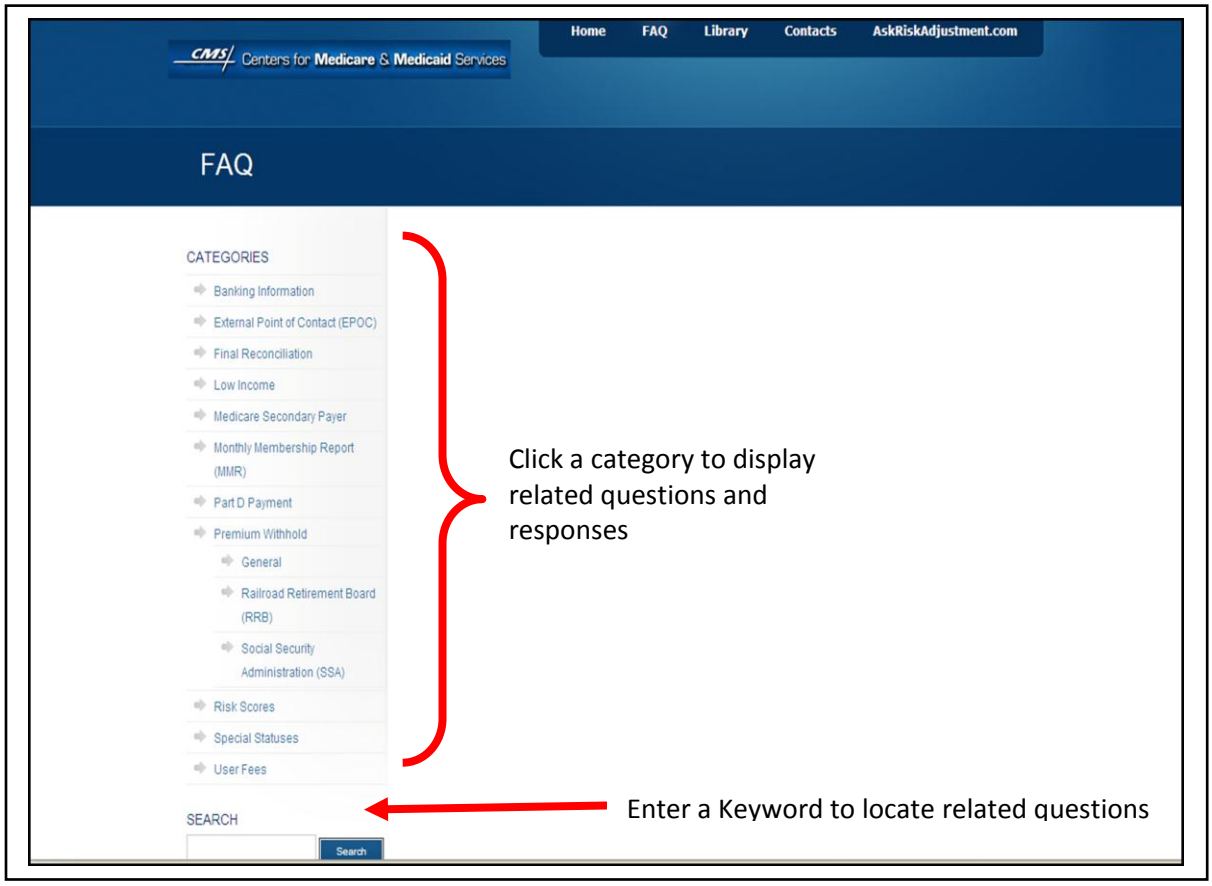
Figure 2C – Premium Withhold and Payment Operations (PWSOPS) Web Portal



2.5.1 PWSOPS – FAQs

CMS developed a database of questions received from Plans regarding all aspects of payment (excluding risk adjustment). The web portal provides access to the responses to these questions. The web portal organizes the questions by category. Figure 2D demonstrates the FAQ page.

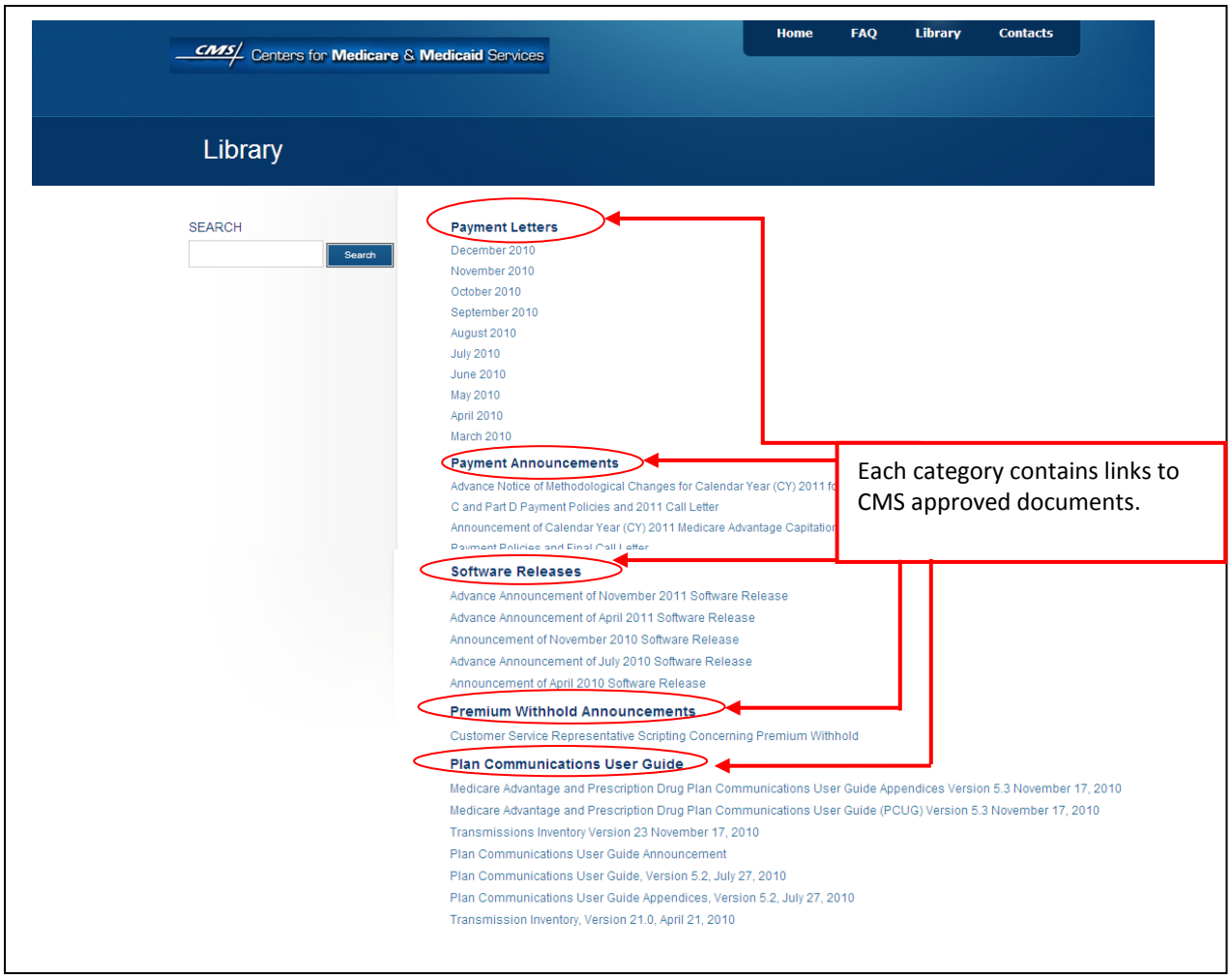
Figure 2D – PWSOPS FAQs



2.5.2 PWSOPS – Library

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

Figure 2E – PWSOPS Library Page



2.5.3 PWSOPS – Contacts Page

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

Figure 2F – PWSOPS Contacts Page*

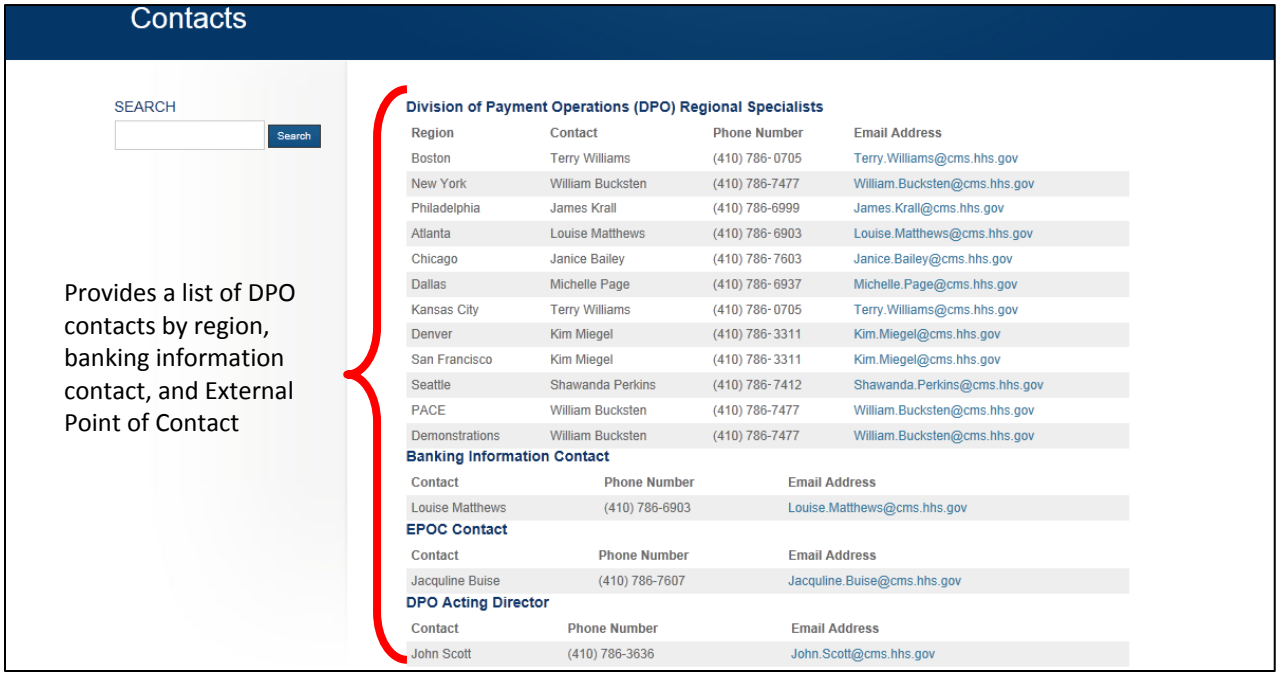


*Image as of August 2012. Access the www.pwsops.com to view updated contacts.

MODULE 3 – MONTHLY MEMBERSHIP REPORT

Purpose

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

Learning Objectives

At the completion of this module, participants will be able to:
- Describe the versions of the MMR
- Identify the payment-related fields on the MMR that map to the PPR
- Explain the fields and functions of report
- Recognize most recent enhancements to MMR

ICON KEY	
Definition	
Example	
Reminder	
Resource	

3.1 Overview

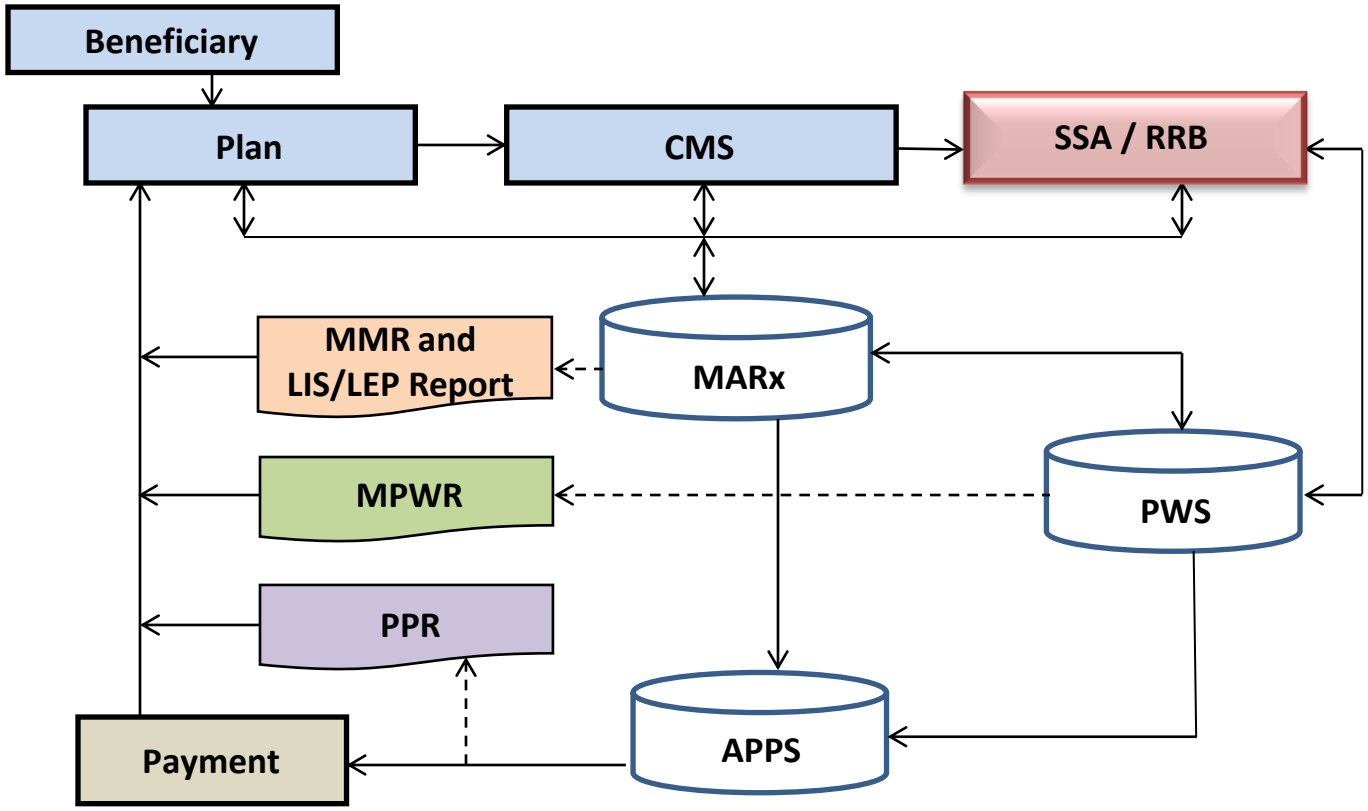
The MMR provides beneficiary-level information to Plans monthly and is available in both a report and detailed data file format. The payment reported on the MMR is the capitated payment for each beneficiary enrolled in the Plan.

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

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

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

Figure 3A – Flow of Data



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

TABLE 3A – MMR REPORT VERSIONS

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

3.2 Monthly Membership Detail Report Layout

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

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

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

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

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

3.2.1 Monthly Membership Detail Report Layout – Non-Drug

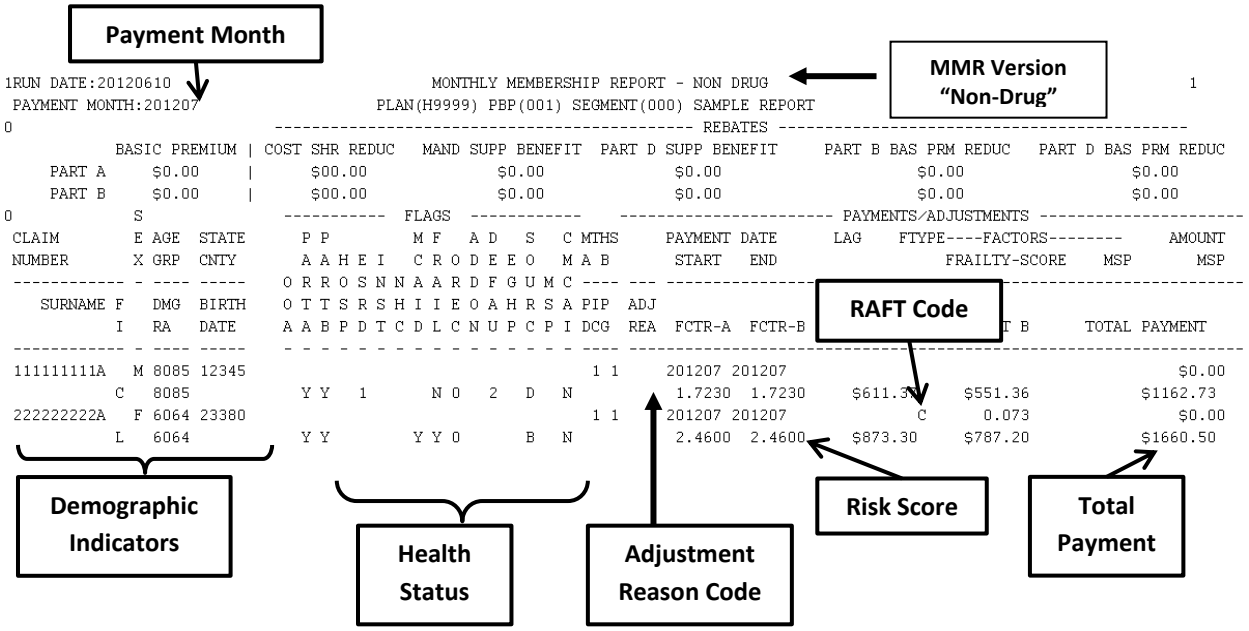
The non-drug MMR report lists all beneficiaries enrolled in the Plan as of a specific month. The payment amounts listed on the report are displayed as Part A and Part B for each beneficiary. This is consistent with how the Plan's capitated payment is displayed in Table 1 of the PPR on the plan-level.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

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

Effective August 2011, the MMR includes the plan-specific payment rate for Part A and Part B in Fields 89 and 90 on the MMR Data File. The plan-specific rates include the star rating the plan receives based on the 5-star rating scale. The plan-specific payment rates are multiplied by the Part A and Part B risk factors (Fields 24 and 25 on the MMR Data File) to determine the Risk Adjusted portion of the capitated payment.

Figure 3B illustrates a sample of the non-drug MMR report layout highlighting some of the features of the report.

Figure 3B — Sample Non-Drug Monthly Membership Report



1RUN DATE:20120610 MONTHLY MEMBERSHIP REPORT - NON DRUG 1
PAYMENT MONTH:201207 PLAN(H9999) PBP(001) SEGMENT(000) SAMPLE REPORT

0 ---------- 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	$00.00	$0.00	$0.00	$0.00	$0.00
PART B	$0.00	$00.00	$0.00	$0.00	$0.00	$0.00

0 S ---------- FLAGS ---------- ---------- PAYMENTS/ADJUSTMENTS ----------

CLAIM NUMBER	E X	AGE GRP	STATE CNTY	P A	P A	H R	E O	I S	C N	M H	F A	A P	D T	E C	E D	O I	M C	B	PAYMENT DATE START	END	LAG	FTYPE----FACTORS-------- FRAILTY-SCORE	AMOUNT MSP	AMOUNT MSP
SURNAME	F I	DMG RA	BIRTH DATE	O A	T A	T B	S P	R D	S T	H C	I D	I L	E C	O N	A U	H P	R C	S P	A I	PIP DCG	ADJ REA					
111111111A	M	8085	12345																	1 1		201207	201207			$0.00
	C	8085		Y	Y	1			N	0	2		D		N							1.7230	1.7230	$611.30	$551.36	$1162.73
222222222A	F	6064	23380																	1 1		201207	201207			$0.00
	L	6064		Y	Y				Y	Y	0		B		N							2.4600	2.4600	$873.30	$787.20	$1660.50

3.2.2 Monthly Membership Detail Report Layout – Drug

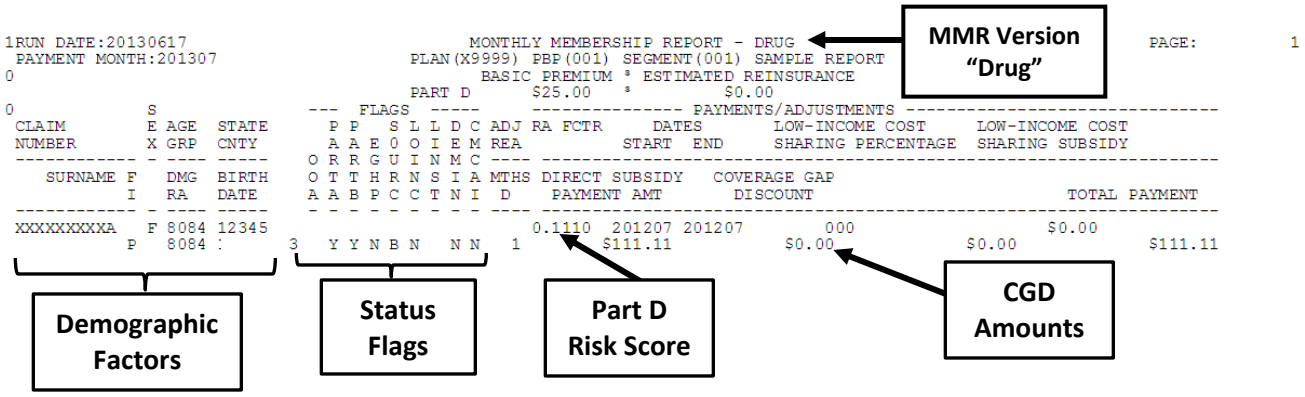
The Part D MMR Drug Report lists every Part D Medicare member of the Plan and provides details about the payments and adjustments made for each. The MMR Detail Drug Report follows the same format as the non-Drug version; however, it includes information specific to the Part D benefit.

To accommodate the Coverage Gap Discount (CGD) Program, established under the Affordable Care Act (ACA) in 2011, CMS adjusted the MMR to include fields specific to the Coverage Gap. As a Part D payment component, the CGD is included in summaries of the Total Part D Payment in the MMR beginning with 2011 payments. Both the detail and summary versions of the MMR include a separate payment bucket for the CGD payment component.

In August 2011, CMS began reporting the Part D payment rate on the MMR in Field 91, which is used in determining the Part D risk adjusted payment.

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

Figure 3C — Sample Drug Monthly Membership Report



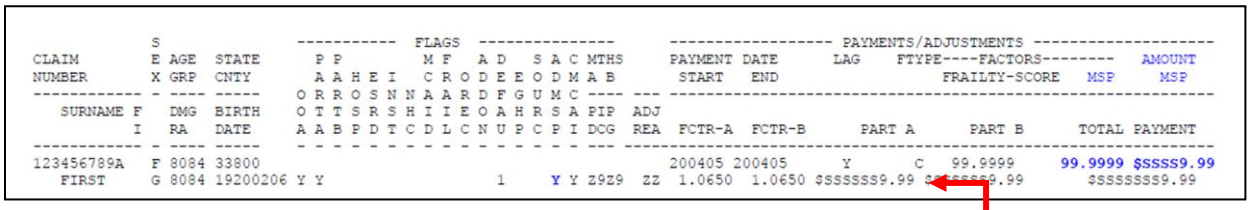
NOTE: PACE PLANS DO NOT RECEIVE CGD PAYMENTS AND CONTINUE TO RECEIVE THE "OLD" FORMAT OF THIS REPORT.

3.2.3 Reconciling the Capitated Payment Using the MMR

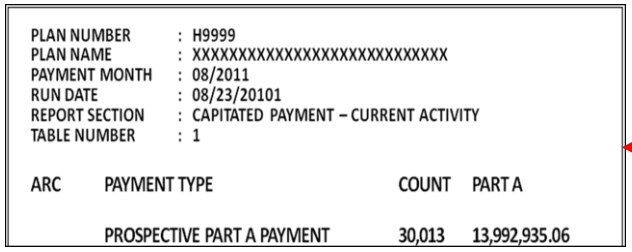
All capitated payments for each enrollee in the plan are summed and reported on Table 1 of the PPR. Plans can roll-up beneficiary-level payments reported on the MMR to reconcile the capitated payment reported on the PPR. Figure 3D illustrates a snapshot of the MMR and a snapshot of Table 1 of the PPR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

Figure 3D – Capitated Payment MMR - PPR

MMR Snapshot



PPR Snapshot



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

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

3.2.3.1 Beneficiary Information

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

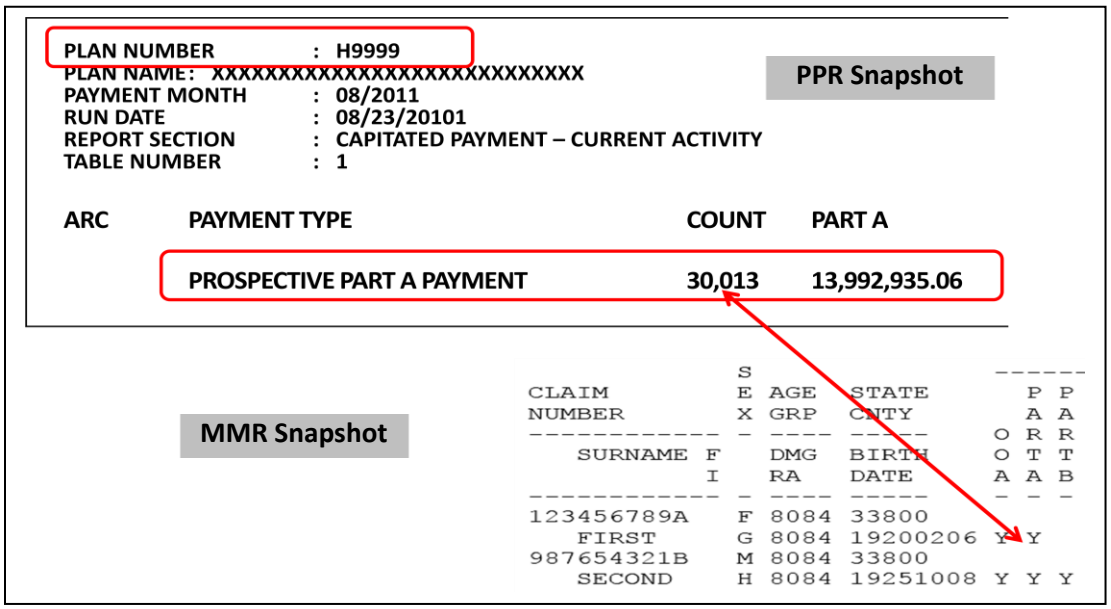
Table 3B describes the beneficiary information in this section of the report.

TABLE 3B – BENEFICIARY INFORMATION

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

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

Figure 3E – MMR Beneficiary Information/PPR Count Information



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

Exception
There is an exception to the member count equaling the member count on the MMR, and as a result the payments are affected. There can be a difference in the member count for Parts A/B and Part D on the PPR where it does not equal the member count on the MMR. The member count for Part D on the MMR could be higher than the member count for Part D on the PPR. The exception occurs when calculating the Direct Subsidy. When the Direct Subsidy equals the plan premium, the Direct Subsidy dollars paid to the plan are zero because the premium is subtracted from the Direct Subsidy. The formula for Direct Subsidy is (Part D Rate*Part D Risk Factor) – Part D Premium.

As a result, plans may also notice that the Part D risk score is populated with zero (0). Part D risk scores are only populated on the MMR if the beneficiary has Direct Subsidy as a non-zero (>0) amount.

Therefore, when the Direct Subsidy dollars for the beneficiary is zero, they are not included in the sum count of Part D payments on the PPR.

3.2.3.2 Flags/Indicators

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

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

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

Prior to 2011, the Part D payment included multipliers for low income and long term institutional status. Effective 2011, instead of a base model with multipliers for low income and long term institutional status, the RxHCC model has five sets of coefficients: long term institutional, aged low income, aged non-low income, disabled low income, and disabled non-low income. CMS publishes the factors in the Payment Announcement at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. LTI applies to both Parts C and D payments.

Example 1: In May 2010, Plan sponsor Apple Health has an enrollee with a Low-Income (LI) Indicator. On the June MMR the enrollee has both the LI Indicator and the Long Term Institutional (LTI) Indicator. Under Part D, an enrollee cannot receive payment for both LI and LTI. When calculating the Part D risk score, only the LTI coefficients will be used in the calculation because when a beneficiary has both, LTI takes precedence over LI status.

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

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

Note: In either case, payment is still based upon the LTI status. For the 2011 payment year and forward, refer to Field #87, Part D RAFT code, to verify inclusion of the LTI status. The Part D RAFT code is not available on the report layout version of the MMR.

Risk Adjustment Factor Type (RAFT)

The MMR reports the factor type for Part C on the non-drug MMR (Field 47) and the Part D factor type (Field 87) on the drug MMR. The factor type informs Plans the model used in calculating payments. The models include new enrollee, institutionalized, community, low income, various ESRD models, and PACE (for 2012 and beyond). Each model applies different factors. Therefore, awareness of the model used for each beneficiary is imperative in calculating accurate payment. Table 3C lists the Factor Type code and descriptions for Part C and Part D.

TABLE 3C – FACTOR TYPE/DESCRIPTIONS

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

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

New Enrollee RAFT Codes vs. Default Risk Factor Codes
Similar to understanding RAFT codes effect on the appropriate risk adjustment model and payment, it is important to understand Default Risk Factor Codes.

A New Enrollee factor is used when a beneficiary is newly eligible to Medicare and has less than 12 months of Part B coverage. This is because the enrollee does not have a full 12 months of diagnoses that can be used to calculate a risk score for full risk beneficiaries. In this case, the Risk Adjustment System (RAS) generates a New Enrollee risk score and identifies the RAFT Code in Field 47 of the MMR data file as indicated above.

Beneficiaries with less than 12 months of Part B will get the new enrollee risk score, except for the small number of Part A only beneficiaries that the plan can opt to get paid full risk. In this case, a default factor is generated by the system due to the lack of a risk adjustment factor for these beneficiaries and flagged in Field 23 of the MMR with the type of default enrollee. A default factor can also be assigned for new enrollment in Medicare after the model run, change in status (i.e., new to ESRD), a change in HIC number, or in rare cases when there is a lapse in Part B coverage (i.e., when a beneficiary has not paid their premium).

While the New Enrollee and Default codes are triggered for different reasons, they link to the same tables for relative factors for the beneficiaries. So, in calculating the risk score for two beneficiaries, one with RAFT code E1 and one with Default Risk Factor Code 5, the same table of relative factors is used. Table 3D maps the Default Risk Factor Codes to the RAFT codes.

TABLE 3D – DEFAULT RISK FACTOR TO RAFT CODE

Default Risk Factor Code	Description	RAFT Code
1	Default/New Enrollee - Aged/Disabled	E
2	Default/New Enrollee - ESRD dialysis	ED
3	Default/New Enrollee - ESRD Transplant Kidney, Month 1	G1
4	Default/New Enrollee - ESRD Transplant Kidney, Months 2-3	G2
5	Default/New Enrollee - ESRD Post Graft, Months 4-9	E1
6	Default/New Enrollee - ESRD Post Graft, 10+Months	E2
7	Default/New Enrollee - Chronic Care SNP Enrollee	SE

At final payment reconciliation, all beneficiaries enrolled during the payment year receive a RAS-generated risk score.

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

There is no form needed to notify CMS of termination of ESRD benefits. CMS becomes aware of termination:
- 12 months after the last date of dialysis treatment

OR
- 36 months after the month a member has a kidney transplant

Once a beneficiary has begun dialysis, the only way they can lose ESRD status is to regain kidney function and discontinue dialysis without a transplant. This is an extremely rare occurrence.

After having a transplant, a beneficiary that is in Medicare due to age or disability will never lose their ESRD status. After a transplant, the beneficiary goes into functioning graft status and will always have the ESRD flag in MARx and on the reports.

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

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

Example 2: Sunny Day Health Plan identified the ESRD flag on the February 2012 MMR indicating one of the new enrollee members is now flagged as ESRD. The RA Factor Type Code on the MMR is "blank" and the Default Risk Factor Code is "2" (Default New Enrollee - Dialysis). Sunny Day determines that the payment received is the default payment. Sunny Day will receive the payment calculated by the Risk Adjustment System and see a RAFT code of "ED" appear on the MMR in July 2012.

Date of MMR	ESRD Flag	Default Payment	Next Model Run	Mid-Year Payment Adjustment and RAFT Code Reported
February 2012	"Y"	Default Payment Calculated Based on Default Factor Code "2"	March 2012	July 2012

CMS is notified of ESRD status, based on the form (CMS 2728), which identifies ESRD beneficiaries. CMS updated the ESRD flag on the MMR with the appropriate Default Risk Factor Code because it was after the initial model run and before the mid-year model run. The payment system calculated the payment based on the "2" Default Risk Factor Code. While the beneficiary is identified as ESRD, the actual ESRD score is calculated by RAS during the Risk Adjustment System model run for the new enrollee RA Factor Type Code of ED = New Enrollee Dialysis. The model runs three times for a payment year. Data for dates of service July 1 through June 30 of the year prior to the payment year that was submitted by the first Friday of September is reflected in the Initial Payment (January). Data for dates of service January through December of the year prior to payment year that was submitted by the first Friday of March of the payment year is reflected in the Mid-Year Payment (July). The final run/reconciliation includes data submitted by January of the year following the payment year, and is reflected as a lump sum payment in August of the following year. During final reconciliation, ESRD status is reconciled to obtain the most precise month-by-month status. The ESRD actual risk score is based on whether the beneficiary status is dialysis or transplant and that is dependent upon the notification. In the case of post graph beneficiaries, CMS applies the submitted diagnoses.

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

Example 3: Winter Health Plan offers a Part D benefit. When calculating payment in November 2010, the payment calculated did not reflect ESRD. Beginning in January 2011, the Plan is unable to reconcile the direct subsidy payment. The Plan has noticed an ARC 08 and was not sure how it applied to payment.

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

Medicare as Secondary Payer (MSP) Flag

The Medicare as Secondary Payer (MSP) provisions have protected Medicare Trust Funds by ensuring that Medicare does not pay for services and items that certain health insurance or coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare is not responsible for the beneficiary's primary health insurance coverage. Plans with beneficiaries who are working and covered under an employer's insurance policy or under a working spouse's policy receive a reduced payment. MSP adjustments are taken when MSP coverage periods are on file for the beneficiary. The MSP coverage period records are established from a number of reporting sources including other Government agencies.

Payments for Working Aged/Disabled beneficiaries are flagged with a "Y" in Field 16, Aged/Disabled MSP. Payments for Working Aged/Disabled and ESRD beneficiaries where MSP status is applicable show the MSP Reduction Amounts in Fields 83 (for Part A) and 84 (for Part B). The Part A and Part B payments are each multiplied by the MSP factor shown in Field 82. The calculated amounts are then subtracted from the Part A and Part B payments. The Part A and Part B payments are then reduced by the result to determine the final payment.

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

- 'Y' = Aged/Disabled factor applicable to Beneficiary;

OR

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

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

Table 3E illustrates the basic calculation of the Total Part A payment including the MSP reduction.

Table 3E – Total Part A Payment Calculation Formula (MSP)

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

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

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

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

ECRS Batch Submittal File
Plans can also submit an ECRS batch file with other healthcare information (OHI) to CMS *(rather than submittal through the ECRS on-line system).* The file can be submitted through Gentran (through December 2012), TIBCO MFT (January 2013 forward), or Connect:Direct.

The Header Record of the ECRS Flat File Submission layout distinguishes between Part C and Part D submissions. Therefore, depending on whether the plan is submitting for Part C or Part D, the field is populated with a 'C' or 'D'.

In April 2012, CMS announced enhancements to ECRS for Part D plan sponsors. These include new fields related to MSP and a new Prescription Drug Assistance Request transaction for updating or deleting a prescription drug record pertaining to coverage that is supplemental or primary to Part D.

The link below provides the ECRS user manual for instructions on accessing the system.

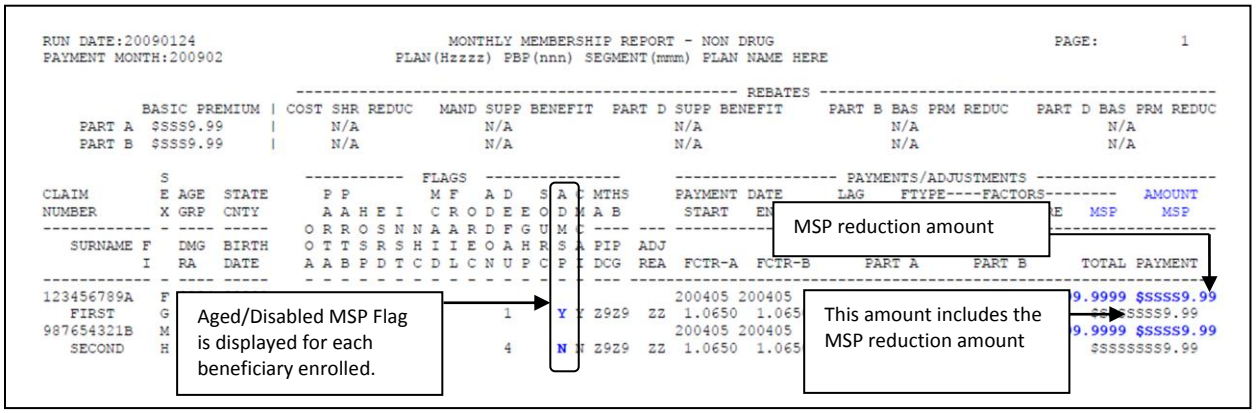
📖 The ECRS User's Guide is available at https://www.cms.gov/manuals/downloads/msp105c05_att1.pdf

Example 4: Rainy Day Health Plan member John DoeRae indicated the Aged/Disabled MSP (Field 16) of "Y". Rainy Day Health Plan's Part A/B Bid was under the benchmark and therefore they also receive an MA Rebate. Rainy Day calculated the risk adjusted payment reported on the MMR in Fields 33 and 34 and added the MA Rebates found in Fields 56-59 and 62-63, but could not reconcile this sum to the amount reported in Field 66, Total MA Payment Amount.

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

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

Figure 3F – MMR - MSP Fields



Hospice Flag

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

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

- Beneficiaries flagged with Hospice
- Beneficiaries flagged with ESRD
- All other beneficiaries

Example 5: Plan Capital Med receives a lower than expected payment for an enrollee. Upon examining the MMR, it is found that the enrollee has received a flag for Hospice, ESRD, Medicaid, and Institutional.

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

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

Example 6: If MA Plan Sunny Day's bid is $400 and the benchmark is $450 and an enrollee has entered hospice. What is the Plan's payment if there are no Part B and Part D premiums?

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

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

3.3 MMR Detail Data File

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

TABLE 3F – BENEFICIARY FLAGS ON THE MMR DETAIL DATA FILE

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

3.3.1 Reconciling PPR Table 1 Payments and Adjustments

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

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

TABLE 3G – MMR/PPR PROSPECTIVE DATA

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

*Fields from Table 5-Summary of the PPR
**PPR does not sum the total Part A and B payments only the full capitated payments including Parts A, B, and D

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

3.3.2 Reconciling PPR Table 1 Adjustment Reason Codes (ARCs)

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

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

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

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

3.3.2.1 Part D Coverage Gap

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

CMS advances CGD payments to plans for 12 months and then annually reconciles the CGD amounts after each payment year. CMS includes the CGD amount in each non-LIS enrollee's Part D monthly prospective payment. CGD prospective payments are adjusted for changes in enrollment and LIS statuses. Prospective CGD payments are included in summaries of the Total Part D Payment in the MMR.

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

Note: Since PACE plans are not paid CGD payments, the PACE MMR Detail Report print format does not include the CGD field.

3.3.3 MMR Payment Data Fields

Table 3H 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 3H – MMR DETAIL FILE DATA MAPPING

	Field Number	Field Name	Actual Payment Data	Key Information Mapping
Medicare Advantage Payment (Part C)		**Part A**		
	33	Risk Adjuster Paymt/Adjustmt Rate A		Field 64
	54	Part C Basic Premium – Part A Amount		Field 64
	56	Rebate for Part A Cost Sharing Reduction		Field 64
	58	Rebate for Other Part A Mandatory Supplemental Benefits		Field 64
	62	Rebate for Part D Supplemental Benefits – Part A Amount		Field 64
	83	MSP Reduction/Reduction Adjustment Amount-Part A		Field 64
	64	**Total Part A MA Payment**	**X**	
		Part B		
	34	Risk Adjuster Paymt/Adjustmt Rate B		Field 65
	55	Part C Basic Premium – Part B Amount		Field 65
	57	Rebate for Part B Cost Sharing Reduction		Field 65
	59	Rebate for Other Part B Mandatory Supplemental Benefits		Field-65
	63	Rebate for Part D Supplemental Benefits – Part B Amount		Field-65
	84	MSP Reduction/Reduction Adjustment Amount-Part B		Field 65
	65	**Total Part B MA Payment**	**X**	
	66	**Total MA Payment Amount**	**X**	

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

	Field Number	Field Name	Actual Payment Data	Key Information Mapping
Prescription Drug Payment (Part D)		**Part D**		
	35	LIS Premium Subsidy		Field-77
	72	Rebate for Part D Basic Premium Reduction		Field-77
	73	Part D Basic Premium Amount – For Payment Purposes		Field-74
	74	Part D Direct Subsidy Payment Amount		Field-77
	75	Reinsurance Subsidy Amount		Field-77
	76	Low-Income Subsidy Cost-Sharing Amount		Field-77
	79	PACE Premium Add On		Field-77
	80	PACE Cost Sharing Add-On		Field-77
	86	Part D Coverage Gap Discount Amount		Field 74
	77	**Total Part D Payment**	**X**	
MA Rebate Accounting				
	56	Rebate for Part A Cost Sharing Reduction		
	57	Rebate for Part B Cost Sharing Reduction		
	58	Rebate for Other Part A Mandatory Supplemental Benefits		
	59	Rebate for Other Part B Mandatory Supplemental Benefits		
	60	Rebate for Part B Premium Reduction – Part A Amount		X
	61	Rebate for Part B Premium Reduction – Part B Amount		X
	62	Rebate for Part D Supplemental Benefits – Part A Amount		
	63	Rebate for Part D Supplemental Benefits – Part B Amount		
	72	Rebate for Part D Basic Premium Reduction		
		Total MA Rebate Amount		
Factors and Multipliers				
	67	Part D RA Factor		Field-74
	68	Part D Low-Income Indicator		Field-74
	69	Part D Low-Income Multiplier (Prior to January 2011)*		Field-74
	70	Part D Long Term Institutional Indicator		Field-74
	71	Part D Long Term Institutional Multiplier (Prior to January 2011)*		Field-74

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

3.3.4 Capitated Payments, Rebates, and Premiums

CMS makes capitated payments to health plans that provide Medicare Parts A, B and D benefits for Medicare beneficiaries enrolled in their plans. For Medicare Parts A and B, beneficiaries can select traditional Medicare Fee-for-Service (FFS) or a Medicare Advantage (MA) plan. For Part D, beneficiaries can choose to receive all three-benefit types (Medicare Parts A, B, and D) by enrolling in a Medicare Advantage-Prescription Drug (MA-PD) plan. Alternatively, beneficiaries opting to enroll in FFS for Parts 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 3I.

TABLE 3I – 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 and is subtracted from the Risk Adjusted Payment.

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

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

Example 7: Summer MA organization created an internal reports to reconcile beneficiary-level payment amounts for each of the following plan types offered:

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

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

Since the calculation is slightly different for each plan type based on the bid/benchmark relations or plan type the report displays the payment amounts received for five different beneficiaries enrolled in the five different plans listed above. Based on an April 2012 MMR, Summer MA Organization calculates the beneficiary level payment for Rain MA-PD plan, shown in Table 3J as "#1 Rain MA-PD, Part A/B Bid< BM".

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

Step 1: Calculate Part A Payment

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

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

Step 2: Calculate Part B Payment

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

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

Step 3: Calculate Total MA Payment

Summer will then add the amounts of the Total Part A ($107.17) plus the Total Part B ($100.50) for this beneficiary that results in the Total MA payment amount of $207.67.

Step 4: Calculate Part D Payment

Since the beneficiary also receives Part D benefits and is enrolled as an LIS beneficiary, Summer Plan will also calculate the Part D portion of payment.

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

Step 5: Calculating the Total Payment

To obtain the final payment for the beneficiary, Summer will add all total amounts from Steps 1, 2, and 4.

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

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

Calculating MA Rebate Accounting

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

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

TABLE 3J – SUMMER MA ORGANIZATION PLAN EXAMPLES (APRIL 2012)

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

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

MMR Field Number and Field Name Listed By Payment Type	#1. Rain MA-PD, Part A/B Bid < BM	#2. Snow MA-PD, Part A/B Bid > BM	#3. Storm MA Only, Part A/B Bid < BM	#3. Storm MA Only, Part A/B Bid = BM	#4. Winter PACE Plan, Dual Eligible Beneficiary	#5. Sunny Prescription Drug Plan (PDP)
Prescription Drug Payment (Part D)						
35. LIS Premium Subsidy		$ 26.00			$ 26.00	$ 26.00
72. Rebate for Part D Basic Premium Reduction						
75. Reinsurance Subsidy Amount	$ 85.00	$ 85.00			$ 85.00	$ 85.00
76. Low-Income Subsidy Cost-Sharing Amount	$ 115.00	$ 115.00			$ 115.00	$ 115.00
74. Part D Direct Subsidy Payment Amount	$ 47.25	$ 47.25			$ 47.25	$ 47.25
79. PACE Premium Add-On					$ (+) 45.00	
80. PACE Cost Sharing Add-On					$ (+) 60.00	
86. Part D Coverage Gap Discount Amount	$ 25.00					
77. Total Part D Payment	**$ 277.25**	**$ 273.25**			**$ 378.25**	**$ 273.25**
MA Rebate Accounting						
56. Rebate for Part A Cost Sharing Reduction	$ 15.00	$ -	$ 10.00	$ -	$ -	$ -
57. Rebate for Part B Cost Sharing Reduction	$ 14.00	$ -	$ 8.00	$ -	$ -	$ -
58. Rebate for Other Part A Mandatory Supplemental Benefits	$ 7.00	$ -	$ 16.00	$ -	$ -	$ -
59. Rebate for Other Part B Mandatory Supplemental Benefits	$ 6.50	$ -	$ 14.00	$ -	$ -	$ -
60. Rebate for Part B Premium Reduction – Part A Amount	$ 10.00		$ 10.00			
61. Rebate for Part B Premium Reduction – Part B Amount	$ 10.00		$ 9.00			
62. Rebate for Part D Supplemental Benefits – Part A Amount	$ 6.00	$ -	$ -	$ -	$ -	$ -
63. Rebate for Part D Supplemental Benefits – Part B Amount	$ 5.70	$ -	$ -	$ -	$ -	$ -
72. Rebate for Part D Basic Premium Reduction	$ 5.00		$ -	$ -	$ -	$ -
XX. Total MA Rebate Amount	**$ 79.20**		**$ 67.00**	**$ -**	**$ -**	**$ -**

NOTES

1: Rebate for Part B Premium Reduction not included in MA Payment (60/61), Provided for information purposes only. Rebate for Part D Basic Premium Reduction added to D Payment (72).
2: Part C Basic Premium deducted from MA Payment, no MA Rebate (54/55).
3: Rebates for Part D not available (62/63/72).
4: No MA Rebate available, PACE Add-On payments for Dual Eligibles (79/80).
5: No MA Rebate available, no MA payment (66).

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

3.3.4.1 Premium Settlement

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

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

Table 3K – MMR/PPR Reconciling Part D Low Income Premium Subsidy

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

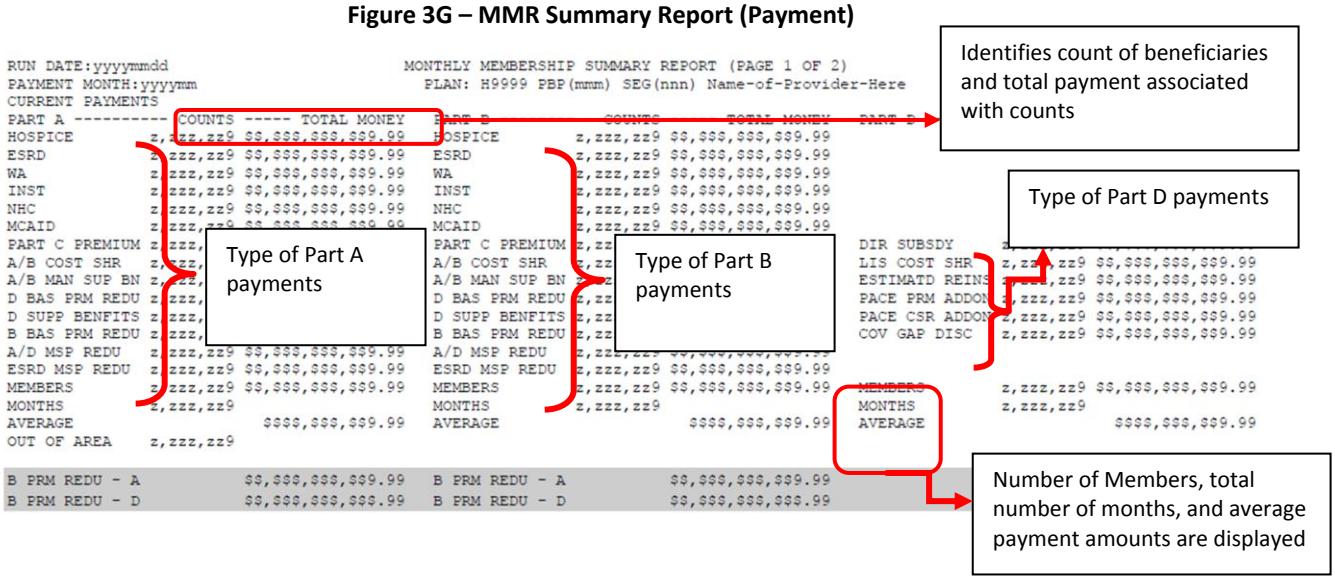
3.4 MMR Summary Report

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

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

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

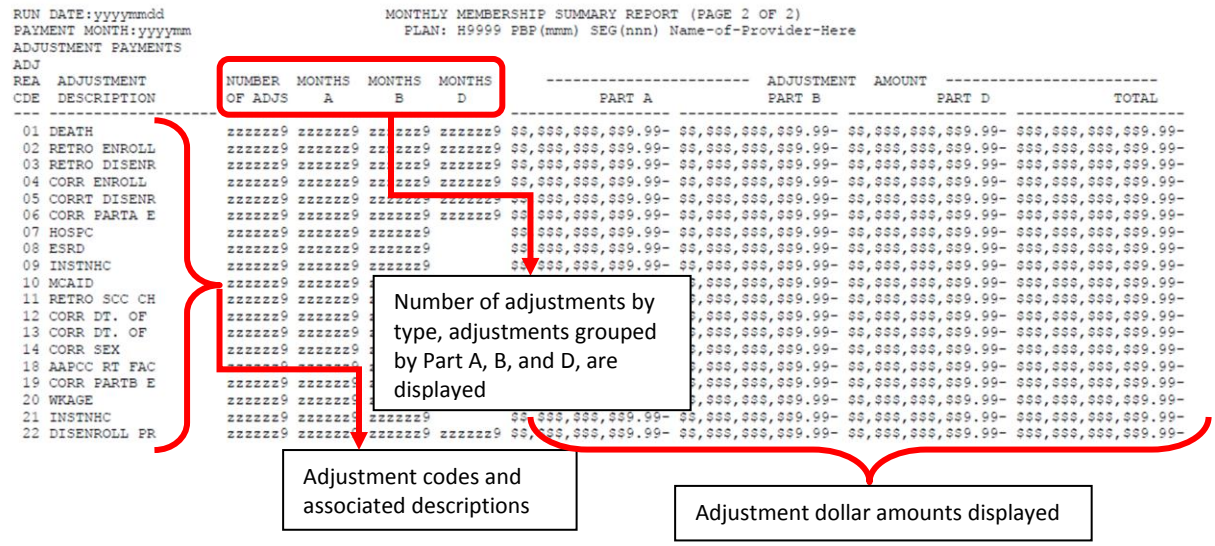
Figure 3G – MMR Summary Report (Payment)



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

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

Figure 3H – MMR Summary Report (Adjustment)



3.5 MMR Enhancements

With the implementation of the Financial Alignment Demonstrations in 2013, CMS is currently evaluating the systems and reports to determine the potential impacts. As CMS determines the impacts to the MMR, CMS will communicate to Plans through HPMS notices, monthly Payment Letters, and the Software Releases.

Appendix: Monthly Membership Report (MMR) Detail Data File

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE

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

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (CONTINUED)

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

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
23	Default Risk Factor Code	1	71 - 71	• Prior to 2004, 'Y' indicates a new enrollee risk adjustment (RA) factor was in use. • In the period 2004 through 2008, 'Y' indicates that a default factor was generated by the system due to lack of a RA factor. • For 2009 and after, for payments and payment adjustments and regardless of the effective date of the adjustment, the following applies: '1' = Default Enrollee- Aged/Disabled '2' = Default Enrollee- ESRD dialysis '3' = Default Enrollee- ESRD Transplant Kidney, Month 1 '4' = Default Enrollee- ESRD Transplant Kidney, Months 2-3 '5' = Default Enrollee- ESRD Post Graft, Months 4-9 '6' = Default Enrollee- ESRD Post Graft, 10+Months '7' = Default Enrollee Chronic Care SNP Blank = The beneficiary is not a default enrollee.
24	Risk Adjuster Factor A	7	72 - 78	NN.DDDD
25	Risk Adjuster Factor B	7	79 - 85	NN.DDDD
26	Number of Paymt/ Adjustmt Months Part A	2	86 - 87	99
27	Number of Paymt/ Adjustmt Months Part B	2	88 - 89	99
28	Adjustment Reason Code	2	90 - 91	FORMAT: 99 Always Spaces on Payment and MSA Deposit or Recovery Records
29	Paymt/Adjustment/MSA Start Date	8	92 - 99	FORMAT: YYYYMMDD
30	Paymt/Adjustment/MSA End Date	8	100 - 107	FORMAT: YYYYMMDD
31	Demographic Paymt/ Adjustmt Rate A	9	108 - 116	FORMAT: -99999.99 Prior to 2008, Demographic Paymt/Adjustmt Rate A is displayed. In 2008 and beyond, Demographic Paymt/Adjustmt Rate A is displayed as 0.00.
32	Demographic Paymt/ Adjustmt Rate B	9	117 - 125	FORMAT: -99999.99 Prior to 2008, Demographic Paymt/Adjustmt Rate B is displayed. In 2008 and beyond, Demographic Paymt/Adjustmt Rate B is displayed as 0.00.
33	Monthly Paymt/ Adjustmt Amount Rate A	9	126 - 134	Part A portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
34	Monthly Paymt/Adjustmt Amount Rate B	9	135 - 143	Part B portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
35	LIS Premium Subsidy	8	144 - 151	FORMAT: -9999.99

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
36	ESRD MSP Flag	1	152 - 152	As of January 2011: T = Transplant/Dialysis P = Post Graft Blank = ESRD MSP not applicable Prior to 2011: Format X. Values = 'Y' or 'N'(default) Indicates if Medicare is the Secondary Payer
37	MSA Part A Deposit/Recovery Amount	8	153 - 160	MSA lump sum Part A dollars for deposit/recovery. Deposits are positive values; recoveries are negative. FORMAT: -9999.99
38	MSA Part B Deposit/Recovery Amount	8	161 - 168	MSA lump sum Part B dollars for deposit/recovery. Deposits are positive values; recoveries are negative. FORMAT: -9999.99
39	MSA Deposit/Recovery Months	2	169 - 170	Number of months associated with MSA deposit or recovery dollars
40	Current Medicaid Status	1	171 - 171	Beginning in mid-2008, this field reports the beneficiary's current Medicaid status. (Prior to 11/07, Medicaid status was reported in Field #19.) '1' = Beneficiary is determined as Medicaid as of current payment month minus two (CPM –2) or minus one (CPM – 1), '0' = Beneficiary was not determined as Medicaid as of current payment month minus two (CPM – 2) or minus one (CPM – 1), Blank = This is a retroactive transaction and Medicaid status is not reported. The four sources to determine Current Medicaid Status are: 1. MMA State files or Dual Medicare Table 2. Low Income Territory Table 3. Medicaid Eligibility Table (Only valid records with a Medicaid source code of "003U" and "003C" are used.) 4. Point of Sale Table
41	Risk Adjuster Age Group (RAAG)	4	172 - 175	BBEE BB = Beginning Age EE = Ending Age Beginning in 2011, if the risk adjuster factor is from RAS, the Risk Adjuster Age Group reported is the one used by RAS in calculating the risk factor
42	Previous Disable Ratio (PRDIB)	7	176 - 182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – Only on pre-2004 adjustments
43	De Minimis	1	183 - 183	Prior to 2008, flag is spaces. Beginning 2008: 'N' = "de minimis" does not apply, 'Y' = "de minimis" applies.
44	Beneficiary Dual and Part D Enrollment Status Flag	1	184 - 184	'0' – Non-Drug Plan without drug benefit, beneficiary not dual enrolled '1' – Drug Plan with drug benefit, beneficiary not dual enrolled '2' – Non-Drug Plan without drug benefit, beneficiary dual enrolled '3' – Drug Plan with drug benefit, beneficiary dual enrolled.
45	Plan Benefit Package Id	3	185 - 187	Plan Benefit Package Id FORMAT 999

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
46	Race Code	1	188 - 188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
47	RA Factor Type Code	2	189 - 190	Type of factors in use (see Fields 24-25): C = Community C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) E1 = New Enrollee Post-Graft I (ESRD) E2 = New Enrollee Post-Graft II (ESRD) G1 = Graft I (ESRD) G2 = Graft II (ESRD) I = Institutional I1 = Institutional Post-Graft I (ESRD) I2 = Institutional Post-Graft II (ESRD) SE = New Enrollee Chronic Care SNP
48	Frailty Indicator	1	191 - 191	Y = MCO-level Frailty Factor Included
49	Original Reason for Entitlement Code (OREC)	1	192 - 192	0 = Beneficiary insured due to age 1 = Beneficiary insured due to disability 2 = Beneficiary insured due to ESRD 3 = Beneficiary insured due to disability and current ESRD 9 = None of the above
50	Lag Indicator	1	193 - 193	Y = Encounter data used to calculate RA factor lags payment year by 6 months
51	Segment ID	3	194 - 196	Identification number of the segment of the PBP. Blank if there are no segments.
52	Enrollment Source	1	197 - 197	The source of the enrollment. Values are: A = Auto-enrolled by CMS, B = Beneficiary election, C = Facilitated enrollment by CMS, D = Systematic enrollment by CMS (rollover)
53	EGHP Flag	1	198 - 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. FORMAT: -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. FORMAT: -9999.99

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
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. FORMAT: -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. FORMAT: -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. FORMAT: -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. FORMAT: -9999.99
60	Rebate for Part B Premium Reduction – Part A Amount	8	247 - 254	The Part A amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non-ESRD members and it is subtracted from ESRD member's payments. FORMAT: -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. FORMAT: -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. FORMAT: -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. FORMAT: -9999.99
64	Total Part A MA Payment	10	279 - 288	The total Part A MA payment. FORMAT: -999999.99
65	Total Part B MA Payment	10	289 - 298	The total Part B MA payment. FORMAT: -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. FORMAT: -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 - 317	From 2006 through 2010, an indicator to identify if the Part D Low-Income multiplier is included in the Part D payment. Values are 1 (subset 1), 2 (subset 2) or blank. Beginning 2011, value 'Y' indicates the beneficiary is Low Income, value 'N' indicates the beneficiary is not Low Income for the payment/adjustment being made.
69	Part D Low-Income Multiplier	7	318 - 324	The member's Part D low-income multiplier. NN.DDDD For payment months 2011 and beyond, this field is zero.

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
70	Part D Long Term Institutional Indicator	1	325 - 325	From 2006 through 2010, an indicator to identify if the Part D Long-Term Institutional multiplier is included in the Part D payment. Values are A (aged), D (disabled) or blank. For payment months 2011 and beyond, this field is blank.
71	Part D Long Term Institutional Multiplier	7	326 - 332	The member's Part D institutional multiplier. NN.DDDD For payment months 2011 and beyond, this field is zero.
72	Rebate for Part D Basic Premium Reduction	8	333 - 340	Amount of the rebate allocated to reducing the member's basic Part D premium. FORMAT: -9999.99
73	Part D Basic Premium Amount	8	341 - 348	The Plan's Part D premium amount. FORMAT: -9999.99
74	Part D Direct Subsidy Monthly Payment Amount	10	349 - 358	The total Part D Direct subsidy payment for the member. When POS contract (X is first character of contract number), then it is total POS Direct Subsidy for the member. FORMAT: -999999.99
75	Reinsurance Subsidy Amount	10	359 - 368	The amount of the reinsurance subsidy included in the payment. FORMAT: -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. FORMAT: -999999.99
77	Total Part D Payment	11	379 - 389	The total Part D payment for the member FORMAT: -9999999.99
78	Number of Paymt/Adjustmt Months Part D	2	390 - 391	99
79	PACE Premium Add On	10	392 - 401	Total Part D Pace Premium Add-On amount FORMAT: -999999.99
80	PACE Cost Sharing Add-On	10	402 - 411	Total Part D Pace Cost Sharing Add On amount FORMAT: -999999.99
81	Part C Frailty Score Factor	7	412 - 418	Beneficiary's Part C frailty score factor. NN.DDDD; otherwise, spaces
82	MSP Factor	7	419 - 425	Beneficiary's MSP secondary payor reduction factor. NN.DDDD; otherwise, spaces
83	MSP Reduction/Reduction Adjustment Amount – Part A	10	426 - 435	Net MSP reduction or reduction adjustment dollar amount– Part A FORMAT: SSSSSS9.99
84	MSP Reduction/Reduction Adjustment Amount – Part B	10	436 - 445	Net MSP reduction or reduction adjustment dollar amount – Part B FORMAT: SSSSSS9.99

MONTHLY MEMBERSHIP REPORT DETAIL DATA FILE (CONTINUED)

ITEM	FIELD NAME	SIZE	POSITION	DESCRIPTION
85	Medicaid Dual Status Code	2	446 - 447	Entitlement status for the dual eligible beneficiary. The valid values when Field 40 = 1 are: 01 = Eligible is entitled to Medicare- QMB only 02 = Eligible is entitled to Medicare- QMB AND Medicaid coverage 03 = Eligible is entitled to Medicare- SLMB only 04 = Eligible is entitled to Medicare- SLMB AND Medicaid coverage 05 = Eligible is entitled to Medicare- QDWI 06 = Eligible is entitled to Medicare- Qualifying individuals 08 = Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB,QDWI or QI) with Medicaid coverage 09 = Eligible is entitled to Medicare – Other Dual Eligibles but without Medicaid coverage 99 = Unknown The valid value when Field 40 = 0 is: 00 = No Medicaid Status The valid value when Field 40 is blank is: Blank
86	Part D Coverage Gap Discount Amount	8	448 - 455	The amount of the Coverage Gap Discount Amount included in the payment. FORMAT: -9999.99
87	Part D RA Factor Type	2	456 - 457	Beginning with January 2011 payment, type of factors in use (see Field 67): D1 = Community Non-Low Income Continuing Enrollee, D2 = Community Low Income Continuing Enrollee, D3 = Institutional Continuing Enrollee, D4 = New Enrollee Community Non-Low Income Non-ESRD, D5 = New Enrollee Community Non-Low Income ESRD, D6 = New Enrollee Community Low Income Non-ESRD, D7 = New Enrollee Community Low Income ESRD, D8 = New Enrollee Institutional Non-ESRD, D9 = New Enrollee Institutional ESRD, Blank when it does not apply.
88	Default Part D Risk Factor Code	1	458 - 458	Beginning with January 2011 payment : 1=Not ESRD, Not Low Income, Not Originally Disabled, 2=Not ESRD, Not Low Income, Originally Disabled, 3=Not ESRD, Low Income, Not Originally Disabled, 4=Not ESRD, Low Income, Originally Disabled, 5= ESRD, Not Low Income, Not Originally Disabled, 6= ESRD, Low Income, Not Originally Disabled, 7= ESRD, Not Low Income, Originally Disabled, 8= ESRD, Low Income, Originally Disabled, Blank when it does not apply.
89	Part A Monthly Payment Rate	9	459 - 467	Effective Part A Monthly Payment Rate FORMAT: -99999.99
90	Part B Monthly Payment Rate	9	468 - 476	Effective Part B Monthly Payment Rate FORMAT: -99999.99
91	Part D Monthly Payment Rate	9	477 - 485	Effective Part D Monthly Payment Rate FORMAT: -99999.99
92	Cleanup ID	10	486 - 495	Cleanup Identifier, a reference linking to further documentation about a specific cleanup