DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard, Mail Stop C1-05-17
Baltimore, Maryland 21244-1850

Medicare Plan Accountability Group

DATE: March 11, 2005

LETTER TO: All Medicare Advantage (MA) Plans, Part D Plans (PDPs), Cost-Based Organizations and Demonstrations

SUBJECT: 2006 Medicare Advantage and Part D Enrollment and Payment Systems Changes Part I --Action

The purpose of this letter is to begin to provide the operational details of the enrollment and payment system changes related to the implementation of the Medicare Modernization Act (MMA). This letter addresses changes in the following areas:

- enrollment/disenrollment/plan benefit package (PBP) enrollment transactions (including a new 72 change transaction) and
- monthly membership data changes (including premium and rebate amounts).

Future letters will address the new transaction reply codes, the new Plan Premium Report and changes to the Plan Payment Letter.

These systems changes will be discussed during the MA Technical User Group Calls. On the March 11 call, we will go over the membership report changes (See Attachment B of this letter.) The call is from 1:00 – 3:00, eastern time and access is via 1-888-790-9440. The passcode is SOLIEL.

Enrollment/Disenrollment/Change Transactions
Additional data must be collected in order to support the payment, premium withhold and coordination of benefit processing mandated by the MMA. CMS is also adding a new transaction type to report changes to this new data or to provide a mechanism to report it after enrollment. Below is a table clarifying the use of the plan-submitted transactions.

Transaction Type	Purpose
60/61 Enrollment	To submit enrollment information to CMS including premiums, premium withhold option, creditable coverage, secondary insurer, etc.
71 PBP Enrollment	To submit PBP enrollment information to CMS. All information related to an enrollment must be submitted, including the election type.
72 Change	To submit changes to previously provided information or to report information not available at the time of enrollment. The beneficiary identification information, the PBP# and the effective date are required

	fields. The plan will provide information in the remaining fields only if the data is being updated; i.e., the "change to" value.
51 Disenrollment	To submit disenrollment information to CMS including the Part D opt out flag.

The revised layouts are attached along with field reporting requirements. Note that the required fields differ depending on the type of plan.

- **MA-only plans** must report data in the following fields: EGHP, Election Type, Segment ID (if applicable to your plan), the Premium Withhold Option and the Part C Premium amount. These are the "Part C" type fields.

- **Part D-only plans** must report data in the following fields: EGHP, Election Type, Premium Withhold Option, Part D Premium amount, Creditable Coverage data, Employer subsidy override flag, Part D opt out flag, RX IDs/Group numbers and secondary insurer data. These are the "Part D" type fields.

- **MA-PD plans** must report data in all of the Part C and Part D fields.

The following table provides an explanation of the new fields, why they are needed and how they are to be reported.

Data Element	**Reason for Reporting**	**Reporting Transaction Type**
EGHP Flag	To identify EGHP members for tracking and reporting.	60/61 Enrollment, 71 PBP Enrollment, 72 Change
Election Type	To support Enrollment Period editing.	60/61 Enrollment, 71 PBP Enrollment, 51 Disenrollment; 72 Change only if the Premium Withhold Option is being changed (This option can only be changed during an AEP or a SEP.)
Application Date	To support Enrollment Period and Multiple Transaction editing. Note for signed paper enrollment forms, this field is the signature date on the form. For other enrollment mechanisms this field is the date the enrollment request is received by the organization.	60/61 Enrollment, 71 PBP Enrollment
Segment ID	To support payment computation and to determine the plan premium amounts. This field is valid for local MA-only and MA-PD plans that choose to segment their PBPs. If a plan does not have segments, this field is blank.	60/61 Enrollment, 71 PBP Enrollment, 72 Change
Premium Withhold Option/C and D	To determine how plan premiums are to be paid; directly to the plan or withheld from SSA, RRB or OPM benefits. (Refer to the discussion regarding the processing of this field at the end of this	60/61 Enrollment, 71 PBP Enrollment, 72 Change

	table.)	
Part C Premium Amount	The total Part C premium owed by the member; including amounts related to optional supplemental benefits. CMS collects the premiums from SSA/RRB/OPM and forwards them to the plan for members that elect to have them withheld from their benefit checks.	60/61 Enrollment, 71 PBP Enrollment, 72 Change
Part D Premium Amount	The total Part D premium owed by the member. CMS collects the premiums from SSA/RRB/OPM and forwards them to the plan for members that elect to have them withheld from their benefit checks	60/61 Enrollment, 71 PBP Enrollment, 72 Change
Creditable Coverage Flag	Used in determining the higher premium charge for late enrollment.	60/61 Enrollment, 71 PBP Enrollment, 72 Change
Number of Uncovered Months	If a beneficiary fails to enroll in a Part D plan timely, a higher premium is assessed based on the number of months that the individual lacked drug coverage. This data element is used in determining the higher premium amount.	60/61 Enrollment, 71 PBP Enrollment, 72 Change
Employer Subsidy Enrollment Override Flag	To allow enrollment into a Part D plan by an individual that is already covered by an employer subsidized by CMS to provide drug coverage. (Refer to the discussion related to the processing of this data after the end of this table.)	60/61 Enrollment, 71 PBP Enrollment
Part D Opt Out Flag	To allow disenrollment from a Part D plan by an individual that was auto-enrolled into the plan by CMS. This also serves to exclude the beneficiary from future auto-enrollment processing when requested.	51 Disenrollment
RX ID	The ID # assigned to the member by the Part D plan. It supports member out-of-pocket cost determination via claims data collected by CMS.	60/61 Enrollment, 71 PBP Enrollment, 72 Change
RX Group	The Group # assigned to the member by the Part D plan. It supports member out-of-pocket cost determination via claims data collected by CMS	60/61 Enrollment, 71 PBP Enrollment, 72 Change
Secondary Drug Insurance Flag	To support coordination of benefits.	60/61 Enrollment, 71 PBP Enrollment, 72 Change
Secondary Insurer RX ID	The ID # assigned to the member by the secondary insurer. It supports coordination of benefits.	60/61 Enrollment, 71 PBP Enrollment, 72 Change
Secondary Insurer Group ID	The Group # assigned to the member by the secondary insurer. It supports coordination of benefits.	60/61 Enrollment, 71 PBP Enrollment, 72 Change

Premium Withhold Option/Part C and D

The MMA allows beneficiaries to have their Part C and Part D premiums withheld from their monthly benefits received from SSA, RRB or OPM. Beneficiaries can also continue to pay their premiums directly to the plans.

The premium withhold process relies on data reported by the plans and on an interface between SSA/RRB/OPM and CMS. Plans submit premium information for new members on the enrollment transaction and for current members on the new Change Transaction type 72.

The premium payment options for beneficiaries are direct pay to the organization or withhold from a SSA, RRB or OPM benefit check. In the former case, the plan receives payment directly from the member. In the latter case, CMS reimburses the plan after receiving confirmation that a specified premium amount was deducted from the member's benefits. If SSA, RRB or OPM are unable to deduct the full amount of the premium from the benefit check (due to insufficient funds), CMS notifies the plan to bill the member.

There are two rules associated with the premium withhold process; the "all or nothing" rule and the "single payment option" rule.

The **all or nothing** rule is that the entire premium amount due must be able to be deducted from the beneficiary's monthly benefit. Partial deductions are not allowed. No deduction will occur even if a portion of the premium amount due could be withheld. In this situation, CMS will notify the plan to bill the member for the premiums due and for subsequent monthly premiums.

The **single payment option** rule is that, when both a Part C and a Part D premium are applicable, only one payment option can be elected by the member. This rule applies to a single plan enrollment. If a beneficiary is enrolled in two plans, two payment options can be elected.

EXAMPLE

- Beneficiary enrolls in a MA-PD plan for Part C and Part D coverage. The member must elect one payment option.

Part C/D premiums – Withhold from RRB benefit

- Beneficiary enrolls in a Private Fee for Service plan for Part C coverage and a PDP for Part D coverage. The member may elect one or two payment options.

Part C premium – Direct pay
Part D premium – Withhold from SSA benefit

Employer Subsidy Enrollment Override Flag

CMS subsidizes some employers that provide creditable drug coverage to their retirees; therefore, these individuals may not need to enroll in a Part D plan. If such an individual, for whatever reason, chooses to enroll in a Part D plan, it will be allowed. However, to ensure that the individual is cognizant of the consequences of this action, the enrollment will occur in two steps. The initial enrollment must be submitted as usual (i.e., without the Override Flag set). If CMS identifies the individual as covered by creditable

employer group coverage, it will reject the enrollment as incomplete. When the plan receives the rejection, the beneficiary must be notified of the reason. If the beneficiary still wants to enroll in the Part D plan, resubmit the enrollment with the Override flag set to Y and it will be accepted. No enrollment for an individual covered by a subsidized employer will be accepted unless these steps occur in this order.

Correction Transaction Type 01

In order to have a consistent record length across all of the transactions, 103 bytes of filler will be added to the Transaction type 01. See the attached layout. All transactions will now have a length of 183 bytes.

IMPORTANT NOTE - HEADER RECORD FORMAT CHANGE

The current header record format begins with the following header message:

ZZZHEADERZZZ

To facilitate processing the files, the new header message will be:

AAAAAAHEADER.

The remainder of the header record format is unchanged.

Monthly Membership Data Changes

New fields will be added to the Monthly Membership Report (MMR) to support MMA processing related to Parts C and D. Refer to the attached layouts.

Fields related to the computation of the MA payment as well as the Part D risk adjustment factor/payment will be included on the same MMR data file. The following table identifies the new fields.

DATA ELEMENT	**COMMENTS**
Part C Basic Premium Amount	This is the premium amount for determining the MA payment. It is subtracted from the MA plan payment for plans that bid above the benchmark.
Nondrug Rebate Amounts	The amount of the rebate (for plans that bid below the benchmark) applicable to the A/B benefit. This rebate can be allocated into Part A/B cost-sharing reduction, Part A/B mandatory supplemental benefits and Part B Premium Reduction.
Part B Premium Reduction Rate	The amount of the rebate that is being used to reduce the member's Part B Premium. This amount is retained by CMS for nonESRD members, For ESRD members, this amount is subtracted from their payment.
Total MA Payment Amount	This is the total MA payment amount after subtracting the basic premium amount **or** adding the rebate amount (after subtracting the Part B Premium Reduction Amount, if appropriate). This amount also includes the rebate amount for Part D Supplemental benefits. All rebate components except for the rebate allocated to the Part D Basic Premium Reduction are included in the MA Payment. (Note: For ESRD payments (2006 only) the amount of rebate (if any)

	applied to a Part D basic premium reduction will be subtracted from their A/B payment.)
Part D Risk Adjustment Factor	The beneficiary's Part D risk adjustment factor.
Part D Low-Income Indicator	The Part D payment can include one of two low-income multipliers. The values are 1 or 2. This multiplier is not used if the beneficiary also qualifies for the Long Term Institutional multiplier.
Part D Long Term Institutional Indicator	The Part D payment can include one of two long term institutional multipliers. The values are A (aged) or D (disabled). This multiplier is used if the beneficiary also qualifies for the Low income multiplier.
Drug Rebate Amounts	The amount of the MA plan's rebate that is allocated to the Part D benefit. This rebate can be allocated into Part D basic premium reduction and Part D supplemental benefits. Only the amount allocated to the Part D basic premium reduction is included in the Part D payment.
Part D Basic Premium	The Part D premium to be subtracted from the Part D payment.
Reinsurance Subsidy	The amount of the payment related to the reinsurance subsidy.
Low-Income Subsidy Cost-Sharing Amount	The amount of the payment related to low-income subsidy members' cost-sharing.
Total Part D Payment	Total Part D payment for the member.

Note that the Part A/B ESRD risk adjustment factor types are expanded as you were notified last year.

Contact Information

If you have any questions regarding this letter, please contact the central office staff listed for the region where your plan is located.

Boston**:** Jacquline Buise
(410)786-7607
Jbuise@cms.hhs.gov

New York: Juan Lopez
(410)786-7621
Jlopez@cms.hhs.gov

Philadelphia: James Dorsey
(410)786-1143
Jdorsey1@cms.hhs.gov

Atlanta: Gloria Webster
(410)786-7655
Gwebster@cms.hhs.gov

Chicago: Janice Bailey
(410)786-7603
Jbailey1@cms.hhs.gov

Dallas:	Joanne Weller (410)786-5111 Jweller@cms.hhs.gov
Kansas City:	Gloria Webster (410)786-7655 Gwebster@cms.hhs.gov
Denver:	Luigi Distefano (410)786-7611 LDistefano@cms.hhs.gov
San Francisco:	Ed Howard (410)786-6368 Ehoward1@cms.hhs.gov
Seattle:	David Evans (410)786-0412 Devans2@cms.hhs.gov

Sincerely,

Cynthia A. Moreno
Director

ATTACHMENT A – TRANSACTION FORMATS

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (EMPLOYER & MCO) 60/61			DISENROLLMENT 51			PLAN ELECTION (PBP CHANGE) 71			PLAN CHANGE 72*		
				MA	MA-PD	PDP	MA	MA-PD	PDP	MA	MA-PD	PDP	MA	MA-PD	PDP
1	HIC#	12	1 – 12	R	R	R	R	R	R	R	R	R	R	R	R
2	Surname	12	13 – 24	R	R	R	R	R	R	R	R	R	R	R	R
3	First Name	7	25 – 31	R	R	R	R	R	R	R	R	R	R	R	R
4	M. Initial	1	32												
5	Sex	1	33	R	R	R	R	R	R	R	R	R	R	R	R
6	Birth Date (YYYYMMDD)	8	34 – 41	R	R	R	R	R	R	R	R	R	R	R	R
7	EGHP Flag	1	42	blank field has a meaning	blank field has a meaning	blank field has a meaning	N/A	N/A	N/A	blank field has a meaning	blank field has a meaning	blank field has a meaning	blank = no change	blank = no change	blank = no change
8	PBP #	3	43 – 45	R	R	R	N/A	N/A	N/A	R (Change-to value)	R (Change-to value)	R (Change-to value)	R	R	R
9	Election Type	1	46	R	R	R	R	R	R	R	R	R	R for premium withhold option changes; otherwise, N/A	R for premium withhold option changes; otherwise, N/A	R for premium withhold option changes; otherwise, N/A
10	Contract #	5	47 – 51	R	R	R	R	R	R	R	R	R	R	R	R
11	Application Date	8	52 – 59	R	R	R	N/A	N/A	N/A	R	R	R	N/A	N/A	N/A
12	Transaction Code	2	60 – 61	R	R	R	R	R	R	R	R	R	R	R	R
13	Disenrollment Reason (Future Use)	2	62 – 63	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

14	Effective Date (YYYYMMDD)	8	64 – 71	R	R	R	R	R	R	R	R	R	R	R
15	Segment ID	3	72-74	R, blank for non-segmented organizations; otherwise, 3-digits	R, blank for non-segmented organizations; otherwise, 3-digits	N/A	N/A	N/A	N/A	R, blank for non-segmented organizations; otherwise, 3-digits	R, blank for non-segmented organizations; otherwise, 3-digits	N/A	Blank or change-to value for local plans; otherwise, N/A	Blank or change-to value for local plans; otherwise, N/A	N/A
16	Filler	5	75-79	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
17	Prior Commercial Override	1	80	If applies; otherwise, zero or blank	If applies; otherwise, zero or blank	N/A	N/A	N/A	N/A	If applies; otherwise, zero or blank	If applies; otherwise, zero or blank	N/A	N/A	N/A	N/A
18	Premium Withhold Option/ Parts C-D	1	81	R	R	R	N/A	N/A	N/A	R	R	R	blank or change-to value	blank or change-to value	blank or change-to value
19	Part C Premium Amount (XXXXvXX)	6	82 – 87	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value	N/A
20	Part D Premium Amount (XXXXvXX)	6	88 – 93	N/A	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
21	Creditable Coverage Flag	1	94	N/A	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
22	Number of Uncovered Months	3	95-97	N/A	R, blank = zero, meaning no uncovered months	R, blank = zero, meaning no uncovered months	N/A	N/A	N/A	N/A	R, blank = zero, meaning no uncovered months	R, blank = zero, meaning no uncovered months	N/A	Blank or change-to value	Blank or change-to value
23	Employer Subsidy Enrollment Override Flag	1	98	N/A	R if beneficiary has Employer Subsidy status; otherwise blank	R if beneficiary has Employer Subsidy status; otherwise blank	N/A	N/A	N/A	N/A	R if beneficiary has Employer Subsidy status; otherwise blank	R if beneficiary has Employer Subsidy status; otherwise blank	N/A	N/A	N/A

24	Part D Opt-Out Flag	1	99	N/A	N/A	N/A	N/A	R for auto-enrollees only; otherwise, N/A	R for auto-enrollees only; otherwise, N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	Rx ID	11	100-110	N/A	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
26	Rx Group	12	111-122	N/A	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
27	Secondary Drug Insurance Flag	1	123	N/A	R (Blank if auto-enroll)	R (Blank if auto-enroll)	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
28	Secondary Rx ID	11	124-134	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	N/A	N/A	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	R if secondary insurance change-to value is Y	R if secondary insurance change-to value is Y
29	Secondary Rx Group	12	135-146	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	N/A	N/A	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	R if secondary insurance change-to value is Y	R if secondary insurance change-to value is Y
30	Enrollment Source	1	147	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER
31	SSN	9	148-156	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	FILLER	FILLER	FILLER
32	Trustee Routing Number	9	157-165	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	Blank or change-to value	FILLER	FILLER
33	Bank Account Number	17	166-182	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	Blank or change-to value	FILLER	FILLER
34	Bank Account Type	1	183	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	Blank or change-to value	FILLER	FILLER

CORRECTION TRANSACTION				
ITEM	**FIELDS**	**SIZE**	**POSITION**	**DESCRIPTION**
1	HIC#	12	1 – 12	Nine-byte SSN of primary beneficiary (Beneficiary Claim Account Number); two-byte BIC (Beneficiary Identification Code); one-byte filler (except RRB)
2	Surname	12	13 – 24	Beneficiary Surname
3	First Name	7	25 – 31	Beneficiary Given Name
4	M. Initial	1	32	Beneficiary Middle Initial
5	Action Code	1	33	D = Institutional ON E = Medicaid ON R = Medicaid OFF G = Nursing Home Certifiable (NHC) ON
6	Filler	13	34 – 41	Spaces
10	Contract #	5	47 – 51	Contract Number
11	Filler	8	52 – 59	Spaces
12	Transaction Code	2	60 – 61	"01"
13	Filler	122	62 – 183	Spaces

ATTACHMENT B – MMR DATA FORMAT

#	Field Name	Len	Pos	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	HIC Number	12	20-31	Member's HIC #
5	Surname	7	32-38	
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

#	Field Name	Len	Pos	Description
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	Working Aged	1	63-63	Y = Working Aged
17	Institutional	1	64-64	Y = Institutional
18	NHC	1	65-65	Y = Nursing Home Certifiable
19	Medicaid	1	66-66	Y = Medicaid Status
20	FILLER	1	67-67	SPACES
21	Medicaid Indicator	1	68-68	Y = Medicaid Addon
22	PIP-DCG	2	69-70	PIP-DCG Category - **Only on pre-2004 adjustments**

#	Field Name	Len	Pos	Description
23	Default Indicator	1	71-71	Y = default RA factor in use • For pre-2004 adjustments, a "Y" indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a "Y" indicates that a default factor was generated by the system due to lack of a RA factor.
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
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	99 Always Spaces on Payment
29	Paymt/Adjustmt Start Date	8	92-99	YYYYMMDD
30	Paymt/Adjustmt End Date	8	100-107	YYYYMMDD

#	Field Name	Len	Pos	Description
31	Demographic Paymt/Adjustmt Rate A	9	108-116	-$$$$$.99
32	Demographic Paymt/Adjustmt Rate B	9	117-125	-$$$$$.99
33	Risk Adjuster Paymt/Adjustmt Rate A	9	126-134	-$$$$$.99
34	Risk Adjuster Paymt/Adjustmt Rate B	9	135-143	-$$$$$.99
35	FILLER	28	144-171	SPACES
36	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
37	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – **Only on pre-2004 adjustments**
38	FILLER	2	183-184	SPACES
39	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999

#	Field Name	Len	Pos	Description
39	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
40	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)
41	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
42	Previously Disabled Indicator	1	192-192	Y = Previously Disabled – **Only on post-2003 payments/adjustments**
43	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months

#	Field Name	Len	Pos	Description
44	Segment ID	3	194 – 196	Identification number of the segment of the PBP. Blank if there are no segments.
45	Enrollment Source	1	197	The source of the enrollment. Values are A = Auto-enrolled by CMS, B = Beneficiary election, C = Facilitated enrollment by CMS, D = Systematic enrollment by CMS (rollover)
46	EGHP Flag	1	198	Employer Group flag; Y = member of employer group, N = member is not in an employer group
47	Part C Basic Premium – Part A Amount	6	199-204	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. -$$$.99
48	Part C Basic Premium – Part B Amount	6	205 - 210	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA plan payment for plans that bid above the benchmark. -$$$.99
49	Rebate for Part A Cost Sharing Reduction	6	211 - 216	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. -$$$.99

#	Field Name	Len	Pos	Description
50	Rebate for Part B Cost Sharing Reduction	6	217 - 222	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. -$$$.99
51	Rebate for Other Part A Mandatory Supplemental Benefits	6	223 - 228	The amount of the rebate allocated to providing Part A supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -$$$.99
52	Rebate for Other Part B Mandatory Supplemental Benefits	6	229 - 234	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. -$$$.99
53	Rebate for Part B Premium Reduction – Part A Amount	6	235 - 240	The Part A amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -$$$.99

#	Field Name	Len	Pos	Description
54	Rebate for Part B Premium Reduction – Part B Amount	6	241 - 246	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. -$$$.99
55	Rebate for Part D Supplemental Benefits – Part A Amount	6	247 – 252	Part A Amount of the rebate allocated to providing Part D supplemental benefits. -$$$.99
56	Rebate for Part D Supplemental Benefits – Part B Amount	6	253 – 258	Part B Amount of the rebate allocated to providing Part D supplemental benefits. -$$$.99
57	Total Part A MA Payment	6	259 – 264	The total Part A MA payment. -$$$.99
58	Total Part B MA Payment	6	265 – 270	The total Part B MA payment. -$$$.99
59	Total MA Payment Amount	9	271 - 279	The total MA A/B payment including MMA adjustments. This also includes the Rebate Amount for Part D Supplemental Benefits -$$$$$.99
60	Part D RA Factor	7	280 - 286	The member's Part D risk adjustment factor. NN.DDDD
61	Part D Low-Income Indicator	1	287	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.

#	Field Name	Len	Pos	Description
62	Part D Long Term Institutional Indicator	1	288	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.
63	Rebate for Part D Basic Premium Reduction	6	289 - 294	Amount of the rebate allocated to reducing the member's basic Part D premium. -$$$.99
64	Part D Basic Premium Amount	6	295 - 300	The member's Part D premium amount. -$$$.99
65	Part D Direct Subsidy Payment Amount	6	301 – 306	The total Part D Direct subsidy payment for the member. -$$$.99
66	Reinsurance Subsidy Amount	6	307 - 312	The amount of the reinsurance subsidy included in the payment. -$$$.99
67	Low-Income Subsidy Cost-Sharing Amount	6	313 - 318	The amount of the low-income subsidy cost-sharing amount included in the payment. -$$$.99
68	Total Part D Payment	9	319 - 327	The total Part D payment for the member. -$$$$$.99