DEPARTMENT OF HEALTH &
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Centers for Medicare & Medicaid
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CENTER FOR MEDICARE

DATE: October 31, 2023

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

FROM: Jennifer R. Shapiro, Director, Medicare Plan Payment Group

SUBJECT: Medicare Advantage/Prescription Drug System (MARx) November 2023 Payment – INFORMATION

This letter provides information about the November 2023 Medicare Advantage/Prescription Drug payment, which is scheduled for receipt on November 01, 2023.

2022 Final Risk Adjustment Reconciliation

The final 2022 risk adjustment reconciliation adjustments are included in the November 2023 payment. As announced in the May 5, 2023 HPMS memo, "Deadline for Submitting Risk Adjustment Data for Use in Risk Score Calculation Runs for Payment Years 2022, 2023, 2024 and 2025," the final 2022 risk scores are based on diagnoses with dates of service from January 1, 2021 to December 31, 2021 submitted to CMS through July 31, 2023. The payment adjustments will appear on the November 2023 Monthly Membership Report (MMR) with Adjustment Reason Code (ARC) 25 – Part C Risk Adjustment Factor Change/Recon, and ARC 37 – Part D Risk Adjustment Factor Change.

2015 Risk Adjustment Reconciliation Rerun

The November 2023 payment includes 2015 risk adjustment reconciliation rerun adjustments. Adjustments to the risk scores incorporate an updated CPT/HCPCS list used to filter FFS diagnoses from FFS outpatient claims. In the December 6, 2022 HPMS memo, *Rerun of Payment Year (PY) 2016*, we announced that we had applied this update to the 2016 rerun, and noted that the PY 2015 rerun included a similar update but that the updated CPT/HCPCS list used to filter FFS diagnoses from FFS outpatient claims was not applied correctly. We further stated that we would make corrections to the application of the updated CPT/HCPCS list in a future rerun of PY 2015.

This PY 2015 rerun maintains the CPT/HCPCS list updated to service year 2014 from the prior PY 2015 rerun (conducted in 2022) but corrects the application of the updated list. This correction may affect the risk scores for beneficiaries who were enrolled in FFS during any time in the data collection year. Specifically, as described in The Medicare Managed Care Manual, Chapter 7, Risk Adjustment, Section 120.1.1, CMS excludes diagnoses from outpatient settings for specific services. As stated in the December 6, 2022 HPMS memo, this is not a change to our filtering rules,

but an update to the list of CPT/HCPCS codes used for the specific data collection year in the run. The CPT/HCPCS list applied to this 2015 risk adjustment reconciliation rerun is posted on CSSC Operations website https://www.csscoperations.com/internet/csscw3_files.nsf/F2/2015%20Outpatient%20CPT%20HCPCS%20Excluded%20Services%20List.pdf/$FILE/2015%20Outpatient%20CPT%20HCPCS%20Excluded%20Services%20List.pdf. CMS will post the updated lists for each year as we apply them in reruns. The payment adjustments will appear on the November 2023 Monthly Membership Report (MMR) with Adjustment Reason Code (ARC) 25 – Part C Risk Adjustment Factor Change/Recon, and ARC 37 – Part D Risk Adjustment Factor Change.

Sequestration Suspension

While the suspension of sequestration has ended, as required by the statute, we continue to apply the suspension of sequestration for retroactive payment adjustments made for the months of May 2020 through March 2022 and will sequester 1 percent of retroactive payment adjustments made for the months of April 2022 through June 2022 and 2 percent of payments and adjustments for months beginning with July 2022.

End of Year Processing 2023: Part C Premium Processing (Transaction Code 78)

To reduce the number of Part C Premium Change transactions (TC 78) to be processed for existing enrollments at year end, the MARx system will automatically populate beneficiary records with the 2024 premium amount for a plan benefit package – any premiums for basic and mandatory supplemental benefits from the Health Plan Management System (HPMS). MARx will perform this update for **all existing** enrollees, including **those impacted by plan rollovers** via the HPMS Crosswalk.

Unless the enrollee has elected optional supplemental benefits for Part C, plans should not need to submit Part C Premium Change transactions for existing enrollments, since MARx will already be using the premium amount without the optional supplemental benefits. For enrollees who elect optional supplemental benefits with 2024 effective dates, Part C plans are required to submit Part C Premium Change transactions (TC 78) with the correct Part C premium amounts (i.e., any premiums for basic and/or mandatory supplemental benefits, plus premiums for optional supplemental benefits).

Plans **must not** submit these transactions before November 6, 2023. Part C Premium Change (TC 78) transactions for effective date January 2024 must be submitted to MARx beginning November 6, 2023, and ending on the December plan data due date of December 8, 2023, in order to be reflected in the January 2024 payment.

If a plan misses the December 8, 2023 plan data due date, MARx will accept and process plan submitted Part C Premium Changes (TC 78, effective January 1, 2024), until the plan data due date of February 2, 2024.

The 2024 payment/premium configurations will be processed between November 6 and November 9, 2023. After configurations are established, the Part C Premium/PPO transactions will be processed.

No Premiums Due

For enrollees who may have been inadvertently put into a "No Premium Due" status, the "No Premium Due Data File" should be made available during the second full week of November. Plans should wait until then before submitting premium transactions for those enrollees.

For example, if the Part C premium amount is composed only of elected optional supplemental benefits, and no Part D premium is due, plans should also review the "No Premium Due Data File" to identify enrollees who may have been changed to a "No Premium Due" status.

End of Year Premium and Premium Payment Option Processing for CMS Generated Rollovers
CMS will process CMS generated rollover and termination actions on November 2 and 3, 2023. During this time, CMS will move members (or "rollover" membership) between PBPs where necessary and, in some circumstances, between contract numbers as specified in the HPMS Crosswalk.

Because the 2024 CMS generated rollover process is executed prior to when the 2024 Payment/Premium data is loaded to the MARx databases, the MARx premium process will assess the prior year's Part C premium amount to the new plan's Part C premium amount. If the premium amount is inconsistent between the two plans, MARx will use the minimum Part C premium amount from the new plan and will also change the Premium Payment Option (PPO) to direct bill. The plan is notified via the Daily Transaction Reply Report (DTRR), with a Transaction Reply Code (TRC) 144 – "PPO CHANGED TO DIRECT BILL," and TRC 182 – "INVALID PT C PREMIUM SUBMITTED CORRECTED, ACCEPTED."

In these cases, plans should submit both a Part C Premium Change (TC 78) and a Premium Payment Option Change (TC 75) transaction for 2024.

End of Year Processing 2023: Premium Payment Option Processing (Transaction Code 75)
New premium withholding requests must be submitted by CMS to either the Social Security Administration (SSA) or Railroad Retirement Board (RRB) for confirmation before taking effect on January 1, 2024.

Plans **must not** submit these transactions before November 6, 2023. Premium Payment Option Change (TC 75) transactions for effective date January 2024 must be submitted to MARx beginning November 6 and end on the December plan data due date of December 8, 2023.

Plan PPO changes submitted to MARx after the plan data due date of December 8, 2023, will be set to "direct bill" for January 2024. The plan will be notified of this via the DTRR, with a TRC 144 – "PPO CHANGED TO DIRECT BILL."

End of Year Processing 2023: Automatic Assignment of Segment IDs in MARx
CMS automates the assignment of Segment IDs for segmented MA organizations. Each State and County Code (SCC) in a plan's service area may only belong to one segment. This enables MARx to automate the assignment of Segment IDs according to the residence SCC of the beneficiary. If a plan does not provide a Segment ID, MARx uses the residence SCC to select the appropriate Segment ID. This assigned Segment ID is returned in the DTRR.

If, for the upcoming plan year, the segments of a plan have been redefined, either because segments have been renumbered or SCCs have been mapped to different segments, MARx will

automatically generate Segment Change Transactions (Transaction Type 77) to maintain impacted beneficiaries in the appropriate plan segments for the New Year. If a segment terminates at the end of year, MARx will also automatically move impacted beneficiaries to any of the remaining active segments according to their residence SCC.

CMS continues to permit plans to submit Segment IDs as they do now. If the beneficiary is not out of area, MARx uses the submitted Segment ID rather than the system-derived one. If a beneficiary is flagged as out of area for the plan, the MARx system automatically assigns a default Segment ID. This occurs even if the plan submits a Segment ID on the enrollment transaction. When the beneficiary is assigned to a default Segment ID, the plan receives a TRC 316 – "DEFAULT SEGMENT ID ASSIGNMENT." The default segment will be the segment with the lowest premium.

Additionally, CMS may change a beneficiary's Segment ID when notified that the beneficiary's address has changed. The newly derived SCC is used to assign the new Segment ID. This activity generates a TRC 317 – "SEGMENT ID REASSIGNED AFTER ADDRESS UPDATE."

If the new address places the beneficiary out of area for the contract, the beneficiary is assigned the default Segment ID.

If premium withholding is requested on the enrollment transaction or the premium payment option transaction for a beneficiary assigned to a default Segment ID, it will be considered as having an out of area status, and the beneficiary's Premium Payment Option automatically changes to "Direct Bill." This will generate TRC 393 ("PPO CHANGED TO DIRECT BILL; OUT OF AREA"). However, if a beneficiary with established withholding moves out of area, CMS will report the default Segment ID assignment to SSA/RRB but leave the withholding status unchanged.

CMS alerts MA organizations to default Segment ID assignments and reassignments of Segment IDs due to changes in the SCC through the following defined TRCs on the DTRR:

- TRC 316, "ID ASSIGNMENT" ID ASSIGNMENT"
- TRC 317, "SEGMENT ID REASSIGNED AFTER ADDRESS UPDATE"

The segment assignment process will include service area expansions. If a plan expands the service area of a PBP, MARx will detect this change. If applicable, MARx will move impacted beneficiaries from a default segment to a segment that now contains the SCCs of their addresses and plans will receive TRC 317 – "SEGMENT ID REASSIGNED AFTER ADDRESS UPDATE."

End of Year Processing 2023: Payment Processing for Contracts Non-Renewing for 2024

(1) Access to the MARx System and Reports for Contracts Non-Renewing 2024:

To comply with federal privacy and security laws and guidance, CMS must disable system access for all users when a contract has ended. Access to data for a contract that has terminated will be disabled in Identity Manager (IDM) and MARx 60 days after the contract ends.

In addition, MARx will no longer push monthly payment reports (i.e., Daily Transaction Reply Data File, Monthly Membership Data File, Plan Payment Report) to organizations/sponsors via

TIBCO/GENTRAN after 60 days of the contract's termination, and CMS will cease the distribution of the monthly Plan Payment Report (PPR) after December 31, 2023.

(2) Access to the Health Plan Management System (HPMS):
Plans may retain access to HPMS to perform reporting functions (e.g., DIR, MLR, risk adjustment overpayments, cost reports, and complaint resolution) that continue after the CMS contract has ended. Users must complete the annual user recertification process and maintain their password to retain their CMS user ID.

(3) Retroactive Payment Adjustments:
Organizations/sponsors that need to submit retroactive enrollment or disenrollment transactions, and State and County Code changes that can cause a retroactive payment adjustment after non-renewal/termination should submit corrected information to the Retroactive Processing Contractor (RPC) within 45 days from the date of its last MARx monthly payment reports. The requested corrections will be verified and, if verified, applied to the plan's member records. Payment adjustments calculated based on information updated by the RPC will be included in the plan's final settlement payment.

(4) Final Settlement:
CMS's final settlement process lasts for a minimum of 18 months after the end of the calendar year in which the contract ended with CMS. As part of the final settlement process, it is important for plans to understand that all applicable reconciliations must process before CMS will officially calculate, disburse, or collect any final settlement payment. Therefore, no payment disbursements or collections will occur between any reconciliation. For contracts ending in 2023, these reconciliation processes include:

1) 2023 Final Risk Adjustment Reconciliation
2) 2023 Part D Annual Reconciliation
3) 2023 Coverage Gap Discount Program Annual Reconciliation
4) 2023 Medical Loss Ratio Remittance

Plans can expect to receive a final settlement package from CMS after July 2025 explaining whether the plans will receive or owe CMS a settlement payment. In part of delivering the final settlement package to the organizations/sponsors, CMS will include all the Monthly Membership Reports (MMRs) created from the time the contract ended until the month the final settlement was processed. These reports will include details for retroactive payment adjustments that accumulated after the contract ended.

However, it is important to note that plans that fail to comply with their remaining data submission requirements may delay the receipt of their final settlement payment. Questions regarding the final settlement process may be emailed to James.Krall@cms.hhs.gov.

Questions or concerns about any of the information within this letter should be directed to the MAPD Help Desk at mapdhelp@cms.hhs.gov, or 1-800-927-8069.