.DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Drug and Health Plan Choice
7500 Security Boulevard, Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: October 31, 2008

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations and Demonstrations

FROM: Thomas Hutchinson /s/
Director

SUBJECT: Medicare Advantage Prescription Drug System (MARx) November 2008 Payment – INFORMATION

This letter provides information related to the November 2008 payment scheduled for October 31, 2008, and provides an updated DPO contact list.

2007 Part D Reconciliation

The reconciliation of the 2007 Part D payments is included in the November payment. The net adjustment amount applied in the November payment is +$225M. About 30 plans' monthly payments are not sufficient to offset the amount owed; approximately $240M remains to be offset from future payments.

Payment reconciliation reports were available to the plans on 9/30/2008. If there are any questions about the reports or the reconciliation, please contact CSSC at 877-534-2772.

Cleanup of 2007 Overpayments – PACE Plans

The November 2008 plan payment will include reversing adjustments of 2007 overpayments for a small number of beneficiaries enrolled in PACE plans during 2004. The overpayments were triggered by beneficiary updates that exposed an error in converting data from the 2004 system. The reversals will appear on the Monthly Membership Report under Adjustment Reason Code 18.

Cleanup of Erroneous Payments for Deceased Beneficiaries

A cleanup that continues CMS' efforts to address overpayments associated with deceased beneficiaries was included in the November payment. The impacted beneficiaries will be disenrolled and the associated adjustments will appear on the MMR under reason code 01.

Checking Medicaid Status

Plans have had many questions related to the various Medicaid fields on the MMR. Attached is a table that provides guidance on how to use these fields to determine Medicaid status and impact on the risk adjustment payment. Definitions of these fields are also included for your convenience.

MBD Address Processing

The MBD performed a cleanup to update the address information on its database. As a result, some payment adjustments were created. They will be under adjustment reason code 11 on your MMRs.

Revised DPO Rep Contact List

The Division of Payment Operations and the Division of Prospective Payments would like to remind you to contact your Plan Account Manager for enrollment issues that involve policy, the MMA Help Desk for questions on data communication or technical enrollment issues, and your DPO representative for payment errors or issues directly related to payment processing. Please note a revised DPO contact list is attached.

If you have any questions about the information in this letter please feel free to contact your DPO representative per the attached list.

Attachment

cc: Ms. Marla Kilbourne, CMS
Mr. Randy Brauer, CMS
Ms. Cynthia Tudor, CMS
Ms. Cheri Rice, CMS
DPO

DPO REGIONAL ASSIGNMENTS

Payment Specialist

Boston and New York	William Bucksten (410) 786-7477 William.Bucksten@cms.hhs.gov
Philadelphia:	James Krall (410) 786-6999 James.Krall@cms.hhs.gov
Atlanta:	Joanne Weller (410) 786-5111 Joanne.Weller@cms.hhs.gov
Chicago:	Janice Bailey (410) 786-7603 Janice.Bailey@cms.hhs.gov or Louise Matthews (410) 786-6903 Louise.Matthews@cms.hhs.gov
Dallas:	Joanne Weller (410) 786-5111 Joanne.Weller@cms.hhs.gov
Kansas City And Denver:	Terry Williams (410) 786-0705 Terry.Williams@cms.hhs.gov
San Francisco:	Kim Miegel (410) 786-3311 Kim.Miegel@cms.hhs.gov
Seattle:	Mary Stojak (410) 786-6939 Mary.Stojak@cms.hhs.gov
PACE and And Demos	William Bucksten (410) 786-7477 William.Bucksten@cms.hhs.gov

Checking Medicaid status used in payment

(for a description of fields 19, 21, 23, and 47, please see the end of this document)

If the enrollee is a "full risk" enrollee, i.e., has 12 months of Part B in the data collection period --	Field 47 (RA Factor Type code) = C, C1, C2, D, G1, G2, I, I1, or I2 and Field 23 (Default Risk Factor code) = blank
Medicaid is used in calculating the risk score if enrollee was Medicaid for at least one month in the *data collection* period	Field 19 = blank **Use Field 21 to determine Medicaid status --** Field 21 = Y indicates that Medicaid status was used in calculating the risk score, i.e., at least a one month period of Medicaid eligibility during the *data collection* period was established in CMS systems at the time that risk scores were calculated. Field 21 = blank, indicates that no Medicaid period of eligibility was established in CMS systems during the *data collection* period
If the enrollee is a "new enrollee," i.e., does not have 12 months of Part B in the data collection period – And they were present in the Medicare Beneficiary Database at the time that the Risk Adjustment System (RAS) pulled data for calculating risk scores... A "new enrollee" risk score will be assigned in RAS.	Field 47 (RA Factor Type code) = E, ED, E1, or E2 and Field 23 (Default Risk Factor code) = blank
Medicaid is used in assigning the new enrollee risk score if the enrollee was Medicaid for at least one month in the *payment* year.	Field 19 = blank **Use Field 21 to determine Medicaid status --** Field 21 = Y indicates that Medicaid status was used in assigning the new enrollee risk score, i.e., at least a one month period of Medicaid eligibility during the *payment* year was established in CMS systems at the time that the risk score was assigned. Field 21 = blank indicates that no Medicaid period of eligibility was established in CMS systems during the *payment* year Note: The application of Medicaid status based on Medicaid periods during the payment year will happen at final payment reconciliation (conducted in the year following the payment year). New enrollees who are assigned a RAS risk score during the <u>initial</u> risk score run are assigned Medicaid status if they are Medicaid for at least one month during the lagged data collection period (July-June prior to the payment year) or during any one month after June, but prior to the risk score run. New enrollees who are assigned a RAS risk score during the <u>mid-year</u> risk score run are assigned Medicaid status if they are Medicaid for at least one month during the year prior to the payment year or any one month during the payment year. At final payment reconciliation, Medicaid status will be applied to the final risk score if there is a Medicaid period of at least one month during the payment year.
If the enrollee does not have a RAS-generated risk score, either because –	Field 47 (RA Factor Type code) = blank and

0 the enrollee was <u>not</u> present in the Medicare Beneficiary Database at the time that RAS pulled data for calculating risk scores, i.e., they were neither entitled to Part A nor enrolled in Part B at the time of the risk score run, or 0 the enrollee has RAS factors for community and institutional, but has a newly-reported ESRD status (RAS did not know to generate a CMS-HCC ESRD risk score for the beneficiary) – The payment system will not have the appropriate risk score passed to it from RAS for these beneficiaries; the payment system will assign the appropriate default risk score in these cases (aged/disabled, ESRD).	Field 23 (Default Risk Factor code) = Y Indicates that a default risk score was assigned by the payment system. Starting with January 2009 payment, field 23 will be populated with 1, 2, 3, 4, 5, 6, or blank depending on type of default score used, rather than simply a 'Y' or blank. <u>Note</u>: Default risk scores may be needed throughout the payment year, since RAS may not be able to generate the appropriate risk scores during the initial and mid-year risk score runs. At final payment reconciliation (conducted in the year following the payment year), all beneficiaries enrolled during the payment year – both full risk and new enrollees -- will receive RAS-generated risk scores, i.e., no default risk scores are assigned at final payment reconciliation.
Medicaid is used in assigning the default risk score if the enrollee was Medicaid for at least one month in the *payment year*.	Field 21 = blank **Use Field 19 to determine Medicaid status --** Field 19 = Y indicates that Medicaid status was used in assigning the new enrollee risk score, i.e., at least a one month period of Medicaid eligibility during the *payment* year was established in CMS payment system at the time that the default risk score was assigned. Field 19 = N indicates that no Medicaid period of eligibility was established in CMS systems during the *payment* year Note: For default risk scores assigned to beneficiaries at the beginning of a payment year, the payment system assigns default risk scores using Medicaid if the beneficiary has Medicaid for at least one month in the year previous to the payment year (since payment-year Medicaid status is unknown). During the payment year, the payment system checks quarterly for updates to the Medicaid status of default beneficiaries and adjusts their Medicaid status according to the rules for default enrollees.

Notes: The data collection period is the 12 month period from which CMS uses diagnoses when calculating risk scores. For mid-year and final risk scores, the data collection period is the calendar year prior to the payment year (2007 for 2008 payment year). For initial risk scores (those used for prospective payments from January – June), the data collection period is the July (two years prior) – June (in the year prior to payment year). For example, for 2008 initial risk scores, CMS used July 1, 2006 – June 30, 2007 for the data collection period.

Selected Fields on the MMR Data File

Field	Description
Field 19 – New Medicare Beneficiary Medicaid Status Flag	Prior to calendar 2008, payments and payment adjustments report as follows: **Y** = Medicaid status, **Blank** = not Medicaid. In calendar 2008, payments and payment adjustments were reported as follows: **Y** = Beneficiary is Medicaid and a default risk factor was used, **N** = Beneficiary is not Medicaid and a default risk factor was used, **Blank** = CMS is not using a default risk factor or the beneficiary is Part D only. Beginning in calendar 2009: • Payment adjustments with effective dates in 2008 and after, and all prospective payments report as follows: **Y** = Beneficiary is Medicaid and a default risk factor was used, **N** = Beneficiary is not Medicaid and a default risk factor was used, **Blank** = CMS is not using a default risk factor or the beneficiary is Part D only. • Payment adjustments with effective dates in 2007 and earlier report as follows: **Y** = A payment adjustment was made at a "Medicaid" rate to the demographic component of a blended payment. **N** = A payment adjustment was made to the demographic payment component of a blended payment. The adjustment was not at a "Medicaid" rate. **Blank** = Either the adjusted payment had no demographic component, or only the risk portion of a blended payment was adjusted.
Field 21 – Medicaid Indicator	**Y** = Medicaid Add-on to beneficiary RAS factor **Blank** = No Medicaid Add-on
Field 23 – Default Risk Factor Code (Prior to 2009, this field is referred to as the Default Indicator)	2008 and earlier year **Y**= default RA factor in use For pre-2004 adjustments, a "Y" indicates that a new enrollee RA factor is in use. For 2003-2008 payments and adjustments, a "Y" indicates that a default factor was generated by the system due to lack of a RA factor. Beginning in 2009 **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 4-9 months **6** = Default Enrollee- ESRD Post Graft 10+ months **Blank** = Not a default enrollee - Risk Adjustment
Field 47 – RA Factor Type Code	Type of risk adjustment factor used to calculate the payment or adjustment amount (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) **Blank** – Part C Default risk factor used in the calculation