Plan Communication User Guide for

MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

August 31, 2018

Version 12.2

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Change Log

Section	Change Description
Global	• Updated the version to 12.2. • Updated the publication date to August 31, 2018. • Updated Table of Contents, Layout, Report, Table, Figure, and Section references.
1	Introduction: • No Change.
2	Establish Connectivity: • No Change.
3	Eligibility and Enrollment: • Updated item 36 in the Daily Transaction Reply Report (DTRR) Detail Record by adding J = Seamless Conversion Enrollment Mechanism to the description. • Updated item 12 in the the Agent Broker Compensation Detail Record • Updated the Compensation Rate Submission section. • Removed Transaction Code 73 and Layout
4	Low Income Subside (LIS) Status: • Updated the Low Income Subsidy (LIS) Status description.
5	Premium: • Updated Calculating Late Enrollment Penalty (LEP) Description • Added Transaction Code 73 to Allowable Range of Dates tabl. • Updated the Late Enrollment Penalty (LEP) Dataset Naming Convention.
6	Payment: • Updated the Monthly Membership Report (MMR) Detail Data File.
7	Outbound Files and Miscellaneous: • No Change.
8	MARx UI: • Updated screenshots for the Daily and Yearly Reports.

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Table of Contents

List of File Layouts

List of Reports

List of Tables

List of Figures

List of Website Links

The following is a list of website links that are contained in this document. Each one is a hyperlink to the placement in the document where the actual URL of the website can be found and accessed.

1 Introduction

The Centers for Medicare & Medicaid Services (CMS) is a federal agency that ensures health care coverage for more than 100 million Americans. The **Medicare Advantage Prescription Drug (MAPD) Plan Communication User Guide (PCUG)** provides information to Medicare Managed Care Plans and Prescription Drug Sponsors (both hereafter referred to as Plans) for the participation in the MAPD Program, the use of the Medicare Advantage Prescription Drug (MARx) User Interface (UI) System, and the exchange of data files and reports between the Plans and CMS.

The PCUG is organized into the following sections:

Section 2, **Establish Connectivity**, provides instructions for establishing user connectivity to MARx along with methods for exchanging data with CMS.

Section 3, Eligibility and Enrollment, provides information & file layouts used for enrollment and eligibility verification of Medicare beneficiary applications.

Section 4, Low Income Subsidy (LIS) Status, provides explanations & data file layouts concerning LIS, including information regarding co-pay levels to ensure Part D Plans charge LIS beneficiaries the correct premium and cost-sharing amounts.

Section 5, Premium, provides information & file layouts on premium and premium withhold processes for beneficiaries.

Section 6, Payment, provides an overview of Part C and Part D payment and payment calculations, including payment related data file layouts and reports.

Section 7, Outbound Files and Miscellaneous, provides the All Transmissions Overview, which lists all of the file and report information exchanged between CMS and the Plans, and also provides information on outbound and miscellaneous files.

Section 8, Medicare Advantage Prescription Drug User Interface – MARx UI, provides information for Plans to access enrollment, eligibility, payment, premium withhold, and 4Rx information for beneficiaries.

Section 9, Glossary and Acronyms, provides a list of terms, definitions, and acronyms used throughout the PCUG.

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2 Establish Connectivity

The purpose of this section is to provide guidance to Plans to perform the following:

- Establish Contract Number(s) with CMS.
- Establish access to the MARx User Interface (UI).
- Establish the data exchange process for participation in the MAPD Program.

All new Plans participating in the MAPD Program must receive a contract number(s) from CMS or the Health Plan Management System (HPMS) before they can begin. After obtaining a contract number(s), Plans must register a designated person(s) to enter the Plan's connectivity data into the HPMS Plan Connectivity Data (PCD) Module.

CMS requires a scanned copy of the data entered into the PCD Module, with signature of the Plan External Point of Contact (EPOC) Approver, to be emailed to the MAPD Help Desk for all contract numbers before any files will be exchanged. Once all contact and connectivity data is entered into the module, Plans can select the "*Create PDF option*" to print the completed PCD form. Only one (1) signed form is required if all new contract numbers will use the same data exchange mechanism (Connect:Direct, TIBCO MFT Internet Server or Third Party Administrator (TPA)); otherwise, separate forms per transfer mechanism are required.

Plans that wish to exchange data with CMS via a T1 line and Connect:Direct software must be complete in the PCD Module. After completing the "*Plan Connectivity Data – General*" form, Plans must also complete the "*Plan Connectivity Data – T1 Connect:Direct /3rd Party*" form within the PCD module. In addition, the Secure Point of Entry (SPOE) ID Request form must be completed and submitted to CMS.

Note: In early August of each year, the MAPD Help Desk extracts a list from HPMS of all active contracts for the coming calendar year. Once these contracts are identified, the Help Desk will send an email communication to new Plans advising of the required steps for successfully connecting to CMS to enable file transfer.

Detailed instructions for this process can also be found on the MAPD Help Desk website on the **Plan Connectivity Preparation** page at this link: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan-Connectivity-Preparation.html. The following documents are available for download on this page:

- Data Exchange Preparation Procedures (DEPP).
- Plan Connectivity Checklist.
- Secure Point of Entry (SPOE) ID Request Form.
- Enterprise File Transfer (EFT) Partner Server Form.
- External Point of Contact (EPOC) Designation Letter.
- EPOC Access Acknowledgement Form.

2.1 CMS Points of Contact

Table 2-1: Points of Contact by Topic

CMS Points of Contact by Topic		
Topic	**Description**	**Contact Information**
MAPD Help Desk	The Medicare Advantage Prescription Drug (MARx) is the primary CMS online and batch system that provides access to information about Medicare enrollment, payment, premium withhold, for beneficiaries.	Website: http://go.cms.gov/mapdhelpdesk Email: mapdhelp@cms.hhs.gov Phone: 800-927-8069
Risk Adjustment System (RAS) and Encounter Data Systems (EDS)	RAS provides MARx with beneficiary-specific, risk-adjusted factors for calculating Part C and Part D payments. Based on each beneficiary's medical history, the factors reflect claims and encounter data.	Website for RAS and EDS: http://www.csscoperations.com Email for RAS: riskadjustment@cms.hhs.gov Email for EDS: Encounterdata@cms.hhs.gov
Prescription Drug Event (PDE) Submission Questions	PDE provides information about Risk Adjustment, Medicare Encounter Data, Medicare Medicaid Data and Prescription Drug Programs; including opportunities to enroll to submit data and obtain comprehensive information about data submission and reporting.	Website: http://www.csscoperations.com Email: pdejan2011@cms.hhs.gov Phone: 877-534-2772
Health Plan Management Systems (HPMS)	HPMS contains complete information about contracts between Plans and CMS. It provides information about contracts, PBPs, segment numbers, and service areas. HPMS also provides MARx with information about terminations, rollovers, payment rates, and rebate amounts.	Website to HPMS Helpdesk: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HelpDeskInfo.html
Social Security Administration (SSA)	SSA maintains beneficiary benefit checks. SSA is responsible for withholding Part B, C, and D Premiums and processing Part B Premium Reductions based on information received from CMS.	Website: https://www.SSA.gov/ Phone: Local Office or 800-772-1213
Railroad Retirement Board (RRB)	RRB maintains their retiree benefit checks. RRB withholds Part B, C, and D premiums and processes Part B Premium Reductions based on information received from CMS.	Website: https://www.RRB.gov Phone: 877-772-5772

3 Eligibility and Enrollment

For completing an enrollment request, Plans must verify Medicare entitlement for the prospective Plan enrollee using one of the following methods:

- Batch Eligibility Query Process.
- Third Party Submitters.
- MARx User Interface (UI).

This section covers the following topics:

3.1 Batch Eligibility Query (BEQ) Process

The BEQ Process provides a vehicle for all Plans to verify the following information about a beneficiary:

- Medicare eligibility.
- Prescription Drug Plan (PDP) eligibility.
- Low Income Subsidy (LIS) information.
- Past drug coverage period information.
    - With this information, Plans can determine the Number of Uncovered Months (NUNCMO) relating to Late Enrollment Penalty (LEP).

The following sections provide detail information about the BEQ Request and Response File Processes.

3.1.1 *BEQ Request File Process*

Each transaction on the BEQ Request File should identify a prospective or current Plan enrollee. Plans may submit BEQ transactions only for individuals who have requested enrollment. Plans may not submit BEQ transactions for individuals who have not requested enrollment.

CMS generates one BEQ Response File for every BEQ Request File. The BEQ Response File includes the transaction records contained in the request. If a Plan submits multiple BEQ Request Files during a regular business day, the Plan receives multiple BEQ Response files, corresponding to each BEQ Request File, during that same business day.

Note: BEQ Response Files are not time-stamped, so the Plan must process these files immediately upon receipt.

For Plans using a Connect:Direct data transmission protocol, if a second BEQ Response File is received by the Plan prior to the Plan's processing of a previous one, a Connect:Direct transmission error results and the Plan must manually retransmit the file.

Plans can use the Detail Record Sequence Number (Field 6) located in each BEQ Request Detail Record to track individual transactions sent to and received from CMS.

3.1.2 BEQ Request File

System	Type	Frequency	File Length	BEQ Request File Dataset Naming Conventions
MBD	Data File	PRN (Plans can send multiple files in a day)	750	**Gentran Mailbox/TIBCO MFT Internet Server: **** [GUID].[RACFID].MBD.D.xxxxx.BEQ.[P/T][.ZIP] **Connect:Direct:** P#EFT.IN.PLxxxxx.BEQ4RX.DYYMMDD.THHMMSST **Note:** DYYMMDD.THHMMSST must be coded as shown, as it is a literal

This file includes the following records:

- **BEQ Request Header Record.**
- **BEQ Request Detail Record.**
- **BEQ Request Trailer Record.**

Layout 3-1: BEQ Request Header Record

BEQ Request File Header Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	File ID Name	8	1- 8	CHAR	MMABEQRH	Critical Field: This code identifies the file as a BEQ Request File and this record as the Header Record of the file.
2	Sending Entity	8	9-16	CHAR	Sending Organization (left justified space filled) Acceptable Values: 5-position Contract. (3 Spaces are for Future use)	Critical Field: This field provides CMS with the identification of the entity that is sending the BEQ Request File. The value for this field is provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Trailer Record.
3	File Creation Date	8	17-24	CHAR	CCYYMMDD	Critical Field: The date that the Sending Entity created the BEQ Request File. For example, January 3 2017 is the value 20170103. This value should agree with the corresponding value in the Trailer Record. CMS returns this information to the Sending Entity on all Detail Records of a BEQ Response File.

BEQ Request File Header Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity	Critical Field The specific Control Number assigned by the Sending Entity to the BEQ Request File. CMS returns this information to the Sending Entity on all Detail Records of a BEQ Response File. This value should agree with the corresponding value in the Trailer Record.
5	Filler	717	34-750	CHAR	Spaces	

Layout 3-2: BEQ Request Detail Record

BEQ Request File Detail Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	Record Type	5	1-5	CHAR	DTL01 = BEQ Transaction **Note:** The value above is DTL-zero-one.	Critical Field This code identifies the record as a Detail Record for processing specifically for BEQ Service.
2	Beneficiary ID	12	6-17	CHAR	Beneficiary ID or RRB	Critical Field •Before the Medicare Beneficiary Identifier (MBI) Transition period, the acceptable values are the Health Insurance Claim Number (HICN) and the Railroad Retirement Board (RRB) Number. •During the MBI Transition period, the acceptable values are the HICN, RRB Number and MBI. •When the MBI Transition period ends, the acceptable value is the MBI. •The last position may be a space.
3	Filler	9	18-26	CHAR	Spaces	
4	DOB	8	27-34	CHAR	CCYYMMDD	Critical Field The date of the beneficiary's birth. The value should not include dashes, decimals, or commas. The value should include only numbers.
5	Gender Code	1	35	CHAR	0 – Unknown 1 – Male; 2 - Female	Not Critical Field The gender of the beneficiary.
6	Detail Record Sequence Number	7	36-42	NUM	Seven-byte number unique within the BEQ Request File	Critical Field A unique number assigned by the Sending Entity to the Detail Record.
7	Filler	708	43-750	CHAR	Spaces	

Layout 3-3: BEQ Request Trailer Record

BEQ Request File Trailer Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	File ID Name	8	1-8	CHAR	MMABEQRT	Critical Field This code identifies the record as the Trailer Record of a BEQ Request File.
2	Sending Entity (CMS)	8	9-16	CHAR	Sending Organization (left justified space filled) Acceptable Values: 5-position Contract Identifier + 3 Spaces (3 Spaces for Future use)	Critical Field This field provides CMS with the identification of the entity that is sending the BEQ Request File. The value for this field is provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Header Record.
3	File Creation Date	8	17-24	CHAR	CCYYMMDD	Critical Field The date when the Sending Entity created the BEQ Request File. For example, January 3, 2017 is the value 20170103. This value should agree with the corresponding value in the Header Record. CMS will pass this information back to the Sending Entity on all Detail Records of a BEQ Response File.
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity	Critical Field The specific Control Number assigned by the Sending Entity to the BEQ Request File. CMS will return this information to the Sending Entity on all Detail Records of a BEQ Response File. This value should agree with the corresponding value in the Header Record.
5	Record Count	7	34-40	NUM	Numeric value greater than Zero, with leading zeroes.	Critical Field The total number of Detail Records supplied on the BEQ Request File.
6	Filler	710	41-750	CHAR	Spaces	

3.1.3 Sample BEQ Request File Pass and Fail Acknowledgments

The Medicare enrollment system issues an e-mail acknowledgment of receipt and status to the Sending Entity. If the status is accepted, the file is processed. If the status is rejected, the e-mail informs the Sending Entity of the first File Error Condition that caused the BEQ Request File's rejection. A rejected file is not returned.

Sample e-mail of a Pass and Fail Acknowledgement appear below:

Figure 3-1: Example of BEQ Request File "Pass" Acknowledgment

TO: Jim.Doe@xxs.net
TO: Chris.Doe@dxxx.org
TO: Falcon.Doe@xxxx.org
FROM: MBD#BQ94.HCFJES@cms.hhs.gov
Subject: CMS MMA DATA EXCHANGE FOR MMABTCH

MMABTCH file has been received and passed surface edits by CMS.
QUESTIONS? Contact 1-800-927-8069 or E-mail mapdhelp@cms.hhs.gov

INPUT HEADER RECORD
MMABEQRHS0094 20170306F20070306

INPUT TRAILER RECORD
MMABEQRTS0094 20170306F200703060000074

Figure 3-2: Example of BEQ Request File "Fail" Acknowledgment

TO: Jim.Doe@xxs.net
TO: Chris.Doe@dxxx.org
TO: Falcon.Doe@xxxx.org
FROM: MBD#BQ30.HCFJES@cms.hhs.gov
Subject: CMS MMA DATA EXCHANGE FOR MMABTCH

MMABTCH file has been received and failed surface edits by CMS.
QUESTIONS? Contact 1-800-927-8069 or E-mail mapdhelp@cms.hhs.gov

INPUT HEADER RECORD
MMABEQRHH0030 20170228 84433346

INPUT TRAILER RECORD
MMABEQRTH0030 20170221 844333460074065

THE TRAILER RECORD IS INVALID

3.1.4 BEQ Request File Error Conditions

BEQ Request File Level Error Conditions

The following table contains File Level Error Conditions. File Level Errors represent conditions in which a BEQ Request File is rejected and not processed.

Table 3-1: BEQ Response File Level Error Conditions

BEQ Response File Level Error Conditions		
Source Of Error	**Error Message**	**Error Condition**
Header Record	The Header Record is missing.	● The Header Record is not provided on the file. ● The Header Record is unreadable. ● More than one Header Record is provided on the file.
Header Record	The Header Record is Invalid.	● The Header Record is incorrectly formatted. ● The Header Record contains invalid values. ● The Header Record contains Critical Fields that are not provided.
Trailer Record	The Trailer Record is missing.	● The Trailer Record is not provided on the file. ● The Trailer Record is unreadable. ● More than one Trailer Record is provided on the file.
Trailer Record	The Trailer Record is invalid.	● The Trailer Record is incorrectly formatted. ● The Trailer Record contains invalid values. ● The Trailer Record contains Critical Fields that are not populated. ● The Record Count in the Trailer Record is more than 2 different from the actual number of Detail Records in the file.
File Content	The File has no Transactions.	● There are no Detail Records found in the file.

BEQ Request Detail Record Error Conditions

The following Flag fields are provided in the BEQ Response File Detail Record. Flag fields represent the successful or unsuccessful result of processing data within a Detail Record of the Request file.

Table 3-2: BEQ Request Detail Record Error Conditions

BEQ Request Detail Record Error Conditions			
Flag	**Flag Code**	**Flag Code Result**	**Flag Result Condition**
Processed Flag	Y	The Transaction is accepted for processing.	All critical fields on the Transaction are populated with valid values.
Processed Flag	N	The Transaction is not accepted for processing.	At least one critical field on the Transaction is populated with a value other than the prescribed valid values.
Beneficiary Match Flag	Y	The beneficiary on the Transaction is successfully located in the MBD.	The beneficiary is successfully located by the combination of the HICN, RRB or MBI; date of birth, and gender.
Beneficiary Match Flag	N	The beneficiary on the Transaction is not successfully located in the MBD.	The beneficiary is not successfully located by the combination of the HICN, RRB or MBI; date of birth, and gender.

3.1.5 *BEQ Response File Process*

CMS analyzes a BEQ Request File to determine the file's acceptance or rejection based on the BEQ Request File Error Conditions. After determining whether the file is accepted or rejected, the BEQ process generates an e-mail acknowledgement of receipt indicating one of the following outcomes:

- If the BEQ Request File is ***accepted***, an e-mail notification informs the Plan that the specific BEQ Request File is accepted and in process.
- If the BEQ Request File is ***rejected***, the e-mail notification informs the Plan of the first File Error Condition that caused the rejection. A rejected file is not returned.

This e-mail acknowledgement/notification is sent to all submitters registered in the EIDM system for the Sending Entity contract.

CMS processes all transactions of an accepted BEQ Request File. Each transaction is uniquely identified and tracked throughout the CMS processing service by the combination of the following:

- Sending Entity – Field 2 on the Header Record.
- File Creation Date – Field 3 on the Header Record.
- File Control Number – Field 4 on the Header Record.
- Detail Record Sequence Number, – Field 6 on the Detail Record.

When a transaction is processed, CMS first verifies that all critical data is provided and valid on the record. CMS then attempts to perform a Beneficiary Match, in which the beneficiary

identifying fields on the transaction locate a single beneficiary and verify Medicare entitlement. Each Detail Record of the BEQ Response File maintains these three critical fields:

- HICN, RRB, or MBI – Field 2.
- Date of Birth – Field 4.
- Gender Code – Field 5.

If all critical fields are not provided, subsequent processing is terminated for that transaction, including any attempt to match the Beneficiary on the database and verify Medicare entitlement. The Processed Flag and the Beneficiary Match Flag in the BEQ Response Detail Record are set to N. All Error Return Codes are assigned the appropriate values.

If all critical data elements are provided, CMS then attempts to perform a Beneficiary Match, in which the beneficiary identifying fields on the transaction locate a single beneficiary on the database and verify Medicare entitlement.

If the beneficiary is matched, the Processed Flag and the Beneficiary Match Flag are set to Y and CMS returns a BEQ Response Detail record populated with the additional fields for the beneficiary.

Note: CMS provides the two most recent occurrences of LIS information. During an open enrollment period, CMS is unaware whether Plans are submitting queries for current year enrollments or for next year's enrollments. Therefore, the BEQ Response File provides the current and future LIS information, so that Plans have the correct information for the year in which they may submit the enrollment transaction.

If the beneficiary is not matched or the transaction contains critical errors, the Processed Flag and the Beneficiary Match Flag are set to N. CMS returns a BEQ Response Detail record, but does not populate any of the additional fields for the beneficiary.

3.1.6 *BEQ Response File*

The BEQ Response File contains records produced from processing the transactions of accepted BEQ Request files. Detail records for all submitted records that are successfully processed contain Processed Flag = Y. Detail records for all submitted records that are not successfully processed contain Processed Flag = N.

The BEQ Response Files are flat files created as a result of processing the Detail Records of accepted BEQ Request Files. CMS sends BEQ Response Files to Plans in the following format.

System	Type	Frequency	File Length	BEQ Response File Dataset Naming Conventions
MBD	Data File	Response to BEQ Request File.	2000	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#BQN4.Dyymmdd.Thhmmsst **Connect:Direct [Mainframe]:** zzzzzzzz.Rxxxxx.#BQN4.Dyymmdd.Thhmmsst **Connect:Direct [Non-mainframe]:** [directory]Rxxxxx.#BQN4.Dyymmdd.Thhmmsst

The following records are included in this file:

- **BEQ Response File Header Record**
- **BEQ Response File Detail Record**
- **BEQ Response File Trailer Record**

Layout 3-4: BEQ Response File Header Record

BEQ Response File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Header Code	8	1 – 8	CHAR	CMSBEQRH
2	Sending Entity	8	9 – 16	CHAR	"MBD ' (MBD + five spaces)
3	File Creation Date	8	17 – 24	CHAR	CCYYMMDD
4	File Control Number	9	25 – 33	CHAR	
5	Filler	1967	34 - 2000	CHAR	Spaces

Layout 3-5: BEQ Response Detail Record (Transaction)

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Record Type	3	1 – 3	CHAR	DTL
Start of Original Detail Record					
2	Record Type	5	4 – 8	CHAR	
3	Beneficiary ID	12	9 – 20	CHAR	This field will contain exactly what is received in the same field of the beneficiary's Detail record in the related BEQ Request file.
4	Filler	9	21 –29	CHAR	
5	Beneficiary's Date of Birth	8	30 – 37	CHAR	
6	Beneficiary's Gender Code	1	38	CHAR	
7	Detail Record Sequence Number	7	39 – 45	ZD	
End of Original Detail Record					
8	Processed Flag	1	46	CHAR	Y or N
9	Beneficiary Match Flag	1	47	CHAR	Y or N
10	Medicare Part A Entitlement Start Date	8	48 – 55	CHAR	CCYYMMDD
11	Medicare Part A Entitlement End Date	8	56 – 63	CHAR	CCYYMMDD
12	Medicare Part B Entitlement Start Date	8	64 – 71	CHAR	CCYYMMDD
13	Medicare Part B Entitlement End Date	8	72 – 79	CHAR	CCYYMMDD
14	Medicaid Indicator	1	80	CHAR	0 or 1
15	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 1)	8	81 – 88	CHAR	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
16	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 1)	8	89 – 96	CHAR	CCYYMMDD
17	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 2)	8	97 – 104	CHAR	CCYYMMDD
18	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 2)	8	105 – 112	CHAR	CCYYMMDD
19	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 3)	8	113 – 120	CHAR	CCYYMMDD
20	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 3)	8	121 – 128	CHAR	CCYYMMDD
21	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 4)	8	129 – 136	CHAR	CCYYMMDD
22	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 4)	8	137 – 144	CHAR	CCYYMMDD
23	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 5)	8	145 – 152	CHAR	CCYYMMDD
24	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 5)	8	153 – 160	CHAR	CCYYMMDD
25	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 6)	8	161 – 168	CHAR	CCYYMMDD
26	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 6)	8	169 – 176	CHAR	CCYYMMDD
27	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 7)	8	177 – 184	CHAR	CCYYMMDD
28	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 7)	8	185 – 192	CHAR	CCYYMMDD
29	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 8)	8	193 – 200	CHAR	CCYYMMDD
30	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 8)	8	201 – 208	CHAR	CCYYMMDD
31	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 9)	8	209 – 216	CHAR	CCYYMMDD
32	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 9)	8	217 – 224	CHAR	CCYYMMDD
33	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 10)	8	225 – 232	CHAR	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
34	Part D Disenrollment Date or Employer Subsidy End Date (occurrence 10)	8	233 – 240	CHAR	CCYYMMDD
35	Sending Entity	8	241 – 248	CHAR	
36	File Control Number	9	249 – 257	CHAR	
37	File Creation Date	8	258 – 265	CHAR	CCYYMMDD
38	Part D Eligibility Start Date	8	266 – 273	CHAR	
39	Deemed / Low-Income Subsidy Effective Date (Occurrence 1)	8	274 – 281	CHAR	CCYYMMDD
40	Deemed / Low-Income Subsidy End Date (Occurrence 1)	8	282 – 289	CHAR	CCYYMMDD
41	Co-Payment Level Identifier (Occurrence 1)	1	290	CHAR	1, 2, 3, 4 or 5
42	Part D Premium Subsidy Percent (Occurrence 1)	3	291 – 293	CHAR	100, 075, 050, or 025
43	Deemed / Low-Income Subsidy Effective Date (Occurrence 2)	8	294 – 301	CHAR	CCYYMMDD
44	Deemed / Low-Income Subsidy End Date (Occurrence 2)	8	302 – 309	CHAR	CCYYMMDD
45	Co-Payment Level Identifier (Occurrence 2)	1	310	CHAR	1, 2, 3, 4 or 5
46	Part D Premium Subsidy Percent (Occurrence 2)	3	311 – 313	CHAR	100, 075, 050, or 025
Part D/RDS Indicator (10 occurrences)					
47	RDS/Part D Indicator (Occurrence 1)	1	314	CHAR	D or R
48	RDS/Part D Indicator (Occurrence 2)	1	315	CHAR	D or R
49	RDS/Part D Indicator (Occurrence 3)	1	316	CHAR	D or R
50	RDS/Part D Indicator (Occurrence 4)	1	317	CHAR	D or R
51	RDS/Part D Indicator (Occurrence 5)	1	318	CHAR	D or R
52	RDS/Part D Indicator (Occurrence 6)	1	319	CHAR	D or R
53	RDS/Part D Indicator (Occurrence 7)	1	320	CHAR	D or R
54	RDS/Part D Indicator (Occurrence 8)	1	321	CHAR	D or R
55	RDS/Part D Indicator (Occurrence 9)	1	322	CHAR	D or R
56	RDS/Part D Indicator (Occurrence 10)	1	323	CHAR	D or R
Uncovered Months Data (20 occurrences)					
57	Start Date (Occurrence 1)	8	324 – 331	CHAR	CCYYMMDD
58	Number of Uncovered Months (Occurrence 1)	3	332 – 334	NUM	
59	Number of Uncovered Months Status Indicator (Occurrence 1)	1	335	CHAR	
60	Total Number of Uncovered Months (Occurrence 1)	3	336 – 338	ZD	
61	Uncovered Months (Occurrence 2)	15	339 – 353	See Fields 57 – 60	

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
62	Uncovered Months (Occurrence 3)	15	354 – 368	See Fields 57 – 60	
63	Uncovered Months (Occurrence 4)	15	369 – 383	See Fields 57 – 60	
64	Uncovered Months (Occurrence 5)	15	384 – 398	See Fields 57 – 60	
65	Uncovered Months (Occurrence 6)	15	399 – 413	See Fields 57 – 60	
66	Uncovered Months (Occurrence 7)	15	414 – 428	See Fields 57 – 60	
67	Uncovered Months (Occurrence 8)	15	429 – 443	See Fields 57 – 60	
68	Uncovered Months (Occurrence 9)	15	444 – 458	See Fields 57 – 60	
69	Uncovered Months (Occurrence 10)	15	459 – 473	See Fields 57 – 60	
70	Uncovered Months (Occurrence 11)	15	474 – 488	See Fields 57 – 60	
71	Uncovered Months (Occurrence 12)	15	489 – 503	See Fields 57 – 60	
72	Uncovered Months (Occurrence 13)	15	504 – 518	See Fields 57 – 60	
73	Uncovered Months (Occurrence 14)	15	519 – 533	See Fields 57 – 60	
74	Uncovered Months (Occurrence 15)	15	534 – 548	See Fields 57 – 60	
75	Uncovered Months (Occurrence 16)	15	549 – 563	See Fields 57 – 60	
76	Uncovered Months (Occurrence 17)	15	564 – 578	See Fields 57 – 60	
77	Uncovered Months (Occurrence 18)	15	579 – 593	See Fields 57 – 60	
78	Uncovered Months (Occurrence 19)	15	594 – 608	See Fields 57 – 60	
79	Uncovered Months (Occurrence 20)	15	609 – 623	See Fields 57 – 60	

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
80	Beneficiary's Retrieved Date of Birth (as retrieved from CMS database for matching beneficiary)	8	624 – 631	CHAR	CCYYMMDD
81	Beneficiary's Retrieved Gender Code (as retrieved from CMS database for matching beneficiary)	1	632	CHAR	0 = Unknown. 1 = Male. 2 = Female.
82	Last Name	40	633 – 672	CHAR	
83	First Name	30	673 – 702	CHAR	
84	Middle Initial	1	703	CHAR	
85	Current State Code	2	704 – 705	CHAR	
86	Current County Code	3	706 – 708	CHAR	
87	Date of Death	8	709 – 716	CHAR	CCYYMMDD
88	Part C/D Contract Number (if available)	5	717 – 721	CHAR	
89	Part C/D Enrollment Start Date (if available)	8	722 – 729	CHAR	CCYYMMDD
90	Part D Indicator (if available)	1	730	CHAR	Y = Yes. N = No. Space.
91	Part C Contract Number (if available)	5	731 – 735	CHAR	
92	Part C Enrollment Start Date (if available)	8	736 – 743	CHAR	
93	Part D Indicator (if available)	1	744	CHAR	N = No. Space.
94	End Stage Renal Disease Indicator	1	745	CHAR	ESRD Indicator 0 = No ESRD. 1 = ESRD.
95	PBP Number (associated with contract number in Field 88, positions 717 – 721)	3	746 – 748	CHAR	Plan Benefit Package number

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
96	Plan Type Code (associated with PBP number in Field 95, positions 746 – 748)	2	749 – 750	CHAR	Type of plan: 01 = HMO. 02 = HMOPOS. 04 = Local PPO. 05 = PSO (State License). 07 = MSA. 08 = RFB PFFS. 09 = PFFS. 18 = 1876 Cost. 19 = HCPP 1833 Cost. 20 = National PACE. 28 = Chronic Care. 29 = Medicare Prescription Drug Plan. 30 = Employer/ Union Only Direct Contract PDP. 31 = Regional PPO. 40 = Employer/ Union Only Direct Contract PFFS. 42 = RFB HMO. 43 = RFB HMOPOS. 44 = RFB Local PPO. 45 = RFB PSO (State License). 46 = Point-of-Sale Contractor. 47 = Employer/ Union Only Direct Contract PPO. 48 = Medicare-Medicaid Plan HMO. 49 = Medicare-Medicaid Plan HMOPOS. 50 = Medicare-Medicaid Plan PPO. 99 = Undefined Historical Data.
97	EGHP Indicator (associated with PBP number in Field 95, positions 746 – 748)	1	751	CHAR	EGHP Switch: Y = EGHP. N = not EGHP.
98	PBP Number (associated with contract number in Field 91, positions 731 – 735)	3	752 – 754	CHAR	Plan Benefit Package number.
99	Plan Type Code (associated with PBP number in Field 98, positions 752 – 754)	2	755 – 756	CHAR	See values in Field 96, positions 749 – 750.

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
100	EGHP Indicator (associated with PBP number in Field 98, positions 752 – 754)	1	757	CHAR	Employer Group Health Plan Switch: Y = EGHP. N = not EGHP.
101	Mailing Address Line 1	40	758 – 797	CHAR	
102	Mailing Address Line 2	40	798 – 837	CHAR	
103	Mailing Address Line 3	40	838 – 877	CHAR	
104	Mailing Address Line 4	40	878 – 917	CHAR	
105	Mailing Address Line 5	40	918 – 957	CHAR	
106	Mailing Address Line 6	40	958 – 997	CHAR	
107	Mailing Address City	40	998 – 1037	CHAR	
108	Mailing Address Postal State Code	2	1038-1039	CHAR	
109	Mailing Address ZIP Code	9	1040–1048	CHAR	
110	Mailing Address Start Date	8	1049–1056	CHAR	CCYYMMDD
111	Residence Address Line 1	60	1057–1116	CHAR	
112	Residence Address City	40	1117–1156	CHAR	
113	Residence Address Postal State Code	2	1157–1158	CHAR	
114	Residence Address ZIP Code	9	1159–1167	CHAR	
115	Residence Address Start Date	8	1168- 175	CHAR	CCYYMMDD
116	Medicare Plan Ineligibility Due to Incarceration Start Date(1)	8	1176–1183	CHAR	CCYYMMDD
117	Medicare Plan Ineligibility Due to Incarceration End Date(1)	8	1184–1191	CHAR	CCYYMMDD
118	Medicare Plan Ineligibility Due to Incarceration Start Date(2)	8	1192–1199	CHAR	CCYYMMDD
119	Medicare Plan Ineligibility Due to Incarceration End Date(2)	8	1200–1207	CHAR	CCYYMMDD
120	Medicare Plan Ineligibility Due to Incarceration Start Date(3)	8	1208–1215	CHAR	CCYYMMDD
121	Medicare Plan Ineligibility Due to Incarceration End Date(3)	8	1216–1223	CHAR	CCYYMMDD
122	Medicare Plan Ineligibility Due to Incarceration Start Date(4)	8	1224–1231	CHAR	CCYYMMDD
123	Medicare Plan Ineligibility Due to Incarceration End Date(4)	8	1232–1239	CHAR	CCYYMMDD
124	Medicare Plan Ineligibility Due to Incarceration Start Date(5)	8	1240–1247	CHAR	CCYYMMDD
125	Medicare Plan Ineligibility Due to Incarceration End Date(5)	8	1248–1255	CHAR	CCYYMMDD
126	Medicare Plan Ineligibility Due to Incarceration Start Date(6)	8	1256–1263	CHAR	CCYYMMDD
127	Medicare Plan Ineligibility Due to Incarceration End Date(6)	8	1264–1271	CHAR	CCYYMMDD
128	Medicare Plan Ineligibility Due to Incarceration Start Date(7)	8	1272–1279	CHAR	CCYYMMDD
129	Medicare Plan Ineligibility Due to Incarceration End Date(7)	8	1280–1287	CHAR	CCYYMMDD
130	Medicare Plan Ineligibility Due to Incarceration Start Date(8)	8	1288–1295	CHAR	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
131	Medicare Plan Ineligibility Due to Incarceration End Date(8)	8	1296–1303	CHAR	CCYYMMDD
132	Medicare Plan Ineligibility Due to Incarceration Start Date(9)	8	1304–1311	CHAR	CCYYMMDD
133	Medicare Plan Ineligibility Due to Incarceration End Date(9)	8	1312–1319	CHAR	CCYYMMDD
134	Medicare Plan Ineligibility Due to Incarceration Start Date(10)	8	1320–1327	CHAR	CCYYMMDD
135	Medicare Plan Ineligibility Due to Incarceration End Date(10)	8	1328–1335	CHAR	CCYYMMDD
136	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(1)	8	1336-1343	CHAR	CCYYMMDD
137	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (1)	8	1344-1351	CHAR	CCYYMMDD
138	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(2)	8	1352-1359	CHAR	CCYYMMDD
139	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (2)	8	1360-1367	CHAR	CCYYMMDD
140	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(3)	8	1368-1375	CHAR	CCYYMMDD
141	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (3)	8	1376-1383	CHAR	CCYYMMDD
142	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(4)	8	1384-1391	CHAR	CCYYMMDD
143	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (4)	8	1392-1399	CHAR	CCYYMMDD
144	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(5)	8	1400-1407	CHAR	CCYYMMDD
145	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (5)	8	1408-1415	CHAR	CCYYMMDD
146	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(6)	8	1416-1423	CHAR	CCYYMMDD
147	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (6)	8	1424-1431	CHAR	CCYYMMDD
148	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(7)	8	1432-1439	CHAR	CCYYMMDD
149	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (7)	8	1440-1447	CHAR	CCYYMMDD
150	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(8)	8	1448-1455	CHAR	CCYYMMDD
151	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (8)	8	1456-1463	CHAR	CCYYMMDD
152	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(9)	8	1464-1471	CHAR	CCYYMMDD
153	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (9)	8	1472-1479	CHAR	CCYYMMDD
154	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(10)	8	1480-1487	CHAR	CCYYMMDD
155	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (10)	8	1488-1495	CHAR	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
156	Current Enrollment Source Type Code (associated with PBP number in Field 95, positions 746 – 748)	1	1496	CHAR	A = Part D Auto-Enrolled by CMS. B = Beneficiary Election. C = Part D Facilitated enrollment by CMS. D = System-Generated Enrollment (Rollover). E = Plan-submitted auto-enrollments. F = Plan-submitted facilitated enrollments. G = Point of Sale (POS) submitted enrollments. H = CMS or Plan submitted re-assignment enrollments. I = Assigned to Plan-submitted transactions with enrollment source other than any of the following: B, E, F, G, H and space. J = State-Submitted MMP Passive Enrollment. K = CMS-Submitted MMP Passive Enrollment. L = Beneficiary MMP Election.
157	Current Enrollment Source Type Code (associated with PBP number in Field 98, positions 752– 754)	1	1497	CHAR	See values in Field 156, position 1496.
158	Prior Part C/D Contract Number	5	1498-1502	CHAR	
159	Prior Part C/D Enrollment Start Date (associated with PBP Number in Field 162, positions 1520-1522)	8	1503-1510	CHAR	CCYYMMDD
160	Prior Part C/D Disenrollment Date (associated with PBP Number in Field 162, positions 1520-1522)	8	1511-1518	CHAR	CCYYMMDD
161	Prior Part D Indicator (associated with PBP Number in Field 162, positions 1520-1522)	1	1519	CHAR	Y = Yes. N = No. Space.

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
162	Prior PBP Number (associated with Contract Number in Field 158, positions 1498-1502)	3	1520-1522	CHAR	Plan Benefit Package number
163	Prior Plan Type Code (associated with PBP Number in Field 162, positions 1520-1522)	2	1523-1524	CHAR	See values in Field 96 (positions 749-750).
164	Prior EGHP Indicator (associated with PBP Number in Field 162, positions 1520-1522)	1	1525	CHAR	Employer Group Health Plan Switch: Y = EGHP. N = not EGHP.
165	Prior Enrollment Source Type Code (associated with PBP Number in positions 1520-1522)	1	1526	CHAR	See values in Field 156 (position 1496).
166	Prior Part C Contract Number	5	1527-1531	CHAR	
167	Prior Part C Enrollment Start Date (associated with PBP Number in Field 170, positions 1549-1551)	8	1532-1539	CHAR	CCYYMMDD
168	Prior Part C Disenrollment Date (associated with PBP Number in Field 170, positions 1549-1551)	8	1540-1547	CHAR	CCYYMMDD
169	Prior Part D Indicator (associated with PBP Number in Field 170, positions 1549-1551)	1	1548	CHAR	N = No Space
170	Prior PBP Number (associated with Contract Number in Field 166, positions 1527-1531)	3	1549-1551	CHAR	Plan Benefit Package number
171	Prior Plan Type Code (associated with PBP Number in Field 170, positions 1549-1551)	2	1552-1553	CHAR	See values in Field 96 (positions 749-750).
172	Prior EGHP Indicator (associated with PBP Number in Field 170, positions 1549-1551)	1	1554	CHAR	Employer Group Health Plan Switch Y = EGHP N = not EGHP
173	Prior Enrollment Source Type Code (associated with PBP Number in Field 170, positions 1549-1551)	1	1555	CHAR	See values in Field 156 (position 1496).
174	Active MBI	11	1556-1566	CHAR	The MBI from the beneficiary's active Beneficiary MBI period. The value is a system-generated identifier used internally and externally to uniquely identify the beneficiary in the Medicare database.
175	Filler	434	1557-2000	CHAR	Spaces

Layout 3-6: BEQ Response Trailer Record

BEQ Response Trailer Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Trailer Code	8	1 – 8	CHAR	CMSBEQRT
2	Sending Entity	8	9 – 16	CHAR	'MBD ' (MBD + five spaces)
3	File Creation Date	8	17 – 24	CHAR	CCYYMMDD
4	File Control Number	9	25 – 33	CHAR	
5	Record Count	7	34 – 40	ZD	Right justified.
6	Filler	1960	41 – 2000	CHAR	Spaces.

3.2 Enrollment/Disenrollment/Change Transaction Process

Plans may submit multiple transaction files during any CMS business day, Monday through Friday. Plan transactions are processed as received; there is no minimum or maximum limit to the number of files that Plans may submit in a day.

All Plan-submitted files should comply with the record formats and field definitions as described for each file type. Plans should send files in a flat file structure that conform to the Dataset Naming Conventions unique to each file type.

CMS recognizes Plan submitted files by the information supplied in the Header and Trailer Records. Header Record information is critical as CMS uses it to track, control, formulate, and route files and transactions through the CMS systems and is used to send response files back to the Plans.

Transactions also enter the system from other sources, including the 1-800 MEDICARE Service Center. For an overview of the methodologies that CMS employs for transaction processing, see the Medicare Managed Care Eligibility and Enrollment website link: http://www.cms.gov/MedicareMangCareEligEnrol/01_Overview.asp. In the **Downloads** section, refer to the Enrollment and Disenrollment Guidance documents.

3.2.1 *Transaction Process Flow*

In general, transaction and processing occurs throughout the Current Calendar Month (CCM). Transactions processed on or before the Plan Data Cut-Off date will be included in the prospective payment to the Plan.

After the Cut-Off date, the MARx month-end process performs the payment calculation of beneficiary-level payments to Plan-level payments. While CMS is reviewing monthly payments for approval, Plan transaction processing resumes for the next month. Once CMS approves the monthly prospective payments, reports are distributed to the Plans.

The following steps are taken to process transactions from a Plan:

- Plans submit transaction files using the selected data exchange method**.**
- MARx processes the submitted transactions, resulting in actions that affect beneficiary enrollment, payment, and status.
- The Plan receives accepted transactions in the *Daily Transaction Reply Report* (DTRR. These records contain a Transaction Reply Code (TRC), which describes CMS response.
- MARx calculates prospective payments, and/or retroactive adjustments.
- An unaccepted transaction results in either a rejected or failed status.
    - A ***rejection*** results when incoming data is of the correct type but is not successfully processed due to some inconsistency that violates an enrollment validation check or rule. For example, if the contract number does not identify a valid contract for the submitter, MARx rejects the transaction. Rejected transactions are reported on the DTRR and transmitted to the Plan.
    - A ***failure*** results when incoming data is inconsistent with the database rules. A transaction fails during processing when it contains an error that is too severe to

attempt to process and store the data in the system. The transaction is written to the *Batch Completion Status Summary* (BCSS), and transmitted to the Plan.

3.2.2 *MARx Monthly Calendar*

It is vital that everyone involved in the Medicare enrollment and payment operations of the contract is aware of these dates. The MARx Monthly Calendar for the current year indicates the following dates:

- **Plan Data Cut-Off:** This is the last day for Plans to transmit records to the CMS Data Center for processing in the Current Processing Month. Plans must complete the transmission by 8:00 PM Eastern time on the date noted**.**
- **Payment to Plan:** This is the date that CMS deposits the monthly payment to the Plans. All deposits are made to arrive on the first calendar day of the month unless the first day falls on a weekend or a Federal holiday. In this case, the deposit arrives on the last workday prior to the first of the month.
- **Monthly Reports Available**: This is the date the CMS monthly reports are available for downloading from the mailbox or available in the MARx UI.
- **Annual Election Period**: The Annual Election Period (AEP) is October 15 through December 7 every year. Elections made during the AEP are effective January 1 of the following year.
- **Certification of Enrollment:** This is the date by which Plans must certify the accuracy of the enrollment information of the MARx Report. Plans must send the Certification via the Health Plan Management System (HPMS).
- **CMS Holidays:** These are the Federal Holidays where the CMS Offices are closed. The MAPD Help Desk is closed on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas.

The MARx Monthly Calendar and other useful calendars and schedules can be found on the MAPD Help Desk website on the **MAPD/MARx Calendars and Schedules** page at the following link:
https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/MAPD-MARx-Calendars-and-Schedules.html

3.2.3 MARx Batch Input Transaction Data File

On a daily basis, Plans may submit a *MARx Batch Input Transaction Data File* to CMS to enroll/update information about a beneficiary. This file consists of a header record followed by detail transaction records. The **Transaction Code (TC)** in each detail record identifies the type of transaction. Plans may submit any number of detail transaction records for one or more beneficiaries.

System	Type	Frequency	File Length	MARx Batch Input Dataset Naming Conventions
MARx	Data File	Batch - Daily PRN	300	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].MARX.D.xxxxx.FUTURE.[P/T][.ZIP] **Note:** FUTURE is part of the filename and does not change. **Connect:Direct:** P#EFT.IN.uuuuuuu.MARXTR.DYYMMDD.THHMMSST **Note:** DYYMMDD.THHMMSST must be coded as shown, as it is a literal

The table below provides a list of the types of detail transaction records that can be submitted in the MARx Batch Input Transaction Data file.

Table 3-3: MARx Batch Input Transaction Codes

MARx Batch Input Transaction Codes		
Transaction Code	**MARx Batch Input Detail Transaction Record Description**	**Layout Reference**
51	Disenrollment Record	3.2.5
54	Disenrollment Record (only used by the Medicare Customer Service Center)	
61	Enrollment Record	3.2.6
72	4Rx Data Change Record	3.2.7
74	Employer Group Health Plan (EGHP) Change Record	3.2.8
75	Premium Payment Option (PPO) Change Record	**Section 5 (Premiums)**
76	Residence Address Change Record	3.2.9
77	Segment ID Change Record	**Section 5 (Premiums)**
78	Part C Premium Change Record	**Section 5 (Premiums)**
79	Part D Opt-Out Record	3.2.10
80	Cancellation of Enrollment Record	3.2.11
81	Cancellation of Disenrollment Record	
82	Medicare and Medicaid Plan (MMP) Enrollment Cancellation Record	3.2.12
83	MMP Opt-Out Update Record	3.2.13
90	Point of Sale (POS) Drug Edit Record	3.2.14
91	Innovation Center (IC) Model Participation Record	3.2.15

The table below provides a list of the allowable range of dates for the MARx Batch Input Transaction Data file detail transaction record types.

Table 3-4: Allowable Range of Dates for MARx Batch Input Detail Transaction Record Types

Allowable Range of Dates for MARx Batch Input Detail Transaction Record Types				
Transaction Code	**Description**	**Earliest Date**	**Latest Date**	**Other**
51 and 54	Disenrollment Record	CCM – 3 (Employer Group Health Plans [EGHP] Only/EGHP Cost Plans) CCM – 2 (EGHP Only/EGHP Cost Plans) CCM – 1 CCM CCM + 1 CCM + 2 CCM + 3		
61	Enrollment Record	CCM – 3 (EGHP Only) CCM – 2 (EGHP Only) CCM – 1 CCM CCM + 1 CCM + 2 CCM + 3		
72	4Rx Data Change	Effective date must fall in one of the beneficiary's enrollment in the contract/PBP. There is no future date limitation.		
74	EGHP Change	CCM – 1	CCM + 3	
76	Residence Address Change	No timeliness edits. The effective date occurs during an enrollment.		
79	Part D Opt-Out Change	No timeliness edits.		
80	Cancellation of Enrollment Record	Effective date of the enrollment being canceled and removes a prior successfully processed enrollment or disenrollment action submitted by the current Plan and reinstates the beneficiary's enrollment to its prior state when MARx enrollment edits permit.		
81	Cancellation of Disenrollment Record	Effective date of disenrollment being canceled and removes a prior successfully processed enrollment or disenrollment action submitted by the current Plan and reinstates the beneficiary's enrollment to its prior state when MARx enrollment edits permit.		
82	Medicare and Medicaid Plan (MMP) Enrollment Cancellation Record	Must equal the enrollment date		
83	MMP Opt-Out Update Record	No timeliness edits.		
90	Point of Sale (POS) Drug Edit Record	No timeliness edits.		

Allowable Range of Dates for MARx Batch Input Detail Transaction Record Types				
Transaction Code	**Description**	**Earliest Date**	**Latest Date**	**Other**
91	Innovation Center (IC) Model Participation Record	No timeliness edits.		

3.2.4 MARx Batch Input Header Record

The MARx Batch Input Data File consists of a Header Record and one or more of the 17 types of Detail Records outlined in this section.

The format of the Detail Transaction Record follows a similar pattern for each transaction code. The first four (4) fields in each record will identify the beneficiary and the remaining fields are specific to the transaction code.

Layout 3-7: MARx Batch Input Header Record

MARx Batch Input Header Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Header Message	12	1-12	AAAAAAHEADER
2	Filler	1	13	Spaces
3	Batch File Type	5	14-18	Spaces = no special approval required. RETRO = Retroactive submission. POVER = Plan rollover submission. SVIEW = Special Review submission.
4	Filler	1	19	Spaces
5	CMS Approval Request ID	10	20-29	Spaces when **Batch File Type**, Field 3, contains spaces; otherwise, the right justified CMS pre-approval request ID from the special batch request utility.
6	Filler	4	30-33	Spaces
7	Current Calendar Month (CCM)	6	34-39	MMCCYY Reference month for enrollment processing. The CCM date determines whether to accept a file and evaluates the appropriate effective date for submitted transactions.
8	Filler	261	40-300	Spaces

3.2.5 TC 51/54: Disenrollment Effective Dates

Plans accept disenrollment requests from beneficiaries as allowed. Once the processes and requirements are fully satisfied, the Plan must generate and submit the appropriate disenrollment transaction to CMS. Additionally, Plans may, under limited circumstances, report involuntary disenrollment actions.

Plans should refer to Chapter 2 of the *Medicare Managed Care Manual* at the following link: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html. In the Download section, click on the *MA_Enrollment_and_Disenrollment_Guidance* document.

The effective date of disenrollment is reported on the MARx disenrollment transaction as the first day of the month following the month enrollment ended. For example, if a beneficiary

disenrolled as of March 31, the disenrollment transaction, TC 51, is submitted with April 1 as the effective date.

Plans should refer to the table below to determine the appropriate effective disenrollment date and Plan type for use with the disenrollment transaction.

Table 3-5: Disenrollment Transaction and Effective Dates

Disenrollment Transaction and Effective Dates		
Code	**Definition**	**Effective Date**
51	Disenrollment submitted by Plan	CCM – 3 (EGHP Only/EGHP Cost Plans) CCM – 2 (EGHP Only/EGHP Cost Plans) CCM – 1 CCM CCM + 1 CCM + 2 CCM + 3

Plans must include a valid disenrollment reason code on all TC 51 disenrollment transactions. The table below lists the valid disenrollment reason code values.

Table 3-6: Plan Submitted Disenrollment Reason Codes

Plan Submitted Disenrollment Reason Codes		
Code	**Definition**	**When to Use**
11	Voluntary Disenrollment	Beneficiary requested disenrollment during a valid enrollment period.
63	Auto Disenrollment	MMP Opt-Out After Enrolled – For use by MMP Plans only.
64	Auto Disenrollment	Loss of Demonstration Eligibility – For use by MMP Plans only.
65	Auto Disenrollment	Loss of Employer Group Waiver Plan (EGWP) Eligibility – For use by EGWP Plans only.
91	Involuntary Disenrollment for Failure to Pay Plan Premiums	Beneficiary fails to pay Plan premiums and Plan completes all necessary steps in CMS disenrollment guidance to effectuate an involuntary disenrollment.
92	Involuntary Disenrollment for a Move Out of Plan Service Area	It is determined that the Beneficiary is out of the Plan service area, according to the procedures in CMS disenrollment guidance, and the Plan meets all requirements necessary to effectuate an involuntary disenrollment.
93	Involuntary Disenrollment for Loss of Special Needs Plan (SNP) Eligibility	It is determined that the Beneficiary no longer meets the eligibility requirements for enrollment in an exclusive SNP, and the Plan meets all requirements to effectuate an involuntary disenrollment, as defined in CMS disenrollment guidance, and including the deemed continuous eligibility provisions.

No other disenrollment reason code values are valid or acceptable on Plan-submitted disenrollment transactions. Failure to include a valid value does not result in a rejected transaction. Instead, MARx defaults the value to Disenrollment Reason Code (DRC) 99. CMS may use this information to track compliance or non-compliance with program requirements. CMS-generated disenrollment actions may contain other reason code values as applicable.

Layout 3-8: MARx Batch Input Detail Record: Disenrollment – TC 51 or 54

MARx Batch Input Detail – Disenrollment Transaction – TC51 or 54				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP (Health Care Prepayment Plan) and CCIP/FFS (Chronic Care Improvement Program/Fee-for-Service) demos. For these non-PBP organizations, populate with spaces.

MARx Batch Input Detail – Disenrollment Transaction – TC51 or 54				
Item	**Field**	**Size**	**Position**	**Description**
9	Election Type	1	46	Required for all Plan types except: • HCPP. • COST 1 without drug. • COST 2 without drug. • CCIP/FFS demo. • MDHO demo. • MSHO demo. • PACE National Plans. Valid Values: A = AEP. D = MADP. E = IEP. F = IEP2. I = ICEP. R = 5 Star Quality Rating SEP. S = Other SEP. T = OEPI. U = Dual/LIS SEP. V = Permanent Change in Residence SEP. W = EGHP SEP. X = Administrative SEP. Y = CMS/Case Worker SEP. I, A, D, O, S, N, U, V, W, X, Y and T are valid for MA only enrollments. I, A, D, O, S, U, V, W, X, Y, E, F, N, and T are valid for MAPD enrollments. A, S, U, V, W, X, Y, E and F are valid for PDP enrollments.
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60-61	51 = Disenrollment (MCO or CMS) 54 = Disenrollment (Submitted by 1-800-MEDICARE)

MARx Batch Input Detail – Disenrollment Transaction – TC51 or 54				
Item	**Field**	**Size**	**Position**	**Description**
13	Disenrollment Reason Code	2	62-63	Required for Involuntary Disenrollments. Optional for Voluntary Disenrollments. 11 = Voluntary Disenrollment. 63 = Auto Disenrollment – MMP Opt-Out after enrolled. 64 = Auto Disenrollment – Loss of Demonstration Eligibility. 65 = Auto Disenrollment – Loss of Employer Group Waiver Plan (EGWP). 91 = Involuntary Disenrollment for Failure to Pay Plan Premiums. 92 = Involuntary Disenrollment for a Move Out of Plan Service Area. 93 = Involuntary Disenrollment for Loss of Special Needs Plan (SNP) Eligibility.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Segment ID	3	72-74	The three character segment identifier, 001-999 (zero-padded). Only local MA/MAPD Plans (Hxxxx) may have segments. For non-segmented Plans, populate with spaces.
16	Filler	24	75-98	Spaces.
17	Part D Opt-Out Flag	1	99	This flag indicates that the beneficiary does not want AE in a Part D Plan. It applies to LIS beneficiaries who are subject to AE-FE into Part D. Y = add the flag to opt-out of Part D AE-FE. N = remove the flag to opt-out of Part D AE-FE. Space = no change to opt-out status
18	MMP Opt-Out Flag	1	100	This flag indicates the beneficiary does not want passive enrollment into an MMP. Y = add the flag to opt-out of passive enrollment into MMPs. N = remove the flag to opt-out of passive enrollment into an MMP. Space = no change to opt-out status.
19	Filler	109	101-209	Spaces.
20	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
21	Filler	76	225-300	Spaces.

3.2.6 TC 61: Enrollment Effective Dates

Plans accept enrollment requests from beneficiaries as provided in the CMS Enrollment and Disenrollment guidance applicable to their Plan type. After fulfilling the processes and requirements outlined in that guidance, the Plan must generate and submit the appropriate enrollment transaction to CMS, within the timeframes prescribed by the applicable guidance.

The enrollment effective date reported on the Enrollment Transaction Record is the first day of the month that the beneficiary is enrolled, i.e., that the beneficiary begins receiving benefits from the Plan, and represents the first month for which the Plan is requesting payment. The Current Calendar Month (CCM) affects the enrollment and disenrollment effective dates for Plans to submit to CMS using the different TCs available.

Plans should refer to the table below to determine the appropriate effective enrollment date and Plan type for use with the enrollment transaction.

Table 3-7: Enrollment Transaction and Effective Dates

Enrollment Transaction and Effective Dates		
Code	**Definition**	**Effective Date Options**
61	Enrollment into Contract, PBP, EGHP, and Retroactive one Month	CCM – 3 (EGHP Only) CCM – 2 (EGHP Only) CCM – 1 CCM CCM + 1 CCM + 2 CCM + 3

Layout 3-9: MARx Batch Input Detail Record: Enrollment – TC 61

MARx Batch Input Detail – Enrollment Transaction – TC 61				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1 – 12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13 – 24	Beneficiary's last name. Required.
3	First Name	7	25 – 31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34 – 41	CCYYMMDD Required
7	Employer Group Health Plan (EGHP) Flag	1	42	This flag indicates whether the Plan is an EGHP. Y = EGHP Space for all others.
8	PBP #	3	43 – 45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.

MARx Batch Input Detail – Enrollment Transaction – TC 61				
Item	**Field**	**Size**	**Position**	**Description**
9	Election Type	1	46	Required for all Plan types except: • HCPP. • COST 1 without drug. • COST 2 without drug. • CCIP/FFS demo. • MDHO demo. • MSHO demo. • PACE National Plans. Valid Values: A = AEP. D = MADP. E = IEP. F = IEP2. I = ICEP. R = 5 Star Quality Rating SEP. S = Other SEP. T = OEPI. U = Dual/LIS SEP. V = Permanent Change in Residence SEP. W = EGHP SEP. X = Administrative SEP. Y = CMS/Case Worker SEP. I, A, D, O, S, N, U, V, W, X, Y and T are valid for MA only enrollments. I, A, D, O, S, U, V, W, X, Y, E, F, N, and T are valid for MAPD enrollments. A, S, U, V, W, X, Y, E and F are valid for PDP enrollments.
10	Contract #	5	47 – 51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Application Date	8	52 – 59	CCYYMMDD. Required. The application date associated with this enrollment transaction. The application date is generally the date the enrollment request was initially received by the Plan, as further defined in the CMS Plan Enrollment Manual guidance.
12	Transaction Code	2	60 – 61	61
13	Disenrollment Reason Code	2	62 – 63	Not populated on the enrollment transaction. Spaces.
14	Effective Date	8	64 – 71	CCYYMMDD. Required. The effective date for the transaction.

MARx Batch Input Detail – Enrollment Transaction – TC 61				
Item	**Field**	**Size**	**Position**	**Description**
15	Segment ID	3	72 – 74	The three character segment identifier, 001-999 (zero-padded). Only local MA/MAPD Plans (Hxxxx) may have segments. For non-segmented Plans, populate with spaces.
16	Filler	5	75 – 79	Spaces
17	End Stage Renal Disease Override	1	80	This is populated to enroll an ESRD beneficiary into a non-PDP Plan. Any alpha-numeric value (1-9 and A-F) indicates an override. Plans should use a value F in the ESRD Override field for all override cases. Zero (0) or space indicates no override.
18	Premium Payment Option (PPO)/Parts C-D	1	81	Required for all Plan types except: • HCPP • COST 1 without drug • COST 2 without drug • CCIP/FFS demo • MSA/MA • MSA/demo This indicates the PPO requested by the beneficiary on this transaction. D = Direct self-pay. S = Deduct from SSA benefits. R = Deduct from RRB benefits. N = No Premium. The option applies to both Part C and D Premiums.
19	Part C Premium Amount	6	82 – 87	Required for all Plan types except: • HCPP • COST 1 • COST 2 • CCIP/FFS demo • MSA/MA • MSA/demo The amount of the Part C Premium is formatted as six digits with leading zeroes. A decimal point is assumed 2-digits from right; XXXXvXX. Zero is interpreted as an actual value. If Part C Premium does not apply to the enrollment, this field is treated as spaces.
20	Filler	6	88 – 93	Spaces

MARx Batch Input Detail – Enrollment Transaction – TC 61				
Item	**Field**	**Size**	**Position**	**Description**
21	Creditable Coverage Flag	1	94	Required for all Part D Plans; otherwise space. This indicates whether the beneficiary has creditable drug coverage in the period prior to this enrollment in a Part D Prescription Plan. Y = Has creditable coverage. N = Does not have creditable coverage.
22	Number of Uncovered Months (NUNCMO)	3	95 – 97	Required for all Part D Plans; otherwise space. The number of months during which the beneficiary did not have creditable coverage in the period prior to this enrollment, as determined by the Plan according to the applicable CMS policy. A NUNCMO may be greater than 0 only if the Creditable Coverage Flag is N. This field is populated with zeroes if the Creditable Coverage Flag is Y.
23	Employer Subsidy Enrollment Override Flag	1	98	Required if beneficiary has Employer Subsidy status for Part D; otherwise space. This flag indicates that the Beneficiary is currently in a Plan receiving an employer subsidy, but still wants to enroll in a Part D Plan. Y = Override the employer subsidy check and enroll the beneficiary. Space = No override.
24	Part D Opt-Out Flag	1	99	This flag indicates that the beneficiary does not want AE in a Part D Plan. It applies to LIS beneficiaries who are subject to AE-FE into Part D. Y = add the flag to opt-out of Part D AE-FE. N = remove the flag to opt-out of Part D AE-FE. Space = no change to opt-out status.
25	Filler	35	100 – 134	Spaces

MARx Batch Input Detail – Enrollment Transaction – TC 61				
Item	**Field**	**Size**	**Position**	**Description**
26	Secondary Drug Insurance Flag	1	135	Required for Part D Plans. This flag indicates whether that beneficiary has secondary drug insurance. Y = Beneficiary has secondary drug insurance. N = Beneficiary does not have secondary drug insurance. Space = Status of beneficiary's secondary drug insurance is unknown. Space = For auto/facilitated enrollments and rollovers, and for non-Part D plans.
27	Secondary Rx ID	20	136 – 155	Required when the Secondary Drug Insurance Flag = Y. Otherwise space. Secondary insurance Plan's identifier for the beneficiary. Can consist of any combination of alphanumeric characters.
28	Secondary Rx Group	15	156 – 170	Required when the Secondary Drug Insurance Flag = Y. Otherwise space. Secondary insurance Plan's Group ID for the beneficiary. Can consist of any combination of alphanumeric characters.
29	Enrollment Source	1	171	Required for POS submitted enrollment transactions. Otherwise optional. Indicates the source of the enrollment. A = Auto enrolled by CMS. B = Beneficiary Election. C = Facilitated enrollment by CMS. D = CMS Annual Rollover. E = Plan initiated auto-enrollment. F = Plan initiated facilitated-enrollment. G = Point-of-sale enrollment. H = CMS or Plan reassignment. I = Invalid submitted value (transaction is not rejected). J = State-submitted passive enrollment. K = CMS-submitted passive enrollment. L = MMP beneficiary election. N = Rollover by Plan Transaction. Space = not applicable.
30	Rolled from Contract	5	172-176	Required for Rollover enrollment transactions submitted on a POVER special batch file. Otherwise spaces.
31	Rolled from PBP	3	177-179	Required for Rollover enrollment transactions submitted on a POVER special batch file. Otherwise spaces.
32	Filler	30	180 – 209	Spaces.

MARx Batch Input Detail – Enrollment Transaction – TC 61				
Item	**Field**	**Size**	**Position**	**Description**
33	Transaction Tracking ID	15	210 – 224	Optional value created and used by the Plan to track the replies of the transaction.
34	Part D Rx BIN	6	225 – 230	Required for all Part D Plans except PACE National and MMP. Otherwise spaces. Part D insurance Plan's Beneficiary Identification Number (BIN). Numeric and right justified Example: If BIN is five-position numeric (12345), the submitted BIN is a six-position numeric with zero added in the first position (012345).
35	Part D Rx PCN	10	231 – 240	Required for all Part D Plans. Otherwise spaces. Part D insurance Plan's Pharmacy Control Number (PCN) for the Beneficiary. Alphanumeric (upper case and/or numeric) and left justified.
36	Part D Rx Group	15	241 – 255	Required for all Part D plans. Otherwise spaces. Part D insurance Plan's group identifier for the Beneficiary. Alphanumeric (upper case and/or numeric) and left justified.
37	Part D Rx ID	20	256 – 275	Required for all Part D plans except PACE National and MMP. Otherwise, spaces. Part D insurance Plan's ID for the Beneficiary. Alphanumeric (upper case and/or numeric) and left justified.
38	Secondary Drug BIN	6	276 – 281	Required when the secondary drug insurance flag = Y. Otherwise spaces. Secondary insurance Plan's BIN for the Beneficiary. Alphanumeric (upper case and/or numeric) and left justified
39	Secondary Drug PCN	10	282 – 291	Required when the secondary drug insurance flag = Y. Otherwise spaces. Secondary insurance Plan's PCN identifier for the Beneficiary. Alphanumeric (upper case and/or numeric) and left justified
40	Filler	9	292 – 300	Spaces

3.2.7 TC 72 4Rx Data Change

Layout 3-10: MARx Batch Input Detail Record: 4Rx Data Change – TC 72

MARx Batch Input Detail – 4Rx Data Change Transaction – TC 72				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1 – 12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13 – 24	Beneficiary's last name. Required.
3	First Name	7	25 – 31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34 – 41	CCYYMMDD. Required.
7	Filler	1	42	Space.
8	PBP #	3	43 – 45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space
10	Contract #	5	47 – 51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.

MARx Batch Input Detail – 4Rx Data Change Transaction – TC 72				
Item	**Field**	**Size**	**Position**	**Description**
11	Filler	8	52 – 59	Spaces
12	Transaction Code	2	60 – 61	72
13	Filler	2	62 – 63	Spaces
14	Effective Date	8	64 – 71	CCYYMMDD. Required. The effective date for the transaction.
15	Filler	63	72-134	Spaces
16	Secondary Drug Insurance Flag	1	135	Required for Part D Plans. This flag indicates whether that beneficiary has secondary drug insurance. Y = Beneficiary has secondary drug insurance. N = Beneficiary does not have secondary drug insurance. Space = Status of beneficiary's secondary drug insurance is unknown. Space = For auto/facilitated enrollments and rollovers, and for non-Part D plans.
17	Secondary Rx ID	20	136-155	Required when the Secondary Drug Insurance Flag = Y. Otherwise space. Secondary insurance Plan's identifier for the beneficiary. Can consist of any combination of alphanumeric characters.
18	Secondary Rx Group	15	156-170	Required when the Secondary Drug Insurance Flag = Y. Otherwise space. Secondary insurance Plan's Group ID for the beneficiary. Can consist of any combination of alphanumeric characters.
19	Filler	54	171-209	Spaces
20	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
21	Part D Rx BIN	6	225-230	Required together with Part D Rx ID when changing 4Rx primary insurance information. Must include either the beneficiary's current field value or the change-to value. Spaces are appropriate when not changing a beneficiary's 4Rx primary insurance information.
22	Part D Rx PCN	10	231-240	Change-to value, either a new value or spaces. Spaces remove the beneficiary's existing value.
23	Part D Rx Group	15	241-255	Change-to value, either a new value or spaces. Spaces remove the beneficiary's existing value.

MARx Batch Input Detail – 4Rx Data Change Transaction – TC 72				
Item	**Field**	**Size**	**Position**	**Description**
24	Part D Rx ID	20	256-275	Required together with Part D Rx ID when changing 4Rx primary insurance information. Must include either the beneficiary's current field value or the change-to value. Spaces are appropriate when not changing a beneficiary's 4Rx primary insurance information.
25	Secondary Drug BIN	6	276-281	Spaces or new additional value. Spaces do not remove or replace existing data.
26	Secondary Drug PCN	10	282-291	Spaces or new additional value. Spaces do not remove or replace existing data.
27	Filler	9	292-300	Spaces

3.2.8 *TC 74 EGHP Change*

Layout 3-11: MARx Batch Input Detail Record: EGHP Change – TC 74

MARx Batch Input Detail – EGHP Change Transaction – TC 74				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.

MARx Batch Input Detail – EGHP Change Transaction – TC 74				
Item	**Field**	**Size**	**Position**	**Description**
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	EGHP Flag	1	42	This flag indicates whether the Plan is an EGHP. Y = EGHP Space for all others.
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space.
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60-61	74
13	Filler	2	62-63	Spaces.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Filler	138	72-209	Spaces.
16	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
17	Filler	76	225-300	Spaces.

3.2.9 TC 76 Residence Address Change

Layout 3-12: MARx Batch Input Detail Record: Residence Address Change – TC 76

MARx Batch Input Detail – Residence Address Change Transaction – TC 76				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	5	42-46	Spaces.
8	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
9	Filler	8	52-59	Spaces.
10	Transaction Code	2	60-61	76
11	Filler	2	62-63	Spaces.
12	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
13	Filler	3	72-74	Spaces.

MARx Batch Input Detail – Residence Address Change Transaction – TC 76				
Item	**Field**	**Size**	**Position**	**Description**
14	Residence Address Line 1	65	75-139	Required when Address Update/Delete Flag indicates “Update” code.
15	Residence Address Line 2	65	140-204	Optional.
16	Filler	4	205-208	Spaces.
17	Address Update/Delete Flag	1	209	Required. U = Update (add). D = Delete.
18	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
19	Residence City	57	225-281	Required when Address Update/Delete Flag indicates “Update” code.
20	Residence State	2	282-283	Required when Address Update/Delete Flag indicates “Update” code.
21	Residence Zip Code	5	284-288	Required when Address Update/Delete Flag indicates “Update” code.
22	Residence Zip Code+4	4	289-292	Optional.
23	End Date	8	293-300	Optional.

3.2.10 TC 79 Part D Opt Out

Layout 3-13: MARx Batch Input Detail Record: Part D Opt-Out – TC 79

MARx Batch Input Detail – Part D Opt-Out Transaction – TC 79				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space.
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space.
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.

MARx Batch Input Detail – Part D Opt-Out Transaction – TC 79				
Item	**Field**	**Size**	**Position**	**Description**
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60-61	79
13	Filler	2	62-63	Spaces.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Filler	27	72-98	Spaces.
16	Part D Opt-Out Flag	1	99	Required. This flag indicates that the beneficiary does not want AE in a Part D Plan. It applies to LIS beneficiaries who are subject to AE-FE into Part D. Y = add the flag to opt-out of Part D AE-FE. N = remove the flag to opt-out of Part D AE-FE.
17	Filler	110	100-209	Spaces.
18	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
19	Filler	76	225-300	Spaces.

3.2.11 TC 80/81 Reinstatement of Enrollment/Disenrollment

Transaction Codes 80 and 81 removes a prior successfully processed enrollment or disenrollment action submitted by the current Plan and reinstates the beneficiary's enrollment to its prior state when MARx enrollment edits permit. Payments and premiums are also re-calculated and election period rules do not count against the beneficiary.

Reinstatement Criteria

Plans should consider the following criteria when MARx reinstates an enrollment period:

- Prior to beneficiary reinstatement, MARx evaluates the beneficiary and Plan status to ensure all values are within eligibility limits. The beneficiary is not reinstated for any month in which eligibility requirements are not met for the following subject areas:
  - Death of the beneficiary,
  - Medicare entitlement and Part D eligibility,
  - Beneficiary does not meet the health status requirements of the Plan, and
  - Plan is not open and active.
- A reinstated enrollment is not evaluated against the same rules as a new enrollment, such as timeliness of submission, Plan enrollment status, or election periods. The reinstatement qualifications are similar to the qualifications for remaining enrolled. For example, an enrollment is not reinstated when the beneficiary does not have sufficient entitlement or eligibility.
- MARx recalculates all beneficiary payments and premiums.

Reinstatement of Enrollment from Erroneous Auto Disenrollments

Notification of a beneficiary's date of death (DOD) triggers an automatic disenrollment in MARx. Sometimes these DODs are reversed or refined by subsequent updates, such that the original disenrollment is no longer appropriate.

A mechanism within the MARx system will attempt to automatically reinstate enrollments for beneficiaries who were auto-disenrolled by a report of DOD where there was a subsequent DOD correction or removal that impacts the Plan enrollment.

In conjunction with the reinstatement of enrollment, Plans receive appropriate TRCs that contain the information on the updated DOD and reinstated enrollment.

Reinstatement Resulting from Erroneous Auto Disenrollment Criteria

- Changes to the DOD effective date are applicable to auto reinstatement where Plan enrollment is impacted.
- All affected Plans receive a communication concerning reinstated enrollments.
- A reinstatement of enrollment does not exhaust or count against a beneficiary's usage of an election period.
- A corrected DOD that results in an earlier DOD also adjusts the Plan disenrollment.

Layout 3-14: MARx Batch Input Detail Record: Cancellation of Enrollment – TC 80

MARx Batch Input Detail – Cancellation of Enrollment Transaction – TC 80				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space.
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space.
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60-61	80

MARx Batch Input Detail – Cancellation of Enrollment Transaction – TC 80				
Item	**Field**	**Size**	**Position**	**Description**
13	Filler	2	62-63	Spaces.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Filler	138	72-209	Spaces.
16	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
17	Filler	76	225-300	Spaces.

Layout 3-15: MARx Batch Input Detail Record: Cancellation of Disenrollment – TC 81

MARx Batch Input Detail – Cancellation of Disenrollment Transaction – TC 81				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space.

MARx Batch Input Detail – Cancellation of Disenrollment Transaction – TC 81				
Item	**Field**	**Size**	**Position**	**Description**
8	PBP	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space.
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60-61	81
13	Filler	2	62-63	Spaces.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Segment ID	3	72-74	The three character segment identifier, 001-999 (zero-padded). Only local MA/MAPD Plans (Hxxxx) may have segments. For non-segmented Plans, populate with spaces.
16	Filler	135	75-209	Spaces.
17	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
18	Filler	76	225– 300	Spaces.

3.2.12 TC 82 MMP Enrollment Cancellation

Layout 3-16: MARx Batch Input Detail Record: MMP Enrollment Cancellation – TC 82

MARx Batch Input Detail – MMP Enrollment Cancellation Transaction – TC 82				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space.
8	PBP	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space.
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.

MARx Batch Input Detail – MMP Enrollment Cancellation Transaction – TC 82				
Item	**Field**	**Size**	**Position**	**Description**
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60-61	82
13	Disenrollment Reason Code	2	62-63	Optional. 11 = Voluntary Disenrollment. 63 = Auto Disenrollment – MMP Opt-Out after enrolled. 64 = Auto Disenrollment – Loss of Demonstration Eligibility. 65 = Auto Disenrollment – Loss of Employer Group Waiver Plan (EGWP). 91 = Involuntary Disenrollment for Failure to Pay Plan Premiums. 92 = Involuntary Disenrollment for a Move Out of Plan Service Area. 93 = Involuntary Disenrollment for Loss of Special Needs Plan (SNP) Eligibility.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Filler	28	72-99	Spaces.
16	MMP Opt-Out Flag	1	100	This flag indicates the beneficiary does not want passive enrollment into an MMP. Y = add the flag to opt-out of passive enrollment into MMPs. N = remove the flag to opt-out of passive enrollment into an MMP. Space = no change to opt-out status.
17	Filler	109	101-209	Spaces.
18	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
19	Filler	76	225-300	Spaces.

3.2.13 TC 83 MMP Opt-Out Update

Layout 3-17: MARx Batch Input Detail Record: MMP Opt-Out Update – TC 83

MARx Batch Input Detail – MMP Opt-Out Update Transaction – TC 83				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space.
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60-61	83

MARx Batch Input Detail – MMP Opt-Out Update Transaction – TC 83				
Item	**Field**	**Size**	**Position**	**Description**
13	Filler	2	62-63	Spaces.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Filler	28	72-99	Spaces.
16	MMP Opt-Out Flag	1	100	Required. This flag indicates the beneficiary does not want passive enrollment into an MMP. Y = add the flag to opt-out of passive enrollment into MMPs. N = remove the flag to opt-out of passive enrollment into an MMP.
17	Filler	109	101-209	Spaces.
18	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
19	Filler	76	225-300	Spaces.

3.2.14 *TC 90 POS Drug Edit*

Layout 3-18: MARx Batch Input Detail Record: POS Drug Edit – TC 90

MARx Batch Input Detail – POS Drug Edit Transaction – TC 90				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1 – 12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13 – 24	Beneficiary's last name. Required.
3	First Name	7	25 – 31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.

MARx Batch Input Detail – POS Drug Edit Transaction – TC 90				
Item	**Field**	**Size**	**Position**	**Description**
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34 – 41	CCYYMMDD. Required.
7	Filler	5	42 - 46	Spaces.
8	Contract #	5	47 – 51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
9	Filler	8	52 – 59	Spaces.
10	Transaction Code	2	60 – 61	90
11	Filler	13	62 – 74	Spaces.
12	Update/Delete Flag	1	75	Required. This flag indicates whether the POS Drug Edit Record is an update or delete. U = Update (add) D = Delete
13	POS Drug Edit Status	1	76	Required. The POS Drug Edit Status for the Beneficiary. N = Notification I = Implementation T = Termination
14	POS Drug Edit Class	3	77 - 79	Required. The restricted class of drugs. OPI = Opioids
15	POS Drug Edit Code	3	80 - 82	Required. The POS Drug Edit Code that details the level of drug usage allowed. The higher the number the less restrictive the allowance code. PS1 = No drugs allowed in the drug class (most restrictive drug allowance code) PS2 = One or more drugs in the class allowed (less restrictive drug allowance code)
16	Notification Date	8	83 - 90	CCYYMMDD, Required. The date of the POS Drug Edit Notification to the beneficiary.
17	Implementation Date	8	91 - 98	CCYYMMDD, Required if POS Drug Edit Status is I or Status is T and an Implementation record exists. The date of the POS Drug Edit Implementation.
18	Termination Date	8	99 - 106	CCYYMMDD, Required if POS Drug Edit Status is T. The date of the POS Drug Edit Termination.
19	Filler	103	107 - 209	Spaces.

MARx Batch Input Detail – POS Drug Edit Transaction – TC 90				
Item	**Field**	**Size**	**Position**	**Description**
20	Transaction Tracking ID	15	210 - 224	Optional value created and used by the Plan to track the replies of the transaction.
21	Filler	76	225 - 300	Spaces.

3.2.15 *TC 91 IC Model Participation*

Layout 3-19: MARx Batch Input Detail Record: IC Model Participation – TC 91

MARx Batch Input Detail – IC Model Participation Transaction – TC 91				
Item	**Field**	**Size**	**Position**	**Required/Optional**
1	Beneficiary Identifier	12	1 – 12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13 – 24	Beneficiary's last name. Required.
3	First Name	7	25 – 31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34 – 41	CCYYMMDD. Required.
7	Filler	1	42	Space.
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space.

MARx Batch Input Detail – IC Model Participation Transaction – TC 91				
Item	**Field**	**Size**	**Position**	**Required/Optional**
10	Contract #	5	47 – 51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52 – 59	Spaces.
12	Transaction Code	2	60 – 61	91
13	Filler	2	62 – 63	Spaces.
14	IC Model Start Date	8	64 – 71	CCYYMMDD, Required. This field indicates the date upon which the participating Plan determined that the enrollee in question was deemed to have conditions or characteristics that led to the provision of enhanced MTM services or offering of VBID benefits.
15	Filler	3	72 – 74	Spaces.
16	IC Model Update/Delete Flag	1	75	Required. U = Update (add). D = Delete.
17	IC Model Type Indicator	2	76 – 77	Required 01 = Value Based Insurance Design (VBID). 02 = Medication Therapy Management (MTM).
18	IC Model Benefit Status Code	2	78 - 79	Required if IC Model Type Indicator is 01; Spaces for other Type Indicator. This field indicates whether an enrollee in the MA-VBID model has "earned" benefits made conditional on participation in a disease management, wellness or other like program, and will assist CMS in understanding why an enrollee who otherwise appears eligible for VBID benefits does not appear to be receiving them. 01 = Full Status. 02 = Unearned Status.
19	IC Model End Date	8	80 - 87	CCYYMMDD, Optional. This field indicates the date upon which the participating Plan stopped deeming the enrollee eligible to receive enhanced MTM services or VBID benefits according to their approved application.
20	IC Model End Date Reason Code	2	88 – 89	Required if IC Model End Date is present. This signals to CMS why an enrollee is no longer being targeted by the participating Plan for enhanced MTM services or being offered VBID benefits. 01 = No longer Eligible. 02 = Opted out of program. 03 = Benefit Status Change. Spaces = Not applicable.
21	Filler	120	90 – 209	Spaces.

MARx Batch Input Detail – IC Model Participation Transaction – TC 91				
Item	**Field**	**Size**	**Position**	**Required/Optional**
22	Transaction Tracking ID	15	210 – 224	Optional value created and used by the Plan to track the replies of the transaction.
23	Filler	76	225 – 300	Spaces.

Table 3-8: IC Model Beneficiary Participation End Date Reason Codes

IC Model Beneficiary Participation End Date Reason Codes				
Code	**Description**	**MARx UI**	**Auto-Dis**	**Plan Submit (TC 91)**
01	No Longer Eligible	N/A	N/A	Y
02	Opted out of program	N/A	N/A	Y
03	Benefit status change	N/A	N/A	Y
04	Automatic CMS Disenrollment	N/A	Y	N/A

3.3 Cost Plan Transaction Process

Because beneficiaries can choose to enroll in separate or stand-alone PDPs and enroll in or remain enrolled in a Cost Plan, CMS uses PBP-level processing for Cost Plan organizations.

The Health Plan Management System (HPMS) provides available drug and non-drug PBP numbers for Cost Plans to MARx. If the Cost Plan does not have an approved non-drug PBP, HPMS generates a dummy non-drug PBP number of 999 for this Plan. This is unnecessary for drug PBPs, as Cost Plans are required to create drug PBPs.

Beneficiaries who are members of a non-drug PBP of a Cost Plan may elect to obtain Part D coverage through the Cost Plan if it is offered as an optional, supplemental benefit by the Cost Plan or through a separate PDP.

If a current member elects to obtain Part D through the Cost Plan, the Plan submits a TC 61to move the member from the non-drug PBP to the drug PBP, including the valid election type and Part D premium-related information. If a current member elects to obtain Part D through a PDP while remaining in the Cost Plan, the Cost Plan submits no transactions. When the PDP submits a TC 61 to enroll the beneficiary, CMS does not disenroll the member from the Cost Plan.

If a current member enrolled in the Part D benefit of the Cost Plan requests to drop Part D, i.e. move from the drug PBP to the non-drug PBP, the Plan submits a TC 61 transaction to move the member and includes the valid election type that permits the disenrollment from Part D.

If a new member elects to enroll in the non-drug portion of the Cost Plans, the Plan submits a TC 61 with a non-drug PBP number. The number 999 is used if the user does not have a non-drug PBP approved in HPMS.

If a new member elects to enroll in the drug portion of the Cost Plans, the Plan submits a TC 61 with the drug PBP number, election type, and Part D premium-related information.

The following clarifications related to election periods also impact Cost Plans. In two of the three scenarios, the user must specify an election type:

- Enrollment into a Cost Plan's non-drug PBP from FFS or a non-MA Plan does not require the specification of an election type. The beneficiary does not utilize an election when enrolling in non-MA or non-Part D Plans.
- Enrollment into a Cost Plan's non-drug PBP requires that the member indicate if they are enrolled in an MA or MAPD. This occurs because the beneficiary must utilize an election to disenroll from the latter Plan types. At the time of enrollment, the Cost Plan may need to query the beneficiary if they are currently enrolled in an MA Plan.
- Enrollment into, or disenrollment from, a Cost Plan's drug PBP always requires the specification of a Part D election type of AEP, IEP, or SEP. The beneficiary must request enrollment during a valid enrollment period.

3.4 Daily Transaction Reports

MARx communicates a transaction disposition through the BCSS and DTRR reports transmitted to the Plan. Upon receipt of a transaction file, the Plan representative-transmitter who submits the file receives the BCSS. Following the completion of a batch process, the DTRR is received by the user. The DTRR provides a disposition for the transactions submitted daily, along with results from various system notifications and CMS actions.

Plans may correct and resubmit failed and rejected transactions for processing. Plans validate payments at the beneficiary level based on information effective at the time of processing, i.e., enrollment, disenrollment, cancellation, applicable health statuses. This information is available via the DTRR, as well as other reports and data files described in later sections.

3.4.1 *Batch Completion Status Summary (BCSS) Report*

The BCSS file is the daily communication created to ensure Plans confirm the status of their transactions submitted to CMS in a timely manner. Plans use this file as a receipt. When CMS receives the Plan-submitted transaction, the BCSS summarizes the Plan's submission.

This data file is sent to the submitter after a batch of submitted transactions is processed. It provides a count of all transactions within the batch and summarizes the number of rejected and accepted transactions. It also provides an image of the submitted transaction for each transaction that failed.

All BCSS records begin with a one-character record type identifier (H/C/P/F) that designates the type of data reported in that section. It is followed by one digit that identifies the sequence number of the record within that section.

System	Type	Frequency	File Length	BCSS Dataset Naming Conventions
MARx	Data File	Once batch is processed	323	**Gentran Mailbox/TIBCO MFT Internet Server:** P.uuuuuuu.BCSSD.Annnnn.Bnnnnn.Thhmmss **Connect:Direct [Mainframe]:** zzzzzzzz.uuuuuuu.BCSSD.Annnnn.Bnnnnn.Thhmmss **Connect:Direct [Non-mainframe]:** [directory]uuuuuuu.BCSSD.Annnnn.Bnnnnn.Thhmmss

The following table is an example of a BCSS Report showing the following types of records:

- **Header Records (H1 – H8)** report information on the receipt, identification, and processing of the submitted batch file.
- **Transaction Count Records (C 1 – C5)** report the total number of records that were submitted for each transaction code (T51, T61, etc.). The first count on the C1 Tran CNTS1 record is not paired with a transaction code and reports the total number of transactions received in the file. The transaction code 'TXX' reports the number of transactions that were submitted with invalid transaction codes.
- **Processing Results Records (P1 – P4)** summarize the total transactions received, accepted, rejected, and failed.
- **Failed Records (F)** return an exact image of the submitted transaction that failed.

Table 3-9: BCSS Report Example

```
H1 TRANSACTIONS RECEIVED ON 2012-03-27 AT 16.59.49
H2 TRANSACTIONS PROCESSED ON 2012-03-27 AT 17.03.50
H3 ENROLLMENT PROCESSING COMPLETED
H4 HEADER CODE= AAAAAAHEADER
H5 HEADER DATE= 032012
H6 REQUEST ID =
H7 BATCH ID   = 0123456789
H8 USER ID    = X7YZ
C1 TRAN CNTS1 = 00000019 T01 0000000 T51 0000000 T61 0000000 T72 0000001
C2 TRAN CNTS2 =         T73 0000002 T74 0000000 T75 0000000 T76 0000000
C3 TRAN CNTS3 =         T77 0000000 T78 0000000 T79 0000002 T80 0000002
C4 TRAN CNTS4 =         T81 0000003 T82 0000004 T83 0000005 T90 0000000
C5 TRAN CNTS5 =   T91 0000000 TXX 0000000
P1 TOTAL TRANSACTIONS PROCESSED = 00000019
P2 TOTAL ACCEPTED TRANSACTIONS = 00000017
P3 TOTAL REJECTED TRANSACTIONS = 0000002
P4 TOTAL FAILED TRANSACTIONS   = 0000000
F……failed transaction text image……
```

Layout 3-20: BCSS Failed Transaction

Each record with record type ‘F’ reports one submitted transaction that failed. An exact image of the submitted transaction is returned along with up to five (5) TRCs that identify why the transaction failed.

BCSS Failed Transaction				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type Identifier	2	1-2	Failed Record Type: “F” (F and space).
2	Filler	1	3	Spaces.
3	Failed Input Transaction Record Text	300	4-303	Failed transaction text.
4	Filler	5	304-308	Spaces.
5	TRC	3	309-311	First TRC.
6	TRC	3	312- 314	Second TRC; otherwise, spaces.
7	TRC	3	315 - 317	Third TRC; otherwise, spaces.
8	TRC	3	318-320	Fourth TRC; otherwise, spaces.
9	TRC	3	321-323	Fifth TRC; otherwise, spaces.

3.4.2 BCSS Error Conditions

There are six (6) Error Conditions that can be returned in the Message Text when an error condition prevents the submitted transaction file from processing. The text for the error condition is in the ***H3 row*** and shown as follows:

1. **Invalid User ID.**
   H3 USER ID (aaaa) NOT AUTHENTICATED: USER ID NOT FOUND
2. **Inactive User ID.**
   H3 USER ID (aaaa) NOT AUTHENTICATED: INACTIVE USER
3. **Invalid or Missing Header Date.**
   H3 HEADER RECORD IS MISSING OR INVALID
4. **Future Header Date.**
   H3 HEADER RECORD DATE IS A FUTURE CALENDAR MONTH
5. **Header Date earlier than CCM.**
   H3 HEADER RECORD DATE IS EARLIER THAN CURRENT CALENDAR MONTH
6. **Transaction File Rejection Reason.** – When a submitted Special file (Retro, Rollover, or Special) is reviewed by CMS and rejected, the following Message text is returned.
   H3 THIS <RETRO/ROLLOVER/REVIEW> FILE WAS REJECTED BY <CMS Approver Name>

3.4.3 BCSS for Special Transaction Files

When plans submit a special transaction file that requires CMS review and approval before processing, the ***H3 and H4 rows*** will contain the following text:

1. **Retro File Detected.**
   H3 RETRO FILE DETECTED FOR USERID <aaaa>
   H4 HEADER CODE= AAAAAAHEADER RETRO
2. **Rollover File Detected.**
   H3 ROLLOVER FILE DETECTED FOR USERID <aaaa>
   H4 HEADER CODE= AAAAAAHEADER POVER
3. **Review File Detected.**
   H3 REVIEW FILE DETECTED FOR USERID <aaaa>
   H4 HEADER CODE= AAAAAAHEADER SVIEW

3.4.4 Daily Transaction Reply Report (DTRR)

To assure Plans receive proper payment, the Plan's Medicare membership records must agree with those reported to and maintained by CMS. The DTRR identifies whether a beneficiary submission was accepted or rejected and provides additional information about Plan membership.

There are three (3) types of records:

1 **Reply Records** – indicate the types of CMS action taken on the transactions submitted by the Plans daily, if transactions were received and processed.
2 **Maintenance Records** – indicates existing membership records were updated because CMS has initiated action to change or update.
3 **Plan Submitted Transaction Records** – displays the transaction submitted by Plans; does not show results, but allows Plans to view a transaction paired with its generated replies.

Upon receipt of the DTRR, it is important that Plans continue to reconcile their beneficiary records with these reports. Plans should submit corrected transactions to CMS promptly. Plans should not try to resolve a system issue by submitting falsified or incorrect data.

Each record in the DTRR is for a specific purpose defined by the three-digit Transaction Reply Code (TRC).

The DTRR is created each evening, Monday through Saturday, and is available for Plans the following business day. All Plans receive a DTRR for all contracts whether the Plan has or has not submitted transactions for processing by MARx. The TRC of 000 indicates that there is no data within the DTRR for processing by the Plan. In turn, the Plan does not need to take any action and may discard this file.

The DTRR contains the following types of information:

- **Acceptance TRCs** – returned in response to a submitted transaction which was successfully processed. Most of these are in response to a transaction submitted by the Plan, but some are system-generated.
- **Rejection TRCs** – returned in response to a submitted transaction which was rejected. The TRC on the record explains the reason for rejection.
- **Informational TRCs** – these records accompany a reply for an accepted transaction. They give the Plan additional information about the enrollment or beneficiary. For example, these may report Low Income Subsidy information, Out of Area status, etc.
- **Maintenance TRCs** – these records are sent to give the Plan information about a beneficiary who has an enrollment in their Plan. These communicate changes to the beneficiary's status, address, etc. These are initiated by CMS.
- **Verbatim records** – these have a record type of 'P'. They return an exact copy of the transaction that was submitted by the Plan. The DTRR includes a Verbatim record for each Plan-submitted transaction that was processed. These allow the Plan to review the information that they submitted when there is any question about the processing results.

System	Type	Frequency	File Length	DTRR Dataset Naming Conventions
MARx	Data File	Daily	500	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.DTRRD.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.DTRRD.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.DTRRD.Dyymmdd.Thhmmsst

Layout 3-21: DTRR Data File Detail Record

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary ID	12	1 – 12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end
2	Surname	12	13 – 24	Beneficiary Surname.
3	First Name	7	25 – 31	Beneficiary Given Name.
4	Middle Initial	1	32	Beneficiary Middle Initial.
5	Gender Code	1	33	Beneficiary Gender Identification Code. 1 = Male. 2 = Female. 0 = Unknown.
6	Date of Birth	8	34 – 41	CCYYMMDD.
7	Record Type	1	42	T = TRC record.
8	Contract Number	5	43 – 47	Plan Contract Number.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
9	State Code	2	48 – 49	Beneficiary Residence State Code; otherwise, spaces if not applicable.
10	County Code	3	50 – 52	Beneficiary Residence County Code; otherwise, spaces if not applicable.
11	Disability Indicator	1	53	0 = No Disability. 1 = Disabled without ESRD. 2 = ESRD Only. 3 = Disabled with ESRD. Space = not applicable.
12	Hospice Indicator	1	54	0 = No Hospice. 1 = Hospice. Space = not applicable.
13	Institutional/NHC/HCBS Indicator	1	55	0 = No Institutional. 1 = Institutional. 2 = NHC. 3 = HCBS. Space = not applicable.
14	ESRD Indicator	1	56	0 = No End-Stage Renal Disease. 1 = End-Stage Renal Disease. Space = not applicable.
15	Transaction Reply Code	3	57 – 59	TRC
16	Transaction Code	2	60 – 61	TC
17	Entitlement Type Code	1	62	Beneficiary Entitlement Type Code: Y = Entitled to Part A and B. Z = Entitled to Part A or B. Space = not applicable. Space reported with TRCs 121, 194, and 223 has no meaning.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
18	Effective Date	8	63 – 70	CCYYMMDD. Effective date is present for all TRCs unless listed below. Field content is TRC dependent for the following TRCs: 071 & 072 = Effective date of the hospice period. 090 = Current Calendar Month. 091 = Previously reported incorrect death date. 121, 194, and 223 = PBP enrollment effective date. 245 = The date that payments will begin to be impacted due to the addition of the Medicare Secondary Payer (MSP) period. 280 = The date that payments will begin to be impacted due to the addition of the MSP period. 293 = Enrollment End Date; Last day of the month. 305 = New ZIP Code Start Date. 366 = The effective date of the change in Medicaid status. 368 = Beginning date of the period for which the Plan's payments are impacted by MSP, based on the MSP start date. 701 = New enrollment period start date. 702 = Fill-in enrollment period start date. 703 = Start date of cancelled enrollment period. 704 = Start date of enrollment period cancelled for PBP correction. 705 = Start date of enrollment period for corrected PBP. 706 = Start date of enrollment period cancelled for segment correction. 707 = Start date of enrollment period for corrected segment. 708 = Enrollment period end date assigned to existing opened ended enrollment. 709 & 710 = New start date resulting from update. 711 & 712 = New end date resulting from update. 713 – "00000000" = End date removed. Original end date is in Field 24-x.
19	WA Indicator	1	71	0 = Not Working Aged. 1 = Working Aged. Space = not applicable.
20	Plan Benefit Package ID	3	72 – 74	PBP number.
21	Filler	1	75	Space.
22	Transaction Date	8	76 – 83	CCYYMMDD. Present for all transaction reply codes. For TRCs 121, 194, and 223, the report generation date.
23	UI Initiated Change Flag	1	84	0 = transaction from source other than user interface. 1 = transaction created through user interface. Space = not applicable.
24	Positions 85 – 96 are dependent upon the value of the TRC. Spaces except where indicated below.			
a	Effective Date of the Disenrollment	8	85 – 92	CCYYMMDD. Present only when TRC is one of the following: 13, 14, 18, or 293.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
b	New Enrollment Effective Date	8	85 – 92	CCYYMMDD. Present only when TRC is 17.
c	Claim Number (old)	12	85 – 96	Present only when TRC is one of the following: 22, 25, 86, or 301.
d	Date of Death	8	85 – 92	CCYYMMDD. Present only when TRC is one of the following: 90 (with TC 01), 92.
e	Hospice End Date	8	85 – 92	CCYYMMDD. Present only when TRC is 71 or 72. If blank for TRC 71, then the Hospice Period is open-ended.
f	ESRD Start Date	8	85 – 92	CCYYMMDD. Present only when TRC is 73.
g	ESRD End Date	8	85 – 92	CCYYMMDD. Present only when TRC is 74.
h	Institutional/ NHC Start Date	8	85 – 92	CCYYMMDD. Present only when TRC is one of the following: 48, 75, 158, or 159.
i	Medicaid Start Date	8	85 – 92	CCYYMMDD. Present only when TRC is 77.
j	Medicaid End Date	8	85 – 92	CCYYMMDD. Present only when TRC is 78.
k	Part A End Date	8	85 – 92	CCYYMMDD. Present only when TRC is 79.
l	WA Start Date	8	85 – 92	CCYYMMDD. Present only when TRC is 66.
m	WA End Date	8	85 – 92	CCYYMMDD. Present only when TRC is 67.
n	Part A Reinstate Date	8	85 – 92	CCYYMMDD. Present only when TRC is 80.
o	Part B End Date	8	85 – 92	CCYYMMDD. Present only when TRC is 81.
p	Part B Reinstate Date	8	85 – 92	CCYYMMDD. Present only when TRC is 82.
q	Old State and County Codes	5	85 – 89	Beneficiary's prior state and county code. Present only when TRC is 85.
r	Attempted Enroll Effective Date	8	85 - 92	CCYYMMDD. The effective date of an enrollment transaction that was submitted but rejected. Present only when Transaction Reply code is the following: 35, 36, 45, or 56.
s	PBP Effective Date	8	85 – 92	CCYYMMDD. Effective date of a beneficiary's PBP change. Present only when TRC is 100.
t	Correct Part D Premium Rate	12	85 – 96	ZZZZZZZZ9.99. Part D premium amount reported by HPMS for the Plan. Present only when the TRC is 181.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
u	Date Identifying Information Changed by UI User	8	85 – 92	CCYYMMDD. Field content is dependent on TRC: 702 – Fill-in enrollment period end date. 705 – End date of enrollment period for corrected PBP, spaces when end date not provided by Plan. 707 – End date of enrollment period for corrected segment, spaces when end date not provided by Plan. 709 & 710 – Enrollment period start date prior to start date change. 711, 712, & 713 – Enrollment period end date prior to end date change.
v	Modified Part C Premium Amount	12	85 – 96	ZZZZZZZZ9.99. Part C premium amount reported by HPMS for the Plan. Present only when the TRC is 182.
w	Date of Death Removed	8	85 – 92	CCYYMMDD. Previously reported erroneous date of death. Present only when TRC is 091.
x	Dialysis End Date	8	85 – 92	CCYYMMDD. Will be present when TRC is 268 and the dialysis period has an end date.
y	Transplant Failure Date	8	85 – 92	CCYYMMDD. Will be present when TRC is 269 and the transplant has an end date.
z	New ZIP Code	10	85 - 94	#####-#### Format. Will be present when TRC is 305.
aa	Previous Contract for POS Drug Edit Active Indicator	5	85-89	Will be present when TRC is 322.
bb	MSP Period Start Date	8	85 – 92	CCYYMMDD. Will be present when TRC is 245, 280, or 368 and will contain the Medicare Secondary Payer (MSP) Period Start Date.
cc	Maximum NUNCMO Calculated	3	85 – 87	Maximum incremental number of uncovered months that can be submitted for the effective date; otherwise, spaces. Present only when TRC is one of the following: 216, 300, or 341.
dd	IC Model End Date	8	85 – 92	CCYYMMDD. Will be present when TRC is 351 or 359 and the IC Model End Date is populated, or when TRC is 362.
25	District Office Code	3	97 – 99	Code of the originating district office. Present only when TC is 53; otherwise, spaces if not applicable.
26	Previous Part D Contract/PBP for TrOOP Transfer.	8	100 – 107	CCCCCPPP Format. Present only if previous enrollment exists within reporting year in Part D Contract. Otherwise, field will be spaces. CCCCC = Contract Number. PPP = Plan Benefit Package (PBP) Number.
27	Filler	8	108 – 115	Spaces.
28	Source ID	5	116 – 120	Transaction Source Identifier.
29	Prior Plan Benefit Package ID	3	121 – 123	Prior PBP number for PBP Change transaction. Present only when TC is 61; otherwise, spaces.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
30	Application Date	8	124 – 131	CCYYMMDD; otherwise, spaces if not applicable. The date the Plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper).
31	UI User Organization Designation	2	132 – 133	01 = Plan. 02 = Regional Office. 03 = Central Office. Spaces = not a UI transaction.
32	Out of Area Flag	1	134	Y = Out of area. N = Not out of area. Space = not applicable.
33	Segment Number	3	135 – 137	Further definition of PBP by geographic boundaries; otherwise, spaces when not applicable.
34	Part C Beneficiary Premium	8	138 – 145	Cost to beneficiary for Part C benefits; otherwise, spaces if not applicable.
35	Part D Beneficiary Premium	8	146 – 153	Cost to beneficiary for Part D benefits; otherwise, spaces if not applicable.
36	Election Type Code	1	154	A = AEP. C = Plan-submitted Rollover SEP. D = MADP. E = IEP. F = IEP2. I = ICEP. J = Seamless Conversion Enrollment Mechanism N = OEPNEW. O = OEP. R = 5 Star SEP. S = Other SEP. T = OEPI. U = Dual/LIS SEP. V = Permanent Change in Residence SEP. W = EGHP SEP. X = Administrative Action SEP. Y = CMS/Case Work SEP. Space = not applicable. MAs use A, C, D, F, I, J, N, O, R, S, T, U, V, W, X, and Y. MAPDs use A, C, E, F, I, J, N, O, R, S, T, U, V, W, X, and Y. PDPs use A, C, E, F, R, S, U, V, W, X, and Y.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
37	Enrollment Source Code	1	155	Required for POS submitted enrollment transactions. Otherwise optional. Indicates the source of the enrollment. A = Auto enrolled by CMS. B = Beneficiary Election. C = Facilitated enrollment by CMS. D = CMS Annual Rollover. E = Plan initiated auto-enrollment. F = Plan initiated facilitated-enrollment. G = Point-of-sale enrollment. H = CMS or Plan reassignment. I = Invalid submitted value (transaction is not rejected). J = State-submitted passive enrollment. K = CMS-submitted passive enrollment. L = MMP beneficiary election. N = Rollover by Plan Transaction. Space = not applicable.
38	Part D Opt-Out Flag	1	156	Y = Opted out of Part D AE/FE. N = Not opted out of Part D AE/FE. Space = No change to opt-out status.
39	Premium Withhold Option/Parts C-D	1	157	D = Direct self-pay. N = No premium applicable. R = Deduct from RRB benefits. S = Deduct from SSA benefits. Space = not applicable. Option applies to both Part C and D Premiums and is populated only for TRCs related to enrollment acceptance, premium or premium withholding. Rejection TRCs report the submitted PPO. TRCs 120, 185 and 186 report the PPO involved with the communication with the Withholding Agency. All others report the PPO in effect as of the Effective Date after the submitted transaction is processed.
40	Cumulative Number of Uncovered Months	3	158 – 160	Count of Total Months without drug coverage as of the effective date submitted; otherwise, spaces. Present with Enrollment Acceptance TRCs, or when TRC is the following: 141, 216, 300, or 341.
41	Creditable Coverage Flag	1	161	Y = Covered. N = Not Covered. A = Setting uncovered months reset to zero due to a new IEP. L = Setting uncovered months reset to zero due to a beneficiary Low Income. R = Setting uncovered months to zero (other). U = Reset removed and uncovered month restored to previous value. Space = not applicable.
42	Employer Subsidy Override Flag	1	162	Y = Beneficiary is in a plan receiving an employer subsidy, flag allows enrollment in a Part D plan. Space = no flag submitted by plan.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
43	Processing Timestamp	15	163 – 177	HH.MM.SS.SSSSS. Transaction processing time, or, for TRCs 121, 194, or 223, the report generation time.
44	End Date	8	178 - 185	CCYYMMDD. End Date associated with the TRC when applicable: • TRCs that report a Premium Payment Option (PPO) value that is not open-ended. • MSP TRCs 245, 280, and 368 - contains the MSP period end date, if available.
45	Submitted Number of Uncovered Months	3	186 – 188	Incremental Number of Uncovered Months submitted in the transaction; otherwise, spaces. Present with Enrollment Acceptance TRCs, or when TRC is the following: 141, 216, 300, or 341.
46	Filler	9	189 – 197	Spaces
47	Secondary Drug Insurance Flag	1	198	TC 61 MAPD and PDP transactions: Y = Beneficiary has secondary drug insurance. N = Beneficiary does not have secondary drug insurance available. Space = No flag submitted by Plan. TC 72 MAPD and PDP transactions: Y = Secondary drug insurance available. N = No secondary drug insurance available. Space = no change.
48	Secondary Rx ID	20	199 – 218	Beneficiary's secondary insurance Plan's ID number taken from the input transaction (61 or 72); otherwise, spaces for any other transaction code.
49	Secondary Rx Group	15	219 – 233	Beneficiary's secondary insurance Plan's Group ID number taken from the input transaction (61 or 72); otherwise, spaces for any other transaction code.
50	EGHP	1	234	TC 61 transactions: Y = EGHP. Space = Not EGHP. TC 74 transactions: Y = EGHP. N = Not EGHP. Space = no change.
51	Part D Low-Income Premium Subsidy Level	3	235 – 237	Part D LIPS percentage category: 000 = No subsidy. 025 = 25% subsidy level. 050 = 50% subsidy level. 075 = 75% subsidy level. 100 = 100% subsidy level. Spaces = not applicable.
52	Low-Income Co-Pay Category	1	238	Definitions of the co-payment categories: 0 = none, not low-income. 1 = High. 2 = Low. 3 = 0. 4 = 15%. 5 = Unknown. Space = not applicable.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
53	Low-Income Period Effective Date	8	239 - 246	CCYYMMDD. Date low income period starts. Spaces if not applicable.
54	Part D Late Enrollment Penalty Amount	8	247 - 254	-9999.99; otherwise, spaces if not applicable. Calculated Part D late enrollment penalty, not including adjustments indicated by Fields 53 and 54.
55	Part D Late Enrollment Penalty Waived Amount	8	255 - 262	-9999.99; otherwise, spaces if not applicable. Amount of Part D late enrollment penalty waived.
56	Part D Late Enrollment Penalty Subsidy Amount	8	263 - 270	-9999.99; otherwise, spaces if not applicable. Amount of Part D late enrollment penalty low-income subsidy.
57	Low-Income Part D Premium Subsidy Amount	8	271- 278	-9999.99; otherwise, spaces if not applicable. Amount of Part D low-income premium subsidy as of the enrollment period start date.
58	Part D Rx BIN	6	279 - 284	Beneficiary's Part D Rx BIN taken from the input transaction (61 or 72); otherwise, spaces for any other transaction code.
59	Part D Rx PCN	10	285 - 294	Beneficiary's Part D Rx PCN taken from the input transaction (61 or 72); otherwise, spaces if not provided via a transaction.
60	Part D Rx Group	15	295 - 309	Beneficiary's Part D Rx Group taken from the input transaction (61 or 72); otherwise, spaces for any other transaction code.
61	Part D Rx ID	20	310 - 329	Beneficiary's Part D Rx ID taken from the input transaction (61 or 72); otherwise, spaces for any other transaction code.
62	Secondary Rx BIN	6	330 - 335	Beneficiary's secondary insurance BIN taken from the input transaction (61 or 72); otherwise, spaces for any other transaction code.
63	Secondary Rx PCN	10	336 - 345	Beneficiary's secondary insurance PCN taken from the input transaction (61 or 72); otherwise, spaces for any other transaction code.
64	De Minimis Differential Amount	8	346 - 353	-9999.99; otherwise, spaces if not applicable. Amount by which a Part D de minimis Plan's beneficiary premium exceeds the applicable regional low-income premium subsidy benchmark.
65	MSP Status Flag	1	354	P = Medicare primary payer. S = Medicare secondary payer. N = Non-respondent beneficiary. Space = not applicable.
66	Low Income Period End Date	8	355 - 362	CCYYMMDD; otherwise, spaces if not applicable. Date low income period closes. The end date is either the last day of the PBP enrollment or the last day of the low income period itself, whichever is earlier. This field is spaces for LIS applicants with an open ended award or when the TRC is not one of the LIS TRCs 121, 194, 223.
67	Low Income Subsidy Source Code	1	363	A = Approved SSA applicant. D = Deemed eligible by CMS. Space = not applicable.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
68	Enrollee Type Flag, PBP Level	1	364	Designation relative to the report generation date (Transaction Date, Field 22). C = Current PBP enrollee. P = Prospective PBP enrollee. Y = Previous PBP enrollee. Space = not applicable.
69	Application Date Indicator	1	365	Identifies whether the application date associated with a MARx UI submitted enrollment has a system generated default value: Y = Default value for MARx UI enrollment. Space = Not applicable.
70	TRC Short Name	15	366 – 380	TRC's short-name identifier.
71	Disenrollment Reason Code	2	381 – 382	DRC
72	MMP Opt Out Flag	1	383	Y = Opted out of passive enrollment into MMP plan. N = Not opted out of passive enrollment into MMP plan. Space = Not applicable.
73	Cleanup ID	10	384 – 393	Populated if there is a Cleanup ID associated with the transaction. Spaces if no value exists. Used to identify transactions that were created to correct payment data.
74	POS Drug Edit Update/Delete Flag	1	394	U = Update (Add). D = Delete. Space = Not applicable.
75	POS Drug Edit Status	1	395	N = Notification. I = Implementation. T = Termination. Space = Not applicable.
76	POS Drug Edit Class	3	396-398	Drug class identifier. Spaces = Not applicable. Present only when TC is 90 and POS Drug Edit Class is provided, otherwise blank.
77	POS Drug Edit Code	3	399-401	POS Drug Edit Code. Spaces = Not applicable. Present only when TC is 90 and POS Drug Edit Code is provided, otherwise blank.
78	Notification Date	8	402--409	CCYYMMDD. Date beneficiary is notified of a POS Drug Edit. Present only when TC is 90 and notification date is provided, otherwise blank.
79	Implementation Date	8	410-417	CCYYMMDD. Date POS Drug Edit is implemented. Present only when TC is 90 and implementation date is provided, otherwise blank.
80	Termination Date	8	418-425	CCYYMMDD. Date POS Drug Edit is terminated. Present only when TC is 90 and termination date is provided, otherwise blank.
81	Hospice Provider Number	13	426 – 438	Hospice Medicare Provider Number.

DTRR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
82	IC Model Type Indicator	2	439-440	Present only when TC is 91. 01 = Value Based Insurance Design (VBID). 02 = Medication Therapy Management (MTM). Spaces = Not applicable.
83	IC Model End Date Reason Code	2	441-442	Present only when TC is 91 and the IC Model End Date is provided. 01 = No longer Eligible. 02 = Opted out of program. 03 = Benefit Status Change. 04 = CMS Auto Dis. Spaces = Not applicable.
84	IC Model Benefit Status	2	443-444	Present only when TC is 91. 01 = Full Status. 02 = Unearned Status. Spaces = Not Applicable.
85	Updated Medicaid Status for Community RAF beneficiary	1	445	Medicaid Status of a beneficiary whose payments are calculated using a Community Risk Adjustment Factor: F = Full Dual. P = Partial Dual. N = Non-dual.
86	Filler	29	446 - 474	Spaces.
87	System Assigned Transaction Tracking ID	11	475 – 485	System assigned transaction tracking ID.
88	Plan Assigned Transaction Tracking ID	15	486 – 500	Plan submitted batch input transaction tracking ID.

Layout 3-22: Verbatim Plan Submitted Transaction on DTRR

Verbatim Plan Submitted Transaction on DTRR				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	The same beneficiary ID submitted on the transaction.
2	Surname	12	13-24	Beneficiary Surname.
3	First Nam	7	25-31	Beneficiary Given Name.
4	Middle Initial	1	32	Beneficiary Middle Initial.
5	Gender Code	1	33	0 = Unknown. 1 = Male. 2 = Female.
6	Date of Birth	8	34-41	CCYYMMDD
7	Record Type	1	42	P = Plan submitted transaction text.
8	Contract Number	5	43-47	Plan Contract Number.
9	Plan Transaction Text	300	48-347	Copy of Plan submitted transaction.
10	Filler	126	348-473	Spaces.
11	Transaction Accept/Reject Status Flag	1	474	A = System accepted transaction. R = System rejected transaction.
12	System Assigned Transaction Tracking ID	11	475-485	System assigned request tracking ID.
13	Plan Assigned Transaction Tracking ID	15	486-500	Plan submitted batch input transaction tracking ID.

3.4.5 Transaction Reply Codes (TRCs)

The Transaction Reply Code (TRC) provides the specific explanation about the change, whether the change was accepted or rejected, and other important information for the Plan to appropriately handle the beneficiary information in the Plans' systems. This section contains the following tables:

- **Table 3-10** lists the different types of TRCs.
- **Table 3-11** lists all TRCs.
- **Table 3-12** groups similar TRCs used for a common purpose.

Table 3-10: Transaction Reply Code Types

Transaction Reply Code Types		
Code	**Description**	**Explanation**
A	Accepted	A transaction is accepted and the requested action is applied.
R	Rejected	A transaction is rejected due to an error or other condition. The requested action is not applied to the CMS System. The TRC indicates the reason for the transaction rejection. The Plan should analyze the rejection to validate the submitted transaction and to determine whether to resubmit the transaction with corrections.
I	Informational	These replies accompany Accepted TRC replies and provide additional information about the transaction or Beneficiary. For example: If an enrollment transaction for a Beneficiary who is "out of area" is accepted, the Plan receives an accepted TRC (TRC 011) and an additional reply is included in the Transaction Reply Report (TRR) that gives the Plan the additional information that the Beneficiary is "Out of Area" (TRC 016).
M	Maintenance	These replies provide information to Plans about the beneficiaries enrolled in their Plans. They are sent in response to information received by CMS. For example: If CMS is informed of a change in a beneficiary's ID, a reply is included in the Plan's TRR with TRC 086, giving the Plan the new beneficiary ID
F	Failed	A transaction failed due to an error or other condition and the requested action did not occur. The TRC indicates the reason for the transaction's failure. The Plan should analyze the failed transaction and determine whether to resubmit with corrections. Replies with the Failed TRCs are not included in the DTRR. These are provided on the Failed Records reported in the BCSS that goes back to the submitter.

Table 3-11: Transaction Reply Code Values (TRC)

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
000	I	No Data to Report	NO REPORT	This TRC can appear on both the DTRR and the Failed Payment Reply Report (FPRR) data files. On the DTRR it indicates that none of the following occurred during the reporting period for the given contract/PBP, a beneficiary status change, user interface (UI) activity, or CMS or Plan transaction processing. The reporting period is the span between the previous DTRR and the current DTRR. On the FPRR it indicates the presence of all prospective payments for the Plan (contract/PBP), none are missing. **Plan Action:** None.
001	F	Invalid Transaction Code	BAD TRANS CODE	A transaction failed because the Transaction Type Code (field 16) contained an invalid value. Valid Transaction Type Code values are 01, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 90 and 91. This transaction should be resubmitted with a valid Transaction Type Code. **Note:** Transaction Types 41, 42 and 54 are valid but not submitted by the Plans. This TRC is returned in the Batch Completion Status Summary (BCSS) Report along with the failed record and is not returned in the DTRR. **Plan Action:** Correct the Transaction Type Code and resubmit if appropriate.
002	F	Invalid Correction Action Code	BAD ACTION CODE	This TRC is returned on a failed transaction (Transaction Type 01) when the supplied action code contains an invalid value. The valid action code values are D, E, F and G. This TRC is returned in the BCSS Report along with the failed record. This TRC is not returned in the DTRR. **Plan Action:** Correct the Action Code and resubmit if appropriate.
003	F	Invalid Contract Number	BAD CONTRACT #	A transaction (Transaction Types 01, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 90 and 91) failed because CMS did not recognize the contract number. This TRC is returned in the Batch Completion Status Summary (BCSS) Report along with the failed record. This TRC will not be returned in the DTRR. **Plan Action:** Correct the Contract Number and resubmit if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
004	R	Beneficiary Name Required	NEED MEMB NAME	A transaction (Transaction Types 01, 41, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82,83, 90 and 91) was rejected, because both of the beneficiary name fields (Surname and First Name) were blank. The beneficiary's name must be provided. **Plan Action:** Populate the Beneficiary Name fields and resubmit if appropriate.
006	R	Incorrect Birth Date	BAD BIRTH DATE	A transaction (Transaction Types 01, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 90 and 91) was rejected because the Birth Date, while non-blank and formatted correctly as YYYYMMDD (year, month, and day), is before 1870 or greater than the current year. The system tried to identify the beneficiary with the remaining demographic information but could not. **Note:** A blank Birth Date does not result in TRC 006 but may affect the ability to identify the appropriate beneficiary. See TRC 009. **Plan Action:** Correct the Birth Date and resubmit if appropriate.
007	R	Invalid Beneficiary ID	BAD BENE ID FORMAT	A transaction (Transaction Types 01, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 90 and 91) was rejected, because the beneficiary identifier was not in a valid format. Format must be one of the following: • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions alphanumeric. • RRB is a 7 to 12 position value, with the first 1 to 3 positions alphanumeric and the last 6 or 9 positions numeric. • MBI is an 11 position value, with the 2nd, 5th, 8th and 9th positions alphanumeric. • String must contain NO embedded spaces. **Plan Action:** Determine the correct beneficiary identifier (HICN, RRB, or MBI) and resubmit the transaction if appropriate.
008	R	Beneficiary Identifier Not Found	BENE ID NOT FOUND	A transaction (Transaction Types 01, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 90 and 91) was rejected, because a beneficiary with this identifier was not found. The Plan must resubmit the transaction with a valid Beneficiary ID. **Plan Action:** Determine the correct beneficiary identifier (HICN, RRB, or MBI) and resubmit the transaction if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
009	R	No beneficiary match	NO BENE MATCH	A transaction (Transaction Types 01, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 90 and 91) attempted to process but the system was unable to find the beneficiary based on the identifying information submitted in the transaction. A match on beneficiary identifier (HICN, RRB, or MBI) is required, along with a match on 3 of the following 4 fields: surname, first initial, date of birth and sex code. **Plan Action:** Correct the beneficiary identifying information and resubmit if appropriate.
011	A	Enrollment Accepted as Submitted	ENROLL ACCEPTED	The new enrollment (Transaction Type 61) has been successfully processed. The effective date of the new enrollment is reported in DTRR field 18. This is the definitive enrollment acceptance record. Other accompanying replies with different TRCs may give additional information about this enrollment. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
013	A	Disenrollment Accepted as Submitted	DISENROL ACCEPT	A disenrollment transaction (Transaction Type 51 or 54) has been successfully processed. The last day of the enrollment is reported in DTRR fields 18 and 24. The disenrollment date is always the last day of the month. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record and that the beneficiary's disenrollment date matches the date in field 24. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
014	A	Disenrollment Due to Enrollment in Another Plan	DISNROL-NEW MCO	This TRC is returned when the system generates a disenrollment date due to a beneficiary's enrollment in another Plan. It is returned on a reply with Transaction Type 51 or 61. The last day of the enrollment is reported in DTRR fields 18 and 24. This date is always last day of the month. For the Transaction Type 51 transaction, the beneficiary has been disenrolled from this Plan because they were successfully enrolled in another Plan The Source ID (field 28) contains the Contract number of the Plan that submitted the new enrollment which caused this disenrollment. For the Transaction Type 61 transaction, the TRC is issued whenever a retroactive enrollment runs into an existing enrollment that prevails according to application date edits. The Source ID (field 28) contains the Contract number of the prevailing Plan. TRC 014 will not be generated if the TC 61 is a result of a PBP change. **Plan Action:** Update the Plan's records accordingly, ensuring that the beneficiary's information matches the data included in the DTRR record and that the beneficiary's disenrollment date matches the date in field 24. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**

015	A	Enrollment Removed	ENROLL REMOVED	An existing enrollment was removed from the list of the beneficiary's active enrollments. The effective date of the enrollment that was removed is reported in the Effective Date field (18). This TRC is reported on a reply with a Transaction Type 51 or 54.
				
				When an enrollment is removed, it means that the enrollment never occurred.
				
				A removal may be the result of an action on the part of the beneficiary, CMS, or another Plan. Examples:
				
				• The beneficiary enrolled in another plan before this enrollment began.
				• The beneficiary died before the enrollment began.
				• An enrollment that was the result of a rollover was removed before it began. This can be due to:
				  o The beneficiary disenrolled from the original plan with an effective date before the rollover enrollment began.
				  o The plan into which the beneficiary was rolled over removed the enrollment before it began.
				• The enrollment falls completely within a period during which the beneficiary was incarcerated or not lawfully present.
				
				Note: This removal is different from enrollment cancellations generated with an Enrollment Cancellation Transaction Code 80. An Enrollment cancellation attempts to reinstate the beneficiary into the previous plan. When a plan receives a TRC 015 saying the enrollment was removed, no reinstatements in previous plans occur.
				
				Plan Action: Because it was removed, this entire enrollment that was scheduled to begin on the date in field 18 should be removed from the Plan's enrollment records. Take the appropriate actions as per CMS enrollment guidance.

016	I	Enrollment Accepted, Out Of Area	ENROLL-OUT AREA	The beneficiary's residence state and county codes placed the beneficiary outside of the Plan's approved service area. This TRC provides additional information about a new enrollment or PBP change (Transaction Type 61) for which an acceptance was sent in a separate Transaction Reply record with an enrollment acceptance TRC. The Effective Date of the enrollment for which this information is pertinent is reported in DTRR field 18. **Plan Action:** Investigate the apparent discrepancy and take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
017	I	Enrollment Accepted, Payment Default Rate	ENROLL-BAD SCC	CMS was unable to derive a valid state and county code for the beneficiary who has been successfully enrolled. Part C payment for this beneficiary is at the Plan bid rate with no geographic adjustment. This TRC provides additional information about a new enrollment or PBP change (Transaction Type 61) for which an acceptance was sent in a separate Transaction Reply with an enrollment acceptance TRC. The effective date of the new enrollment for which this information is pertinent is reported in DTRR fields 18 and 24. **Plan Action:** Contact the MAPD Help Desk for assistance.
018	A	Automatic Disenrollment	AUTO DISENROLL	The beneficiary has been disenrolled from the Plan. The last day of enrollment is reported in DTRR fields 18 and 24. This date is always the last day of the month. The disenrollment may result from an action on the part of the beneficiary, CMS or another Plan. A DTRR reply with this TRC is usually accompanied by one or more replies, which make the reason for automatic disenrollment evident. For example, in the case of a disenrollment due to a beneficiary's death, the reply with TRC 018 is accompanied by a reply with TRC 090 (Date of Death Established). Or in the case of beneficiary loss of entitlement, TRC018 will be accompanied by one of the following benefit termination TRCs – 079 (Part A Term), 081 (Part B Term), 197 (Part D Eligibility Term). **Plan Action:** Update the Plan's records to reflect the disenrollment using the date in field 24. Take the appropriate actions as per CMS enrollment guidance.
019	R	Enrollment Rejected - No Part A & Part B Entitlement	NO ENROLL-NO AB	A submitted enrollment or PBP change transaction (Transaction Type 61) was rejected because the beneficiary does not have Medicare entitlement as of the effective date of the transaction. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.
020	R	Enrollment Rejected - Under 55	NO ENROLL-NOT55	A submitted enrollment or PBP change transaction (Transaction Type 61) for a PACE Plan was rejected because the beneficiary is not yet 55 years of age. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
022	A	Transaction Accepted, Beneficiary ID Change	NEW BENE ID	A transaction (Transaction Types 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, and 83) has been successfully processed. The effective date of the transaction is shown in DTRR field 18. Additionally, the beneficiary identifier has changed. The new beneficiary identifier is in DTRR field 1 and the old beneficiary identifier is reported in field 24. For enrollment acceptance (Transaction Type 61), TRC 022 is reported in lieu of TRC 011. Other accompanying replies with different TRCs may give additional information about this enrollment. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS guidance. Change the beneficiary identifier in the Plan's records. Any future submitted transactions for this beneficiary must use the new beneficiary identifier.
023	A	Transaction Accepted, Name Change	NEW NAME	A transaction (Transaction Types 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, and 83) has been successfully processed. The effective date of the transaction is reported in DTRR field 18. Additionally, the beneficiary's name has changed. The new name is reported in DTRR fields 2, 3 and 4. For enrollment acceptance (Transaction Type 61), TRC 023 is reported in lieu of TRC 011 or TRC 100. Other accompanying replies with different TRCs may give additional information about this enrollment. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance. Change the beneficiary's name in the Plan's records. To ensure accurate identification of the beneficiary, future submitted transactions for this beneficiary should use the new name.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
025	A	Disenrollment Accepted, Beneficiary Identifier Change	DISROL-NEW MBI	A disenrollment transaction (Transaction Type 51 or 54) submitted by the Plan has been successfully processed. The effective date of the disenrollment is reported in DTRR field 18. The disenrollment date is always the last day of the month. Additionally, the beneficiary identifier has changed. The new beneficiary identifier is in DTRR field 1 and the old beneficiary identifier is reported in field 24. **Plan Action:** Update the Plan's records to reflect the disenrollment using the date in field 24. Take the appropriate actions as per CMS enrollment guidance. Change the beneficiary identifier in the Plan's records. Future submitted transactions for this beneficiary must use the new beneficiary identifier.
026	A	Disenrollment Accepted, Name Change	DISROL-NEW NAME	A disenrollment transaction (Transaction Type 51 or 54) submitted by the Plan has been successfully processed. The effective date of the disenrollment is reported in the DTRR field 18. The disenrollment date is always the last day of the month. Additionally, The beneficiary's name has changed. The new name is reported in DTRR fields 2, 3 and 4 and in the corresponding columns in the printed report. **Plan Action:** Update the Plan's records to reflect the disenrollment using the date in field 24. Take the appropriate actions as per CMS enrollment guidance. Change the beneficiary's name in the Plan's records. To ensure accurate identification of the beneficiary, future submitted transactions for this beneficiary should use the new name.
032	R	Transaction Rejected, Beneficiary Not Entitl Part B	MEMB HAS NO B	This TRC is returned when the system rejects an enrollment (Transaction Type 61) into, or a disenrollment cancellation (Transaction Type 81) from, an MCO (MA, MAPD, HCPP, Cost 1, Cost 2 or Demos) because the beneficiary is not entitled to Part B. • TC61 – transaction rejects because the submitted enrollment date is outside the beneficiary's Part B entitlement period. • TC81 – transaction rejects because the enrollment reinstatement period is outside the beneficiary's Part B entitlement period. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
033	R	Transaction Rejected, Beneficiary Not Entitl Part A	MEMB HAS NO A	This TRC is returned when the system rejects an enrollment (Transaction Type 61) into, or a disenrollment cancellation (Transaction Type 81) from, an MCO (MA, MAPD, HCPP, Cost 1, Cost 2 or Demos) because the beneficiary is not entitled to Part A. • TC61 – transaction rejects because the submitted enrollment date is outside the beneficiary's Part A entitlement period. • TC81 – transaction rejects because the enrollment reinstatement period is outside the beneficiary's Part A entitlement period. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.
034	R	Enrollment Rejected, Beneficiary is Not Age 65	MEMB NOT AGE 65	A submitted enrollment or PBP change transaction (Transaction Type 61) was rejected because the beneficiary was not age 65 or older. The age requirement is Plan-specific. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.
035	R	Enrollment Rejected, Beneficiary is in Hospice	MEMB IN HOSPICE	A submitted enrollment or PBP change transaction (Transaction Type 61) was rejected because the beneficiary was in Hospice status. The Hospice requirement is Plan-specific (e.g. applies only to MSA/MA, MSA/Demo, OFM Demo, ESRD I Demo, ESRD II Demo, and PACE National Plans). The attempted enrollment date is reported in DTRR field 18 and 24. **Plan Action:** Update the Plan records accordingly and take the appropriate actions as per CMS enrollment guidance.
036	R	Transaction Rejected, Beneficiary is Deceased	MEMB DECEASED	A submitted enrollment or PBP change transaction (Transaction Type 61) or disenrollment cancellation transaction (Transaction Type 81) enrollment reinstatement was rejected because the beneficiary is deceased. **Plan Action:** Update the Plan records accordingly and take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
037	R	Transaction Rejected, Incorrect Effective Date	BAD ENROLL DATE	A transaction (Transaction Types 01, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, and 83) was rejected because the submitted effective date is not appropriate. Inappropriate effective dates include: • For all transaction types, date is not first day of the month • For all transaction types, date is greater than current calendar year plus one, or, date does not meet Current Calendar Month (CCM) constraints • For Transaction Type 61, non-EGHP enrollment, date is more than one month prior to CCM or greater than three months after CCM • For Transaction Type 61 transaction, EGHP enrollment, date is more than three months prior to the CCM or greater than three months after CCM • Transaction Type 72 4Rx Record Update transaction with an effective date not equal to the effective date of an existing enrollment period • Transaction Type 73 Uncovered Months Change transaction (Creditable Coverage Flag = N or Y) with an effective date not equal to the effective date of an existing enrollment period • Transaction Type 80 Enrollment Cancellation transaction with an effective date not equal to the effective date of an existing enrollment • Transaction Type 81 Disenrollment Cancellation transaction with an effective date not equal to the effective date of an existing disenrollment • Transaction Type 82 MMP Enrollment Cancellation transaction with an effective date not equal to the effective date of an existing enrollment **Plan Action:** Correct the Effective Date and resubmit if appropriate. If this is a retroactive transaction, contact CMS for instructions on submitting retroactive transactions.
038	R	Enrollment Rejected, Duplicate Transaction	DUPLICATE	An enrollment transaction (Transaction Type 61) was rejected because it was a duplicate transaction. CMS has already processed another enrollment transaction submitted for the same contract, PBP, application date and effective date. **Plan Action:** None required
039	R	Enrollment Rejected, Currently Enrolled in Same Plan	ALREADY ENROLL	An enrollment or PBP change transaction (Transaction Type 61) was rejected because the beneficiary is already enrolled in this contract/PBP. **Plan Action:** None required

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
042	R	Transaction Rejected, Blocked	ENROLL BLOCKED	An enrollment or PBP change transaction (Transaction Type 61) or disenrollment cancellation transaction (Transaction Type 81) [enrollment reinstatement] was rejected because the Plan is currently blocked from enrolling new beneficiaries. **Plan Action:** Check HPMS and contact CMS.
044	R	Transaction Rejected, Outside Contracted Period	NO CONTRACT	This TRC is returned for an enrollment or PBP change transaction (Transaction Type 61), enrollment cancellation transaction (Transaction Type 80), disenrollment cancellation transaction (Transaction Type 81), and MMP enrollment cancellation (Transaction Type 82) [enrollment reinstatement]. • TC61 – transaction was rejected because the submitted enrollment date is outside the Plan's contracted period • TC80, TC81, and TC82 – transaction was rejected because the enrollment reinstatement period is outside the Plan's contracted period **Plan Action:** Check HPMS and contact CMS.
045	R	Enrollment Rejected, Beneficiary is in ESRD	MEMB HAS ESRD	An enrollment or PBP change transaction (Transaction Type 61) was rejected because the beneficiary is in ESRD (end-stage renal disease) status. The attempted enrollment effective date is reported in DTRR field 18 and 24. Affected Plans cannot enroll ESRD members unless the individual was previously enrolled in the commercial side of the Plan or the Plan has been previously approved for such enrollments. **Plan Action:** Review full CMS guidance on enrollment of ESRD beneficiaries in the Medicare Managed Care Manual (MMCM) or PDP Enrollment Guidance. If the Plan has approval to enroll ESRD members, they should resubmit the enrollment with an A in the Prior Commercial Indicator field (position 80).
048	A	Nursing Home Certifiable Status Set	NHC ON	A correction transaction (Transaction Type 01) placed the beneficiary in Nursing Home Certifiable (NHC) status. The NHC health status is Plan specific, e.g., applies to SHMO I, Mass. Dual Eligible, MDHO and MSHO Plans. The effective date of the NHC status is reported in DTRR field 18 and 24. **Note:** This TRC is only applicable for effective dates prior to 1/1/2008. **Plan Action:** Update the Plan records.
050	R	Disenrollment Rejected, Not Enrolled	NOT ENROLLED	A disenrollment transaction (Transaction Type 51) was rejected, because the beneficiary was not enrolled in the contract as of the effective date of the disenrollment. **Plan Action:** Verify the Plan's enrollment information for this beneficiary.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
051	R	Disenrollment Rejected, Incorrect Effective Date	BAD DISENR DATE	A disenrollment transaction (Transaction Type 51) or a disenrollment cancellation transaction (Transaction Type 81) was rejected because the submitted enrollment effective date was either: • Not the first day of the month, or • More than three months beyond the Current Calendar Month (CCM+3) **Note:** Transactions with effective dates prior to CCM are returned with TRC 054. **Plan Action:** Correct the Effective Date and resubmit if appropriate. If this is a retroactive transaction, contact CMS for instructions on submitting retroactive transactions
052	R	Disenrollment Rejected, Duplicate Transaction	DUPLICATE	A disenrollment transaction (Transaction Type 51), enrollment cancellation transaction (Transaction Type 80), disenrollment cancellation transaction (Transaction Type 81) or MMP enrollment cancellation (Transaction Type 82) was rejected because it was a duplicate transaction. CMS has already processed another a similar transaction submitted for the same contract with the same effective date. The effective date of the disenrollment is reported in the Effective Date field (18) on the DTRR data file. **Plan Action:** None required
054	R	Disenrollment Rejected, Retroactive Effective Date	RETRO DISN DATE	A disenrollment transaction (Transaction Type 51 or 54) was rejected because the submitted effective date was prior to the earliest allowed date for disenrollment transactions. Effective dates for disenrollment transactions (Transaction Type 51) are no earlier than one month prior to the Current Calendar Month (CCM) or two months prior for Transaction Type 54 transactions. The requested disenrollment effective date is reported in the Effective Date field (18) on the DTRR data file. **Plan Action:** Correct the Effective Date and resubmit if appropriate. If this is a retroactive transaction, contact CMS for instructions on submitting retroactive transactions.
055	M	ESRD Cancellation	ESRD CANCELED	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary was previously in End State Renal Disease (ESRD) status. That status has been cancelled. The effective date of the ESRD status cancellation is reported in DTRR field 18 and 24. **Plan Action:** Update the Plan records.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
056	R	Demonstration Enrollment Rejected	FAILS DEMO REQ	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary did not meet the Demonstration requirements. For example, the beneficiary is currently known as Working Aged or not known as ESRD. These requirements are Plan specific. The attempted enrollment effective date is reported in DTRR fields 18 and 24. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.
060	R	Transaction Rejected, Not Enrolled	NOT ENROLLED	A Correction (Transaction Type 01), Cancellation of Enrollment (Transaction Type 80), Cancellation of Disenrollment (Transaction Type 81), MMP Enrollment Cancellation (Transaction Type 82) or change transaction (Transaction Types 74, 75, 76, 77, 78, 79, and 83) was rejected because the beneficiary was not enrolled in a Plan as of the submitted effective date. For NUNCMO Change transactions, Transaction Type 73, either the beneficiary is not enrolled in the Plan submitting this transaction as of the month of the submission, or, the submitted effective date does not fall within a Part D Plan enrollment. **Plan Action:** Verify the beneficiary identifying information and resubmit the transaction with updated information, if appropriate.
062	R	Correction Rejected, Overlaps Other Period	INS-NHC OVERLAP	A Correction (Transaction Type 01) was rejected because this transaction would have resulted in overlapping Institutional and Nursing Home Certifiable (NHC) periods. The beneficiary is not allowed to have both Institutional and NHC status. These two types of periods are mutually exclusive. **Note:** This TRC is only applicable for effective dates prior to 1/1/2008. **Plan Action:** Ensure that the Plan's records reflect the correct dates.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
071	M	Hospice Status Set	HOSPICE ON	This TRC is returned on a reply with Transaction Type 01. A notification has been received that this beneficiary is in Hospice status. The date on which Hospice Status became effective is reported in DTRR field 18. The end date for the Hospice Status is reported in DTRR field 24. The effective and end date for Hospice Status is not restricted to the first or last day of the month. It may be any day of the month. This is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. The hospice provider number is reported on the DTRR field 81. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
072	M	Hospice Status Terminated	HOSPICE OFF	This TRC is returned on a reply with Transaction Type 01. A notification has been received that this beneficiary's Hospice Status has been terminated. The date on which Hospice Status became effective is reported in DTRR field 18. The end date for the Hospice Status is reported in DTRR field 24. The effective and end date for Hospice Status is not restricted to the first or last day of the month. It may be any day of the month. This is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. The hospice provider number is reported on the DTRR field 81. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
073	M	ESRD Status Set	ESRD ON	This TRC is returned on a reply with Transaction Type 01 and occasionally with Transaction Type 61. When returned with Transaction Type 01, the TRC is in response to a change in beneficiary ESRD status. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. In the case of Transaction Type 01, a notification has been received that this beneficiary is in End Stage Renal Disease (ESRD) status. The date on which ESRD Status became effective reported in DTRR fields 18 and 24. When this TRC is returned with Transaction Type 61 the TRC is in response to a retroactive enrollment and is identifying the fact that an enrollment end date has been established due to the beneficiary's ESRD status. The enrollment start date is in DTRR field 18 and the enrollment end date is in field 24. In this circumstance it is accompanied by TRC 018, Automatic Disenrollment, as well. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
074	M	ESRD Status Terminated	ESRD OFF	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. A notification has been received that this beneficiary's End Stage Renal Disease (ESRD) Status has been terminated. The end date for the ESRD Status is reported in DTRR fields 18 and 24. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
075	A	Institutional Status Set	INSTITUTION ON	A correction transaction (Transaction Type 01) placed the beneficiary in Institutional status. The effective date of the Institutional status is shown in DTRR field 24. Institutional status automatically ends each month; therefore, there is no Institutional Status termination transaction. This TRC is only applicable for application dates prior to 01/01/2008. **Plan Action:** Update the Plan records. Take the appropriate actions as per CMS enrollment guidance. **Note:** This TRC is only applicable for effective dates prior to 01/01/2008.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
077	M	Medicaid Status Set	MEDICAID ON	This TRC is returned on a reply with Transaction Type 01. This beneficiary has been identified as having Medicaid. The effective date of the Medicaid Status is reported in field 18 (Effective Date) and field 24. The beneficiary's Medicaid status identification may be the result of any of the following: • The Medicaid status was updated for a beneficiary whose payments are calculated using a default factor. • The beneficiary's Medicaid status was updated through the UI by CMS. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
078	M	Medicaid Status Terminated	MEDICAID OFF	This TRC is returned on a reply with Transaction Type 01. A period of Medicaid status for this beneficiary has ended. The end date of the Medicaid Status is reported in field 18 (Effective Date) and field 24. The beneficiary's Medicaid status change may be the result of any of the following: • The Medicaid status was updated for a beneficiary whose payments are calculated using a default factor. • The beneficiary's Medicaid status was updated through the UI by CMS. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
079	M	Part A Termination	MEDICARE A OFF	This TRC is returned on a reply with Transaction Type 01 and occasionally with Transaction Type 61. When returned with Transaction Type 01, the TRC is in response to a change in beneficiary Part A Entitlement. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. In the case of Transaction Type 01, this beneficiary's Part A Entitlement has been terminated. The effective date of the termination is reported in DTRR fields 18 and 24. When this TRC is returned with Transaction Type 61, the TRC is in response to a retroactive enrollment and is identifying the fact that an enrollment end date has been established due to the beneficiary's termination of Part A. The enrollment start date is in DTRR field 18 and the enrollment end date is in field 24. In this circumstance it is also accompanied by TRC 018, Automatic Disenrollment. **Note:** A DTRR record with this reply code is only reported to the Plan in which the beneficiary is currently enrolled, even if it affects periods of enrollment in other Plans. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
080	M	Part A Reinstatement	MEDICARE A ON	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. This beneficiary's Part A Entitlement has been reinstated. The effective date of the start of Part A entitlement is reported in DTRR fields 18 and 24. **Note:** A DTRR record with this reply code is only reported to the Plan in which the beneficiary is currently enrolled, even if it affects periods of enrollment in other Plans. If, as a result of a loss of Part A entitlement, the beneficiary is disenrolled and does not continue enrollment in some managed care contract, the reply code is not issued. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
081	M	Part B Termination	MEDICARE B OFF	This TRC is returned on a reply with Transaction Type 01 and occasionally with Transaction Type 51 and Transaction Type 61. When returned with Transaction Type 01, the TRC is in response to a change in beneficiary Part B Entitlement. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. If applicable, CMS will disenroll the beneficiary from the Plan and return TRC 018 in addition to TRC 081. In the case of Transaction Type 01, this beneficiary's Part B Entitlement has been terminated. The effective date of the termination is reported in DTRR fields 18 and 24. When this TRC is returned with Transaction Types 51 or 61, the TRC is in response to a retroactive enrollment and is identifying the fact that an enrollment end date has been established due to the beneficiary's termination of Part B. The enrollment start date is in DTRR field 18 and the enrollment end date is in field 24. In this circumstance it is also accompanied by TRC 018, Automatic Disenrollment. **Note:** A DTRR record with this reply code is only reported to the Plan in which the beneficiary is currently enrolled, even if it affects periods of enrollment in other Plans. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
082	M	Part B Reinstatement	MEDICARE B ON	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. This beneficiary's Part B Entitlement has been reinstated. The effective date of the start of Part B entitlement is reported in field 18 and the Part B Reinstate Date is reported in field 24 of the DTRR. **Note:** A DTRR record with this reply code is only reported to the Plan in which the beneficiary is currently enrolled, even if it affects periods of enrollment in other Plans. If, as a result of a loss of Part B entitlement, the beneficiary has been disenrolled, but not re-enrolled, the reply code is not issued. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
085	M	State and County Code Change	NEW SCC	This TRC is returned on a reply with Transaction Type 01. It supplies the Plan with additional beneficiary information. This beneficiary's State and County Code (SCC) information has changed. The new SCC information is reported in DTRR fields 9 (state code), 10 (county code), and together in field 24. **Plan Action:** Update the Plan's records.
086	M	Beneficiary Identifier Change	NEW MBI	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. This beneficiary's MBI has changed. The new beneficiary identifier is reported in DTRR field 1 and the old beneficiary identifier is in Field 24. **Plan Action**: Update the Plan's records. The new beneficiary identifier is used on all future transactions for this beneficiary.
087	M	Name Change	NEW NAME	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. This beneficiary's name has changed. The new name is reported in the DTRR name fields (2, 3 and 4), SURNAME, FIRST NAME and MI. The effective date field (field 18) reports the date the name change was processed by CMS. **Plan Action:** Update the Plan's records. To ensure accurate identification of the beneficiary, future submitted transactions for this beneficiary should use the new name.
088	M	Sex Code Change	NEW SEX CODE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. This beneficiary's sex code has changed. The new sex code is reported in DTRR field 5. The effective date field (field 18) reports the date CMS processed the sex code change. **Plan Action:** Update the Plan's records. To ensure accurate identification of the beneficiary, future submitted transactions for this beneficiary should use the new sex code.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
089	M	Date of Birth Change	NEW BIRTH DATE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary's date of birth has changed. The new date of birth is reported in DTRR field 6 (DOB) and field 24. Field 18 (Effective Date) reports the date the DOB change was processed by CMS. **Plan Action:** Update the Plan's records. To ensure accurate beneficiary identification, future submitted transactions for this beneficiary should use the new date of birth.
090	M	Date of Death Established	MEMB DECEASED	This TRC is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. When CMS is notified of a beneficiary's death, the Plan receives multiple replies in their DTRR. • Transaction Type 01 with TRC 090 – received by any Plan with an enrollment affected by the beneficiary's death. • Transaction Type 51 with TRC 018 or TRC 015 – for any automatic disenrollments or enrollment cancellations triggered as a result of the beneficiary's death. • Transaction replies with other TRCs may also accompany these replies. Examples include status terminations and SSA responses. On the Transaction Type 01 with TRC 090, the beneficiary's actual date of death is reported in DTRR fields 18 and 24. On a Transaction Type 51 transaction with TRC 018, fields 18 and 24 report the effective date of the disenrollment resulting from the report of death. This is always on the first of the month following the date of death, if the beneficiary is actively enrolled in a Plan. If the Plan's enrollment is not yet effective, the Plans will receive a Type 51 transaction with TRC 015 and these fields will report the effective date of the enrollment being cancelled. **Plan Action:** Update the Plan's records with the beneficiary's date of death from the Transaction Type 01 transaction. It is the Transaction Type 51 transaction with TRC 018 or 015 that is processed as the auto-disenrollment or cancellation. Take the appropriate actions as per CMS enrollment guidance. **Note:** The above transaction replies may not appear in the same DTRR.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
091	M	Date Of Death Removed	DEATH DATE OFF	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. Although the Plan has previously received a transaction reply reporting a date of death for this beneficiary, the date of death has been removed. The beneficiary is still alive. DTRR fields 18 and 24 contain the date of death that was previously reported to the Plan. If the date of death is removed after the auto disenrollment has taken effect, the Plan will not receive this transaction reply. The removal of the Date of Death may initiate the reinstatement of an enrollment. (See TRC 287) **Plan Action:** Update the Plan's records and restore the beneficiary's enrollment with the original enrollment start and end dates. Take the appropriate actions as per CMS enrollment guidance.
092	M	Date of Death Corrected	NEW DEATH DATE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. The date of death for this beneficiary has been corrected. The corrected date of death is reported in DTRR field 24. *The correction of the DOD may initiate the reinstatement of an enrollment. (See TRC 287)* **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
099	M	Medicaid Period Change/Cancellation	MCAID CHANGE	A change has been made to a period of Medicaid status information for the beneficiary. **Plan Action:** Plan should update beneficiary record.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
100	A	PBP Change Accepted as Submitted	PBP CHANGE OK	A submitted PBP Change transaction (Transaction Type 61) has been successfully processed. The beneficiary has been moved from the original PBP to the new PBP. The effective date of enrollment in the new PBP is reported in fields 18 and 24 of the DTRR. The effective date is always the first day of the month. This is the definitive PBP Change acceptance record. Other accompanying replies with different TRCs may give additional information about this accepted PBP Change. Field 20 (Plan Benefit Package ID) contains the new PBP identifier. The old PBP is reported in field 29 (Prior Plan Benefit Package ID). **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
102	R	Rejected; Incorrect or Missing Application Date	BAD APP DATE	If the Application Date on an enrollment transaction (Transaction Type 61) is blank or contains a valid date that is not appropriate for the submitted transaction, TRC 102 is returned in the DTRR record. Examples of inappropriate application dates: • Date is blank. • Date is later than the submitted Effective Date. • Date does not lie within the election period specified on the submitted transaction. **Note:** Plans should see *Chapter 2 of the MMCM or the PDP Guidance on Eligibility, Enrollment and Disenrollment* for detailed descriptions of the Election Periods. **Plan Action:** Correct the Application Date and resubmit if appropriate.
103	R	Missing A/B Entitlement Date	NO A/B ENT	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary does not have entitlement for Part A and/or enrollment in Part B on record (required for enrollment transactions). This TRC will only be returned on enrollment transactions submitted with election type I (Initial Coverage Election Period), E (Initial Enrollment Period for Part D) or J (Seamless Conversion Enrollment Mechanism). **Plan Action:** Verify the beneficiary's Part A / Part B entitlement / enrollment. Take the appropriate actions as per CMS enrollment guidance. If the election type is J (Seamless Conversion Enrollment Mechanism), the plan is not allowed to resubmit the enrollment transaction.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
104	R	Rejected; Invalid or Missing Election Type	BAD ELECT TYPE	An enrollment (Transaction Type 61) or disenrollment (Transaction Type 51) was rejected because the submitted Election Type Code is missing, contains an invalid value, or is not appropriate for the plan or for the transaction type. The valid Election Type Code values are: A - Annual Election Period (AEP) D - MA Annual Disenrollment Period (MADP) E - Initial Enrollment Period for Part D (IEP) F - Second Initial Enrollment Period for Part D (IEP2) I - Initial Coverage Election Period (ICEP) J - Seamless Conversion Enrollment Mechanism (SCEM) O - Open Enrollment Period (OEP) (Valid through 3/31/2010) N - Open Enrollment for Newly Eligible Individuals (OEPNEW) (Valid through 12/31/2010) T - Open Enrollment Period for Institutionalized Individuals (OEPI) Special Enrollment Periods C - SEP for Plan-submitted rollovers • *Plan-submitted rollover enrollments (Enrollment Source Code = N)* U - SEP for Loss of Dual Eligibility or for Loss of LIS V - SEP for Changes in Residence

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
104 Con't	R	Rejected; Invalid or Missing Election Type	BAD ELECT TYPE	W – SEP EGHP (Employer/Union Group Health Plan) Y – SEP for CMS Casework Exceptional Conditions X – SEP for Administrative Change • *Involuntary Disenrollment* • *Premium Payment Option Change* • *Plan-submitted "Canceling" Transaction* Z – SEP for: • *Auto-Enrollment (Enrollment Source Code = A)* • *Facilitated Enrollment (Enrollment Source Code = C)* • *Plan-Submitted Auto-Enrollment (Enrollment Source Code = E) and Transaction Type 61 (PBP Change) and MA or Cost Plan (all conditions must be met)* • *LINET Enrollment (Enrollment Source Code = G)* S – Special Enrollment Period (SEP) The value expected in Election Type Code depends on the Plan and transaction type, as well as on when the beneficiary gains entitlement. Each Election Type Code can be used only during the election period associated with that election type. Additionally, there are limits on the number of times each election type may be used by the beneficiary. **Plan Action:** Review the detailed information on Election Periods in *Chapter 2 of the Medicare Managed Care Manual or the PDP Guidance on Eligibility, Enrollment and Disenrollment*. Determine the appropriate Election Type Code value and resubmit, if appropriate.
105	R	Rejected; Invalid Effective Date for Election Type	BAD ELECT DATE	An enrollment or disenrollment transaction (Transaction Types 61, 51) was rejected because the effective date was not appropriate for the election type or for the submitted application date. Examples of inappropriate effective dates: • Date is outside of the election period defined by the submitted election type. (ex: Election Type = A and Effective Date = 2/1/2007) • Date is not appropriate for the application date (ex: App date = 6/10/2007 & Eff Date =11/01/2007) **Plan Action:** Correct the Effective Date or Election Type and resubmit if appropriate. Review *Chapter 2 of the MMCM or the PDP Guidance on Eligibility, Enrollment and Disenrollment* for detailed descriptions of the Election Periods and corresponding effective dates.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
106	R	Rejected, Another Trans Rcvd with Later App Date	LATER APPLIC	An enrollment transaction (Transaction Type 61) was rejected because a previously received enrollment transaction exists with the following criteria: • An application date that is more recent or equal to the application date provided on the submitted enrollment transaction; and • An effective date that is earlier or equal to the effective date provided on the submitted enrollment transaction. An enrollment transaction (Transaction Type 61) is rejected because a previously received enrollment transaction exists with the following criteria: The submitted enrollment has been overridden by a previously received enrollment in another contract/PBP. When multiple transactions are received for the same beneficiary with different contract/PBP #s, the application date is used to determine which enrollment to accept. If the application dates are different, the system will accept the election containing the most recent date. **Plan Action:** The beneficiary is not enrolled in the Plan. Update the Plan's records.
107	R	Rejected, Invalid or Missing PBP Number	BAD PBP NUMBER	An enrollment, disenrollment or Record Update transaction (Transaction Types 51, 61, 72, 73, 74, 75, 77, 78, 79, 80, 81, 82, 83 and 91) was rejected because the PBP # was missing or invalid. The PBP # must be of the correct format and be valid for the contract on the transaction. **Note:** PBP # is not required on Residence Address (Transaction Type 76) but when submitted it must be valid for the contract number on the transaction. **Plan Action:** Correct the PBP # and resubmit the transaction if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**

108	R	Rejected, Election Limits Exceeded	NO MORE ELECTS	A transaction for which an election type is required (Transaction Types 51, 61) was rejected because the transaction will exceed the beneficiary's election limits for the submitted election type.
				
				The valid Election Type values which have limits are:
				• A – Annual Election Period (AEP)
				  o 1 per calendar year
				• E – Initial Enrollment Period for Part D (IEP)
				  o 1 per lifetime
				• F – Initial Enrollment Period for Part D (IEP2)
				  o 1 per lifetime
				• I – Initial Coverage Election Period (ICEP)
				  o 1 per lifetime
				• J – Seamless Conversion Enrollment Mechanism (SCEM)
				  o 1 per lifetime
				
				Plan Action: Review the discussion of election type requirements in *Chapter 2 of the Medicare Managed Care Manual or the PDP Guidance on Eligibility, Enrollment and Disenrollment.* Correct the election type and resubmit the transaction if appropriate.

109	R	Rejected, Duplicate PBP Number	ALREADY ENROLL	An enrollment transaction (Transaction Type 61) was rejected because the member is already enrolled in the PBP # on the transaction. The effective date of the requested enrollment is reported in DTRR field 18. **Plan Action:** If the submitted PBP was correct, no Plan Action is required. If another PBP was intended, correct the PBP # and resubmit if appropriate.
110	R	Rejected; No Part A and No EGHP Enrollment Waiver	NO PART A/EGHP	A PBP enrollment change transaction (Transaction Type 61) was rejected because the beneficiary lacks Part A and there was no EGHP Part B-only waiver in place. Plans can offer a PBP for EGHP members only, and, if the Plan chooses, it can define such PBPs for individuals who do not have Part A. **Plan Action:** Review CMS enrollment guidance in *Chapter 2 of the MMCM or the PDP Guidance on Eligibility, Enrollment and Disenrollment* and notify the beneficiary.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
114	R	Drug Coverage Change Rejected; not AEP or OEPI	RX NOT AEP/OEPI	An enrollment change transaction (Transaction Type 61) was rejected because the beneficiary is not allowed to add or drop drug coverage using an O (OEP) or N (OEPNEW) election types. Using O or N, a beneficiary who is in a Plan that includes drug coverage may only move to another Plan with drug coverage. Likewise, if in a Plan without drug coverage, the beneficiary may not enroll in a Plan with drug coverage or a PDP. *Occasionally, if a beneficiary is moving from a Plan with drug coverage to a combination of stand-alone MA and PDP Plans, the enrollment transaction in the MA-only Plan may be processed prior to the enrollment transaction in the PDP Plan. Since this appears to CMS as if the beneficiary is trying to drop drug coverage, the enrollment into the MA only Plan will be rejected with TRC 114. Once the enrollment in the PDP is processed, the enrollment in the MA-only may be resubmitted.* **Plan Action:** Review CMS enrollment guidance on the O and N election type limitations in *Chapter 2 of the MMCM or the PDP Guidance on Eligibility, Enrollment and Disenrollment.* Take the appropriate actions as per CMS enrollment guidance. **Note:** If TRC 114 is received by an MA-only Plan when using the OEP or OEPNEW, the Plan should determine if the beneficiary is enrolled in an accompanying PDP. Once that enrollment is complete, the MA-Only Plan may resubmit their enrollment transaction.
116	R	Transaction Rejected; Invalid Segmt num	BAD SEGMENT NUM	This TRC is returned on a segment change transaction (Transaction Type 77) when the transaction is submitted with an invalid segment number, for a PBP that has been segmented OR A disenrollment cancellation transaction (Transaction Type 81) [enrollment reinstatement] is submitted and the enrollment being reinstated has a non-blank segment which is no longer valid for the PBP. **Plan Action:** Correct the Segment number and resubmit the transaction if appropriate for transaction type 77. Submit enrollment for transaction type 81 if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
117	A	FBD Auto Enrollment Accepted	FBD AUTO ENROLL	This new enrollment transaction (Transaction Type 61) was the result of a Plan-submitted or CMS-initiated auto-enrollment of a full-benefit dual-eligible beneficiary into a Part D Plan. The enrollment was accepted. The effective date of the new enrollment is shown in the Effective Date (field 18) of the DTRR data record. Other accompanying replies with different TRCs may give additional information about this new enrollment. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
118	A	LIS Facilitated Enrollment Accepted	LIS FAC ENROLL	This new enrollment transaction (Transaction Type 61) was the result of a Plan-submitted or CMS-initiated facilitated enrollment of a low income beneficiary into a Part D Plan. The effective date of the new enrollment is shown in the Effective Date (field 18) of the DTRR. Other accompanying replies with different TRCs may give additional information about this new enrollment. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
119	A	Premium Amount Change Accepted	PREM AMT CHG	A Part C Premium Change transaction (Transaction Type 78) was accepted. The Part C premium amount has been updated with the amount submitted on the transaction. The effective date of the new premium will be reported in the Daily Transaction Reply Report data record field 18. The amount of the new Part C premium will be reported in field 34 of the DTRR record. **Plan Action:** Update the Plan's records accordingly, ensuring that the beneficiary's premium amounts are implemented as of the effective date in field 18. Take the appropriate actions as per CMS enrollment guidance.
120	A	PPO Change Sent to W/H Agency	WHOLD UPDATE	As a result of an accepted Plan-submitted transaction (Transaction Types 51, 61, 73, 74, 75) or UI update to a beneficiary's records, information has been forwarded to SSA/RRB to update SSA/RRB records and implement any requested premium withholding changes. Any requested change will not take effect until an SSA/RRB acceptance is received. Plans are notified of the SSA/RRB acceptance with a TRC 185 in a future DTRR data file. **Plan Action:** None required. Take the appropriate actions as per CMS enrollment guidance. **Note:** The Plan will not see the result of any PPO change until they have received a TRC 185 on a future DTRR.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
121	M	Low Income Period Status	LIS UPDATE	This TRC is returned on a reply with Transaction Type 01, 61, 80, and 81. It supplies the plan with additional information about a beneficiary. TRC 121 reports a period of time during which the beneficiary has specific LIS status. It may represent a period during which the beneficiary is DEEMED or a period as an approved SSA LIS Applicant. The following characteristics of the LIS period are provided: • Low-income Subsidy Source Code (Field 67) (Deemed = D or Applicant = A) • Low-income Period Effective date (Field 53) • Low-income Period End Date, if applicable (Field 66) ○ *If the SSA LIS Applicant period is removed the Low-income Period End Date will not be populated* • Part D Low-income Premium Subsidy Level (Field 51) • Low-income Co-Pay Category (Field 52) When a new enrollment is processed, the plan receives one TRC 121 for each of the beneficiary's LIS periods that overlap enrollment in the plan. The system provides one or many TRC 121 replies to report the beneficiary's full LIS status over time. A set of TRC 121's is also supplied with transaction type 01 when the beneficiary has a change to one or more of their LIS periods. The set supplies the beneficiary's full LIS picture, not just a period that changed. Because some of these periods may represent changes affecting previous enrollments in the contract, two fields identify whether the beneficiary is a current, previous, or future enrollee in the plan and provide the Effective date of the enrollment that the LIS period overlaps. • Enrollee Type Flag (Field 68) (Current = C, Prospective = P, or Previous = Y) • PBP Enrollment Effective Date (Field 18) **Note:** When reporting an LIS change, TRC 223 may accompany the set of TRC 121s. The TRC 121s identify periods when the beneficiary has LIS. The TRC 223s identify any periods of time during which the beneficiary was previously reported as having LIS but no longer has LIS. **Plan Action:** Update the Plan's records to reflect the given data for the beneficiary's LIS period. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
122	R	Enrollment/Change Rejected, Invalid Premium Amount	BAD PREMIUM AMT	An enrollment or premium change transaction (Transaction Type 61, or 78) was rejected because the submitted Part C premium amount was non-blank and not numeric. If the Part C premium field is blank on a submitted enrollment transaction (Transaction Type 61), the blank will be converted to zeroes. Any submitted value must be numeric. A blank or invalid Part C premium field is not permitted on the Part C premium change transaction (Transaction Type 78). **Plan Action:** Correct the Part C premium amounts and resubmit if appropriate.
123	R	Enrollment/Change Rejected, Invalid Prm Pay Opt Cd	BAD W/HOLD OPT	An Enrollment or PPO Change transaction (Transaction Types 61, 75) was rejected because the value submitted in the PPO Code field was an invalid value. The valid values include: • D - Direct Bill - Self Pay • R - Deduct from RRB benefits • S - Deduct from SSA benefits • N - No premium applicable **Plan Action:** Correct the PPO code and resubmit if appropriate.
124	R	Enrollment/Change Rejected; Invalid Uncov Months	BAD UNCOV MNTHS	An enrollment or NUNCMO change transaction (Transaction Types 61, 73) was rejected because the NUNCMO field was not correctly populated. This rejection could be the result of the following conditions: • The field contained a non-numeric value • The Uncovered Months field was zero when the Creditable Coverage Switch was set to N • For Transaction Type 61, the Uncovered Months field was greater than zero when the Creditable Coverage Switch was set to Y or blank. • For Transaction Type 73, the Uncovered Months field was greater than zero when the Creditable Coverage Switch was set to Y. **Plan Action:** Correct the NUNCMO value and resubmit the transaction if appropriate. Verify that the Creditable Coverage Flag and NUNCMO combination is valid.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
126	R	Enrollment/Change Rejected; Invalid Cred Cvrg Flag	BAD CRED COV FL	An enrollment or NUNCMO change transaction (Transaction Types 61, 73) was rejected because the Creditable Coverage Flag field was not correctly populated. For Transaction Type 61, the valid values for the Creditable Coverage Flag are Y, N, and blank. For Transaction Type 73, the valid values for the Creditable Coverage Flag are Y and N. Creditable Coverage Flag values of R and U are not available as valid values for Plan submission. **Plan Action:** Correct the Creditable Coverage Flag value and resubmit the transaction if appropriate. Verify that the Creditable Coverage Flag and NUNCMO combination is valid.
127	R	Part D Enrollment Rejected; Employer Subsidy Status	EMP SUB REJ	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary has employer subsidy periods overlapping with the requested enrollment period. The requested effective date is reported in DTRR field 18. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance. Contact the beneficiary to explain the potential consequences of this enrollment. If the beneficiary elects to join the Part D Plan anyway, the enrollment should be resubmitted with the Employer Subsidy Override Flag set to Y.
128	R	Part D Enroll Reject; Emplyr Sbsdy set: No Prior Trn	EMP SUB OVR REJ	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary has employer subsidy periods overlapping with the requested enrollment period. Even though this transaction was submitted with the Employer Subsidy Override Flag set to Y, the override is not valid because there is no record that the enrollment was previously submitted and rejected with TRC 127 (Part D Enrollment Rejected; Employer Subsidy Status). CMS enforces this two-step process to ensure that the Plan discusses the potential consequences of the Part D enrollment (i.e. possible loss of employer health coverage) with the beneficiary before CMS accepts the employer subsidy override. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance. Contact the beneficiary to explain the potential consequences of this enrollment. If the beneficiary elects to join the Part D Plan anyway, the enrollment should be resubmitted with the Employer Subsidy Override Flag set.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
129	I	Part D Enroll Accept; Emp Sbsdy set; Prior Trn Reject	EMP SUB ACC	This TRC provides additional information about a new enrollment (Transaction Type 61). The effective date of the enrollment for which this information is pertinent is reported in DTRR field 18. This newly enrolled beneficiary had employer subsidy periods overlapping with the requested enrollment period. A prior enrollment transaction was rejected with TRC 127 or 128. The Plan resubmission of the enrollment transaction with the Employer Subsidy Override Flag set to Y indicates that the Plan has contacted the beneficiary to explain the potential consequences of this enrollment, and that the beneficiary elected to join the Part D Plan anyway. **Plan Action:** No action required. Process the accompanying transaction enrollment acceptance transaction.
130	R	Part D Opt-Out Rejected, Opt-Out Flag Not Valid	BAD OPT OUT CD	An opt-out from CMS, disenrollment, PBP enrollment change, or Plan-Submitted Opt-Out transaction (Transaction Types 41, 51, 54, 61, 79) was rejected because the Part D Opt-Out Flag field was not correctly populated. The valid values for Part D Opt-Out Flag are: • Transaction Types 41 or 79 transactions - 'Y' or 'N' • All other Transaction Types - 'Y,' 'N,' or space. **Plan Action:** If submitted by the Plan (Transaction Types 51, 61, 79), correct the Part D Opt-Out Flag value and resubmit the transaction if appropriate. If submitted by CMS (Transaction Types 41, 54), no Plan Action is required.
131	A	Part D Opt-Out Accepted	OPT OUT OK	A transaction (Transaction Types 51, 79) was received that specified a Part D opt-out flag value or a change to the Part D opt-out flag value. The Part D opt-out flag has been accepted. The new Part D Opt-Out Flag value is reported in DTRR field 38. **Plan Action:** No action necessary.
133	R	Part D Enroll Rejected; Invalid Secndry Insur Flag	BAD 2 INS FLAG	An enrollment, PBP change transaction or 4Rx record update transaction (Transaction Types 61, 72) was rejected because the DTRR data file's Secondary Drug Coverage Flag field was not correctly populated. The valid values for Secondary Drug Coverage Flag are Y, N or blank. **Plan Action:** Correct the Secondary Drug Coverage Flag and resubmit the transaction if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
134	I	Missing Secondary Insurance Information	NO 2 INS INFO	This TRC is returned on a rejected enrollment or 4Rx record update transaction (Transaction Types 61or 72) when the submitted Secondary Drug Coverage Flag is invalid. . No changes to the beneficiary's secondary insurance information are made. This is not a transaction rejection. The submitted transaction is accepted and a reply is provided in the DTRR with an appropriate acceptance TRC. This reply provides additional information about the transaction. The Effective Date of the transaction for which this information is pertinent is reported in DTRR field 18. The Transaction Type reflects the Transaction Type of the submitted transaction. (Transaction Types 61 or 72). **Plan Action:** If appropriate, submit a 4Rx Record Update transaction (Transaction Type 72) with the correct Secondary Insurance RxID and Secondary Insurance RxGroup values.
135	M	Beneficiary Has Started Dialysis Treatments	DIALYSIS START	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS has been notified that the beneficiary has ESRD and has begun dialysis treatments. The effective date of the change is reported in DTRR field 18. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
136	M	Beneficiary Has Ended Dialysis Treatments	DIALYSIS END	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS has been notified that the beneficiary has ESRD and is no longer receiving dialysis treatments. The effective date of the change is reported in DTRR field 18. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Process the TRC 136 to remove the prior period, if the effective date of the TRC 136 (field 18) is equal to the "start" date of an ESRD period reported to the Plan previously. Alternatively, process the TRC 136 to update the prior period, if the effective date of the TRC 136 (field 18) is not equal to the "start" date of an ESRD period reported to the Plan in a prior DTRR. Then process the TRC 135 to add the new corrected period as of the start date in field 18. The end date of the new, corrected period, if there is one, is not included. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
137	M	Beneficiary Has Received a Kidney Transplant	TRANSPLANT ADD	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS has been notified that the beneficiary has ESRD and has received a transplanted kidney. The effective date of the change is reported in DTRR field 18. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
138	M	Beneficiary Address Change to Outside the U.S.	ADDR NOT U.S.	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS has been notified that the beneficiary's address is now outside of the U.S. The effective date of the change is reported in DTRR field 18. **Plan Action:** Research the beneficiary's new address and update the Plan's beneficiary records. Take the appropriate actions as per CMS enrollment guidance.
139	A	EGHP Flag Change Accepted	EGHP FLAG CHG	An EGHP Update transaction (Transaction Type 74) was accepted. This transaction changed the beneficiary's EGHP flag. The EGHP Update transaction may have been submitted by the Plan or initiated by a CMS User. The value in DTRR field 48 on the DTRR record will contain the new EGHP flag. The effective date of the change is reported in field 18 of the DTRR record and in the EFF DATE column on the printed report. All data provided for change other than the EGHP Flag fields has been ignored. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
140	A	Segment ID Change Accepted	SEGMENT ID CHG	A Segment ID Update transaction (Transaction Type 77) was accepted. This transaction changed the Segment ID for the beneficiary. The value in DTRR field 33 contains the new Segment ID. The effective date of the change is reported in field 18 All data provided for change other than the Segment ID field has been ignored. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
141	A	Uncovered Months Change Accepted	UNCOV MNTHS CHG	A NUNCMO Record Update transaction (Transaction Type 73) was accepted. This transaction updated the creditable coverage information (Creditable Coverage Flag and/or NUNCMO) for the beneficiary. The values in DTRR fields 40 and 41 on the DTRR record will contain the new creditable coverage values. The effective date of the change is reported in field 18. Total uncovered months are displayed in field 24. All data provided for change, other than the Uncovered Months fields, has been ignored. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
143	A	Secondary Insurance Rx Number Change Accepted	4RX SCD INS CHG	A 4Rx Record Update transaction (Transaction Type 72) was accepted. This transaction updated the secondary drug insurance information (Secondary RxID, Secondary RxBIN, Secondary Rx Group, Secondary RxPCN) for the beneficiary. The 4Rx Record Update transaction may have been submitted by the Plan or initiated by a CMS User. The values in DTRR fields 46, 47, 60 & 61 on the DTRR record will contain the new secondary drug insurance information. The effective date of the change is reported in field 18. All data provided for change, other than the 4Rx fields, has been ignored. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
144	M	PPO changed to Direct Bill	PREM WH OPT CHG	CMS has changed the PPO specified on the transaction to "D – Direct Bill" for one of the following reasons: • Retroactive premium withholding was requested. • The beneficiary's retirement system [Social Security Administration (SSA), or RRB was unable to withhold the entire premium amount from the beneficiary's monthly check. • The beneficiary has a BIC of M or T and chose "SSA" as the withhold option. SSA cannot withhold premiums for these beneficiaries as there is no benefits check from which to withhold. • The beneficiary chose "OPM" as the withhold option. OPM is not withholding premiums at this time. • The Plan has submitted a Part C premium amount that exceeds the maximum Part C premium value provided by HPMS. • RRB Withholding was requested for an effective date prior to 06/01/2011. • The beneficiary is Out-of-Area for a segmented Contract/PBP. • Retroactive premium withhold was requested and during one of the periods the beneficiary was Out-of-Area for a segmented Contract/PBP. This TRC may generate in response to an accepted Enrollment, PBP change, or PPO Change transaction (Transaction Types 61, 75) or CMS may initiate it. **Plan Action:** Update the Plan's beneficiary records to reflect the direct bill payment method. Take the appropriate actions as per CMS enrollment guidance.
150	I	Enrollment accepted, Exceeds Capacity Limit	OVER CAP LIMIT	Although a submitted enrollment or PBP change transaction (Transaction Type 61) was accepted, the resulting enrollment count exceeds the capacity limit for the contract or PBP. This TRC provides additional information about a new enrollment or PBP change (Transaction Type 61) for which an acceptance was sent in a separate DTRR data record with an enrollment acceptance TRC. The effective date of the new enrollment for which this information is pertinent is reported in field 18. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
152	M	Race Code Change	NEW RACE CODE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS has been notified that the beneficiary's race code has changed. The effective date of the change is reported in DTRR field 18. The new race code will be reported in the next Monthly Membership Detail Report (MMR). **Plan Action:** Update the Plan's records accordingly, ensuring that the beneficiary's information matches the data included in the DTRR record.
154	M	Out of Area Status	OUT OF AREA	This TRC is returned either on a reply with Transaction Type 01 in response to a state and county code change or ZIP Code change. It is intended to supply the Plan with additional information about the beneficiary. In the case of the 01 transaction, CMS has information that the beneficiary is no longer in the Plan's service area. This can be the result of: • A change in the Plan's service area and the beneficiary's address is outside the new area • A change in the beneficiary's address which places them Out of area **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
155	M	Incarceration Notification Received	INCARCERATED	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS has been notified that the beneficiary is incarcerated. The effective date of the change is reported in DTRR field 18. **Plan Action:** Contact the beneficiary to confirm the incarceration. Review full CMS guidance on enrollment of incarcerated beneficiaries in the MMCM or PDP Enrollment Guidance and take appropriate actions.
156	F	Transaction Rejected, User Not Authrzed for Cntrct	BAD USR FOR PLN	This TRC is returned on a failed transaction (Transaction Types 01, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, and 83) when the transaction was submitted by a user who is not authorized to submit transactions for the contract. This TRC will not be returned in the DTRR. **Plan Action:** Resubmit using the correct submitter if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
157	R	Contract Not Authorized for Transaction Code	UNAUT REQUEST	A transaction (Transaction Types 41, 51, 54, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, and 83) was rejected because the Plan is not authorized to submit that type of transaction. **Plan Action:** Correct the Transaction Type and resubmit if appropriate.
158	M	Institutional Period Change/Cancellation	INST CHANGE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS has changed or cancelled an Institutional period for the beneficiary. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
159	M	NHC Period Change/Cancellation	NHC CHANGE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS has changed or cancelled a NHC period for the beneficiary. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
161	M	Beneficiary Record Alert from MBD	MBD ALERT	This TRC is returned on a Transaction Type 01 and not the result of a Plan submitted transaction. The beneficiary ID had a discrepancy within the CMS systems, which resulted in this Transaction Code being generated. **Plan Action**: Contact the MAPD Help Desk. CMS will review the beneficiary id and make the appropriate corrections.
162	R	Invalid EGHP Flag Value	BAD EGHP FLAG	An enrollment or EGHP change transaction (Transaction Types 61, 74) was rejected because the submitted EGHP Flag value was invalid. The valid values for EGHP Flag is Y or blank for enrollment Transaction Type 61. Y or N is accepted for EGHP change Transaction Type 74. **Plan Action**: Correct the EGHP Flag value and resubmit if appropriate.
165	R	Processing delayed due to MARx system problems	SYSTEM DELAY	This TRC does not apply to Plans and is only for internal CMS use. Processing of this transaction has been delayed due to CMS system conditions. No action is required by the user. CMS will process the transaction as soon as possible. **Plan Action:** None required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
166	R	Part D FBD Auto Enroll or Facilitated Enroll Reject	PARTD AUTO REJ	This TRC is returned on a rejected Plan-submitted auto or facilitated Part D enrollment when CMS has a record of a Part D 'opt out' option on file for the beneficiary. **Plan Action:** Update the Plan's records to ensure that the beneficiary is not enrolled in the Plan. Take the appropriate actions as per CMS enrollment guidance.
169	R	Reinsurance Demonstration Enrollment Rejected	EMP SUBSIDY	An enrollment transaction (Transaction Type 61) placing the beneficiary into a reinsurance demonstration Plan was rejected because the beneficiary has employer subsidy periods overlapping with the requested enrollment period. This TRC is equivalent to TRC 127 except that it applies to Reinsurance Demonstration Plans only. The requested effective date is reported in DTRR field 18. **Plan Action:** Contact the beneficiary to explain the potential consequences of this enrollment. If the beneficiary elects to join the Part D Plan anyway, the enrollment should be resubmitted with the Employer Subsidy Override Flag set to Y.
170	I	Premium Withhold Option Changed to Direct Billing	PREM WH OPT CHG	The beneficiary's PPO was changed to Direct Billing (D) because the beneficiary is a member of an employer group. Retirees who are members of an employer group cannot elect SSA withholding. This TRC provides additional information about an enrollment, PBP change, or PPO Change transaction (Transaction Types 61, 75) for which an acceptance was sent in a separate Transaction Reply with an enrollment acceptance TRC. The Effective Date of the enrollment for which this information is pertinent is reported in DTRR field 18. **Plan Action:** Update the Plan's billing method and contact the beneficiary to explain the consequences of this change.
171	R	Record Update Rejected, Invalid Chg Effective Dt	BAD CHG EFF DT	An EGHP Change, PPO Change, Segment ID Change, or Part C Premium Change (Transaction Types 74, 75, 77, or 78) was rejected because the submitted transaction effective date was incorrect. The Effective Date on the Transaction Type 75 must be in the CPM to CPM+2 range. The Effective Date on the Transaction Type 78 must be in the CPM-3 to CPM+2 range. The Effective date on the Transaction Types 74 or77 must be in the CCM-1 to CCM+3 range. **Plan Action:** Correct the effective date and resubmit the transaction if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
172	R	Change Rejected; Creditable Coverage/2 Drug Info NA	CRED COV/RX NA	A 4RX or NUNCMO transaction (Transaction Type 72 or 73) was rejected because the information was not applicable to the selected Plan type (MAs and other Plans without drug coverage). Non-drug Plans should not submit drug Plan information. The inappropriate information included on the transaction could be any or all of the following: • Creditable Coverage Information (Creditable Coverage Flag and NUNCMO) • Primary Drug Insurance Information (Rx ID, Rx GRP, Rx PCN and Rx BIN) • Secondary Drug Insurance Information (Secondary Insurance Flag, Rx ID, Rx GRP, Rx PCN and Rx BIN) **Plan Action:** Verify that the above fields are not populated and resubmit the transaction if appropriate.
173	R	Change Rejected; Premium Not Previously Set	NO PREMIUM INFO	An Uncovered Months, PPO, or Part C premium amount change transaction (Transaction Types 73, 75, 78) was rejected because the beneficiary's premium was not established as of the transaction effective date. **Plan Action:** Review the beneficiary's premium data and resubmit if appropriate.
176	R	Transaction Rejected, Another Transaction Accepted	TRANS REJ	An enrollment transaction (Transaction Type 61) was rejected. A transaction enrolling the beneficiary into another contract was previously accepted. That transaction and this submitted one had the same effective and application dates. The beneficiary is not enrolled in the Plan in this newly submitted transaction. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
177	M	Change in Late Enrollment Penalty	NEW PENALTY AMT	This TRC is intended to supply the Plan with additional information about the beneficiary. The beneficiary's total late enrollment penalty has changed. This may be the result of: • A change to the beneficiary's NUNCMO (but there are still uncovered months); • A change to the beneficiary's LIS status; • A new Initial Election Period (IEP); or • The addition, withdrawal, or change in the CMS-granted waiver of penalty. **Plan Action:** Adjust the beneficiary's payment amount. The new total penalty amount can be determined by subtracting amounts in DTRR fields 55 (waived amount) and 56 (subsidized amount) from field 54 (base penalty). Take the appropriate actions as per CMS enrollment guidance.
178	M	Late Enrollment Penalty Rescinded	PNLTY RESCINDED	This TRC is intended to supply the Plan with additional information about the beneficiary. The LEP, reported in field 52 of the DTRR, associated with the specified effective date has been rescinded (set to zero). **Plan Action:** Adjust the beneficiary's payment amount. Take the appropriate actions as per CMS enrollment guidance.
179	A	Transaction Accepted, No Change to Premium Record	NO CHNG TO PREM	A Record Update transaction (Transaction Type 73, 75, 78) was submitted, however, no data change was made to the beneficiary's premium. The submitted transaction contained premium data values that matched those already on record with CMS for the specified period. This transaction had no effect on the beneficiary's records. **Plan Action:** Ensure that the Plan's system reflects the amounts in the DTRR record.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
182	I	Invalid PTC Premium Submitted Corrected, Accepted	PTC PRM OVERIDE	An Enrollment, Residence Address Change, Segment ID Change, PBP change, Enrollment Cancellation, Disenrollment Cancellation or Part C Premium Record Update transaction (Transaction Types 61, 76, 77, 78, 80, 81, 82) was accepted but the Part C premium did not agree with the Plan's HPMS contracted Part C premium rate. The premium has been adjusted to reflect the contracted rate. • If the submitted Part C premium amount has pennies, the Part C premium amount was rounded to the nearest dime. • If the rounded Part C premium amount was less than the HPMS contracted Part C premium minimum amount or greater than the HPMS contracted Part C premium maximum amount for the Plan, MARx has reset the premium to the HPMS contracted Part C premium minimum amount. **Note:** If any of the HPMS contracted Part C premium amounts contained pennies, the amounts were rounded for these comparisons. The updated Part C premium rate is reported in Daily Transaction Reply Report (DTRR) data record fields 24 and 34. TRC 182 is the acceptance TRC for Transaction Type 78. For the other transaction types, normal acceptance TRCs will be returned along with TRC 182. **Plan Action:** Update the Plan's beneficiary records with the premium information in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
184	R	Enrollment Rejected, Beneficiary is in Medicaid	MBR IN MEDICAID	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary was in Medicaid status and the Plan is not eligible to enroll Medicaid beneficiaries. This TRC is Plan specific. It only applies to MSA/MA and MSA/Demo Plans. **Plan Action:** Update the Plan's beneficiary records to reflect the fact that the beneficiary is not enrolled in the Plan. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
185	M	Withholding Agency Accepted Transaction	ACCEPTED	CMS submitted information on a beneficiary to SSA/RRB (See TRC 120). TRC 185 is sent to the Plan when SSA/RRB acknowledges that they have accepted and processed the beneficiary data. If the submittal to SSA/RRB was the result of a requested premium withholding change, TRC 185 informs the Plan that SSA/RRB has accepted and processed the change. The beneficiary's PPO is reported in DTRR field 39. The effective date of the PPO change is reported in field 18. **Note:** The reported new PPO may be the same as the existing PPO. Plans will not see the results of any requested premium withholding changes until TRC 185 is received. **Plan Action:** Ensure the Plan's system matches the information, primarily the PPO, included in the DTRR.
186	I	Withholding Agency Rejected Transaction	REJECTED	CMS submitted information on a beneficiary to SSA/RRB (See TRC 120). This data transmittal was rejected by SSA/RRB. This is exclusive to the communication between CMS and SSA/RRB. CMS will continue to interface with SSA/RRB to resolve the rejection. If CMS is unable to resolve this rejection and the Beneficiary-requested PPO is changed, the Plan may receive a TRC 144. **Plan Action:** No action required.
187	R	No Change in Number of Uncovered Mths Information	DUP NO UNCV MTH	A NUNCMO Record Change transaction (Transaction Type 73) was rejected. No data change was made to the beneficiary's record. The submitted transaction contained NUNCMO Information that matched those already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action:** None required.
188	A	No Change in Segment ID	DUP SEGMENT ID	A Segment ID Update transaction (Transaction Type 77) was accepted, however, no data change was made to the beneficiary's record. The submitted transaction contained a Segment ID value that matched the Segment ID already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action:** None required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
189	A	No Change in EGHP Flag	DUP EGHP FLAG	An EGHP Record Update transaction (Transaction Type 74) was submitted, however, no data change was made to the beneficiary's record. The submitted transaction contained an EGHP Flag value that matched the EGHP Flag already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action:** None required.
190	A	No Change in Secondary Drug Information	DUP SECNDARY RX	A 4Rx Record Update transaction (Transaction Type 72) was submitted, however, no data change was made to the beneficiary's record. The submitted transaction contained Secondary Drug Insurance Information (Secondary Drug Insurance flag, Secondary Rx ID, Secondary Rx Group, Secondary Rx BIN, Secondary Rx PCN) that matched the Secondary Drug Insurance values already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action:** None required.
191	R	No Change in Premium Withhold Option	DUP PRM WH OPTN	A Premium Payment Option Change transaction (Transaction Type 75) was rejected and no data change was made to the beneficiary's record for one of the following reasons: 1. The submitted transaction contained a Premium Payment Option value that matched the Premium Payment Option already on record with CMS. 2. Beneficiary has a premium. Setting the Premium Payment Option to "no premium" (N), is not acceptable. Beneficiary premium may be due wholly or in part to a late enrollment penalty. 3. Beneficiary premiums are zero. Withholding cannot be established. 4. A Premium Payment Option request of 'Deduct from SSA (S)' or 'Deduct from RRB (R)' was submitted on a Premium Payment Option Change transaction (Transaction Type 75) when the beneficiary has 'No Premiums'. The Premium Payment Option was set to 'N', which matches the Premium Payment Option already on record with CMS. 5. SSA or RRB Withholding was requested for a LINET, MMP or PACE Plan. This transaction had no effect on the beneficiary's records. **Plan Action:** None required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
195	M	SSA Unsolicited Response	SSA WHOLD UPDT	An unsolicited response has been received from SSA. The PPO for this beneficiary is set to Direct Bill. This action is not in response to a Plan-initiated transaction. The effective change date change is reported in DTRR field 18. **Plan Action:** Change the beneficiary to direct bill as of the effective date in field 18. Take the appropriate actions as per CMS enrollment guidance.
196	R	Transaction Rejected, Bene not Eligible for Part D	NO PART D	An enrollment transaction or PBP change transaction (Transaction Type 61) or disenrollment cancellation transaction (Transaction Type 81) [enrollment reinstatement] was rejected. Part D eligibility is required for Part D Plan enrollment. • TC61 – transaction was rejected because the submitted enrollment date is outside the beneficiary's Part D eligibility period. • TC81 – transaction was rejected because the enrollment reinstatement period is outside the beneficiary's Part D eligibility period. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
197	M	Part D Eligibility Termination	PART D OFF	This TRC is returned on a reply with Transaction Type 01 and occasionally with Transaction Type 51 and Transaction Type 61. When returned with Transaction Type 01, the TRC is in response to a change in beneficiary Part D Eligibility. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. In the case of Transaction Type 01, this beneficiary's Part D eligibility has been terminated. The effective date of the termination is reported in DTRR fields 18 and 24. If applicable, CMS will automatically disenroll the beneficiary from the Plan. A Transaction Type 51 transaction will be sent in this or another DTRR. When this TRC is returned with Transaction Type 61 the TRC is in response to a retroactive enrollment and is identifying the fact that an enrollment end date has been established due to the beneficiary's termination of Part D. The enrollment start date is in DTRR field 18 and the enrollment end date is in field 24. In this circumstance it is accompanied by TRC 018, Automatic Disenrollment, as well. **Note:** A DTRR record with this reply code is only reported to the Plan in which the beneficiary is currently enrolled, even if it affects periods of enrollment in other Plans. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
198	M	Part D Eligibility Reinstatement	PART D ON	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary's Part D eligibility has been reinstated. The effective date Part D eligibility start date is reported in DTRR fields 18 and 24. **Note:** A DTRR record with this reply code is only reported to the Plan in which the beneficiary is currently enrolled, even if it affects periods of enrollment in other Plans. If, as a result of a loss of Part D eligibility, the beneficiary has been disenrolled, but not re-enrolled, the reply code is not issued. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
200	R	Rx BIN Blank or Not Valid	BIN BLANK/INVLD	An enrollment transaction or 4Rx change transaction (Transaction Types 61, 72) was rejected because the primary drug insurance Rx BIN field was either blank or did not have a valid value. Exception: Rx Bin for primary drug insurance is not a mandatory field for enrollments transactions for PACE National Part D Plans or MMPs. **Plan Action:** Correct the Primary Rx BIN value and resubmit the transaction if appropriate.
201	R	Rx ID Blank or Not Valid	ID BLANK/INVLID	An enrollment transaction or 4Rx change transaction (Transaction Types 61, 72) was rejected because the primary drug insurance Rx ID field was either blank or does not have a valid value. Exception: Rx ID for primary drug insurance is not a mandatory field for enrollment transactions for PACE National Part D Plans or MMPs. **Plan Action:** Correct the Primary Rx ID value and resubmit the transaction if appropriate.
202	R	Rx Group Not Valid	RX GRP INVALID	An enrollment transaction or 4Rx change transaction (Transaction Types 61, 72) was rejected because the primary drug insurance Rx GRP field does not have a valid value. **Plan Action:** Correct the Primary Rx GRP value and resubmit the transaction if appropriate.
203	R	Rx PCN Not Valid	RX PCN INVALID	An enrollment or 4Rx change transaction (Transaction Types 61, 72) was rejected because the primary drug insurance Rx PCN field does not have a valid value. **Plan Action:** Correct the Primary Rx PCN value and resubmit the transaction if appropriate.
204	A	Record Update for Primary 4Rx Data Successful	4RX CHNG ACPTED	A submitted 4Rx Record Update transaction (Transaction Type 72) included a request to change primary drug insurance 4Rx data. The 4Rx data were successfully changed. **Note:** At a minimum, values must be provided for both of the mandatory primary 4Rx fields, RX BIN and RX ID **Plan Action:** No action required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
205	I	Invalid Disenrollment Reason Code	INV DISENRL RSN	A disenrollment transaction (Transaction Type 51) was submitted with a blank or invalid disenrollment reason code. CMS substituted the default value of '99' for the disenrollment reason code. See Page I-103 for CMS enrollment guidance regarding valid disenrollment reason codes. This TRC provides the Plan with additional information on a disenrollment that was processed successfully. It is received in addition to the appropriate disenrollment acceptance TRC. **Plan Action:** None required.
206	I	Part C Premium has been corrected to zero	PTC PREM ZEROED	An enrollment, PBP change or Part C Premium Update transaction (Transaction Types 61, 78) was submitted and accepted for a Part D only Plan. This transaction contained an amount other than zero in the Part C premium field. Since a Part C premium does not apply to a Part D only Plan, the Part C premium has been corrected to be zero. This TRC provides additional information about an enrollment, PBP change, or Part C Premium Update transaction (Transaction Types 61, 78) for which an acceptance was sent in a separate Transaction Reply with an acceptance TRC. The effective date of the enrollment for which this information is pertinent is reported in DTRR field 18. **Plan Action:** Update the Plan's records accordingly, ensuring that the beneficiary's information matches zero Part C premium amount included in the DTRR record.
209	R	4Rx Change Rejected, Invalid Change Effective Date	NO ENROLL MATCH	A 4Rx change transaction (Transaction Type 72) for 4Rx information for primary drug insurance was rejected because the beneficiary was not enrolled as of the submitted transaction effective date. Plans may only submit 4Rx data for periods when the beneficiary is enrolled in the Plan. **Plan Action:** Correct the dates and resubmit the transaction if appropriate.
210	A	POS Enrollment Accepted	POS ENROLLMENT	An enrollment into a POS designated Part D Plan that was submitted by a Point Of Sale (POS/POS 10) contractor or CMS (MBD) has been successfully processed. The effective date of the new enrollment is shown in the Effective Date (field 18) of the DTRR. The date in field 18 will always be the first day of the month. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
211	R	Re-Assignment Enrollment Rejected	RE-ASN ENRL REJ	A reassignment enrollment request transaction (Transaction Type 61) which would move the beneficiary into another Part D Plan was rejected because CMS has record of an "Opt-Out" option on file for the beneficiary. The beneficiary has 'opted out' of auto or facilitated enrollment. **Plan Action:** Do not move the beneficiary's enrollment to the new Plan. Keep the beneficiary in the Plan in which they are currently enrolled. Take the appropriate actions as per CMS enrollment guidance.
212	A	Re-Assignment Enrollment Accepted	REASSIGN ACCEPT	A reassignment enrollment request transaction (Transaction Type 61) to move the beneficiary into a new Part D Plan has been successfully processed. The beneficiary has been moved from the original contract and PBP to the new contract and PBP. The effective date of enrollment in the new PBP is reported in fields 18 and 24 of the DTRR. Other accompanying replies with different TRCs may give additional information about this accepted reassignment. Field 20 (Plan Benefit Package ID) contains the new PBP identifier and the old PBP is reported in field 29 (Prior Plan Benefit Package ID). **Plan Action:** Update the Plan's records accordingly with the information in the DTRR record, ensuring that the Plan's beneficiary's information reflects enrollment in the new contract and PBP.
213	I	Premium Withhold Exceeds Safety Net Amount	EXCEED SNET AMT	CMS has changed the PPO specified on the transaction to "D – Direct Bill" because the transaction would result in SSA withholding exceeding the Safety Net amount from the beneficiary's check in one month. This TRC may be generated in response to an accepted enrollment or PBP change (Transaction Type 61), NUNCMO Record Update (Transaction Type 73), Part C Premium Update (Transaction Type 78), PPO Change (Transaction Type 75), or may be initiated by CMS. **Plan Action:** Change the beneficiary to Direct Bill and contact them to explain the consequences of the PPO change. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
215	R	Uncovered Months Chng Rejected, Incorrect Eff Date	BAD NUNCMO EFF	A NUNCMO Change (Transaction Type 73) transaction was rejected because the submitted effective date is incorrect. The date may have been incorrect for one of the following reasons: • The submitted effective date is prior to August 1, 2006. • The submitted effective date is after the Current Calendar Month (CCM) plus 3. • The submitted effective date falls within a Part D Plan enrollment but does not match the contract enrollment start date. **Plan Action:** Correct the effective date and resubmit the transaction. If the Plan still does not get a successful transaction, please contact the MAPD Help desk.
216	I	Uncovered months exceeds max possible value	NUNCMO EXDS MAX	This TRC is returned on an accepted enrollment transaction (Transaction Type 61) when the submitted incremental NUNCMO value exceeds the maximum possible value. This does NOT cause the rejection of the enrollment transaction but zero uncovered months (000) is associated with the effective date of the enrollment. This informational TRC may accompany the enrollment transaction's acceptance TRC. Field 24 (Maximum Number of Uncovered Months) reports the maximum incremental NUNCMO value that could be associated with the enrollment effective date submitted. Field 40 (Cumulative Number of Uncovered Months) reports the total uncovered months as of the effective date. Field 45 (Submitted Number of Uncovered Months) reports the incremental NUNCMO value submitted by the Plan. **Plan Action:** Update the Plan's records. If the NUNCMO should be another value, review CMS enrollment guidance and correct the NUNCMO value using a new NUNCMO Record Update (Transaction Type 73) transaction.
217	R	Can't Change number of uncovered months	CANT CHG NUNCMO	An uncovered month's change transaction (Transaction Type 73) was rejected because the submitted transaction attempted to change the NUNCMO for an effective date corresponding to a "LEP Reset" transaction in the CMS database. **Plan Action:** Review CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
218	M	LEP Reset Undone	LEP RESET UNDNE	CMS has re-established the beneficiary's late enrollment penalty (LEP). The previous LEP RESET was removed. **Plan Action:** Update the Plan's records accordingly, ensuring that the beneficiary's LEP information matches the data included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
219	M	LEP Reset Accepted	LEP RESET	CMS has reset the beneficiary's NUNCMO to zero. The Late Enrollment Penalty (LEP) amount is now zero. **Plan Action:** Update the Plan's records accordingly, ensuring that the beneficiary's LEP information matches the data included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
220	R	Transaction Rejected; Invalid POS Enroll Source CD	BAD POS SOURCE	Enrollment source code submitted by a POS/POS 10 contractor for a POS/POS 10 enrollment transaction was other than 'G'. Transaction rejected. **Plan Action:** Correct the Enrollment Source Code and resubmit transaction if appropriate.
222	I	Bene Excluded from Transmission to SSA/RRB	BENE EXCLUSION	This TRC can be returned on a reply with various Transaction Types (51, 61, 73, 78) and the maintenance Transaction Type (01). It is intended to supply the Plan with additional information about the beneficiary. CMS has excluded beneficiary from transmission to SSA/RRB. **Plan Action:** None required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
223	M	Low Income Period Removed from Enrollment Period	LIS REMOVED	This TRC is returned on a reply with Transaction Type 01. It supplies the Plan with additional information about the beneficiary. TRC 223 reports a period of time during which the beneficiary was previously reported as having LIS but is no longer LIS for an Applicant status, or when a previously LIS period is completely removed. When the beneficiary's LIS status changes, TRC 223s may accompany the set of TRC 121s that report the beneficiary's new LIS periods. If, as a result of the change, the beneficiary has NO remaining LIS periods, TRC 223 may be reported alone. The following characteristics of the former LIS period are provided: • Low-income Subsidy Source Code (Field 67) (Deemed = D or Applicant = A). • Low-income Period Effective date (Field 53). • Low-income Period End Date (Field 66). • Part D Low-income Premium Subsidy Level (Field 51). • Low-income Co-Pay Category (Field 52). Because the periods during which the beneficiary lost LIS may affect previous or future enrollments in the contract, two fields identify whether the beneficiary is a current, previous, or future enrollee in the plan and provide the Effective date of the enrollment that the lost LIS period overlapped. • Enrollee Type Flag (Field 68) (Current = C, Prospective = P, or Previous = Y). • PBP Enrollment Effective Date (Field 18). **Note:** TRCs 223 typically are reported for one of the following conditions: • An existing LIS period is removed or shortened. • An end date is added to an open-ended LIS period (because this signals an end to a period that previously went into the future, the open-ended period after the end date is reported with TRC 223). • During an open-ended SSA Applicant LIS period, the beneficiary is Deemed with an end date of 12/31/xxxx. The Applicant period ends one day prior to the Deemed Period and the period after the end of the Deemed period is reported with TRC 223 (because this period was previously included in the open-ended Applicant period). **Plan Action:** Update the Plan's records to reflect the given data for the beneficiary's LIS period. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
225	I	Exceeds SSA Benefit & Safety Net Amount	Insuf fund&snet	CMS has changed the PPO specified on the transaction to "D – Direct Bill" because the transaction would result in the SSA benefit being insufficient to cover the withholding and the withholding would exceed the Safety Net amount. This TRC may be generated in response to an accepted enrollment or PBP change (Transaction Type 61), NUNCMO Record Update (Transaction Type 73), Part C Premium Update (Transaction Type 78), PPO Change (Transaction Type 75), or may be initiated by CMS. **Plan Action:** Change the beneficiary to direct bill and contact them to explain the consequences of the PPO change. Take the appropriate actions as per CMS enrollment guidance.
235	I	SSA Accepted Part B Reduction Transaction	SSA PT B ACCEPT	CMS submitted Part B Reduction information on a beneficiary to SSA (See TRC 237). TRC 235 is sent to the Plan when SSA acknowledges that they have accepted and processed the beneficiary data. If the submittal to SSA was the result of a requested Part B Reduction change, TRC 235 informs the Plan that SSA has accepted and processed the change. Plans will not see the results of any requested Part B Reduction change until TRC 235 is received and SSA has processed the request. This may take as long as 60 days. **Plan Action:** No action required.
236	I	SSA Rejected Part B Reduction Transaction	SSA PT B REJECT	CMS submitted Part B Reduction information on a beneficiary to SSA (See TRC 237). This data transmittal was rejected by SSA. This is exclusive to the communication between CMS and SSA. CMS will continue to interface with SSA to resolve the rejection. **Plan Action:** No action required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
237	I	Part B Premium Reduction Sent to SSA	PT B RED UPDATE	As a result of an accepted Plan-submitted transaction (Transaction Types 51, 61, 72, 73, 75, 78) or UI update to a beneficiary's records, information has been forwarded to SSA/RRB to update SSA/RRB records and implement any requested Part B premium reduction changes. Any requested change will not take effect until an SSA/RRB acceptance is received. Plans are notified of the SSA/RRB acceptance with a TRC 235 on a future DTRR. **Plan Action:** None required. Take the appropriate actions as per CMS enrollment guidance. **Note:** The Plan will not see the result of any Part B Reduction change until they have received a TRC 235 or 236 on a future DTRR.
238	I	RRB Rejected Part B Reduction, Delayed Processing	DELAY RRB PROC	CMS submitted Part B Reduction information for a beneficiary to RRB (See TRC 237). This data transmittal was rejected by RRB because they are unable to process the data at this time. CMS continues to interface with RRB to resolve the rejection. **Plan Action:** No action required.
239	I	RRB Rejected Part B Reduction, Jurisdiction	NOT RRB JRSDCTN	CMS submitted Part B Reduction information for a beneficiary to the RRB (See TRC 237). This data transmittal was rejected by the RRB. The beneficiary no longer falls under the RRB jurisdiction. **Plan Action:** The beneficiary jurisdiction must be assessed and aligned between agencies to successfully process the data.
240	A	Transaction Received, Withholding Pending	WHOLD UPDATE	As a result of an accepted Plan-submitted transaction to update a beneficiary's PPO (Transaction Type 75) or a UI update of same, a request will soon be forwarded to SSA. Plans will receive TRC 120 when this request is forwarded to SSA. Plans are notified of the subsequent SSA acceptance or rejection of the PPO change with a TRC 185 or 186, respectively, on a future DTRR. All data provided for change other than the PPO field was ignored. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance. **Note:** The Plan will not see the result of any PPO change until they have received a TRC 185 on a future DTRR.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
241	I	No Change in Part D Opt Out Flag	DUP PTD OPT OUT	A Part D Opt-Out Record Update transaction (Transaction Type 79) was submitted, however, no data change was made to the beneficiary's record. The submitted transaction contained a Part D Opt Out Flag value that matched the Part D Opt Out Flag already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action:** None required.
242	I	No Change in Primary Drug Information	DUP PRIMARY RX	A 4Rx Record Update transaction (72) was submitted, however, no data change was made to the beneficiary's record. The submitted transaction contained Primary Drug Insurance Information (Primary Rx ID, Primary Rx Group, Primary Rx BIN, Primary Rx PCN) that matched the Primary Drug Insurance values already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action:** None required.
243	R	Change to SSA Withholding rejected due to no SSN	NO SSN AT CMS	A PPO Change transaction (Transaction Type 75) was submitted to change the beneficiary's PPO to SSA withholding, however, there is no Social Security Number (SSN) on file at CMS. The beneficiary's PPO is not changed to SSA withholding. The beneficiary's records were unchanged. **Plan Action:** Update the Plan's beneficiary record accordingly. Take the appropriate action with member as per CMS enrollment guidance.
245	M	Member has MSP period	MEMBER IS MSP	This TRC is returned with a transaction type 01. The beneficiary has a change to their MSP (Medicare Secondary Payer) period that impacts payments for one or more of the beneficiary's enrollments in your plan. TRC 245 is sent to the plan(s) that have enrollment(s) that are impacted by the new/changed MSP period. • Field 18 will contain the Start Date of the payments impacted by the MSP period • Field 24 will contain the actual start date of the MSP period • Field 44 will contain the actual end date of the MSP period if available **Plan Action:** Update the Plan's records accordingly.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
252	I	Prem Payment Option Changed to Direct Bill; No SSN	W/O CHG;NO SSN	CMS has changed the PPO specified on the transaction to "D – Direct Bill" because the beneficiary does not have a Social Security number on file at CMS. This TRC may be generated in response to an accepted Enrollment, PBP change or PPO Change transaction (Transaction Types 61 or, 75) or may be initiated by CMS. **Plan Action:** Update the Plan's beneficiary records to reflect the direct bill payment method. Take the appropriate actions with member as per CMS enrollment guidance.
253	M	Changed to Direct Bill; no Funds Withheld	W/O CHG;NO W/H	CMS has changed the PPO to "D-Direct Bill" because no funds have been withheld by the withholding agency in the two months since withholding was accepted. **Plan Action:** Update the Plan's beneficiary records to reflect the direct bill payment method. Take the appropriate actions with member as per CMS enrollment guidance.
254	I	Beneficiary set to Direct Bill, spans jurisdiction	DIR BIL JRSDCTN	CMS has changed the PPO to "D-Direct Bill" because the withholding request spans two different withholding agency jurisdictional periods. This could occur for one of the following reasons: • SSA is the beneficiary's current withholding agency but the withholding request contains one or more periods from when RRB was the beneficiary's withholding agency. • RRB is the beneficiary's current withholding agency but the withholding request contains one or more periods from when SSA was the beneficiary's withholding agency. **Plan Action:** Update the Plan's beneficiary records to reflect the Direct Bill payment method. Take the appropriate actions with member as per CMS enrollment guidance.
255	I	Plan Submitted RRB W/H for SSA Beneficiary	RRB WHOLD 4 SSA	CMS has changed the PPO to "S-SSA Withhold" because SSA is the correct withholding agency for this beneficiary. **Plan Action:** None required.
256	I	Plan Submitted SSA W/H for RRB Beneficiary	SSA WHOLD 4 RRB	CMS has changed the PPO to "R-RRB Withhold" because RRB is the correct withholding agency for this beneficiary. **Plan Action:** None required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
257	F	Failed; Birth Date Invalid for Database Insertion	INVALID DOB	An Enrollment transaction (Transaction Type 61), change transaction (Transaction Types 72, 73, 74, 75, 77, 78, 79, 83), residence address transaction (Transaction Type 76), cancellation transaction (Transaction Types 80, 81, 82), or POS drug edit (Transaction Type 90), or IC Model Participation transaction (Transaction Type code 91) failed because the submitted birth date was either • Not formatted as YYYYMMDD (e.g., "Aug 1940"). • Formatted correctly but contained a nonexistent month or day (e.g., "19400199"). As a result, the beneficiary could not be identified. The transaction record will not appear on the Daily Transaction Reply Report (DTRR) data file but will be returned on the Batch Completion Status Summary (BCSS) data file along with the failed record. **Plan Action:** Correct the date format and resubmit transaction.
258	F	Failed; Efctv Date Invalid for Database Insertion	INVALID EFF DT	A disenrollment transaction (Transaction Types 51, 54), enrollment transaction (Transaction Type 61), change transaction (Transaction Types 72, 73, 74, 75, 77, 78, 79, 83), residence address transaction (Transaction Type 76) or cancellation transaction (Transaction Types 80, 81, 82) or IC Model Participation transaction (Transaction Type 91) failed because the submitted effective date was either: • Blank. • Not formatted as YYYYMMDD (e.g., "Aug 1940"). • Formatted correctly but contained a nonexistent month or day (e.g., "19400199"). The transaction record will not appear on the Daily Transaction Reply Report (DTRR) data file but will be returned on the Batch Completion Status Summary (BCSS) data file along with the failed record. **Plan Action:** Correct the date format and resubmit transaction.
259	F	Failed; End Date Invalid for Database Insertion	INVALID END DT	A residence address transaction (Transaction Type 76) failed because the submitted end date was either not formatted as YYYYMMDD (e.g., "Aug 1940") or was formatted correctly but contained a nonexistent month or day (e.g., "19400199"). The transaction record does not appear on the DTRR data file is returned on the BCSS data file along with the failed record. **Plan Action:** Correct the date format and resubmit transaction.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
260	R	Rejected; Bad End Date on Residence Address Change	BAD RES END DT	A residence address transaction (Transaction Type 76) was rejected because the End Date is not appropriate for one or more of the following reasons: • It is earlier than address change start date. • It is not the last day of the month. • It is not within the contract enrollment period. **Plan Action:** Correct the End Date and resubmit.
261	R	Rejected; Incomplete Residence Address Information	BAD RES ADDR	A residence address transaction (Transaction Type 76) was rejected for one of the following reasons: The residence address information was incomplete – • Residence Address Line 1 was empty. • Residence City was empty. • USPS state code was missing. • Residence zip code was missing or non-numeric. • The value specified for the Address Update/Delete Flag was blank or not valid. • The supplied residence address information could not be resolved in terms of identifiable address components. • The address was not a U.S. address. **Plan Action:** Correct address information and resubmit.
262	R	Bad RRB Premium Withhold Effective Date	INVALID EFF DTE	A PPO Change Transaction (Transaction Type 75) was rejected because request for RRB withholding is NOT allowed for effective date prior to 6/1/2011. **Plan Action:** Correct the Effective date and resubmit.
263	F	Failed; Aplctn Date Invalid for Database Insertion	INVALID APP DT	An enrollment transaction (Transaction Type 61) failed and did not process because the submitted application date was either not formatted as YYYYMMDD (e.g., "Aug 1940") or was formatted correctly but contained a nonexistent month or day (e.g., "19400199"). The transaction record does not appear on the DTRR data file is returned on the BCSS data file along with the failed record. **Plan Action:** Correct the date format and resubmit transaction.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
265	A	Residence Address Change Accepted, New SCC	RES ADR SCC	A residence address change transaction (Transaction Type 76) was accepted. The submitted residence address overrides the beneficiary's default address for the submitted effective period. The state and county code (SCC) and/or zip code used for enrollment changes and payments may have changed. The SCC and/or zip code in this residence address will be used for the effective period to determine if the beneficiary is out of area for the Plan. SCC values are returned in DTRR fields 9 (state code) and 10 (county code). The residence address period start date is in field 18 and any provided end date is in field 24. This TRC may be accompanied by TRC 154 if the submitted residence address has placed the beneficiary outside the Plan's service area. **Plan Action:** Update the Plan's records.
266	R	Unable to Resolve SSA State County Codes	SCC UNRESOLVED	A residence address transaction (Transaction Type 76) was rejected because SSA state and county codes (SCC) could not be resolved. The beneficiary's residence address was not changed. **Plan Action:** Confirm the address specified in the transaction. Update and resubmit the transaction if necessary; otherwise, contact your district office for assistance.
267	M	PPO set to N due to No Premium	PPO SET TO N	The beneficiary's PPO was set to N because their premium is $0. This occurs as part of an end-of-year process based on the Plan's basic Part C premium for the upcoming year. **Plan Action:** Submit a transaction to reset the Part C premium and to renew a request for withholding status if appropriate.
268	I	Beneficiary Has Dialysis Period	DIALYSIS EXISTS	This TRC is returned on an enrollment. It is intended to supply the Plan with additional information about the beneficiary. Each TRC 268 returns start and end dates for each dialysis period that overlaps the enrollment period. There may be more than one TRC 268 returned. The effective date for the dialysis period is shown in the Effective Date field (field 18). The end date, if one exists, is in the Open Data field (field 24). **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
269	I	Beneficiary Has Transplant	TRNSPLNT EXISTS	This TRC is returned on an enrollment. It is intended to supply the Plan with additional information about the beneficiary. Each TRC 269 returns transplant and failure dates for each kidney transplant that overlaps the enrollment period. There may be more than one TRC 269 returned. The transplant date is shown in the Effective Date field (field 18). The end date, if one exists, is shown in Transplant End Date (field 24). **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
270	M	Beneficiary Transplant Has Ended	TRANSPLANT END	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS was notified that the beneficiary's transplant s failed or was an error. The effective date of the failure or removal is reported in field 18 of the DTRR record and in the EFF DATE column on the printed report. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
280	M	Member MSP Period Ended	MEMBER NOT MSP	This TRC is returned with a transaction type 01. The beneficiary has an MSP (Medicare Secondary Payer) period that has been ended or updated. The MSP period change impacts payments for one or more of the beneficiary's enrollments in your plan. TRC 280 is sent to the Plan(s) that have enrollment(s) that are impacted by the change in the MSP period. • Field 18 will contain the earliest date that the payments are impacted by the MSP period change, based on the MSP new/changed end date. • Field 24 will contain the actual start date of the MSP period. • Field 44 will contain the end date of the MSP period. **Note:** If the MSP period has both start and end dates, plans will receive both TRC 245 and 280. **Plan Action:** Update the Plan's records accordingly.
282	A	Residence Address Deleted	RES ADR DELTD	The residence address associated with the DTRR effective date (in field 18) has been deleted and is no longer valid. The address was removed either through "delete" action via the 76 transaction or because an overlapping residence address change was submitted with the same or earlier effective date. **Plan Action:** None required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
283	R	Residence Address Delete Rejected	RJCTD ADR DELT	The residence address delete attempted was rejected. No residence address exists for the effective date provided. See DTRR field 18. **Plan Action:** Correct effective date and resubmit.
284	R	Cancellation Rjctd, Prior Enroll/Disenrol l Changed	NO REINSTATE	A Disenrollment Cancellation (Transaction Type 81) was rejected. The cancellation action attempted the reinstatement of the enrollment and this reinstatement could not be accomplished. The reinstatement could not be accomplished because some aspect of the enrollment, or the beneficiary's status during that enrollment, has been changed by the Plan (examples include: 4Rx, Residence Address or Segment ID) prior to their issuance of this current cancellation transaction. **Plan Action:** Enroll the beneficiary using a Transaction Type 61, Enrollment.
285	I	Enrollment Cancellation Accepted	ACPT ENROLL CAN	An Enrollment Cancellation (Transaction Type 80) transaction was accepted. The identified enrollment is cancelled. The start date of the cancelled enrollment period is reported in the DTRR Effective Date field 18. **Plan Action:** Update the Plan's records accordingly.
286	R	Enrollment Cancellation Rejected	RJCT ENROLL CAN	An Enrollment Cancellation (Transaction Type 80) or an MMP Enrollment Cancellation (Transaction Type 81) transaction was rejected. Rejection occurred for one of the following reasons: The cancellation was submitted more than one month after the enrollment became active, the transaction attempts to cancel a Rollover, Auto or Facilitated Enrollment, or when the transaction attempts to cancel a closed enrollment period. **Plan Action:** Submit a Disenrollment transaction.
287	A	Enrollment Reinstated	ENROLL REINSTAT	The identified enrollment period was reinstated. The start date of the reinstated period is reported in the DTRR Effective Date field 18. The reinstatement occurred for one of the following reasons: • For Transaction Type 80, cancellation of another Plan's enrollment. • For Transaction Type 81, cancellation of Plan's disenrollment. • For Transaction Type 82, cancellation of another Plan's enrollment. • For Transaction Type 01, change or removal of a date of death. If the reinstated enrollment has an end date, it is reported in the DTRR field 24. The end date may or may not have existed with the enrollment originally. **Plan Action:** Update the Plan's records accordingly following CMS guidance for enrollment reinstatement.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
288	A	Disenrollment Cancellation Accepted	ACPT DISNRL CAN	A Disenrollment Cancellation (Transaction Type 81) transaction was accepted. The identified disenrollment was cancelled. The start date of the cancelled disenrollment period is reported in the DTRR Effective Date field 18. The Disenrollment Cancellation (Transaction Type 81) may have been submitted by a Plan or the result of a Date of Death Change or Date of Death Rescinded notification that cancels an auto-disenrollment that was created by a Date of Death notification. **Plan Action:** Update the Plan's records accordingly.
289	R	Disenrollment Cancellation Rejected	RJCT DISNRL CAN	A Disenrollment Cancellation (Transaction Type 81) transaction was rejected. Rejection occurred for one of the following reasons: • Beneficiary was still enrolled in plan, never disenrolled. • Beneficiary was not enrolled in the plan. • Disenrollment being cancelled was not submitted by the Plan. • Cannot restore prior enrollment due to associated disenrollment reason codes 5, 6, 8, 9, 10, 13, 15, 18, 19, 54, 56, 57, 61. • Reinstated enrollment would conflict with another existing enrollment. • The beneficiary's benefits have been suspended due to confirmed incarceration or a Not Lawfully Present period. **Plan Action:** Submit Enrollment transaction.
290	I	IEP NUNCMO Reset	NUNCMO RSET IEP	This TRC was the result of an automatic system reset, or zeroing, of the cumulative uncovered months for the identified beneficiary. This reset occurred for one of the following reasons: • Disabled beneficiary became age-qualified for Medicare. • An aged beneficiary had a retroactive NUNCMO transaction with an effective date prior to aged qualification at the beginning of the IEP period. Reset effective date is in DTRR field 18. **Plan Action:** Update Plan records accordingly.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
291	I	Enrollment Reinstated, Disenrollment Cancellation	ENROLL REINSTAT	A Disenrollment Cancellation (Transaction Type 81) transaction cancelled a disenrollment and the enrollment was reinstated. The start date of the reinstated period is reported in the DTRR Effective Date field 18. If the reinstated enrollment has an end date, it is reported in the DTRR field 24. The end date may or may not have existed with the enrollment originally. **Plan Action:** Update the Plan's records accordingly following CMS guidance for enrollment reinstatement.
292	R	Disenrollment Rejected, Was Cancellation Attempt	NOT CANCELLATN	A Disenrollment transaction (Transaction Type 51) was rejected. The submitted disenrollment effective date is the same as the enrollment start date. Only Auto or Facilitated enrollments may be cancelled using the Transaction Type 51. **Plan Action:** Submit an Enrollment Cancellation transaction (Transaction Type 80) if it is desired to cancel the enrollment; otherwise, correct the disenrollment effective date and resubmit.
293	A	Disenroll, Failure to Pay Part D IRMAA	FAIL PAY PTD IRMAA	A disenrollment transaction (Transaction Type 51) has been successfully processed due to failure to pay Part D IRMAA. The last day of the enrollment is reported in DTRR fields 18 and 24. The disenrollment date is always the last day of the month. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record and that the beneficiary's disenrollment date matches the date in field 24. Take the appropriate actions as per CMS enrollment guidance.
294	I	No 4Rx Insurance Changed	NO INSUR CHANGE	A 4Rx Change (Transaction Type 72) transaction was received with no primary or secondary insurance information provided on the transaction. No insurance data changes took place for this beneficiary. **Plan Action:** Resubmit with new 4Rx data as needed.
295	M	Low Income NUNCMO RESET	NUNCMO RSET LIS	This TRC was the result of an automatic system reset, or zeroing, of the cumulative uncovered months for the identified beneficiary. This reset occurred because the beneficiary has been identified as having the Part D low-income subsidy. Reset effective date is in DTRR field 18. **Plan Action:** Update Plan records accordingly.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
300	R	NUNCMO Change Rejected, Exceeds Max Possible Value	NM CHG EXDS MAX	A NUNCMO Record Update transaction (73) was rejected because the submitted incremental NUNCMO exceeds the maximum possible value. The original (existing) incremental NUNCMO associated with this effective date has been retained. Field 24 (Maximum Number of Uncovered Months) reports the maximum incremental NUNCMO value that could be associated with the enrollment effective date submitted. Field 40 (Cumulative Number of Uncovered Months) reports the total uncovered months as of the effective date. Field 45 (Submitted Number of Uncovered Months) reports the incremental NUNCMO value submitted by the Plan. **Plan Action:** Review the incremental NUNCMO submitted, the maximum incremental NUNCMO calculated by the system, and/or the effective date submitted. If the NUNCMO and/or the effective date should be another value, review CMS enrollment guidance, and correct the NUNCMO value using a new NUNCMO Record Update (73) transaction.
301	M	Merged Beneficiary Identifier Change	BENE MBI MERGE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary had multiple conflicting beneficiary identifier (MBIs) which were merged under a single MBI. This DTRR reports the VALID MBI in field 1 and the INVALID MBI in field 24. **Plan Action**: Update the Plan's records to use the VALID MBI from field 1 for this beneficiary. The valid beneficiary identifier must be used on all future transactions for this beneficiary.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
302	M	Enrollment Cancelled, Beneficiary Identifier Change	ENRL CNCL MERGE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary had multiple conflicting MBIs, which were merged into one. Plan enrollments for the conflicting MBIs have been combined under a valid MBI. This enrollment conflicted with another existing enrollment. As a result, the conflicting enrollment period was cancelled. The effective date of the enrollment which has been cancelled is reported in the Effective Date field (18). The termination date of the enrollment (if present) is reported in field 24. **Plan Action:** Because the enrollment period is now cancelled, the enrollment period should be adjusted in the Plan's enrollment records. This change may impact premiums that you collected directly from the beneficiary. Take the appropriate actions as per CMS enrollment guidance.
303	M	Termination Date Change due to Beneficiary Merge	TRM DT CHG MERGE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary had multiple conflicting beneficiary identifier (MBIs) which were merged into one. Plan enrollments for the conflicting MBIs have been combined under a valid MBI. This enrollment conflicted with another existing enrollment. Current enrollment rules regarding the application signature date were applied and this enrollment's termination date was changed from the original date. The effective date of the enrollment with the changed termination date is reported in the Effective Date field (18). The new termination date of this enrollment is reported in Field 24. **Plan Action:** Because the termination date has changed, the enrollment period should be adjusted in the Plan's enrollment records. This change may impact premiums that you collected directly from the beneficiary. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
305	M	ZIP Code Change	ZIP CODE CHANGE	A notification has been received that this beneficiary's zip code has changed. The new zip code is reported in field 24 of the DTRR. The effective date of the change is reported in field 18. **Note:** A reply with this TRC only reports changes in the Zip Code the beneficiary has on file with SSA/CMS. It does not report changes in a Plan-submitted Residence Address. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
306	R	NUNCMO Change Rejected, No Part D Eligibility	NUNCMO, NO PTD	A NUNCMO Change transaction (Transaction Type 73) was rejected because beneficiary does not have Part D Eligibility as of the submitted effective date. **Plan Action:** Verify the beneficiary identifying information and resubmit the transaction with updated information, if appropriate.
307	A	MMP Passive Enrollment Accepted	PASSIVE ACCEPT	This TRC is returned on a successful MMP passive enrollment transaction (TC 61). The effective date of the new enrollment is reported in DTRR field 18. This is the definitive MMP enrollment acceptance record. Other accompanying replies with different TRCs may give additional information about this enrollment. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
308	R	MMP Passive Enrollment Rejected	PASSIVE REJECT	An MMP passive enrollment transaction (TC 61) was rejected because the beneficiary did not meet the MMP requirements or the beneficiary opted out of passive enrollment. The attempted enrollment effective date is reported in DTRR fields 18 and 24. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance.
309	I	No Change in MMP Opt-Out Flag	DUP FA OPT OUT	An MMP Opt-Out Record Update transaction (TCs 42, 83) was submitted; however, no data change was made to the beneficiary's record. The submitted transaction contained an MMP Opt-Out Flag value that matched the MMP Opt-Out already on record with CMS. This transaction did not affect the beneficiary's records. **Plan Action:** None required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
310	R	MMP Opt-Out Rejected, Invalid Opt-Out Code	BAD FA OPT OUT	An opt-out from CMS, disenrollment, or Plan submitted Opt-Out transaction (TCs 42, 51, 54, 82, 83) was rejected because the MMP Opt-Out Flag field was incorrectly populated. The valid values for MMP Opt-Out are: • TCs 42 or 83 transactions - Y or N. • All other TCs - Y, N, or space. **Plan Action:** If submitted by the Plan (TCs 51, 82, 83), correct the MMP Opt-Out Flag value and resubmit the transaction if appropriate.
311	A	MMP Opt-Out Accepted	FA OPT OUT ACPT	A transaction (TCs 42, 51, 54, 82, 83) was received that specified an MMP Opt-Out Flag value or a change to the MMP Opt-Out Flag value. The MMP Opt-Out Flag was accepted. The new MMP Opt-Out Flag value is reported in DTRR field 70. **Plan Action:** No action necessary.
312	A	MMP Enrollment Cancellation Accepted	ACPT FA CANCEL	An Enrollment Cancellation (TC 82) was accepted. The identified enrollment was cancelled. The start date of the cancelled enrollment period is reported in DTRR field 18. **Plan Action:** Update the Plan's records accordingly.
313	R	MMP Enrollment Cancellation Rejected	RJCT FA CANCEL	An MMP Enrollment Cancellation (TC 82) transaction was rejected because the cancellation was submitted after the enrollment became active. **Plan Action:** Submit a Disenrollment transaction.
314	R	Invalid Cancellation TC	BAD CANCEL CODE	An enrollment cancellation transaction was rejected because the wrong Transaction Type Code (Field 16) was used. TC 82 can only be used for cancelling MMP enrollments. TC 80 is only used for cancelling non-MMP enrollments. **Plan Action:** Correct the TC and resubmit if appropriate.
315	R	Archived Beneficiary Transaction Rejected	ARCH BENE REJ	This reply can be returned for all transaction types. The transaction is rejected because it is for an archived beneficiary. A beneficiary is eligible for archiving under the following conditions: • Deceased for 15 years with no activity for 2 years. • No DOD, 120+ years of age and a BIC of M or T with no activity for 2 years. **Plan Action:** Double check the beneficiary information and submit a corrected transaction. Contact the MAPD Help Desk for assistance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
316	I	Default Segment ID Assignment	DEFAULT SEG ID	A default Segment ID is assigned because the beneficiary is Out-of-Area for the Contract/PBP. For enrollments with effective dates prior to 2014, the default Segment is the Segment with the lowest valid Segment ID for the Contract/PBP. For years 2014 and later, the default Segment is the Segment with the lowest premiums. **Plan Action:** Verify the beneficiary's address is correct. Submit a Residence Address Change if appropriate.
317	I	Segment ID Reassigned after Address Update	SEG ID REASSIGN	A Segment ID reassigns because updated address information is received. The updated address information either results from a Plan-submitted Residence Address Change (Transaction Type 76) or an SCC change notification. This TRC is returned when a Segment ID reassigns for one of the following reasons: • Updated address information is received. The updated address information is either a result of a Plan-submitted Residence Address Change (Transaction Type 76) or a State and County Code change notification. • An Enrollment Transaction (Transaction Type 61) or Segment ID Change (Transaction Type 77) is received for a segmented Plan where part of the enrollment has a terminated Segment ID. Examples include: o A retroactive enrollment that spans more than one year and the Segment ID is not valid for both years. o An enrollment that is effective at the end of one year and the Segment ID is not valid for the upcoming year. • An Enrollment Transaction (Transaction Type 61) is received with an invalid Segment ID. The effective date of the reassignment is reported in field 18. **Plan Action:** Verify the Segment ID is correct. Submit a Residence Address Change or a Segment ID change if appropriate.
318	R	Invalid or Missing MMP Demo Enrlmt Source Code	INVALID MMP SRC	A Medicare and Medicaid Plan (MMP) enrollment transaction was rejected because the enrollment source code was missing or invalid. Valid values are J, K, and L. **Plan Action:** Correct the enrollment source code and resubmit.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
319	M	RRB to SSA Beneficiary Jurisdiction Change	RRB - SSA Jur	A beneficiary undergoes a jurisdiction change from RRB to SSA. CMS attempts to establish premium withholding with SSA, which may take up to two months. If the transfer is successful, a TRC 185 is issued. If it is unsuccessful, TRCs 186 and 144 are issued. This action is not in response to a Plan-initiated transaction. **Plan Action:** None required at this time.
320	M	SSA to RRB Beneficiary Jurisdiction Change	SSA - RRB Jur	A beneficiary undergoes a jurisdiction change from SSA to RRB. CMS attempts to establish premium withholding with RRB, which may take up to two months. If the transfer is successful, a TRC 185 is issued. If it is unsuccessful, TRCs 186 and 144 are issued. This action is not in response to a Plan-initiated transaction. **Plan Action:** None required at this time.
321	A	POS Drug Edit Accepted as Submitted	PSDE ACC	A submitted POS Drug Edit transaction (Transaction Type code 90) was successfully processed. The TRC is applicable for both update and delete transactions. The TRC will also be issued when a POS Drug Edit record is submitted via the MARx UI by a Plan User with POS Drug Edit Update Authority. **Plan Action:** None.
322	I	New Enrollee POS Drug Edit Notification	PSDE ENR NOT	The beneficiary had an active POS Drug Edit associated with the enrollment immediately preceding this enrollment. The contract ID associated with this earlier enrollment is supplied in DTRR data record field 24. This TRC supplies additional information about an accepted enrollment transaction. For a beneficiary with an active POS Drug Edit, the transaction reply with TRC322 is provided in addition to the reply with the enrollment acceptance TRC. **Plan Action:** Contact the Plan associated with the previous enrollment for pertinent details about the beneficiary's POS Drug Edit and overutilization case file.
323	R	POS Drug Edit Invalid Enrollment	PSDE INV ENR	A POS drug edit transaction (Transaction Type code 90) was rejected for one of the following reasons: • The notification, implementation, or termination date is outside of the contract enrollment period. • There is an enrollment gap between two of the dates on the transaction. **Plan Action:** Correct the date(s) and resubmit the transaction, if appropriate. If the beneficiary re-enrolled in the Contract with a gap between the two enrollments, submit new records using a notification date that is equal to or later than the new enrollment effective date.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
324	R	POS Drug Edit Invalid Contract	PSDE INV CON	A POS drug edit transaction (Transaction Type 90) was rejected because the submitting contract is: • LiNet Plan. • Not a Part D Plan. **Plan Action:** Correct the contract number and resubmit the POS Drug Edit transaction, if appropriate.

325	R	POS Drug Edit Status/Date Error	PSDE DATE ERR	A POS drug edit transaction (Transaction Type code 90) was rejected due to one of the following date errors:
				• POS status of N and:
				  ○ Implementation or Termination date is populated (these must be blank).
				• POS status of I and:
				  ○ Required Implementation date is blank
				  ○ Termination date is populated (this must be blank).
				• POS status of T and:
				  ○ Required Implementation (if exists) and/or Termination dates are blank.
				
				Plan Action: Correct the dates and resubmit the POS Drug Edit Transaction, if appropriate.

326	R	POS Drug Edit Implementation Date Incorrect	PSDE IMP DT INC	A POS drug edit transaction (Transaction Type code 90) with a status of I was rejected because the implementation date is before the notification date. **Plan Action:** Correct the dates and resubmit the POS Drug Edit Transaction, if appropriate.
327	R	POS Drug Edit Termination Date Incorrect	PSDE TERM DT INC	A POS drug edit transaction (Transaction Type Code 90) with a status of T was rejected because: • The termination date is before the implementation date if the latest status is I, or • The termination date is before the notification date if the latest status is N. **Plan Action:** Correct the dates and resubmit the POS Drug Edit Transaction, if appropriate.
328	R	POS Drug Edit Duplicate Transaction	PSDE DUP	A POS Drug Edit transaction (Transaction Type code 90) was rejected because it is a duplicate. The submitted transaction matched the following values on an existing POS Drug Edit record: • Status • POS Drug Edit Class • POS Drug Edit Code • POS Drug Edit dates (notification, implementation and/or termination) This TRC will only be issued for update transactions not delete. **Plan Action:** None required.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
329	R	POS Drug Edit Delete Error	PSDE DEL ERR	A POS Drug Edit transaction (Transaction Type 90) was rejected because the transaction attempted to delete an existing POS Drug Edit but there was no corresponding existing record. **Plan Action:** Correct the information provided and resubmit the transaction, if appropriate.
330	R	POS Drug Edit Without Associated Records	PSDE WO ASSOC	A POS Drug Edit transaction (Transaction Type Code 90) was rejected because it was submitted for a beneficiary without a corresponding POS Drug Edit record. • When Status = I - Submitted notification date must match an existing record. • When Status = T - Both the submitted notification date and implementation date (if exists) must match an existing record(s). • When Status = I or T - POS Drug Edit Class must match an existing notification record with the same notification date. • When Status = I or T - POS Drug Edit Code must be the same or less restrictive as the notification record with the same notification date. • When Status = T – POS Drug Edit Code must be the same as the implementation record with the same implementation date provided. A notification record can only be associated with one implementation and termination record (same POS Drug Edit Class and POS Drug Edit Code). **Plan Action:** Verify the dates associated with the POS Drug Edit to be updated. Verify that the correct POS Drug Edit Code and Class were submitted. Correct and resubmit the transaction, if appropriate.
331	R	Future POS Drug Edit Date Exceeds CCM Plus One	PSDE DT FUT	A POS Drug Edit transaction (Transaction Type 90) was rejected because a submitted notification, implementation or termination date is later than the end of the month that follows the current calendar month. **Plan Action:** Correct the date(s) and resubmit the transaction, as appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
332	F	Failed, PSDE Dates Invalid for Database Insertion	F PSDE DT INVAL	A POS Drug Edit transaction (Transaction Type 90) failed because one of the following dates was either not formatted as YYYYMMDD (e.g., "Aug 1940") or was formatted correctly but contained a nonexistent month or day (e.g., "19400199"): • Notification Date. • Implementation Date. • Termination Date. The failed transaction record is not returned in the DTRR data file. It is returned on the Batch Completion Status Summary (BCSS) data file. **Plan Action:** Correct the date(s) and resubmit the transaction, as appropriate.
333	R	Reject, Invalid POS Drug Edit Status	PSDE INV STATUS	A POS Drug Edit transaction (Transaction Type 90) was rejected because the submitted POS Drug Edit Status field was blank or contained an invalid value. Valid values are: • N – Notification. • I – Implementation. • T – Termination. **Plan Action:** Correct the POS Drug Edit Status and resubmit the transaction, if appropriate.
334	R	Reject, Invalid POS Drug Edit Class	PSDE INV CLASS	A POS Drug Edit transaction (Transaction Type 90) was rejected because the submitted Drug Class field was blank or contained an invalid value. **Plan Action:** Correct the Drug Class and resubmit the transaction, if appropriate.
335	R	Reject, Invalid POS Drug Edit Code	PSDE INV CODE	A POS Drug Edit transaction (Transaction Type 90) was rejected because the submitted Drug Edit Code field was blank or contained an invalid value. **Plan Action:** Correct the Drug Edit Code and resubmit the transaction, if appropriate.
336	R	Reject, Invalid POS Drug Edit U/D	PSDE INV U/D	A POS Drug Edit transaction (Transaction Type 90) was rejected because the submitted POS Drug Edit Update/Delete flag was blank or contained an invalid value. Valid values are: • U – Update. • D – Delete. **Plan Action:** Correct the POS Drug Edit Update/Delete flag and resubmit the transaction, if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
337	A	POS Drug Edit Event Deleted - Plan	PSDE EVT DEL P	A Plan User with POS Drug Edit update Authority deleted a POS Drug Edit event via the MARx UI for this beneficiary. • If the latest status was T (Termination), the associated Notification, Implementation (if exists) and Termination POS Drug Edit records were deleted. • If the latest status was I (Implementation), the associated Notification and Implementation POS Drug Edit records were deleted. • If the latest status was N, the Notification POS Drug Edit record was deleted. If the Notification record is associated with a different valid Implementation record the Notification record will not be deleted; it will remain associated with that event. **Plan Action:** None.
338	I	Enrollment Accepted, PPO Changed	PPO CHG	CMS has changed the Premium Payment Option specified on the enrollment transaction because the beneficiary is enrolled in a LINET, MMP, or PACE plan. If the beneficiary premiums are zero, the PPO is changed to 'N – No Premium'. If the beneficiary premiums are greater than zero, the PPO is changed to 'D – direct bill'. This TRC may be generated in response to an accepted Enrollment or PBP change (Transaction Type 61). **Plan Action:** Update the Plan's beneficiary records to reflect the updated premium payment method.
339	I	Enrollment Accepted, PBP Changed	PBP CHANGE OK	A submitted Enrollment transaction (Transaction Type 61) for the Limited Income Newly Eligible Transition (LINET) Plan has been successfully processed. The beneficiary has been moved from the submitted PBP to the PBP that is active for the transaction processing date. Field 20 (Plan Benefit Package ID) contains the new PBP identifier. The submitted PBP is reported in Field 29 (Prior Plan Benefit Package ID). **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
340	A	DISENROLLMENT DUE TO MMP PASSIVE ENROLLMENT	DISNROL-NEW MMP	The beneficiary has been automatically disenrolled from the Plan. The last day of enrollment is reported in DTRR fields 18 and 24. This date is always the last day of the month. This disenrollment results from an action by CMS or a state to passively enroll a full benefit dual eligible beneficiary into a Medicare-Medicaid Plan (MMP). **Plan Action:** Update the Plan's records to reflect the disenrollment using the date in field 24. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
341	I	Maximum NUNCMO Calculation	MAX NUNCMO CALC	This TRC provides additional information about an accepted enrollment or NUNCMO record update transaction (Transaction Types 61, 73) for which an acceptance was sent in a separate Transaction Reply. This reply informs the plan of the maximum incremental NUNCMO value that could be associated with the enrollment effective date submitted. Field 24 (Maximum Number of Uncovered Months) reports the maximum incremental NUNCMO value. Field 40 (Cumulative Number of Uncovered Months) reports the total uncovered months as of the effective date. Field 45 (Submitted Number of Uncovered Months) reports the incremental NUNCMO value submitted on the transaction. **Plan Action:** Review the incremental NUNCMO submitted and the maximum incremental NUNCMO calculated by the system. If the NUNCMO should be another value, review CMS enrollment guidance and correct the NUNCMO value using a new NUNCMO Record Update (73) transaction.
342	R	Reject, Multiple Notification	PSDE MULT NOT	A POS Drug Edit transaction (Transaction Type code 90) was rejected because a valid notification record with the same contract, drug class, and notification date currently exists for this beneficiary. **Plan Action:** If appropriate, delete the existing notification and resubmit the transaction.
343	I	POS Drug Edit Class Inactive	PSDE CLASS OBS	CMS added an end date to one of the Drug Classes used for reporting POS Drug Edits. This beneficiary has a POS Drug Edit record with a notification or implementation date that is after the end date for the Drug Class. **Plan Action:** Terminate or delete the impacted POS Drug Edit Records, if appropriate.
344	R	Reject, More Restrictive Implementation	PSDE RES IMP	A POS Drug Edit transaction was rejected because the Drug Edit Code supplied on the implementation transaction is not less restrictive than a previous implementation associated with the same notification record. **Plan Action:** If a less restrictive implementation is correct, submit a new implementation transaction with the less restrictive Drug Edit Code. If the more restrictive implementation is correct, the beneficiary must be notified of the more restrictive implementation. Submit a new notification transaction with the more restrictive Drug Edit Code. Then, submit a new implementation transaction with the more restrictive Drug Edit Code.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
345	R	Enrollment Rejected – Confirmed Incarceration	CNFRMD INCARC	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary's benefits have been suspended due to confirmed incarceration and the enrollment effective date falls within the period when the beneficiary's benefits were suspended. **Plan Action:** Update the Plan's records accordingly. Take the appropriate actions as per CMS enrollment guidance.
346	M	Prisoner Suspension Period Cancel/Disenroll	PRSNR SUSPENSE	The benefits for this beneficiary were suspended due to a confirmed incarceration. As a result, an existing enrollment that falls within the suspension period was either shortened (disenrolled) or removed (cancelled). This TRC provides additional information about the disenrollment (TRC 018) or enrollment removal (TRC 015) which was sent as a separate reply in the same DTRR. The last day of the enrollment is reported in Transaction Reply Report data record field 18. This date will always be the last day of the first month of the prisoner suspension. **Plan Action:** Update the Plan's records to reflect the removal of the existing enrollment or the disenrollment using the date in field 18. Take the appropriate actions as per CMS enrollment guidance.
347	I	Reenrollment due to Closed Incarceration Period	REENROLL INCARC	This TRC provides additional information about an enrollment acceptance (TRC 011) which was sent as a separate reply in the same DTRR. An existing enrollment has been given a new start date because the beneficiary has a period when their benefits were suspended due to a confirmed incarceration. The existing enrollment overlapped the end of the suspension period and has been changed to begin the first day of the month when the suspension period ended. When this occurs, the plan will see the removal of the original enrollment (TRC 015 and TRC 346) followed by the reenrollment with the new enrollment effective date (TRC 011 and TRC 347). The start date of the reenrollment period is reported in the Daily Transaction Reply Report (DTRR) data record Effective Date field, Field 18. This date will always be the first day of the month that the Prisoner Suspension Period ended. **Plan Action:** Update the Plan's records accordingly. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
348	R	Enrollment Rejected – Not Lawfully Present Period	CNFRMD NOTLAWFL	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary's benefits have been suspended due to confirmed Not Lawfully Present period, and the enrollment effective date falls within the Medicare Plan Ineligibility period. **Plan Action:** Update the Plan's records accordingly. Take the appropriate actions as per CMS enrollment guidance.
349	I	Disenrollment Due to Not Lawfully Present Period	DISENRL NOTLAW PRESNT	The benefits for this beneficiary were suspended due to a confirmed Not Lawfully Present period. As a result, an existing enrollment that falls within the suspension period was either shortened (disenrolled) or removed (cancelled). This TRC provides additional information about the disenrollment (TRC 018) or enrollment removal (TRC 015), which was sent as a separate reply in the same DTRR. The last day of the enrollment is reported in Transaction Reply Report data record Field 18. **Plan Action:** Using the date in Field 18, update the Plan's records to reflect the disenrollment or the removal of the existing enrollment. Take the appropriate actions as per CMS enrollment guidance.
350	I	MBI is available for beneficiary	MBI AVAILABLE	A transaction was submitted with a HICN during the transition to MBI and it was accepted. A Medicare Beneficiary Identification (MBI) number is assigned to the beneficiary. This TRC provides the MBI number assigned to the beneficiary in the Beneficiary Identifier field. **Plan Action:** None
351	A	IC Model Participation Accepted	IC MDL PRT ACC	A submitted IC Model Participation transaction (Transaction Type code 91) was successfully processed. The TRC is applicable for both update and delete transactions. **Plan Action:** None

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
352	R	IC Model Participation Duplicate Transaction	IC MDL PRT DUP	An IC Model Participation transaction (Transaction Type code 91) was rejected because it is a duplicate. The submitted transaction matched the following values on an existing IC Model Participation record: • MBI. • Contract and PBP. • IC Model Indicator. • IC Model Benefit Status Code. • IC Model Start Date. • IC Model End Date (if exists). • IC Model End Date Reason Code. This TRC will only be issued for update transactions not delete. **Plan Action:** Two options to correct this error: 1. Edit the previous period so the new period will not overlap (put an end date on previous period record). 2. If intent is to correct the Start Date of a previously submitted period, submit a Delete transaction with the original record data, then submit a new transaction with the new Start Date.
353	R	IC Model Participation Delete Error	IC MDL DEL ERR	An IC Model Participation transaction (Transaction Type code 91) was rejected because the transaction attempted to delete an existing IC Model Participation entry but there was no corresponding existing record. **Plan Action:** Correct the information provided and resubmit the transaction, if appropriate.
354	R	Reject, Invalid IC Model Type Indicator	NVLD IC MDL IND	An IC Model Participation transaction (Transaction Type code 91) was rejected because of one the following reasons: • IC Model Type Indicator code was blank. • IC Model Type Indicator code is not valid. • IC Model Type Indicator code is not correct for the specified Contract/PBP. Valid values for the IC Model Type Indicator are ‘01’ for VBID and ‘02’ for MTM. **Plan Action:** Correct the information provided and resubmit the transaction, if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
355	R	Enrollment Rejected, Pln RO not in POVER file	PLN RO NT POVER	This Plan-Submitted Rollover transaction was rejected because it was not submitted via a POVER file. The transaction was recognized as a 'Plan-Submitted Rollover' because it was submitted with Enrollment Source Code = 'N' (Rollover by Plan Transaction) or Election Type Code = 'C' (Special Enrollment Period (SEP) for Plan-submitted rollovers). Plan-submitted rollover enrollment transactions must have an Enrollment Source Code = 'N', Election Type Code = 'C', and must be submitted in a POVER special batch file. **Plan Action:** Correct the file header and resubmit the special batch file. The file header record should say POVER and go through the CMS approval process for a file of Plan-submitted rollover enrollment transactions.
356	R	Enrollment Rejected, Pln RO without ESC or ETC	PL RO WO C OR N	This transaction was rejected because it contained an Enrollment Source Code or Election Type Code that indicated it was a Plan-Submitted Rollover, but only one of these values were submitted. Plan-submitted rollover enrollment transactions must have an Enrollment Source Code = 'N', Election Type Code = 'C', and be submitted in a POVER special batch file. **Plan Action:** Correct the enrollment source code or election type code and resubmit the special batch file.
357	R	Enrollment Rejected, Pln RO Impacts Dual Enroll	PLN RO DUAL ENR	This Plan-Submitted Rollover transaction was rejected because it would disenroll a dual-enrolled beneficiary from both the MA and PDP plans. For example, a beneficiary is dual-enrolled in both an MA and a PDP Plan. If the MA Plan is rolled over to an MAPD Plan, the beneficiary would be disenrolled from both the MA and PDP plans. **Plan Action:** Review the beneficiary's enrollment and resubmit the rollover transaction if appropriate.
358	F	Fail, IC Model End Date had an Invalid format	NVLD IC END DT	An IC Model Participation transaction (Transaction Type code 91) failed because the IC Model End Date was either not formatted as YYYYMMDD (e.g., "08312013" or "Aug 2014") or was formatted correctly but contained a nonexistent month or day (e.g., "20170199"). **Plan Action:** Correct the IC Model End Date and resubmit the transaction, if appropriate.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
359	R	ICM Trans Start Date is Incorrect	IC STRT DT ERR	An IC Model Participation transaction (Transaction Type code 91) was rejected because the IC Model Start Date is not within the contract/PBP IC Model period, or is not within the beneficiary's enrollment period for the contract/PBP specified in the transaction. **Plan Action:** Correct the IC Model Start Date, contract and PBP, and resubmit the transaction, if appropriate.
360	R	Reject, Invalid IC Model U/D	IC MDL INV U/D	An IC Model Participation transaction (Transaction Type code 91) was rejected because the submitted Update/Delete flag was blank or contained an invalid value. Valid values are: • U – Update. • D – Delete. **Plan Action:** Correct the Update/Delete flag and resubmit the transaction, if appropriate.
361	R	Reject, Invalid IC Model End Date Reason Code	IC END RSN ERR	An IC Model Participation transaction (Transaction Type code 91) was rejected because the submitted End Date Reason Code field was blank when an End Date is present in the transaction or contained an invalid value. Valid values are: • 01 – No Longer Eligible • 02 – Opted out of program • 03 – Benefit Status Change **Plan Action:** Correct the End Date Reason Code and resubmit the transaction, if appropriate.
362	R	IC Model End Date Incorrect	IC END DT ERROR	An IC Model Participation transaction (Transaction Type code 91) was rejected because the IC Model End Date: • Is earlier than the IC Model Start Date or • Is after the Enrollment End Date. **Plan Action:** Correct the IC Model End Date and resubmit the transaction, if appropriate.
363	R	ICM Trans Dates Overlap an Existing ICM Prd	OVERLAP DATES	An IC Model Participation update transaction (Transaction Type code 91) was rejected because the IC Model Start or End Date overlaps an existing IC Model period for a beneficiary that has the same contract number, PBP, and transaction type indicator. **Plan Action:** Submit a Transaction Type code 91 with Delete for the stored IC Model Participation record. Submit a second Transaction Type code 91 with Update and the new dates.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
365	R	Reject, Invalid IC Model Benefit Status Code	BNFT STUS ERR	An IC Model Participation transaction (Transaction Type code 91) was rejected because the submitted Benefit Status Code field was blank or contained an invalid value when the IC Model Type Indicator is '01' (VBID). Valid values are: • 01 – Full Status. • 02 – Unearned Status. **Plan Action:** Correct the Benefit Status Code and resubmit the transaction, if appropriate.
366	M	Community Medicaid Status	MEDICAID UPDATE	This TRC is returned on a reply with Transaction Type 01. An update has been made to the Medicaid status used to determine the Community Risk Adjustment Factor that will impact future payments. The effective date of the change of Medicaid status is reported in Field 18. The new Medicaid status is reported in Field 85: • F – Full Dual. • P – Partial Dual. • N – Non-dual. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS guidance.
367	R	Enrollment Rejected, incorrect ESC or ETC	BAD ESC OR ETC	This enrollment transaction was rejected because it contained an Enrollment Source Code or Election Type Code that indicated it was a seamless conversion enrollment transaction, but only one of these values was submitted. Plan-submitted seamless conversion enrollment transactions must have an Enrollment Source Code = 'B' (Beneficiary Election) and Election Type Code = 'J' (Seamless Conversion Enrollment Mechanism). **Plan Action:** Correct the enrollment source code or election type code and resubmit the enrollment transaction.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
368	I	Member MSP Period Exists	MEMBER HAS MSP	This TRC is returned with transaction types 61, 76, 77, 80, 81, or 82. The beneficiary has an existing MSP (Medicare Secondary Payer) period. This TRC accompanies an enrollment acceptance TRC that is included in the same DTRR. It provides additional information related to the beneficiary's accepted enrollment. One TRC 368 for each MSP period is sent to the plan(s) that have enrollment(s) impacted by the MSP period. • Field 18 contains the Start Date of the payments impacted by the MSP period change. • Field 24 contains the actual start date of the MSP period. • Field 44 contains the end date of the MSP period. **Plan Action:** Update the Plan's records accordingly.
369	R	Enrollment Rejected, IEP/ICEP enroll available	IEP/ICEP AVAIL	This seamless conversion enrollment transaction (Transaction Type 61) was rejected because an IEP/ICEP enrollment transaction with the same application date was already accepted. **Plan Action:** Update the Plan's records accordingly. Take the appropriate actions as per CMS enrollment guidance.
370	R	Enrollment Rejected, Invalid Plan for SCEM	INVAL SCEM PLN	This seamless conversion enrollment transaction (Transaction Type 61) was rejected because it was submitted for an invalid Plan. Seamless conversion enrollments are only valid for MA and MAPD plans. **Plan Action:** Update the Plan's records accordingly. Take the appropriate actions as per CMS enrollment guidance.
371	I	LEP Exceeds SSA Harm Limit	LEP HARM	A NUNCMO Change transaction (Transaction Type 73) was processed for a period of SSA withholding. The sum of the current premium amount and additional retroactive LEP amounts to be collected exceeds the SSA Harm Limit of $300.00 per month. The additional LEP amount for retroactive months will be directly collected from the beneficiary by the plan. The amount to be directly collected will be reported as a Harm Detail Record on the LEP Data File. **Plan Action:** Update the Plan's records accordingly and collect amounts reported as Harm Detail Records from the beneficiary. LEP amounts previously collected by the withholding agency will remain with CMS.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
372	I	SSA Harm LEP Refund	HRM LEP RFND	There is a subsequent change to retroactive LEP, and the beneficiary is due a partial or full refund of the amount that was previously collected based on the TRC 371. Harm Detail Records on the LEP Data File will report the negative LEP amounts to be refunded to the beneficiary. **Plan Action:** Update the Plan's records accordingly and refund amounts reported as Harm Detail Records to the beneficiary.
701	A	New UI Enrollment (Open Ended)	UI ENROLLMENT	A CMS User enrolled this beneficiary in this contract under the indicated PBP (if applicable) and segment (if applicable). DTRR data record, field 18 contains the enrollment effective date. This is an open-ended enrollment, which does not have a disenrollment date. The Part C Premium amount may have been populated automatically with the base Part C premium amount. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Verify the Part C premium amount and submit a Record Update transaction if necessary. Take the appropriate actions as per CMS enrollment guidance.
702	A	UI Fill-In Enrollment	UI FILL-IN ENRT	A CMS User enrolled this beneficiary in this contract under the indicated PBP (if applicable) and segment (if applicable). This enrollment is a Fill-In Enrollment and represents a complete enrollment period that begins on the date in DTRR data record field 18 and ends on the date in field 24. This is a distinct enrollment period and does not affect any existing enrollments. The Part C Premium amount may have been populated automatically with the base Part C premium amount. **Plan Action:** Update the Plan's records to reflect the beneficiary's enrollment as of the effective date in Daily Transaction Reply Report data record field 18 and ending on the date in field 24. This end date should not affect the beginning of any existent enrollment periods. Verify the Part C premium amount and submit a Record Update transaction if necessary. Take the appropriate actions as per CMS enrollment guidance.
703	A	UI Enrollment Cancel (Delete)	UI ENROLL CANCL	A CMS User cancelled the beneficiary's existing enrollment and the beneficiary is disenrolled. When an enrollment is cancelled, it means that the enrollment never occurred. DTRR field 18 contains the effective date (start date) of the cancelled enrollment period. **Plan Action:** Remove the indicated enrollment from the Plan's records. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
704	A	UI Enrollment Cancel PBP Correction	UI CNCL PBP COR	A CMS User updated the PBP on an existing enrollment. This generates two transaction replies, a Transaction Type 51 with TRC 704 and a Transaction Type 61 with TRC 705. This reply with TRC 704 (Transaction Type 51) represents the cancellation of the enrollment in the original PBP. The effective (start) and disenrollment (end) dates of the enrollment being cancelled are found in DTRR fields 18 & 24, respectively. When an enrollment is cancelled it means that the enrollment never occurred. **Plan Action:** Remove the indicated enrollment in the original PBP from the Plan's records. Look for the accompanying reply with TRC 705 to determine the replacement enrollment period. Take the appropriate actions as per CMS enrollment guidance.
705	A	UI Enrollment PBP Correction	UI ENR PBP COR	A CMS User updated the PBP on an existing enrollment. This generates two transaction replies, a Transaction Type 51 with TRC 704 and a Transaction Type 61 with TRC 705. This reply with TRC 705 (Transaction Type 61) represents the enrollment in the new PBP. The effective (start) and disenrollment (end) dates of the enrollment in this new PBP are found in DTRR fields 18 & 24, respectively. This enrollment should replace the enrollment cancelled by the associated Transaction Type 51 transaction (TRC 704). The Part C Premium amount may have been populated automatically with the base Part C premium amount. **Plan Action:** Update the Plan records to reflect the beneficiary's enrollment in the new Contract, PBP. Look for the accompanying reply with TRC 704 to ensure that the original PBP enrollment was cancelled. Verify the Part C premium amount and submit a Record Update transaction if necessary. Take the appropriate actions as per CMS enrollment guidance.
706	A	UI Enrollment Cancel Segment Correction	UI CNCL SEG COR	A CMS User updated the Segment on an existing enrollment. This generates two transaction replies, a Transaction Type 51 with TRC 706 and a Transaction Type 61 with TRC 707. This reply (Transaction Type 51) represents the cancellation of the enrollment in the original Segment. When an enrollment is cancelled it means that the enrollment never occurred. The effective (start) and disenrollment (end) dates of the enrollment being cancelled are found in DTRR fields 18 & 24, respectively. **Plan Action:** Remove the indicated enrollment in the original Segment from the Plan's records. Look for the accompanying reply with TRC 707 to determine the replacement enrollment period. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
707	A	UI Enrollment Segment Correction	UI ENR SEG COR	A CMS User updated the Segment on an existing enrollment. This generates two transaction replies, a Transaction Type 51 with TRC 706 and a Transaction Type 61 with TRC 707. This reply (Transaction Type 61) represents the enrollment in the new Segment. The effective (start) and disenrollment (end) dates of the enrollment in this new Segment are found in DTRR fields 18 & 24, respectively. This enrollment should replace the enrollment cancelled by the associated Transaction Type 51 transaction (TRC 706). The Part C Premium amount may have been populated automatically with the base Part C premium amount. **Plan Action:** Update the Plan records to reflect the beneficiary's enrollment in the new Contract, PBP. Segment. Look for the accompanying reply with TRC 706 to ensure that the original Segment enrollment was cancelled. Verify the Part C premium amount and submit a Record Update transaction if necessary. Take the appropriate actions as per CMS enrollment guidance.
708	A	UI Assigns End Date	UI ASSGN END DT	A CMS User assigned an end date to existing open-ended enrollment. The last day of enrollment is in Daily Transaction Reply Report data record field 18. The enrollment effective date (start date) remains unchanged. **Plan Action:** Update the Plan records to reflect the beneficiary's disenrollment from the Plan. Take the appropriate actions as per CMS enrollment guidance.
709	A	UI Moved Start Date Earlier	UI ERLY STRT DT	A CMS User updated the start date of an existing enrollment to an earlier date. This reply has a Transaction Type of 61. The new start date is reported in DTRR field 18 (Effective Date) and the original start date is reported in field 24. The existing enrollment was changed to begin on the date in DTRR field 18. The end date of the existing enrollment (if it exists) remains unchanged. The Part C Premium amount may have been populated automatically with the base Part C premium amount. **Plan Action:** Locate the enrollment for this beneficiary that starts on the date in field 24. Update the Plan records for this enrollment to start on the date in field 18. Verify the Part C premium amount and submit a Record Update transaction if necessary. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
710	A	UI Moved Start Date Later	UI LATE STRT DT	A CMS User updated the start date of an existing enrollment to a later date. This reply has a Transaction Type of 51. The new start date is reported in field 18 (effective date) and the original start date is reported in DTRR field 24. The existing enrollment has been reduced to begin on the date in DTRR field 18. The end date of the existing enrollment (if it exists) remains unchanged. **Plan Action:** Locate the enrollment for this beneficiary that starts on the date in field 24. Update the Plan records for this enrollment to start on the date in field 18. Take the appropriate actions as per CMS enrollment guidance.
711	A	UI Moved End Date Earlier	UI ERLY END DT	A CMS User updated the end date of an existing enrollment to an earlier date. This reply has a Transaction Type of 51. The new end date is reported in field 18 (effective date) and the original end date is reported in Daily Transaction Reply Report data record field 24. The existing enrollment was reduced to end on the date in Daily Transaction Reply Report data record field 18. The start date of the existing enrollment remains unchanged. **Plan Action:** Locate the enrollment for this beneficiary that ends on the date in field 24. Update the Plan records for this enrollment to end on the date in field 18. Take the appropriate actions as per CMS enrollment guidance.
712	A	UI Moved End Date Later	UI LATE END DT	A CMS User updated the end date of an existing enrollment to a later date. This reply has a Transaction Type of 61. The new end date is reported in field 18 (effective date) and the original end date is reported in DTRR field 24. The existing enrollment was extended to end on the date in DTRR field 18. The start date of the existing enrollment remains unchanged. The Part C Premium amount may have been populated automatically with the base Part C premium amount. **Plan Action:** Locate the enrollment for this beneficiary that ends on the date in field 24. Update the Plan records for this enrollment to end on the date in field 18. Verify the Part C premium amount and submit a Record Update transaction if necessary. Take the appropriate actions as per CMS enrollment guidance.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
713	A	UI Removed Enrollment End Date	UI REMVD END DT	A CMS User removed the end date from an existing enrollment. This reply has a Transaction Type of 61. DTRR field 18 (effective date) contains zeroes (00000000) and the original end date is reported in field 24. The existing enrollment was extended to be an open-ended enrollment. The start date of the existing enrollment remains unchanged. The Part C Premium amount may have been populated automatically with the base Part C premium amount. **Plan Action:** Locate the enrollment for this beneficiary that ends on the date in DTRR field 24. Update the Plan records for this enrollment to remove the end date and to extend this enrollment to be an open-ended enrollment. Verify the Part C premium amount and submit a Record Update transaction if necessary. Take the appropriate actions as per CMS enrollment guidance.
714	I	UI Part D Opt-Out Change Accepted	UI OPT OUT OK	A CMS User added or changed the value of the Part D Opt-Out Flag for this beneficiary. The new Part D Opt-Out Flag is reported in Daily Transaction Reply Report data record field 38 on the DTRR record. **Plan Action:** Update the Plan's records accordingly.
715	M	Medicaid Change Accepted	MCAID CHG ACEPT	A CMS User changed the beneficiary's Medicaid status. This may or may not have changed the beneficiary's actual status since multiple sources of Medicaid information are used to determine the beneficiary's actual Medicaid status. The Plan will see the result of any changes to the beneficiary's actual Medicaid status included in the next scheduled update of Medicaid status. **Plan Action:** Update the Plan's records accordingly.
716	I	UI changed the Number of Uncovered Months	UI CHGD NUNCMO	A CMS User updated the beneficiary's Number of Uncovered Months. **Plan Action:** Update the Plan's records accordingly. Ensure that the Plan is billing the correct amount for the LEP. Take the appropriate actions as per CMS enrollment guidance.
717	I	UI changed only the Application Date	UI CHGD APP DT	A CMS User updated only the Application Date of a beneficiary's enrollment, which results in a blank TC on the DTRR, field 16. **Plan Action:** Update the Plan's records accordingly.
718	I	UI MMP Opt-Out Change Accepted	UI MMP OPTOUT OK	A CMS User added or changed the value of the MMP Opt-Out Flag for this beneficiary. The new MMP Opt-Out Flag is reported in DTRR data record field 70. **Plan Action:** Update the Plan's records accordingly.

Transaction Reply Codes				
Code	**Type**	**Title**	**Short Definition**	**Definition**
719	I	UI Enrollment Source Code Accepted	UI ENRL SRC OK	A CMS User updates the Enrollment Source Code on this beneficiary's enrollment record. **Plan Action:** Update the Plan's records accordingly.
720	I	CMS Audit Review POS Drug Edit	PSDE REVIEW	A CMS User flagged this beneficiary's POS Drug Edit for review. **Plan Action:** Review the POS Drug Edit transactions for this beneficiary and submit corrections if appropriate. Contact CMS via e-mail at PartDPolicy@cms.hhs.gov with subject "POS Edit Reporting" to discuss the flagged POS Drug Edit information.
721	A	POS Drug Edit Accepted as submitted –UI	PSDE ACC UI	A CMS User added (updated) or deleted a POS Drug Edit record via the MARx UI for this beneficiary. **Plan Action:** None.
722	A	POS Drug Edit Event Deleted - CMS	PSDE EVT DEL C	A CMS User deleted a POS Drug Edit event via the MARx UI for this beneficiary. If the latest status was T (Termination), the associated Notification, Implementation (if exists) and Termination POS Drug Edit records were deleted. If the latest status was I (Implementation), the associated Notification and Implementation POS Drug Edit records were deleted. If the latest status was N, the Notification POS Drug Edit record was deleted. **Plan Action:** None.
990 – 995				These codes appear only on special DTRRs that are generated for specific purposes; for example, those generated to communicate Full Enrollment or to report beneficiaries losing low-income deeming. When a special DTRR produces one of these TRCs, CMS will provide the Plans with communications which define the TRC descriptions and Plan Actions (if applicable).
996	I	EOY Loss of Low Income Subsidy Status	EOY LOSS SBSDY	Identifies those beneficiaries who are losing their deemed or LIS Applicant status as of December 31st of the current year with no low income status determined for January of the following year. **Plan Action:** Update Plan records accordingly.
997 – 999				These codes appear only on special DTRRs that are generated for specific purposes; for example, those generated to communicate Full Enrollment or to report beneficiaries losing low-income deeming. When a special DTRR produces one of these TRCs, CMS will provide the Plans with communications which define the TRC descriptions and Plan Actions (if applicable).

Table 3-12: Transaction Reply Code Groupings

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
4Rx TRC GROUPING	
143-A	SECONDARY INSURANCE RX NUMBER CHANGE ACCEPTED
190-A	NO CHANGE IN SECONDARY DRUG INFORMATION
200-R	RX BIN BLANK OR NOT VALID
201-R	RX ID BLANK OR NOT VALID
202-R	RX GROUP NOT VALID
203-R	RX PCN NOT VALID
204-A	RECORD UPDATE FOR PRIMARY 4RX DATA SUCCESSFUL
209-R	4RX CHANGE REJECTED, INVALID CHANGE EFFECTIVE DATE
242-I	NO CHANGE IN PRIMARY DRUG INFORMATION
294-I	NO 4RX INSURANCE CHANGED
ALL TRANSACTIONS TRC GROUPING	
001-F	INVALID TRANSACTION CODE
002-F	INVALID CORRECTION ACTION CODE
003-F	INVALID CONTRACT NUMBER
004-R	BENEFICIARY NAME REQUIRED
006-R	INCORRECT BIRTH DATE
007-R	INVALID BENEFICIARY ID
008-R	BENEFICIARY IDENTIFIER NOT FOUND
009-R	NO BENEFICIARY MATCH
022-A	TRANSACTION ACCEPTED BENEFICIARY ID CHANGE
023-A	TRANSACTION ACCEPTED, NAME CHANGE
037-R	TRANSACTION REJECTED INCORRECT EFFECTIVE DATE
104-R	REJECTED; INVALID OR MISSING ELECTION TYPE
105-R	REJECTED; INVALID EFFECTIVE DATE FOR ELECTION TYPE
106-R	REJECTED, ANOTHER TRANS RCVD WITH LATER APP DATE
107-R	REJECTED; INVALID OR MISSING PBP NUMBER
108-R	REJECTED, ELECTION LIMITS EXCEEDED
109-R	REJECTED, DUPLICATE PBP NUMBER
156-F	TRANSACTION REJECTED, USER NOT AUTHORIZED FOR CONTRACT
157-R	CONTRACT NOT AUTHORIZED FOR TRANSACTION CODE
165-R	PROCESSING DELAYED DUE TO MARX SYSTEM PROBLEMS
315-R	ARCHIVED BENEFICIARY TRANSACTION REJECTED
AUTOMATIC RESET OF NUMBER OF UNCOVERED MONTHS (NUNCMO)	
060-R	TRANSACTION REJECTED, NOT ENROLLED
290-I	IEP NUNCMO RESET
295-M	LOW INCOME NUNCMO RESET

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
BENEFICIARY CROSS REFERENCE MERGE	
301-M	MERGED BENEFICIARY, IDENTIFIER CHANGE
302-M	ENROLLMENT CANCELLED, BENEFICIARY IDENTIFIER CHANGE
CMS-ONLINE UPDATES TRC GROUPING	
701-A	NEW UI ENROLLMENT (OPEN ENDED)
702-A	UI FILL-IN ENROLLMENT
703-A	UI ENROLLMENT CANCEL (DELETE)
704-A	UI ENROLLMENT CANCEL-PBP CORRECTION
705-A	UI ENROLLMENT PBP CORRECTION
706-A	UI ENROLLMENT CANCEL SEGMENT CORRECTION
707-A	UI ENROLLMENT SEGMENT CORRECTION
708-A	UI ASSIGNS END DATE
709-A	UI MOVED START DATE EARLIER
710-A	UI MOVED START DATE LATER
711-A	UI MOVED END DATE EARLIER
712-A	UI MOVED END DATE LATER
713-A	UI REMOVED ENROLLMENT END DATE
714-I	UI PART D OPT OUT CHANGE ACCEPTED
715-M	MEDICAID CHANGE ACCEPTED
716-I	UI CHANGED THE NUMBER OF UNCOVERED MONTHS
717-I	UI CHANGED ONLY THE APPLICATION DATE
DEMONSTRATION TRC GROUPING	
056-R	DEMONSTRATION ENROLLMENT REJECTED
169-R	REINSURANCE DEMONSTRATION ENROLLMENT REJECTED
307-A	MMP PASSIVE ENROLLMENT ACCEPTED
308-R	MMP PASSIVE ENROLLMENT REJECTED
309-I	NO CHANGE IN MMP OPT-OUT FLAG
310-R	MMP OPT-OUT REJECTED; INVALID OPT-OUT CODE
311-A	MMP OPT-OUT ACCEPTED
312-A	MMP ENROLLMENT CANCELLATION ACCEPTED
313-R	MMP ENROLLMENT CANCELLATION REJECTED
314-R	INVALID CANCELLATION TRANSACTION
318-R	INVALID OR MISSING MMP DEMO ENRLMT SOURCE CODE
718-I	UI MMP OPT-OUT CHANGE ACCEPTED
DISENROLLMENT TRC GROUPING	
013-A	DISENROLLMENT ACCEPTED AS SUBMITTED
014-A	DISENROLLMENT DUE TO ENROLLMENT IN ANOTHER PLAN
018-A	AUTOMATIC DISENROLLMENT
025-A	DISENROLLMENT ACCEPTED, BENEFICIARY IDENTIFIER CHANGE
026-A	DISENROLLMENT ACCEPTED, NAME CHANGE

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
050-R	DISENROLLMENT REJECTED, NOT ENROLLED
051-R	DISENROLLMENT REJECTED, INCORRECT EFFECTIVE DATE
052-R	DISENROLLMENT REJECTED, DUPLICATE TRANSACTION
054-R	DISENROLLMENT REJECTED, RETROACTIVE EFFECTIVE DATE
090-M	DATE OF DEATH ESTABLISHED
104-R	REJECTED; INVALID OR MISSING ELECTION TYPE
105-R	REJECTED; INVALID EFFECTIVE DATE FOR ELECTION TYPE
108-R	REJECTED; ELECTION LIMITS EXCEEDED
114-R	DRUG COVERAGE CHANGE REJECTED; NOT AEP
120-A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
205-I	INVALID DISENROLLMENT REASON CODE
293-A	DISENROLL, FAILURE TO PAY PART D IRMAA
340-A	DISENROLLMENT DUE TO MMP PASSIVE ENROLLMENT
346-M	PRISONER SUSPENSION PERIOD CANCEL/DISENROLL
349-I	DISENROLLMENT DUE TO NOT LAWFULLY PRESEMT PERIOD
DISENROLLMENT CANCELLATION TRC GROUPING	
036-R	TRANSACTION REJECTED BENEFICIARY IS DECEASED
042-R	TRANSACTION REJECTED, BLOCKED
044-R	TRANSACTION REJECTED, OUTSIDE CONTRACT PERIOD
116-R	ENROLLMENT OR CHANGE REJECTED; INVALID SEGMT NUM
284-R	CANCELLATION REJECTED, ENROLL/DISENROLL CANCELLATION
288-A	DISENROLLMENT CANCELLATION ACCEPTED
289-R	DISENROLLMENT CANCELLATION REJECTED
291-I	ENROLLMENT REINSTATED, DISENROLLMENT CANCELLATION
DISENROLLMENT TRANSACTION (TC 51) ***Rejected when used to attempt an enrollment Cancellation***	
292-R	DISENROLLMENT REJECTED, WAS CANCELLATION ATTEMPT
EGHP TRC GROUPING	
110-R	REJECTED; NO PART A AND NO EGHP ENROLLMENT WAIVER
127-R	PART D ENROLLMENT REJECTED, EMPLOYER SUBSIDY
128-R	PART D ENROLL REJECT, EMPLYR SBSDY SET: NO PRIOR TRN
129-I	PART D ENROLL ACCEPT, EMP SBSDY SET: PRIOR TURN REJECT
139-A	EGHP FLAG CHANGE ACCEPTED
162-R	INVALID EGHP FLAG VALUE
189-A	NO CHANGE IN EGHP FLAG
ENROLLMENT TRC GROUPING	
011-A	ENROLLMENT ACCEPTED AS SUBMITTED
015-A	ENROLLMENT CANCELED
016-I	ENROLLMENT ACCEPTED, OUT OF AREA
017-I	ENROLLMENT ACCEPTED, PAYMENT DEFAULT RATE
019-R	ENROLLMENT REJECTED- NO PART- A & PART-B ENTITLEMENT

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
020-R	ENROLLMENT REJECTED-PACE UNDER 55
032-R	ENROLLMENT REJECTED, BENEFICIARY NOT ENTIT PART B
033-R	ENROLLMENT REJECTED, BENEFICIARY NOT ENTIT PART A
034-R	ENROLLMENT REJECTED, BENEFICIARY IS NOT AGE 65
035-R	ENROLLMENT REJECTED, BENEFICIARY IS IN HOSPICE
036-R	TRANSACTION REJECTED, BENEFICIARY IS DECEASED
038-R	ENROLLMENT REJECTED, DUPLICATE TRANSACTION
039-R	ENROLLMENT REJECTED, CURRENTLY ENOLL IN SAME PLAN
042-R	TRANSACTION REJECTED, BLOCKED
044-R	TRANSACTION REJECTED, OUTSIDE CONTRACT PERIOD
045-R	ENROLLMENT REJECTED, BENEFICIARY IS IN ESRD
056-R	DEMONSTRATION ENROLLMENT REJECTED
100-A	PBP CHANGE ACCEPTED AS SUBMITTED
102-R	REJECTED; INCORRECT OR MISSING APPLICATION DATE
103-R	ICEP/IEP ELECTION, MISSING A/B ENTITLEMENT DATE
104-R	REJECTED; INVALID OR MISSING ELECTION TYPE
105-R	REJECTED; INVAILD EFFECTIVE DATE FOR ELECTION TYPE
106-R	REJECTED; ANOTHER TRANSACTION RECEIVED WITH LATER APPLICATION DATE
108-R	REJECTED; ELECTION LIMITS EXCEEDED
114-R	DRUG COVERAGE CHANGE REJECTED; NOT AEP
116-R	ENROLLMENT OR CHANGE REJECTED; INVALID SEGMT NUM
120-A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
124-R	ENROLLMENT/CHANGE REJECTED; INVALID UNCOVERED MONTHS
126-R	ENROLLMENT/CHANGE REJECTED; INVALID CRED CVRG FLAG
127-R	PART D ENROLLMENT REJECTED; EMPLOYER SUBSIDY STATUS
128-R	PART D ENROLLMENT REJECT, EMPLYR SBSDY SET; NO PRIOR TRN
129-I	PART D ENROLL ACCEPT; EMP SBSDY SET; PRIOR TRN REJECT
133-R	PART D ENROLL REJECTED; INVALID SECNDRY INSUR FLAG
134-I	MISSING SECONDARY INSURANCE INFORMATION
150-I	ENROLLMENT ACCEPTED, EXCEEDS CAPACITY LIMIT
176-R	TRANSACTION REJECTED, ANOTHER TRANSACTION ACCEPTED
184-R	ENROLLMENT REJECTED, BENEFICIARY IS Medicaid
196-R	TRANSACTION REJECTED, BENE NOT ELIGIBLE FOR PART D
211-R	RE-ASSIGNMENT ENROLLMENT REJECTED
212-A	RE-ASSIGNMENT ENROLLMENT ACCEPTED
268-I	BENEFICIARY HAS DIALYSIS PERIOD
269-I	BENEFICIARY HAS TRANSPLANT
307-A	MMP PASSIVE ENROLLMENT ACCEPTED
308-R	MMP PASSIVE ENROLLMENT REJECTED
312-A	MMP ENROLLMENT CANCELLATION ACCEPTED
313-R	MMP ENROLLMENT CANCELLATION REJECTED
367-R	ENROLLMENT REJECTED, INCORRECT ESC OR ETC

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
369-R	ENROLLMENT REJECTED, IEP/ICEP ENROLL AVAILABLE
370-R	ENROLLMENT REJECTED, INVALID PLAN FOR SCEM
338-I	ENROLLMENT ACCEPTED, PPO CHANGED
339-I	ENROLLMENT ACCEPTED, PBP CHANGED
345-R	ENROLLMENT REJECTED – CONFIRMED INCARCERATION
347-I	REENROLLMENT DUE TO CLOSED INCARCERATION PERIOD
348-R	ENROLLMENT REJECTED – NOT LAWFULLY PRESENT PERIOD
355-R	ENROLLMENT REJECTED, PLN RO NOT IN POVER FILE
356-R	ENROLLMENT REJECTED, PLN RO WITHOUT ESC OR ETC
357-R	ENROLLMENT REJECTED, PLN RO IMPACTS DUAL ENROLL
719-I	UI ENROLLMENT SOURCE CODE ACCEPTED
ENROLLMENT CANCELLATION TRC GROUPING	
060-R	TRANSACTION REJECTED, NOT ENROLLED
285-A	ENROLLMENT CANCELLATION ACCEPTED
286-R	ENROLLMENT CANCELLATION REJECTED
287-A	ENROLLMENT REINSTATED
292-R	DISENROLLMENT REJECTED, WAS CANCELLATION ATTEMPT
312-A	MMP ENROLLMENT CANCELLATION ACCEPTED
313-R	MMP ENROLLMENT CANCELLATION REJECTED
314-R	INVALID CANCELLATION TRANSACTION
ESRD TRC GROUPING	
055-M	ESRD CANCELLATION
073-M	ESRD STATUS SET
074-M	ESRD STATUS TERMINIATED
135-M	BENEFICIARY HAS STARTED DIALYSIS TREATMENTS
136-M	BENEFICIARY HAS ENDED DIALYSIS TREATMENTS
137-M	BENEFICIARY HAS RECEIVED A KIDNEY TRANSPLANT
268-I	BENEFICIARY HAS DIALYSIS PERIOD
269-I	BENEFICIARY HAS TRANSPLANT
FAILED PAYMENT	
000-I	NO DATA TO REPORT
264-I	PAYMENT NOT YET COMPLETED
299-I	CORRECTION TO PREVIOUSLY FAILED PAYMENT
FAILED TRCs GROUPING	
257-F	FAILED; BIRTH DATE INVALID FOR DATABASE INSERTION
258-F	FAILED; EFFECTIVE DATE INVALID FOR DATABASE INSERTION
259-F	FAILED; END DATE INVALID FOR DATABASE INSERTION
263-F	APPLICATION DATE INVALID FOR DATABASE INSERTION
332-F	FAILED, PSDE DATES INVALID FOR DATABASE INSERTION

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
HOSPICE TRC GROUPING	
071-M	HOSPICE STATUS SET
072-M	HOSPICE STATUS TERMINATED
IC MODEL TRC GROUPING	
351-A	IC MODEL PARTICIPATION ACCEPTED
352-R	IC MODEL PARTICIPATION DUPLICATE TRANSACTION
353-R	IC MODEL PARTICIPATION DELETE ERROR
354-R	REJECT, INVALID IC MODEL TYPE INDICATOR
358-F	FAIL, IC MODEL END DATE HAD AN INVALID FORMAT
359-R	ICM TRANS START DATE IS INCORRECT
360-R	REJECT, INVALID IC MODEL U/D
361-R	REJECT, INVALID IC MODEL END DATE REASON CODE
362-R	IC MODEL END DATE INCORRECT
363-R	ICM TRANS DATES OVERLAP AN EXISTING ICM PRD
365-R	REJECT, INVALID IC MODEL BENEFIT STATUS CODE
LATE ENROLLMENT PENALTY/LEP TRC GROUPING	
177-M	CHANGE IN LATE ENROLLMENT PENALTY
178-M	LATE ENROLLMENT PENALTY RESCINDED
218-M	LEP RESET UNDONE
219-M	LEP RESET ACCEPTED
LIS/AUTO/FACI TRC GROUPING	
117-A	FBD AUTO ENROLLMENT ACCEPTED
118-A	LIS FACILITATED ENROLLMENT ACCEPTED
121-M	LOW INCOME PERIOD STATUS
166-R	PART D FBD AUTO ENROLLMENT OR FACILITATED ENROLLMENT REJECTED
223-I	LOW INCOME PERIOD CLOSED
MEDICAID TRC GROUPING	
077-M	MEDICAID STATUS SET
078-M	MEDICAID STATUS TERMINATED
099-M	MEDICAID PERIOD CHANGE/CANCELLATION
184-R	ENROLLMENT REJECTED, BENEFICIARY IS IN MEDICAID
366-M	COMMUNITY MEDICAID STATUS
MEDICARE SECONDARY PAYER/MSP TRC GROUPING	
245-M	MEMBER HAS MSP PERIOD
280-I	MEMBER MSP PERIOD HAS ENDED
368-I	MEMBER MSP PERIOD EXISTS
NUMBER OF UNCOVERED MONTHS/NUNCMO TRC GROUPING	
120-A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
124-R	ENROLLMENT/CHANGE REJECTED, INVALID UNCOV MONTHS

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
126-R	ENROLLMENT/CHANGE REJECTED, INVALID CRED CVRG FLAG
141-A	UNCOVERED MONTHS CHANGE ACCEPTED
187-A	NO CHANGE IN NUMBER OF UNCOVERED MONTHS INFORMATION
215-R	UNCOVERED MONTHS CHANGE REJECTED, INCORRECT EFF DATE
216-I	UNCOVERED MONTHS EXCEEDS MAX POSSIBLE VALUE
217-R	CAN'T CHANGE NUMBER OF UNCOVERED MONTHS
290-I	IEP NUNCMO RESET
295-M	LOW INCOME NUNCMO RESET
300-R	NUNCMO CHANGE REJECTED, EXCEEDS MAX POSSIBLE VALUE
306-R	NUNCMO CHANGE REJECTED, NO PART D ELIGIBILITY
341-I	MAXIMUM NUNCMO CALCULATION
PLAN CHANGES TRC GROUPING	
060-R	TRANSACTION REJECTED, NOT ENROLLED IN PLAN
116-R	ENROLLMENT OR CHANGE REJECTED; INVALID SEGMT NUM
134-I	MISSING SECONDARY INSURANCE INFORMATION
140-A	SEGMENT ID CHANGE ACCEPTED
171-R	RECORD UPDATE REJECTED, INVALID CHG EFFECTIVE DATE
172-R	CHANGE REJECTED; CREDITABLE COVERAGE//2 DRUG INFO NOT APPLICABLE
188-A	NO CHANGE IN SEGMENT ID
316-I	DEFAULT SEGMENT ID ASSIGNMENT
317-I	SEGMENT ID REASSIGNED AFTER ADDRESS UPDATE
PART D OPT OUT TRC GROUPING	
130-R	PART D OPT-OUT REJECTED, OPT-OUT FLAG NOT VALID
131-A	PART D OPT-OUT ACCEPTED
241-I	NO CHANGE IN PART D OPT OUT FLAG
POINT OF SALE (POS) TRC GROUPING	
210-A	POS ENROLLMENT ACCEPTED
220-R	TRANSACTION REJECTED; INVALID POS ENROLL SOURCE CODE
321-A	POS DRUG EDIT ACCEPTED AS SUBMITTED
322-I	NEW ENROLLEE POS DRUG EDIT NOTIFICATION
323-R	POS DRUG EDIT INVALID EROLLMENT
324-R	POS DRUG EDIT INVALID CONTRACT
325-R	POS DRUG EDIT STATUS/DATE ERROR
326-R	POS DRUG EDIT IMPLEMENTATION DATE INCORRECT
327-R	POS DRUG EDIT TERMINATION DATE INCORRECT
328-R	POS DRUG EDIT DUPLICATE TRANSACTION
329-R	POS DRUG EDIT DELETE ERROR
330-R	POS DRUG EDIT WITHOUT ASSOCIATED RECORDS
331-R	FUTURE POS DRUG EDIT DATE EXCEEDS CCM PLUS ONE
333-R	REJECT, INVALID POS DRUG EDIT STATUS
334-R	REJECT, INVALID POS DRUG EDIT CLASS

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
335-R	REJECT, INVALID POS DRUG EDIT CODE
336-R	REJECT, INVALID POS DRUG EDIT U/D
337-A	POS DRUG EDIT EVENT DELETED - PLAN
343-I	POS DRUG EDIT CLASS INACTIVE
342-R	REJECT, MULTIPLE NOTIFICATION
344-R	REJECT, MORE RESTRICTIVE IMPLEMENTATION
720-I	CMS AUDIT REVIEW POS DRUG EDIT
721-A	POS DRUG EDIT ACCEPTED AS SUBMITTED –UI
722-A	POS DRUG EDIT EVENT DELETED - CMS
PREMIUM PAYMENT TRC GROUPING	
119-A	PREMIUM AMOUNT CHANGE ACCEPTED
120-A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
122-R	ENROLLMENT/CHANGE REJECTED, INVALID PREM AMT
123-R	ENROLLMENT/CHANGE REJECTED, INVALID PREM PAY OPT CD
144-M	PREMIUM PAYMENT OPTION CHANGED TO DIRECT BILL
170-I	PREMIUM WITHHOLD OPTION CHANGE TO DIRECT BILL
173-R	CHANGE REJECTED; PREMIUM NOT PREVIOUSLY SET
179-A	TRANSACTION ACCEPTED- NO CHANGE TO PREMIUM RECORD
182-A	INVALID PTC PREMIUM SUBMITTED, CORRECTED, ACCEPTED
191-A	NO CHANGE IN PREMIUM WITHHOLD OPTION
206-I	PART C PREMIUM HAS BEEN CORRECTED TO ZERO
213-I	PREMIUM WITHHOLD OPTION CHANGE TO DIRECT BILL
222-I	BENE EXCLUDED FROM TRANSMISSION TO SSA/RRB
237-I	PART B PREMIUM REDUCTION SENT TO SSA
240-A	TRANSACTION RECEIVED, WITHHOLDING PENDING
243-R	CHANGE TO SSA WITHHOLDING REJECTED DUE TO NO SSN
252-I	PREM PAYMENT OPTION CHANGED TO DIRECT BILL, NO SSN
253-M	CHANGED TO DIRECT BILL; NO FUNDS WITHHELD
267-M	PREMIUM PAYMENT OPTION SET TO "**N**" DUE TO NO PREMIUM
371-I	LEP EXCEEDS SSA HARM LIMIT
372-I	SSA HARM LEP REFUND
RESIDENCE ADDRESS CHANGE TRC GROUPING	
154-M	OUT OF AREA STATUS
260-R	REJECTED; BAD END DATE, REJECT RESIDENCE ADDRESS CHANGE
261-R	REJECTED; INCOMPLETE RESIDENCE ADDRESS INFORMATION
265-A	RESIDENCE ADDRESS CHANGE ACCEPTED, NEW SCC
266-R	UNABLE TO RESOLVE SSA STATE COUNTY CODES
282-A	RESIDENCE ADDRESS DELETED
283-R	RESIDENCE ADDRESS DELETE REJECTED

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
RRB TRC GROUPING	
120-A	PPO CHANGE SENT TO W/H AGENCY
123-R	ENROLLMENT/CHANGE REJECTED, INVALID PRE PAY OPT CD
144-M	PREMIUM PAYMENT OPTION CHANGED TO DIRECT BILL
185-M	WITHHOLDING AGENCY ACCEPTED TRANSACTION
186-I	WITHHOLDING AGENCY REJECTED TRANSACTION
191-A	NO CHANGE IN PREMIUM WITHHOLD OPTION
222-I	BENE EXCLUDED FROM TRANSMISSION TO SSA/RRB
238-I	RRB REJECTED PART B REDUCTION, DELAYED PROCESSING
239-I	RRB REJECTED PART B REDUCTION, JURISDICTION
252-I	PRE PAYMENT OPTION CHANGED TO DIRECT BILL; NO SSN
254-I	BENE SET TO DIRECT BILL, SPANS JURISDICTION
255-I	PLAN SUBMITTED RRB W/H FOR SSA BENE
256-I	PLAN SUBMITTED SSA W/H FOR RRB BENE
262-R	BAD RRB PREMIUM WITHHOLD EFFECTIVE DATE
319-M	RRB TO SSA BENEFICIARY JURISDICTION CHANGE
SCC ADDRESS TRC GROUPING	
085-M	STATE AND COUNTY CODE CHANGE
138-M	BENEFICIARY ADDRESS CHANGE TO OUTSIDE THE U.S.
154-M	OUT OF AREA STATUS
305-M	ZIP CODE CHANGE
SPECIAL REPLY TRC GROUPING	
990-995	APPEAR ON SPECIAL TRR GENERATED FOR SPECIFIC PURPOSE. WHEN A SPECIAL TRR PRODUCES ONE OF THESE CODES, CMS WILL PROVIDE COMMUNICATIONS TO EXPLAIN THE TRC
996-I	EOY LOSS OR LOW INCOME SUBSIDY STATUS
997-999	APPEAR ON SPECIAL TRR GENERATED FOR SPECIFIC PURPOSE. WHEN A SPECIAL TRR PRODUCES ONE OF THESE CODES, CMS WILL PROVIDE COMMUNICATIONS TO EXPLAIN THE TRC
SSA TRC GROUPING	
185-M	WITHHOLDING AGENCY ACCEPTED TRANSACTION
186-I	WITHHOLDING AGENCY REJECTED TRANSACTION
195-M	SSA UNSOLICITED RESPONSE (SSA WITHHOLD UPDATE)
225-I	EXCEEDS SSA BENEFIT & SAFETY NET AMOUNT
235-I	SSA ACCEPTED PART B REDUCTION TRANSACTION
236-I	SSA REJECTED PART B REDUCTION TRANSACTION
243-R	CHANGE TO SSA WITHHOLDING REJECTED DUE TO NO SSN
320-M	SSA TO RRB BENEFICIARY JURISDICTION CHANGE
371-I	LEP EXCEEDS SSA HARM LIMIT
372-I	SSA HARM LEP REFUND

Transaction Reply Code Groupings	
TRC-Type	**TRC Title**
SYSTEM NOTIFICATION TRC GROUPING	
048-R	NURSEING HOME CERTIFIABLE STATUS SET
062-R	CORRECTION REJECTED, OVERLAPS OTHER PERIOD
075-A	INSTITUTIONAL STATUS SET
079-M	PART A TERMINATION
080-M	PART A REINSTATEMENT
081-M	PART B TERMINIATION
082-M	PART B REINSTATEMENT
086-M	BENEFICIARY IDENTIFIER CHANGE
087-M	NAME CHANGE
088-M	SEX CODE CHANGE
089-M	DATE OF BIRTH CHANGE
090-M	DATE OF DEATH ESTABLISHED
091-M	DATE OF DEATH REMOVED
092-M	DATE OF DEATH CORRECTED
121-M	LOW INCOME PERIOD STATUS
152-M	RACE CODE CHANGE
154-M	OUT OF AREA STATUS
155-M	INCARCERATION NOTIFICATION RECEIVED
158-M	INSTITUTIONAL PERIOD CHANGE/CANCELLATION
159-M	NURSING HOME CERT PERIOD CHANGE/CANCELLATION
161-M	BENEFICIARY RECORD ALERT FROM MBD
165-R	PROCESSING DELAYED DUE TO MARX SYSTEM PROBLEMS
194-M	DEEMED CORRECTION
197-M	PART D ELIGIBILITY TERMINATION
198-M	PART D ELIGIBILITY REINSTATEMENT
267-M	PREMIUM PAYMENT OPTION SET TO **"N"** DUE TO NO PREMIUM
270-M	BENEFICIARY TRANSPLANT HAS ENDED
303-M	TERMINATION DATE CHANGE DUE TO BENEFICIARY MERGE
350-I	MBI IS AVAILABLE FOR BENEFICIARY

3.4.6 Full Enrollment File

The Full Enrollment Data File provides Managed Care and Prescription Drug organizations with their official membership list on record with CMS each month. This invaluable tool helps Plans reconcile their membership records with CMS records.

This file includes all active Plan membership for the date that the file published. This file is considered a definitive statement of current Plan enrollment. CMS announces the availability of each month's file with the proper dataset name and file transfer date. To distinguish this file from other Transaction Reply Reports, the TRC on all records is 999.

System	Type	Frequency	File Length	Full Enrollment Data File Dataset Naming Conventions
MARx	Data File	Monthly	278	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.FEFD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.FEFD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.FEFD.Dyymm01.Thhmmsst

Layout 3-23: Full Enrollment Data File Record

Full Enrollment File Data Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary ID	12	1 – 12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end
2	Surname	12	13 – 24	Beneficiary Surname.
3	First Name	7	25 – 31	Beneficiary Given Name.
4	Middle Initial	1	32	Beneficiary Middle Initial.
5	Gender Code	1	33	Beneficiary Gender Identification Code. 0 = Unknown. 1 = Male. 2 = Female.
6	Date of Birth	8	34 – 41	CCYYMMDD
7	Medicaid Indicator	1	42	Space.
8	Contract Number	5	43 – 47	Plan Contract Number.
9	State Code	2	48 – 49	Beneficiary State Code.
10	County Code	3	50 – 52	Beneficiary County Code.
11	Disability Indicator	1	53	Space.
12	Hospice Indicator	1	54	Space.
13	Institutional/NHC/HCBS Indicator	1	55	Space.
14	ESRD Indicator	1	56	Space.
15	TRC	3	57 – 59	Transaction Reply Code; default to 999.
16	TC	2	60 – 61	Transaction Code; default to 01 for special reports.

Full Enrollment File Data Record				
Item	**Field**	**Size**	**Position**	**Description**
17	Entitlement Type Code	1	62	Space.
18	Effective Date	8	63 – 70	CCYYMMDD
19	WA Indicator	1	71	Space.
20	Plan Benefit Package (PBP) ID	3	72 – 74	PBP ID number.
21	Filler	1	75	Space.
22	Transaction Date	8	76 – 83	Set to Current Date, CCYYMMDD.
23	Filler	1	84	Space.
24	Subsidy End Date	12	85 – 96	End date of LIS Period (Present if Beneficiary is deemed for the full year, or if the Beneficiary is losing Low Income status before the end of the current year.)
25	District Office Code	3	97 – 99	Spaces.
26	Filler	8	100 – 107	Spaces.
27	Filler	8	108 – 115	Spaces.
28	Source ID	5	116 – 120	Spaces.
29	Prior Plan Benefit Package ID	3	121 – 123	Spaces.
30	Application Date	8	124 – 131	Spaces.
31	Filler	2	132 – 133	Spaces.
32	Out of Area Flag	1	134 – 134	Spaces.
33	Segment Number	3	135 – 137	Default to 000 if blank.
34	Part C Beneficiary Premium	8	138 – 145	Part C Premium Amount; the amount submitted on the enrollment record for Part C premium
35	Part D Beneficiary Premium	8	146 – 153	Part D Premium Amount: the Part D Total Premium Net of Rebate from the HPMS file.)
36	Election Type	1	154 – 154	Spaces
37	Enrollment Source Code	1	155 – 155	A = Auto enrolled by CMS. B = Beneficiary Election. C = Facilitated enrollment by CMS. D = CMS Annual Rollover. E = Plan initiated auto-enrollment. F = Plan initiated facilitated-enrollment. G = Point-of-sale enrollment. H = CMS or Plan reassignment. I = Invalid submitted value (transaction is not rejected). J = State-submitted passive enrollment. K = CMS-submitted passive enrollment. L = MMP beneficiary election. N = Rollover by Plan Transaction.
38	Part D Opt-Out Flag	1	156 – 156	Space.
39	Filler	1	157 – 157	Space.
40	Number of Uncovered Months	3	158 – 160	Spaces.
41	Creditable Coverage Flag	1	161 – 161	Space.
42	Employer Subsidy Override Flag	1	162 – 162	Space.
43	Rx ID	20	163 – 182	Spaces.
44	Rx Group	15	183 – 197	Spaces.
45	Secondary Drug Insurance Flag	1	198-198	Space.

Full Enrollment File Data Record				
Item	**Field**	**Size**	**Position**	**Description**
46	Secondary Rx ID	20	199 – 218	Spaces.
47	Secondary Rx Group	15	219 – 233	Spaces.
48	EGHP	1	234 – 234	Space.
49	Part D LIPS Level	3	235 – 237	Part D LIPS category: 000 = No subsidy (default for blank). 025 = 25% subsidy level. 050 = 50% subsidy level. 075 = 75% subsidy level. 100 = 100% subsidy level.
50	Low-Income Co-Pay Category	1	238 – 238	Definitions of the co-payment categories: 0 = none, not low-income (default for blank). 1 = (High). 2 = (Low). 3 = $0. 4 = 15%. 5 = unknown.
51	Low-Income Co-Pay Effective Date	8	239 – 246	CCYYMMDD.
52	Part D LEP Amount	8	247 – 254	Spaces.
53	Part D LEP Waived Amount	8	255 – 262	Spaces.
54	Part D LEP Subsidy Amount	8	263 – 270	Spaces.
55	Low-Income Part D Premium Subsidy Amount	8	271- 278	Part D Low-Income Premium Subsidy Amount.

3.5 Reporting RxID/RxGroup/RxPCN/RxBIN Data

The 4Rx Notification process is a data exchange between the Plans and CMS. Plans provide CMS with Plan enrollment and claims processing information to support Point of Sale (POS) and other pharmacy-related information needs. This exchange makes 4Rx data available to the True Out-of-Pocket (TrOOP) Facilitator and through the Facilitator to the pharmacy.

Pharmacies operate in a real-time processing environment and require accurate information at POS to properly adjudicate the claim with all payers that cover the beneficiary. In addition, many pharmacies' automated billing is based on eligibility data. The sooner Plans submit their 4Rx data to CMS, the faster complete data is available from the *E1 Eligibility Query*, which the transaction pharmacies submit to the TrOOP Facilitator to obtain 4Rx data. As a result, CMS requires prompt submission of 4Rx data. Plans must include 4Rx data on Plan-submitted enrollment transactions. However, for CMS-generated enrollments, for example facilitated and auto-enrollments, Plans are required to submit their 4Rx data within 72 hours of the Plan's receipt of the DTRR reporting these enrollments. One of the most difficult issues for CMS and the TrOOP Facilitator is collecting the 4Rx data from the Plans and ensuring a steady flow of the information to the TrOOP Facilitator.

This enables pharmacies to assist beneficiaries who are unable to identify the Plan in which they are enrolled. Pharmacists rely on the *E1 Eligibility Query* to obtain beneficiary billing information, particularly the Cardholder Identification Number (ID), which is a National Council of Prescription Drug Programs (NCPDP) mandatory field in the pharmacy billing transaction. When pharmacists are unable to obtain the 4Rx information from an E1 transaction, they must rely on dedicated phone lines at Plans and their processors to provide the required beneficiary billing information.

3.5.1 *Plan Submission of 4Rx Data*

The four Rx data elements are:

- RxBIN – Benefit Identification Number (BIN).
- RxPCN – Processor Control Number (PCN).
- RxID – Identification Number (ID).
- RxGRP – Group Number.

Plans must submit 4Rx data using Enrollment TC 61 and 4Rx Data Change TC 72 in the following fields.

- Part D Rx BIN, Mandatory.
- Part D Rx ID, Mandatory.
- Part D Rx PCN, Optional.
- Part D Rx Group, Optional.
- Secondary Rx BIN, Optional.
- Secondary Rx ID, Optional.
- Secondary Rx PCN, Optional.
- Secondary Rx Group, Optional.

Plans must use 4Rx Data Change TC 72 to submit 4Rx data changes in the following circumstances:

- Auto-assigned enrollment.
- CMS facilitated enrollment.
- Any other CMS-generated enrollments not initiated by the Plan where 4Rx data is not included in the enrollment transaction:
    - Regional Office/Central Office (RO/CO) actions.
    - Retro processing contractor actions.
    - Reassignment.
    - Annual rollover activity.

Plans may submit multiple TC 72 transactions for the same beneficiary in the same transmission file. The current requirement for effective dates submitted with TC 72s are within a date range of the Current Calendar Month (CCM) minus one month (CCM-1) through CCM plus three months (CCM+3). This is referred to as the allowable range.

However, editing for allowable date range is not performed on TC 72s, since auto-enrollments can have a retroactive effective date of several months and facilitated enrollments can have a prospective effective date of several months. Any TC 72 submitted with 4Rx data is accepted as long as the effective date in the transaction falls within the Plan's enrollment period.

3.5.2 *CMS Editing of 4Rx Data*

CMS edits against all 4Rx data fields. Any fields on an enrollment TC 61 or TC 72 transactions containing invalid information reject with an appropriate TRC.

Note: CMS does not edit against any 4Rx data fields for MA-only Plans, along with other Plans that do not provide Part D benefits; these Plans submit blanks in the 4Rx data fields.

When 4Rx data is rejected, the entire enrollment is rejected. Plans should correct and resubmit the enrollment transaction using the same transaction code as originally submitted. All TCs 61 submitted for Part D Plan enrollments, i.e., any contract and PBP combination with Part D coverage that must include 4Rx data elements for enrollments are edited for 4Rx data elements.

Editing of the 4Rx data elements does not occur in the following situations:

- Enrollment TC 61 submitted by Plans that do not include Part D coverage.
- 4Rx Data Change TC 72, unless at least one field is submitted; then all edits apply.
- 4Rx information stored in CMS files. These files are sent towards the end of the month.

3.5.3 *Monthly NoRx File*

CMS creates and sends monthly NoRx files to Plans identifying all enrollees that do not currently have 4Rx information stored in CMS files. Typically, these files are sent the third week of the month. CMS uses this file to inform the Plans of the incomplete 4Rx information and requests Plans to submit 4Rx information for the Beneficiary.

System	Type	Frequency	File Length	No Rx File Dataset Naming Conventions
MBD	Data File	Monthly	750	Gentran Mailbox/TIBCO MFT Internet Server: P.Rxxxxx.#NORX.Dyymmdd.Thhmmsst Connect:Direct (Mainframe): zzzzzzzz.Rxxxxx.#NORX.Dyymmdd.Thhmmsst Connect:Direct (Non-Mainframe): [directory]Rxxxxx.#NORX.Dyymmdd.Thhmmsst

The following records are included in this file:

- **No Rx Header Record**
- **No Rx Detail Record**
- **No Rx Trailer Record**

Layout 3-24: No Rx Header Record

No Rx Header Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	File ID Name	8	1-8	CHAR	CMSNRX0H	This code allows recognition of the record as the Header Record of a NoRx File.
2	Sending Entity	8	9-16	CHAR	"MBD" (MBD + 5 spaces)	The value specifically is "MBD" followed by five spaces.
3	File Creation Date	8	17-24	CHAR	CCYYMMDD	The date on which the NoRx file was created by CMS.
4	File Control Number	9	25-33	CHAR	Spaces	This field is set to SPACES and is not referenced for meaningful information.
5	Filler	717	34-750	CHAR	Spaces	

Layout 3-25: No Rx Detail Record

No Rx Detail Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	Record Type	3	1-3	CHAR	NRX	This code allows recognition of the detail record as a No Rx record from CMS.
2	Record Type from Original Detail	5	4-8	CHAR	Spaces.	This field is set to SPACES and is not referenced for meaningful information.
3	HICN or RRB Number	12	9-20	CHAR	HICN or RRB	• Before or during the Medicare Beneficiary Identifier (MBI) Transition period, the RRB Number is populated if present; else the active HICN is populated. • When the MBI Transition period ends, the field is filled with spaces.
4	SSN	9	21-29	CHAR	SSN from CMS	This field may contain the SSN of the Beneficiary that does not have 4Rx data.
5	MBI	11	30-40			The MBI from the beneficiary's active Beneficiary MBI period. The value is a system-generated identifier used internally and externally to uniquely identify the beneficiary in the Medicare database.
6	Filler	49	41-89	CHAR	Spaces.	
7	Contract Number	5	90- 94	CHAR	Contract Number from CMS	This field contains the Contract Number of the beneficiary that does not have 4Rx data.
8	PBP Number	3	95- 97	CHAR	PBP Number from CMS	This field contains the beneficiary PBP number but does not have 4Rx data.
9	Filler	71	98 – 168	CHAR	Spaces.	
10	File Creation Date	8	169-176	CHAR	CCYYMMDD	This field contains the date the NoRx record was created.
11	Filler	574	177-750	CHAR	Spaces.	

Layout 3-26: No Rx Trailer Record

No Rx Trailer Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	File ID Name	8	1-8	CHAR	CMSNRX0T	This code allows recognition of the record as the Trailer Record of a NoRx File.
2	Sending Entity	8	9-16	CHAR	“MBD “ (MBD + 5 spaces)	The value specifically is “MBD” followed by five spaces.
3	File Creation Date	8	17-24	CHAR	CCYYMMDD	The date that CMS created the NoRx file.
4	Filler	9	25-33	CHAR	Spaces	
5	File Record Count	7	34-40	NUM	Numeric value greater than Zero.	The total number of NoRx records on this file. This value is right-justified in the field with leading zeroes.
6	Filler	710	41-750	CHAR	Spaces	

3.6 Agent Broker Compensation

For Plan enrollments, MARx established a status of initial or renewal compensation cycle. This status provides Plans with the information necessary to determine how to pay agents for specific beneficiary enrollments. Plans pay agents an initial amount or a renewal amount as provided in the CMS agent compensation guidance.

Based on the qualification rules, Year 1 is the initial year and Years 2 and beyond are the renewal years. Plans are responsible for using this information together with their internal payment and enrollment tracking systems to determine if an agent was used and the amount to pay the agent.

The Agent Broker Compensation Report Data File is sent to Plans along with the first DTRR of each calendar month and reports the following:

- All new enrollments, whether retroactive, current, or prospective, with broker compensation cycles.
- All changes to existing and prior enrollments as a result of retroactive enrollments and disenrollments.
- Increments to cycle-year counts each January 1st.

Plans can re-order the Agent Broker Compensation Report Data File via the MARx UI.

3.6.1 Agent Broker Compensation Report Data File

System	Type	Frequency	File Length	Agent Broker Compensation Dataset Naming Conventions
MARx	Data File	Monthly	150	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rnnnnn.COMPRPT.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rnnnnn.COMPRPT.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rnnnnn.COMPRPT.Dyymmdd.Thhmmsst

The following records are included in this file:

- **Agent Broker Compensation Detail Record**
- **Agent Broker Compensation Trailer Record**

Layout 3-27: Agent Broker Compensation Detail Record

Agent Broker Compensation Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	1	1	1 – Detail.
2	Contract Number	5	2-6	Contract identification.
3	PBP	3	7-9	Plan Benefit Package.
4	Beneficiary ID	12	10-21	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end
5	Last Name	12	22-33	Beneficiary Surname.
6	First Name	7	34-40	Beneficiary Given Name.
7	Middle Initial	1	41	Beneficiary Middle Initial.
8	DOB	8	42-49	Beneficiary Birth Date CCYYMMDD
9	Gender	1	50	Beneficiary Gender Identification Code. 0 = Unknown. 1 = Male. 2 = Female.
10	Application Date	8	51-58	The date the Plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper). CCYYMMDD; otherwise, spaces if not applicable.
11	Enrollment Effective Start Date	8	59-66	Date Beneficiary's Plan enrollment starts. CCYYMMDD

Agent Broker Compensation Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
12	Compensation Type as of Enrollment Effective Date	1	67	Compensation type to be paid to the broker for the first year of enrollment (I or R) that never appeared on the Broker's Compensation Data file; or the data element "Correction Indicator" field is populated. Additionally, the data element shall be left blank for all 1-1-xx enrollments that either had no change from the previous year or where on an Oct. through Dec. MARx report for new 1-1-xx effective enrollments (meaning AEP enrollments). I – Initial R – Renewal Blank – See above explanation
13	Report Generation Date	8	68-75	Date data file created. CCYYMMDD
14	Cycle-Year as of Report Generation Date	3	76-78	Numeric value representing the broker compensation cycle-year as of the data file generation date: -1 = no compensation cycle exists for this enrollment because the data file generation date is before the effective date of the enrollment. 1 = first calendar year. 2 = second calendar year. 3 = third calendar year. 4 = fourth calendar year. 5 = fifth calendar year. 6 = sixth calendar year. The numeric value can go as high as 999 years. Right justified.
15	Compensation Payment Year	3	79-81	If the enrollment is prospective with a start date in the upcoming year, the numeric value representing the cycle year as of the enrollment effective date. Otherwise, the numeric value representing the broker compensation cycle-year as of the data file generation date. 1 = first calendar year. 2 = second calendar year. 3 = third calendar year. 4 = fourth calendar year. 5 = fifth calendar year. 6 = sixth calendar year. The numeric value can go as high as 999 years. Right justified.

Agent Broker Compensation Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
16	Prior Plan Type	7	82-88	Broad classification of the Beneficiary's immediately prior Plan-type: None = no prior Plan. MA = non-drug Medicare Advantage Plan. MAPD = MA Plan offering prescription drugs. COST = Non-drug Medicare COST Plan. COST/PD = Medicare COST Plan providing prescription drugs. PDP = Prescription Drug Plan.
17	Correction Indicator	2	89-90	R – Retroactive enrollment. o Any enrollment processed by MARx after the effective date of the enrollment. ER – Enrollment reinstated. o A disenrollment cancellation was processed by MARx. o A cancelled enrollment reinstated a previous enrollment. IR – Change in Initial or Renewal. o An enrollment was previously reported as Initial or Renewal however this information has been updated due to new information received by MARx. O – Change in the Compensation Year. Spaces – the enrollment does not have a corrected field.
18	Filler	60	91-150	Spaces.

Layout 3-28: Agent Broker Compensation Trailer Record

Agent Broker Compensation Trailer Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	1	1	2 – Trailer.
2	Contract Number	5	2-6	Contract identification.
3	Detail Record Count	8	7-14	Right justified – number of detail records on the data file. The trailer record itself is not included in this count.
4	Filler	136	15-150	Spaces.

3.6.2 *Compensation Rate Submission*

CMS regulations at 42 CFR §§422.2274(a)(1)(i)(A) and 423.2274(a)(1)(i)(A) stipulate that the compensation amount paid to an independent agent or broker for an enrollment is at or below the fair market value (FMV) cut-off amounts published yearly by CMS. These amounts can be found on the HPMS, and are posted yearly by June 1st.

As in past years, all Plans must inform CMS whether they are using employed, captive, or independent agents. Plans that use independent agents must provide the compensation amount or range of amounts paid for these agents. Additionally, if referral fees are paid, Plans must disclose the referral fee amount. The most currently released HPMS Marketing Module User Guide includes data entry instructions.

Plans may submit their agent/broker information in the HPMS Marketing Module during the dates outlined in the HPMS memorandum posted yearly. Please note that the submission process is not complete until the Plan's CEO, COO, or CFO has completed the attestation in HPMS. Plans failing to submit and attest to their agent/broker compensation data by the deadline outlined in the HPMS memorandum are out of compliance.

CMS expect Plans to keep full records providing the compensation schedules are updated and agent/brokers are paid per CMS requirements.

CMS will make the compensation information available for beneficiaries to view before the annual election period for each calendar year at the following website: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/AgentBroker.html.

3.7 Coordination of Benefits

CMS provides Coordination of Benefits (COB) – Other Health Insurance (OHI) information for the Plan's enrollees. The COB-OHI file contains only members for whom there is COB information available. Each member on the file may have multiple records associated with primary and supplemental insurers.

3.7.1 *COB-OHI File Data Element Definitions and Instructions for Part D Plans*

This section defines and provides instructions on the use of data elements found in the COB-OHI File. The OHI information contained in the COB file is collected by the Benefits Coordination & Recovery Center (BCRC) through the following sources:

- Data Sharing Agreements (DSAs).
- COB Agreements (COBAs).
- Other data exchanges with non-Part D payers:
  - Pharmacy Benefit Manager (PBMs).
  - Employer Group Health Plan (EGHP) sponsors.
  - Section 111 Responsible Reporting Entity (RREs).
  - State programs.
- Questionnaires filled out by beneficiaries.
- Employers and providers.
- Leads submitted from Part D Plans and other Medicare contractors.

The information collected by the BCRC and provided to the Part D Plan assists the Part D Plan in fulfilling its requirement to coordinate with OHI.

The COB-OHI File consists of a Detail (DTL) record identifying the Part D Plan's Contract Number, the Plan Benefit Package (PBP) number, and identifying information for the enrollee whose OHI is contained in the records attached to the DTL record. The DTL record may have two types of subordinate records:

- **Primary (PRM) Record**: PRM records contain OHI that is primary to Part D. Primary does not necessarily refer to a single primary insurance, but to all occurrences of insurance that are statutorily required to pay prior to, i.e., primary to, Part D. It is possible to have multiple occurrences of primary insurance. Each occurrence of primary insurance is contained in PRM records subordinate to the DTL record.
- **Supplemental (SUP) Record**: SUP records contain all supplemental insurance that pays after, i.e., supplemental to, Part D. Each occurrence of supplemental insurance is contained in SUP records subordinate to the DTL record.

The COB-OHI File contains full-record replacements for Medicare Part D enrollees that had a change in their enrollment record (enroll, disenroll, reinstate, change in Medicare plan 4Rx) or with newly discovered or changed OHI. The addition, change or deletion of an enrollee's OHI record triggers a full replacement of that enrollee's DTL and subordinate PRM and SUP records. The Part D Plan replaces its entire existing OHI profile for an enrollee with the most recent DTL and subordinate PRM and SUP records for that enrollee.

The Medicare Beneficiary Database (MBD) sends the COB File to Part D Plans via the MARx system. The COB-OHI File is automatically sent to Part D Plans when, at enrollment, the MBD

already contains OHI information on that enrollee. For instance, if an individual has OHI, disenrolls from Part D Plan A, and then enrolls in Part D Plan B, all of the OHI that the MBD held and previously sent to Plan A is automatically sent to Plan B in the COB File.

Note: When the beneficiary disenrolls from Plan A, Plan A continues receiving updates for the beneficiary for 27 months after member is terminated with Plan A. Plan A will no longer receive updates for the beneficiary only in two scenarios:

- The member is CNE (Contract Never effective) – termed prior to actual enrollment starting (for example: effective date 01/01/2018 – termed 01/01/2018).
- The member's disenrollment date is beyond 27 months in the past (for example: term date 09/30/2015. Plan A will never receive any updates for this member).

The COB-OHI File is sent out to Part D Plans as the BCRC collects OHI and applies records to the MBD. This can occur as often as daily. The Part D Plan may or may not receive the COB-OHI File daily; if it does receive a file, it includes records for new or current enrollees with changed or newly discovered OHI, and members with a termination date within 27 months from the COB-OHI File date. Most data exchanges administered by the BCRC for CMS are monthly. However, each data exchange partner has a unique submission schedule. The BCRC can receive file submissions from data exchange partners on any given day. The BCRC conducts development, i.e., phone calls, mailed questionnaires, on a continual basis. The BCRC may apply records originating from development or data exchanges to the MBD any day. As soon as the records are applied to the MBD, the COB-OHI File is sent to the Part D Plan of the OHI enrollee.

The Part D Plan uses the elements contained in the PRM and SUP records to make payment determinations, recover mistaken payments, identify whether or not payments made by OHI count towards True Out-of-Pocket (TrOOP), and to populate the claim's response to the pharmacy.

Under provisions found in § 1860D-2(a) (4) of the Medicare Modernization Act (MMA), the Medicare Secondary Payer (MSP) rules were incorporated in the MMA and apply to Part D Plans as payers of Medicare benefits and to non-Part D GHP and non-GHP prescription drug payers that meet the MSP rules. The MSP rules are found at 42 U.S.C. § 1395y(b).

In some cases, the Part D Plan makes mistaken primary payments, i.e., if the BCRC, CMS, and the Part D Plan are all unaware of any primary coverage. Under other circumstances, the Part D Plan makes conditional payments. These circumstances include:

- When the Part D Plan is aware that the enrollee has Workers' Compensation (WC)/no-fault/liability coverage but is unaware whether the drugs for which a bill is sent are related to the WC/no-fault/liability incident.
- When the Part D Plan learns of potential primary coverage and sends information to the BCRC for development and it chooses to wait for validation before considering itself a secondary payer. This option is entirely up to the Plan; it may act as a secondary payer immediately or wait for validation, depending on its confidence of the information's validity.
- When the Part D Plan is aware that the primary WC/no-fault/liability coverage applies but the primary payer does not make prompt payment.

When these mistaken or conditional primary payments are made, the Part D Plan is required to recover the primary payment from the relevant employer, insurer, WC/no-fault/liability carrier, or enrollee. The Part D Plan is also subject to audit or reporting requirements.

3.7.2 COB-OHI PRM Record Layout Elements

OHI contained in the PRM record is primary to, i.e., pays before, Part D. The following are definitions and instructions on the use of elements contained in the PRM record layout. Some of the PRM record layout elements are the same as elements contained in the SUP record layout. Note that * indicates that the element is found in both, but may have slightly different definitions and instructions. Not all element fields populate, depending on the information that the BCRC possesses when it applies the record to the MBD.

RxID Number*

The National Council of Prescription Drug Programs (NCPDP) standard Rx Identification Number (ID) is used for network drug benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and the RxID number to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

RxGroup Number*

The NCPDP standard Rx Group Number is used for network drug benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and may use the RxGroup number to identify an individual in the recovery of mistaken payments, as well.

Benefit Identification Number Rx (BIN)*

The NCPDP standard International BIN is used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and may use the RxBIN number to identify an individual in the recovery of mistaken payments, as well.

Processor Control Number Rx (PCN)*

The NCPDP standard PCN used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and may use the RxPCN number to identify an individual in the recovery of mistaken payments, as well.

Rx Plan Toll-Free Number*

The help desk number for the pharmacy benefit is the primary insurance. The Part D Plan displays this in the reply to the pharmacy.

Sequence Number*

The unique identifier for the PRM occurrence, the Sequence Number may identify the PRM occurrence when inquiring about a record to the BCRC.

COB Source Code*

The code for the BCRC, Common Working File, and MBD is used to identify the origin from which the BCRC received primary insurance information. Customer Service may use the COB Source Code when inquiring about a record to the BCRC.

Note: For any instances where an unknown COB Source Code is provided, Plans should contact BCRC for clarification.

MSP Reason*

Medicare is the Secondary Payer, i.e., the other insurance is primary to Medicare. For EGHPs, MSP (Reason codes A, B, and G), the Part D Plans reject Primary payment. The EGHP is statutorily required to make primary payment in those cases. For non-GHP, MSP (Reason codes D, E, L, H, and W), the Part D Plan makes conditional primary payment, as it is possible these MSP types are incident related. However, if the Part D Plan is certain that the claim is incident related, and that primary insurance for this incident exists, it should reject primary payment in the same way it rejects EGHP MSP primary insurance. If the Part D Plan makes a conditional primary payment, it must reconcile with the non-GHP insurance post Point-of-Sale (POS).

Coverage Code*

This code identifies whether the coverage offered by the primary insurance is a network drug or non-network drug benefit. When the primary insurance is a network drug benefit coverage type (U), the record includes routing information, i.e., BIN and PCN, when available; however, for COB PRM records MSP Reason codes A, B and G, RxID, RxGroup and RxBIN are required. The Group and Individual Policy Number Fields may populate when the primary insurance is a non-network drug benefit coverage type (A, V, W, X, Y & Z).

Insurer's Name*

The name of the primary insurance carrier can assist in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Insurer's Address-1*
Insurer's Address-2*
Insurer's City*
Insurer's State*
Insurer's Zip Code*

The Address, City, State, and Zip Code of the primary insurance carrier can assist in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Insurer Tax Identification Number (TIN)

The TIN of primary insurance carrier may assist in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Individual Policy Number*

The Individual Policy Number used for non-network drug benefit primary insurance. Part D Plan uses this to identify non-network drug benefit primary insurance and may use the Individual Policy Number to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Group Policy Number*

The Group Policy Number used for non-network drug benefit primary insurance. The Part D Plan uses this to identify non-network drug benefit primary insurance and may use the Group Policy Number to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

COB Effective Date*

For EGHP MSP (Reason codes A, B, and G) it identifies start date. For non-GHP MSP (Reason codes D, E, L, H, and W) it identifies the date of the accident, illness, or injury; or it identifies the Medicare entitlement date, whichever is earlier.

Note: This date is a manipulated date and does not reflect the actual effective date of the other coverage and therefore should not be used for purposes of Part D coordination of benefits. Part D Sponsors should use the Effective Date of Other Drug Coverage (Position 1084-1091 in Primary records and position 516-523 in Supplemental records) for coordination of benefits.

Termination Date*

MSP end date, which identifies whether or not the primary insurance is terminated. For non-GHP MSP (Reason codes D, E, L, H, and W), it identifies the date of settlement/judgment/award. If the insurance is open, the field is populated with all zeroes.

Relationship Code*

Relationship to primary insurance policyholder used for MSP determinations.

Payer ID*

Future

Person Code*

NCPDP standard Person Code used by the Plan to identify specific individuals on the primary insurance policy. Used for routing of network drug benefit, the Part D Plan displays the Person Code in the reply to the pharmacy and may use the Person Code in the recovery of mistaken payments.

Payer Order*

The order of payment for primary insurance, the Part D Plan displays this in reply to the pharmacy in order of Payment Order Indicator. The lowest number in ascending order, i.e., 001 to 400, is the first primary insurance displayed in the reply to the pharmacy. OHI with a payment order less than 401 is displayed prior, i.e., primary to, the Part D Plan. The rules that BCRC use to assign the Payer Order are attached for reference.

Policy Holder's First Name

The first name of the primary GHP (MSP Reason codes: A, B, and G) insurance policy holder. Part D Plans may use the Policy Holder's first name in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Policy Holder's Last Name

The last name of the primary GHP (MSP Reason codes: A, B, and G) insurance policy holder. Part D Plans may use the Policy Holder's last name to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Policy Holder's Social Security Number (SSN)

The Social Security Number of the primary GHP (MSP Reason codes: A, B, and G) insurance policy holder. Part D Plans may use the Policy Holder's SSN to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Employee Information Code

Not used.

Employer's Name
The name of Employer sponsor of primary GHP (MSP Reason codes: A, B, and G) insurance. Part D Plans may use the Employer's Name in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Employer's Address 1
Employer's Address 2
Employer's City
Employer's State
Employer's Zip Code

The address, city, state, and zip code of the Employer sponsoring the primary GHP (MSP Reason codes: A, B, and G) insurance. Part D Plans may use the Employer's Address in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Employer's TIN

Attorney's Name

The name of the attorney handling the incident related case (MSP Reason codes D, E, L, H, and W) for the enrollee. Part D Plans may use the Attorney's Name in the recovery of mistaken payments, as well. CMS provides guidance for recoveries to Part D Plans.

Attorney's Address 1
Attorney's Address 2
Attorney's City
Attorney's State
Attorney's Zip

The address of the attorney Part D Plans may use in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Lead Contractor

The assigned lead Medicare claims payment contractor responsible for developing, tracking, and recovering Medicare payments made where the enrollee received payments from a liability insurer. Part D Plans may use the Lead Contractor in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

Class Action Type

This is assigned where a liability case is a class action lawsuit involving more than one Medicare beneficiary.

Administrator Name

The administrator of WC Set-Aside (WCSA) Settlement that CMS will bill for payment of future claims related to the incident that allowed the enrollee to receive WC benefits. CMS is developing payment and recovery rules for WCSAs.

Administrator Address 1
Administrator Address 2
Administrator City
Administrator State
Administrator Zip

The Address, City, State, and Zip Code of the WCSA settlement; CMS is developing payment and recovery rules for WCSAs.

Workers Compensation Set Aside (WCSA) Amount

WCSA Indicator

WCSA Indicator; CMS is developing payment and recovery rules for WCSAs.

Workers Compensation Set-Aside (WCSA) Settlement Date

Administrator's Telephone Number

Total Rx Settlement Amount

Rx $ Included in the WCSA Settlement Amount

Claim Diagnosis Code 1 – 25

Claim Diagnosis Indicator 1 – 25

International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) Diagnosis code – Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the U.S. National Center for Health Statistics and CMS are the U.S. governmental agencies responsible for overseeing all changes to the ICD-9-CM. No instructions at this time.

Effective Date of Other Drug Coverage*

This date is the actual effective date of other drug insurance coverage provided by the other insurance. This date should be used for coordination of benefits. The Part D Sponsor should compare Date of Service (DOS) to both the Part D effective period and the other coverage effective period to determine if coordination of benefits is necessary.

3.7.3 COB-OHI SUP Record Layout Elements

OHI contained in the SUP record is supplemental to, i.e., pays after, Part D. The following are definitions and instructions on the use of elements contained in the SUP record layout. Some of the SUP record layout elements are the same as elements contained in the PRM record layout, but may have slightly different definitions and instructions. Not all element fields populate, depending on the information that the BCRC possesses when it applies the record to the MBD.

RxID Number*

NCPDP standard Rx Identification Number used for network drug benefit of the supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.

RxGroup Number*

NCPDP standard Rx Group Number used for network drug benefit of the supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.

RxBIN Number*

NCPDP standard International BIN used for the network drug benefit routing of supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.

RxPCN Number*

The NCPDP standard PCN used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy.

Rx Plan Toll-Free Number*

The Part D Plan displays this help desk number of the pharmacy benefit in the Plan's reply to the pharmacy. For Supplemental Insurance Type Code P, this field instead populates with contact information for the Patient Assistance Program (PAP).

Sequence Number*

The unique identifier for the supplemental SUP occurrence, Part D Plans may use the number to identify the SUP occurrence when inquiring about a record to the BCRC.

COB Source Code*

The code the BCRC, Common Working File, and MBD use to identify the process from which the BCRC received supplemental insurance information. Customer service may use the COB Source Code when inquiring about a record to the BCRC.

Supplemental Type Code

The type of supplemental insurance contained in the record. The Part D Plan uses this to determine if the payments made by this supplemental insurance count towards TrOOP. Supplemental Insurance Type Codes Q (SPAP), S (ADAP), and R (Charity) count towards TrOOP. All other codes do not count toward TrOOP.

Coverage Code*

This code identifies whether the supplemental insurance drug benefit is a network drug or non-network drug benefit. When the supplemental insurance is a network drug benefit coverage type (U), the record requires routing information RxBIN (and RxPCN when available). However, for COB SUP records with Supplemental Type Codes Q (SPAP) and S (ADAP), RxID, RxBIN, and RxPCN are required. For COB SUP records with Supplemental Type Code N (State Prog – non qualified SPAP), all 4Rx values are required.

Insurer's Name*

The name of the supplemental insurance carrier, the Part D Plan uses this to identify supplemental insurance carrier.
Insurer's Address-1*
Insurer's Address-2*
Insurer's City*
Insurer's State*
Insurer's Zip Code*

The Address, City, State, and Zip Code of the supplemental insurance carrier, which customer service may use.

Individual Policy Number*

Group Policy Number*

COB Effective Date*

The COB insurance start date.

Note: This date is a manipulated date and does not reflect the actual effective date of the other coverage and therefore should not be used for purposes of Part D coordination of benefits. Part D Sponsors should use the Effective Date of Other Drug Coverage (Position 1084-1091 in Primary records and position 516-523 in Supplemental records) for coordination of benefits.

Termination Date*

The supplemental insurance end date, which identifies whether or not the supplemental insurance terminated. If the insurance is open, the field populates with all zeroes.

Relationship Code*

Relationship to supplemental insurance policyholder. No instructions at this time.

Payer ID*

Future

Person Code*

The NCPDP standard Person Code the supplemental insurance uses to identify specific individuals on the supplemental insurance policy. Used for routing of network drug benefit, the Part D Plan displays the Person Code in the reply to the pharmacy.

Payer Order*

The order of payment for supplemental insurance, the Part D Plan displays this in reply to the pharmacy in order of the Payment Order Indicator. The lowest number in ascending order, i.e., 401 to 999, is the first supplemental insurance displayed in the reply to the pharmacy. OHI with a payment order greater than or equal to 401 is displayed after, i.e., secondary or supplemental to, the Part D Plan.

Effective Date of Other Drug Coverage*

This date is the actual effective date of other drug insurance coverage provided by the other insurance. This date should be used for coordination of benefits. The Part D Sponsor should compare Date of Service (DOS) to both the Part D effective period and the other coverage effective period to determine if coordination of benefits is necessary.

3.7.4 COB–OHI File (Part D Only)

This file is sent to Part D Plans and contains beneficiary other drug coverage. Part C Plans receive the Monthly Medicare Secondary Payer (MSP) Information File that reports MA MSP.

The COB-OHI file contains members' primary and secondary drug coverage, validated through COB processing. MARx forwards this report to a Part D Plan whenever the Plan's enrollees are affected, which may occur as often as daily. The enrollees included on the report are those newly enrolled in the Part D Plan who has known OHI and existing Plan enrollees who have changes to their Drug OHI.

System	Type	Frequency	File Length	COB-OHI Dataset Naming Conventions
MBD (MARx)	Data File	As Needed (can be daily)	1100	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MARXCOB.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MARXCOB.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MARXCOB.Dyymmdd.Thhmmsst

The following records are included in this file:

- **COB-OHI Detail Record**
- **COB-OHI Primary Record**
- **COB-OHI Supplemental Record**

The table below provides an example of how the COB-OHI records are organized for each beneficiary.

Table 3-13: COB-OHI Organization of Records

COB-OHI File Organization of Records
Detail Record (DTL) Record 1 (Beneficiary A)
Primary (PRM) records associated with DTL Record 1 (Beneficiary A)
Supplemental (SUP) records associated with DTL Record 1 (Beneficiary A)
DTL Record 2 (Beneficiary B)
PRM records associated with DTL Record 2 (Beneficiary B)
SUP records associated with DTL Record 2 (Beneficiary B)
DTL Record 3 (Beneficiary C)
PRM records associated with DTL Record 3 (Beneficiary C)
SUP records associated with DTL Record 3 (Beneficiary C)
DTL Record n
PRM records associated with DTL Record n
SUP records associated with DTL Record n

Layout 3-29: COB-OHI Detail Record

Indicates the Beginning of a Series of Beneficiary Subordinate Detail Records

COB-OHI Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
1	Record Type	3	1-3	CHAR	DTL
2	Beneficiary Identifier	12	4-15	CHAR	A system-generated identifier used by CMS to uniquely identify the beneficiary internally and externally. The value will be in the Medicare Beneficiary Identifier (MBI) format that CMS implemented in April of 2018 as a part of the New Medicare Card project.
3	SSN	9	16-24	ZD	000000000 if unknown.
4	Date of Birth (DOB)	8	25-32	CHAR	CCYYMMDD
5	Gender Code	1	33	CHAR	0 = Unknown. 1 = Male. 2 = Female.
6	Contract Number	5	34-38	CHAR	
7	Plan Benefit Package	3	39-41	CHAR	
8	Action Type	1	42	CHAR	2 = Full replacement.
9	Filler	1058	43-1100	CHAR	Spaces.

Layout 3-30: COB OHI Primary Record

Subordinate to Detail Record (Unlimited Occurrences)

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
1	Record Type	3	1-3	CHAR	PRM
2	Beneficiary Identifier	12	4-15	CHAR	A system-generated identifier used by CMS to uniquely identify the beneficiary internally and externally. The value will be in the MBI format that CMS implemented in April of 2018 as part of the New Medicare Card project.
3	SSN*	9	16-24	ZD	000000000 if unknown.
4	Date of Birth (DOB)*	8	25-32	CHAR	CCYYMMDD
5	Gender Code*	1	33	CHAR	0 = Unknown. 1 = Male. 2 = Female.

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
6	RxID Number*	20	34-53	CHAR	The National Council of Prescription Drug Programs (NCPDP) standard Rx Identification Number (ID) is used for network drug benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and the RxID number to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
7	RxGroup Number*	15	54-68	CHAR	The NCPDP standard Rx Group Number is used for network drug benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and may use the RxGroup number to identify an individual in the recovery of mistaken payments, as well.
8	RxBIN Number*	6	69-74	ZD	The NCPDP standard International BIN is used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and may use the RxBIN number to identify an individual in the recovery of mistaken payments, as well.
9	RxPCN Number*	10	75-84	CHAR	The NCPDP standard PCN used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy and may use the RxPCN number to identify an individual in the recovery of mistaken payments, as well.
10	Rx Plan Toll Free Number*	18	85-102	CHAR	The help desk number for the pharmacy benefit is the primary insurance. The Part D Plan displays this in the reply to the pharmacy.
11	Sequence Number*	3	103-105	CHAR	The unique identifier for the PRM occurrence, the Sequence Number may identify the PRM occurrence when inquiring about a record to the BCRC.

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
12	COB Source Code* **Note:** There may be instances where an unknown COB Source Code will be provided. Plans should contact BCRC for clarification on any unknown Source Codes.	5	106-110	CHAR	The code for the BCRC, Common Working File, and MBD is used to identify the origin from which the BCRC received primary insurance information. 11100 – Non Payment/Payment Denial. 11101 – IEQ (Initial Enrollment Questionnaire). 11102 – Data Match. 11103 – HMO. 11104 – Litigation Settlement BCBS. 11105 – Employer Voluntary Reporting. 11106 – Insurer Voluntary Reporting. 11107 – First Claim Development. 11108 – Trauma Code Development. 11109 – Secondary Claims Investigation. 11110 – Self Report. 11111 – 411.25. 11112 – BCBS Voluntary Agreements. 11113 – OPM Data Match (Office of Personnel Management). 11114 – WC Data Match. 11118 – PBM (Pharmacy Benefit Manager). 11120 – COBA. 11125 – RAC 1 (Recovery Audit Contractor). 11126 – RAC 2 (Recovery Audit Contractor). 11127 – RAC 3 (Recovery Audit Contractor). P0000 – PBM. S0000 – Assistance Program. **Note:** Contractor numbers 11100 - 11199 are reserved for COB.

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
13	MSP Reason (Entitlement Reason from COB)	1	111	CHAR	Medicare is the Secondary Payer, i.e., the other insurance is primary to Medicare, for EGHPs, MSP Reason codes A, B, and G, and the Part D Plan rejects Primary payment. The EGHP is statutorily required to make primary payment in those cases, i.e. A, B, and G. The Part D Plan makes conditional primary payment, as it is possible these MSP types are incident related. Without a diagnosis code, the Part D Plan cannot determine whether or not the non-EGHP insurance is primary for that particular claim, unless the Part D Plan is certain that the claim is related to the incident. If the Part D Plan is certain that the claim is incident related, and that primary insurance for this incident exists, it should reject primary payment in the same way it rejects GHP MSP primary insurance. If the Part D Plan makes a conditional primary payment, it must reconcile with the non-GHP insurance post Point-of-Sale (POS). A = Working Aged. B = ESRD. C = Conditional Payment. D = Automobile Insurance, No fault. E = WC. F = Federal (public). G = Disabled. H = Black Lung. I = Veterans. L = Liability. W = Workers Compensation Set Aside (WCSA).

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
14	Coverage Code*	1	112	CHAR	This code identifies whether the coverage offered by the primary insurance is a network drug or non-network drug benefit. When the primary insurance is a network drug benefit coverage type (U), the record includes routing information, i.e., BIN and PCN, when available; however, for COB PRM records MSP Reason codes A, B and G, RxID, RxGroup and RxBIN are required. The Group and Individual Policy Number Fields may populate when the primary insurance is a non-network drug benefit coverage type (A, U, V, W, X, Y & Z). A = Hospital and Medical. U = Drug (network benefit). V = Drug with Major Medical (non-network benefit). W = Comprehensive, Hospital, Medical, Drug (network). X = Hospital and Drug (network). Y = Medical and Drug (network). Z = Health Reimbursement Account (hospital, medical, and drug).
15	Insurer's Name*	32	113-144	CHAR	The name of the primary insurance carrier can assist in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
16	Insurer's Address-1*	32	145-176	CHAR	The Address, City, State, and Zip Code of the primary insurance carrier can assist in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
17	Insurer's Address-2*	32	177-208	CHAR	
18	Insurer's City*	15	209-223	CHAR	
19	Insurer's State*	2	224-225	CHAR	
20	Insurer's Zip Code*	9	226-234	CHAR	
21	Insurer TIN	10	235-244	CHAR	The TIN of primary insurance carrier may assist in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
22	Individual Policy Number*	17	245-261	CHAR	The Individual Policy Number used for non-network drug benefit primary insurance. Part D Plan uses this to identify non-network drug benefit primary insurance and may use the Individual Policy Number to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
23	Group Policy Number*	20	262-281	CHAR	The Group Policy Number used for non-network drug benefit primary insurance. The Part D Plan uses this to identify non-network drug benefit primary insurance and may use the Group Policy Number to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
24	COB Effective Date*	8	282-289	ZD	This is a manipulated date and does not reflect the actual effective date of the other coverage and therefore should not be used for purposes of Part D coordination of benefits. Part D Sponsors should use the Effective Date of Other Drug Coverage (Position 1084-1091 in Primary records and position 516-523 in Supplemental records) for coordination of benefits. CCYYMMDD.
25	Termination Date*	8	290-297	ZD	MSP end date, which identifies whether or not the primary insurance is terminated. For non-GHP MSP types D, E, L, H, and W, it identifies the date of settlement/judgment/award. If the insurance is open, the field is populated with all zeroes. CCYYMMDD
26	Relationship Code*	2	298-299	CHAR	Relationship to primary insurance policyholder used for MSP determinations. 01 = Beneficiary is Policy Holder. 02 = Spouse. 03 = Child. 04 = Other.
27	Payer ID*	10	300-309	CHAR	This is a future element.
28	Person Code*	3	310-312	CHAR	NCPDP standard Person Code used by the Plan to identify specific individuals on the primary insurance policy. Used for routing of network drug benefit, the Part D Plan displays the Person Code in the reply to the pharmacy and may use the Person Code in the recovery of mistaken payments.
29	Payer Order*	3	313-315	ZD	The order of payment for primary insurance, the Part D Plan displays this in reply to the pharmacy in order of Payment Order Indicator. The lowest number in ascending order, i.e., 001 to 400, is the first primary insurance displayed in the reply to the pharmacy. OHI with a payment order less than 401 is displayed prior, i.e., primary to, the Part D Plan.

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
30	Policy Holder's First Name	9	316-324	CHAR	The first name of the primary GHP (MSP Types: A, B, and G) insurance policy holder. Part D Plans may use the Policy Holder's first name in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
31	Policy Holder's Last Name	16	325-340	CHAR	The last name of the primary GHP (MSP Types: A, B, and G) insurance policy holder. Part D Plans may use the Policy Holder's last name to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
32	Policy Holder's SSN	12	341-352	CHAR	The Social Security Number of the primary GHP (MSP Types: A, B, and G) insurance policy holder. Part D Plans may use the Policy Holder's SSN to identify an individual in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
33	Employee Information Code	1	353	CHAR	P = Patient. S = Spouse. M = Mother. F = Father.
34	Employer's Name	32	354-385	CHAR	The name of Employer sponsor of primary GHP (MSP Reason codes: A, B, and G) insurance. Part D Plans may use the Employer's Name in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
35	Employer's Address 1	32	386-417	CHAR	The address, city, state, and zip code of the Employer sponsoring the primary GHP (MSP Reason codes: A, B, and G) insurance. Part D Plans may use the Employer's Address in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
36	Employer's Address 2	32	418-449	CHAR	
37	Employer's City	15	450-464	CHAR	
38	Employer's State	2	465-466	CHAR	
39	Employer's Zip Code	9	467-475	CHAR	
40	Filler	20	476-495	CHAR	
41	Employer TIN	10	496-505	CHAR	
42	Filler	70	506-575	CHAR	
43	Attorney's Name	32	576-607	CHAR	The name of the attorney handling the incident related case (MSP Types D: Automobile Insurance, No Fault, E: WC, L: Liability) for the enrollee. Part D Plans may use the Attorney's Name in the recovery of mistaken payments, as well. CMS provides guidance for recoveries to Part D Plans.

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
44	Attorney's Address 1	32	608-639	CHAR	The address of the attorney Part D Plans may use in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
45	Attorney's Address 2	32	640-671	CHAR	
46	Attorney's City	15	672-686	CHAR	
47	Attorney's State	2	687-688	CHAR	
48	Attorney's Zip	9	689-697	CHAR	
49	Lead Contractor	9	698-706	CHAR	The assigned lead Medicare claims payment contractor responsible for developing, tracking, and recovering Medicare payments made where the enrollee received payments from a liability insurer. Part D Plans may use the Lead Contractor in the recovery of mistaken payments. CMS provides guidance for recoveries to Part D Plans.
50	Class Action Type	2	707-708	CHAR	This is assigned where a liability case is a class action lawsuit involving more than one Medicare beneficiary.
51	Administrator Name	32	709-740	CHAR	The administrator of WC Set-Aside (WCSA) Settlement that CMS will bill for payment of future claims related to the incident that allowed the enrollee to receive WC benefits. CMS is developing payment and recovery rules for WCSAs.
52	Administrator Address 1	32	741-772	CHAR	The Address, City, State, and Zip Code of the WCSA settlement. CMS is developing payment and recovery rules for WCSAs.
53	Administrator Address 2	32	773-804	CHAR	
54	Administrator City	15	805-819	CHAR	
55	Administrator State	2	820-821	CHAR	
56	Administrator Zip	9	822-830	CHAR	
57	Workers Compensation Set Aside (WCSA) Amount	12	831-842	NUM	Integer value. WCSA Amount; CMS is developing payment and recovery rules for WCSAs.
58	WCSA Indicator	2	843-844	CHAR	WCSA Indicator; CMS is developing payment and recovery rules for WCSAs. A = Approved. D = Denied. P = Pending. Z = Zero set aside amount.
59	Workers Compensation Medical Set Aside (WCMSA) Settlement Date	8	845-852	ZD	CCYYMMDD
60	Administrator's Telephone Number	18	853-870	CHAR	
61	Total Rx Settlement Amount	12	871-882	CHAR	Includes decimal point: 9999999999.99

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
62	Rx $ included in the WCMSA Settlement Amount	1	883	CHAR	Y = Yes. N = No.
Diagnosis Indicator 1 – 25 and Claim Diagnosis Code 1 – 25: International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) Diagnosis code – Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the U.S. National Center for Health Statistics and CMS are the U.S. governmental agencies responsible for overseeing all changes to the ICD-9-CM. No instructions at this time.					
63	Diagnosis Indicator 1	1	884	CHAR	9 = ICD-9. 0 = ICD-10.
64	Claim Diagnosis Code 1	7	885-891	CHAR	
65	Diagnosis Indicator 2	1	892	CHAR	9 = ICD-9. 0 = ICD-10.
66	Claim Diagnosis Code 2	7	893-899	CHAR	
67	Diagnosis Indicator 3	1	900	CHAR	9 = ICD-9. 0 = ICD-10.
68	Claim Diagnosis Code 3	7	901-907	CHAR	
69	Diagnosis Indicator 4	1	908	CHAR	9 = ICD-9. 0 = ICD-10.
70	Claim Diagnosis Code 4	7	909-915	CHAR	
71	Diagnosis Indicator 5	1	916	CHAR	9 = ICD-9. 0 = ICD-10.
72	Claim Diagnosis Code 5	7	917-923	CHAR	
73	Diagnosis Indicator 6	1	924	CHAR	9 = ICD-9. 0 = ICD-10.
74	Claim Diagnosis Code 6	7	925-931	CHAR	
75	Diagnosis Indicator 7	1	932	CHAR	9 = ICD-9. 0 = ICD-10.
76	Claim Diagnosis Code 7	7	933-939	CHAR	
77	Diagnosis Indicator 8	1	940	CHAR	9 = ICD-9. 0 = ICD-10.
78	Claim Diagnosis Code 8	7	941-947	CHAR	
79	Diagnosis Indicator 9	1	948	CHAR	9 = ICD-9. 0 = ICD-10.
80	Claim Diagnosis Code 9	7	949-955	CHAR	
81	Diagnosis Indicator 10	1	956	CHAR	9 = ICD-9. 0 = ICD-10.
82	Claim Diagnosis Code 10	7	957-963	CHAR	
83	Diagnosis Indicator 11	1	964	CHAR	9 = ICD-9. 0 = ICD-10.
84	Claim Diagnosis Code 11	7	965-971	CHAR	

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
85	Diagnosis Indicator 12	1	972	CHAR	9 = ICD-9. 0 = ICD-10.
86	Claim Diagnosis Code 12	7	973-979	CHAR	
87	Diagnosis Indicator 13	1	980	CHAR	9 = ICD-9. 0 = ICD-10.
88	Claim Diagnosis Code 13	7	981-987	CHAR	
89	Diagnosis Indicator 14	1	988	CHAR	9 = ICD-9. 0 = ICD-10.
90	Claim Diagnosis Code 14	7	989-995	CHAR	
91	Diagnosis Indicator 15	1	996	CHAR	9 = ICD-9. 0 = ICD-10.
92	Claim Diagnosis Code 15	7	997-1003	CHAR	
93	Diagnosis Indicator 16	1	1004	CHAR	9 = ICD-9. 0 = ICD-10.
94	Claim Diagnosis Code 16	7	1005-1011	CHAR	
95	Diagnosis Indicator 17	1	1012	CHAR	9 = ICD-9. 0 = ICD-10.
96	Claim Diagnosis Code 17	7	1013-1019	CHAR	
97	Diagnosis Indicator 18	1	1020	CHAR	9 = ICD-9. 0 = ICD-10.
98	Claim Diagnosis Code 18	7	1021-1027	CHAR	
99	Diagnosis Indicator 19	1	1028	CHAR	9 = ICD-9. 0 = ICD-10.
100	Claim Diagnosis Code 19	7	1029-1035	CHAR	
101	Diagnosis Indicator 20	1	1036	CHAR	9 = ICD-9. 0 = ICD-10.
102	Claim Diagnosis Code 20	7	1037-1043	CHAR	
103	Diagnosis Indicator 21	1	1044	CHAR	9 = ICD-9. 0 = ICD-10.
104	Claim Diagnosis Code 21	7	1045-1051	CHAR	
105	Diagnosis Indicator 22	1	1052	CHAR	9 = ICD-9. 0 = ICD-10.
106	Claim Diagnosis Code 22	7	1053-1059	CHAR	
107	Diagnosis Indicator 23	1	1060	CHAR	9 = ICD-9. 0 = ICD-10.
108	Claim Diagnosis Code 23	7	1061-1067	CHAR	
109	Diagnosis Indicator 24	1	1068	CHAR	9 = ICD-9. 0 = ICD-10.
110	Claim Diagnosis Code 24	7	1069-1075	CHAR	

COB-OHI Primary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
111	Diagnosis Indicator 25	1	1076	CHAR	9 = ICD-9. 0 = ICD-10.
112	Claim Diagnosis Code 25	7	1077-1083	CHAR	
113	Effective Date of Other Drug Coverage	8	1084-1091	CHAR	CCYYMMDD. This is the actual effective date of other drug insurance coverage provided by the other insurance. This date should be used for coordination of benefits. The Part D Sponsor should compare Date of Service (DOS) to both the Part D effective period and the other coverage effective period to determine if coordination of benefits is necessary
114	Filler	9	1092-1100	CHAR	Spaces

*Indicates that these fields have same position in PRM and SUP record layouts.

Layout 3-31: COB OHI Supplemental Record

Subordinate to Detail Record (Unlimited Occurrences)

COB OHI Supplemental Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
1	Record Type	3	1-3	CHAR	SUP
2	Beneficiary Identifier	12	4-15	CHAR	A system-generated identifier used by CMS to uniquely identify the beneficiary internally and externally. The value will be in the MBI format that CMS implemented in April of 2018 as a part of the New Medicare Card project.
3	SSN*	9	16-24	ZD	000000000 if unknown.
4	Date of Birth (DOB)*	8	25-32	CHAR	CCYYMMDD
5	Gender Code*	1	33	CHAR	0 = Unknown. 1 = Male. 2 = Female.
6	RxID Number*	20	34-53	ZD	NCPDP standard Rx Identification Number used for network drug benefit of the supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.
7	RxGroup Number*	15	54-68	CHAR	NCPDP standard Rx Group Number used for network drug benefit of the supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.
8	RxBIN Number*	6	69-74	ZD	NCPDP standard International BIN used for the network drug benefit routing of supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.
9	RxPCN Number*	10	75-84	CHAR	The NCPDP standard PCN used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy.
10	Rx Plan Toll Free Number*	18	85-102	CHAR	The Part D Plan displays this help desk number of the pharmacy benefit in the Plan's reply to the pharmacy. For Supplemental Insurance Type Code P, this field instead populates with contact information for the Patient Assistance Program (PAP).
11	Sequence Number*	3	103-105	CHAR	The unique identifier for the supplemental SUP occurrence, Part D Plans may use the number to identify the SUP occurrence when inquiring about a record to the BCRC.

COB OHI Supplemental Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
12	COB Source Code* **Note:** There may be instances where an unknown COB Source Code will be provided. Plans should contact BCRC for clarification on any unknown Source Codes.	5	106-110	CHAR	The code the BCRC, Common Working File, and MBD use to identify the process from which the BCRC received supplemental insurance information. Customer service may use the COB Source Code when inquiring about a record to the BCRC. 11100 = Non Payment/Payment Denial. 11101 = IEQ. 11102 = Data Match. 11103 = HMO. 11104 = Litigation Settlement BCBS. 11105 = Employer Voluntary Reporting. 11106 = Insurer Voluntary Reporting. 11107 = First Claim Development. 11108 = Trauma Code Development. 11109 = Secondary Claims Investigation. 11110 = Self Report. 11111 = 411.25. 11112 = BCBS Voluntary Agreements. 11113 = OPM Data Match. 11114 = WC Data Match. 11118 = PBM. 11120 = COBA. 11125 = RAC 1. 11126 = RAC 2. 11127 = RAC 3. P0000 = PBM. S0000 = Assistance Program. **Note:** Contractor numbers 11100 - 11199 are reserved for COB.
13	Supplemental Type Code	1	111	CHAR	The type of supplemental insurance contained in the record. The Part D Plan uses this to determine if the payments made by this supplemental insurance count towards TrOOP. Supplemental Insurance Type Codes Q (SPAP), S (ADAP), and R (Charity) count towards TrOOP. All other codes do not count toward TrOOP. L = Supplemental. M = Medigap. N = State Program (Non-Qualified SPAP). O = Other. P = Patient Assistance Program. Q = Qualified SPAP. R = Charity. S = AIDS Drug Assistance Program. T = Federal Health Program. 1 = Medicaid. 2 = Tricare. 3 = Major Medical.

COB OHI Supplemental Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
14	Coverage Code*	1	112	CHAR	This code identifies whether the supplemental insurance drug benefit is a network drug or non-network drug benefit. When the supplemental insurance is a network drug benefit coverage type (U), the record requires routing information RxBIN (and RxPCN when available). However, for COB SUP records with Supplemental Type Codes Q (SPAP) and S (ADAP), RxID, RxBIN, and RxPCN are required. For COB SUP records with Supplemental Type Code N (State Prog – non qualified SPAP) all 4RX values are required. U = Drug (network benefit). V = Drug with Major Medical (non-network benefit). Z = Health Reimbursement Account (hospital, medical, and drug).
15	Insurer's Name*	32	113-144	CHAR	The name of the supplemental insurance carrier. The Part D Plan uses this to identify supplemental insurance carrier.
16	Insurer's Address-1*	32	145-176	CHAR	The Address, City, State, and Zip Code of the supplemental insurance carrier, which customer service may use.
17	Insurer's Address-2*	32	177-208	CHAR	
18	Insurer's City*	15	209-223	CHAR	
19	Insurer's State*	2	224-225	CHAR	
20	Insurer's Zip Code*	9	226-234	CHAR	
21	Filler	10	235-244	CHAR	Spaces.
22	Individual Policy Number*	17	245-261	CHAR	The Individual Policy Number is used for non-network drug benefit supplemental insurance. The Part D Plan uses the Individual Policy Number to identify non-network drug benefit supplemental insurance.
23	Group Policy Number*	20	262-281	CHAR	The Group Policy number is used for non-network drug benefit supplemental insurance. The Part D Plan uses the Group Policy number to identify non-network drug benefit supplemental insurance.
24	COB Effective Date*	8	282-289	ZD	This is a manipulated date and does not reflect the actual effective date of the other coverage and therefore should not be used for purposes of Part D coordination of benefits. Part D Sponsors should use the Effective Date of Other Drug Coverage (Position 1084-1091 in Primary records and position 516-523 in Supplemental records) for coordination of benefits. CCYYMMDD

COB OHI Supplemental Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
25	Termination Date*	8	290-297	ZD	The supplemental insurance end date, which identifies whether or not the supplemental insurance terminated. If the insurance is open, the field populates with all zeroes. CCYYMMDD
26	Relationship Code*	2	298-299	CHAR	Relationship to supplemental insurance policyholder. No instructions at this time. 01 = Bene is Policy Holder. 02 = Spouse. 03 = Child. 04 = Other.
27	Payer ID*	10	300-309	CHAR	Future use.
28	Person Code*	3	310-312	CHAR	The NCPDP standard Person Code the supplemental insurance uses to identify specific individuals on the supplemental insurance policy. Used for routing of network drug benefit, the Part D Plan displays the Person Code in the reply to the pharmacy.
29	Payer Order*	3	313-315	ZD	The order of payment for supplemental insurance, the Part D Plan displays this in reply to the pharmacy in order of the Payment Order Indicator. The lowest number in ascending order, i.e., 401 to 999, is the first supplemental insurance displayed in the reply to the pharmacy. OHI with a payment order greater than or equal to 401 is displayed after, i.e., secondary or supplemental to, the Part D Plan.
30	Diagnosis Indicator 1	1	316	CHAR	9 = ICD-9. 0 = ICD-10.
31	Claim Diagnosis Code 1	7	317-323	CHAR	
32	Diagnosis Indicator 2	1	324	CHAR	9 = ICD-9. 0 = ICD-10.
33	Claim Diagnosis Code 2	7	325-331	CHAR	
34	Diagnosis Indicator 3	1	332	CHAR	9 = ICD-9. 0 = ICD-10.
35	Claim Diagnosis Code 3	7	333-339	CHAR	
36	Diagnosis Indicator 4	1	340	CHAR	9 = ICD-9. 0 = ICD-10.
37	Claim Diagnosis Code 4	7	341-347	CHAR	
38	Diagnosis Indicator 5	1	348	CHAR	9 = ICD-9. 0 = ICD-10.
39	Claim Diagnosis Code 5	7	349-355	CHAR	
40	Diagnosis Indicator 6	1	356	CHAR	9 = ICD-9. 0 = ICD-10.
41	Claim Diagnosis Code 6	7	357-363	CHAR	
42	Diagnosis Indicator 7	1	364	CHAR	9 = ICD-9. 0 = ICD-10.
43	Claim Diagnosis Code 7	7	365-371	CHAR	

COB OHI Supplemental Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
44	Diagnosis Indicator 8	1	372	CHAR	9 = ICD-9. 0 = ICD-10.
45	Claim Diagnosis Code 8	7	373-379	CHAR	
46	Diagnosis Indicator 9	1	380	CHAR	9 = ICD-9. 0 = ICD-10.
47	Claim Diagnosis Code 9	7	381-387	CHAR	
48	Diagnosis Indicator 10	1	388	CHAR	9 = ICD-9. 0 = ICD-10.
49	Claim Diagnosis Code 10	7	389-395	CHAR	
50	Diagnosis Indicator 11	1	396	CHAR	9 = ICD-9. 0 = ICD-10.
51	Claim Diagnosis Code 11	7	397-403	CHAR	
52	Diagnosis Indicator 12	1	404	CHAR	9 = ICD-9. 0 = ICD-10.
53	Claim Diagnosis Code 12	7	405-411	CHAR	
54	Diagnosis Indicator 13	1	412	CHAR	9 = ICD-9. 0 = ICD-10.
55	Claim Diagnosis Code 13	7	413-419	CHAR	
56	Diagnosis Indicator 14	1	420	CHAR	9 = ICD-9. 0 = ICD-10.
57	Claim Diagnosis Code 14	7	421-427	CHAR	
58	Diagnosis Indicator 15	1	428	CHAR	9 = ICD-9. 0 = ICD-10.
59	Claim Diagnosis Code 15	7	429-435	CHAR	
60	Diagnosis Indicator 16	1	436	CHAR	9 = ICD-9. 0 = ICD-10.
61	Claim Diagnosis Code 16	7	437-443	CHAR	
62	Diagnosis Indicator 17	1	444	CHAR	9 = ICD-9. 0 = ICD-10.
63	Claim Diagnosis Code 17	7	445-451	CHAR	
64	Diagnosis Indicator 18	1	452	CHAR	9 = ICD-9. 0 = ICD-10.
65	Claim Diagnosis Code 18	7	453-459	CHAR	
66	Diagnosis Indicator 19	1	460	CHAR	9 = ICD-9. 0 = ICD-10.
67	Claim Diagnosis Code 19	7	461-467	CHAR	
68	Diagnosis Indicator 20	1	468	CHAR	9 = ICD-9. 0 = ICD-10.
69	Claim Diagnosis Code 20	7	469-475	CHAR	
70	Diagnosis Indicator 21	1	476	CHAR	9 = ICD-9. 0 = ICD-10.

COB OHI Supplemental Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values/Description**
71	Claim Diagnosis Code 21	7	477-483	CHAR	
72	Diagnosis Indicator 22	1	484	CHAR	9 = ICD-9. 0 = ICD-10.
73	Claim Diagnosis Code 22	7	485-491	CHAR	
74	Diagnosis Indicator 23	1	492	CHAR	9 = ICD-9. 0 = ICD-10.
75	Claim Diagnosis Code 23	7	493-499	CHAR	
76	Diagnosis Indicator 24	1	500	CHAR	9 = ICD-9. 0 = ICD-10.
77	Claim Diagnosis Code 24	7	501-507	CHAR	
78	Diagnosis Indicator 25	1	508	CHAR	9 = ICD-9. 0 = ICD-10.
79	Claim Diagnosis Code 25	7	509-515	CHAR	
80	Effective Date of Other Drug Coverage	8	516-523	CHAR	This is the actual effective date of other drug insurance coverage provided by the other insurance. This date should be used for coordination of benefits. The Part D Sponsor should compare DOS to both the Part D effective period and the other coverage effective period to determine if coordination of benefits is necessary. CCYYMMDD
81	Filler	577	524-1100	CHAR	Spaces

*Indicates that these fields have same position in PRM and SUP record layout.

3.7.5 Payer Order Rules

The order of payment for primary insurance, the Part D Plan displays this in reply to the pharmacy in order of Payment Order Indicator. The lowest number in ascending order, i.e., 001 to 400, is the first primary insurance displayed in the reply to the pharmacy. OHI with a payment order less than 401 is displayed prior, i.e., primary to, the Part D Plan. The rules that the BCRC uses to assign the Payer Order are in the table below.

Table 3-14: Payment Order Rules

Payment Order Rules				
Payment Order Range	**Payment Type**	**MSP Reason**	**Supplemental Insurance Type**	**Coverage (to Medicare)**
001 – 100	GHP w/ Patient Relationship= 1	A, B, G		Primary
101 – 200	GHP w/ Patient Relationship >= 2	A, B, G		Primary
201 – 300	Non-GHP	C, D, E, F, H, I, L, W		Primary
301 – 400	For Future Use			N/A
401 – 500	Secondary Insurer w/ Person Code = 1		L, M, O,	Secondary
501 – 600	Secondary Insurer w/ Person Code>= 2		L, M, O	Secondary
601 – 700	Federal Government Programs		T, 2	Secondary
701 – 750	Patient Association Programs (PAPs), Charities (Note: COB SUP PAP and Charity records created prior to 01/01/2016 had a payer order range of 701-800)		N, P, R,	Secondary
751 - 800	SPAPs (Note: COB SUP SPAP records created prior to 01/01/2016 had a payer order range of 801-900)		Q	Secondary
801 – 900	Medicaid (Note: COB SUP Medicaid records created prior to 01/01/2016 had a payer order range of 901-999)		1	Secondary
901 – 999	AIDS Drug Assistance Programs (ADAPs) (Note: COB SUP ADAP records created prior to 01/01/2016 had a payer order range of 701-800)		S	Secondary

1. 'Payment Order Indicator' indicates payment ordering; the lowest number in ascending order, 001 to 999, is the first coverage billed at the pharmacy.
2. All drug coverage with a payment order less than 401 is billed using the COB-OHI PRM record prior, or primary to, the Part D Plan; all drug coverage with a payment order greater than or equal to 401 is billed using the COB-OHI SUP record after, or secondary to, the Part D Plan.
3. EGHPs include MSP Types A (Working Aged), B (End Stage Renal Disease [ESRD]) and G (Disabled). These are applied payment orders in the 001 to 200 range.
4. Non-EGHPs include MSP Types D (Automobile Insurance, No Fault), E (WC), L (Liability) and H (Black Lung); these applied payment orders are in the 201 to 300 range.
5. For two GHPs with a Patient Relationship Code of 1, the GHP with the earlier effective date is before the GHP with the later effective date.
6. For two GHPs with Patient Relationship Code of 1, with the same effective date, the GHP with the first accretion date is before the later accretion date.

7. For two GHPs with Patient Relationship Code of 2 or more, the GHP with the earlier effective date is before the GHP with the later effective date.
8. For two GHPs with Patient Relationship Code of 2 or more, and with the same effective date, the GHP with the first accretion date is before the later accretion date.
9. For two insurers with Person Code of 1, the insurer with the first accretion date is before the later accretion date.
10. For two insurers with Person Code of 2 or more, the insurer with the first accretion date is before the later accretion date.
11. If the record represents a supplemental insurer, the Insurance Type code determines the order. Within the Supplemental Types, those for Federal Government Programs take precedence over the PAPs and Charities, which take precedence over the State Pharmaceutical Assistance Programs, which take precedence over Medicaid and ADAPs.
12. ESRD: A beneficiary receives the ESRD status when a physician prescribes a regular course of dialysis because the member reaches that stage of renal impairment that a kidney transplant or a regular course of dialysis is necessary to maintain life. Medicare pays the Plan at the higher ESRD rate for that beneficiary, unless the beneficiary elects hospice care.

3.7.6 *Benefits Coordination & Recovery Center (BCRC) Points of Contact*

Table 3-15: BCRC Points of Contact

BCRC Points of Contact	
Topic	**Point Of Contact Information**
BCRC Contractor	1-800-999-1118
BCRC Contractor Electronic Data Interchange Department	1-646-458-6740
BCRC Help Desk	1-212-615-4357

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4 Low Income Subsidy (LIS) Status

To establish the correct premium, cost sharing, and deductible levels with the correct effective dates for current, prior, and prospective enrollees, Part D sponsors should refer to the Daily Transaction Reply Report (DTRR).

As discussed in Section 1 of the memorandum, the DTRRs provide full replacement LIS profiles to Plans in response to Part D enrollments and Plan Benefit Package (PBP) changes as well as any LIS change that impacts a Part D enrollment period. Therefore, the DTRR is the definitive source of LIS eligibility information. It is important to note that these changes represent a shift in reporting methodology. Unlike much of the data provided in the DTRR, LIS eligibility information is not based on Current Calendar Month (CCM) reporting.

4.1 Key Changes in LIS Data Reporting

- LIS TRCs independently accompany enrollment and PBP change transaction responses.
- Plans receive full replacement LIS profiles in response to low-income changes that accumulate over the weekly and monthly reporting cycles. Replacement profiles are established using data known to CMS at the end of each reporting cycle. Reported data spans a PBP enrollment.
- TRC 223 now identifies LIS periods that were removed from and are no longer affecting an enrollment.
- An ensemble composed of one or more of the TRCs 121, 194, and 223 represents full replacement LIS profiles. Each profile returns LIS period start and end dates, premium subsidy percentage, co-payment level, enrollee type flag, and LIS source code. Low-Income Premium Subsidy (LIPS) percentage and co-payment level values retain their current definitions. The enrollee type flag identifies a beneficiary as a prior, current, or prospective enrollee. The source code identifies whether the LIS period is the result of CMS deeming or Social Security Administration (SSA) approval.

4.2 Low Income Subsidy Overview

Beneficiaries who receive Medicaid benefits or Supplemental Security Income automatically qualify for the Low Income Subsidy. Other low income beneficiaries can apply for the subsidy through their State's Medicaid program or by application through the Social Security Administration (SSA). Plans should see CMS Guidance for details on the requirements to qualify for LIS.

Beneficiaries are classified as 'Deemed' (those who automatically qualify for LIS) or 'Applicant'. The data associated with a Deemed beneficiary vs. an Applicant beneficiary have different characteristics. States and SSA provide CMS with the information used to categorize the LIS beneficiaries.

4.2.1 *Deemed Beneficiaries*

Deemed beneficiaries include:

- Medicare beneficiaries who have both Medicare and full Medicaid benefits (Full-benefit Dual Eligibles – FBDEs).
- Beneficiaries who receive Supplemental Security Income (SSI) from SSA (even if they do not qualify for their State's Medicaid).
- Beneficiaries who participate in the Medicare Saving Programs (MSP). These include:
    - Qualified Medicare Beneficiaries (QMB).
    - Specified Low Income Medicare Beneficiary (SLMB).
    - Qualified Individuals (QI).

As information is received from States or SSA, CMS deems qualified beneficiaries as often as daily. Deemed periods have the following characteristics:

- Beneficiaries who are deemed based on Medicaid status from the States are deemed for the balance of the calendar year. For example, a beneficiary whose record from the State has an Eligibility Month of January is deemed effective January 1 through the end of the calendar year. A beneficiary whose record has an Eligibility Month of July through December is deemed for the balance of the calendar year and all of the next calendar year. For example, a beneficiary whose State record has an Eligibility Month/Year of July 2016 is deemed from July 2016 through December 2017.
- Beneficiaries are usually deemed retroactively. A new Deemed period may have a begin date that is several years retroactive.
- Deemed LIS periods always have end dates. A new deemed period is assigned an end date of the last day of the year. They are not open-ended.
- Deemed beneficiaries qualify for 100% LIS Premium Subsidy Level, which determines the portion of their premium that is subsidized.
- Deemed beneficiaries are assigned to one of three Copay Categories, which specifies the beneficiary's copay amount at the pharmacy.
- States submit all beneficiaries with Medicaid to CMS each month, so a beneficiary will be included in each month's state file as long as they have Medicaid. Because a beneficiary is deemed through the end of the year, the deemed period may extend beyond the state-reported Medicaid months.

- Beneficiaries may be reported on more than one State's Medicaid file in a given month.
- SSA submits records weekly for beneficiaries who have begun receiving Supplemental Security Income (SSI) benefits. The SSI record from SSA has a start date and an end date within the same calendar year.

4.2.2 Redeeming

CMS reviews and redeems all currently deemed beneficiaries each year in July and August. The Redeeming Process consists of the following activities:

- Qualifying beneficiaries are redeemed for the next year.
- A beneficiary's co-pay level is determined for the next year.
- During the first week in August, SSA submits a file with records for all beneficiaries currently receiving SSI benefits. These records have a start date of January with an end date of December of the next year.
- Communications to beneficiaries inform them if they are deemed for the New Year, along with the new subsidy and co-pay level. The deeming process does not notify beneficiaries if deemed for next year. The process only notifies beneficiaries who have lost deeming for next year.

4.2.3 SSA LIS Applicants

Beneficiaries who do not meet the qualifications to be deemed may apply for LIS through the SSA or their State. These beneficiaries may be granted LIS at several subsidy levels.

- LIS Premium Subsidy Level identifies what percentage of the beneficiary's premium will be subsidized.
    - No subsidy.
    - 25%.
    - 50%.
    - 75%.
    - 100%.
- Copay Category indicates the amount a beneficiary will pay for their prescriptions at the pharmacy.
    - 1 = High.
    - 2 = Low.
    - 3 = Zero copay.
    - 4 = 15%.

SSA notifies CMS of changes to an applicant's LIS status.

Applicant LIS periods have the following characteristics:

- The applicant LIS period has a begin date but is often open-ended.
- End dates are not originally assigned to applicant periods. They are assigned when SSA changes, terminates, or cancels the LIS award.
- Applicant LIS periods can cross calendar year boundaries.
- An applicant's LIS status can increase, decrease, or terminate at any point during the year.
- If a beneficiary becomes deemed, the applicant LIS period ends or is cancelled.

4.2.4 *SSA Re-Determination*

Each year SSA reviews beneficiary LIS eligibility:

- SSA selects the beneficiaries for review. Not all beneficiaries are reviewed each year.
- Selected beneficiaries provide requested information to SSA.
- Beneficiaries are notified of any change in or termination of their LIS status.
- Beneficiaries not reviewed have no change in their status.

4.3 Auto Enrollment and Facilitated Enrollment

CMS ensures that all LIS beneficiaries, deemed or applicant, are enrolled in a Prescription Drug Plan (PDP) unless they have current prescription drug coverage or they opt-out of such enrollment. Specific Opt Out transactions (TC 41 or 83) communicates to CMS that the beneficiary is opting out of Part D enrollment. These transactions are submitted by a Plan or by 1-800-Medicare.

Deemed beneficiaries who are not already enrolled in a Part D Plan are auto-enrolled into the Limited Income Newly Eligible Transition (LINET) Plan and subsequently, within 3 months, prospectively enrolled into an eligible PDP. Applicants are prospectively enrolled into an eligible PDP through Facilitated Enrollment.

The prospective Auto and Facilitated enrollments are only into PDPs with premium amount at or below the LIS premium subsidy amount.

For general CMS guidance on the auto/facilitated enrollment process for PDPs, see Section 40.1.4 of the *PDP Eligibility, Enrollment, and Disenrollment Guidance* at the following link: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/index.html. In the Download section, click on the *PDP_Enrollment_and_Disenrollment_Guidance* document.

For general CMS guidance on auto/facilitated enrollment in MA/cost plans, see Section 40.1.5 of Chapter 2 of the *Medicare Managed Care Manual* at the following link: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html. In the Download section, click on the *MA_Enrollment_and_Disenrollment_Guidance* document.

4.3.1 *Auto Enrollment*

Auto enrollments have the following characteristics:

- Only deemed beneficiaries who do not have current Part D coverage are auto enrolled.
- The initial enrollment is into the LINET Plan, a Plan that accepts all new retroactive auto enrollments that are submitted during a calendar year, as well as enrollments through a pharmacy. A new LINET Plan may be designated each year.
- The effective date of LINET auto enrollments is retroactive to the start of full dual status. This may be up to several years retroactive.
- Partial Duals and LIS Applicants are not automatically enrolled into the LINET Plan.
- Beneficiaries in the LINET Plan are then auto enrolled into a qualifying PDP with a prospective effective date.
- Auto enrollment is done daily.

4.3.2 Facilitated Enrollment

Facilitated enrollments have the following characteristics:

- Beneficiaries who qualify for LIS but are not deemed are enrolled into qualifying PDPs via Facilitated Enrollment.
- The Facilitated Enrollment has a prospective effective date. This is usually the first day of the second month after CMS identifies the beneficiary as an LIS beneficiary.

4.3.3 Auto Enrollment and Facilitated Enrollment in MARx

When a beneficiary is enrolled in the LINET Plan or a PDP through auto enrollment or facilitated enrollment, an enrollment transaction (TC 61) is generated to be processed by MARx. Once accepted, the Plan receives the Transaction Reply in the DTRR data file:

- TRC 117 – FBD Auto Enrollment Accepted.
- TRC 118 – LIS Facilitated Enrollment Accepted.

4.3.4 Reassignments

At the end of the year, PDPs may also see enrollments that are the result of reassignments. If a beneficiary's enrollment in a Plan was through auto or facilitated enrollment and the premiums of the Plan will become higher than the regional benchmark for the coming year, CMS reassigns the beneficiary to a PDP that has a premium within the benchmark. Beneficiaries who chose their own Plan are not reassigned.

Reassignment is also done for Low Income beneficiaries who are enrolled in a PDP that is terminating or reducing its service area.

4.4 LIS Information in Data Files

Some Medicare beneficiaries are granted LIS to enable them to afford the premiums, deductibles, and copays associated with enrollment in a Medicare Prescription Drug Plan. MARx provides the Plans with data related to these beneficiaries and their subsidies. This section gives an overview of the data files that include information on beneficiary LIS Status.

- **Daily Transaction Reply Report (DTRR),** provides full replacement LIS profiles to Plans in response to Part D enrollments and Plan Benefit Package (PBP) changes as well as any LIS change that impacts a Part D enrollment period.
- **Beneficiary Eligibility Query (BEQ) Response File,** is provided in response to a Plan-submitted Beneficiary Eligibility Request. It provides beneficiary eligibility status including LIS periods and subsidy levels.
- **LIS/Part D Premium File,** provides beneficiaries from the premium profile table with a low-income designation. It is provided on a bi-weekly basis and is the reference file used to determine the LIS Match Rate.
- **LIS History File (LIS HIST)**, provides a comprehensive list of a sponsor's current LIS membership. The data on each beneficiary spans through the most recent 36 consecutive months of contract enrollment. This report also informs Plans whether a beneficiary is LIS in the next calendar year.
- **Loss of Subsidy File,** notifies Plans about the beneficiaries who will lose LIS Deemed status for the following year. It is provided based on CMS Redeeming activities.
- **Auto Assignment Address Notification File for AE-FE**, provides LIS information and immediate access to full name and address data for these beneficiaries.
- **MA Full Dual Auto Assignment Notification Data File**, identifies the MA enrollees who are full-benefit dual eligible and therefore eligible for Plan-submitted auto enrollment into one of the contract's Plans that include Part D.
- **Monthly Full Enrollment Data File,** provides the LIS details that are in effect for the coverage month.
- **Monthly Membership Report (MMR)**, provides a Part D Low Income Indicator and includes LIS values that were considered when calculating the Plan's payment.

4.4.1 LIS/Part D Premium File

The bi-weekly LIS/Part D Premium data file provides beneficiaries from the premium profile table with a low-income designation and is the reference file used to determine the LIS Match Rate.

System	Type	Frequency	File Length	LIS/Part D Premium Dataset Naming Conventions
MARx	Data File	Biweekly	278	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LISPRMD.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LISPRMD.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LISPRMD.Dyymmdd.Thhmmsst

Layout 4-1: LIS/Part D Premium File Record

LIS/Part D Premium Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary ID	12	1-12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end
2	Contract Number	5	13-17	Contract Identification Number.
3	PBP Number	3	18-20	Beneficiary's PBP ID, spaces if none.
4	Segment Number	3	21-23	Beneficiary's Segment Identification Number, spaces if none.
5	Run Date	8	24-31	Data File Generation Date. CCYYMMDD.
6	Subsidy Start Date	8	32-39	Beneficiary's Subsidy Start Date. CCYYMMDD.
7	Subsidy End Date	8	40-47	Beneficiary's Subsidy End Date. CCYYMMDD.
8	Part D Premium Subsidy Percentage	3	48-50	Beneficiary's LIPS Percent: 100 = 100% Premium Subsidy. 075 = 75% Premium Subsidy. 050 = 50% Premium Subsidy. 025 = 25% Premium Subsidy.
9	Low-Income Co-Payment Level ID	1	51	Co-Payment Category Definitions: 1=High. 2=Low. 3=$0. 4=15%.
10	Beneficiary Enrollment Effective Date	8	52-59	Beneficiary's Enrollment effective date. CCYYMMDD.
11	Beneficiary Enrollment End Date	8	60-67	Beneficiary's Enrollment End Date. CCYYMMDD, spaces if none.

LIS/Part D Premium Record				
Item	**Field**	**Size**	**Position**	**Description**
12	Part C Premium Amount	8	68-75	Beneficiary's Part C Premium Amount. (----9.99).
13	Part D Premium Amount	8	76-83	Beneficiary's Part D Premium Amount Net of De Minimis if applicable, (----9.99).
14	Part D Late Enrollment Penalty Amount	8	84-91	Beneficiary's Part D LEP Amount. (—9.99).
15	LIS Subsidy Amount	8	92-99	Beneficiary's LIS Subsidy Amount. (----9.99).
16	LIS Penalty Subsidy Amount	8	100-107	Beneficiary's LIS Penalty Subsidy Amount, (----9.99).
17	Part D Penalty Waived Amount	8	108-115	Beneficiary's Part D Penalty Waived Amount, (----9.99).
18	Total Premium Amount	8	116-123	Total Calculated Premium for Beneficiary (----9.99).
19	De Minimis Differential Amount	8	124-131	Amount by which a Part D De Minimis Plan's beneficiary premium exceeds the applicable regional low-income premium subsidy benchmark.
20	Filler	147	132- 278	Spaces.

4.4.2 LIS History (LISHIST) File

The monthly LISHIST provides the most complete picture of LIS eligibility over a period not to exceed 36 months. This data file includes LIS activity for past, present, and future enrollees.

System	Type	Frequency	File Length	LISHIST Dataset Naming Conventions
MARx	Data File	Monthly	165	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LISHIST.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LISHIST.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LISHIST.Dyymmdd.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the CCM.

The following records are included in this file:

- **LISHIST Header Record**
- **LISHIST Detail Record**
- **LISHIST Trailer Record**

Layout 4-2: LISHIST Header Record

LISHIST Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type	1	1	CHAR	H = Header Record.
2	MCO Contract Number	5	2-6	CHAR	Contract ID: 9xxxx, Exxxx, Fxxxx, Hxxxx, Rxxxx, or Sxxxx, where "xxxx" is the contract's numeric designation.
3	Data file Date	8	7-14	CHAR	Date this data file created. CCYYMMDD.
4	Calendar Month	6	15-20	CHAR	First six digits contain calendar year and month the report generated. CCYYMM.
5	Filler	145	21-165	CHAR	Spaces.

Layout 4-3: LISHIST Detail Record

LISHIST Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type	1	1	CHAR	D = Detail Record.
2	MCO Contract Number	5	2-6	CHAR	Contract ID: 9xxxx, Exxxx, Fxxxx, Hxxxx, Rxxxx, or Sxxxx, where "xxxx" is the contract's numeric designation.
3	PBP Number	3	7-9	CHAR	PBP Number, spaces when Beneficiary premium profile is unavailable.

LISHIST Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
4	Beneficiary ID	12	10-21	CHAR	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
5	Surname	12	22-33	CHAR	Beneficiary's Surname.
6	First Name	7	34-40	CHAR	Beneficiary's First Initial.
7	Middle Initial	1	41	CHAR	Beneficiary's Middle Initial.
8	Sex	1	42	CHAR	M = Male. F = Female.
9	Date of Birth	8	43-50	CHAR	Date of Birth. CCYYMMDD
10	Low Income Period Start Date	8	51-58	CHAR	Start date for beneficiary's Low Income Period Amount. CCYYMMDD
11	Low Income Period End Date	8	59-66	CHAR	End date for beneficiary's Low Income Period Amount. CCYYMMDD
12	LIPS Percentage	3	67-69	CHAR	Beneficiary's LIPS Percentage. 100 = 100% Premium subsidy. 075 = 75% Premium subsidy. 050 = 50% Premium subsidy. 025 = 25% Premium subsidy.
13	Premium LIS Amount	8	70-77	CHAR	The portion of the Part D basic premium paid by the Government on behalf of a low-income individual. A zero dollar amount represents several possibilities: • There is no Plan premium and therefore no premium subsidy. • Although the Beneficiary is enrolled and LIS eligible, a system error occurred making premium data unavailable. Premium LIS Amount is entered in spaces when data is unavailable. 99999.99
14	Low Income Co-pay Level ID	1	78	CHAR	Co-Payment Category Definitions: 1 = High. 2 = Low. 3 = $0. 4 = 15%. Co-pay level IDs 1 and 2 change each year.
15	Beneficiary Source of Subsidy Code	1	79	CHAR	Source of beneficiary subsidy. A = Determined Eligible for LIS by the SSA or a State Medicaid Agency. D = Deemed Eligible for LIS.

LISHIST Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
16	LIS Activity Flag	1	80	CHAR	N = No change in reported LIS data since last month's data file. Y = One of the following may have changed since the last month's data file: • Co-payment level • Low-income premium subsidy level • Low-income period start or end date Changes occur to low-income information that does not impact the Plan. The changes are not yet separable from variations in which the Plan is interested. Although it is possible that data records are flagged as representing a change, the data of interest to the Plan is unaffected.
17	PBP Start Date	8	81-88	CHAR	PBP enrollment effective start date. CCYYMMDD
18	Net Part D Premium Amount	8	89-96	CHAR	The total Part D premium net of any Part A/B rebates less the Beneficiary's premium subsidy amount. Spaces when the premium record is unavailable. 99999.99
19	Contract Year	4	97-100	CHAR	Calendar Year associated with the low income premium subsidy amount. CCYY
20	Institutional Status Indicator	1	101	CHAR	1 = Institutionalized. 2 = Non-Institutionalized. 3 = Home and Community- Based Services (HCBS). 9 = Not applicable.
21	PBP Enrollment Termination Date	8	102-109	CHAR	PBP enrollment termination date. CCYYMMDD
22	Filler	56	110-165	CHAR	Spaces.

Layout 4-4: LISHIST Trailer Record

LISHIST Trailer Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type	1	1	CHAR	T = Trailer Record.
2	MCO Contract Number	5	2-6	CHAR	Contract ID: 9xxxx, Exxxx, Fxxxx, Hxxxx, Rxxxx, or Sxxxx, where "xxxx" is the contract's numeric designation.
3	Totals	8	7-14	CHAR	Total number of Detail Records.
4	Filler	151	15-165	CHAR	Spaces.

4.4.3 *Loss of Subsidy File*

This is a file sent to notify Plans about Beneficiaries' loss of LIS deemed status for the following calendar year based on CMS' annual re-determination of deemed status or SSA's re-determination of LIS awards. The file is sent to Plans twice per year, once in September and once in December.

The September file is informational only and is used to assist Plans in contacting the affected population and encouraging them to file an application to qualify for the upcoming calendar year.

The December file is for transactions and is used by Plans to determine who has lost the LIS as of January 1st of the coming year. The TRC is 996, which indicates the loss of the LIS. This means the Beneficiary is not LIS eligible as of January 1st of the upcoming year.

System	Type	Frequency	File Length	Loss of Subsidy Dataset Naming Conventions
MARx	Data File	Twice Yearly	500	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst

Layout 4-5: Loss of Subsidy Record

Loss of Subsidy Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary ID	12	1-12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
2	Surname	12	13-24	Beneficiary Surname.
3	First Name	7	25-31	Beneficiary Given Name.
4	Middle Initial	1	32	Beneficiary Middle Initial.
5	Gender Code	1	33	Beneficiary Gender Identification Code. 0 = Unknown. 1 = Male. 2 = Female.
6	Date of Birth	8	34-41	CCYYMMDD.
7	Filler	1	42	Spaces.
8	Contract Number	5	43-47	Plan Contract Number.
9	State Code	2	48-49	Beneficiary State Code.
10	County Code	3	50-52	Beneficiary County Code.
11	Filler	4	53-56	Spaces.
12	TRC	3	57-59	996
13	Transaction Code	2	60-61	01
14	Filler	1	62	Spaces.
15	Effective Date	8	63-70	CCYY0101 – January 01 of the next year. Start of Beneficiary's Loss of LIS status.
16	Filler	1	71	Spaces.
17	Plan Benefit Package ID	3	72-74	PBP number.
18	Filler	1	75	Spaces.
19	Transaction Date	8	76-83	Set to Current Date (CCYYMMDD); run date.
20	Filler	1	84	Spaces.
21	Low-Income Subsidy End Date	8	85-92	CCYY1231 – December 31 of the current year. End Date of Beneficiary's LIS Period.
22	Filler	42	93-134	Spaces.
23	Segment Number	3	135-137	000 if no segment in PBP.
24	Filler	97	138-234	Spaces.
25	Part D Low-Income Premium Subsidy Level	3	235-237	Part D low-income premium subsidy category. 000 = No subsidy.
26	Low-Income Co-Pay Category	1	238	Co-payment category. 0 = none, not low-income.
27	Filler	124	239-362	Spaces.
28	LIS Source Code	1	363	A = Approved SSA Applicant. D = Deemed eligible by CMS.
29	Filler	137	364-500	Spaces.

4.4.4 Auto Assignment Address Notification File for AE-FE

CMS enrolls LIS beneficiaries into Drug Plans through AE-FE. The Auto Assignment Address Notification File (aka, PDP Notification File) provides LIS information and immediate access to full name and address data for these beneficiaries. Each October, it also provides information on individuals gained and lost due to reassignment. 1-800-MEDICARE Customer Service Representatives (CSRs) should have access to the data on this file so they can answer beneficiary queries prior to the PDP auto/facilitated enrollments. Also, this file assists Plans in expediting the submission of the 4Rx records for these beneficiaries.

Because CMS performs AE on a daily basis, PDPs may receive this file daily throughout the month. This file only contains assignments, not confirmation that MARx processed AE-FE transactions for beneficiaries. Plans must still check DTRRs to determine whether the assignments were accepted or rejected as actual enrollments into their PDP.

These reports offer two ways for Plans to differentiate between the full and partial dual eligible beneficiaries assigned to them:

1. The Auto Assignment Address Notification file and the DTRR:
    a. Enrollment Source = **A** for Auto-enrollment.
    b. Enrollment Source = **C** for Facilitated enrollment.
2. The DTRR Transaction Reply Code:
    a. TRC 117 = Auto-enrollment.
    b. TRC 118 = Facilitated enrollment.

This file contains monthly addresses of Beneficiaries that are either AE, FE, or reassigned to PDPs.

System	Type	Frequency	File Length	Auto Assignment Address Notification File Dataset Naming Conventions
MBD	Data File	Daily	626	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#APDP4.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#APDP4.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#APDP4.Dyymmdd.Thhmmsst

The following records are included in this file:

- **Auto Assignment Address Notification Header Record**
- **Auto Assignment Address Notification Detail Record**
- **Auto Assignment Address Notification Trailer Record**

The full address, including city/state/zip code, is "wrapped" in the fields "Beneficiary Address Line 1" through "Beneficiary Address Line 6," with the result that street address, city, and state may appear on different lines for different beneficiaries. Different parts of the address appear only on certain lines, as follows:

- Beneficiary Address Lines 1-6 is limited to Representative Payee Name (if applicable), and street address, and these elements "wrap."

- When a Beneficiary has a Representative Payee, the Beneficiary Representative Payee Name prints on Address Line 1, and may use more Address Lines.
- The actual street address in such cases is printed on the line after the name concludes.
- Address Lines print on fewer than six lines with the remainder of the lines padded with space prior to printing.
- City/State/Zip Code data only appear in the fields labeled as City/State/Zip Code data fields.

Layout 4-6: Auto Assignment Address Notification Header Record

Auto Assignment Address Notification Header Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Header Code	9	1-9	MMAAPDPGH Used for file/record identification purposes.
2	Sending Entity	8	10-17	Identifies the sending entity, ‘MBD ‘(MBD + 5 spaces).
3	File Creation Date	8	18-25	The date the file was created in CCYYMMDD format.
4	File Control Number	9	26-34	Unique file identifier created by Sending Entity.
5	Filler	592	35-626	Spaces.

Layout 4-7: Auto Assignment Address Notification Detail Record

Auto Assignment Address Notification Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary HICN or RRB Number	12	1-12	The identifier issued under the SSA or RRB program that is used to uniquely identify the Medicare beneficiary. Based on the following phases of the MBI transition, the value will be populated accordingly. • Before or during the MBI Transition period, the field will contain the RRB if it exists in the beneficiary’s Medicare record; else it will contain the active HICN. • When the MBI Transition period ends, the field will contain spaces.
2	Beneficiary’s Last Name	12	13-24	First twelve characters of the last name of the beneficiary.
3	Beneficiary’s First name	7	25-31	First seven characters of the first name of the beneficiary.
4	Beneficiary’s Middle Initial	1	32	Middle initial of the beneficiary.
5	Beneficiary’s Gender	1	33	Gender of the beneficiary; ‘0’, ‘1’, or ‘2’.
6	Beneficiary’s DOB	8	34-41	Date of birth of the beneficiary in CCYYMMDD format.

Auto Assignment Address Notification Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
7	Medicaid Indicator	1	42	Indicates the beneficiary's Medicaid eligibility. 1 = Yes.
8	Contract Number	5	43-47	Contract assigned to the beneficiary.
9	State Code	2	48-49	Beneficiary's state of residency.
10	County Code	3	50-52	Beneficiary's county of residency.
11	Filler	7	53-59	Spaces.
12	Transaction Code	2	60-61	61
13	Filler	1	62	Spaces.
14	Effective Date	8	63-70	The effective date of the assignment in CCYYMMDD format.
15	Filler	1	71	Spaces.
16	PBP	3	72-74	PBP of the auto-assigned contract.
17	Filler	49	75-123	Spaces.
18	Application Date	8	124-131	The date of the application in CCYYMMDD format.
19	Filler	30	132-161	Spaces.
20	Election Type	1	162	Type of election. A = AEP. C = Plan-submitted Rollover SEP. D = MADP. E = IEP. F = IEP2. I = ICEP. N = OEPNEW. O = OEP. R = 5 Star SEP. S = Other SEP. T = OEPI. U = Dual/LIS SEP. V = Permanent Change in Residence SEP. W = EGHP SEP. X = Administrative Action SEP. Y = CMS/Case Work SEP. Space = not applicable.
21	Enrollment Source	1	163	Source of the enrollment A = Auto enrolled by CMS. C = Facilitated enrolled by CMS.
22	Filler	1	164	Spaces.
23	PPO/Parts C-D	1	165	Payment option for payment of Part C and D premiums. D = Direct self-pay
24	Filler	77	166-242	Spaces.

Auto Assignment Address Notification Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
25	Part D Subsidy Level	3	243-245	Part D Premium subsidy Level. For monthly, value is always 100. For Facilitated, values are either 100, 075, 050, or 025. 025 = 25% subsidy level. 050 = 50% subsidy level. 075 = 75% subsidy level. 100 = 100% subsidy level.
26	Co-Payment Category	1	246	Co-Payment Category. 1=High. 4=15%.
27	Filler	8	247-254	Spaces
28	Beneficiary Address Line 1	40	255-294	First line in the mailing address.
29	Beneficiary Address Line 2	40	295-334	Second line in the mailing address.
30	Beneficiary Address Line 3	40	335-374	Third line in the mailing address.
31	Beneficiary Address Line 4	40	375-414	Fourth line in the mailing address.
32	Beneficiary Address Line 5	40	415-454	Fifth line in the mailing address.
33	Beneficiary Address Line 6	40	455-494	Sixth line in the mailing address.
34	Beneficiary Address City	40	495-534	The city in the mailing address.
35	Beneficiary Address State	2	535-536	The state in the mailing address.
36	Beneficiary Zip Code	9	537-545	The zip code in the mailing address.
37	Full Last Name	40	546-585	Full last name of the beneficiary.
38	Full First Name	30	586-615	Full first name of the beneficiary.
39	MBI	11	616-626	The MBI from the beneficiary's active Beneficiary MBI period. The value is a system-generated identifier used internally and externally to uniquely identify the beneficiary in the Medicare database

Layout 4-8: Auto Assignment Address Notification Trailer Record

Auto Assignment Address Notification Trailer Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Trailer Code	9	1-9	MMAAPDPGT This field used for file/record identification purposes.
2	Sending Entity	8	10-17	This field used to identify the sending entity, 'MBD' (MBD + 5 spaces).
3	File Creation Date	8	18-25	The date the file was created in CCYYMMDD format.
4	File Control Number	9	26-34	Unique file identifier created by Sending Entity.
5	Record Count	9	35-43	Number of Detail Records, right justified with leading zeroes.
6	Filler	583	44-626	Spaces.

4.4.5 MA Full Dual Auto Assignment Notification File

CMS has directed the following organizations to auto/facilitate enroll (AE-FE) LIS beneficiaries from their MA-only Plan into a MAPD Plan or Cost Plan Part D optional supplemental benefit:

- MA organizations that offer MA-only Plans.
- MA PFFS organizations that offer at least one Plan with a Part D benefit.
- 1876 Cost Plans that offer at least one Plan with a Part D optional supplemental benefit.

The organization must first identify LIS beneficiaries in its MA-only Plan or Cost Plan without Part D, e.g., those beneficiaries identified on the LIS bi-weekly report. The organization must then determine the full-dual eligible subsets, which is accomplished by reviewing the monthly MA Full Dual Auto Assignment Notification File. The MA Full Dual Auto Assignment Notification File identifies those who held full-benefit dual eligibility at any time during the calendar year. The organization must distinguish between the two populations because the effective date is calculated differently for full dual eligible for whom the organization auto-enrolls versus partial dual eligible with LIS for whom the organization facilitates enrollment.

This cumulative monthly file identifies organizations' enrollees who are full-benefit dual eligible.

System	Type	Frequency	File Length	MA Full Dual Auto Assignment Notification File Dataset Naming Conventions
MBD	Data File	Monthly	100	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#ADUA4.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#ADUA4.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#ADUA4.Dyymmdd.Thhmmsst

The following records are included in this file:

- **MA Full Dual Auto Assignment Notification Header Record**
- **MA Full Dual Auto Assignment Notification Detail Record**
- **MA Full Dual Auto Assignment Notification Trailer Record**

Layout 4-9: MA Full Dual Auto Assignment Notification Header Record

MA Full Dual Auto Assignment Notification Header Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	File ID Name	8	1-8	CHAR	MMAADUAH	This field is always set to the value MMAADUAH. This code identifies the record as the Header Record of an Auto Assignment Full Dual Notification File.
2	Sending Entity: MBD	8	9-16	CHAR	"MBD " (MBD + 5 Spaces)	The value specifically is MBD + 5 following Spaces. This value agrees with the corresponding value in the Trailer Record.

MA Full Dual Auto Assignment Notification Header Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
3	File Creation Date	8	17-24	CHAR	CCYYMMDD	The date on which the Full Dual File was created by CMS. This value agrees with the corresponding value in the Trailer Record.
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity (MBD)	The specific Control Number assigned by CMS to the Full Dual Notification File. CMS utilizes this value to track the Full Dual Notification File through CMS processing and archive. This value agrees with the corresponding value in the Trailer Record.
5	Filler	67	34-100	CHAR	Spaces	

Layout 4-10: MA Full Dual Auto Assignment Notification Detail Record

MA Full Dual Auto Assignment Notification Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Contract Number	5	1-5	Contract assigned to the beneficiary.
2	Run Date	8	6-13	Creation date of the file in CCYYMMDD format.
3	Filler	6	14-19	Spaces
4	Beneficiary's HICN/RRB	12	20-31	• Before and during the Medicare Beneficiary Identifier (MBI) Transition period, the RRB Number is written if a value is present in the beneficiary's record; else, the HICN is written. • After the MBI Transition period ends, the field is filled with spaces.
5	Beneficiary's Surname	12	32-43	Last name of the beneficiary.
6	Initial of Beneficiary's First Name	1	44	Initial of the first name of the beneficiary.
7	Beneficiary's Gender	1	45	Gender of the beneficiary.
8	Beneficiary's Date of Birth	8	46-53	This field provides the date of birth of the beneficiary in CCYYMMDD format.
9	MBI	11	54-64	A system-generated identifier used by CMS to identify the beneficiary. The field will contain the active MBI from the beneficiary's Medicare record. Eventually, this identifier replaces the HICN and RRB Number.
10	Filler	36	65-100	Spaces

Layout 4-11: MA Full Dual Auto Assignment Notification Trailer Record

MA Full Dual Auto Assignment Notification Trailer Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Definition**
1	File ID Name	8	1- 8	CHAR	MMAADUAT	This code identifies the record as the Trailer Record of an Auto Assignment Full Dual Notification File.
2	Sending Entity MBD	8	9-16	CHAR	"MBD " (MBD + 5 Spaces).	The value specifically is MBD + 5 following Spaces. This value agrees with the corresponding value in the Header Record.
3	File Creation Date	8	17-24	CHAR	CCYYMMDD	The date on which the Full Dual Notification File was created by CMS.
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity (MBD).	The specific Control Number assigned by CMS to the Full Dual Notification File. CMS utilizes this value to track the Full Dual Notification File through CMS processing and archive. This value agrees with the corresponding value in the Header Record.
5	Record Count	9	34-42	NUM	Numeric value greater than Zero.	The total number of Transactions or Detail Records on the Full Dual Notification File. This value is right justified in the field, with leading zeroes.
6	Filler	58	43-100	CHAR	Spaces.	

4.5 LIS Transaction Reply Codes (TRCs)

Plans receive and process the DTRR data file daily. This file provides the responses to transactions submitted by the Plan, as well as replies that communicate CMS-initiated actions, auto disenrollments, health status changes, LIS status changes, and other beneficiary-specific information. In the DTRR, Plans receive timely notification of a beneficiary's current LIS status and any LIS status changes.

4.5.1 *LIS TRCs for New Enrollments and PBP Changes*

When MARx processes a new enrollment or a PBP change, an acceptance TRC is provided in the Plan's DTRR. If the beneficiary is Low Income, the acceptance TRC is accompanied by one or more replies that together provide the complete picture of the beneficiary's LIS status. In addition to the enrollment acceptance TRC, the Plan receives one TRC 121 (Low Income Period Status) for each LIS period that overlaps the enrollment. This set of LIS periods is a complete replacement for any previously communicated LIS status.

Each TRC 121 reply includes the following data for one LIS period:

- LIS Start Date.
- LIS End Date.
    - For periods when the beneficiary is Deemed, LIS End Date will always be populated. This date is always the last day of the year.
    - For periods when the beneficiary is an Applicant, LIS End Date may be blank or populated. Initial applicant periods are open-ended (no end date) but SSA may terminate the period at any time (end date populated).
- Beneficiary Source of Subsidy (Applicant or Deemed).
- Low Income Premium Subsidy Percentage (LIS %).
- Low Income Co-pay Level.
- Low Income Subsidy Amount.

4.5.2 *TRCs for LIS Changes*

When there is a change in the beneficiary's LIS Percentage, LIS Co-pay Level, LIS period start date, or LIS period end date, the Plan receives a new set of TRC 121. These represent the periods (new or updated) that overlap the beneficiary's enrollment in the Plan. TRC 223 (Low Income Period Removed) reports any period that was originally part of the beneficiary's LIS picture but is no longer valid. TRC 223 tells the plan definitively that for a specific period of time the period is not LIS, even though the period may have been valid before. This may represent the removal of an entire LIS period or an LIS period that is ended on an earlier date. The TRC 223 has two purposes:

- It prevents Plans from assuming that a previously reported LIS period (TRC 121) is still in effect when it has been removed. The Plan should not assume that the period was 'accidentally omitted' in the file.
- When a beneficiary had only one LIS period and it is removed, the beneficiary will no longer have any LIS periods. Without TRC 223, the Plan will not be aware that the beneficiary's LIS status changed.

4.5.3 Interpreting LIS TRCs

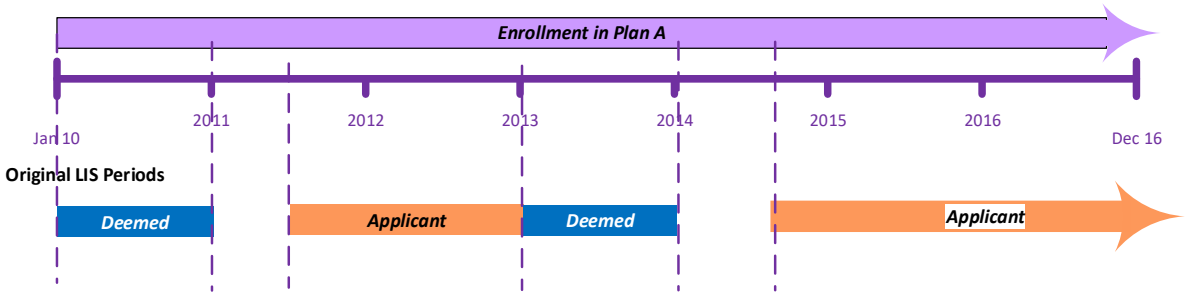
It is important to understand how TRC 121 and 223 may be encountered in a beneficiary's DTRR data. TRC 121 is straightforward. A reply with TRC 121 always represents a distinct LIS period. The Beneficiary Source of Subsidy field tells the Plan whether the beneficiary is Deemed or an Applicant for the period. The end date may be blank for open-ended Applicant periods but will always be populated with 12/31/CCYY for Deemed periods. An enrollment acceptance TRC for a beneficiary with LIS is only accompanied by TRC 121s, not TRC 223.

- TRC 223 is only present when MARx is reporting the full or partial removal of an LIS period.
- A reply with TRC 223 may or may not have an end date.

The following examples demonstrate different TRC 223 scenarios. The assumption for all examples is that the beneficiary is only enrolled under one plan for the entire time-period reported.

Example 1: TRCs with Enrollment Acceptance

- A retroactive enrollment with effective date of 01/01/10 and open-ended is accepted.
- The beneficiary has four existing LIS periods during the enrollment in Plan A.



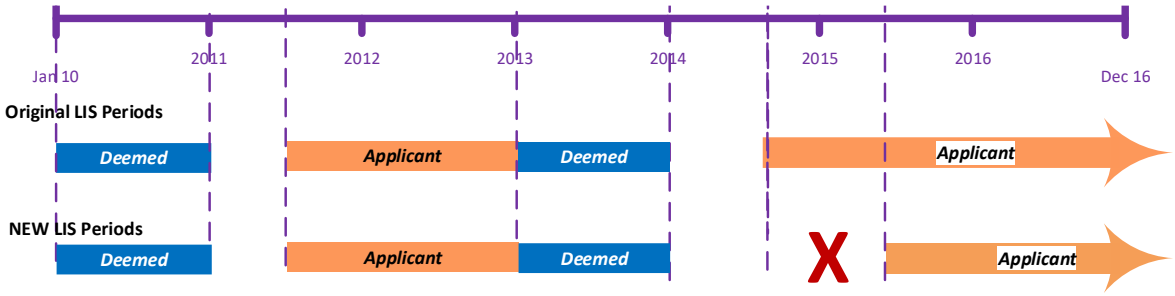
- When the enrollment is accepted, the following LIS TRCs accompany the TRC 011 (Enrollment Accepted):
  - TRC 121 – 01/01/2010 – 12/31/2010 (Deemed).
  - TRC 121 – 06/01/2011 – 12/31/2012 (Applicant).
  - TRC 121 – 01/01/2013 – 12/31/2013 (Deemed).
  - TRC 121 – 08/01/2014 – open ended (Applicant).

Example 2: TRCs with LIS Change

Original LIS Period: The Beneficiary had the following periods:

- Deemed period from 01/01/2010 to 12/31/2010.
- Applicant period from 06/01/2011 – 12/31/2012.
- Deemed period from 01/01/2013 – 12/31/2013.
- Applicant period from 08/01/2014 – open ended.

Changes to LIS Period: The applicant period that began 08/01/2014 is corrected to actually begin 06/01/2015. The beneficiary no longer has LIS from 08/01/2014 to 05/31/2015.



- When the LIS changes, the following LIS TRCs are sent to the Plan:
  - TRC 121 – 01/01/2010 – 12/31/2010 (Deemed).
  - TRC 121 – 06/01/2011 – 12/31/2012 (Applicant).
  - TRC 121 – 01/01/2013 – 12/31/2013 (Deemed).
  - TRC 223 – 08/01/2014 – 05/31/2015 (Applicant) – **LIS Period Removed**.
  - TRC 121 – 06/01/2015 – open ended (Applicant).

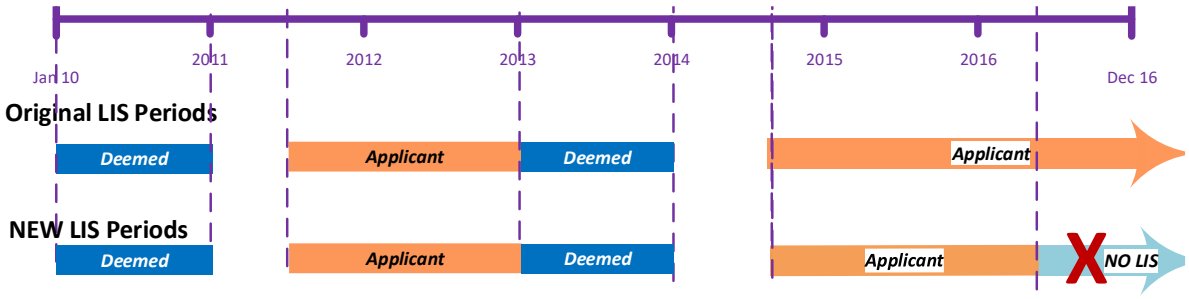
Example 3: TRCs with LIS Change – Putting an end date on an open-ended period.

Original LIS Period: The Beneficiary had the following periods:

- Deemed period from 01/01/2010 to 12/31/2010.
- Applicant period from 06/01/2011 – 12/31/2012.
- Deemed period from 01/01/2013 – 12/31/2013.
- Applicant period from 08/01/2014 – open-ended.

Changes to LIS Period:

- An end date of 03/31/2016 is put on the applicant period that began 08/01/2014. The beneficiary no longer has LIS beginning 04/01/2016 – open-ended.



- When the LIS changes, the following LIS TRCs are sent to the Plan:
  - TRC 121 – 01/01/2010 – 12/31/2010 (Deemed).
  - TRC 121 – 06/01/2011 – 12/31/2012 (Applicant).
  - TRC 121 – 01/01/2013 – 12/31/2013 (Deemed).
  - TRC 121 – 08/01/2014 – 03/31/2016 (Applicant).
  - TRC 223 – 04/01/2016 – open-ended (Applicant) – **LIS Period Removed.**

  Note: TRC 223 has an open end date. This is because the original period that was shortened had an open end date. The period being removed represents the portion of the original period that is no longer in effect.

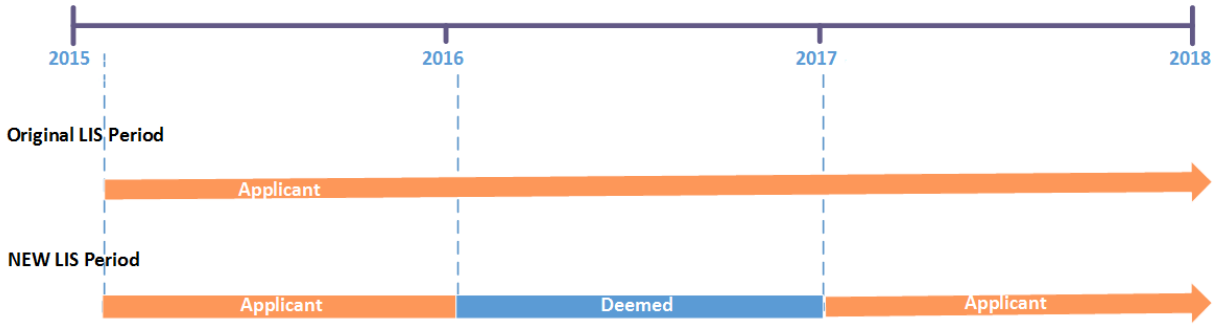
Example 4: TRCs with LIS Change – Original LIS Terminated and Reinstated.

Original LIS Period: The Beneficiary had the following period:

- Applicant period from 02/01/2015 – open-ended.

Changes to LIS Period:

- An end date of 01/31/2016 is put on the applicant period that began 02/01/2015.
- A retroactive Deeming period starts on 02/01/2016 and ends 12/31/2016 (deemed).
- The applicant period is reinstated from 01/01/2017 – open-ended.



- When the LIS changes, the following LIS TRCs are sent to the Plan:
  - TRC 121 – 02/01/2015 – 01/31/2016 (Applicant).
  - TRC 121 – 02/01/2016 – 12/31/2016 (Deemed).
  - TRC 121 – 01/01/2017 – open-ended (Applicant.)

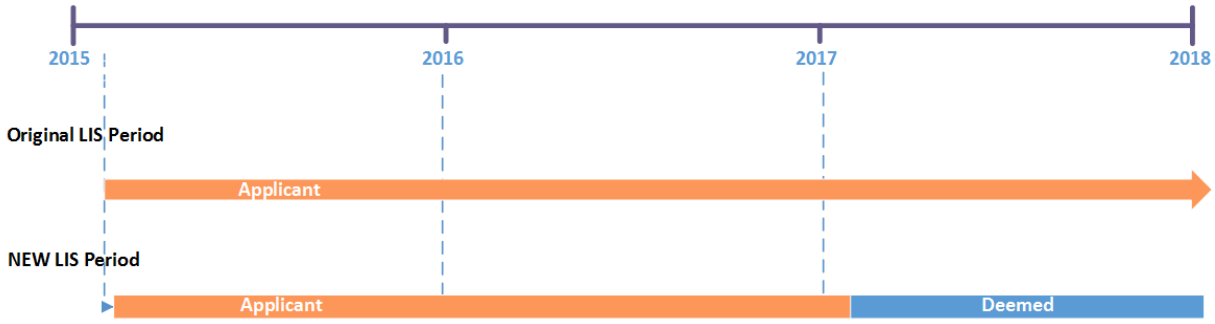
Example 5: TRCs with LIS Change – Original LIS Terminated and Not Reinstated.

Original LIS Period: The Beneficiary had the following period:

- Applicant period from 02/01/2015 – open-ended.

Changes to LIS Period:

- An end date of 01/31/2017 is put on the applicant period that began 02/01/2015.
- A retroactive Deeming period starts on 02/01/2017 and ends 12/31/2017 (Deemed).
- No LIS period is reinstated after the Deeming period ends in 2017.



- When the LIS changes, the following LIS TRCs are sent to the Plan:
  - TRC 121 – 02/01/2015 – 01/31/2017 (Applicant).
  - TRC 121 – 02/01/2017 – 12/31/2017 (Deemed).
  - TRC 223 – 01/01/2018 – open-ended (Applicant) – **LIS Period Removed.**
  - TRC 223 – 02/01/2017 – open-ended (Applicant) – **LIS Period Removed.**

  Note: TRC 223 has an open-ended date field. The period being removed represents the portion of the original period that is no longer in effect.

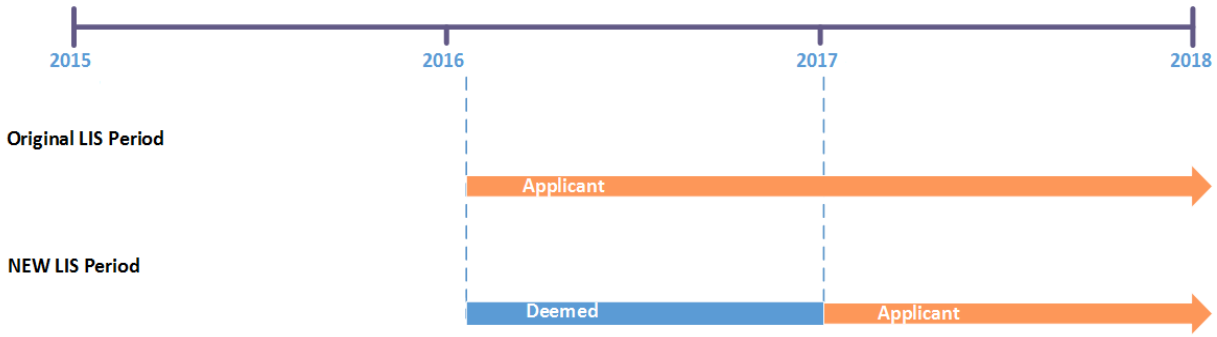
Example 6: TRCs with LIS Change – Original LIS Audited and Reinstated.

Original LIS Period: The Beneficiary had the following period:

- Applicant period from 02/01/2016 – open-ended.

Changes to LIS Period:

- The applicant period that began 02/01/2016 – open-ended is audited on 4/13/2017 (Applicant).
- A retroactive Deeming period starts on 02/01/2016 and ends 12/31/2016 (Deemed).
- The applicant period from 01/01/2017 – open-ended is reinstated.



- When the LIS changes, the following LIS TRCs are sent to the Plan:
  - TRC 121 – 02/01/2016 – 12/31/2016 (Deemed).
  - TRC 121 - 01/01/2017 – open-ended (Applicant).

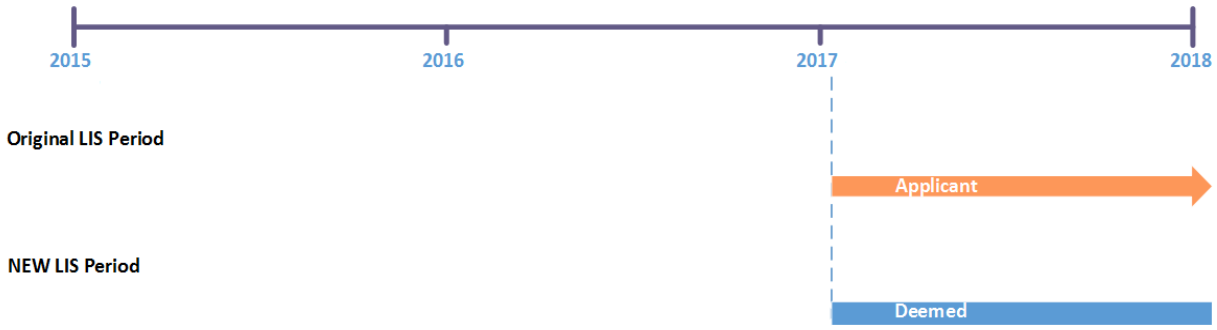
Example 7: TRCs with LIS Change – Original LIS Audited and Not Reinstated.

Original LIS Period: The Beneficiary had the following period:

- Applicant period from 02/01/2017 – open-ended.

Changes to LIS Period:

- The applicant period that began 02/01/2017 – open-ended is audited on 4/13/2017 (Applicant).
- A retroactive Deeming period starts on 02/01/2017 and ends 12/31/2017 (Deemed).
- No LIS periods are reinstated after 12/31/2017.



- When the LIS changes, the following LIS TRCs are sent to the Plan:
  - TRC 223 – 01/01/2018 – open-ended (Applicant) – **LIS Period Removed.**
  - TRC 121 – 02/01/2017 – 12/31/2017 (Deemed).
  - TRC 223 – 01/01/2018 – open-ended (Applicant) – **LIS Period Removed.**

  Note: TRC 223 has an open-ended date field. This tells the Plan there are no more LIS periods in 2018.

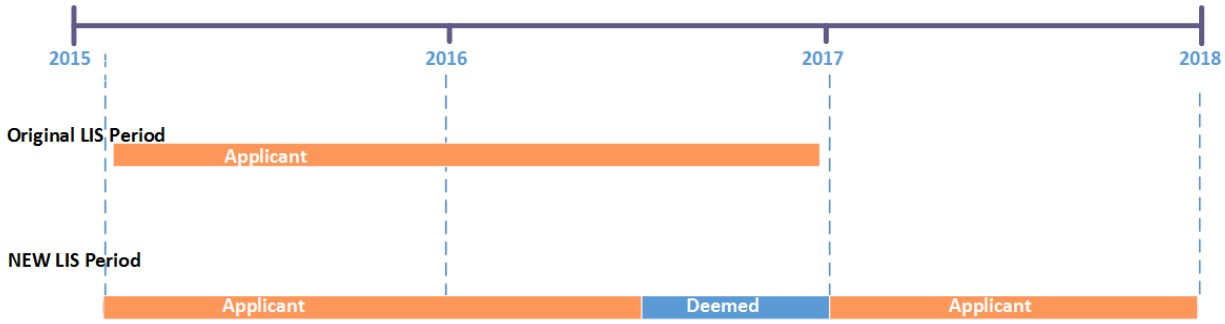
Example 8: TRCs with LIS Change – Original LIS with Termination Date Reinstated.

Original LIS Period: The Beneficiary had the following period:

- Applicant period from 02/01/2015 – 01/31/2017.

Changes to LIS Period:

- The applicant period that begins 02/01/2015 is end-dated 05/31/2016 (Applicant).
- A retroactive Deeming period starts on 06/01/2016 and ends 12/31/2016 (Deemed).
- The applicant period for 01/01/2017 to 01/31/2017 is reinstated.



- When the LIS changes, the following LIS TRCs are sent to the Plan:
  - TRC 121 – 02/01/2015 – 05/31/2016 (Applicant).
  - TRC 121 – 06/01/2016 – 12/31/2016 (Deemed).
  - TRC 121 – 01/01/2017 – 01/31/2017 (Applicant).

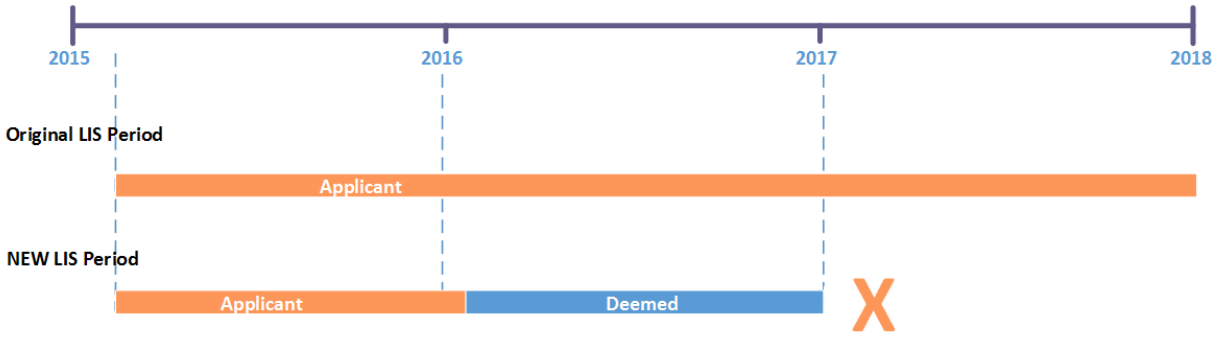
Example 9: TRCs with LIS Change – Original LIS with Termination Date Not Reinstated.

Original LIS Period: The Beneficiary had the following period:

- Applicant period from 02/01/2015 – 12/31/2017.

Changes to LIS Period:

- The applicant period that begins 02/01/2015 is end-dated 01/31/2016 (Applicant).
- A retroactive Deeming period starts on 02/01/2016 and ends 12/31/2016 (Deemed).
- No LIS periods are reinstated after 2017.



- When the LIS changes, the following LIS TRCs are sent to the Plan:
  - TRC 121 – 02/01/2015 – 01/31/2016 (Applicant).
  - TRC 121 – 02/01/2016 – 12/31/2016 (Deemed).
  - TRC 223 – 01/01/2017 – 12/31/2017 – **LIS Period Removed.**

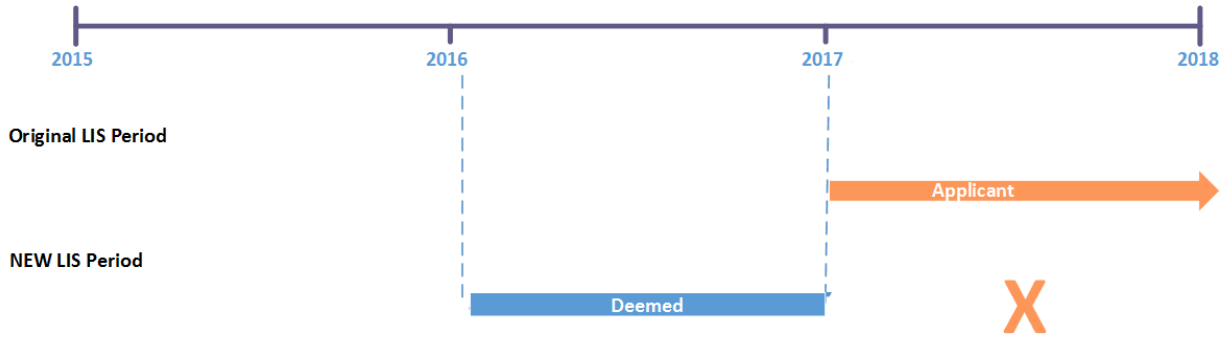
Example 10: TRCs with LIS Change – Original LIS Not Reinstated – Part D Termination.

Original LIS Period: The Beneficiary had the following period:

- Applicant period from 02/01/2016 – open ended.

Changes to LIS Period:

- A retroactive Deeming period starts on 02/01/2016 and ends 12/31/2016 (Deemed)
- The Beneficiary's Part D Eligibility Period ended on 12/31/2016. As the beneficiary is no longer eligible for Part D in 2017, no LIS periods can be reinstated or established.



- When the LIS changes, the following LIS TRCs are sent to the Plan:
  - TRC 223 – 01/01/2017 – open-ended (Applicant) – **LIS Period Removed.**
  - TRC 121 – 02/01/2016 – 12/31/2016 (Deemed).
  - TRC 223 – 01/01/2017 – open-ended (Applicant) – **LIS Period Removed.**

  Note: TRC 223 had an open-end date; however, since the beneficiary lost Part D eligibility effective 01/01/2017, no LIS periods can be established or reinstated.

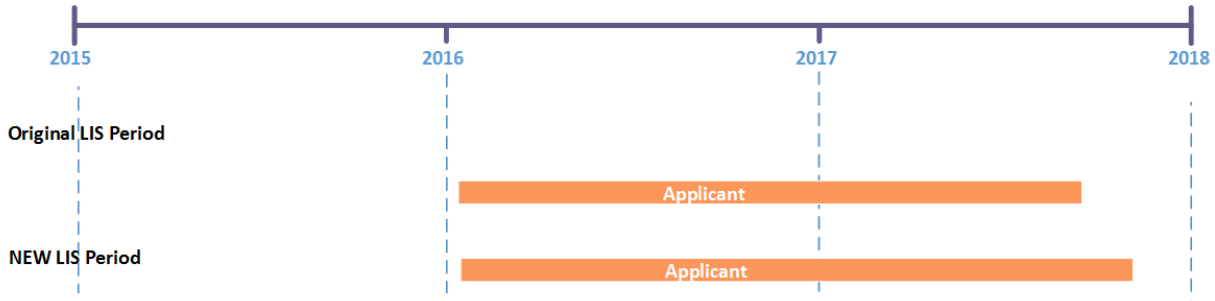
Example 11: TRCs with LIS Change – Original LIS End Date Moved to a Future End Date.

Original LIS Period: The Beneficiary had the following period:

- Applicant period from 02/01/2016 – 05/31/2017.

Changes to LIS Period:

- An SSA notice is received to change the end date on the Applicant period to 08/31/2017.



- When the LIS period end date changes, the following LIS TRC is sent to the Plan:
  - TRC 121 – 02/01/2016 – 08/31/2017 (Applicant).

4.6 LIS Periods on the MARx UI

A beneficiary's LIS status, periods, premium subsidies, and copays are displayed on the following MARx UI screens.

- M232 – Beneficiary Eligibility.
- M203 – Beneficiary Snapshot.
- M231 – Premiums View.
- M256 – Status Activity.
- M257 – Status Detail: Medicaid.

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5 Premium

This section covers the following topics:

5.1 Premium Withhold Process

Beneficiaries may elect to withhold their Part C and Part D premiums from their monthly Social Security Administration (SSA) and Railroad Retirement Board (RRB) benefits if the benefit amount equals or exceeds their premiums.

For Part C premiums, the presence of optional supplemental benefit premiums precludes MARx from identifying the exact amount. Therefore, MARx edits the Part C premium using a range defined by the lowest Part C premium amount, which starts at zero for the PBP, and the highest Part C premium amount, which is the sum of all available optional supplemental premiums for the PBP that the member could elect. As long as the submitted Part C premium falls within this range, it is accepted unchanged. If it is not within this range, MARx changes it to the lowest possible Part C premium for the PBP and notifies the Plan with a Transaction Reply Code (TRC) 182, *Invalid PTC Premium Submitted, Corrected, Accepted*.

If the beneficiary elects the Direct self-pay option (D), the Plan receives payment directly from the member. If the beneficiary elects Deduct from SSA benefits option (S), CMS transmits this information to SSA. Monthly, SSA withholds premiums and sends them to CMS, which verifies the premiums and passes payment to the Plans. If SSA is unable to deduct a beneficiary's premium from their benefit check due to insufficient funds or some type of data issue, CMS notifies the Plan with a TRC 144, *PPO changed to Direct Bill*, which instructs the Plan to bill the member for the premiums.

Note: SSA may reject withholding requests due to insufficient funds even if the premiums are relatively low due to the difference in the timing of the payment cycles between SSA and CMS. This difference often requires SSA to process a withholding request with premiums due for two or three months. Additionally, SSA limits premium withholding to $300 a month per beneficiary, which can also impact SSA's ability to accept and process premium withholding for a member.

5.1.1 *Low-Income Premium Subsidy (LIPS)*

If a member is determined eligible for LIPS and elects the Deduct from SSA benefits option (S), SSA withholds the non-subsidized amount, if any, and CMS pays the subsidy to the Plan. If the member elects the Direct self-pay option (D), the Plan bills the non-subsidized amount, if any, to the member and CMS pays the Plan the subsidy. The Monthly Membership Report (MMR) reports the LIPS payments to the Plans.

5.1.2 *Late Enrollment Penalty (LEP)*

For members assessed an LEP, their premium includes a penalty. If the member elects the Deduct from SSA benefits option (S), SSA withholds the penalty amount and CMS retains it. Plans can view the amounts on the Monthly Premium Withhold Report Data File (MPWR). If the member elects the Direct self-pay option (D), the Plan bills the premium amount that includes the LEP and CMS deducts the LEP from the Plan payment. Plans can view the amounts on the LEP Report.

5.1.3 All or Nothing Rule

The All or Nothing rule means that the beneficiary may deduct their entire premium amount due, i.e., the sum of Part C and Part D premiums for one Plan, from their monthly SSA benefit. Partial deductions are not allowed. When the benefit amount is insufficient to cover the entire premium amount, SSA rejects the withhold request and notifies CMS. CMS notifies the Plan of the insufficient benefit amount and rejection of the Deduct from SSA benefits option (S), and instructs the Plan to change the member to Direct self-pay option (D), for the full amount of premiums due and for subsequent monthly premiums. CMS notifies the Plan with a modified TRC 213, *Exceed Safety Net Amount*, for transactions rejected due to the $300 safety net.

5.1.4 Single Payment Option Rule

The single payment option rule requires that both the Part C and Part D premiums are either direct bill or withhold as a beneficiary may only elect one payment option. This rule applies to a single Plan enrollment. For beneficiaries legally enrolled in two different Plans, they may elect two payment options. Examples:

- Beneficiary enrolls in a Medicare Advantage Prescription Drug (MAPD) Plan for Part C and Part D coverage, which results in a single premium; the member must elect one payment option, either withholding or direct bill.
- Beneficiary enrolls in a Private Fee-for-Service (FFS) Plan for Part C coverage and a Prescription Drug Plan (PDP) for Part D coverage, which results in enrollment in two different types of Plans and two different premiums. The member may elect to pay the Part C premium Direct self-pay option (D), and the Part D premium as Deduct from SSA benefits option (S).

5.1.5 Part D Creditable Coverage and Late Enrollment Penalty (LEP)

Medicare-eligible beneficiaries are legally required to have prescription drug coverage, either from a Medicare PDP or a non-Medicare equivalent insurer that provides drug coverage. If a Medicare-eligible beneficiary does not have prescription drug coverage after Part D eligibility is established, an LEP is assessed against the beneficiary. The penalty is added to the Part D premium once the beneficiary is enrolled in a Medicare PDP.

To establish whether or not a beneficiary is assessed an LEP, Plans must determine the number of months in which a Medicare-eligible beneficiary did not have creditable drug coverage for a continuous period of 63 days or more, and report this as the Number of Uncovered Months (NUNCMO) to CMS.

5.1.6 Calculating LEP

CMS calculates the LEP by multiplying a percentage, currently 1 percent, of the national base beneficiary Part D premium for the current coverage year by the total NUNCMO, regardless of the year(s) in which those months occurred. This calculation occurs annually because the percentage and the base beneficiary Part D premium changes each year.

Plans report the NUNCMO to CMS by including it on an enrollment, Transaction Code (TC) 61 or separately on a TC 73 if the determination is made after the enrollment transaction is

submitted. If there are no uncovered months to report, Plans must place a Y in the Creditable Coverage Flag and 000 in the NUNCMO field. If there are uncovered months to report, Plans place an N in the Creditable Coverage Flag and the applicable number in the NUNCMO field.

The table below summarizes the actions Plans should take to submit NUNCMO data:

Table 5-1: Summary of Plan Action to Add, Change, or Remove the NUNCMO for Enrolled Beneficiary

Summary of Plan Action to Add, Change, or Remove the NUNCMO for Enrolled Beneficiary			
Action	**Creditable Coverage Flag**	**NUNCMO Field Value**	**Effective Date on Transaction Code 73**
Submit a new NUNCMO	N	Number greater than 0	Equal to existing enrollment effective date **Note:** An enrollment TC 61 may also provide this information.
Change/correct an existing NUNCMO due to Plan error or reconsideration decision	N	Revised existing number to a number greater than 0 – new number of months (>0)	Equal to existing enrollment effective date
	Y	0 to remove the existing number completely.	Equal to existing enrollment effective date

5.2 Premium Withhold Transaction Process

Plans may submit multiple transaction files during any CMS business day, Monday through Friday. Plan transactions are processed as received; there is no minimum or maximum limit to the number of files that Plans may submit in a day.

All Plan-submitted files should comply with the record formats and field definitions as described for each file type. Plans should send files in a flat file structure that conform to the Dataset Naming Conventions unique to each file type.

On a daily basis, Plans may submit a *MARx Batch Input Transaction Data File* to CMS to enroll/update information about a beneficiary. This file consists of a header record followed by detail transaction records. The **Transaction Code (TC)** in each detail record identifies the type of transaction. Plans may submit any number of detail transaction records for one or more beneficiaries.

Table 5-2: MARx Batch Transaction Codes (Premium)

MARx Batch Transaction Codes (Premium)	
Transaction Code	**Transaction Code Description**
73	Number of Uncovered Months Change
75	Premium Payment Option (PPO) Change Record
77	Segment ID Change Record
78	Part C Premium Change Record

Table 5-3: Allowable Date Range for TC 73, 75, 77, and 78

Allowable Date Range for TC 73, 75, 77, and 78				
Transaction Code	**Description**	**Earliest Date**	**Latest Date**	**Other**
73	Number of Uncovered Months Change	No timeliness edits. The effective date must match the start date of an enrollment.		Current Plan can submit for the current enrollment and all prior enrollment even if the enrollment was with a different Plan. The beneficiary must have enrolled in the submitting Plan as of the CCM that is in the header record. A prior Plan submitting a NUNCMO update for its enrollment must submit via a Retro file that has a header date during the enrollment in the Prior Plan.

Allowable Date Range for TC 73, 75, 77, and 78				
Transaction Code	**Description**	**Earliest Date**	**Latest Date**	**Other**
75	Premium Payment Option Change	CPM	CPM + 2	Notice that this option is based on the CPM. Most options are based on the CCM.
77	Segment ID Change	CCM – 1 (CCM – 3 for EGHP)	CCM + 3	Normal enrollment transaction range.
78	Part C Premium Change	The effective date must occur during an enrollment in the submitting Plan.		

5.2.1 TC 73 Number of Uncovered Months Data Change

Layout 5-1: MARx Batch Input Detail Record: NUNCMO Change – TC 73

MARx Batch Input Detail – NUNCMO Change Transaction – TC 73				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space

MARx Batch Input Detail – NUNCMO Change Transaction – TC 73				
Item	**Field**	**Size**	**Position**	**Description**
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52-59	Spaces
12	Transaction Code	2	60-61	73
13	Filler	2	62-63	Spaces
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Filler	22	72-93	Spaces
16	Creditable Coverage Flag	1	94	This indicates whether the beneficiary has creditable drug coverage in the period prior to this enrollment in a Part D Prescription Plan. Y = Beneficiary has creditable coverage. N = Beneficiary does not have creditable coverage. To set a beneficiary's NUNCMO to zero for a particular date, Plans should use Creditable Coverage Flag = Y and NUNCMO = 0.
17	NUNCMO	3	95-97	Required for all Part D Plans; otherwise spaces. The number of months during which the beneficiary did not have creditable coverage in the period prior to this enrollment, as determined by the Plan according to the applicable CMS policy. A NUNCMO may be greater than 0 only if the Creditable Coverage Flag is N. This field is populated with zeroes if the Creditable Coverage Flag is Y.
18	Filler	112	98-209	Spaces.
19	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
20	Filler	76	225-300	Spaces.

5.2.2 TC 75 Premium Payment Option Change

The premium withhold process relies on data reported by the Plans and on an interface between the SSA, RRB, and CMS. Processing begins when Plans submit premium information for new members on the Enrollment TC 61 and for current members on the Premium Payment Option (PPO) Change TC 75. On both of these transactions, Plans report the beneficiary Part C and Part D premiums as applicable and the PPO option selected by the member. Current options are:

- D = Direct self-pay.
- S = Deduct from SSA benefits.
- R = Deduct from RRB benefits.
- N = No Premium.

Layout 5-2: PPO Change – TC 75

PPO Change Transaction – TC 75				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space.

PPO Change Transaction – TC 75				
Item	**Field**	**Size**	**Position**	**Description**
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space.
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60- 61	75
13	Filler	2	62- 63	Spaces.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Filler	9	72-80	Spaces.
16	PPO/Parts C-D	1	81	Required for all Plan types except: • HCPP • COST 1 without drug • COST 2 without drug • CCIP/FFS demo • MSA/MA • MSA/demo This indicates the PPO requested by the beneficiary on this transaction. D = Direct self-pay. S = Deduct from SSA benefits. R = Deduct from RRB benefits. N = No Premium. The option applies to both Part C and D Premiums.
17	Filler	128	82-209	Spaces.
18	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
19	Filler	76	225- 300	Spaces.

5.2.3 TC 77 Segment ID Change

An MA Plan's service area can be divided into segments composed of one or more counties. Segmenting permits a Plan to offer the same package of benefits, but at different premium rates and cost-sharing levels. Rules requiring uniformity of premiums and cost-sharing levels for all enrollees in the Plan apply to the segment (and not the Plan's entire service area).

Layout 5-3: Segment ID Change – TC 77

Segment ID Change Transaction – TC 77				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space.
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space

Segment ID Change Transaction – TC 77				
Item	**Field**	**Size**	**Position**	**Description**
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60-61	77
13	Filler	2	62-63	Spaces.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Segment ID	3	72-74	The three character segment identifier, 001-999 (zero-padded). Only local MA/MAPD Plans (Hxxxx) may have segments.
16	Filler	135	75-209	Spaces.
17	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
18	Filler	76	225-300	Spaces.

5.2.4 TC 78 Part C Premium

The Part C premium amount reported by the Plan to CMS includes additional premium amounts for any optional supplemental benefits selected by the member. Part C Premium Change, TC 78 is used to submit Part C premium amounts.

Layout 5-4: Part C Premium Change – TC 78

Part C Premium Change Transaction – TC 78				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Beneficiary's last name. Required.
3	First Name	7	25-31	Beneficiary's first name. Required.
4	M. Initial	1	32	Beneficiary's middle initial. Optional.
5	Gender Code	1	33	Required. 1 = Male. 2 = Female. 0 = Unknown.
6	Birth Date	8	34-41	CCYYMMDD. Required.
7	Filler	1	42	Space
8	PBP #	3	43-45	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded). PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with spaces.
9	Filler	1	46	Space

Part C Premium Change Transaction – TC 78				
Item	**Field**	**Size**	**Position**	**Description**
10	Contract #	5	47-51	Contract Number. Required. Hxxxx = Local Plans. Rxxxx = Regional Plans. Sxxxx = PDPs. Fxxxx = Fallback Plans. Exxxx = Employer sponsored MA/MAPD and PDP Plans.
11	Filler	8	52-59	Spaces.
12	Transaction Code	2	60-61	78
13	Filler	2	62-63	Spaces.
14	Effective Date	8	64-71	CCYYMMDD. Required. The effective date for the transaction.
15	Filler	10	72-81	Spaces.
16	Part C Premium Amount	6	82-87	The amount of the Part C Premium is formatted as six digits with leading zeroes. A decimal point is assumed 2-digits from right; XXXXvXX. Zero is interpreted as an actual value.
17	Filler	122	88-209	Spaces.
18	Transaction Tracking ID	15	210-224	Optional value created and used by the Plan to track the replies of the transaction.
19	Filler	76	225-300	Spaces.

5.3 Retroactive LEP Increase and SSA Benefit Safety Net

When NUNCMO is increased retroactively, it results in a larger LEP amount and will be transmitted to the withholding agency if the beneficiary elected for premium withholding during that time period. If the LEP amounts to be collected for prior periods combined with the current month's premium exceeds SSA's current safety net limit, the following will happen:

- Identify beneficiaries exceeding the safety net limit due to a retroactive LEP increase and prevent transmission of increased LEP to SSA.
- If the beneficiary's prospective monthly premium amount remains below $300.00, the beneficiary's PPO will remain set to SSA Withhold.
- If the beneficiary's prospective premium is above $300.00 the PPO will be changed to direct bill.
- The Plan bills the additional LEP amounts to be collected for prior periods and CMS deducts the LEP from the Plan payment. Plans can view the amounts on the LEP Data File, record type 'HD' (Harm Detail Record).

Table 5-4: Example Calculations for TRCs 371 and 372

PROSPECTIVE PREMIUM STAYS *BELOW* SSA HARM LIMIT (TRC 371)		
#	**Condition**	**Value**
Premium		
a)	Beneficiary's PPO is currently set to SSA Withhold	TRUE
b)	Current monthly premium amount Current monthly LEP amount **Current monthly premium amount:**	$245.00 $5.00 **$250.00**
c)	Increase of monthly LEP amount (per month) **New prospective premium amount total:**	$15.00 **$265.00**
d)	LEP increase is due for 10 retroactive months ($15.00 * 10 months)	**$150.00**
	Total premium amount owed (for 1 month): (New monthly premium amount + 10 mo. LEP increase due)	**$415.00**
MARx Action		
a)	Beneficiary's PPO *remains set to SSA Withhold*	TRUE
b)	DTRR will display TRC 371 (SSA LEP Exceeds Harm Limit) LEP increase for 10 retroactive months is Direct Billed by Plan **Direct Billed by Plan:**	TRUE **$150.00**
c)	New prospective monthly premium amount **Withheld by SSA:**	 **$265.00**
d)	Total premium amount owed (for 1 month)	**$415.00**

PROSPECTIVE PREMIUM *EXCEEDS* SSA HARM LIMIT (TRC 371)		
#	**Condition**	**Value**
Premium		
a)	Beneficiary's PPO is currently set to SSA Withhold	TRUE

b)	Current monthly premium amount Current monthly LEP amount **Current monthly premium amount:**	$245.00 $40.00 **$285.00**
c)	Increase of monthly LEP amount (per month) **New prospective premium amount total:**	$20.00 **$305.00**
d)	LEP increase is due for 10 retroactive months ($20.00 * 10 months)	**$200.00**
	Total premium amount owed (for 1 month): (New monthly premium amount + 10 mo. LEP increase due)	**$505.00**
MARx Action		
a)	Beneficiary's PPO *will change to Direct Bill*	TRUE
b)	DTRR will display TRC 371 (SSA LEP Exceeds Harm Limit) LEP increase for 10 retroactive months is Direct Billed by Plan **Direct Billed by Plan:**	TRUE **$200.00**
c)	DTRR will display TRC 144 (PPO Changed to Direct Bill) New prospective premium amount **Direct Billed by Plan:**	 **$305.00**
d)	Total premium amount owed (for 1 month)	**$505.00**

PROSPECTIVE MONTHLY PREMIUM STAYS *BELOW* SSA HARM LIMIT (TRC 372)

#	Condition	Value
Premium		
a)	Beneficiary's PPO is currently set to SSA Withhold	TRUE
b)	Current monthly premium amount Current monthly LEP amount **Current monthly premium amount:**	$245.00 $5.00 **$250.00**
c)	Increase of monthly LEP amount (per month) **New prospective monthly premium amount total:**	$15.00 **$265.00**
d)	LEP increase is due for 10 retroactive months ($15.00 * 10 months)	**$150.00**
	Total premium amount owed (for 1 month): (New monthly premium amount + 10 mo. LEP increase due)	**$415.00**
MARx Action		
a)	Beneficiary's PPO *remains set to SSA Withhold*	TRUE
b)	DTRR will display TRC 371 (SSA LEP Exceeds Harm Limit) LEP increase for 10 retroactive months is Direct Billed by Plan **Direct Billed by Plan:**	TRUE **$150.00**
c)	New prospective monthly premium amount **Withheld by SSA:**	 **$265.00**
d)	Total premium amount owed (for 1 month)	**$415.00**
Subsequent Premium Conditions		
a)	Beneficiary's PPO is currently set to SSA Withhold	TRUE
b)	Current monthly premium amount Current monthly LEP amount **Current monthly premium amount :**	$245.00 $20.00 **$265.00**
c)	Decrease of monthly LEP amount (per month) **New prospective monthly premium amount total:**	($15.00) **$250.00**

d) LEP decrease should be refunded for 10 retroactive months ($15.00 * 10 months)	**($150.00)**
MARx Action	
a) Beneficiary's PPO *remains set to SSA Withhold*	TRUE
b) DTRR will display TRC 372 (SSA Harm Limit Refund) LEP decrease for 10 retroactive months is refunded by Plan	TRUE
Refunded by Plan:	**($150.00)**
c) New monthly premium amount	
Withheld by SSA:	**$250.00**

5.4 Premium Data Files

The following Premium Reports are covered in this section:

- **Late Enrollment Penalty (LEP) Data File**
- **Monthly Premium Withholding Report (MPWR) Data File**
- **No Premium Due Data File**

5.4.1 *Late Enrollment Penalty (LEP) Data File*

The LEP report provides information on direct-billed Beneficiaries with late enrollment penalties. CMS retains the LEP obtained from these members electing premium withhold prior to passing these premiums to the Plans. CMS offsets the LEP for directly billed members from the Plans' monthly payments.

System	Type	Frequency	File Length	LEP Dataset Naming Convention
MARx	Data File	Monthly	165	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LEPD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LEPD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LEPD.Dyymm01.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the current payment month.

The file includes the following records:

- **LEP Header Record**
- **LEP Detail Record**
- **LEP Trailer Record**

Layout 5-5: LEP Header Record

LEP Header Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	3	1-3	H = Header Record.
2	Contract Number	5	4-8	Contract Number.
3	Payment/Payment Adjustment Date	8	9-16	CCYYMMDD
4	Data file Date	8	17-24	Date this data file was created. CCYYMMDD
5	Filler	141	25-165	Spaces.

Layout 5-6: LEP Detail Record

LEP Detail Record				
Item	**Field**	**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 HD = Harm Detail Record "Harm" means the retroactive premium amount exceeds the allowed collection limitation established by the withholding agency but the beneficiary remains in withholding.
2	Contract Number	5	4-8	Contract Number.
3	PBP Number	3	9-11	PBP Number.
4	Plan Segment Number	3	12-14	Plan Segment Number.
5	Beneficiary ID	12	15-26	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end
6	Surname	7	27-33	Beneficiary's last name.
7	First Initial	1	34	First initial of the beneficiary's first name
8	Sex	1	35	M = Male. F = Female.
9	DOB	8	36-43	Beneficiary's data of birth. CCYYMMDD
10	Filler	1	44	Space.
11	Premium/Adjustment/Harm Period Start Date	8	45-52	PD: current processing start date. AD: adjustment period start date. HD: harm adjustment period start date. CCYYMMDD
12	Premium/Adjustment/Harm Period End Date	8	53-60	PD: current processing end date. AD: adjustment period end date. HD: harm adjustment period end date. CCYYMMDD
13	Number of Months in Premium/Adjustment Period	2	61-62	Number of Months between the Premium/Adjustment Period Start and End Date.
14	Number of Uncovered Months (NUNCMO)	3	63-65	The number of months during which the beneficiary did not have creditable coverage.

LEP Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
15	LEP Amount for Direct Billed Members	8	66-73	PD: Prospective LEP Amount owed by the Direct Bill Beneficiary for the premium period. AD: Computed adjustment for each month in the (affected) payment period (if the payment was already made). HD: Computed adjustment for each month in the (affected) payment period (if retroactive LEP amounts cause the premium to exceed the collection limitation established by the withholding agency). Format: -9999.99 **Note:** A refund will be reported as a negative amount. A charge will be reported as a positive amount.
16	Cleanup ID	10	74-83	If LEP adjustment is the result of a cleanup = XXXXXXXXXX. All other records will = Spaces.
17	Filler	82	84-165	Spaces.

Layout 5-7: LEP Trailer Record

LEP Trailer Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	3	1-3	Trailer Record PT1 = Prospective total for contract/PBP/segment. AT1 = Adjustment total for contract/PBP/segment. HT1 = Harm total for contract/PBP/segment. CT1 = Total for contract/PBP/segment. PT2 = Prospective total for contract/PBP. AT2 = Adjustment total for contract/PBP. HT2 = Harm total for contract/PBP. CT2 = Total for contract/PBP. PT3 = Prospective total for contract. AT3 = Adjustment total for contract. HT3 = Harm total for contract. CT3 = Total for contract.
2	Contract Number	5	4-8	Contract Number.
3	PBP Number	3	9-11	PBP Number.
4	Segment Number	3	12-14	Segment Number.
5	Total LEP Amount	14	15-28	Total LEP Amount. Format: -9999999999.99
6	Record Count	14	29-42	Count of records on the data file for combination of contract/PBP/segments.
7	Filler	123	43-165	Spaces.

5.4.2 Monthly Premium Withholding Report (MPWR) Data File

The MPWR is a monthly reconciliation file of premiums withheld from SSA or RRB checks. It includes Part C and Part D premiums and any Part D Late Enrollment Penalties (LEPs). This file is produced by the Premium Withhold System (PWS), which makes this report available to Plans as part of the month-end processing.

System	Type	Frequency	File Length	MPWR Dataset Naming Conventions
PWS (MARx)	Data File	Monthly	165	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MPWRD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MPWRD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MPWRD.Dyymm01.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the CPM.

The file includes the following records:

- **MPWR Header Record**
- **MPWR Detail Record**
- **MPWR Trailer Record**

Layout 5-8: MPWR Header Record

MPWR Header Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	2	1-2	H = Header Record.
2	MCO Contract Number	5	3-7	MCO Contract Number.
3	Payment Date	8	8-15	CCYYMMDD First 6 digits contain payment month.
4	Report Date	8	16-23	CCYYMMDD Date this report created.
5	Filler	142	24-165	Spaces.

Layout 5-9: MPWR Detail Record

MPWR Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	2	1-2	D = Detail Record.
2	MCO Contract Number	5	3-7	MCO Contract Number.
3	Plan Benefit Package Id	3	8-10	Plan Benefit Package ID.
4	Plan Segment Id	3	11-13	
5	Beneficiary ID	12	14-25	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
6	Surname	7	26-32	First seven characters of beneficiary's last name.
7	First Initial	1	33	First character of beneficiary's first name.
8	Sex	1	34	M = Male. F = Female.
9	Date of Birth	8	35-42	CCYYMMDD
10	PPO	3	43-45	PPO in effect for this Pay Month. SSA = Withholding by SSA. RRB = Withholding by RRB.
11	Filler	1	46	Space.
12	Premium Period Start Date	8	47-54	Starting Date of Period Premium Payment Covers. CCYYMMDD
13	Premium Period End Date	8	55-62	Ending Date of Period Premium Payment Covers. CCYYMMDD
14	Number of Months in Premium Period	2	63-64	
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.
16	Part D Premiums Collected	8	73-80	Part D Premiums Collected (excluding LEP) for this Beneficiary, Plan, and premium period. A negative amount indicates a refund by withholding agency to Beneficiary of premiums paid in a prior premium period.
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.
18	Cleanup ID	10	89-98	If collected premium is the result of a cleanup = XXXXXXXXXX. All other records will = Spaces.
19	Filler	67	99-165	Spaces.

Layout 5-10: MPWR Trailer Record

MPWR 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.
2	MCO Contract Number	5	3-7	MCO contract number.
3	Plan Benefit Package (PBP) ID	3	8-10	PBP ID, not populated on T3 records.
4	Plan Segment Id	3	11-13	Not populated on T2 or T3 records.
5	Total Part C Premiums Collected	14	14-27	Total withholding collections as specified by Trailer Record type, Field 1.
6	Total Part D Premiums Collected	14	28-41	Total withholding collections as specified by Trailer Record type, Field 1.
7	Total Part D LEPs Collected	14	42-55	Total withholding collections as specified by Trailer Record type, Field 1.
8	Total Premiums Collected	14	56-69	Total Premiums Collected = + Total Part C Premiums Collected + Total Part D Premiums Collected + Total Part D Penalties Collected.
9	Filler	96	70-165	Spaces.

5.4.3 *No Premium Due Data File*

MA enrollees who elect optional supplemental benefits may also elect SSA premium withholding. In mid-November, MARx begins preparing the premium records for the next year. Since MARx cannot anticipate which optional premiums an enrollee may elect for next year, an enrollee only paying optional premiums may convert from "SSA Premium Withholding" status in one year to "No Premium Due" status for the next year.

Plans should use the No Premium Due Data File to identify enrollees in a "No Premium Due" status for the next year. Plans should review the report and submit both a Part C Premium Change (TC 78) to update the Part C premium amount, and a PPO Change (TC 75) to request SSA Withholding Status, for enrollees who are renewing both elections for the next year.

System	Type	Frequency	File Length	No Premium Due Dataset Naming Conventions
MARx	Data File	Yearly	500	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.SPCLPEX.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.SPCLPEX.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.SPCLPEX.Dyymmdd.Thhmmsst

Layout 5-11: No Premium Due Record

No Premium Due Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary ID	12	1-12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
2	Surname	12	13-24	Beneficiary Surname.
3	First Name	7	25-31	Beneficiary Given Name.
4	Middle Initial	1	32	Beneficiary Middle Initial.
5	Gender Code	1	33	Beneficiary Gender Identification Code 0 = Unknown. 1 = Male. 2 = Female.
6	Date of Birth	8	34-41	CCYYMMDD
7	Filler	1	42	Space.
8	Contract Number	5	43-47	Plan Contract Number.
9	State Code	2	48-49	Spaces.
10	County Code	3	50-52	Spaces.
11	Disability Indicator	1	53	Space.
12	Hospice Indicator	1	54	Space.
13	Institutional/NHC Indicator	1	55	Space.

No Premium Due Record				
Item	**Field**	**Size**	**Position**	**Description**
14	ESRD Indicator	1	56	Space.
15	TRC	3	57-59	TRC defaulted to 267.
16	Transaction Code	2	60-61	TC Defaulted to 01 for special reports.
17	Entitlement Type Code	1	62	Space.
18	Effective Date	8	63-70	CCYYMMDD Example: 20180101 (set to first of January of the upcoming year).
19	WA Indicator	1	71	Space.
20	PBP ID	3	72-74	PBP number.
21	Filler	1	75	Space.
22	Transaction Date	8	76-83	CCYYMMDD Set to the report generation date.
23	UI Initiated Change Flag	1	84	Space.
24	FILLER	12	85-96	Spaces.
25	District Office Code	3	97-99	Spaces.
26	Previous Part D Contract/PBP for TrOOP Transfer.	8	100-107	Spaces.
27	End Date	8	108-115	Spaces.
28	Source ID	5	116-120	Spaces.
29	Prior PBP ID	3	121-123	Spaces.
30	Application Date	8	124-131	Spaces.
31	UI User Organization Designation	2	132-133	Spaces.
32	Out of Area Flag	1	134	Space.
33	Segment Number	3	135-137	Further definition of PBP by geographic boundaries; Default to ‘000’ when blank.
34	Part C Beneficiary Premium	8	138-145	Part C Premium Amount: Since this report is only reporting on Beneficiaries that have No Premium Due, by definition, this amount is zero.
35	Part D Beneficiary Premium	8	146-153	Part D Premium Amount: Since this report is only reporting on Beneficiaries that have No Premium Due, by definition, this amount is zero.
36	Election Type	1	154	Space.
37	Enrollment Source	1	155	Space.
38	Part D Opt-Out Flag	1	156	Space.
39	Premium Withhold Option/Parts C-D	1	157	N = No premium applicable.
40	Number of Uncovered Months	3	158-160	Spaces.
41	Creditable Coverage Flag	1	161	Space.
42	Employer Subsidy Override Flag	1	162	Space.
43	Processing Timestamp	15	163-177	The report generation time. Format: HH.MM.SS.SSSSSS
44	Filler	20	178-197	Spaces.

No Premium Due Record				
Item	**Field**	**Size**	**Position**	**Description**
45	Secondary Drug Insurance Flag	1	198	Space.
46	Secondary Rx ID	20	199-218	Spaces.
47	Secondary Rx Group	15	219-233	Spaces.
48	EGHP	1	234	Space.
49	Part D LIPS Level	3	235-237	Spaces.
50	Low-Income Co-Pay Category	1	238	Space.
51	Low-Income Period Effective Date	8	239-246	Spaces.
52	Part D LEP Amount	8	247-254	Spaces.
53	Part D LEP Waived Amount	8	255-262	Spaces.
54	Part D LEP Subsidy Amount	8	263-270	Spaces.
55	Low-Income Part D Premium Subsidy Amount	8	271- 278	Spaces.
56	Part D Rx BIN	6	279-284	Spaces.
57	Part D Rx PCN	10	285-294	Spaces.
58	Part D Rx Group	15	295-309	Spaces.
59	Part D Rx ID	20	310-329	Spaces.
60	Secondary Rx BIN	6	330-335	Spaces.
61	Secondary Rx PCN	10	336-345	Spaces.
62	De Minimis Differential Amount	8	346-353	Spaces.
63	MSP Status Flag	1	354	Space.
64	Low Income Period End Date	8	355-362	Spaces.
65	LIS Source Code	1	363	Space.
66	Enrollee Type Flag, PBP Level	1	364	Space.
67	Application Date Indicator	1	365	Space.
68	Filler	135	366-500	Spaces.

6 Payment

This section covers the following topics:

- **Arrange for Payments.**
- **Part C Payment Calculation.**
- **Part D Payment Calculation.**
- **Coverage Gap Discount Program Payments**
- **Reconciliation of Plan Data with CMS Data**
- **Payment Data Files.**

The capitation payments provided to Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) sponsors are calculated and paid on a monthly basis. The estimated payments are based on system information at the time monthly payments are made. Part C payments are finalized annually with the final reconciliation of risk adjustment (RA) data. Part D payments are finalized annually with the final reconciliation of Prescription Drug Event (PDE) data.

At the end of each Current Processing Month (the Plan Data Due Date), MARx calculates the final beneficiary payments and adjustments, which ultimately result in payments to the Plans for the Current Payment Month (CPM). MARx then assembles the monthly CMS reports. CMS reports contain Plan Medicare membership and payment information as indicated in CMS systems for that CPM. Once the CPM advances to the next month, MARx is no longer processing transactions to include in the CPM payments and begins processing transactions reflected in the next CPM.

As changes to beneficiary or Plan data are received, adjustments are made to monthly payments. Changes will cause a recalculation of one or more payment components. The adjustments are processed retroactively to the change effective date and reported to the Plans on the monthly payment reports.

Note: Prior to January 1, 2015, policy dictated that the actual payment adjustments are generally limited to the three-year period preceding the CPM. Effective January 1, 2015, MARx will begin to retroactively calculate payment adjustments, both positive and negative, going back seven full payment years prior to the current payment year. This limitation is known as the Payment Adjustment Period (PAP).

6.1 Arrange for Payments

The Automated Plan Payment System (APPS) calculates the final monthly payment to the Plans, prepares the electronic transmittal, and sends to the U.S. Treasury for payment.

When the contract/Plan Benefit Package (PBP) is activated, the Plan must submit banking information and other identifying information to CMS using the **Payment Information Form**, on the following page.

CMS enters the data in APPS to identify the financial institution where the funds are deposited on the payment date. Additionally, CMS must have the Employee Identification Number/Tax Identification Number (EIN/TIN), and the associated name as registered with the IRS, for income reporting purposes to each Plan.

To ensure timely payments, Plans are required to submit the following to the attention of the Payment Administrator in DPO either by fax 410-786-0486 or e-mail DPO_Payment_Administrator@cms.hhs.gov.

- Completed Payment Information Form.
- Copy of a voided check or a letter from their bank confirming the account information.
- Copy of their W-9 form.

It is the Plan's responsibility to provide CMS with updates to the banking information by submitting changes on a new Payment Information Form.

Figure 6-1: CMS Payment Information Form

CMS Payment Information Form
ORGANIZATION INFORMATION

NAME OF ORGANIZATION: _____
DBA, if any: _____

ADDRESS:
CITY: _____ STATE: _____ ZIP CODE:_____

CONTACT PERSON NAME: _____
TELEPHONE NUMBER: _____

CONTRACT NUMBERS: H _____; H _____; H _____; H _____
(If known)

EIN/TIN NAME of business for tax purposes (as registered with the IRS: a W-9 may be required)
_____

EMPLOYER/TAX IDENTIFICATION NUMBER (EIN or TIN): _____

Mailing address for 1099 tax form:
STR1: _____
STR2: _____
CITY: _____
STATE:_____ ZIP: _____ - _____

FINANCIAL INSTITUTION

NAME OF BANK: _____
ADDRESS: _____
CITY: _____ STATE: _____ZIP CODE: _____ - _____

ACH/EFT COORDINATOR NAME: _____
TELEPHONE NUMBER: _____

NINE DIGIT ROUTING TRANSIT (ABA) NUMBER: _____
DEPOSITOR ACCOUNT TITLE: _____
DEPOSITOR ACCOUNT NUMBER: _____
CIRCLE ACCOUNT TYPE: CHECKING SAVINGS (Please attach a copy of a voided check)

SIGNATURE & TITLE OF ORGANIZATION'S AUTHORIZED REPRESENTATIVE:

_____DATE: _____
Signature Title

_____ _____
Print Name Phone Number

3/12/03

6.2 Part C Payment Calculation

This section provides an overview of Part C payment calculation. Part C payments are paid to a Plan in exchange for providing Medicare Part A and/or B coverage to Medicare beneficiaries enrolled in the Plan.

An overview of the methodologies that CMS employs to reimburse all types of Medicare Advantage (MA) Plans is available at the *Medicare Managed Care Manual (MMCM):* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLSort=0&DLSortDir=ascending; then click on Chapter 8 in the Downloads section.

Before the payment process begins, the beneficiary submits the enrollment application to the Plan, and the Plan checks the eligibility of the beneficiary and transmits an enrollment transaction to CMS. If the enrollment transaction is accepted, CMS calculates the Part C payment. If CMS rejects the enrollment, the Plan is notified. If possible, the Plan must correct the rejected information and resubmit the transaction.

The calculation of Part C payments varies and is separately described in the following sections:

- **Beneficiaries electing Hospice Coverage.**
- **Beneficiaries with End Stage Renal Disease (ESRD).**
- **Aged or Disabled Beneficiaries enrolled in an MA Plan.**
- **Aged or Disabled Beneficiaries enrolled in a Program for All-Inclusive Care for the Elderly (PACE) Plan.**
- **When Medicare Secondary Payer (MSP) Status applies**.

The following table lists the fields in the Monthly Membership Detail Data File that are used to calculate Part C Payments.

Note: This section does not describe Part C payment for beneficiaries enrolled in Cost Plans, Healthcare Prepayment Plans (HCPP), Chronic Care Demonstrations, and Medical Savings Account (MSA) Plans.

Table 6-1: Part C Payment Calculation Fields

Monthly Membership Detail Data File Fields used for Part C Payment Calculations				
Item	**Field**	**Size**	**Position**	**Description**
24	Risk Adjustment Factor A	7	72-78	Part A Risk Adjustment Factor used for the Payment Calculation.
25	Risk Adjustment Factor B	7	79-85	Part B Risk Factor used for the Payment Calculation.
33	Monthly Payment/Adjustment Amount Rate A	9	126-134	Part A portion of the payment or 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 Membership Detail Data File Fields used for Part C Payment Calculations				
Item	**Field**	**Size**	**Position**	**Description**
34	Monthly Payment/Adjustment Amount Rate B	9	135-143	Part B portion of the payment or 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.
53	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.
54	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.
55	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.
56	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.
57	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.
58	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.
59	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.
60	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.
61	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.
62	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.
63	Total Part A MA Payment	10	279–288	The total Part A MA payment.
64	Total Part B MA Payment	10	289–298	The total Part B MA payment.
65	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.

Monthly Membership Detail Data File Fields used for Part C Payment Calculations				
Item	**Field**	**Size**	**Position**	**Description**
80	Part C Frailty Score Factor	7	412-418	Part C frailty score factor used in this payment or adjustment calculation.
81	MSP Factor	7	419-425	MSP secondary payer reduction factor used in this payment or adjustment calculation.
82	MSP Reduction/Reduction Adjustment Amount – Part A	10	426-435	Net MSP reduction or reduction adjustment dollar amount– Part A.
83	MSP Reduction/Reduction Adjustment Amount – Part B	10	436-445	Net MSP reduction or reduction adjustment dollar amount – Part B.
88	Part A Risk Adjusted Monthly Rate Amount for Payment/Adjustment	9	459-467	The Part A Risk Adjusted amount used in the payment or adjustment calculation. Payments = Rate amount in effect for payment period. Adjustments = Rate amount in effect for adjustment period.
89	Part B Risk Adjusted Monthly Rate Amount for Payment/Adjustment	9	468-476	The Part B Risk Adjusted amount used in the payment or adjustment calculation. Payments = Rate amount in effect for payment period. Adjustments = Rate amount in effect for adjustment period.

6.2.1 *Hospice Payment Calculation*

Traditional Medicare Fee-for-Service (FFS) provides Medicare Part A and B benefits for a beneficiary electing Hospice Coverage. If the beneficiary is already enrolled in an MA Plan at the time of election, the Part C payment to the MA Plan is only for extra benefits provided by the Plan that are not provided by FFS.

The Part C payment is equal to the MA rebate, excluding any MA rebates for Part B premium reduction and Part D basic premium reduction. Otherwise, it equals zero. See the table below for calculation details.

Table 6-2: Hospice Payment Calculation

Part C Payment for Beneficiaries Electing Hospice Coverage	
Total	**Calculation using these fields**
Total MA Payment Part A (#63) =	+ MA Rebate Part A Cost Sharing Reduction (#55)
	+ MA Rebate Part A Other Mandatory Supplemental Benefits (#57)
	+ MA Rebate Part A Part D Supplemental Benefits (#61).
Total MA Payment Part B (#64) =	+ MA Rebate Part B Cost Sharing Reduction (#56)
	+ MA Rebate Part B Other Mandatory Supplemental Benefits (#58)
	+ MA Rebate Part B Part D Supplemental Benefits (#62).
Total MA Payment (#65) =	+ Total MA Payment Part A (#63)
	+ Total MA Payment Part B (#64).

6.2.2 ESRD Payment Calculation

Prospective payments are made based on the ESRD health status. The process of passing the information through the various databases may take as long as four months from the time the beneficiary is identified by the physician as having ESRD. Therefore, the Plan may not begin receiving the ESRD capitation rate of pay for the beneficiary for at least four months.

When the health status is included in the capitation/risk adjustment (RA) rate for the beneficiary already in Medicare, MARx automatically calculates retroactively to include the first month of ESRD health status within the PAP. However, if the beneficiary is entitled to Medicare as a result of ESRD, there is a three-month waiting period before Medicare entitlement begins.

The Renal Management Information System (REMIS) automatically adjusts for the three-month waiting period and updates the Enrollment Database (EDB) system and MARx, resulting in Plans receiving payment at the ESRD capitation/RA rate of pay. The health status is based on the first date of dialysis as indicated on the ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration, Form CMS-2728-U3. In addition, the physician's clearly legible signature and signature date are necessary before the ESRD facility can enter any information in the Standard Information Management System (SIMS).

The managed care staff at the Retro-Processing Contractor, the regional office, or central office cannot enter ESRD status changes and corrections into MARx. The managed care staff can synchronize MBD to the Enrollment Database if these systems' data do not match. This process may result in a change in the ESRD status and the associated positive or negative payment. The ESRD facilities enter the data from the CMS-2728-U3, which is transmitted to the CMS CROWN Web system through an automated process. The CMS-2728-U3 is the key source of documentation to ensure that a beneficiary is identified with ESRD health status indicator. The ESRD facility must complete the CMS-2728-U3 within 45-days of beginning a regular course of dialysis or receiving a kidney transplant, which was prescribed by a physician.

- The ESRD facility forwards a copy of the CMS 2728-U3 to its local SSA Field Office
- For individuals diagnosed with ESRD, the SSA determines eligibility for the Medicare ESRD entitlement based on CMS-2728-U3 under the ESRD provisions of the law.
- The ESRD facility inputs the information into the CMS CROWN Web data system.
- CMS updates the information in REMIS, the CMS central repository for beneficiaries with ESRD.
- Daily, REMIS updates the EDB with ESRD health status start and/or end dates for the Plan member. MARx is the source of information used in computing the monthly capitation rates that the Plan receives.

Plans may contact the appropriate Facility or Renal Network to verify specific discrepancy data by visiting: https://www.medicare.gov/people-like-me/esrd/esrd.html The ESRD facility will only supply the following information:

- The first date of dialysis or date of transplant.
- Date the beneficiary's CMS-2728-U3 was submitted to DMS by the ESRD facility.
- Current Renal Status.

Note: This information is not required for a retroactive adjustment.

Medicare Part A and B benefits for beneficiaries with ESRD are provided by their Plans. The applicable monthly payment rates are set by CMS and remain outside the bidding process. Beneficiaries in Dialysis or Transplant statuses are paid State rates. Beneficiaries in Functioning Graft Status receive payment using CMS benchmark county rates.

Beneficiaries with ESRD who are enrolled in an MA Plan where an MA Rebate for Part B Premium Reduction or MA Rebate for Part D Basic Premium Reduction is applicable receive these rebate benefits through their enrollment in the Plan, despite the fact that the Part C risk-adjusted payment is not based upon the Plan's bid. The risk-adjusted portion of the Part C payment is therefore reduced by the MA Rebate premium reduction benefits to make room to provide the required rebate benefits. See table below for calculation details.

For beneficiaries with ESRD who are enrolled in a PACE Plan, the Part C Payment calculations are exactly the same as if enrolled in an MA Plan, except MA Rebates are not applicable.

Table 6-3: ESRD Payment Calculation

Part C Payment for Beneficiaries with ESRD	
Total	**Calculation using these fields**
RA Payment Part A (#33)	Part A Monthly Payment Rate (#88)
	* RA Factor A (#24).
Total MA Payment Part A (#63) =	+ RA Payment Part A (#33)
	- MA Rebate Part A for Part B Premium Reduction (#59)
	- MA Rebate Part D Basic Premium Reduction (Part A portion) (#71).
RA Payment Part B (#34) =	Part B Monthly Payment Rate (#89)
	* RA Factor B (#25).
Total MA Payment Part B (#64) =	+ RA Payment Part B (#34)
	- MA Rebate Part B for Part B Premium Reduction (#60)
	- MA Rebate Part D Basic Premium Reduction (Part B portion) (#71).
Total MA Payment (#65) =	+ Total MA Payment Part A (#63)
	+ Total MA Payment Part B (#64).

6.2.3 Aged or Disabled Payment Calculation

Calculation of Part C Payments for Aged/Disabled Beneficiaries in an MA Plan depends upon the relationship of the Plan's A/B Bid to the applicable CMS Benchmark. The following tables show the Part C Payment calculation when the Plan A/B bid equals, is less than, and is greater than the CMS Benchmark.

Table 6-4: Part C Payment for Aged or Disabled enrolled in MA Plan: Plan A/B Bid Equal to CMS Benchmark

Part C Payment for Aged or Disabled enrolled in MA Plan: Plan Bid Equal Benchmark	
Total	**Calculation using these fields**
RA Payment Part A (#33)	Part A Monthly Payment Rate (#88)
	* RA Factor A (#24).
Total MA Payment Part A (#63) =	RA Payment Part A (#33)
RA Payment Part B (#34) =	Part B Monthly Payment Rate (#89)
	* RA Factor B (#25).
Total MA Payment Part B (#64) =	RA Payment Part B (#34)
Total MA Payment (#65) =	+ Total MA Payment Part A (#63)
	+ Total MA Payment Part B (#64).

Table 6-5: Part C Payment for Aged or Disabled enrolled in MA Plan: Plan A/B Bid Less than CMS Benchmark

Part C Payment for Aged or Disabled enrolled in MA Plan: Plan Bid Less than Benchmark	
Total	**Calculation using these fields**
RA Payment Part A (#33)	Part A Monthly Payment Rate (#88)
	* RA Factor A (#24).
Total MA Payment Part A (#63) =	+ RA Payment Part A (#33)
	+ MA Rebate Part A Cost Sharing Reduction (#55)
	+ MA Rebate Part A Other Mandatory Supplemental Benefits (#57)
	+ MA Rebate Part A Part D Supplemental Benefits (#61).
RA Payment Part B (#34) =	Part B Monthly Payment Rate (#89)
	* RA Factor B (#25).
Total MA Payment Part B (#64) =	+ RA Payment Part B (#34)
	+ MA Rebate Part B Cost Sharing Reduction (#56)
	+ MA Rebate Part B Other Mandatory Supplemental Benefits (#58)
	+ MA Rebate Part B Part D Supplemental Benefits (#62)
Total MA Payment (#65) =	+ Total MA Payment Part A (#63)
	+ Total MA Payment Part B (#64).

Table 6-6: Part C Payment for Aged or Disabled enrolled in MA Plan: Plan A/B Bid Greater than CMS Benchmark

Part C Payment for Aged or Disabled enrolled in MA Plan: Plan Bid Greater than Benchmark	
Total	**Calculation using these fields**
RA Payment Part A (#33)	Part A Monthly Payment Rate (#88)
	* RA Factor A (#24).
Total MA Payment Part A (#63) =	+ RA Payment Part A (#33).
	- Part C Basic Premium Amount Part A (#53).
RA Payment Part B (#34) =	Part B Monthly Payment Rate (#89)
	* RA Factor B (#25).
Total MA Payment Part B (#64) =	+ RA Payment Part B (#34).
	- Part C Basic Premium Amount Part B (#54).
Total MA Payment (#65) =	+ Total MA Payment Part A (#63)
	+ Total MA Payment Part B (#64).

6.2.4 *PACE Plan Payment Calculation*

Part C Payment calculations for Aged/Disabled Beneficiaries in a PACE Plan are based upon monthly payment rates set by CMS which, like ESRD, remain outside the bidding process. MA Rebates and Part C Basic premiums are components of bid-based payments and do not apply.

Aged/Disabled Beneficiaries enrolled in a PACE Plan who reside in a community setting also receive a Frailty Factor Adjustment in addition to the normal Risk Adjustment. See the following table for calculation details.

Table 6-7: Part C Payment for a PACE Plan

Part C Payment for Aged or Disabled enrolled in PACE Plan	
Total	**Calculation using these fields**
RA Payment Part A (#33)	Part A Monthly Payment Rate (#88)
	* (RA Factor A (#24) + Part C Frailty Score (#80)).
Total MA Payment Part A (#63) =	RA Payment Part A (#33).
RA Payment Part B (#34) =	Part B Monthly Payment Rate (#89)
	* (RA Factor B (#25) + Part C Frailty Score (#80)).
Total MA Payment Part B (#64) =	RA Payment Part B (#34).
Total MA Payment (#65) =	+ Total MA Payment Part A (#63)
	+ Total MA Payment Part B (#64).

6.2.5 Medicare Secondary Payer (MSP) Payment Calculation

Medicare is a secondary payer for Aged or Disabled beneficiaries with employer-provided health insurance, or for beneficiaries with ESRD, during the coordination of benefits period. When MSP Status applies, the risk-adjusted portion of the Part C Payment is reduced to account for the coverage that the employer provides for Working Aged or Working Disabled beneficiaries, or that the health Plan provides for beneficiaries with ESRD.

The MSP Reduction Amount is an additional Part C payment adjustment that is applied after all other calculations described in the previous sections are completed.

For Part C Payments involving an MA Rebate, the Rebate is ignored in computing the MSP Reduction Amounts. See the table below for calculation details.

Table 6-8: Part C Payment when MSP Status Applies and involves an MA Rebate

Part C Payment when MSP Status Applies and involves an MA Rebate	
Total	**Calculation using these fields**
MSP Reduction Amount Part A (#82) =	RA Payment Part A (#33)
	* (1 - MSP Factor (#81)).
Total MA Payment Part A (#63) =	Total MA Payment Part A (#63)
	- MSP Reduction Amount Part A (#82).
MSP Reduction Amount Part B (#83) =	RA Payment Part B (#34)
	* (1 - MSP Factor (#81)).
Total MA Payment Part B (#64) =	Total MA Payment Part B (#64)
	- MSP Reduction Amount Part B (#83).
Total MA Payment (#65) =	+ Total MA Payment Part A (#63)
	+ Total MA Payment Part B (#64).

For Part C Payments involving a Part C Basic Premium, the Premium is subtracted from the RA Payment before computing the MSP Reduction Amounts. See the table below for calculation details.

Table 6-9: Part C Payment when MSP Status Applies and involves Part C Basic Premium

Part C Payment when MSP Status Applies and involves Part C Basic Premium	
Total	**Calculation using these fields**
MSP Reduction Amount Part A (#82) =	RA Payment Part A (#33)
	- Part C Basic Premium Amount Part A (#53)
	* (1 - MSP Factor (#81).
Total MA Payment Part A (#63) =	MA Part A Payment/Adjustment (#33)
	- MSP Reduction Amount Part A (#82).
MSP Reduction Amount Part B (#83) =	RA Payment Part B (#34)
	- Part C Basic Premium Amount Part B (#54)
	* (1 - MSP Factor (#81).

Part C Payment when MSP Status Applies and involves Part C Basic Premium	
Total	**Calculation using these fields**
Total MA Payment Part B (#64) =	MA Part B Payment/Adjustment (#34)
	- MSP Reduction Amount Part B (#83).
Total MA Payment (#65) =	+ Total MA Payment Part A (#63)
	+ Total MA Payment Part B (#64).

6.3 Part D Payment Calculation

Plans receive Part D payments in exchange for providing Medicare Part D coverage to Medicare beneficiaries.

Before the payment process begins, the beneficiary submits the enrollment application, and the Plan checks the beneficiary's eligibility and transmits an enrollment transaction to CMS. If the enrollment transaction is accepted, CMS finalizes the accepted enrollment and notifies the Plan, which then notifies the beneficiary. If CMS rejects the enrollment, the Plan is notified and must correct the rejection reason. With an accepted enrollment transaction, CMS calculates the Part D payment.

Several Part D Payment components are estimated amounts subject to a cost-based annual Part D payment reconciliation; these results are reflected on the Plan Payment Report (PPR), and not on the Monthly Membership Report (MMR). The estimated payments are:

- Part D Low-Income Cost-Sharing (LICS) Subsidy.
- Part D Reinsurance Subsidy.
- Part D Coverage Gap Discount Amount[1]

The following table lists the fields in the Monthly Membership Detail Data File that are used to calculate Part D Payments.

Table 6-10: Part D Payment Calculation Fields

Monthly Membership Detail Data File Field Names for Part D Payment Calculations				
Item	**Field**	**Size**	**Position**	**Description**
35	Part D Low-Income Premium Subsidy (LIPS) Amount	8	144-151	
37	Medication Therapy Management (MTM) Add-On	10	153-162	
66	Part D RA Factor	7	310-316	
71	MA Rebate Part D Basic Premium Reduction	8	333-340	
72	Part D Basic Premium Amount	8	341-348	
73	Part D Direct Subsidy Amount	10	349-358	
74	Part D Reinsurance Subsidy Amount	10	359-368	
75	Part D LICS Subsidy	10	369-378	
76	Total Part D Payment	11	379-389	
78	PACE Part D Premium Add-on	10	392-401	
79	PACE Part D Cost Sharing Add-on	10	402-411	
85	Part D Coverage Gap Discount Amount	8	448-455	
90	Part D Monthly Payment Rate	9	477-485	

[1] The Coverage Gap Discount is not a subsidy, but an advance to provide cash flow. Offsets against the Plan's total payment are periodically taken when the discount payments are made by drug manufacturers, and again during the Annual Part D Reconciliation.

6.3.1 Calculation of the Part D Direct Subsidy

The Plan's Part D bid is reported on the MMR and shown below as the Part D Monthly Payment Rate. The Part D Basic Premium Amount reported on the MMR, and included in the formula below, is not necessarily the same as the premium paid by the beneficiary but an amount specifically calculated for use in this payment formula. See the table below for calculation details.

Note: It is possible for the Part D Direct Subsidy calculation to result in a negative amount for an individual beneficiary.

Table 6-11: Part D Direct Subsidy

Part D Direct Subsidy	
Total	**Calculation using these fields**
Part D Direct Subsidy Amount (#73) =	(Part D Monthly Payment Rate (#90)
	* Part D RA Factor (#66))
	- Part D Basic Premium Amount (#72).

6.3.2 Calculation of the Total Part D Payment

The Total Part D Payment (#76) for a beneficiary is the sum of the following amounts; no individual payment includes all components:

Item	Field
35	Part D Low-Income Premium Subsidy (LIPS) Amount
37	Medication Therapy Management (MTM) Add-On
71	MA Rebate Part D Basic Premium Reduction
73	Part D Direct Subsidy Amount
74	Part D Reinsurance Subsidy Amount
75	Part D LICS Subsidy
78	PACE Part D Premium Add-on
79	PACE Part D Cost Sharing Add-on
85	Part D Coverage Gap Discount Amount
76	Total Part D Payment

6.4 Coverage Gap Discount Program

The Coverage Gap Discount Program (CGDP) provides manufacturer discounts to eligible Medicare beneficiaries receiving covered Part D drugs while in the coverage gap (i.e., the "donut hole"). Eligible Medicare beneficiaries in the program consist of non-low income subsidy eligible (non-LIS) beneficiaries who are not enrolled in an Employer Group Waiver Plan (EGWP) or a Program of the All Inclusive Care for the Elderly (PACE) organization. Part D sponsors must provide the discounts for applicable drugs in the coverage gap at point-of-sale (POS). CMS coordinates the collection of discount payments from manufacturers and payment to Part D sponsors that provided the discount.

6.4.1 *Prospective Payments*

CMS provides a monthly prospective CGDP payment that is calculated on the projection in each Part D Plan's bid and their current enrollment. These prospective payments provide cash flow to Part D sponsors for advancing the gap discounts at the POS.

Prospective CGDP payments for a contract year begin with the January monthly payment for the contract year and end with the December monthly payment. Adjustments for a contract year continue until January 31 of the following year. For example, the first prospective payment for a benefit year is in the January monthly payment and the last payment containing adjustments is in the following January monthly payment. The prospective CGDP payment amounts will be found on the Monthly Membership Report (MMR).

6.4.2 *Manufacturers Offset*

On a quarterly basis, CMS will invoice manufacturers for discounts provided by Part D sponsors. Manufacturers will remit payments for invoiced amounts directly to Part D sponsors. The prospective payments made to Part D sponsors will be reduced by the discount amounts invoiced to manufacturers. These offsets will ensure that Part D sponsors do not receive duplicate payments for discounts made available to their enrollees.

On a quarterly basis following the invoicing cycle, CMS offsets monthly prospective CGDP payments for discount amounts invoiced to manufacturers. The offset amount will appear as a negative adjustment to the next monthly prospective payment processed through Automated Plan Payment System (APPS). When the APPS offset exceed the prospective CGDP payment for that month, CMS will apply the offset to the Part D sponsor's total payment.

6.4.3 CGDP Reconciliation

After the end of the contract year, 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. The actual manufacturer discount amounts will be determined based on the manufacturer discount amounts reported by Part D sponsors on the Prescription Drug Event (PDE) records. Active Plans during the reconciliation benefit year will receive a set of management reports from the Payment Reconciliation System (PRS) detailing the inputs and results of the CGDP reconciliation process for the contract year. Questions regarding Coverage Gap Discount Reconciliation should be directed to the Reconciliation Support Contractor at: PartDPaymentSupport@acumenllc.com.

6.5 Reconciliation of Plan Data with CMS Data

Plans are responsible for providing CMS with timely and accurate information regarding the beneficiaries' enrollment, disenrollments, special membership status, and State and County Code changes. CMS is responsible for providing Plans with timely and accurate reports to verify membership and payment information.

During their monthly reconciliation process, Plans should verify their membership and payment information. To ensure a complete and accurate reconciliation, Plans must understand and review all CMS-provided reports. This User Guide contains all provided reports, data files, and record layouts. It is required that all Plans are familiar with all of these reports and data files and their impact on the accuracy of beneficiaries' information.

CMS also provides reports to Plans for information verification. Some reports have very specialized data, with limited use in the overall reconciliation effort. Plans should use the Daily Transaction Reply Report (DTRR) to reconcile their beneficiary records with the Monthly Membership Report (MMR), which is beneficiary specific.

The Plan Payment Report (PPR) includes contract/PBP payment information and contract/PBP payment adjustment information. Therefore, when reconciling report data, Plans must compare the beneficiary level payment on the MMR with the contract level payment information on the PPR. Plans can refer to the Part C/D Reference Table & Section 6.2, Payment Calculations, for more information.

To complete the final month-end reconciliation, Plans should reconcile the DTRRs with the MMR, PPR, Monthly Premium Withholding Report (MPWR) Data File, and LIS and LEP Reports. Plans must submit certification of enrollment monthly, to attest to the completion of reconciliation of membership and payment reports. The MARx Monthly Calendar on the MAPD Help Desk website lists certification due dates. Plans with specific reconciliation questions should contact the Division of Payment Operations (DPO) Central Office (CO) contact person.

6.6 Payment Data Files and Reports

CMS reports contain Plan Medicare membership and payment information as indicated in CMS systems for the Current Payment Month (CPM). In general, these data files allow Plans to compare Medicare membership and payment information with the Plan's internal records to assist Plans in identifying and correcting any discrepancies.

This section contains the following Payment Data Files and reports:

6.6.1 Monthly Membership Report (MMR) Data File

The Monthly Membership Detail data file (MMR) is the basic accounting file of beneficiary level payments and adjustments for Medicare Advantage and Part D organizations.

System	Type	Frequency	File Length	Monthly Membership Detail Report Dataset Naming Conventions
MARx	Data File	Monthly	495	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MONMEMD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MONMEMD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MONMEMD.Dyymm01.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the current payment month.

Layout 6-1: Monthly Membership Detail Report

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
1	Contract Number	5	1-5	Plan Contract Number.
2	Run Date	8	6 - 13	Date the file was produced. CCYYMMDD
3	Payment Date	6	14 - 19	Payment month for the report. CCYYMM
4	Beneficiary ID	12	20 - 31	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end
5	Surname	7	32 - 38	First 7 characters of beneficiary's last name
6	First Initial	1	39	First initial of the beneficiary's first name
7	Gender Code	1	40	Beneficiary's Gender Code. M = Male. F = Female.
8	Date of Birth	8	41 - 48	Beneficiary's date of birth. (CCYYMMDD

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
9	Age Group	4	49 - 52	Age group for the beneficiary for this payment month (BBEE). BB = Beginning Age of range. EE = Ending Age of range. *The field was used in determining Demographic payments and is not relevant since payments are based on 100% RA.*
10	State & County Code	5	53 - 57	Beneficiary State and County Code.
11	Out of Area Indicator	1	58	Indicator that the beneficiary is Out of Area for the Plan. Y = Out of Contract-level service area. Space = Not out of area. Always Space on Adjustment records.
12	Part A Entitlement	1	59	Indicator that the beneficiary is entitled to Part A. Y = Entitled to Part A. Space = Not entitled to Part A.
13	Part B Entitlement	1	60	Indicator that the beneficiary is entitled to Part B. Y = Entitled to Part B. Space = Not entitled to Part B.
14	Hospice	1	61	Indicator that the beneficiary is in Hospice status. Y = Hospice. Space = Not in Hospice status.
15	ESRD	1	62	Indicator that the beneficiary has ESRD. Y = ESRD. Space = Not ESRD.
16	MSP Aged/Disabled	1	63	Indicator that Medicare is Secondary Payer. Y = aged/disabled factor applicable to beneficiary. N = aged/disabled factor not applicable to beneficiary.
17	Institutional	1	64	Indicator that the beneficiary is institutional. Y = Institutional (monthly). Space = Not institutional. *The field was used in determining Demographic payments and is no longer relevant to payment.*
18	Nursing Home Certifiable (NHC)	1	65	Indicator that the beneficiary is in Nursing Home Certifiable (NHC) status. Y = NHC. Space = Beneficiary is not NHC. *The field was used in determining Demographic payments and is no longer relevant to payment.*

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
19	Medicaid Status of a New Medicare Beneficiary	1	66	Beneficiary's Medicaid Status used for the month being paid or adjusted. Y = Medicaid and a default risk factor was used. N = Not Medicaid and a default risk factor was used. Space = No default risk factor or beneficiary is Part D only.
20	Long Term Instituional (Part C)	1	67	Indicator that beneficiary has Part C Long Term Institutional (LTI) Status. Y = Part C LTI. Space = Not LTI.
21	Medicaid Add-on Factor (Part C PACE, LTI/HCC, or ESRD)	1	68	Indicator that the RASS Medicaid Add-on score was used for this payment or adjustment for a beneficiary that is enrolled in a PACE plan or has ESRD or LTI status. When: • A RASS supplied add-on score is used in the payment Space = No Medicaid Add-on was used in the payment.
22	PIP-DCG	2	69-70	PIP-DCG Category - Only on pre-2004 adjustments. *The field is no longer relevant to payment.*
23	Default Risk Factor Code (Part C)	1	71	Indicator that a Default Risk Adjustment Factor (RAF) was used for calculating this payment or adjustment. *A Default Risk Adjustment Factor (score) is used only if the RASS system did not provide MARx rrisk scores for this beneficiary. In these cases MARx assigns a default score based upon "demographics" of the beneficiary.* 1 = Default Enrollee- Aged/Disabled. 2 = Default Enrollee- ESRD dialysis. 3 = Default Enrollee- ESRD Kidney Transplant- Month 1. 4 = Default Enrollee- ESRD Kidney Transplant - 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. Space = The beneficiary is not a default enrollee.
24	Risk Adjustment Factor (Part A)	7	72-78	Part A Risk Adjustment Factor used for the Payment Calculation. NN.DDDD

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
25	Risk Adjustment Factor (Part B)	7	79-85	Part B Risk Adjustment Factor used for the Payment Calculation. NN.DDDD
26	Number of Payment/Adjustment Months (Part A)	2	86-87	Number of months included in this payment or adjustment for Part A
27	Number of Payment/Adjustment Months (Part B)	2	88-89	Number of months included in this payment or adjustment for Part B
28	Adjustment Reason Code (ARC)	2	90-91	Code that indicates the reason for this adjustment. Spaces = a Prospective Payment.
29	Start Date Payment/Adjustment	8	92-99	Earliest date covered by this payment or adjustment. CCYYMMDD
30	End Date Payment/Adjustment	8	100-107	Latest date covered by this payment or adjustment. CCYYMMDD
31	Demographic Payment/Adjustment Rate (Part A)	9	108-116	Part A Demographic Rate used in this payment or adjustment calculation. -99999.99 **2008 and later** = Always 0.00 because Demographic component is no longer part of the payment calculation. **Prior to 2008** = Demographic Payment/Adjustment Rate A. *The field was used in determining Demographic payments and is no longer relevant to payment.*
32	Demographic Payment/Adjustment Rate (Part B)	9	117-125	Part B Demographic Rate used in this payment or adjustment calculation. -99999.99 **2008 and later** = Always 0.00 because Demographic component is no longer part of the payment calculation **Prior to 2008** = Demographic Payment/Adjustment Rate B. *The field was used in determining Demographic payments and is no longer relevant to payment.*
33	Risk Adjustment Amount (Part A)	9	126-134	Part A portion of the payment or adjustment dollars. -99999.99
34	Risk Adjustment Amount (Part B)	9	135-143	Part B portion of the payment or adjustment dollars. -99999.99
35	LIS Premium Subsidy (Part D)	8	144-151	Low Income Premium Subsidy Amount for the beneficiary. -9999.99

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
36	MSP ESRD	1	152	Indicator that Medicare is a Secondary Payer due to ESRD. As of January 2011: T = MSP due to Transplant/Dialysis. P = MSP due to Post Graft. Space = ESRD MSP not applicable.
37	Medication Therapy Management (MTM) Amount (Part D)	10	153-162	The total Medication Therapy Management (MTM) Add-On for the member. 999999.99.
38	Filler	8	163-170	Spaces
39	Medicaid Status	1	171	The Medicaid status that is in effect for the month used to determine the appropriate community risk score for a NON-ESRD, Full-risk, NON-PACE beneficiary. *(Medicaid status = CPM-3)* For all other risk scores, this field is informational. 1 = Beneficiary is determined to be full or partial Medicaid 0 = Beneficiary is not Medicaid Space = This is a retroactive adjustment for a month prior to January 2017.
40	Risk Adjustment Age Group (RAAG)	4	172-175	The Risk Adjustment Age Group for the beneficiary (BBEE). BB = Beginning Age EE = Ending Age *Note: This field should be used for all payments after 2007 (and not Item #9).*
41	Previous Disable Ratio (PRDIB)	7	176-182	Percentage of Year (in months) for Previous Disable Add-On. NN.DDDD Greater than 0.00 – Only on adjustments for pre-2004 periods. 0.00 – On adjustments beyond 2004. Spaces – On prospective payments. *FIELD OBSOLETE*
42	De Minimis (Part D)	1	183	Indicates if de minimis applies for this row. Prior to 2008, flag is spaces. Beginning 2008: N = de minimis does not apply. Y = de minimis applies.

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
43	Concurrent Enrollment	1	184	The beneficiary's concurrent enrollment status (A beneficiary that is enrolled in two (2) Contracts): 0 = Plan without drug benefit, beneficiary not dual enrolled 1 = Plan with drug benefit, beneficiary not dual enrolled. 2 = Plan without drug benefit, beneficiary dual enrolled. 3 = Plan with drug benefit, beneficiary dual enrolled.
44	Plan Benefit Package ID	3	185-187	PBP Number
45	Race Code	1	188	Beneficiary's Race: 0 = Unknown. 1 = White. 2 = Black. 3 = Other. 4 = Asian. 5 = Hispanic. 6 = North American Native.
46	Risk Adjustment Factor Type Code	2	189-190	The type of Part C Risk Adjustment Factor used to calculate this payment or adjustment. C = Community (Adjustments before 2017; PACE only beginning 1/2017) C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) CF = Community Full Dual CP = Community Partial Dual CN = Community Non-Dual 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 PA = PACE Dialysis Factor PB = PACE New Enrollee Dialysis Factor PC = PACE Community Post Graft 4-9 PD = PACE Institutional Post Graft 4-9 PE = PACE New Enrollee Post Graft 4-9 PF = PACE Community Post Graft 10+ PG = PACE Institutional Post Graft PH = PACE New Enrollee Post Graft 10+

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
47	Frailty Indicator (PACE/FIDE SNPs only)	1	191	Indicator that a Plan-level Frailty Factor was included in the calculation of the payment or adjustment. Y = Frailty Factor Included. N = No Frailty Factor.
48	Original Reason for Entitlement Code (OREC)	1	192	The original reason that the beneficiary was entitled to Medicare. 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.
49	Risk Adjustment Lag Indicator	1	193	Indicator that there is a lag in the encounter data used to calculate RAF. Y = Lags payment year by 6 months. N = No lag.
50	Segment Number	3	194-196	Segment number for the beneficiary's enrollment. 000 = Plan with no segments.
51	Enrollment Source	1	197	The source of the enrollment. A = Auto-enrolled by CMS. B = Beneficiary election. C = Facilitated enrollment by CMS. D = Systematic enrollment by CMS (rollover). N = Plan-submitted rollover.
52	EGHP Flag	1	198	Indicator that the Plan is an Employer Group Health Plan. Y = Employer Group Health Plan. N = Not an Employer Group Health Plan.
53	Basic Part C Premium Amount (Part A)	8	199-206	The premium amount for determining the MA payment attributable to Part A. -9999.99
54	Basic Part C Premium Amount (Part B)	8	207-214	The premium amount for determining the MA payment attributable to Part B. -9999.99
55	MA Rebate Cost Sharing Reduction (Part A)	8	215-222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. -9999.99
56	MA Rebate Cost Sharing Reduction (Part B)	8	223-230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. -9999.99
57	MA Rebate Mandatory Supplemental Benefits (Part A)	8	231-238	The amount of the rebate allocated to providing Part A supplemental benefits. -9999.99
58	MA Rebate Mandatory Supplemental Benefits (Part B)	8	239-246	The amount of the rebate allocated to providing Part B supplemental benefits. -9999.99

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
59	MA Rebate Part B Premium Reduction (Part A)	8	247-254	The Part A amount of the rebate allocated to reducing the member's Part B premium. -9999.99
60	MA Rebate Part B Premium Reduction (Part B)	8	255-262	The Part B amount of the rebate allocated to reducing the member's Part B premium. -9999.99
61	MA Rebate Part D Supplemental Benefits (Part A)	8	263–270	Part A Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
62	MA Rebate Part D Supplemental Benefits (Part B)	8	271–278	Part B Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
63	Total MA Amount (Part A)	10	279–288	The total Part A MA payment. -999999.99
64	Total MA Amount (Part B)	10	289–298	The total Part B MA payment. -999999.99
65	Total MA Amount (Part C)	11	299-309	The total MA A/B payment. -9999999.99
66	Risk Adjustment Factor (Part D)	7	310-316	Part D Risk Adjustment Factor used for the Payment Calculation. NN.DDDD
67	Low-Income Multiplier Indicator (Part D)	1	317	Indicator of beneficiary's Low Income status for the Part D payment or adjustment. **For 2011 and later:** Y = beneficiary is Low Income. N = beneficiary is not Low Income. Space = Not applicable.
68	Low-Income Multiplier (Part D)	7	318-324	The Part D low-income multiplier used in the calculation of the payment or adjustment. NN.DDDD
69	Long Term Institutional (Part D)	1	325	Indicator of beneficiary's Long Term Institutional (LTI) status for the Part D payment or adjustment. A = LTI (aged) D = LTI (disabled) Space = No LTI
70	Long Term Institutional Multiplier (Part D)	7	326-332	Part D LTI multiplier used in the calculation of the payment or adjustment. NN.DDDD
71	Basic Premium Reduction (Part D)	8	333-340	Amount of the rebate allocated to reducing the member's basic Part D premium included in the total Part D Payment amount. -9999.99
72	Basic Premium Amount (Part D)	8	341-348	Plan's basic Part D premium amount for payment purposes. -9999.99

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
73	Direct Subsidy Amount (Part D)	10	349-358	Total Part D Direct subsidy payment for the member. -999999.99
74	Reinsurance Subsidy Amount (Part D)	10	359-368	The amount of reinsurance subsidy included in the payment. -999999.99
75	Low-Income Cost-Sharing Subsidy Amount (Part D)	10	369-378	The amount low-income subsidy cost-sharing amount included in the payment. -999999.99
76	Total Part D Amount	11	379-389	The total Part D payment for the member. -9999999.99
77	Number of Payment/Adjustment Months (Part D)	2	390-391	Number of months included in this payment or adjustment.
78	PACE Premium Add On Amount (Part D)	10	392-401	Total Part D Pace Premium Add-on amount. -999999.99
79	PACE Cost Sharing Add-on Amount (Part D)	10	402-411	Total Part D Pace Cost Sharing Add-on amount. -999999.99
80	Frailty Factor (Part C)	7	412-418	Part C frailty score factor used in this payment or adjustment calculation. NN.DDDD Spaces = Not applicable *Only used for PACE, and FIDE SNPs*
81	MSP Reduction Factor (Part C)	7	419-425	MSP reduction factor used in this payment or adjustment calculation. NN.DDDD Spaces = Not applicable
82	MSP Reduction Amount (Part A)	10	426-435	Net MSP reduction or reduction amount– Part A. SSSSSS9.99 *Reported as a POSTIVE AMT, is actually a NEGATIVE AMT.*
83	MSP Reduction Amount (Part B)	10	436-445	Net MSP reduction amount – Part B. SSSSSS9.99 *Reported as a POSTIVE AMT, is actually a NEGATIVE AMT.*

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
84	Medicaid Dual Status Code	2	446-447	This field reports the Medicaid dual status code. 00 = No Medicaid status 01 = Eligible - entitled to Medicare- QMB only (Partial Dual) 02 = Eligible - entitled to Medicare- QMB AND Medicaid coverage (Full Dual) 03 = Eligible - entitled to Medicare- SLMB only (Partial Dual) 04 = Eligible - entitled to Medicare- SLMB AND Medicaid coverage (Full Dual) 05 = Eligible - entitled to Medicare- QDWI (Partial Dual) 06 = Eligible - entitled to Medicare- Qualifying individuals (Partial Dual) 08 = Eligible - entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB, QDWI or QI) with Medicaid coverage (Full Dual) 09 = Eligible - entitled to Medicare – Other Dual Eligibles but without Medicaid coverage (Non-Dual) 10 = Other Full Dual 99 = Unknown
85	Coverage Gap Discount Amount (Part D)	8	448-455	Amount of the Coverage Gap Discount Amount included in the payment (-9999.99)

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
86	Risk Adjustment Factor Type (Part D)	2	456-457	The type of Part D Risk Adjustment Factor used to calculate this payment or adjustment. 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. P1 = PACE New Enrollee Community Low Income Non- ESRD. P2 = PACE New Enrollee Community Non- Low Income Non-ESRD. P3 = PACE New Enrollee Institutional Non-ESRD. P4 = PACE New Enrollee Institutional ESRD. P5 = PACE New Enrollee Community Low Income ESRD. P6 = PACE New Enrollee Community Non- Low Income ESRD. P7 = PACE Community Non- Low Income CONTINUING Enrollee. P8 = PACE Community Low Income Continuing Enrollee. P9 = PACE Institutional Continuing Enrollee. Spaces = Not applicable.
87	Default Risk Factor Code (Part D)	1	458	The Part D default risk factor code: 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. Spaces = Not applicable

Monthly Membership Detail Report				
Item	**Field**	**Size**	**Position**	**Description**
88	Monthly Rate (Part A)	9	459-467	The Part A Risk Adjusted amount used in the payment or adjustment calculation. -99999.99
89	Monthly Rate (Part B)	9	468-476	The Part B Risk Adjusted amount used in the payment or adjustment calculation. -99999.99
90	Monthly Rate (Part D)	9	477-485	The Part D Direct Subsidy amount used in the payment or adjustment calculation. -99999.99
91	Cleanup ID	10	486-495	The Cleanup ID field is used in the event of a MARx data cleanup. The field will contain the ticket number related to the data cleanup.

6.6.2 MMR Adjustment Reason Codes (ARC)

The table below lists the MMR Adjustment Reason Codes and descriptions that are used in the following files:

- Monthly Membership Detail Record, Field 28.
- Monthly Membership Summary Report Data File Record, Field 4.
- PPR/IPPR Capitated Payment – Current Activity Record, Field 4.

Table 6-12: MMR Adjustment Reason Codes (ARC)

MMR Adjustment Reason Codes	
Code	**Description**
00	Prospective Payment Components
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
15	Obsolete
16	Obsolete
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	Obsolete
25	Part C Risk Adjustment Factor Change/Recon
26	Mid-year Part C Risk Adjustment 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 Status

MMR Adjustment Reason Codes	
Code	**Description**
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
44	Retroactive correction of previously failed Payment (affects Part C and D)
45	Disenroll for Failure to Pay Part D IRMAA Premium – Reported for Pt C and Pt D
46	Correction of Part D Eligibility – Reported for Pt D
50	Payment adjustment due to Beneficiary Merge
60	Part C Payment Adjustments created as a result of the RAS overpayment file processing
61	Part D Payment Adjustments created as a result of the RAS overpayment file processing
65	Confirmed Incarceration – Reported for Pt C and Pt D
66	Not Lawfully Present
90	System of Record History Alignment
94	Special Payment Adjustment Due to Cleanup

6.6.3 Monthly Membership Summary Report (MMSR)

This report summarizes payments to a Plan for the month, in several categories, and adjustments, by all adjustment categories. When the report automatically generates as part of month-end processing, it covers one contract in one payment month. When the report generates on user request, it is based on the transactions received to-date for the current payment month and may generate for one contract or for all contracts in a region.

System	Type	Frequency	File Length	MMSR Dataset Naming Conventions
MARx	Data File	Monthly	220	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMSD.Dyymm01.Thhmmsst P.Rxxxxx.MONMEMSD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMSD.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMSD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEMSD.Dyymm01.Thhmmsst [directory]Rxxxxx.MONMEMSD.Dyymm01.Thhmmsst

Report 6-1: Monthly Membership Summary Report (MMSR)

RUN DATE:20170813 MONTHLY MEMBERSHIP SUMMARY REPORT (PAGE 1 OF 2)
PAYMENT MONTH:201709 PLAN: HXXXX PBP(XXX) SEG(XXX) Name-of-Provider-Here
CURRENT PAYMENTS

PART A	COUNTS	TOTAL MONEY	PART B	COUNTS	TOTAL MONEY	PART D	COUNTS	TOTAL MONEY
HOSPICE	0	$0.00	HOSPICE	0	$0.00			
ESRD	0	$0.00	ESRD	0	$0.00			
WA	0	$0.00	WA	0	$0.00			
INST	0	$0.00	INST	0	$0.00			
NHC	0	$0.00	NHC	0	$0.00			
MCAID	0	$0.00	MCAID	0	$0.00	DIR SUBSDY	0	$0.00
PART C PREMIUM	0	$0.00	PART C PREMIUM	0	$0.00	LIS COST SHR	0	$0.00
A/B COST SHR	0	$0.00	A/B COST SHR	0	$0.00	ESTIMATD REINS	0	$0.00
A/B MAN SUP BN	0	$0.00	A/B MAN SUP BN	0	$0.00	PACE PRM ADDON	0	$0.00
D BAS PRM REDU	0	$0.00	D BAS PRM REDU	0	$0.00	PACE CSR ADDON	0	$0.00
D SUPP BENFITS	0	$0.00	D SUPP BENFITS	0	$0.00	COV GAP DISC	0	$0.00
B BAS PRM REDU	0	$0.00	B BAS PRM REDU	0	$0.00	MTM ADDON	0	$0.00
A/D MSP REDU	0	$0.00	A/D MSP REDU	0	$0.00	LIPS	0	$0.00
ESRD MSP REDU	0	$0.00	ESRD MSP REDU	0	$0.00			
MEMBERS	0	$0.00	MEMBERS	0	$0.00	MEMBERS	0	$0.00
MONTHS	0		MONTHS	0		MONTHS	0	
AVERAGE		$0.00	AVERAGE		$0.00	AVERAGE		$0.00
OUT OF AREA	0							
B PRM REDU - A		$0.00	B PRM REDU - A		$0.00			
B PRM REDU - D		$0.00	B PRM REDU - D		$0.00			

RUN DATE:20170813 MONTHLY MEMBERSHIP SUMMARY REPORT (PAGE 2 OF 2)
PAYMENT MONTH:201709 PLAN: HXXXX PBP(XXX) SEG(XXX) Name-of-Provider-Here
ADJUSTMENT PAYMENTS

ADJ REA CDE	ADJUSTMENT DESCRIPTION	NUMBER OF ADJS	MONTHS A	MONTHS B	MONTHS D	ADJUSTMENT AMOUNT PART A	PART B	PART D	TOTAL
01	DEATH	0	0	0	0	$0.00	$0.00	$0.00	$0.00
02	RETRO ENROLL	0	0	0	0	$0.00	$0.00	$0.00	$0.00
03	RETRO DISENR	0	0	0	0	$0.00	$0.00	$0.00	$0.00
04	CORR ENROLL	0	0	0	0	$0.00	$0.00	$0.00	$0.00
05	CORR DISENRO	0	0	0	0	$0.00	$0.00	$0.00	$0.00
06	CORR PARTA E	0	0	0	0	$0.00	$0.00	$0.00	$0.00
07	HOSPIC	0	0	0	0	$0.00	$0.00	$0.00	$0.00
08	ESRD	0	0	0	0	$0.00	$0.00	$0.00	$0.00
09	INST	0	0	0	0	$0.00	$0.00	$0.00	$0.00
10	MCAID	0	0	0	0	$0.00	$0.00	$0.00	$0.00
11	RETRO SCC CH	0	0	0	0	$0.00	$0.00	$0.00	$0.00
12	CORR DEATH	0	0	0	0	$0.00	$0.00	$0.00	$0.00
13	CORR BIRTH	0	0	0	0	$0.00	$0.00	$0.00	$0.00
14	CORR SEX	0	0	0	0	$0.00	$0.00	$0.00	$0.00
18	PTC RATE	0	0	0	0	$0.00	$0.00	$0.00	$0.00
19	CORR PARTB E	0	0	0	0	$0.00	$0.00	$0.00	$0.00
20	WKAGE	0	0	0	0	$0.00	$0.00	$0.00	$0.00
21	NHC	0	0	0	0	$0.00	$0.00	$0.00	$0.00
22	DISENROLL PR	0	0	0	0	$0.00	$0.00	$0.00	$0.00
23	DEMO FACTOR	0	0	0	0	$0.00	$0.00	$0.00	$0.00
25	PTC RSK ADJF	0	0	0	0	$0.00	$0.00	$0.00	$0.00
26	RISK ADJ FAC	0	0	0	0	$0.00	$0.00	$0.00	$0.00
27	RETRO CHF	0	0	0	0	$0.00	$0.00	$0.00	$0.00
29	HOSPICE RATE	0	0	0	0	$0.00	$0.00	$0.00	$0.00
30	RTRO PTD PM	0	0	0	0	$0.00	$0.00	$0.00	$0.00
31	RTRO PTD LIP	0	0	0	0	$0.00	$0.00	$0.00	$0.00
32	RTRO CST SHR	0	0	0	0	$0.00	$0.00	$0.00	$0.00
33	RTRO EST REI	0	0	0	0	$0.00	$0.00	$0.00	$0.00
34	RTRO PTC PM	0	0	0	0	$0.00	$0.00	$0.00	$0.00
35	RTRO REBATE	0	0	0	0	$0.00	$0.00	$0.00	$0.00
36	PTD RATE CHG	0	0	0	0	$0.00	$0.00	$0.00	$0.00
37	PTD RAF CHG	0	0	0	0	$0.00	$0.00	$0.00	$0.00
38	SEG ID CHG	0	0	0	0	$0.00	$0.00	$0.00	$0.00
41	PTD RAF ONGO	0	0	0	0	$0.00	$0.00	$0.00	$0.00
42	RETRO MSP	1	12	12	0	$760.44	$728.40	$0.00	$1,488.84
43	PLN SUB PREM	0	0	0	0	$0.00	$0.00	$0.00	$0.00
44	PYMT CORR	0	0	0	0	$0.00	$0.00	$0.00	$0.00
45	FAIL IRMAA D	0	0	0	0	$0.00	$0.00	$0.00	$0.00
46	CORR PARTD E	0	0	0	0	$0.00	$0.00	$0.00	$0.00
50	XRF MRG	0	0	0	0	$0.00	$0.00	$0.00	$0.00
60	PTC OVRPYMT	0	0	0	0	$0.00	$0.00	$0.00	$0.00
61	PTD OVRPYMT	0	0	0	0	$0.00	$0.00		
65	PRSN DISENRL	0	0	0	0	$0.00	$0.00		
66	NTLWFL PRSNT	0	0	0	0	$0.00	$0.00		
90	HIST ALIGNMT	0	0	0	0	$0.00	$0.00		
94	CLNUP ADJ	0	0	0	0	$0.00	$0.00		

TOTAL ADJUSTMENT

MONTHS A :	12	PART A AMOUNT :	$760.44
MONTHS B :	12	PART B AMOUNT :	$728.40
MONTHS D :	0	PART D AMOUNT :	$0.00
NUMBER OF ADJUSTMENTS :	1	TOTAL AMOUNT :	$1,488.84

TOTAL PYMT AMT A	$760.44
TOTAL PYMT AMT B	$728.40
TOTAL PYMT AMT D	$0.00
SUM TOTAL AMOUNT	$1,488.84

6.6.4 Monthly Membership Summary Report (MMSD) Data File

This is a data file version of the Monthly Membership Summary Report (MMSD) for 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.

Note: The date in the file name defaults to "01" denoting the first day of the current payment month.

Layout 6-2: Monthly Membership Summary Report (MMSR) Data File Record

MMSR Data File Record				
Item	**Field**	**Size**	**Position**	**Description**
1	MCO Contract Number	5	1-5	MCO Contract Number.
2	Run Date of the File	8	6-13	CCYYMMDD
3	Payment Date	6	14-19	CCYYMM
4	Adjustment Reason Code (ARC)	2	20-21	This is populated with a valid ARC for adjustments. For prospective payment components, it is populated with 00.
5	Record Description	10	22-31	This field is populated with a short description of the type of data reported in the record.
6	Payment Adjustment Count	7	32-38	Beneficiary Count.
7	Month count	7	39-45	Payment Record: 1 for each member on the record. Adjustment record: Spaces.
8	Part A Member count	7	46-52	Payment Record: Beneficiary count for Part A. Adjustment record: Spaces.
9	Part A Month count	7	53-59	Payment Record: 1 for each member with Part A. Adjustment record: The number of months adjusted for Part A.
10	Part B Member count	7	60-66	Payment Record: Beneficiary count for Part B. Adjustment record: Spaces.
11	Part B Month count	7	67-73	Payment Record: 1 for each member with Part B. Adjustment record: The number of months adjusted for Part B.
12	Part A Payment/Adjustment Amount	15	74-88	Part A Amount.
13	Part B Payment/Adjustment Amount	15	89-103	Part B Amount.
14	Total Amount	15	104-118	Total Payment/Adjustment Amount.
15	Part A Average	9	119-127	Average Part A Amount per Part A Member.
16	Part B Average	9	128-136	Average Part B Amount per Part B Member.
17	Payment/Adjustment Indicator	1	137-137	P = Payment. A = Adjustment.
18	PBP Number	3	138-140	Plan Benefit Package Number. PBP = Contract Level summarization.
19	Segment Number	3	141-143	Segment Number. 000 = PBP Level summarization. SEG = Contract Level summarization.

MMSR Data File Record				
Item	**Field**	**Size**	**Position**	**Description**
20	Part D Member Count	7	144-150	Payment Record: Beneficiary count for Part D. Adjustment record: Spaces.
21	Part D Month Count	7	151-157	Payment Record: 1 for each member with Part D. Adjustment record: The number of months adjusted for Part D.
22	Part D Amount	15	158-172	Part D Amount.
23	Part D Average	9	173-181	Average Part D Amount per Part D Member.
24	LIS Band 25% member count	7	182-188	Count of Beneficiaries in the 25% LIS band.
25	LIS Band 50% member count	7	189-195	Count of Beneficiaries in the 50% LIS band.
26	LIS Band 75% member count	7	196-202	Count of Beneficiaries in the 75% LIS band.
27	LIS Band 100% member count	7	203-209	Count of Beneficiaries in the 100% LIS band.
28	Filler	11	210-220	Spaces.

6.6.5 Plan Payment Report (PPR) – APPS Payment Letter

Also known as the Automated Plan Payment System (APPS) Payment Letter, this report itemizes the final monthly payment to the Plan. This report is produced by APPS when final payments are calculated.

The PPR includes Part D payments and adjustments, the National Medicare Education Campaign (NMEC) and COB User Fees and premium settlement information. There is one version of the PPR applicable to all Plans and it is provided monthly.

System	Type	Frequency	File Length	PPR/IPPR Dataset Naming Conventions
APPS	Data File	As needed	250	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PPRID.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PPRID.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory].Rxxxxx.PPRID.Dyymmdd.Thhmmsst

Report 6-2: Plan Payment Report (PPR)

CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : HXXXX — PAGE: 1/5
PLAN NAME : PLAN NAME
PAYMENT MONTH : 09/2017
RUN DATE : 08/23/2017
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	104	108,431.15			108,431.15
	PROSPECTIVE PART B PAYMENT	102		128,011.33		128,011.33
	PROSPECTIVE PART D PAYMENT	106			82,610.45	82,610.45
(01)	DEATH OF BENEFICIARY	1	-1,101.62	-1,301.55	-895.28	-3,298.45
(02)	RETROACTIVE ENROLLMENT	1	607.42	717.66	848.83	2,173.91
(03)	RETROACTIVE DISENROLLMENT	2	-3,792.36	-4,480.63	-2,191.65	-10,464.64
(06)	CORRECT PART A ENT	0	0.00	0.00	0.00	0.00
(07)	RETRO HOSPICE STATUS	0	0.00	0.00	0.00	0.00
(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	0	0.00	0.00	0.00	0.00
(12)	DATE OF DEATH CORRECTION	0	0.00	0.00	0.00	0.00
(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	0	0.00	0.00	0.00	0.00
(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	0	0.00	0.00	0.00	0.00
(44)	RETRO CORRECT FAILD PAY	0	0.00	0.00	0.00	0.00
(45)	DISENR FAIL PAY IRMAA PREM	0	0.00	0.00	0.00	0.00
(46)	RETRO CORRECT D ELIGIBILIT	0	0.00	0.00	0.00	0.00
(50)	BENE MERGE ADJUSTMNT	0	0.00	0.00	0.00	0.00
(60)	PT. C RISK ADJUST OVERPAY	0	0.00	0.00	0.00	0.00
(61)	PT. D RISK ADJUST OVERPAY	0	0.00	0.00	0.00	0.00
(65)	CONFIRMED INCARCERATION	0	0.00	0.00	0.00	0.00
(66)	NOT LAWFULLY PRESENT	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		316	104,144.59	122,946.81	80,372.35	307,463.75

** THE TOTAL PART D INCLUDES COVERAGE GAP DISCOUNT OF:
PROSPECTIVE = 0.00
ADJUSTMENT = 0.00
TOTAL = 0.00

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

6.6.6 Interim Plan Payment Report (IPPR)

Also known as the Interim Payment Letter, this report itemizes interim payments to the MCO. It is produced by APPS when interim payments are calculated. CMS computes interim payments on an as-needed basis. When this occurs, the interim payment letter is pushed to the involved Plan(s). The APPS IPPR is provided when a Plan is approved for an interim payment outside of the normal monthly process. The report contains the amount and reason for the interim payment to the Plan. Plans may request the IPPR via the MARx UI under the weekly report section of the menu.

Report 6-3: Interim Plan Payment Report (IPPR)

CMS INTERIM PLAN PAYMENT REPORT

PLAN NUMBER : HXXXX PAGE: 1/5
PLAN NAME : PLAN NAME
PAYMENT MONTH : 04/2016
RUN DATE : 04/27/2016
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	0	0.00			0.00
	PROSPECTIVE PART B PAYMENT	0		0.00		0.00
	PROSPECTIVE PART D PAYMENT	0			0.00	0.00
(01)	DEATH OF BENEFICIARY	0	0.00	0.00	0.00	0.00
(02)	RETROACTIVE ENROLLMENT	0	0.00	0.00	0.00	0.00
(03)	RETROACTIVE DISENROLLMENT	0	0.00	0.00	0.00	0.00
(06)	CORRECT PART A ENT	0	0.00	0.00	0.00	0.00
(07)	RETRO HOSPICE STATUS	0	0.00	0.00	0.00	0.00
(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	0	0.00	0.00	0.00	0.00
(12)	DATE OF DEATH CORRECTION	0	0.00	0.00	0.00	0.00
(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	0	0.00	0.00	0.00	0.00
(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	0	0.00	0.00	0.00	0.00
(44)	RETRO CORRECT FAILD PAY	0	0.00	0.00	0.00	0.00
(45)	DISENR FAIL PAY IRMAA PREM	0	0.00	0.00	0.00	0.00
(46)	RETRO CORRECT D ELIGIBILIT	0	0.00	0.00	0.00	0.00
(50)	BENE MERGE ADJUSTMNT	0	0.00	0.00	0.00	0.00
(60)	PT. C RISK ADJUST OVERPAY	0	0.00	0.00	0.00	0.00
(61)	PT. D RISK ADJUST OVERPAY	0	0.00	0.00	0.00	0.00
(65)	CONFIRMED INCARCERATION	0	0.00	0.00	0.00	0.00
(66)	NOT LAWFULLY PRESENT	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		0	0.00	0.00	0.00	0.00

** THE TOTAL PART D INCLUDES COVERAGE GAP DISCOUNT OF:
PROSPECTIVE = 0.00
ADJUSTMENT = 0.00
TOTAL = 0.00

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

6.6.7 Plan Payment Report (PPR)/Interim Plan Payment Report (IPPR) Data File

The PPR is also referred to as the Payment Letter, and displays the payment amount wired by the U.S. Treasury to the Plan's bank account each month, including the Part A/Part B and Part D payment amounts. The PPR contains the total number of members and the amount paid for those members for the upcoming month, prospectively. The report also shows Plan-level adjustments for that payment amount.

This report itemizes the final monthly payments to the Plans. Produced by APPS when final payment is calculated, CMS makes the PPR available to Plans as part of the month-end processing.

The PPR includes the following:

- Part D payments and adjustments.
- National Medicare Education Campaign (NMEC).
- Coordination of Benefits (COB) User Fees.
- Premium settlement information.

The IPPR is provided when a Plan is approved for an interim payment outside of the normal monthly process. The data file/report contains the amount and reason for the interim payment to the Plan.

The following records are included in this file:

- **PPR/IPPR Header Record.**
- **PPR/IPPR Capitated Payment – Current Activity Record.**
- **PPR/IPPR Premium Settlement Record.**
- **PPR/IPPR Fees Record.**
- **PPR/IPPR Special Adjustments Record.**
- **PPR/IPPR Previous Cycle Balance Summary Record.**
- **PPR/IPPR Payment Balance Carried Forward Record.**
- **PPR/IPPR Payment Summary Record.**

Layout 6-3: PPR/IPPR Header Record

PPR/IPPR Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Definition**
1	Contract Number	5	1-5	CHAR	Contract Number.
2	Record Identification Code	1	6	CHAR	Record Type Identifier. H = Header Record.
3	Contract Name	50	7-56	CHAR	Name of the Contract.
4	Payment Cycle Date	6	57-62	CHAR	Identified the month and year of payment. CCYYMM
5	Run Date	8	63-70	CHAR	Identifies the date file was created. CCYYMMDD
6	Filler	180	71-250	CHAR	Spaces.

Layout 6-4: PPR/IPPR Capitated Payment – Current Activity Record

PPR/IPPR Capitated Payment – Current Activity Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Contract Number	5	1-5	CHAR	Contract Number.
2	Record Identification Code	1	6	CHAR	Record Type Identifier. C = Capitated Payment
3	Table ID Number	1	7	CHAR	1.
4	Adjustment Reason Code	2	8-9	CHAR	Blank = for prospective pay.
5	Part A Total Members	9	10-18	NUM	Number of beneficiaries for whom Part A payments is being made prospectively. For adjustment records this will hold the total number of transactions. ZZZZZZZZ9
6	Part B Total Members	9	19-27	NUM	Number of beneficiaries for whom Part B payments is being made prospectively. Spaces for adjustment records. ZZZZZZZZ9
7	Part D Total Members	9	28-36	NUM	Number of beneficiaries for whom Part D payments is being made prospectively. Spaces for Adjustment records. ZZZZZZZZ9
8	Part A Payment Amount	15	37-51	NUM	Total Part A Amount. SSSSSSSSSSS9.99
9	Part B Payment Amount	15	52-66	NUM	Total Part B Amount. SSSSSSSSSSS9.99
10	Part D Payment Amount	15	67-81	NUM	Total Part D Amount. SSSSSSSSSSS9.99
11	Coverage Gap Discount Amount	15	82 – 96	NUM	The Coverage Gap Discount Amount included in Part D Payment. SSSSSSSSSSS9.99
12	Total Payment	15	97- 111	NUM	Total Payment. SSSSSSSSSSS9.99
13	Filler	139	112 – 250	CHAR	Spaces.

Layout 6-5: PPR/IPPR Premium Settlement Record

PPR/IPPR Premium Settlement Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Contract Number	5	1 – 5	CHAR	Contract Number.
2	Record Identification Code	1	6	CHAR	Record Type Identifier. P = Premium Settlement.
3	Table ID Number	1	7	CHAR	2
4	Part C Premium Withholding Amount	15	8 – 22	NUM	Total Part C Premium Amount. SSSSSSSSSS9.99
5	Part D Premium Withholding Amount	15	23 – 37	NUM	Total Part D Premium Amount. SSSSSSSSSS9.99
6	Part D Low Income Premium Subsidy	15	38 – 52	NUM	Total Low Income Premium Subsidy. SSSSSSSSSS9.99
7	Part D Late Enrollment Penalty	15	53 – 67	NUM	Total Late Enrollment Penalty. SSSSSSSSSS9.99
8	Total Premium Settlement Amount	15	68 – 82	NUM	Total Premium Settlement. SSSSSSSSSS9.99
9	Filler	168	83 – 250	CHAR	Spaces.

Layout 6-6: PPR/IPPR Fees Record

PPR/IPPR Fees Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Contract Number	5	1 – 5	CHAR	Contract Number.
2	Record Identification Code	1	6	CHAR	Record Type Identifier. F = Fees.
3	Table ID Number	1	7	CHAR	3.
4	NMEC Part A Subject to Fee	15	8 – 22	NUM	Part A amount subject to National Medicare Educational Campaign fees. ZZZZZZZZZZ9.99
5	NMEC Part A Rate	7	23 – 29	NUM	Rate used to calculate the fees for Part A. 0.99999
6	Part A Fee Amount	15	30 – 44	NUM	Fee Assessed for Part A. SSSSSSSSSS9.99
7	NMEC Part B Subject to Fee	15	45 – 59	NUM	Part B amount subject to National Medicare Educational Campaign fees. ZZZZZZZZZZ9.99
8	NMEC Part B Rate	7	60 – 66	NUM	Rate used to calculate the fees for Part B. 0.99999
9	Part B Fee Amount	15	67 – 81	NUM	Fee Assessed for Part B. SSSSSSSSSS9.99
10	NMEC Part D Subject to Fee	15	82 – 96	NUM	Part D amount subject to National Medicare Educational Campaign fees. ZZZZZZZZZZ9.99
11	NMEC Part D Rate	7	97 – 103	NUM	Rate used to calculate the fees for Part D. 0.99999
12	Part D Fee Amount	15	104 – 118	NUM	Fee Assessed for Part D. SSSSSSSSSS9.99

PPR/IPPR Fees Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
13	Total NMEC Fee Assessed	15	119 – 133	NUM	Total NMEC Fee Assessed for Part A, B and D. SSSSSSSSSS9.99
14	Total Prospective Part D Members	9	134 – 142	NUM	Total members for Part D. ZZZZZZZZ9
15	Rate for COB Fees	4	143 – 146	NUM	Rate used to calculate the COB fees. 0.99
16	Amount of COB Fees	15	147 – 161	NUM	COB Fees SSSSSSSSSS9.99
17	Total of Assessed Fees	15	162 – 176	NUM	Total of all Fees Assessments. SSSSSSSSSS9.99
18	Filler	74	177 – 250	CHAR	Spaces.

Layout 6-7: PPR/IPPR Special Adjustments Record

PPR/IPPR Special Adjustments Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Contract Number	5	1 – 5	CHAR	Contract Number.
2	Record Identification Code	1	6	CHAR	Record Type Identifier. S = Special Adjustments.
3	Table ID Number	1	7	CHAR	4.
4	Document ID	8	8 – 15	NUM	The document ID for identifying the adjustment.
5	Source	5	16 – 20	CHAR	The CMS division responsible for initiating the adjustments.
6	Description	50	21 – 70	CHAR	The reason the adjustment was made.
7	Adjustment Type	3	71 – 73	CHAR	The payment component the adjustment is for. CMP = Civil Monetary Penalty. CST = Cost Plan Adjustment. PRS = Annual Part D Reconciliation. RSK = Risk Adjustment. CGD = Coverage Gap Invoice. OTH = Other – default non-specific group.
8	Adjustment to Part A	15	74 – 88	NUM	Adjustment amount for Part A. SSSSSSSSSS9.99
9	Adjustment to Part B	15	89 – 103	NUM	Adjustment amount for Part B. SSSSSSSSSS9.99
10	Adjustment to Part D	15	104 – 118	NUM	Adjustment amount for Part D. SSSSSSSSSS9.99
11	Premium C Withholding Part A	15	119 – 133	NUM	Adjustment amount for Premium Withholding Part A. SSSSSSSSSS9.99
12	Premium C Withholding Part B	15	134 – 148	NUM	Adjustment amount for Premium Withholding Part B. SSSSSSSSSS9.99
13	Premium D Withholding	15	149 – 163	NUM	Adjustment amount for Premium D Withholding. SSSSSSSSSS9.99
14	Part D Low Income Premium Subsidy	15	164 – 178	NUM	Adjustment amount for Low Income Subsidy. SSSSSSSSSS9.99
15	Total Adjustment Amount	15	179 – 193	NUM	Total Adjustments. SSSSSSSSSS9.99

PPR/IPPR Special Adjustments Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
16	Filler	57	194 – 250	CHAR	Spaces.

Layout 6-8: PPR/IPPR Previous Cycle Balance Summary Record

PPR/IPPR Previous Cycle Balance Summary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Contract Number	5	1 – 5	CHAR	Contract Number.
2	Record Identification Code	1	6	CHAR	Record Type Identifier. L = Last Period Carry Over Amounts carried over to this month from previous months.
3	Table ID Number	1	7	CHAR	5.
4	Part A Carry Over Amount	15	8 – 22	NUM	Part A Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
5	Part B Carry Over Amount	15	23 – 37	NUM	Part B Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
6	Part D Carry Over Amount	15	38 – 52	NUM	Part D Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
7	Part C Premium Withholding Carry Over Amount	15	53 – 67	NUM	Part C Premium Withholding Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
8	Part D Premium Withholding Carry Over Amount	15	68 – 82	NUM	Part D Premium Withholding Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
9	Part D Low Income Premium Subsidy Carry Over Amount	15	83 – 97	NUM	Part D Low Income Premium Subsidy Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
10	Part D Late Enrollment Penalty Carry Over Amount	15	98 – 112	NUM	Part D Late Enrollment Penalty Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
11	Education User Fee Carry Over Amount	15	113 – 127	NUM	Education User Fee Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
12	Part D COB User Fee Carry Over Amount	15	128 – 142	NUM	Part D COB User Fee Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
13	CMS Special Adjustments Carry Over Amount	15	143 – 157	NUM	CMS Special Adjustments Carry Over Amount - Previous Balance Column. SSSSSSSSSS9.99
14	Total Carry Over Amount	15	158 – 172	NUM	Sum of amounts in Previous Balance Column. SSSSSSSSSS9.99
15	Filler	78	173 – 250	CHAR	Spaces.

Layout 6-9: PPR/IPPR Payment Balance Carried Forward Record

PPR/IPPR Payment Balance Carried Forward Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Contract Number	5	1 – 5	CHAR	Contract Number.
2	Record Identification Code	1	6	CHAR	Record Type Identifier. N = Balance Carried Forward to Next Cycle. Amounts carried forward (and not paid) to next month from this month
3	Table ID Number	1	7	CHAR	5.
4	Part A Amount Carry Forward	15	8 – 22	NUM	Part A Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
5	Part B Amount Carry Forward	15	23 – 37	NUM	Part B Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
6	Part D Amount Carry Forward	15	38 – 52	NUM	Part D Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
7	Part C Premium Withholding Amount Carry Forward	15	53 – 67	NUM	Part C Premium Withholding Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
8	Part D Premium Withholding Amount Carry Forward	15	68 – 82	NUM	Part D Premium Withholding Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
9	Part D Low Income Premium Subsidy Amount Carry Forward	15	83 – 97	NUM	Part D Low Income Subsidy Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
10	Part D Late Enrollment Penalty Amount Carry Forward	15	98 – 112	NUM	Part D Late Enrollment Penalty Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
11	Education User Fee Amount Carry Forward	15	113 – 127	NUM	Education User Fee Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
12	Part D COB User Fee Amount Carry Forward	15	128 – 142	NUM	Part D COB User Fee Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
13	CMS Special Adjustments Amount Carry Forward	15	143 – 157	NUM	CMS Special Adjustments Amount Carry Forward - Balance Forward Column. SSSSSSSSSS9.99
14	Total Carry Forward Amount	15	158 – 172	NUM	Sum of amounts in Balance Forward Column. SSSSSSSSSS9.99
15	Filler	78	173 – 250	CHAR	Spaces.

Layout 6-10: PPR/IPPR Payment Summary Record

PPR/IPPR Payment Summary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Contract Number	5	1 – 5	CHAR	Contract Number.
2	Record Identification Code	1	6	CHAR	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).
3	Table ID Number	1	7	CHAR	5.
4	Part A Amount	15	8 – 22	NUM	Part A amount - Net Payment Column. ZZZZZZZZZZZ9.99
5	Part B Amount	15	23 – 37	NUM	Part B amount - Net Payment Column. ZZZZZZZZZZZ9.99
6	Part D Amount	15	38 – 52	NUM	Part D amount - Net Payment Column. ZZZZZZZZZZZ9.99
7	Part C Premium Withholding Amount	15	53 – 67	NUM	Part C Premium Withholding Amount - Net Payment Column. ZZZZZZZZZZZ9.99
8	Part D Premium Withholding Amount	15	68 – 82	NUM	Part D Premium Withholding Amount - Net Payment Column. ZZZZZZZZZZZ9.99
9	Part D Low Income Premium Subsidy Amount	15	83 – 97	NUM	Part D Low Income Subsidy Amount - Net Payment Column. ZZZZZZZZZZZ9.99
10	Part D Late Enrollment Penalty Amount	15	98 – 112	NUM	Part D Late Enrollment Penalty Amount - Net Payment Column. SSSSSSSSSS9.99
11	Education User Fee Amount	15	113 – 127	NUM	Education User Fee Amount -Net Payment Column. SSSSSSSSSS9.99
12	Part D COB User Fee Amount	15	128 – 142	NUM	Part D COB User Fee Amount - Net Payment Column. SSSSSSSSSS9.99
13	CMS Special Adjustments Amount	15	143 – 157	NUM	CMS Special Adjustments Amount - Net Payment Column. SSSSSSSSSS9.99
14	Total Net Payment	15	158 – 172	NUM	Sum of amounts in Net Payment Column. This is the Plan's Net Payment Amount for this month. If the amount is negative, the payment will be carried forward. SSSSSSSSSS9.99
15	Filler	78	173 – 250	CHAR	Spaces.

6.6.8 820 Format Payment Advice Data File

The 820 Format Payment Advice data file is a Health Insurance Portability & Accountability Act (HIPAA)-compliant version of the Plan Payment Report, which is also known as the APPS Payment Letter. The data file itemizes the final monthly payment to the Plan. It is produced by APPS when final payments are calculated, and is available to Plans as part of the month-end processing. This file is not available through MARx UI.

The table below lists the order of the segments in the 820 Format Payment Advice.

Table 6-13: Order of 820 Format Payment Advice Segments

Order of 820 Format Payment Advice Segments		
Required Order	**Segment Code**	**Description**
1	ST	820 Header
2	BPR	Financial Information
3	TRN	Re-association Key
4	DTM	Coverage Period
5	N1	Premium Receiver's Name
6	N1	Premium Payer's Name
7	RMR	Organization Summary Remittance Detail
8	IT1	Summary Line Item
9	SLN	Member Count
10	ADX	Organization Summary Remittance Level Adjustment
11	SE	820 Trailer

The physical layout of a segment is:

- Segment Identifier, an alphanumeric code, followed by
- Each selected field preceded by a data element separator ("*")
- And terminated by a segment terminator ("~").

Fields are mostly variable in length and do not contain leading/trailing spaces. If fields are empty, they are skipped by inserting contiguous data element separators ("**") unless they are at the end of the segment. Fields that are not selected are represented in the same way as fields that are selected, but as this particular iteration of the transaction set contain no data, they are skipped.
For example, in fictitious segment XXX, fields 2, 3, and 5 (the last field) are skipped:

XXX*field 1 content***field 4 content~

BALANCING REQUIREMENTS[2]
Following are two balancing rules:

1. BPR02 = total of all RMR04

[2] See pp.16 in National EDI Transaction Set Implementation Guide for 820, ASCX12N, 820 (004010X061), dated May 2000

2. RMR04 = RMR05 + ADX01

To comply with balancing rules, BPR02 and RMR04 are set equal to Net Payment (paid amount), RMR05 is set equal to Gross/Calculated Payment (billed amount), and ADX01 is set equal to Adjustment amount.

On Cost/Health Care Prepayment Plan (HCPP) contracts, Plans should enter the actual dollars billed, rather than the "risk equivalent" dollar amounts, into RMR05.

System	Type	Frequency	Dataset Naming Conventions
APPS	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PLAN820D.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PLAN820D.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PLAN820D.Dyymm01.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the CCM.

The following records are included in this file:

- **820 Header Record (segments 1-6 below)**
- **820 Detail Record (segments 7-10 below)**
- **820 Summary Record (segment 11 below)**

Layout 6-11: 820 Header Record

820 Header Record						
Item	**Segment**	**Data Element**	**Description**	**Size**	**Type**	**Contents**
1	820 Header Segment ID			2	AN	ST
2		ST01	Transaction Set ID Code	3/3	ID	820
3		ST02	Transaction Set Control Number	4/9	AN	Begin with 00001 Increment each Run.
4	Beginning Segment For Payment Order/ Remittance Advice			3	AN	BPR
5	BPR	BPR01	Transaction Handling Code	1/2	ID	I = Remittance Information Only.
6	BPR	BPR02	Total Premium Payment Amount	1/18	R	Payment Letter – Net Payment. See discussion on Balancing.
7	BPR	BPR03	Credit/Debit Flag Code	1/1	ID	C = Credit.
8	BPR	BPR04	Payment Method Code	3/3	ID	BOP Financial Institution Option.
9	BPR	BPR16	Check Issue or EFT Effective Date	8/8	DT	Payment Letter – Payment Date. CCYYMMDD
10	Re-Association Key			3	AN	TRN

820 Header Record						
Item	**Segment**	**Data Element**	**Description**	**Size**	**Type**	**Contents**
11	TRN	TRN01	Trace Type Code	1/2	ID	3 = Financial Re-association Trace Number.
12	TRN	TRN02	Check or EFT Trace Number	1/30	AN	USTREASURY
13	Coverage Period			3	AN	DTM
14	DTM	DTM01	Date/Time Qualifier	3/3	ID	582 (Report Period)
15	DTM	DTM05	Date/Time Period Format Qualifier	2/3	ID	RD8 (Range of dates expressed in format CCYYMMDD – CCYYMMDD)
16	DTM	DTM06	Date/Time Period	1/35	AN	Range of Dates for Payment Month. See DTM05.
17	Premium Receiver's Name			2	AN	N1
18	1000A	N101	Entity Identifier Code	2/3	ID	PE = Payee.
19	1000A	N102	Name	1/60	AN	Contract Name.
20	1000A	N103	Identification Code Qualifier	1/2	ID	EQ Insurance Company Assigned ID Number.
21	1000A	N104	Identification Code	2/80	AN	Contract Number.
22	Premium Payer's Name			2	AN	N1
23	1000B	N101	Entity Identifier Code	2/3	ID	PR = Payer.
24	1000B	N102	Name	1/60	AN	CM
25	1000B	N103	Identification Code Qualifier	1/2	ID	EQ Insurance Company Assigned ID Number
26	1000B	N104	Identification Code	2/80	AN	CMS

Layout 6-12: 820 Detail Record

820 Detail Record						
Item	**Segment**	**Data Element**	**Description**	**Size**	**Type**	**Contents**
1	Organization Summary Remittance Detail			3	AN	RMR
2	2300A	RMR01	Reference Identification Qualifier	2/3	ID	CT
3	2300A	RMR02	Contract Number	1/30	AN	Payment Letter – Contract Number.
4	2300A	RMR04	Detail Premium Payment Amount	1/18	R	Payment Letter – Net Payment. See discussion on Balancing.
5	2300A	RMR05	Billed Premium Amount	1/18	R	Payment Letter – Capitated Payment. See discussion on Balancing.
6	Summary Line Item			3	AN	IT1

820 Detail Record						
Item	**Segment**	**Data Element**	**Description**	**Size**	**Type**	**Contents**
7	2310A	IT101	Line Item Control Number	1/20	AN	1 Assigned for uniqueness.
8	Member Count			3	AN	SLN
9	2315A	SLN01	Line Item Control Number	1/20	AN	1 Assigned for uniqueness.
10	2315A	SLN03	Information Only Indicator	1/1	ID	O = Information only.
11	2315A	SLN04	Head Count	1/15	R	Payment Letter – Total Members
12	2315A	SLN05-1	Unit or Basis for Measurement Code	2/2	ID	IE - used to identify that the value of SLN04 represents the number of contract holders with individual coverage.
13	Organization Summary Remittance Level Adjustment			3	AN	ADX
14	2320A	ADX01	Adjustment Amount	1/18	R	Payment Letter – Total Adjustments is the difference between Capitated Payment and Net Payment. See discussion on Balancing.
15	2320A	ADX02	Adjustment Reason Code	2/2	ID	H1 - Information forthcoming – detailed information related to the adjustment is provided through a separate mechanism.

Layout 6-13: 820 Trailer Record

820 Trailer Record						
Item	**Segment**	**Data Element**	**Description**	**Size**	**Type**	**Contents**
1	820 Trailer			3	AN	"SE"
2		SE01	Number of Included Segments	1/10	N0	"11"
3		SE02	Transaction Set Control Number	4/9	AN	Use control number, same as in 820 Header.

6.6.9 Failed Payment Reply Report (FPRR) Data File

Along with the other monthly payment reports, MARx generates the FPRR. If payment calculation for a beneficiary cannot complete, MARx identifies the beneficiary and time period for which the payment calculation is not performed.

System	Type	Frequency	File Length	Failed Payment Reply Report Dataset Naming Conventions
MARx	Data File	Monthly Payment Cycle	500	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.FPRRD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx FPRRD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx. FPRRD.Dyymm01.Thhmmsst

Layout 6-14: Failed Payment Reply Report

Failed Payment Reply Report Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Beneficiary ID	12	1-12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end
2	Surname	12	13-24	Beneficiary's last name, included with PRC 264.
3	First Name	7	25-31	Beneficiary's given name, included with PRC 264.
4	Middle Name	1	32	First initial of beneficiary's middle name, included with PRC 264.
5	Gender Code	1	33	Beneficiary's gender identification code, included with PRC 264. 0 = Unknown. 1 = Male. 2 = Female.
6	Date of Birth	8	34-41	Beneficiary's birth date, included with PRC 264. CCYYMMDD
7	Filler	1	42	Spaces.
8	Contract Number	5	43-47	Plan Contract Number, included with PRC 000 and PRC 264.
9	State Code	2	48-49	Beneficiary's residence SSA state code, included with PRC 264; otherwise, spaces if not available.
10	County Code	3	50-52	Beneficiary's residence SSA county code, included with PRC 264; otherwise, spaces if not available.
11	Filler	4	53-56	Spaces.
12	Payment Reply Code	3	57-59	000 = No missing payments. 264 = Payment not yet completed. 299 = Correction to previously failed payment.
13	Filler	3	60-62	Spaces.
14	Effective Date	8	63-70	Enrollment effective date, included with PRC 264. CCYYMMDD

Failed Payment Reply Report Record				
Item	**Field**	**Size**	**Position**	**Description**
15	Filler	1	71	Spaces.
16	PBP ID	3	72-74	PBP number, included with both PRC 000 and PRC 264.
17	Filler	1	75	Spaces.
18	Transaction Date	8	76-83	Report generation date, included with both PRC 000 and PRC 264. CCYYMMDD
19	Filler	1	84	Spaces.
20	Current Payment Month	12	85- 96	CPM, left justified with six spaces completing the field, and included with both PRC 000 and PRC 264, and PRC 299. CCYYMM
21	Filler	38	97-134	Spaces.
22	Segment Number	3	135-137	Segment in PBP, included with PRC 264.
23	Filler	25	138-162	Spaces.
24	Processing Timestamp	15	163-177	Report generation time, included with both PRC 000 and PRC 264. HH.MM.SS.SSSSSS
25	Filler	188	178-365	Spaces.
26	PRC Short Name	15	366-380	PRC short name. PRC 000 is NO REPORT. PRC 264 is NO PAYMENT. PRC 299 is RESTORED PYMT. Text is left justified with following spaces completing the field.
27	Filler	120	381-500	Spaces.

Table 6-14: Payment Reply Codes – PRC

Payment Reply Codes – PRC			
Code-Type	**Title**	**Short Definition**	**Definition**
000-I	No Data to Report	NO REPORT	This TRC can appear on both the DTRR and the Failed Payment Reply Report (FPRR) data files. On the DTRR it indicates that none of the following occurred during the reporting period for the given contract/PBP: • Beneficiary status change. • MARx UI activity. • CMS or Plan transaction processing. The reporting period is the span between the previous DTRR and the current DTRR. On the FPRR it indicates the presence of all prospective payments for the Plan (contract/PBP), none are missing. **Plan Action:** None.
264-I	Payment Not Yet Completed	NO PAYMENT	A transaction was accepted requiring a payment calculation. The calculation has not been completed. **Plan Action:** None.
299-I	Correction to Previously Failed Payment	RESTORED PYMT	A previously incomplete payment calculation is now completed. **Plan Action:** None.

6.6.10 Medical Savings Account (MSA) Deposit-Recovery Data File

The MSA Deposit-Recovery Data File includes MSA lump sum deposit and recovery amounts for the Current Payment Month (CPM) at the beneficiary level. The file is used by MSA participating Plans to reconcile and identify MSA deposit amounts.

System	Type	Frequency	File Length	MSA Deposit Recovery Dataset Naming Convention
MARx	Data File	Monthly	165	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MSA.Dyymm01.Thhmmsst P.Rxxxxx.MSA.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MSA.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MSA.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MSA.Dyymm01.Thhmmsst [directory]Rxxxxx.MSA.Dyymm01.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the current payment month.

There are three types of records contained in this file:

- **MSA Deposit Recovery Header Record**:
  - Record ID = HDR, provides Contract number and pertinent dates for the file.
- **MSA Deposit Recovery Detail Record**:
  - Record ID = DPT, provides beneficiary level information on the Lump-Sum Deposits.
  - Record ID = RCV, provides beneficiary level information on Lump-Sum Deposit amounts to be recovered from the Plan.
- **MSA Deposit Recovery Trailer Record**:
  - Record ID= TR1, provides a total of Deposit amounts at the Contract/Plan Benefit Package (PBP) level.
  - Record ID = TR2, provides a total of Deposit amounts at the contract level.

All detail records for a single PBP are grouped together. Each group is followed by a TR1 Trailer that provides totals for the PBP. A TR2 Trailer is the last record in the file. It provides the totals at the Contract level (i.e. all PBPs).

Layout 6-15: MSA Deposit Recovery Header Record

MSA Deposit Recovery Header Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record ID	3	1-3	HDR = Header Record.
2	MCO Contract Number	5	4-8	MCO Contract Number.
3	Run Date of the file	8	9-16	Date this data file was created. CCYYMMDD
4	Payment Date	6	17-22	CCYYMM
5	Filler	143	23-165	Spaces.

Layout 6-16: MSA Deposit Recovery Detail Record

MSA Deposit Recovery Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record ID	3	1-3	DPT = MSA Deposit Record. RCV = MSA Recovery Record.
2	MCO Contract Number	5	4-8	MCO Contract Number.
3	Plan Benefit Package ID	3	9-11	Plan Benefit Package ID.
4	Beneficiary ID	12	12-23	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
5	Surname	7	24-30	Surname.
6	First Initial	1	31	First Initial.
7	Sex	1	32	M = Male. F = Female.
8	Date of Birth	8	33-40	CCYYMMDD
9	Filler	1	41	Space.
10	Disenrollment Reason Code	2	42-43	Disenrollment Reason Code associated with the Recovery. Spaces for a Deposit record.
11	MSA Deposit or Recovery Start Date	8	44-51	Start Date for Deposit or Recovery entry. CCYYMMDD
12	MSA Deposit or Recovery End Date	8	52-59	End Date for Deposit or Recovery entry. CCYYMMDD
13	Number of Months in MSA Lump-sum Deposit or Recovery	2	60-61	Indicates Number of Months used to compute Lump-Sum or Recovery Payments.
14	Part A Monthly Deposit Rate	7	62-68	The Medicare Part A dollar amount that is deposited monthly into the beneficiaries MSA Account. 9999.99
15	Part B Monthly Deposit Rate	7	69-75	The Medicare Part B dollar amount that is deposited monthly into the beneficiaries MSA Account. 9999.99
16	Lump-Sum MSA Deposit or Recovery Part A amount	9	76-84	Part A Lump Sum Amount provided to Plan for beneficiary's MSA enrollment. For disenrollment, Part A Lump Sum amount to be recovered from Plan -99999.99 **Note:** A Recovery will be reported as a negative amount. A Deposit will be reported as a positive amount.

MSA Deposit Recovery Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
17	Lump-Sum MSA Deposit or Recovery Part B amount	9	85-93	Part B Lump Sum Amount provided to Plan for beneficiary's MSA enrollment. For disenrollment, Part A Lump Sum amount to be recovered from Plan. -99999.99 **Note:** A Recovery will be reported as a negative amount. A Deposit will be reported as a positive amount
18	Filler	72	94-165	Spaces.

Layout 6-17: MSA Deposit Recovery Trailer Record

MSA Deposit Recovery Trailer Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record ID	3	1-3	Trailer Record. TR1 – Trailer for Contract/PBP level. TR2 – Trailer for Contract level.
2	Contract Number	5	4-8	Contract Number.
3	PBP Number	3	9-11	PBP Number on TR1. Space on TR2.
4	Beneficiary Count	7	12-18	TR1 - Distinct count of beneficiaries based on beneficiary IDs reported this month for the PBP. TR2 – Sum of beneficiaries reported TR1 records. 9999999
5	Detail Record Count	7	19-25	Count of Deposit and Recovery records for the PBP (TR1) or all PBPs (TR2). 9999999
6	PBP Count	4	26-29	Space on TR1. Count of TR1 records for the contract. 9999
7	Filler	2	30-31	Spaces.
8	Part A Total Deposit Amount	13	32-44	Total Part A Lump-Sum MSA Deposit amount. 9999999999.99
9	Part B Total Deposit Amount	13	45-57	Total Part B Lump-Sum MSA Deposit amount. 9999999999.99
10	Part A Total Recovery Amount	14	59-71	Total Part A Lump-Sum MSA Recovery amount. -9999999999.99
11	Part B Total Recovery Amount	14	72-85	Total Part B Lump-Sum MSA Recovery amount. -9999999999.99
12	Total Amount	15	86-100	Sum of all amounts on record -99999999999.99
13	Filler	69	101-165	Spaces.

6.6.11 *Payment Records Report*

This report lists the Part B physician and supplier claims that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract.

Report 6-4: Payment Records Report

PART B CLAIMS RECORDS POSTED IN JUL 2017 PAGE 1
* * * * *HMO HXXXX * * * * *

BENE ID	NAME	EXPENSE FIRST	DATES LAST	ALLOWED TOTAL CHARGES	REIMB AMT	COINSURANCE AMT	DED APP	PHYS SUPP ID	PAY IND	CARRIER NUMBER	CARRIER PAID	INFORMATION CONTROL NUMBER
123456789A	NAME	20160918	20160918	102.65	80.48	22.17	.00	HY068Z	1	09102	20170713	591017174021860
987654321A	NAMEA	20170703	20170703	78.67-	.00	.00	78.67-	H0000BDGPH	1	01212	20170710	333217187070480
987654321A	NAMEA	20170705	20170705	180.96-	68.48-	8.15-	104.33-	H0000BFCZS	1	01212	20170712	333217188084510
123456789D	NAMEC	20170202	20170202	145.29	111.62	33.67	.00	H56410	1	01212	20170711	333217179001320
123456789D	NAMEC	20170214	20170214	69.29	53.23	16.06	.00	H56410	1	01212	20170710	333217179001340
123456789D	NAMEC	20170302	20170302	69.29	53.23	16.06	.00	H56410	1	01212	20170710	333217179001500
123456789D	NAMEC	20170316	20170316	119.52	114.79	4.73	.00	H56410	1	01212	20170713	333217179001520
123456789D	NAMEC	20170328	20170328	91.71	70.46	21.25	.00	H56410	1	01212	20170710	333217179001530

7 Outbound Files and Miscellaneous

This section contains the following Outbound Files and Miscellaneous Information.

7.1 Part C Risk Adjustment Model Output Data File

This is the data file version of the Part C Risk Adjustment Model Output Report, which shows the Hierarchical Condition Codes (HCCs) used by RAS to calculate Part C risk adjustment factors for each Beneficiary. RAS produces the report, and MARx forwards it to Plans as part of the month-end processing.

System	Type	Frequency	File Length	Part C Risk Adjustment Model Output Data File Dataset Naming Conventions
RAS (MARx)	Data File	Monthly	200	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.HCCMODD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.HCCMODD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.HCCMODD.Dyymm01.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the current payment month.

The following records are included in this file:

- **Part C RA Model Output Header Record.**
- **Part C RA Model Output Detail Record Type B, E, and G (PY2012 through PY2018).**
- **Part C RA Model Output Detail Record Type C and F (PY2014 through PY2016).**
- **Part C RA Model Output Detail Record Type D and H (PY2017 through PY2018).**
- **Part C RA Model Output Trailer Record.**

Layout 7-1: Part C RA Model Output Header Record

Part C RA Model Output Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	1 = Header.
2	Contract Number	5	2-6	CHAR	Unique identification for a Medicare Advantage Contract
3	Run Date	8	7-14	CHAR	The run date when this file was created. CCYYMMDD
4	Payment Year and Month	6	15-20	CHAR	This identifies the risk adjustment payment year and month for the model run. CCYYMMDD
5	Filler	180	21-200	CHAR	Spaces.

Layout 7-2: Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	B = Details for new V21 PTC MOR (PACE and PACE ESRD) (RAPS, FFS, and Encounter data) E = Details for new V21 PTC MOR (ESRD) (RAPS and FFS) G = Details for new V21 PTC MOR (ESRD) (Encounter and FFS)
2	Beneficiary ID	12	2-13	CHAR	This is the Health Insurance Claim Account Number (known as HICN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICN, consisting of Beneficiary Claim Number along with the Beneficiary Identification Code, uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-character account number.
3	Beneficiary Last Name	12	14-25	CHAR	First 12 characters of the Beneficiary's Last Name.
4	Beneficiary First Name	7	26-32	CHAR	First 7 characters of the Beneficiary's First Name.
5	Beneficiary Initial	1	33	CHAR	Beneficiary Middle Initial.
6	Date of Birth	8	34-41	CHAR	The date of birth of the Medicare Beneficiary. CCYYMMDD
7	Sex	1	42	CHAR	Represents the sex of the Medicare Beneficiary. 0=Unknown. 1=Male. 2=Female.
8	Social Security Number	9	43-51	CHAR	The beneficiary's current identification number that was assigned by the Social Security Administration
9	RAS ESRD Indicator Switch	1	52	CHAR	The beneficiary's ESRD status as of the model run. Also indicates if the beneficiary was processed by the ESRD models in the model run. Y = ESRD. N = not ESRD.
10	Age Group Female0_34	1	53	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages 0 and 34, inclusive. 1 = If applicable. 0 = Otherwise.
11	Age Group Female35_44	1	54	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages 35 and 44, inclusive. 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
12	Age Group Female45_54	1	55	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages 45 and 54, inclusive. 1 = If applicable. 0 = Otherwise.
13	Age Group Female55_59	1	56	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages 55 and 59, inclusive. 1 = If applicable. 0 = Otherwise.
14	Age Group Female60_64	1	57	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages 60 and 64, inclusive. 1 = If applicable. 0 = Otherwise.
15	Age Group Female65_69	1	58	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages 65 and 69, inclusive. 1 = If applicable. 0 = Otherwise.
16	Age Group Female70_74	1	59	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages 70 and 74, inclusive. 1 = If applicable. 0 = Otherwise.
17	Age Group Female75_79	1	60	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages 75 and 79, inclusive. 1 = If applicable. 0 = Otherwise.
18	Age Group Female80_84	1	61	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages of 80 and 84, inclusive. 1 = If applicable. 0 = Otherwise.
19	Age Group Female85_89	1	62	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages of 85 and 89, inclusive. 1 = If applicable. 0 = Otherwise.
20	Age Group Female90_94	1	63	CHAR	The sex and age group for the beneficiary based on a given as of date: female between ages of 90 and 94, inclusive. 1 = If applicable. 0 = Otherwise.
21	Age Group Female95_GT	1	64	CHAR	The sex and age group for the beneficiary based on a given as of date: female, age 95 or greater. 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
22	Age Group Male0_34	1	65	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 0 and 34, inclusive. 1 = If applicable. 0 = Otherwise.
23	Age Group Male35_44	1	66	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 35 and 44, inclusive. 1 = If applicable. 0 = Otherwise.
24	Age Group Male45_54	1	67	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 45 and 54, inclusive. 1 = If applicable. 0 = Otherwise.
25	Age Group Male55_59	1	68	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 55 and 59, inclusive. 1 = If applicable. 0 = Otherwise.
26	Age Group Male60_64	1	69	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 60 and 64, inclusive. 1 = If applicable. 0 = Otherwise.
27	Age Group Male65_69	1	70	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 65 and 69, inclusive. 1 = If applicable. 0 = Otherwise.
28	Age Group Male70_74	1	71	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 70 and 74, inclusive. 1 = If applicable. 0 = Otherwise.
29	Age Group Male75_79	1	72	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 75 and 79, inclusive. 1 = If applicable. 0 = Otherwise.
30	Age Group Male80_84	1	73	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 80 and 84, inclusive. 1 = If applicable. 0 = Otherwise.
31	Age Group Male85_89	1	74	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 85 and 89, inclusive. 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
32	Age Group Male90_94	1	75	CHAR	The sex and age group for the beneficiary based on a given as of date: male between ages of 90 and 94, inclusive. 1 = If applicable. 0 = Otherwise.
33	Age Group Male95_GT	1	76	CHAR	The sex and age group for the beneficiary based on a given as of date: male, age 95 or greater. 1 = If applicable. 0 = Otherwise.
34	Medicaid Female Disabled	1	77	CHAR	Beneficiary is a female disabled and also entitled to Medicaid. 1 = If applicable. 0 = Otherwise.
35	Medicaid Female Aged	1	78	CHAR	Beneficiary is a female aged (> 64) and also entitled to Medicaid. 1 = If applicable. 0 = Otherwise.
36	Medicaid Male Disabled	1	79	CHAR	Beneficiary is a male disabled and also entitled to Medicaid. 1 = If applicable. 0 = Otherwise.
37	Medicaid Male Aged	1	80	CHAR	Beneficiary is a male aged (> 64) and also entitled to Medicaid. 1 = If applicable. 0 = Otherwise.
38	Originally Disabled Female	1	81	CHAR	Beneficiary is a female and original Medicare entitlement was due to disability. 1 = If applicable. 0 = Otherwise.
39	Originally Disabled Male	1	82	CHAR	Beneficiary is a male and original Medicare entitlement was due to disability. 1 = If applicable. 0 = Otherwise.
40	HCC001	1	83	CHAR	HIV/AIDS. 1 = If applicable. 0 = Otherwise.
41	HCC002	1	84	CHAR	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock. 1 = If applicable. 0 = Otherwise.
42	HCC006	1	85	CHAR	Opportunistic Infections. 1 = If applicable. 0 = Otherwise.
43	HCC008	1	86	CHAR	Metastatic Cancer and Acute Leukemia. 1 = If applicable. 0 = Otherwise.
44	HCC009	1	87	CHAR	Lung and Other Severe Cancers. 1 = If applicable. 0 = Otherwise.
45	HCC010	1	88	CHAR	Lymphoma and Other Cancers. 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
46	HCC011	1	89	CHAR	Colorectal, Bladder, and Other Cancers. 1 = If applicable. 0 = Otherwise.
47	HCC012	1	90	CHAR	Breast, Prostate, and Other Cancers and Tumors. 1 = If applicable. 0 = Otherwise.
48	HCC017	1	91	CHAR	Diabetes with Acute Complications. 1 = If applicable. 0 = Otherwise.
49	HCC018	1	92	CHAR	Diabetes with Chronic Complications. 1 = If applicable. 0 = Otherwise.
50	HCC019	1	93	CHAR	Diabetes without Complication. 1 = If applicable. 0 = Otherwise.
51	HCC021	1	94	CHAR	Protein-Calorie Malnutrition. 1 = If applicable. 0 = Otherwise.
52	HCC022	1	95	CHAR	Morbid Obesity. 1 = If applicable. 0 = Otherwise.
53	HCC023	1	96	CHAR	Other Significant Endocrine and Metabolic Disorders. 1 = If applicable. 0 = Otherwise.
54	HCC027	1	97	CHAR	End-Stage Liver Disease. 1 = If applicable. 0 = Otherwise.
55	HCC028	1	98	CHAR	Cirrhosis of Liver. 1 = If applicable. 0 = Otherwise.
56	HCC029	1	99	CHAR	Chronic Hepatitis. 1 = If applicable. 0 = Otherwise.
57	HCC033	1	100	CHAR	Intestinal Obstruction/Perforation. 1 = If applicable. 0 = Otherwise.
58	HCC034	1	101	CHAR	Chronic Pancreatitis. 1 = If applicable. 0 = Otherwise.
59	HCC035	1	102	CHAR	Inflammatory Bowel Disease. 1 = If applicable. 0 = Otherwise.
60	HCC039	1	103	CHAR	Bone/Joint/Muscle Infections/Necrosis. 1 = If applicable. 0 = Otherwise.
61	HCC040	1	104	CHAR	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease. 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
62	HCC046	1	105	CHAR	Severe Hematological Disorders. 1 = If applicable. 0 = Otherwise.
63	HCC047	1	106	CHAR	Disorders of Immunity. 1 = If applicable. 0 = Otherwise.
64	HCC048	1	107	CHAR	Coagulation Defects and Other Specified Hematological Disorders. 1 = If applicable. 0 = Otherwise.
65	HCC051	1	108	CHAR	Dementia With Complications. 1 = If applicable. 0 = Otherwise.
66	HCC052	1	109	CHAR	Dementia Without Complication. 1 = If applicable. 0 = Otherwise.
67	HCC054	1	110	CHAR	Drug/Alcohol Psychosis. 1 = If applicable. 0 = Otherwise.
68	HCC055	1	111	CHAR	Drug/Alcohol Dependence. 1 = If applicable. 0 = Otherwise.
69	HCC057	1	112	CHAR	Schizophrenia. 1 = If applicable. 0 = Otherwise.
70	HCC058	1	113	CHAR	Major Depressive, Bipolar, and Paranoid Disorders. 1 = If applicable. 0 = Otherwise.
71	HCC070	1	114	CHAR	Quadriplegia. 1 = If applicable. 0 = Otherwise.
72	HCC071	1	115	CHAR	Paraplegia. 1 = If applicable. 0 = Otherwise.
73	HCC072	1	116	CHAR	Spinal Cord Disorders/Injuries. 1 = If applicable. 0 = Otherwise.
74	HCC073	1	117	CHAR	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease. 1 = If applicable. 0 = Otherwise.
75	HCC074	1	118	CHAR	Cerebral Palsy. 1 = If applicable. 0 = Otherwise.
76	HCC075	1	119	CHAR	Polyneuropathy. 1 = If applicable. 0 = Otherwise.
77	HCC076	1	120	CHAR	Muscular Dystrophy. 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
78	HCC077	1	121	CHAR	Multiple Sclerosis. 1 = If applicable. 0 = Otherwise.
79	HCC078	1	122	CHAR	Parkinson's and Huntington's Diseases. 1 = If applicable. 0 = Otherwise.
80	HCC079	1	123	CHAR	Seizure Disorders and Convulsions. 1 = If applicable. 0 = Otherwise.
81	HCC080	1	124	CHAR	Coma, Brain Compression/Anoxic Damage. 1 = If applicable. 0 = Otherwise.
82	HCC082	1	125	CHAR	Respirator Dependence/Tracheostomy Status. 1 = If applicable. 0 = Otherwise.
83	HCC083	1	126	CHAR	Respiratory Arrest. 1 = If applicable. 0 = Otherwise.
84	HCC084	1	127	CHAR	Cardio-Respiratory Failure and Shock. 1 = If applicable. 0 = Otherwise.
85	HCC085	1	128	CHAR	Congestive Heart Failure. 1 = If applicable. 0 = Otherwise.
86	HCC086	1	129	CHAR	Acute Myocardial Infarction. 1 = If applicable. 0 = Otherwise.
87	HCC087	1	130	CHAR	Unstable Angina and Other Acute Ischemic Heart Disease. 1 = If applicable. 0 = Otherwise.
88	HCC088	1	131	CHAR	Angina Pectoris. 1 = If applicable. 0 = Otherwise.
89	HCC096	1	132	CHAR	Specified Heart Arrhythmias. 1 = If applicable. 0 = Otherwise.
90	HCC099	1	133	CHAR	Cerebral Hemorrhage. 1 = If applicable. 0 = Otherwise.
91	HCC100	1	134	CHAR	Ischemic or Unspecified Stroke. 1 = If applicable. 0 = Otherwise.
92	HCC103	1	135	CHAR	Hemiplegia/Hemiparesis. 1 = If applicable. 0 = Otherwise.
93	HCC104	1	136	CHAR	Monoplegia, Other Paralytic Syndromes. 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
94	HCC106	1	137	CHAR	Atherosclerosis of the Extremities with Ulceration or Gangrene. 1 = If applicable. 0 = Otherwise.
95	HCC107	1	138	CHAR	Vascular Disease with Complications. 1 = If applicable. 0 = Otherwise.
96	HCC108	1	139	CHAR	Vascular Disease. 1 = If applicable. 0 = Otherwise.
97	HCC110	1	140	CHAR	Cystic Fibrosis. 1 = If applicable. 0 = Otherwise.
98	HCC111	1	141	CHAR	Chronic Obstructive Pulmonary Disease. 1 = If applicable. 0 = Otherwise.
99	HCC112	1	142	CHAR	Fibrosis of Lung and Other Chronic Lung Disorders. 1 = If applicable. 0 = Otherwise.
100	HCC114	1	143	CHAR	Aspiration and Specified Bacterial Pneumonias. 1 = If applicable. 0 = Otherwise.
101	HCC115	1	144	CHAR	Pneumococcal Pneumonia, Emphysema, Lung Abscess. 1 = If applicable. 0 = Otherwise.
102	HCC122	1	145	CHAR	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage. 1 = If applicable. 0 = Otherwise.
103	HCC124	1	146	CHAR	Exudative Macular Degeneration. 1 = If applicable. 0 = Otherwise.
104	HCC134	1	147	CHAR	Dialysis Status. 1 = If applicable. 0 = Otherwise.
105	HCC135	1	148	CHAR	Acute Renal Failure. 1 = If applicable. 0 = Otherwise.
106	HCC136	1	149	CHAR	Chronic Kidney Disease, Stage 5. 1 = If applicable. 0 = Otherwise.
107	HCC137	1	150	CHAR	Chronic Kidney Disease, Severe (Stage 4). 1 = If applicable. 0 = Otherwise.
108	HCC138	1	151	CHAR	Chronic Kidney Disease, Moderate (Stage 3). 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
109	HCC139	1	152	CHAR	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified). 1 = If applicable. 0 = Otherwise.
110	HCC140	1	153	CHAR	Unspecified Renal Failure. 1 = If applicable. 0 = Otherwise.
111	HCC141	1	154	CHAR	Nephritis. 1 = If applicable. 0 = Otherwise.
112	HCC157	1	155	CHAR	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone. 1 = If applicable. 0 = Otherwise.
113	HCC158	1	156	CHAR	Pressure Ulcer of Skin with Full Thickness Skin Loss. 1 = If applicable. 0 = Otherwise.
114	HCC159	1	157	CHAR	Pressure Ulcer of Skin with Partial Thickness Skin Loss. 1 = If applicable. 0 = Otherwise.
115	HCC160	1	158	CHAR	Pressure Pre-Ulcer Skin Changes or Unspecified Stage. 1 = If applicable. 0 = Otherwise.
116	HCC161	1	159	CHAR	Chronic Ulcer of Skin, Except Pressure. 1 = If applicable. 0 = Otherwise.
117	HCC162	1	160	CHAR	Severe Skin Burn or Condition. 1 = If applicable. 0 = Otherwise.
118	HCC166	1	161	CHAR	Severe Head Injury. 1 = If applicable. 0 = Otherwise.
119	HCC167	1	162	CHAR	Major Head Injury. 1 = If applicable. 0 = Otherwise.
120	HCC169	1	163	CHAR	Vertebral Fractures without Spinal Cord Injury. 1 = If applicable. 0 = Otherwise.
121	HCC170	1	164	CHAR	Hip Fracture/Dislocation. 1 = If applicable. 0 = Otherwise.
122	HCC173	1	165	CHAR	Traumatic Amputations and Complications. 1 = If applicable. 0 = Otherwise.
123	HCC176	1	166	CHAR	Complications of Specified Implanted Device or Graft. 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
124	HCC186	1	167	CHAR	Major Organ Transplant or Replacement Status. 1 = If applicable. 0 = Otherwise.
125	HCC188	1	168	CHAR	Artificial Openings for Feeding or Elimination. 1 = If applicable. 0 = Otherwise.
126	HCC189	1	169	CHAR	Amputation Status, Lower Limb/Amputation Complications. 1 = If applicable. 0 = Otherwise.
127	Disabled Disease HCC006	1	170	CHAR	Disabled (Age<65) and CMS V21 HCC 006 Opportunistic Infections. 1 = If applicable. 0 = Otherwise.
128	Disabled Disease HCC034	1	171	CHAR	Disabled (Age<65) and CMS V21 HCC 034 Chronic Pancreatitis. 1 = If applicable. 0 = Otherwise.
129	Disabled Disease HCC046	1	172	CHAR	Disabled (Age<65) and CMS V21 HCC 046 Severe Hematological Disorders. 1 = If applicable. 0 = Otherwise.
130	Disabled Disease HCC054	1	173	CHAR	Disabled (Age<65) and CMS V21 HCC 054 Drug/Alcohol Psychosis. 1 = If applicable. 0 = Otherwise.
131	Disabled Disease HCC055	1	174	CHAR	Disabled (Age<65) and CMS V21 HCC 055 Drug/Alcohol Dependence. 1 = If applicable. 0 = Otherwise.
132	Disabled Disease HCC110	1	175	CHAR	Disabled (Age<65) and CMS V21 HCC 110 Cystic Fibrosis. 1 = If applicable. 0 = Otherwise.
133	Disabled Disease HCC176	1	176	CHAR	Disabled (Age<65) and CMS V21 HCC 176 Complications of Specified Implanted Device or Graft. 1 = If applicable. 0 = Otherwise.
134	CANCER_ IMMUNE	1	177	CHAR	CANCER_IMMUNE. 1 = If applicable. 0 = Otherwise.
135	CHF_COPD	1	178	CHAR	CHF_COPD. 1 = If applicable. 0 = Otherwise.
136	CHF_RENAL	1	179	CHAR	CHF_RENAL. 1 = If applicable. 0 = Otherwise.
137	COPD_CARD _RESP_FAIL	1	180	CHAR	COPD_CARD_RESP_FAIL. 1 = If applicable. 0 = Otherwise.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
138	DIABETES_ CHF	1	181	CHAR	DIABETES_CHF. 1 = If applicable. 0 = Otherwise.
139	SEPSIS_ CARD_RESP_ FAIL	1	182	CHAR	SEPSIS_CARD_RESP_FAIL. 1 = If applicable. 0 = Otherwise.
140	Medicaid	1	183	CHAR	Beneficiary is entitled to Medicaid. 1 = If applicable. 0 = Otherwise.
141	Originally Disabled	1	184	CHAR	Beneficiary original Medicare entitlement was due to disability. 1 = If applicable. 0 = Otherwise.
142	Disabled Disease HCC039	1	185	CHAR	Disabled (Age<65) and CMS V21 HCC 039 Bone/Joint/Muscle Infections/Necrosis. 1 = If applicable. 0 = Otherwise.
143	Disabled Disease HCC077	1	186	CHAR	Disabled (Age<65) and CMS V21 HCC 077 Multiple Sclerosis. 1 = If applicable. 0 = Otherwise.
144	Disabled Disease HCC085	1	187	CHAR	Disabled (Age<65) and CMS V21 HCC 085 Congestive Heart Failure. 1 = If applicable. 0 = Otherwise.
145	Disabled Disease HCC161	1	188	CHAR	Disabled (Age<65) and CMS V21 HCC 161 Chronic Ulcer of Skin, Except Pressure 1 = If applicable. 0 = Otherwise.
146	ART_ OPENINGS_ PRESSURE_ ULCER	1	189	CHAR	ART_OPENINGS_PRESSURE_ULCER. 1 = If applicable.
147	ASP_SPEC_ BACT_ PNEUM_ PRES_ULC	1	190	CHAR	ASP_SPEC_BACT_PNEUM_PRES_ULC. 1 = If applicable.
148	COPD_ASP_ SPEC_BACT_ PNEUM	1	191	CHAR	COPD_ASP_SPEC_BACT_PNEUM. 1 = If applicable.
149	DISABLED_ PRESSURE_ ULCER	1	192	CHAR	DISABLED_PRESSURE_ULCER. 1 = If applicable.
150	SCHIZO- PHRENIA_ CHF	1	193	CHAR	SCHIZO-PHRENIA_CHF. 1 = If applicable.
151	SCHIZO- PHRENIA_ COPD	1	194	CHAR	SCHIZO-PHRENIA_COPD. 1 = If applicable.
152	SCHIZO- PHRENIA_ SEIZURES	1	195	CHAR	SCHIZO-PHRENIA_SEIZURES. 1 = If applicable.

Part C RA Model Output Detail Record Type B, E, and G (PY2012 – PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
153	SEPSIS_ ARTIF_ OPENINGS	1	196	CHAR	SEPSIS_ARTIF_OPENINGS. 1 = If applicable.
154	SEPSIS_ ASP_SPEC_ BACT_ PNEUM	1	197	CHAR	SEPSIS_ASP_SPEC_BACT_PNEUM 1 = If applicable.
155	SEPSIS_ PRESSURE_ ULCER	1	198	CHAR	SEPSIS_PRESSURE_ULCER. 1 = If applicable.
156	Filler	2	199-200	CHAR	Spaces.

Note: Fields 140-155 are associated with the CMS HCC V21 Institutional Score only.

Layout 7-3: Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	C = Details for new V22 PTC MOR (RAPS and FFS) - non-PACE and non-ESRD F = Details for new V22 PTC MOR (Encounter Data and FFS) - non-PACE and non-ESRD
2	Health Insurance Claim Number	12	2-13	CHAR	This is the HICN identifying the primary Medicare beneficiary under the SSA or RRB programs.
3	Beneficiary Last Name	12	14-25	CHAR	First 12 characters of the beneficiary's last name.
4	Beneficiary First Name	7	26-32	CHAR	First seven characters of the beneficiary's first name.
5	Beneficiary Initial	1	33	CHAR	Beneficiary middle initial.
6	Date of Birth	8	34-41	CHAR	The date of birth of the beneficiary. CCYYMMDD
7	Gender code	1	42	CHAR	Represents the sex of the beneficiary. 0=unknown. 1=male. 2=female.
8	Social Security Number	9	43-51	CHAR	The beneficiary's current identification number that was assigned by the Social Security Administration.
Beneficiary Demographic Indicators:					
9	Age Group Female0_34	1	52	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 0 and 34, inclusive. 1 = If applicable. 0 = otherwise.
10	Age Group Female35_44	1	53	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 35 and 44, inclusive. 1 = If applicable. 0 = otherwise.
11	Age Group Female45_54	1	54	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 45 and 54, inclusive. 1 = If applicable. 0 = otherwise.
12	Age Group Female55_59	1	55	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 55 and 59, inclusive. 1 = If applicable. 0 = otherwise.
13	Age Group Female60_64	1	56	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 60 and 64, inclusive. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
14	Age Group Female65_69	1	57	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 65 and 69, inclusive. 1 = If applicable. 0 = otherwise.
15	Age Group Female70_74	1	58	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 70 and 74, inclusive. 1 = If applicable. 0 = otherwise.
16	Age Group Female75_79	1	59	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 75 and 79, inclusive. 1 = If applicable. 0 = otherwise.
17	Age Group Female80_84	1	60	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 and 84, inclusive. 1 = If applicable. 0 = otherwise.
18	Age Group Female85_89	1	61	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 and 89, inclusive. 1 = If applicable. 0 = otherwise.
19	Age Group Female90_94	1	62	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 and 94, inclusive. 1 = If applicable. 0 = otherwise.
20	Age Group Female95_GT	1	63	CHAR	The sex and age group for the beneficiary based on a given as of date. Female, age 95 or greater. 1 = If applicable. 0 = otherwise.
21	Age Group Male0_34	1	64	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 and 34, inclusive. 1 = If applicable. 0 = otherwise.
22	Age Group Male35_44	1	65	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 and 44, inclusive. 1 = If applicable. 0 = otherwise.
23	Age Group Male45_54	1	66	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 and 54, inclusive. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
24	Age Group Male55_59	1	67	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 and 59, inclusive. 1 = If applicable. 0 = otherwise.
25	Age Group Male60_64	1	68	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 and 64, inclusive. 1 = If applicable. 0 = otherwise.
26	Age Group Male65_69	1	69	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 and 69, inclusive. 1 = If applicable. 0 = otherwise.
27	Age Group Male70_74	1	70	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 and 74, inclusive. 1 = If applicable. 0 = otherwise.
28	Age Group Male75_79	1	71	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 and 79, inclusive. 1 = If applicable. 0 = otherwise.
29	Age Group Male80_84	1	72	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 and 84, inclusive. 1 = If applicable. 0 = otherwise.
30	Age Group Male85_89	1	73	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 and 89, inclusive. 1 = If applicable. 0 = otherwise.
31	Age Group Male90_94	1	74	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 and 94, inclusive. 1 = If applicable. 0 = otherwise.
32	Age Group Male95_GT	1	75	CHAR	The sex and age group for the beneficiary based on a given as of date. Male, age 95 or greater. 1 = If applicable. 0 = otherwise.
33	Medicaid Female Disabled	1	76	CHAR	Beneficiary is a female disabled and also entitled to Medicaid. 1 = If applicable. 0 = otherwise.
34	Medicaid Female Aged	1	77	CHAR	Beneficiary is a female aged (> 64) and also entitled to Medicaid. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
35	Medicaid Male Disabled	1	78	CHAR	Beneficiary is a male disabled and also entitled to Medicaid. 1 = If applicable. 0 = otherwise.
36	Medicaid Male Aged	1	79	CHAR	Beneficiary is a male aged (> 64) and also entitled to Medicaid. 1 = If applicable. 0 = otherwise.
37	Originally Disabled Female	1	80	CHAR	Beneficiary is a female and original Medicare entitlement was due to disability. 1 = If applicable. 0 = otherwise.
38	Originally Disabled Male	1	81	CHAR	Beneficiary is a male and original Medicare entitlement was due to disability. 1 = If applicable. 0 = otherwise.
HCC Indicators:					
39	HCC001	1	82	CHAR	HIV/AIDS. 1 = If applicable. 0 = otherwise.
40	HCC002	1	83	CHAR	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock. 1 = If applicable. 0 = otherwise.
41	HCC006	1	84	CHAR	Opportunistic Infections. 1 = If applicable. 0 = otherwise.
42	HCC008	1	85	CHAR	Metastatic Cancer and Acute Leukemia. 1 = If applicable. 0 = otherwise.
43	HCC009	1	86	CHAR	Lung and Other Severe Cancers. 1 = If applicable. 0 = otherwise.
44	HCC010	1	87	CHAR	Lymphoma and Other Cancers. 1 = If applicable. 0 = otherwise.
45	HCC011	1	88	CHAR	Colorectal, Bladder, and Other Cancers. 1 = If applicable. 0 = otherwise.
46	HCC012	1	89	CHAR	Breast, Prostate, and Other Cancers and Tumors. 1 = If applicable. 0 = otherwise.
47	HCC017	1	90	CHAR	Diabetes with Acute Complications. 1 = If applicable. 0 = otherwise.
48	HCC018	1	91	CHAR	Diabetes with Chronic Complications. 1 = If applicable. 0 = otherwise.
49	HCC019	1	92	CHAR	Diabetes without Complication. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
50	HCC021	1	93	CHAR	Protein-Calorie Malnutrition. 1 = If applicable. 0 = otherwise.
51	HCC022	1	94	CHAR	Morbid Obesity. 1 = If applicable. 0 = otherwise.
52	HCC023	1	95	CHAR	Other Significant Endocrine and Metabolic Disorders. 1 = If applicable. 0 = otherwise.
53	HCC027	1	96	CHAR	End-Stage Liver Disease. 1 = If applicable. 0 = otherwise.
54	HCC028	1	97	CHAR	Cirrhosis of Liver. 1 = If applicable. 0 = otherwise.
55	HCC029	1	98	CHAR	Chronic Hepatitis. 1 = If applicable. 0 = otherwise.
56	HCC033	1	99	CHAR	Intestinal Obstruction/Perforation. 1 = If applicable. 0 = otherwise.
57	HCC034	1	100	CHAR	Chronic Pancreatitis. 1 = If applicable. 0 = otherwise.
58	HCC035	1	101	CHAR	Inflammatory Bowel Disease. 1 = If applicable. 0 = otherwise.
59	HCC039	1	102	CHAR	Bone/Joint/Muscle Infections/Necrosis. 1 = If applicable. 0 = otherwise.
60	HCC040	1	103	CHAR	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease. 1 = If applicable. 0 = otherwise.
61	HCC046	1	104	CHAR	Severe Hematological Disorders. 1 = If applicable. 0 = otherwise.
62	HCC047	1	105	CHAR	Disorders of Immunity. 1 = If applicable. 0 = otherwise.
63	HCC048	1	106	CHAR	Coagulation Defects and Other Specified Hematological Disorders. 1 = If applicable. 0 = otherwise.
64	HCC054	1	107	CHAR	Drug/Alcohol Psychosis. 1 = If applicable. 0 = otherwise.
65	HCC055	1	108	CHAR	Drug/Alcohol Dependence. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
66	HCC057	1	109	CHAR	Schizophrenia. 1 = If applicable. 0 = otherwise.
67	HCC058	1	110	CHAR	Major Depressive, Bipolar, and Paranoid Disorders. 1 = If applicable. 0 = otherwise.
68	HCC070	1	111	CHAR	Quadriplegia. 1 = If applicable. 0 = otherwise.
69	HCC071	1	112	CHAR	Paraplegia. 1 = If applicable. 0 = otherwise.
70	HCC072	1	113	CHAR	Spinal Cord Disorders/Injuries. 1 = If applicable. 0 = otherwise.
71	HCC073	1	114	CHAR	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease. 1 = If applicable. 0 = otherwise.
72	HCC074	1	115	CHAR	Cerebral Palsy. 1 = If applicable. 0 = otherwise.
73	HCC075	1	116	CHAR	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy. 1 = If applicable. 0 = otherwise.
74	HCC076	1	117	CHAR	Muscular Dystrophy. 1 = If applicable. 0 = otherwise.
75	HCC077	1	118	CHAR	Multiple Sclerosis. 1 = If applicable. 0 = otherwise.
76	HCC078	1	119	CHAR	Parkinson’s and Huntington’s Diseases. 1 = If applicable. 0 = otherwise.
77	HCC079	1	120	CHAR	Seizure Disorders and Convulsions. 1 = If applicable. 0 = otherwise.
78	HCC080	1	121	CHAR	Coma, Brain Compression/Anoxic Damage. 1 = If applicable. 0 = otherwise.
79	HCC082	1	122	CHAR	Respirator Dependence/Tracheostomy Status. 1 = If applicable. 0 = otherwise.
80	HCC083	1	123	CHAR	Respiratory Arrest. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
81	HCC084	1	124	CHAR	Cardio-Respiratory Failure and Shock. 1 = If applicable. 0 = otherwise.
82	HCC085	1	125	CHAR	Congestive Heart Failure. 1 = If applicable. 0 = otherwise.
83	HCC086	1	126	CHAR	Acute Myocardial Infarction. 1 = If applicable. 0 = otherwise.
84	HCC087	1	127	CHAR	Unstable Angina and Other Acute Ischemic Heart Disease. 1 = If applicable. 0 = otherwise.
85	HCC088	1	128	CHAR	Angina Pectoris, 1 = If applicable. 0 = otherwise.
86	HCC096	1	129	CHAR	Specified Heart Arrhythmias. 1 = If applicable. 0 = otherwise.
87	HCC099	1	130	CHAR	Cerebral Hemorrhage. 1 = If applicable. 0 = otherwise.
88	HCC100	1	131	CHAR	Ischemic or Unspecified Stroke. 1 = If applicable. 0 = otherwise.
89	HCC103	1	132	CHAR	Hemiplegia/Hemiparesis. 1 = If applicable. 0 = otherwise.
90	HCC104	1	133	CHAR	Monoplegia, Other Paralytic Syndromes. 1 = If applicable. 0 = otherwise.
91	HCC106	1	134	CHAR	Atherosclerosis of the Extremities with Ulceration or Gangrene. 1 = If applicable. 0 = otherwise.
92	HCC107	1	135	CHAR	Vascular Disease with Complications. 1 = If applicable. 0 = otherwise.
93	HCC108	1	136	CHAR	Vascular Disease. 1 = If applicable. 0 = otherwise.
94	HCC110	1	137	CHAR	Cystic Fibrosis. 1 = If applicable. 0 = otherwise.
95	HCC111	1	138	CHAR	Chronic Obstructive Pulmonary Disease. 1 = If applicable. 0 = otherwise.
96	HCC112	1	139	CHAR	Fibrosis of Lung and Other Chronic Lung Disorders. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
97	HCC114	1	140	CHAR	Aspiration and Specified Bacterial Pneumonias. 1 = If applicable. 0 = otherwise.
98	HCC115	1	141	CHAR	Pneumococcal Pneumonia, Emphysema, Lung Abscess. 1 = If applicable. 0 = otherwise.
99	HCC122	1	142	CHAR	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage. 1 = If applicable. 0 = otherwise.
100	HCC124	1	143	CHAR	Exudative Macular Degeneration. 1 = If applicable. 0 = otherwise.
101	HCC134	1	144	CHAR	Dialysis Status. 1 = If applicable. 0 = otherwise.
102	HCC135	1	145	CHAR	Acute Renal Failure. 1 = If applicable. 0 = otherwise.
103	HCC136	1	146	CHAR	Chronic Kidney Disease, Stage 5. 1 = If applicable. 0 = otherwise.
104	HCC137	1	147	CHAR	Chronic Kidney Disease, Severe, Stage 4. 1 = If applicable. 0 = otherwise.
105	HCC157	1	148	CHAR	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone. 1 = If applicable. 0 = otherwise.
106	HCC158	1	149	CHAR	Pressure Ulcer of Skin with Full Thickness Skin Loss. 1 = If applicable. 0 = otherwise.
107	HCC161	1	150	CHAR	Chronic Ulcer of Skin, Except Pressure. 1 = If applicable. 0 = otherwise.
108	HCC162	1	151	CHAR	Severe Skin Burn or Condition. 1 = If applicable. 0 = otherwise.
109	HCC166	1	152	CHAR	Severe Head Injury. 1 = If applicable. 0 = otherwise.
110	HCC167	1	153	CHAR	Major Head Injury. 1 = If applicable. 0 = otherwise.
111	HCC169	1	154	CHAR	Vertebral Fractures without Spinal Cord Injury. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
112	HCC170	1	155	CHAR	Hip Fracture/Dislocation. 1 = If applicable. 0 = otherwise.
113	HCC173	1	156	CHAR	Traumatic Amputations and Complications. 1 = If applicable. 0 = otherwise.
114	HCC176	1	157	CHAR	Complications of Specified Implanted Device or Graft. 1 = If applicable. 0 = otherwise.
115	HCC186	1	158	CHAR	Major Organ Transplant or Replacement Status. 1 = If applicable. 0 = otherwise.
116	HCC188	1	159	CHAR	Artificial Openings for Feeding or Elimination. 1 = If applicable. 0 = otherwise.
117	HCC189	1	160	CHAR	Amputation Status, Lower Limb/Amputation Complications. 1 = If applicable. 0 = otherwise.
Disabled HCCs					
118	Disabled Disease HCC006	1	161	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 006 Opportunistic Infections. 1 = If applicable. 0 = otherwise.
119	Disabled Disease HCC034	1	162	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 034 Chronic Pancreatitis. 1 = If applicable. 0 = otherwise.
120	Disabled Disease HCC046	1	163	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 046 Severe Hematological Disorders. 1 = If applicable. 0 = otherwise.
121	Disabled Disease HCC054	1	164	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 054 Drug/Alcohol Psychosis. 1 = If applicable. 0 = otherwise.
122	Disabled Disease HCC055	1	165	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 055 Drug/Alcohol Dependence. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
123	Disabled Disease HCC110	1	166	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 110 Cystic Fibrosis. 1 = If applicable. 0 = otherwise.
124	Disabled Disease HCC176	1	167	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 176 Complications of Specified Implanted Device or Graft. 1 = If applicable. 0 = otherwise.
Disabled HCCs:					
125	CANCER_ IMMUNE	1	168	CHAR	CANCER_IMMUNE. 1 = If applicable. 0 = otherwise.
126	CHF_COPD	1	169	CHAR	CHF_COPD. 1 = If applicable. 0 = otherwise.
127	CHF_RENAL	1	170	CHAR	CHF_RENAL. 1 = If applicable. 0 = otherwise.
128	COPD_CARD _RESP_FAIL	1	171	CHAR	COPD_CARD_RESP_FAIL. 1 = If applicable. 0 = otherwise.
129	DIABETES_ CHF	1	172	CHAR	DIABETES_CHF. 1 = If applicable. 0 = otherwise.
130	SEPSIS_CARD _RESP_FAIL	1	173	CHAR	SEPSIS_CARD_RESP_FAIL. 1 = If applicable. 0 = otherwise.
Additional Institutional Coefficients					
131	Medicaid	1	174	CHAR	Beneficiary is entitled to Medicaid. 1 = If applicable. 0 = otherwise.
132	Originally Disabled	1	175	CHAR	Beneficiary original Medicare entitlement was due to disability. 1 = If applicable. 0 = otherwise.
133	Disabled Disease HCC039	1	176	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 039 Bone/Joint/Muscle Infections/Necrosis. 1 = If applicable. 0 = otherwise.
134	Disabled Disease HCC077	1	177	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 077 Multiple Sclerosis. 1 = If applicable. 0 = otherwise.
135	Disabled Disease HCC085	1	178	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 085 Congestive Heart Failure. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type C and F (PY2014 – PY2016)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
136	Disabled Disease HCC161	1	179	CHAR	Disabled (Age<65) and CMS Ver 021 HCC 161 Chronic Ulcer of Skin, Except Pressure. 1 = If applicable. 0 = otherwise.
137	DISABLED_PRESSURE_ULCER	1	180	CHAR	DISABLED_PRESSURE_ULCER. 1 = If applicable. 0 = otherwise.
138	ART_OPENINGS_PRESSURE_ULCER	1	181	CHAR	ART_OPENINGS_PRESSURE_ULCER. 1 = If applicable.
139	ASP_SPEC_BACT_PNEUM_PRES_ULC	1	182	CHAR	ASP_SPEC_BACT_PNEUM_PRES_ULC. 1 = If applicable.
140	COPD_ASP_SPEC_BACT_PNEUM	1	183	CHAR	COPD_ASP_SPEC_BACT_PNEUM. 1 = If applicable.
141	SCHIZO-PHRENIA_CHF	1	184	CHAR	SCHIZO-PHRENIA_CHF. 1 = If applicable.
142	SCHIZO-PHRENIA_COPD	1	185	CHAR	SCHIZO-PHRENIA_COPD. 1 = If applicable.
143	SCHIZO-PHRENIA_SEIZURES	1	186	CHAR	SCHIZO-PHRENIA_SEIZURES. 1 = If applicable.
144	SEPSIS_ARTIF_OPENINGS	1	187	CHAR	SEPSIS_ARTIF_OPENINGS. 1 = If applicable.
145	SEPSIS_ASP_SPEC_BACT_PNEUM	1	188	CHAR	SEPSIS_ASP_SPEC_BACT_PNEUM. 1 = If applicable.
146	SEPSIS_PRESSURE_ULCER	1	189	CHAR	SEPSIS_PRESSURE_ULCER. 1 = If applicable.
147	Filler	11	190-200	CHAR	Spaces.

Layout 7-4: Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	Set to "D" or "H" D = Details for V22 PTC model MOR (RAPS and FFS) - non-PACE and non-ESRD H = Details for new V22 PTC model MOR (Encounter Data and FFS) - non-PACE and non-ESRD
2	Health Insurance Claim Account Number	12	2-13	CHAR	This is the Health Insurance Claim Number (known as HICN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICN, consisting of Beneficiary Claim Number along with the Beneficiary Identification Code uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.
3	Beneficiary Last Name	12	14-25	CHAR	First 12 characters of the beneficiary's last name.
4	Beneficiary First Name	7	26-32	CHAR	First seven characters of the beneficiary's first name.
5	Beneficiary Initial	1	33	CHAR	Beneficiary middle initial.
6	Date of Birth	8	34-41	CHAR	The date of birth of the beneficiary.
7	Sex	1	42	CHAR	CCYYMMDD
8	Social Security Number	9	43-51	CHAR	Represents the sex of the beneficiary.
Beneficiary Demographic Indicators:					
9	Age Group Female0_34	1	52	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 0 and 34, inclusive. 1 = If applicable. 0 = otherwise.
10	Age Group Female35_44	1	53	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 35 and 44, inclusive. 1 = If applicable. 0 = otherwise.
11	Age Group Female45_54	1	54	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 45 and 54, inclusive. 1 = If applicable. 0 = otherwise.
12	Age Group Female55_59	1	55	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 55 and 59, inclusive. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
13	Age Group Female60_64	1	56	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 60 and 64, inclusive. 1 = If applicable. 0 = otherwise.
14	Age Group Female65_69	1	57	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 65 and 69, inclusive. 1 = If applicable. 0 = otherwise.
15	Age Group Female70_74	1	58	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 70 and 74, inclusive. 1 = If applicable. 0 = otherwise.
16	Age Group Female75_79	1	59	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages 75 and 79, inclusive. 1 = If applicable. 0 = otherwise.
17	Age Group Female80_84	1	60	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 and 84, inclusive. 1 = If applicable. 0 = otherwise.
18	Age Group Female85_89	1	61	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 and 89, inclusive. 1 = If applicable. 0 = otherwise.
19	Age Group Female90_94	1	62	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 and 94, inclusive. 1 = If applicable. 0 = otherwise.
20	Age Group Female95_GT	1	63	CHAR	The sex and age group for the beneficiary based on a given as of date. Female, age 95 or greater. 1 = If applicable. 0 = otherwise.
21	Age Group Male0_34	1	64	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 and 34, inclusive. 1 = If applicable. 0 = otherwise.
22	Age Group Male35_44	1	65	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 and 44, inclusive. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
23	Age Group Male45_54	1	66	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 and 54, inclusive. 1 = If applicable. 0 = otherwise.
24	Age Group Male55_59	1	67	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 and 59, inclusive. 1 = If applicable. 0 = otherwise.
25	Age Group Male60_64	1	68	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 and 64, inclusive. 1 = If applicable. 0 = otherwise.
26	Age Group Male65_69	1	69	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 and 69, inclusive. 1 = If applicable. 0 = otherwise.
27	Age Group Male70_74	1	70	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 and 74, inclusive. 1 = If applicable. 0 = otherwise.
28	Age Group Male75_79	1	71	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 and 79, inclusive. 1 = If applicable. 0 = otherwise.
29	Age Group Male80_84	1	72	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 and 84, inclusive. 1 = If applicable. 0 = otherwise.
30	Age Group Male85_89	1	73	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 and 89, inclusive. 1 = If applicable. 0 = otherwise.
31	Age Group Male90_94	1	74	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 and 94, inclusive. 1 = If applicable. 0 = otherwise.
32	Age Group Male95_GT	1	75	CHAR	The sex and age group for the beneficiary based on a given as of date. Male, age 95 or greater. 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
33	Originally Disabled Female	1	76	CHAR	Beneficiary is a female and original Medicare entitlement is due to disability. 1 = If applicable. 0 = otherwise.
34	Originally Disabled Male	1	77	CHAR	Beneficiary is a male and original Medicare entitlement is due to disability. 1 = If applicable. 0 = otherwise.
HCC Indicators:					
35	HCC001	1	78	CHAR	HIV/AIDS 1 = If applicable. 0 = otherwise.
36	HCC002	1	79	CHAR	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock 1 = If applicable. 0 = otherwise.
37	HCC006	1	80	CHAR	Opportunistic Infections 1 = If applicable. 0 = otherwise.
38	HCC008	1	81	CHAR	Metastatic Cancer and Acute Leukemia 1 = If applicable. 0 = otherwise.
39	HCC009	1	82	CHAR	Lung and Other Severe Cancers 1 = If applicable. 0 = otherwise.
40	HCC010	1	83	CHAR	Lymphoma and Other Cancers 1 = If applicable. 0 = otherwise.
41	HCC011	1	84	CHAR	Colorectal, Bladder, and Other Cancers 1 = If applicable. 0 = otherwise.
42	HCC012	1	85	CHAR	Breast, Prostate, and Other Cancers and Tumors 1 = If applicable. 0 = otherwise.
43	HCC017	1	86	CHAR	Diabetes with Acute Complications 1 = If applicable. 0 = otherwise.
44	HCC018	1	87	CHAR	Diabetes with Chronic Complications 1 = If applicable. 0 = otherwise.
45	HCC019	1	88	CHAR	Diabetes without Complication 1 = If applicable. 0 = otherwise.
46	HCC021	1	89	CHAR	Protein-Calorie Malnutrition 1 = If applicable. 0 = otherwise.
47	HCC022	1	90	CHAR	Morbid Obesity 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
48	HCC023	1	91	CHAR	Other Significant Endocrine and Metabolic Disorders 1 = If applicable. 0 = otherwise.
49	HCC027	1	92	CHAR	End-Stage Liver Disease 1 = If applicable. 0 = otherwise.
50	HCC028	1	93	CHAR	Cirrhosis of Liver 1 = If applicable. 0 = otherwise.
51	HCC029	1	94	CHAR	Chronic Hepatitis 1 = If applicable. 0 = otherwise.
52	HCC033	1	95	CHAR	Intestinal Obstruction/Perforation 1 = If applicable. 0 = otherwise.
53	HCC034	1	96	CHAR	Chronic Pancreatitis 1 = If applicable. 0 = otherwise.
54	HCC035	1	97	CHAR	Inflammatory Bowel Disease 1 = If applicable. 0 = otherwise.
55	HCC039	1	98	CHAR	Bone/Joint/Muscle Infections/Necrosis 1 = If applicable. 0 = otherwise.
56	HCC040	1	99	CHAR	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease 1 = If applicable. 0 = otherwise.
57	HCC046	1	100	CHAR	Severe Hematological Disorders 1 = If applicable. 0 = otherwise.
58	HCC047	1	101	CHAR	Disorders of Immunity 1 = If applicable. 0 = otherwise.
59	HCC048	1	102	CHAR	Coagulation Defects and Other Specified Hematological Disorders 1 = If applicable. 0 = otherwise.
60	HCC054	1	103	CHAR	Drug/Alcohol Psychosis 1 = If applicable. 0 = otherwise.
61	HCC055	1	104	CHAR	Drug/Alcohol Dependence 1 = If applicable. 0 = otherwise.
62	HCC057	1	105	CHAR	Schizophrenia 1 = If applicable. 0 = otherwise.
63	HCC058	1	106	CHAR	Major Depressive, Bipolar, and Paranoid Disorders 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
64	HCC070	1	107	CHAR	Quadriplegia 1 = If applicable. 0 = otherwise.
65	HCC071	1	108	CHAR	Paraplegia 1 = If applicable. 0 = otherwise.
66	HCC072	1	109	CHAR	Spinal Cord Disorders/Injuries 1 = If applicable. 0 = otherwise.
67	HCC073	1	110	CHAR	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease 1 = If applicable. 0 = otherwise.
68	HCC074	1	111	CHAR	Cerebral Palsy 1 = If applicable. 0 = otherwise.
69	HCC075	1	112	CHAR	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy 1 = If applicable. 0 = otherwise.
70	HCC076	1	113	CHAR	Muscular Dystrophy 1 = If applicable. 0 = otherwise.
71	HCC077	1	114	CHAR	Multiple Sclerosis 1 = If applicable. 0 = otherwise.
72	HCC078	1	115	CHAR	Parkinsons and Huntingtons Diseases 1 = If applicable. 0 = otherwise.
73	HCC079	1	116	CHAR	Seizure Disorders and Convulsions 1 = If applicable. 0 = otherwise.
74	HCC080	1	117	CHAR	Coma, Brain Compression/Anoxic Damage 1 = If applicable. 0 = otherwise.
75	HCC082	1	118	CHAR	Respirator Dependence/Tracheostomy Status 1 = If applicable. 0 = otherwise.
76	HCC083	1	119	CHAR	Respiratory Arrest 1 = If applicable. 0 = otherwise.
77	HCC084	1	120	CHAR	Cardio-Respiratory Failure and Shock 1 = If applicable. 0 = otherwise.
78	HCC085	1	121	CHAR	Congestive Heart Failure 1 = If applicable. 0 = otherwise.
79	HCC086	1	122	CHAR	Acute Myocardial Infarction 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
80	HCC087	1	123	CHAR	Unstable Angina and Other Acute Ischemic Heart Disease 1 = If applicable. 0 = otherwise.
81	HCC088	1	124	CHAR	Angina Pectoris 1 = If applicable. 0 = otherwise.
82	HCC096	1	125	CHAR	Specified Heart Arrhythmias 1 = If applicable. 0 = otherwise.
83	HCC099	1	126	CHAR	Cerebral Hemorrhage 1 = If applicable. 0 = otherwise.
84	HCC100	1	127	CHAR	Ischemic or Unspecified Stroke 1 = If applicable. 0 = otherwise.
85	HCC103	1	128	CHAR	Hemiplegia/Hemiparesis 1 = If applicable. 0 = otherwise.
86	HCC104	1	129	CHAR	Monoplegia, Other Paralytic Syndromes 1 = If applicable. 0 = otherwise.
87	HCC106	1	130	CHAR	Atherosclerosis of the Extremities with Ulceration or Gangrene 1 = If applicable. 0 = otherwise.
88	HCC107	1	131	CHAR	Vascular Disease with Complications 1 = If applicable. 0 = otherwise.
89	HCC108	1	132	CHAR	Vascular Disease 1 = If applicable. 0 = otherwise.
90	HCC110	1	133	CHAR	Cystic Fibrosis 1 = If applicable. 0 = otherwise.
91	HCC111	1	134	CHAR	Chronic Obstructive Pulmonary Disease 1 = If applicable. 0 = otherwise.
92	HCC112	1	135	CHAR	Fibrosis of Lung and Other Chronic Lung Disorders 1 = If applicable. 0 = otherwise.
93	HCC114	1	136	CHAR	Aspiration and Specified Bacterial Pneumonias 1 = If applicable. 0 = otherwise.
94	HCC115	1	137	CHAR	Pneumococcal Pneumonia, Emphysema, Lung Abscess 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
95	HCC122	1	138	CHAR	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage 1 = If applicable. 0 = otherwise.
96	HCC124	1	139	CHAR	Exudative Macular Degeneration 1 = If applicable. 0 = otherwise.
97	HCC134	1	140	CHAR	Dialysis Status 1 = If applicable. 0 = otherwise.
98	HCC135	1	141	CHAR	Acute Renal Failure 1 = If applicable. 0 = otherwise.
99	HCC136	1	142	CHAR	Chronic Kidney Disease, Stage 5 1 = If applicable. 0 = otherwise.
100	HCC137	1	143	CHAR	Chronic Kidney Disease, Severe, Stage 4 1 = If applicable. 0 = otherwise.
101	HCC157	1	144	CHAR	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone 1 = If applicable. 0 = otherwise.
102	HCC158	1	145	CHAR	Pressure Ulcer of Skin with Full Thickness Skin Loss 1 = If applicable. 0 = otherwise.
103	HCC161	1	146	CHAR	Chronic Ulcer of Skin, Except Pressure 1 = If applicable. 0 = otherwise.
104	HCC162	1	147	CHAR	Severe Skin Burn or Condition 1 = If applicable. 0 = otherwise.
105	HCC166	1	148	CHAR	Severe Head Injury 1 = If applicable. 0 = otherwise.
106	HCC167	1	149	CHAR	Major Head Injury 1 = If applicable. 0 = otherwise.
107	HCC169	1	150	CHAR	Vertebral Fractures without Spinal Cord Injury 1 = If applicable. 0 = otherwise.
108	HCC170	1	151	CHAR	Hip Fracture/Dislocation 1 = If applicable. 0 = otherwise.
109	HCC173	1	152	CHAR	Traumatic Amputations and Complications 1 = If applicable. 0 = otherwise.
110	HCC176	1	153	CHAR	Complications of Specified Implanted Device or Graft 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
111	HCC186	1	154	CHAR	Major Organ Transplant or Replacement Status 1 = If applicable. 0 = otherwise.
112	HCC188	1	155	CHAR	Artificial Openings for Feeding or Elimination 1 = If applicable. 0 = otherwise.
113	HCC189	1	156	CHAR	Amputation Status, Lower Limb/Amputation Complications 1 = If applicable. 0 = otherwise.
Disabled HCCs					
114	Disabled Disease HCC6	1	157	CHAR	Disabled, Opportunistic Infections 1 = If applicable. 0 = otherwise.
115	Filler	1	158	CHAR	Not used
116	Filler	1	159	CHAR	Not used
117	Filler	1	160	CHAR	Not used
Disease Interactions					
118	Disease Interactions HCC47_gCancer	1	161	CHAR	Immune Disorders and Cancer Group 1 = If applicable. 0 = otherwise.
119	Disease Interactions HCC85_gDiabetesMellit	1	162	CHAR	Congestive Heart Failure and Diabetes Group 1 = If applicable. 0 = otherwise.
120	Disease Interactions HCC85_gCopdCF	1	163	CHAR	Congestive Heart Failure and Chronic Obstructive Pulmonary Disease Group 1 = If applicable. 0 = otherwise.
121	Disease Interactions HCC85_gRenal	1	164	CHAR	Congestive Heart Failure and Renal Group 1 = If applicable. 0 = otherwise.
122	Disease Interactions HCC85_HCC96	1	165	CHAR	Congestive Heart Failure*Specified Heart Arrhythmias 1 = If applicable. 0 = otherwise.
123	Disease Interactions gRespDepandArre_gCopdCF	1	166	CHAR	Cardiorespiratory Failure Group and Chronic Obstructive Pulmonary Disease Group 1 = If applicable. 0 = otherwise.
124	Disease Interactions gSubstanceAbuse_gPsychiatric	1	167	CHAR	Substance Abuse Group and Psychiatric Group 1 = If applicable. 0 = otherwise.
Additional Institutional Coefficients					

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
125	Medicaid	1	168	CHAR	Beneficiary is entitled to Medicaid 1 = If applicable. 0 = otherwise.
126	Originally Disabled	1	169	CHAR	Beneficiary original Medicare entitlement is due to disability
Disabled HCCs					
127	Disabled Disease DISABLED_HCC39	1	170	CHAR	Disabled, Bone/Joint Muscle Infections/Necrosis 1 = If applicable. 0 = otherwise.
128	Disabled Disease DISABLED_HCC77	1	171	CHAR	Disabled, Multiple Sclerosis 1 = If applicable. 0 = otherwise.
129	Disabled Disease DISABLED_HCC85	1	172	CHAR	Disabled, Congestive Heart Failure 1 = If applicable. 0 = otherwise.
130	Disabled Disease HCC161	1	173	CHAR	Disabled, Chronic Ulcer of the Skin, Except Pressure Ulcer 1 = If applicable. 0 = otherwise.
131	Disabled Disease e-DISABLED_PRESSURE_ULCER	1	174	CHAR	Disabled and Pressure Ulcer 1 = If applicable. 0 = otherwise.
Disease Interactions					
132	Disease Interactions ART_OPENINGS_PRESSURE_ULCER	1	175	CHAR	Artificial Openings for Feeding or Eliminating and Pressure Ulcer 1 = If applicable. 0 = otherwise.
133	Disease Interactions ASP_SPEC_BACTPNEUM_PRES_ULC	1	176	CHAR	Aspiration and Specified Bacterial Pneumonias and Pressure Ulcer 1 = If applicable. 0 = otherwise.
134	Disease Interactions gCopdCF_ASP_SPEC_BACT_PNEUM	1	177	CHAR	Chronic Obstructive Pulmonary Disease and Aspiration and Specified Bacterial Pneumonias 1 = If applicable. 0 = otherwise.
135	Disease Interactions SCHIZOPHRENIA_CHF	1	178	CHAR	Schizophrenia and Congestive Heart Failure 1 = If applicable. 0 = otherwise.
136	Disease Interactions SCHIZOPHRENIA_gCopdCF	1	179	CHAR	Schizophrenia and Chronic Obstructive Pulmonary Disease 1 = If applicable. 0 = otherwise.
137	Disease Interactions SCHIZOPHRENIA_SEIZURES	1	180	CHAR	Schizophrenia and Seizure Disorders and Convulsions 1 = If applicable. 0 = otherwise.

Part C RA Model Output Detail Record Type D and H (PY2017 and PY2018)					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
138	Disease Interactions SEPSIS_ARTIF_OPENINGS	1	181	CHAR	Sepsis and Artificial Openings for Feeding or Elimination 1 = If applicable. 0 = otherwise.
139	Disease Interactions SEPSIS_ASP_SPECBACT_PNEUM	1	182	CHAR	Sepsis and Aspiration and Specified Bacterial Pneumonias 1 = If applicable. 0 = otherwise.
140	Disease Interactions SEPSIS_PRESSURE_ULCER	1	183	CHAR	Sepsis and Pressure Ulcers 1 = If applicable. 0 = otherwise.
141	Filler	17	184 - 200	CHAR	Spaces

Layout 7-5: Part C RA Model Output Trailer Record

Part C RA Model Output Trailer Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	3 = Trailer.
2	Contract Number	5	2-6	CHAR	Unique identification for a Plan to provide coverage to eligible beneficiaries.
3	Total Record Count	9	7-15	CHAR	Record count in display format.
4	Filler	185	16-200	CHAR	Spaces.

7.2 Risk Adjustment System (RAS) Prescription Drug Hierarchical Condition Category (RxHCC) Model Output Data File – PY2016

This file is also known as Part D RA Model Output Data File.

System	Type	Frequency	File Length	Part D RA Model Output Dataset Naming Conventions
RAS (MARx)	Data File	Monthly	168	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMODD.Dyymm01.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the current payment month.

The following records are included in this file:

- **Part D RA Model Output Header Record – PY2016.**
- **Part D RA Model Output Detail/Beneficiary Record – PY2016.**
- **Part D RA Model Output Trailer Record – PY2016.**

Layout 7-6: Part D RA Model Output Header Record – PY2016

The Contract Header Record signals the beginning of the Detail/Beneficiary records for a Medicare Advantage or stand-alone PDP contract.

Part D RA Model Output Header Record – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	1 = Header.
2	Contract Number	5	2-6	CHAR	Unique identification for a Plan to provide coverage to eligible beneficiaries.
3	Run Date	8	7-14	CHAR	The run date when this file was created. CCYYMMDD
4	Payment Year and Month	6	15-20	CHAR	This identifies the risk adjustment payment year and month for the model run. CCYYMM
5	Filler	148	21-168	CHAR	Spaces.

Layout 7-7: Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016

Each Detail/Beneficiary Record contains information for an HCC beneficiary in a Medicare Prescription Drug Contract/Plan, as of the last RAS model run for Payment Year 2016.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	2 = V05 PTD MOR (RAPS and FFS) 4 = V05 PTD MOR (Encounter and FFS) 5 = V05 PTD MOR (PACE) (RAPS, FFS, and Encounter)
2	Beneficiary ID	12	2-13	CHAR	This is the HICN identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICN, consisting of Beneficiary Claim Number along with the Beneficiary Identification Code, uniquely identifies a Medicare beneficiary.
3	Beneficiary Last Name	12	14-25	CHAR	First 12 characters of the Beneficiary's Last Name.
4	Beneficiary First Name	7	26-32	CHAR	First 7 characters of the Beneficiary's First Name.
5	Beneficiary Initial	1	33	CHAR	Beneficiary Middle Initial.
6	Date of Birth	8	34-41	CHAR	The date of birth of the Medicare Beneficiary. CCYYMMDD
7	Sex	1	42	CHAR	Represents the sex of the Medicare Beneficiary. 0=Unknown. 1=Male. 2=Female.
8	Social Security Number	9	43-51	CHAR	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female 0-34	1	52	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 0 and 34. 1 = If applicable. 0 = Otherwise.
10	Age Group Female35_44	1	53	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 35 and 44, inclusive. 1 = If applicable. 0 = Otherwise.
11	Age Group Female45_54	1	54	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 45 and 54, inclusive. 1 = If applicable. 0 = Otherwise.
12	Age Group Female55_59	1	55	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 55 and 59, inclusive. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
13	Age Group Female60_64	1	56	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 60 and 64, inclusive. 1 = If applicable. 0 = Otherwise.
14	Age Group Female65_69	1	57	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 65 and 69, inclusive. 1 = If applicable. 0 = Otherwise.
15	Age Group Female70_74	1	58	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 70 and 74, inclusive. 1 = If applicable. 0 = Otherwise.
16	Age Group Female75_79	1	59	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 75 and 79, inclusive. 1 = If applicable. 0 = Otherwise.
17	Age Group Female80_84	1	60	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 and 84, inclusive. 1 = If applicable. 0 = Otherwise.
18	Age Group Female85_89	1	61	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 and 89, inclusive. 1 = If applicable. 0 = Otherwise.
19	Age Group Female90_94	1	62	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 and 94, inclusive. 1 = If applicable. 0 = Otherwise.
20	Age Group Female95_GT	1	63	CHAR	The sex and age group for the beneficiary based on a given as of date. Female, age 95 and greater. 1 = If applicable. 0 = Otherwise.
21	Age Group Male0_34	1	64	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 and 34, inclusive. 1 = If applicable. 0 = Otherwise.
22	Age Group Male35_44	1	65	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 and 44, inclusive. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
23	Age Group Male45_54	1	66	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 and 54, inclusive. 1 = If applicable. 0 = Otherwise.
24	Age Group Male55_59	1	67	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 and 59, inclusive. 1 = If applicable. 0 = Otherwise.
25	Age Group Male60_64	1	68	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 and 64, inclusive. 1 = If applicable. 0 = Otherwise.
26	Age Group Male65_69	1	69	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 and 69, inclusive. 1 = If applicable. 0 = Otherwise.
27	Age Group Male70_74	1	70	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 and 74, inclusive. 1 = If applicable. 0 = Otherwise.
28	Age Group Male75_79	1	71	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 and 79, inclusive. 1 = If applicable. 0 = Otherwise.
29	Age Group Male80_84	1	72	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 and 84, inclusive. 1 = If applicable. 0 = Otherwise.
30	Age Group Male85_89	1	73	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 and 89, inclusive. 1 = If applicable. 0 = Otherwise.
31	Age Group Male90_94	1	74	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 and 94, inclusive. 1 = If applicable. 0 = Otherwise.
32	Age Group Male95_GT	1	75	CHAR	The sex and age group for the beneficiary based on a given as of date. Male, age 95 and greater. 1 = If applicable. 0 = Otherwise.
33	Originally Disabled Female	1	76	CHAR	Beneficiary is a female and original Medicare entitlement was due to disability. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
34	Originally Disabled Male	1	77	CHAR	Beneficiary is a male and original Medicare entitlement was due to disability. 1 = If applicable. 0 = Otherwise.
35	Disease Coefficients RXHCC1	1	78	CHAR	HIV/AIDS. 1 = If applicable. 0 = Otherwise.
36	Disease Coefficients RXHCC5	1	79	CHAR	Opportunistic Infections. 1 = If applicable. 0 = Otherwise.
37	Disease Coefficients RXHCC15	1	80	CHAR	Chronic Myeloid Leukemia. 1 = If applicable. 0 = Otherwise.
38	Disease Coefficients RXHCC16	1	81	CHAR	Multiple Myeloma and Other Neoplastic Disorders. 1 = If applicable. 0 = Otherwise.
39	Disease Coefficients RXHCC17	1	82	CHAR	Secondary Cancers of Bone, Lung, Brain, and Other Specified Sites; Liver Cancer. 1 = If applicable. 0 = Otherwise.
40	Disease Coefficients RXHCC18	1	83	CHAR	Lung, Kidney, and Other Cancers. 1 = If applicable. 0 = Otherwise.
41	Disease Coefficients RXHCC19	1	84	CHAR	Breast and Other Cancers and Tumors. 1 = If applicable. 0 = Otherwise.
42	Disease Coefficients RXHCC30	1	85	CHAR	Diabetes with Complications. 1 = If applicable. 0 = Otherwise.
43	Disease Coefficients RXHCC31	1	86	CHAR	Diabetes without Complication. 1 = If applicable. 0 = Otherwise.
44	Disease Coefficients RXHCC40	1	87	CHAR	Specified Hereditary Metabolic/Immune Disorders. 1 = If applicable. 0 = Otherwise.
45	Disease Coefficients RXHCC41	1	88	CHAR	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders. 1 = If applicable. 0 = Otherwise.
46	Disease Coefficients RXHCC42	1	89	CHAR	Thyroid Disorders. 1 = If applicable. 0 = Otherwise.
47	Disease Coefficients RXHCC43	1	90	CHAR	Morbid Obesity. 1 = If applicable. 0 = Otherwise.
48	Disease Coefficients RXHCC45	1	91	CHAR	Disorders of Lipoid Metabolism. 1 = If applicable. 0 = Otherwise.
49	Disease Coefficients RXHCC54	1	92	CHAR	Chronic Viral Hepatitis C. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
50	Disease Coefficients RXHCC55	1	93	CHAR	Chronic Viral Hepatitis, Except Hepatitis C. 1 = If applicable. 0 = Otherwise.
51	Disease Coefficients RXHCC65	1	94	CHAR	Chronic Pancreatitis. 1 = If applicable. 0 = Otherwise.
52	Disease Coefficients RXHCC66	1	95	CHAR	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis. 1 = If applicable. 0 = Otherwise.
53	Disease Coefficients RXHCC67	1	96	CHAR	Inflammatory Bowel Disease. 1 = If applicable. 0 = Otherwise.
54	Disease Coefficients RXHCC68	1	97	CHAR	Esophageal Reflux and Other Disorders of Esophagus. 1 = If applicable. 0 = Otherwise.
55	Disease Coefficients RXHCC80	1	98	CHAR	Aseptic Necrosis of Bone. 1 = If applicable. 0 = Otherwise.
56	Disease Coefficients RXHCC82	1	99	CHAR	Psoriatic Arthropathy and Systemic Sclerosis. 1 = If applicable. 0 = Otherwise.
57	Disease Coefficients RXHCC83	1	100	CHAR	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy. 1 = If applicable. 0 = Otherwise.
58	Disease Coefficients RXHCC84	1	101	CHAR	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies. 1 = If applicable. 0 = Otherwise.
59	Disease Coefficients RXHCC87	1	102	CHAR	Osteoporosis, Vertebral and Pathological Fractures. 1 = If applicable. 0 = Otherwise.
60	Disease Coefficients RXHCC95	1	103	CHAR	Sickle Cell Anemia. 1 = If applicable. 0 = Otherwise.
61	Disease Coefficients RXHCC96	1	104	CHAR	Myelodysplastic Syndromes and Myelofibrosis. 1 = If applicable. 0 = Otherwise.
62	Disease Coefficients RXHCC97	1	105	CHAR	Immune Disorders. 1 = If applicable. 0 = Otherwise.
63	Disease Coefficients RXHCC98	1	106	CHAR	Aplastic Anemia and Other Significant Blood Disorders. 1 = If applicable. 0 = Otherwise.
64	Disease Coefficients RXHCC111	1	107	CHAR	Alzheimer's Disease. 1 = If applicable. 0 = Otherwise.
65	Disease Coefficients RXHCC112	1	108	CHAR	Dementia, Except Alzheimer's Disease. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
66	Disease Coefficients RXHCC130	1	109	CHAR	Schizophrenia. 1 = If applicable. 0 = Otherwise.
67	Disease Coefficients RXHCC131	1	110	CHAR	Bipolar Disorders. 1 = If applicable. 0 = Otherwise.
68	Disease Coefficients RXHCC132	1	111	CHAR	Major Depression. 1 = If applicable. 0 = Otherwise.
69	Disease Coefficients RXHCC133	1	112	CHAR	Specified Anxiety, Personality, and Behavior Disorders. 1 = If applicable. 0 = Otherwise.
70	Disease Coefficients RXHCC134	1	113	CHAR	Depression. 1 = If applicable. 0 = Otherwise.
71	Disease Coefficients RXHCC135	1	114	CHAR	Anxiety Disorders. 1 = If applicable. 0 = Otherwise.
72	Disease Coefficients RXHCC145	1	115	CHAR	Autism. 1 = If applicable. 0 = Otherwise.
73	Disease Coefficients RXHCC146	1	116	CHAR	Profound or Severe Intellectual Disability/Developmental Disorder. 1 = If applicable. 0 = Otherwise.
74	Disease Coefficients RXHCC147	1	117	CHAR	Moderate Intellectual Disability/Developmental Disorder. 1 = If applicable. 0 = Otherwise.
75	Disease Coefficients RXHCC148	1	118	CHAR	Mild or Unspecified Intellectual Disability/Developmental Disorder. 1 = If applicable. 0 = Otherwise.
76	Disease Coefficients RXHCC156	1	119	CHAR	Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease. 1 = If applicable. 0 = Otherwise.
77	Disease Coefficients RXHCC157	1	120	CHAR	Spinal Cord Disorders. 1 = If applicable. 0 = Otherwise.
78	Disease Coefficients RXHCC159	1	121	CHAR	Inflammatory and Toxic Neuropathy. 1 = If applicable. 0 = Otherwise.
79	Disease Coefficients RXHCC160	1	122	CHAR	Multiple Sclerosis. 1 = If applicable. 0 = Otherwise.
80	Disease Coefficients RXHCC161	1	123	CHAR	Parkinson's and Huntington's Diseases. 1 = If applicable. 0 = Otherwise.
81	Disease Coefficients RXHCC163	1	124	CHAR	Intractable Epilepsy. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
82	Disease Coefficients RXHCC164	1	125	CHAR	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy. 1 = If applicable. 0 = Otherwise.
83	Disease Coefficients RXHCC165	1	126	CHAR	Convulsions. 1 = If applicable. 0 = Otherwise.
84	Disease Coefficients RXHCC166	1	127	CHAR	Migraine Headaches. 1 = If applicable. 0 = Otherwise.
85	Disease Coefficients RXHCC168	1	128	CHAR	Trigeminal and Postherpetic Neuralgia. 1 = If applicable. 0 = Otherwise.
86	Disease Coefficients RXHCC185	1	129	CHAR	Primary Pulmonary Hypertension. 1 = If applicable. 0 = Otherwise.
87	Disease Coefficients RXHCC186	1	130	CHAR	Congestive Heart Failure. 1 = If applicable. 0 = Otherwise.
88	Disease Coefficients RXHCC187	1	131	CHAR	Hypertension. 1 = If applicable. 0 = Otherwise.
89	Disease Coefficients RXHCC188	1	132	CHAR	Coronary Artery Disease. 1 = If applicable. 0 = Otherwise.
90	Disease Coefficients RXHCC193	1	133	CHAR	Atrial Arrhythmias. 1 = If applicable. 0 = Otherwise.
91	Disease Coefficients RXHCC206	1	134	CHAR	Cerebrovascular Disease, Except Hemorrhage or Aneurysm. 1 = If applicable. 0 = Otherwise.
92	Disease Coefficients RXHCC207	1	135	CHAR	Spastic Hemiplegia. 1 = If applicable. 0 = Otherwise.
93	Disease Coefficients RXHCC215	1	136	CHAR	Venous Thromboembolism. 1 = If applicable. 0 = Otherwise.
94	Disease Coefficients RXHCC216	1	137	CHAR	Peripheral Vascular Disease. 1 = If applicable. 0 = Otherwise.
95	Disease Coefficients RXHCC225	1	138	CHAR	Cystic Fibrosis. 1 = If applicable. 0 = Otherwise.
96	Disease Coefficients RXHCC226	1	139	CHAR	Chronic Obstructive Pulmonary Disease and Asthma. 1 = If applicable. 0 = Otherwise.
97	Disease Coefficients RXHCC227	1	140	CHAR	Pulmonary Fibrosis and Other Chronic Lung Disorders. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
98	Disease Coefficients RXHCC241	1	141	CHAR	Diabetic Retinopathy. 1 = If applicable. 0 = Otherwise.
99	Disease Coefficients RXHCC243	1	142	CHAR	Open-Angle Glaucoma. 1 = If applicable. 0 = Otherwise.
100	Disease Coefficients RXHCC260	1	143	CHAR	Kidney Transplant Status. 1 = If applicable. 0 = Otherwise.
101	Disease Coefficients RXHCC261	1	144	CHAR	Dialysis Status. 1 = If applicable. 0 = Otherwise.
102	Disease Coefficients RXHCC262	1	145	CHAR	Chronic Kidney Disease Stage 5. 1 = If applicable. 0 = Otherwise.
103	Disease Coefficients RXHCC263	1	146	CHAR	Chronic Kidney Disease Stage 4. 1 = If applicable. 0 = Otherwise.
104	Disease Coefficients RXHCC311	1	147	CHAR	Chronic Ulcer of Skin, Except Pressure. 1 = If applicable. 0 = Otherwise.
105	Disease Coefficients RXHCC314	1	148	CHAR	Pemphigus. 1 = If applicable. 0 = Otherwise.
106	Disease Coefficients RXHCC316	1	149	CHAR	Psoriasis, Except with Arthropathy. 1 = If applicable. 0 = Otherwise.
107	Disease Coefficients RXHCC355	1	150	CHAR	Narcolepsy and Cataplexy. 1 = If applicable. 0 = Otherwise.
108	Disease Coefficients RXHCC395	1	151	CHAR	Lung Transplant Status. 1 = If applicable. 0 = Otherwise.
109	Disease Coefficients RXHCC396	1	152	CHAR	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas. 1 = If applicable. 0 = Otherwise.
110	Disease Coefficients RXHCC397	1	153	CHAR	Pancreas Transplant Status. 1 = If applicable. 0 = Otherwise.
111	Originally Disabled	1	154	CHAR	The original reason for Medicare entitlement was due to disability. 1 = If applicable. 0 = Otherwise.
112	NONAGED RXHCC1	1	155	CHAR	Non-Aged and HIV/AIDS. 1 = If applicable. 0 = Otherwise.
113	NONAGED RXHCC130	1	156	CHAR	Non-Aged and Schizophrenia. 1 = If applicable. 0 = Otherwise.
114	NONAGED RXHCC131	1	157	CHAR	Non-Aged and Bipolar Disorders. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
115	NONAGED RXHCC132	1	158	CHAR	Non-Aged and Major Depression. 1 = If applicable. 0 = Otherwise.
116	NONAGED RXHCC133	1	159	CHAR	Non-Aged and Specified Anxiety, Personality, and Behavior Disorders. 1 = If applicable. 0 = Otherwise.
117	NONAGED RXHCC134	1	160	CHAR	Non-Aged and Depression. 1 = If applicable. 0 = Otherwise.
118	NONAGED RXHCC135	1	161	CHAR	Non-Aged and Anxiety Disorders. 1 = If applicable. 0 = Otherwise.
119	NONAGED RXHCC160	1	162	CHAR	Non-Aged and Autism. 1 = If applicable. 0 = Otherwise.
120	NONAGED RXHCC163	1	163	CHAR	Non-Aged and Multiple Sclerosis. 1 = If applicable. 0 = Otherwise.
121	Filler	5	164-168	CHAR	Spaces.

Note: Fields 111-120 are associated with the Rx HCC Continuing Enrollee Institutional Score only.

Layout 7-8: Part D RA Model Output Trailer Record – PY2016

The Contract Trailer Record signals the end of the Detail/Beneficiary records for a MA or stand-alone PDP contract.

Part D RA Model Output Trailer Record – PY2016					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	3 = Trailer.
2	Contract Number	5	2-6	CHAR	Unique identification for a Plan to provide coverage to eligible beneficiaries.
3	Total Record Count	9	7-15	CHAR	Record count, inclusive of all header and trailer records.
4	Filler	153	16-168	CHAR	Spaces.

7.3 Risk Adjustment System (RAS) Prescription Drug Hierarchical Condition Category (RxHCC) Model Output Data File – PY2017 and PY2018

This file is also known as Part D RA Model Output Data File.

System	Type	Frequency	File Length	Part D RA Model Output Dataset Naming Conventions
RAS (MARx)	Data File	Monthly	180	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMODD.Dyymm01.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the current payment month.

The following records are included in this file:

- **Part D RA Model Output Header Record – PY 2017 and PY2018.**
- **Part D RA Model Output Detail/Beneficiary Record – PY2017 and PY2018.**
- **Part D RA Model Output Trailer Record – PY2017 and PY2018.**

The Contract Header Record signals the beginning of the Detail/Beneficiary records for a Medicare Advantage or stand-alone PDP contract.

Layout 7-9: Part D RA Model Output Header Record – PY2017 and PY2018

Part D RA Model Output Header Record – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	1 = Header
2	Contract Number	5	2-6	CHAR	Unique identification for a Plan to provide coverage to eligible beneficiaries.
3	Run Date	8	7-14	CHAR	The run date when this file was created. CCYYMMDD
4	Payment Year and Month	6	15-20	CHAR	This identifies the risk adjustment payment year and month for the model run. CCYYMM
5	Filler	160	21-180	CHAR	Spaces.

Layout 7-10: Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018

Each Detail/Beneficiary Record contains information for an HCC beneficiary in a Medicare Prescription Drug Contract/Plan, as of the last RAS model run for Payment Year 2017 and 2018.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	Set to "2," "4," or "5 "2" = V05 PTD MOR (RAPS and FFS) "4" = V05 PTD MOR (Encounter and FFS) "5" = V05 PTD MOR (PACE) (RAPS, FFS, and Encounter)
2	Beneficiary ID	12	2-13	CHAR	This is the HICN identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICN, consisting of Beneficiary Claim Number along with the Beneficiary Identification Code, uniquely identifies a Medicare beneficiary.
3	Beneficiary Last Name	12	14-25	CHAR	First 12 characters of the Beneficiary's Last Name.
4	Beneficiary First Name	7	26-32	CHAR	First 7 characters of the Beneficiary's First Name.
5	Beneficiary Initial	1	33	CHAR	Beneficiary Middle Initial.
6	Date of Birth	8	34-41	CHAR	The date of birth of the Medicare Beneficiary. CCYYMMDD
7	Sex	1	42	CHAR	Represents the sex of the Medicare Beneficiary. 0=Unknown. 1=Male. 2=Female.
8	Social Security Number	9	43-51	CHAR	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female 0-34	1	52	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 0 and 34. 1 = If applicable. 0 = Otherwise.
10	Age Group Female35_44	1	53	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 35 and 44, inclusive. 1 = If applicable. 0 = Otherwise.
11	Age Group Female45_54	1	54	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 45 and 54, inclusive. 1 = If applicable. 0 = Otherwise.
12	Age Group Female55_59	1	55	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 55 and 59, inclusive. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
13	Age Group Female60_64	1	56	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 60 and 64, inclusive. 1 = If applicable. 0 = Otherwise.
14	Age Group Female65_69	1	57	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 65 and 69, inclusive. 1 = If applicable. 0 = Otherwise.
15	Age Group Female70_74	1	58	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 70 and 74, inclusive. 1 = If applicable. 0 = Otherwise.
16	Age Group Female75_79	1	59	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 75 and 79, inclusive. 1 = If applicable. 0 = Otherwise.
17	Age Group Female80_84	1	60	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 and 84, inclusive. 1 = If applicable. 0 = Otherwise.
18	Age Group Female85_89	1	61	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 and 89, inclusive. 1 = If applicable. 0 = Otherwise.
19	Age Group Female90_94	1	62	CHAR	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 and 94, inclusive. 1 = If applicable. 0 = Otherwise.
20	Age Group Female95_GT	1	63	CHAR	The sex and age group for the beneficiary based on a given as of date. Female, age 95 and greater. 1 = If applicable. 0 = Otherwise.
21	Age Group Male0_34	1	64	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 and 34, inclusive. 1 = If applicable. 0 = Otherwise.
22	Age Group Male35_44	1	65	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 and 44, inclusive. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
23	Age Group Male45_54	1	66	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 and 54, inclusive. 1 = If applicable. 0 = Otherwise.
24	Age Group Male55_59	1	67	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 and 59, inclusive. 1 = If applicable. 0 = Otherwise.
25	Age Group Male60_64	1	68	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 and 64, inclusive. 1 = If applicable. 0 = Otherwise.
26	Age Group Male65_69	1	69	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 and 69, inclusive. 1 = If applicable. 0 = Otherwise.
27	Age Group Male70_74	1	70	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 and 74, inclusive. 1 = If applicable. 0 = Otherwise.
28	Age Group Male75_79	1	71	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 and 79, inclusive. 1 = If applicable. 0 = Otherwise.
29	Age Group Male80_84	1	72	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 and 84, inclusive. 1 = If applicable. 0 = Otherwise.
30	Age Group Male85_89	1	73	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 and 89, inclusive. 1 = If applicable. 0 = Otherwise.
31	Age Group Male90_94	1	74	CHAR	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 and 94, inclusive. 1 = If applicable. 0 = Otherwise.
32	Age Group Male95_GT	1	75	CHAR	The sex and age group for the beneficiary based on a given as of date. Male, age 95 and greater. 1 = If applicable. 0 = Otherwise.
33	Originally Disabled Female	1	76	CHAR	Beneficiary is a female and original Medicare entitlement was due to disability. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
34	Originally Disabled Male	1	77	CHAR	Beneficiary is a male and original Medicare entitlement was due to disability. 1 = If applicable. 0 = Otherwise.
35	Disease Coefficients RXHCC1	1	78	CHAR	HIV/AIDS. 1 = If applicable. 0 = Otherwise.
36	Disease Coefficients RXHCC5	1	79	CHAR	Opportunistic Infections. 1 = If applicable. 0 = Otherwise.
37	Disease Coefficients RXHCC15	1	80	CHAR	Chronic Myeloid Leukemia. 1 = If applicable. 0 = Otherwise.
38	Disease Coefficients RXHCC16	1	81	CHAR	Multiple Myeloma and Other Neoplastic Disorders. 1 = If applicable. 0 = Otherwise.
39	Disease Coefficients RXHCC17	1	82	CHAR	Secondary Cancers of Bone, Lung, Brain, and Other Specified Sites; Liver Cancer. 1 = If applicable. 0 = Otherwise.
40	Disease Coefficients RXHCC18	1	83	CHAR	Lung, Kidney, and Other Cancers. 1 = If applicable. 0 = Otherwise.
41	Disease Coefficients RXHCC19	1	84	CHAR	Breast and Other Cancers and Tumors. 1 = If applicable. 0 = Otherwise.
42	Disease Coefficients RXHCC30	1	85	CHAR	Diabetes with Complications. 1 = If applicable. 0 = Otherwise.
43	Disease Coefficients RXHCC31	1	86	CHAR	Diabetes without Complication. 1 = If applicable. 0 = Otherwise.
44	Disease Coefficients RXHCC40	1	87	CHAR	Specified Hereditary Metabolic/Immune Disorders. 1 = If applicable. 0 = Otherwise.
45	Disease Coefficients RXHCC41	1	88	CHAR	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders. 1 = If applicable. 0 = Otherwise.
46	Disease Coefficients RXHCC42	1	89	CHAR	Thyroid Disorders. 1 = If applicable. 0 = Otherwise.
47	Disease Coefficients RXHCC43	1	90	CHAR	Morbid Obesity. 1 = If applicable. 0 = Otherwise.
48	Disease Coefficients RXHCC45	1	91	CHAR	Disorders of Lipoid Metabolism. 1 = If applicable. 0 = Otherwise.
49	Disease Coefficients RXHCC54	1	92	CHAR	Chronic Viral Hepatitis C. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
50	Disease Coefficients RXHCC55	1	93	CHAR	Chronic Viral Hepatitis, Except Hepatitis C. 1 = If applicable. 0 = Otherwise.
51	Disease Coefficients RXHCC65	1	94	CHAR	Chronic Pancreatitis. 1 = If applicable. 0 = Otherwise.
52	Disease Coefficients RXHCC66	1	95	CHAR	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis. 1 = If applicable. 0 = Otherwise.
53	Disease Coefficients RXHCC67	1	96	CHAR	Inflammatory Bowel Disease. 1 = If applicable. 0 = Otherwise.
54	Disease Coefficients RXHCC68	1	97	CHAR	Esophageal Reflux and Other Disorders of Esophagus. 1 = If applicable. 0 = Otherwise.
55	Disease Coefficients RXHCC80	1	98	CHAR	Aseptic Necrosis of Bone. 1 = If applicable. 0 = Otherwise.
56	Disease Coefficients RXHCC82	1	99	CHAR	Psoriatic Arthropathy and Systemic Sclerosis. 1 = If applicable. 0 = Otherwise.
57	Disease Coefficients RXHCC83	1	100	CHAR	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy. 1 = If applicable. 0 = Otherwise.
58	Disease Coefficients RXHCC84	1	101	CHAR	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies. 1 = If applicable. 0 = Otherwise.
59	Disease Coefficients RXHCC87	1	102	CHAR	Osteoporosis, Vertebral and Pathological Fractures. 1 = If applicable. 0 = Otherwise.
60	Disease Coefficients RXHCC95	1	103	CHAR	Sickle Cell Anemia. 1 = If applicable. 0 = Otherwise.
61	Disease Coefficients RXHCC96	1	104	CHAR	Myelodysplastic Syndromes and Myelofibrosis. 1 = If applicable. 0 = Otherwise.
62	Disease Coefficients RXHCC97	1	105	CHAR	Immune Disorders. 1 = If applicable. 0 = Otherwise.
63	Disease Coefficients RXHCC98	1	106	CHAR	Aplastic Anemia and Other Significant Blood Disorders. 1 = If applicable. 0 = Otherwise.
64	Disease Coefficients RXHCC111	1	107	CHAR	Alzheimer's Disease. 1 = If applicable. 0 = Otherwise.
65	Disease Coefficients RXHCC112	1	108	CHAR	Dementia, Except Alzheimer's Disease. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
66	Disease Coefficients RXHCC130	1	109	CHAR	Schizophrenia. 1 = If applicable. 0 = Otherwise.
67	Disease Coefficients RXHCC131	1	110	CHAR	Bipolar Disorders. 1 = If applicable. 0 = Otherwise.
68	Disease Coefficients RXHCC132	1	111	CHAR	Major Depression. 1 = If applicable. 0 = Otherwise.
69	Disease Coefficients RXHCC133	1	112	CHAR	Specified Anxiety, Personality, and Behavior Disorders. 1 = If applicable. 0 = Otherwise.
70	Disease Coefficients RXHCC134	1	113	CHAR	Depression. 1 = If applicable. 0 = Otherwise.
71	Disease Coefficients RXHCC135	1	114	CHAR	Anxiety Disorders. 1 = If applicable. 0 = Otherwise.
72	Disease Coefficients RXHCC145	1	115	CHAR	Autism. 1 = If applicable. 0 = Otherwise.
73	Disease Coefficients RXHCC146	1	116	CHAR	Profound or Severe Intellectual Disability/Developmental Disorder. 1 = If applicable. 0 = Otherwise.
74	Disease Coefficients RXHCC147	1	117	CHAR	Moderate Intellectual Disability/Developmental Disorder. 1 = If applicable. 0 = Otherwise.
75	Disease Coefficients RXHCC148	1	118	CHAR	Mild or Unspecified Intellectual Disability/Developmental Disorder. 1 = If applicable. 0 = Otherwise.
76	Disease Coefficients RXHCC156	1	119	CHAR	Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease. 1 = If applicable. 0 = Otherwise.
77	Disease Coefficients RXHCC157	1	120	CHAR	Spinal Cord Disorders. 1 = If applicable. 0 = Otherwise.
78	Disease Coefficients RXHCC159	1	121	CHAR	Inflammatory and Toxic Neuropathy. 1 = If applicable. 0 = Otherwise.
79	Disease Coefficients RXHCC160	1	122	CHAR	Multiple Sclerosis. 1 = If applicable. 0 = Otherwise.
80	Disease Coefficients RXHCC161	1	123	CHAR	Parkinson's and Huntington's Diseases. 1 = If applicable. 0 = Otherwise.
81	Disease Coefficients RXHCC163	1	124	CHAR	Intractable Epilepsy. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
82	Disease Coefficients RXHCC164	1	125	CHAR	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy. 1 = If applicable. 0 = Otherwise.
83	Disease Coefficients RXHCC165	1	126	CHAR	Convulsions. 1 = If applicable. 0 = Otherwise.
84	Disease Coefficients RXHCC166	1	127	CHAR	Migraine Headaches. 1 = If applicable. 0 = Otherwise.
85	Disease Coefficients RXHCC168	1	128	CHAR	Trigeminal and Postherpetic Neuralgia. 1 = If applicable. 0 = Otherwise.
86	Disease Coefficients RXHCC185	1	129	CHAR	Primary Pulmonary Hypertension. 1 = If applicable. 0 = Otherwise.
87	Disease Coefficients RXHCC186	1	130	CHAR	Congestive Heart Failure. 1 = If applicable. 0 = Otherwise.
88	Disease Coefficients RXHCC187	1	131	CHAR	Hypertension. 1 = If applicable. 0 = Otherwise.
89	Disease Coefficients RXHCC188	1	132	CHAR	Coronary Artery Disease. 1 = If applicable. 0 = Otherwise.
90	Disease Coefficients RXHCC193	1	133	CHAR	Atrial Arrhythmias. 1 = If applicable. 0 = Otherwise.
91	Disease Coefficients RXHCC206	1	134	CHAR	Cerebrovascular Disease, Except Hemorrhage or Aneurysm. 1 = If applicable. 0 = Otherwise.
92	Disease Coefficients RXHCC207	1	135	CHAR	Spastic Hemiplegia. 1 = If applicable. 0 = Otherwise.
93	Disease Coefficients RXHCC215	1	136	CHAR	Venous Thromboembolism. 1 = If applicable. 0 = Otherwise.
94	Disease Coefficients RXHCC216	1	137	CHAR	Peripheral Vascular Disease. 1 = If applicable. 0 = Otherwise.
95	Disease Coefficients RXHCC225	1	138	CHAR	Cystic Fibrosis. 1 = If applicable. 0 = Otherwise.
96	Disease Coefficients RXHCC226	1	139	CHAR	Chronic Obstructive Pulmonary Disease and Asthma. 1 = If applicable. 0 = Otherwise.
97	Disease Coefficients RXHCC227	1	140	CHAR	Pulmonary Fibrosis and Other Chronic Lung Disorders. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
98	Disease Coefficients RXHCC241	1	141	CHAR	Diabetic Retinopathy. 1 = If applicable. 0 = Otherwise.
99	Disease Coefficients RXHCC243	1	142	CHAR	Open-Angle Glaucoma. 1 = If applicable. 0 = Otherwise.
100	Disease Coefficients RXHCC260	1	143	CHAR	Kidney Transplant Status. 1 = If applicable. 0 = Otherwise.
101	Disease Coefficients RXHCC261	1	144	CHAR	Dialysis Status. 1 = If applicable. 0 = Otherwise.
102	Disease Coefficients RXHCC262	1	145	CHAR	Chronic Kidney Disease Stage 5. 1 = If applicable. 0 = Otherwise.
103	Disease Coefficients RXHCC263	1	146	CHAR	Chronic Kidney Disease Stage 4. 1 = If applicable. 0 = Otherwise.
104	Disease Coefficients RXHCC311	1	147	CHAR	Chronic Ulcer of Skin, Except Pressure. 1 = If applicable. 0 = Otherwise.
105	Disease Coefficients RXHCC314	1	148	CHAR	Pemphigus. 1 = If applicable. 0 = Otherwise.
106	Disease Coefficients RXHCC316	1	149	CHAR	Psoriasis, Except with Arthropathy. 1 = If applicable. 0 = Otherwise.
107	Disease Coefficients RXHCC355	1	150	CHAR	Narcolepsy and Cataplexy. 1 = If applicable. 0 = Otherwise.
108	Disease Coefficients RXHCC395	1	151	CHAR	Lung Transplant Status. 1 = If applicable. 0 = Otherwise.
109	Disease Coefficients RXHCC396	1	152	CHAR	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas. 1 = If applicable. 0 = Otherwise.
110	Disease Coefficients RXHCC397	1	153	CHAR	Pancreas Transplant Status. 1 = If applicable. 0 = Otherwise.
111	Originally Disabled	1	154	CHAR	The original reason for Medicare entitlement was due to disability. 1 = If applicable. 0 = Otherwise.
112	NONAGED RXHCC1	1	155	CHAR	Non-Aged and HIV/AIDS. 1 = If applicable. 0 = Otherwise.
113	NONAGED RXHCC130	1	156	CHAR	Non-Aged and Schizophrenia. 1 = If applicable. 0 = Otherwise.
114	NONAGED RXHCC131	1	157	CHAR	Non-Aged and Bipolar Disorders. 1 = If applicable. 0 = Otherwise.

Part D RA Model Output Detail/Beneficiary Record Types 2, 4, and 5 – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
115	NONAGED RXHCC132	1	158	CHAR	Non-Aged and Major Depression. 1 = If applicable. 0 = Otherwise.
116	NONAGED RXHCC133	1	159	CHAR	Non-Aged and Specified Anxiety, Personality, and Behavior Disorders. 1 = If applicable. 0 = Otherwise.
117	NONAGED RXHCC134	1	160	CHAR	Non-Aged and Depression. 1 = If applicable. 0 = Otherwise.
118	NONAGED RXHCC135	1	161	CHAR	Non-Aged and Anxiety Disorders. 1 = If applicable. 0 = Otherwise.
119	NONAGED RXHCC160	1	162	CHAR	Non-Aged and Autism. 1 = If applicable. 0 = Otherwise.
120	NONAGED RXHCC163	1	163	CHAR	Non-Aged and Multiple Sclerosis. 1 = If applicable. 0 = Otherwise.
121	NONAGED RXHCC145	1	164	CHAR	Non-Aged and Multiple Sclerosis. 1 = If applicable. 0 = Otherwise.
122	NONAGED RXHCC164	1	165	CHAR	Non-Aged and Multiple Sclerosis. 1 = If applicable. 0 = Otherwise.
123	NONAGED RXHCC165	1	166	CHAR	Non-Aged and Multiple Sclerosis. 1 = If applicable. 0 = Otherwise.
124	Filler	14	167-180	CHAR	Spaces.

NOTE: Fields 111-123 are associated with the Rx HCC Continuing Enrollee Institutional Score only.

Layout 7-11: Part D RA Model Output Trailer Record – PY2017 and PY2018

Part D RA Model Output Trailer Record – PY2017 and PY2018					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Type Code	1	1	CHAR	3 = Trailer.
2	Contract Number	5	2-6	CHAR	Unique identification for a Plan to provide coverage to eligible beneficiaries.
3	Total Record Count	9	7-15	CHAR	Record count, inclusive of all header and trailer records.
4	Filler	165	16-180	CHAR	Spaces.

7.4 Medicare Advantage Organization (MAO) 004 Report – Encounter Data Diagnosis Eligible for Risk Adjustment – Phase III, Version 3

Beginning with Payment Year (PY) 2015, diagnoses from encounter data records with 2014 dates of service that are valid for risk adjustment were added as another source of data when calculating risk scores, in addition to diagnoses from the Risk Adjustment Processing System (RAPS) and from fee-for-service (FFS) claims. In December 2015, CMS created the MAO-004 report, a 500 byte flat file, to inform Medicare Advantage Organizations (MAOs) of the risk adjustment eligibility of diagnosis data submitted on accepted Encounter Data Records (EDRs). The MAO-004 reports are produced on a monthly basis from data submitted by contracts to CMS in the immediately preceding month. For example, the MAO-004 reports sent to MAOs in August 2017 were based on EDRs submitted to and accepted by the CMS' Encounter Data Processing System (EDPS) in July 2017.

This report is distributed to MAOs by Contract Identification Number on a monthly basis via MARx.

If you have any questions about the report, please email RiskAdjustment@cms.hhs.gov with the subject line of "MAO-004 report, Contract XXXX.

System	Type	Frequency	File Length	MAO-004 Report Dataset Naming Conventions
RAS (MARx)	Data File	Monthly	500	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MAO004PV.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MAO004PV.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** **[**directory]Rxxxxx.MAO004.Dyymmdd.Thhmmsst

Where:

- zzzzzzzz is the Plan sponsor-provided high level qualifier.
- xxxxx is the contract number.
- ppppp is the contract number, representing the contract that the MAO-004 report is for.
- P = Phase: The Phase can be 1 to 9 or A to Z.
- V= Version: The version can be 1 to 9 or A to Z.
- yy is the two digit year when the file was sent.
- mm is the two digit month when the file was sent.
- dd is the two digit day when the file was sent.
- tttttt is the timestamp, representing the time the file was sent.

The file includes the following records:

- **MAO-004 Header Record**
- **MAO-004 Detail Record**
- **MAO-004 Trailer Record**

Layout 7-12: MAO-004 Header Record – Phase III, Version 3

MAO-004 Header Record – Phase III, Version 3				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	1	1	Numeric, no commas and/or decimals 0=Header.
2	Delimiter	1	2	Alphanumeric Uses the * character.
3	Report ID	7	3-9	Alphanumeric Value is MAO-004.
4	Delimiter	1	10	Alphanumeric Uses the * character.
5	Medicare Advantage Contract ID	5	11-15	Alphanumeric Medicare Contract ID assigned to the submitting contract.
6	Delimiter	1	16	Alphanumeric Uses the * character.
7	Report Date	8	17-24	Numeric CCYYMMDD The last date of the submission month.
8	Delimiter	1	25	Alphanumeric Uses the * character.
9	Report Description	53	26-78	Alphanumeric, Left justify, blank fill Value is “Encounter Data Diagnosis Eligible for Risk Adjustment."
10	Delimiter	1	79	Alphanumeric Uses the * character.
11	Filler	30	80-109	Spaces.
12	Delimiter	1	110	Alphanumeric Uses the * character
13	Submission File Type	4	111-114	Alphanumeric Value of 'PROD,' for production and 'TEST' for test files
14	Delimiter	1	115	Alphanumeric Uses the * character.
15	Phase	1	116	Alphanumeric
16	Delimiter	1	117	Alphanumeric Uses the * character.
17	Version	1	118	Alphanumeric This field will designate which version within the phase.
18	Delimiter	1	119	Alphanumeric Uses the * character.
19	Filler	381	120-500	Spaces/

Layout 7-13: MAO-004 Detail Record – Phase III, Version 3

MAO-004 Detail Record – Phase III, Version 3				
Item	**Field**	**Size**	**Position**	**Format and Comments**
1	Record Type	1	1	Numeric 1=Detail.
2	Delimiter	1	2	Alphanumeric Uses the * character.
3	Report ID	7	3-9	Alphanumeric Value is MAO-004.

MAO-004 Detail Record – Phase III, Version 3				
Item	**Field**	**Size**	**Position**	**Format and Comments**
4	Delimiter	1	10	Alphanumeric Uses the * character.
5	Medicare Advantage Contract ID	5	11-15	Alphanumeric Medicare Contract ID assigned to the submitting contract.
6	Delimiter	1	16	Alphanumeric Uses the * character.
7	Beneficiary Identifier	12	17-28	Alphanumeric Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI).
8	Delimiter	1	29	Alphanumeric Uses the * character.
9	Encounter ICN	20	30-49	Numeric Encounter Data System (EDS) Internal Control Number. In encounter data, only 13 spaces represent the ICN; however, there are 20 spaces on the records to allow enhancement of the ICN.
10	Delimiter	1	50	Alphanumeric Uses the * character.
11	Encounter Type Switch	1	51	Alpha Numeric This field can take on 9 different values: 1 = Encounter. 2 = Void to an Encounter. 3= Replacement to an Encounter. 4 = Chart Review Add. 5 = Void to a Chart Review. 6 = Replacement to a Chart Review. 7 = Chart Review Delete. 8 = Void to a chart review Delete. 9 = Replacement to a chart review Delete.
12	Delimiter	1	52	Alphanumeric Uses the * character.
13	ICN of Encounter Linked To	20	53-72	Alphanumeric Encounter Data System (EDS) Internal Control Number. This field reports the ICN of the record an adjustment, void, linked chart review add, or linked chart review delete is linked to. It will be spaces for original encounters and unlinked chart reviews.
14	Delimiter	1	73	Alphanumeric Uses the * character.

MAO-004 Detail Record – Phase III, Version 3				
Item	**Field**	**Size**	**Position**	**Format and Comments**
15	Allowed/ Disallowed Status of Encounter Linked To	1	74	Alphanumeric This field indicates if the diagnoses on the encounter data record or chart review record that is referenced in Field 13 were allowed or disallowed for risk adjustment. A = Diagnoses on previous record were allowed. D = Diagnoses on previous record were disallowed. Space = (1) If the current record is an original encounter data record. (2) If the current record is an unlinked chart review record and no record is referenced in Field 13. (3) If the record is a linked chart review with an invalid ICN in Field 13. (4) If the diagnoses on the record whose ICN is in Field 13 did not pass the filtering logic and were not previously reported on a MAO-004 report.
16	Delimiter	1	75	Alphanumeric Uses the * character.
17	Encounter Submission Date	8	76-83	Numeric Identifies the date the MAO submitted the encounter. CCYYMMDD
18	Delimiter	1	84	Alphanumeric Uses the * character.
19	"From" Date of Service	8	85-92	Numeric The start date for a provided service. CCYYMMDD
20	Delimiter	1	93	Alphanumeric Uses the * character.
21	"Through" Date of Service	8	94-101	Numeric The end date for a provided service. CCYYMMDD
22	Delimiter	1	102	Alphanumeric Uses the * character.
23	Service Type	1	103	Alphanumeric Type of Claim: P = Professional. I = Inpatient. O = Outpatient. D = DME. N = (All Others) Not Applicable.
24	Delimiter	1	104	Alphanumeric Uses the * character.

MAO-004 Detail Record – Phase III, Version 3				
Item	**Field**	**Size**	**Position**	**Format and Comments**
25	Allowed/ Disallowed flag	1	105	Alphanumeric This field indicates if diagnoses on the current encounter data record (Field 9) are allowed or disallowed for risk adjustment. A = Diagnoses are allowed for risk adjustment. D = Diagnoses are disallowed for risk adjustment. **Note:** Non voids and non-chart review deletes with Service Type (Field #23) designated with 'N' will be 'D'. Space = All voids and chart review deletes, regardless of service type, since allowed and disallowed status do not apply.
26	Delimiter	1	106	Alphanumeric Uses the * character.

MAO-004 Detail Record – Phase III, Version 3				
Item	**Field**	**Size**	**Position**	**Format and Comments**
27	Allowed/ Disallowed Reason Code	1	107	Alphanumeric If applicable, this field will indicate why diagnoses on the current record are disallowed, or will indicate that diagnoses which previously did not pass the CMS filtering logic are now allowed based on an updated CPT/HCPCS list. H = CPT/HCPCS code is not acceptable for risk adjustment. This value is applicable to only outpatient and professional encounters, not to inpatient encounters. T= Type of Bill is not acceptable for risk adjustment. This value is applicable to only outpatient and inpatient encounters, not to professional encounters. Q= the diagnoses on the current encounter are now allowed due to CPT/HCPCS quarterly update. This value is only applicable to reprocessed outpatient and professional encounters, not to inpatient encounters. Blank = the diagnoses on the current record have passed CMS filtering criteria and are allowed. If the diagnosis on the record is disallowed for both type of bill and CPT/HCPCS code, reason code T will be reported. This is only applicable to outpatient encounters. D = Diagnoses on EDRs and CRRs that were submitted and accepted after the risk-adjustment deadline for the relevant payment year. N = All other EDRs and CRRs that are not Inpatient, Outpatient, Professional or DME. **Note:** The risk adjustment deadline will take precedence over TOB and HCPCS disallowed reason codes. If the cutoff date is missed, it doesn't matter whether a record has CPT/HCPCS (Prof & Outpatient) or TOB (Inpatient or Outpatient) since it is disallowed due to the risk adjustment deadline. D (Deadline Date) > T (Type of Bill) > H (CPT/HCPCS)
28	Delimiter	1	108	Alphanumeric Uses the * character.

MAO-004 Detail Record – Phase III, Version 3				
Item	**Field**	**Size**	**Position**	**Format and Comments**
29	Diagnoses ICD	1	109	Alphanumeric ICD code for all the diagnoses. 9 = ICD-9. 0=ICD-10.
30	Delimiter	1	110	Alphanumeric Uses the * character.
31	Diagnosis Codes	7	111-117	Alphanumeric ICD-9 codes will be accepted prior to the ICD-10 implementation date. Only ICD-10 codes will be accepted starting with ICD-10 implementation date.
32	Delimiter	1	118	Alphanumeric Uses the * character.
33	Add or Delete flag	1	119	Alphanumeric This field will indicate if a diagnosis is an Add or Delete. Diagnoses added on original and replacement encounters (including chart reviews) for the first time in that encounter family, will be marked as A. Diagnoses deleted on replacements, voids, and chart review deletes will be marked as D. Diagnoses reported before in the encounter family are reported with a blank. A = Add. D = Delete. Space = diagnosis has been reported before in the encounter family.
34	Delimiter	1	120	Alphanumeric Uses the * character.
35	Diagnosis Codes & Delimiters & Add/Delete flags for 37 diagnoses	370	121-490	Alphanumeric This field includes up to 37 additional diagnoses, for a total of 38 diagnoses per transaction line. When there are more than 38 diagnoses on a record, the remaining diagnoses will wrap around in the next line of the report with all elements of the detail line repeated except the diagnoses.
36	Filler	10	491-500	Spaces.

Layout 7-14: MAO-004 Trailer Record – Phase III, Version 3

MAO-004 Trailer Record – Phase III, Version 3				
Item	**Field**	**Size**	**Position**	**Format and Comments**
1	Record Type	1	1	Numeric 9=Trailer.
2	Delimiter	1	2	Alphanumeric Uses the * character.
3	Report ID	7	3-9	Alphanumeric Value is MAO-004
4	Delimiter	1	10	Alphanumeric Uses the * character.
5	Medicare Advantage Contract ID	5	11-15	Alphanumeric Medicare Contract ID assigned to the submitting contract.
6	Delimiter	1	16	Alphanumeric Uses the * character.
7	Total Number of Records	18	17-34	Numeric Count of detail records on this report.
8	Delimiter	1	35	Alphanumeric Uses the * character.
9	Filler	465	36-500	Alphanumeric Spaces.

7.5 Part B Claims Data File

The Part B Claims Data File lists the Part B physician and supplier claims, and Part B home health claims that were processed under Medicare fee-for-service for beneficiaries enrolled in the contract.

System	Type	Frequency	File Length	Part B Claims Data File Dataset Naming Conventions
MARx	Data File	Monthly	187	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.CLAIMDAT.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.CLAIMDAT.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.CLAIMDAT.Dyymm01.Thhmmsst

Note: The date in the file name defaults to "01" denoting the first day of the current payment month.

The file includes the following records:

- **Part B Claims Record Type 1**
- **Part B Claims Record Type 2**

Layout 7-15: Part B Claims Record Type 1

Part B Claims Data File Record Type 1				
Item	**Field**	**Size**	**Position**	**Description**
1	Contract Number	5	1-5	Plan contract number
2	Record Type	1	6	6 = Physician/Supplier. 7 = Durable Medical Equipment.
3	Beneficiary ID	12	7-18	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
4	Period From	8	19-26	Start Date. CCYYMMDD
5	Period To	8	27-34	End Date. CCYYMMDD
6	Date of Birth	8	35-42	Beneficiary's Date of Birth. CCYYMMDD
7	Surname	6	43-48	First six positions of Beneficiary's surname.
8	First Name	1	49	First letter of Beneficiary's first name.
9	Middle Initial	1	50	First letter of Beneficiary's middle name.

Part B Claims Data File Record Type 1				
Item	**Field**	**Size**	**Position**	**Description**
10	Reimbursement Amount	11	51-61	Reimbursement amount for claim.
11	Total Allowed Charges	11	62-72	Total allowed charges for claim.
12	Report Date	6	73-78	Claims processed through date. CCYYMM. Assigned by the system as it produces this file. This is the cut-off date for including a claim in this file.
13	Contractor identification number	5	79-83	Identification number of the contractor that processed claim.
14	Provider identification number	10	84-93	Provider's identification number.
15	Internal Control Number	15	94-108	Internal control number assigned by the Medicare contractor to claim.
16	Provider Payment Amount	11	109-119	Total amount paid to provider for this claim.
17	Beneficiary Payment Amount	11	120-130	Total amount paid to Beneficiary for this claim.
18	Filler	57	131-187	Spaces.

Layout 7-16: Part B Claims Record Type 2

Part B Claims Data File Record Type 2				
Item	**Field**	**Size**	**Position**	**Description**
1	Contract Number	5	1-5	Plan contract number.
2	Record Type	1	6	5 = Home Health Agency.
3	Beneficiary ID	12	7-18	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
4	Period From	8	19-26	Start Date. CCYYMMDD
5	Period To	8	27-34	End Date. CCYYMMDD
6	Date of Birth	8	35-42	Beneficiary's Date of Birth. CCYYMMDD
7	Surname	6	43-48	First six positions of Beneficiary's surname.
8	First Name	1	49	First letter of Beneficiary's first name.
9	Middle Name	1	50	First letter of Beneficiary's middle name.
10	Reimbursement Amount	11	51-61	Reimbursement amount for claim.
11	Total Charges	11	62-72	Total charges on the claim.

Part B Claims Data File Record Type 2				
Item	**Field**	**Size**	**Position**	**Description**
12	Report Date	6	73-78	Claims processed through date. CCYYMM Assigned by the system when processing claims. This is the cut-off date for including a claim in this file.
13	Contractor identification number	5	79-83	Identification number of the contractor that processed the claim.
14	Provider identification number	6	84-89	Provider's identification number.
15	Filler	98	90-187	Spaces.

7.6 Monthly Medicare Secondary Payer (MSP) Information Data File (Part C Only)

A Medicare Secondary Payment (MSP) file is sent each month to the Plans. The data on this file reflects beneficiaries that have Medicare as their secondary payer sometime during their Medicare enrollment periods in Part A/B. It contains demographic information on the beneficiary as well as information on their primary insurance.

The file has four record types:

- **MSP Header Record**
- **MSP Primary Record**
- **MSP Detail Record.**
- **MSP Trailer Record**

The Primary (PRM) record identifies and provides information about the beneficiary. The PRM record has a Detail Count field that identifies how many detail records will follow the primary record. Each Detail (DET##) record contains the details on a specific MSP period for the beneficiary identified in the PRM record.

The Trailer Record contains a total count of Primary records and a total count of combined Primary and Detail records.

System	Type	Frequency	File Length	MSP File Record Naming Conventions
MARx	Data File	Monthly	700	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory].Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst

Layout 7-17: MSP Header Record

MSP Header Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Header Code	8	1-8	Value = CMSMSPDH.
2	Sending Entity	4	9-12	Value = MARX.
3	File Creation Date	8	13-20	CCYYMMDD
4	Filler	680	21-700	Spaces.

Layout 7-18: MSP Primary Record

MSP Primary Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	3	1-3	Value = PRM.
2	Beneficiary ID	12	4-15	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
3	Detail Count	2	16-17	This is the count of MSP DET records for each beneficiary.
4	Date of Birth	8	18-25	CCYYMMDD
5	Gender Code	1	26	0 = Unknown 1 = Male 2 = Female
6	Contract	5	27-31	Contract Number.
7	PBP	3	32-34	Plan Benefit Package.
This begins the MSP Factor fields for the Prospective Payment.				
8	MSP Factor	7	35-41	Layout (00.0000)
9	Part A RD Amount Sign	1	42	"-" = Negative. Space = Positive.
10	Part A RD Amount	9	43-51	Layout (999999.99)
11	Part B RD Amount Sign	1	52	"-" = Negative. Space = Positive.
12	Part B RD Amount	9	53-61	Layout (999999.99)
13	Paid Flag	1	62	Y = Yes, it was paid. N = No, it was not paid.
This ends the MSP Factor fields for the Prospective Payment.				
14	MSP Factor Adjustment 1	7	63-69	Layout (00.0000)
15	Part A RD Amount Sign Adjustment 1	1	70	"-" = Negative. Space = Positive.
16	Part A RD Amount Adjustment 1	9	71-79	Layout (999999.99)
17	Part B RD Amount Sign Adjustment 1	1	80	"-" = Negative. Space = Positive.
18	Part B RD Amount Adjustment 1	9	81-89	Layout (999999.99)
19	Paid Flag Adjustment 1	1	90	Y = Yes, it was paid. N = No, it was not paid.
20	MSP Factor Adjustment 2	7	91-97	Layout (00.0000)
21	Part A RD Amount Sign Adjustment 2	1	98	"-" = Negative. Space = Positive.

MSP Primary Record				
Item	**Field**	**Size**	**Position**	**Description**
22	Part A RD Amount Adjustment 2	9	99-107	Layout (999999.99)
23	Part B RD Amount Sign Adjustment 2	1	108	"-" = Negative. Space = Positive.
24	Part B RD Amount Adjustment 2	9	109-117	Layout (999999.99)
25	Paid Flag Adjustment 2	1	118	Y = Yes, it was paid. N = No, it was not paid.
26	MSP Factor Adjustment 3	7	119-125	Layout (00.0000)
27	Part A RD Amount Sign Adjustment 3	1	126	"-" = Negative. Space = Positive.
28	Part A RD Amount Adjustment 3	9	127-135	Layout (999999.99)
29	Part B RD Amount Sign Adjustment 3	1	136	"-" = Negative. Space = Positive.
30	Part B RD Amount Adjustment 3	9	137-145	Layout (999999.99)
31	Paid Flag Adjustment 3	1	146	Y = Yes, it was paid. N = No, it was not paid
32	MSP Factor Adjustment 4	7	147-153	Layout (00.0000)
33	Part A RD Amount Sign Adjustment 4	1	154	"-" = Negative. Space = Positive.
34	Part A RD Amount Adjustment 4	9	155-163	Layout (999999.99)
35	Part B RD Amount Sign Adjustment 4	1	164	"-" = Negative Space = Positive
36	Part B RD Amount Adjustment 4	9	165-173	Layout (999999.99)
37	Paid Flag Adjustment 4	1	174	Y = Yes, it was paid. N = No, it was not paid
38	Filler	526	175-700	Spaces

Layout 7-19: MSP Detail Record

MSP Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	5	1-5	Value = DET## Where ## = number of the MSP occurrence; 01 through 17.
2	Beneficiary ID	12	6-17	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
3	Delete Indicator	1	18	D = occurrence to be deleted or audited.
4	Validity Indicator	1	19	I = FI/Carrier added occurrence. N = Beneficiary does not have MSP coverage. Y = BCRC added.
5	MSP Code	1	20	The field value is cross-walked. All values: 12 = Working Aged (A). 13 = ESRD (B). 14 = No Fault (D). 15 = Worker Comp (E). 16 = Federal (Public Health) (F). 41 = Black Lung (H). 42 = Veterans (I). 43 = Disabled (G). 47 = Liability (L).
6	COB Contractor Number	5	21-25	N/A
7	Date Entry Added	8	26-33	CCYYMMDD
8	Update Contractor Number	5	34-38	N/A
9	Maintenance Date	8	39-46	CCYYMMDD Date the data was updated by MSP updating contractor.
10	CWF Occurrence	2	47-48	2 digit numeric value. Spaces if no value present on table.
11	Filler	4	49-52	Spaces.

MSP Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
12	Insurer Type	1	53	A = Insurance or indemnity. B = HMP. C = Preferred provider organization. D = Third party administrator arrangement under an administrative service only contract without stop loss from any entity. E = Third party administrator arrangement with stop loss insurance issued from any entity. F = Self-insured/self-administered. G = Collectively-bargained health and welfare. H = Multiple employer health plan with at least one employer who has more than 100 full and/or part-time employees. J = Hospitalization only plan which covers only Inpatient services. K = Medicare services only plan which covers only non-inpatient services. M = Medicare supplemental plan: Medigap, Medicare Wraparound Plan or Medicare Carve Out Plan. Spaces = unknown.
13	Insurer Name	32	54-85	The name of the group coverage plan in which the beneficiary is enrolled.
14	Insurer Address 1	32	86-117	Insurer's street address line 1.
15	Insurer Address 2	32	118-149	Insurer's street address line 2.
16	Insurer City	15	150-164	The name of Insurer's city.
17	Insurer State Code	2	165-166	Insurer's state code.
18	Insurer Zip Code	9	167-175	Insurer's zip code.
19	Policy Number	17	176-192	The identifier for the group coverage plan in which the beneficiary is enrolled.
20	MSP Effective Date	8	193-200	CCYYMMDD
21	MSP Termination Date	8	201-208	CCYYMMDD

MSP Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
22	Patient Relationship Code	2	209-210	01 = Patient is Insured. 02 = Spouse. 03 = Natural Child, Insured has Financial Responsibility. 04 = Natural Child, Insured does not have Financial Responsibility. 05 = Step Child. 06 = Foster Child. 07 = Ward of the Court. 08 = Employee. 09 = Unknown. 10 = Handicapped Dependent. 11 = Organ Donor. 12 = Cadaver Donor. 13 = Grandchild. 14 = Niece/Nephew. 15 = Injured Plaintiff. 16 = Sponsored Dependent. 17 = Minor Dependent of a Minor Dependent. 18 = Parent. 19 = Grandparent dependent. 20 = Life Partner.
23	Subscriber First Name	9	211-219	First name of policyholder.
24	Subscriber Last Name	16	220-235	Last name of policyholder.
25	Employee ID Number	12	236-247	Employee ID number assigned by employer.

MSP Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
26	Source Code	2	248-249	A = Claim Processing. B = IRS/SSA/CMS Data Match. C = First Claim Development. D = IRS/SSA/CMS Data Match II. E = Black Lung (DOL). F = Veterans (VA). G = Other Data Matches. H = Worker's Compensation. I = Notified by Beneficiary. J = Notified by Provider. K = Notified by Insurer. L = Notified by Employer. M = Notified by Attorney. N = Notified by Group Health Plan/Primary Payer. O = Initial Enrollment Questionnaire. P = HMP Rate Cell Adjustment. Q = Voluntary Insurer Reporting. S = Miscellaneous Reporting. T = IRS/SSA/CMS Data Match III. U = IRS/SSA/CMS Data Match IV. V = IRS/SSA/CMS Data Match V. W = IRS/SSA/CMS Data Match VI. X = Self reports. Y = 411.25. Spaces = Unknown. 0 = COB Contractor. 1 = Initial Enrollment questionnaire. 2 = IRS/SSA/CMS/data match. 3 = HMP Rate cell. 4 = Litigation Settlement. 5 = Employer Voluntary Reporting. 6 = Insurer Voluntary Reporting. 7 = First Claim Development. 8 = Trauma Code Development. 9 = Secondary Claims Investigation. 10 = Self Reports. 11 = 411.25. 12 = BC/BS Voluntary Agreements. 13 = Office of Personnel Management (OPM). 14 = Workmen's Compensation (WC) Data match. 25 = Recovery Audit Contractor (California). 26 = Recovery Audit Contractor (Florida).
27	Employee INFO Data	1	250	P = Patient. S = Spouse. M = Mother. F = Father.
28	Employer Name	32	251-282	The name of the employer providing coverage.
29	Employer Address 1	32	283-314	Employer's street address line 1.
30	Employer Address 2	32	315-346	Employer's street address line 2.
31	Employer City	15	347-361	The name of employer's city.
32	Employer State	2	362-363	Employer's state code.

MSP Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
33	Employer Zip Cd	9	364-372	Employer's zip code.
34	Insurer Group Number	20	373-392	Group number assigned by primary payer.
35	Insurer Group Name	17	393-409	The name of the insurance group.
36	Prepaid Health Plan Date	8	410-417	CCYYMMDD; Date beneficiary was notified that the Medicare is secondary payer for services performed outside the prepaid Health Plan when they could have been performed by a prepaid Health Plan provider.
37	Remarks Code 1	2	418-419	Remarks Code 1.
38	Remarks Code 2	2	420-421	Remarks Code 2.
39	Remarks Code 3	2	422-423	Remarks Code 3.
40	Payer ID	10	424-433	The identifier of the primary payer.
41	Diagnosis Code Ind 1	1	434	0 = ICD 10. 9 = ICD 9.
42	Diagnosis Code 1	7	435-441	Diagnosis Code 1.
43	Diagnosis Code Ind 2	1	442	0 = ICD 10. 9 = ICD 9.
44	Diagnosis Code 2	7	443-449	Diagnosis Code 2.
45	Diagnosis Code Ind 3	1	450	0 = ICD 10. 9 = ICD 9.
46	Diagnosis Code 3	7	451-457	Diagnosis Code 3.
47	Diagnosis Code Ind 4	1	458	0 = ICD 10. 9 = ICD 9.
48	Diagnosis Code 4	7	459-465	Diagnosis Code 4.
49	Diagnosis Code Ind 5	1	466	0 = ICD 10. 9 = ICD 9.
50.	Diagnosis Code 5	7	467-473	Diagnosis Code 5.
51	Diagnosis Code Ind 6	1	474	0 = ICD 10. 9 = ICD 9.
52	Diagnosis Code 6	7	475-481	Diagnosis Code 6.
53	Diagnosis Code Ind 7	1	482	0 = ICD 10. 9 = ICD 9.
54	Diagnosis Code 7	7	483-489	Diagnosis Code 7.
55	Diagnosis Code Ind 8	1	490	0 = ICD 10. 9 = ICD 9.
56	Diagnosis Code 8	7	491-497	Diagnosis Code 8.
57	Diagnosis Code Ind 9	1	498	0 = ICD 10. 9 = ICD 9.
58	Diagnosis Code 9	7	499-505	Diagnosis Code 9.
59	Diagnosis Code Ind 10	1	506	0 = ICD 10. 9 = ICD 9.
60	Diagnosis Code 10	7	507-513	Diagnosis Code 10.
61	Diagnosis Code Ind 11	1	514	0 = ICD 10. 9 = ICD 9.
62	Diagnosis Code 11	7	515-521	Diagnosis Code 11.
63	Diagnosis Code Ind 12	1	522	0 = ICD 10. 9 = ICD 9.

MSP Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
64	Diagnosis Code 12	7	523-529	Diagnosis Code 12.
65	Diagnosis Code Ind 13	1	530	0 = ICD 10. 9 = ICD 9.
66	Diagnosis Code 13	7	531-537	Diagnosis Code 13.
67	Diagnosis Code Ind 14	1	538	0 = ICD 10. 9 = ICD 9.
6	Diagnosis Code 14	7	539-545	Diagnosis Code 14.
69	Diagnosis Code Ind 15	1	546	0 = ICD 10. 9 = ICD 9.
70	Diagnosis Code 15	7	547-553	Diagnosis Code 15.
71	Diagnosis Code Ind 16	1	554	0 = ICD 10. 9 = ICD 9.
72	Diagnosis Code 16	7	555-561	Diagnosis Code 16.
73	Diagnosis Code Ind 17	1	562	0 = ICD 10. 9 = ICD 9.
74	Diagnosis Code 17	7	563-569	Diagnosis Code 17.
75	Diagnosis Code Ind 18	1	570	0 = ICD 10. 9 = ICD 9.
76	Diagnosis Code 18	7	571-577	Diagnosis Code 18.
77	Diagnosis Code Ind 19	1	578	0 = ICD 10. 9 = ICD 9.
78	Diagnosis Code 19	7	579-585	Diagnosis Code 19.
79	Diagnosis Code Ind 20	1	586	0 = ICD 10. 9 = ICD 9.
80	Diagnosis Code 20	7	587-593	Diagnosis Code 20.
81	Diagnosis Code Ind 21	1	594	0 = ICD 10. 9 = ICD 9.
82	Diagnosis Code 21	7	595-601	Diagnosis Code 21.
83	Diagnosis Code Ind 22	1	602	0 = ICD 10. 9 = ICD 9.
84	Diagnosis Code 22	7	603-609	Diagnosis Code 22.
85	Diagnosis Code Ind 23	1	610	0 = ICD 10. 9 = ICD 9.
86	Diagnosis Code 23	7	611-617	Diagnosis Code 23.
87	Diagnosis Code Ind 24	1	618	0 = ICD 10. 9 = ICD 9.
88	Diagnosis Code 24	7	619-625	Diagnosis Code 24.
89	Diagnosis Code Ind 25	1	626	0 = ICD 10. 9 = ICD 9.
90	Diagnosis Code 25	7	627-633	Diagnosis Code 25.
91	Filler	67	634-700	Spaces

Layout 7-20: MSP Trailer Record

MSP Trailer Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Trailer Code	8	1-8	Value = CMSMSPDT.
2	Sending Entity	4	9-12	Value = MARX.
3	File Creation Date	8	13-20	CCYYMMDD
4	Total PRM Count	8	21-28	Total count of primary beneficiary records.
5	Total Records Count	8	29-36	Total count of all records (minus the Header and Trailer).
6	Filler	664	37-700	Spaces.

7.7 Medicare Advantage Medicaid Status Data File

CMS will send a monthly report to Plans that provides the monthly dual statuses and corresponding dual status codes for their beneficiaries who are full or partial duals. Plans will receive a Medicare Advantage Medicaid Status data file to assist in predicting future revenue impacts under the CMS-HCC risk adjustment model, and to assist in benefit coordination. Each report will provide the most recent Medicaid information on plan enrollees, back to the beginning of the payment.

System	Type	Frequency	File Length	Medicare Advantage Medicaid Status Data File Dataset Naming Conventions
MARx	Data File	Monthly	75	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MCMD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MCMD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MCMD.Dyymm01.Thhmmsst

The file includes the following records:

- **Medicare Advantage Medicaid Status Header Record.**
- **Medicare Advantage Medicaid Status Beneficiary Identification Record.**
- **Medicare Advantage Medicaid Status Beneficiary Detail Record.**
- **Medicare Advantage Medicaid Status Trailer Record.**

Layout 7-21: Medicare Advantage Medicaid Status Header Record

Medicare Advantage Medicaid Status Header Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	1	1	1 = File Header.
2	Contract Number	5	2-6	Contract identification.
3	Start Year	4	7-10	Earliest year associated with the data.
4	End Year	4	11-14	Latest year associated with the data.
5	File Generation Date	8	15-22	Date the file was generated. CCYYMMDD
6	Filler	53	23-75	Spaces.

Layout 7-22: Medicare Advantage Medicaid Status Beneficiary Identification Record

Medicare Advantage Medicaid Status Beneficiary Identification Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	1	1	2 = Beneficiary Identification Record.
2	Contract Number	5	2-6	Contract Identification.
3	Beneficiary ID	12	7-18	Beneficiary Identifier.
4	Last Name	12	19-30	Beneficiary Surname.
5	First Name	7	31-37	Beneficiary First Name.
6	Middle Initial	1	38	Beneficiary Middle Initial.
7	DOB	8	39-46	Beneficiary Birth Date. CCYYMMDD
8	Gender	1	47	Beneficiary Gender Identification Code 0 = Unknown 1 = Male 2 = Female
9	Filler	28	48-75	Spaces.

Layout 7-23: Medicare Advantage Medicaid Status Beneficiary Detail Record

Medicare Advantage Medicaid Status Beneficiary Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	1	1	3 = Beneficiary Detail Record.
2	Contract Number	5	2-6	Contract Identification.
3	Medicaid Status Start Date	8	7-14	Medicaid Status Start Date. CCYYMMDD
4	Medicaid Status End Date	8	15-22	Medicaid Status End Date. CCYYMMDD Spaces if there is no end date.
5	Medicaid Status	1	23	F = Full P = Partial
6	Dual Status Code Start Date	8	24-31	Dual Status Code Start Date. CCYYMMDD
7	Dual Status Code End Date	8	32-39	Dual Status Code End Date. CCYYMMDD
8	Dual Status Code	2	40-41	Dual Status Code.
9	Record Add Timestamp	12	42-53	Record Add Timestamp for Dual Status Code. CCYYMMDDHHMM

Medicare Advantage Medicaid Status Beneficiary Detail Record				
Item	**Field**	**Size**	**Position**	**Description**
10	Record Update Timestamp	12	54-65	Record Update Timestamp for Dual Status Code. CCYYMMDDHHMM
11	Filler	18	66-75	Spaces.

Layout 7-24: Medicare Advantage Medicaid Status Trailer Record

Medicare Advantage Medicaid Status Trailer Record				
Item	**Field**	**Size**	**Position**	**Description**
1	Record Type	1	1	4 = File Trailer.
2	Contract Number	5	2-6	Contract Identification.
3	Record Count	7	7-13	Number of records on the data file (count of Type 1, Type 2, Type 3, and Type 4 records). Left padded with zeroes.
4	Beneficiary Record Count	7	14-20	Number of beneficiary records (Type 2) on the data file. Left padded with zeroes.
5	Filler	55	21-75	Spaces.

7.8 Long-Term Institutionalized (LTI) Resident Report File

The LTI Resident Report provides Part D sponsors with a list of their enrolled beneficiaries who are LTI residents for longer than 90 days.

CMS releases the LTI report quarterly each year. This report provides information to Part D Sponsors on institutionalized enrollees, as well as the names and addresses of the particular long-term care (LTC) facilities in which those beneficiaries reside. This information is obtained by linking Medicare enrollment information with data from the Minimum Data Set (MDS) of nursing home assessments.

System	Type	Frequency	File Length	LTI Resident Report File Dataset Naming Conventions
MDS	Data File	Quarterly	299	Gentran Mailbox/TIBCO MFT Internet Server: P.Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst Connect:Direct (Mainframe): zzzzzzzz.Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst Connect:Direct (Non-Mainframe): [directory]Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst

Layout 7-25: LTI Resident Report File Record

LTI Resident Report File Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Part D Contract Number	5	1-5	CHAR	Part D Contract Number associated with the resident during the month of the last nursing home assessment date.
2	Part D Plan Number	3	6-8	CHAR	Part D Plan Number associated with the resident during the month of the last nursing home assessment date.
3	Part D Plan Name	50	9-58	CHAR	Part D Plan Name associated with the resident during the month of the last nursing home assessment date.
4	Last Name	24	59-82	CHAR	Beneficiary Last Name.
5	First Name	15	83-97	CHAR	Beneficiary First Name.
6	Beneficiary ID	12	98-109	CHAR	Beneficiary Identifier associated with the resident.
7	Date of Birth	8	110-117	DATE	Beneficiary's Date of Birth. CCYYMMDD
8	Gender Code	1	118	CHAR	Beneficiary Gender Code. 1 = Male. 2 = Female. 0 = Unknown.
9	Nursing Home Length of Stay	6	119-124	CHAR	Nursing Home Length of Stay in days (0 – 999999) at the time of the last Nursing Home assessment.
10	Nursing Home Admission Date	8	125-132	DATE	Admission date associated with the last assessment for the resident. CCYYMMDD

LTI Resident Report File Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
11	Last Nursing Home Assessment Date	8	133-140	DATE	Target date of the last assessment for the resident. CCYYMMDD
12	Prospective Payment System (PPS) Indicator	1	141	CHAR	Identifies those long-term nursing home residents whose last reported resident assessment was a Medicare-PPS type assessment. (Data source: Minimum Data Set (MDS) system, Field A0310B). This field was formerly known as the Part A Indicator.
13	Nursing Home Name	50	142-191	CHAR	Name of Nursing Home associated with the last assessment for the resident.
14	Medicare Provider ID	12	192-203	CHAR	Medicare Provider ID of Nursing Home associated with the last assessment for the resident.
15	Provider Telephone Number	13	204-216	CHAR	Telephone Number of Nursing Home associated with the last assessment for the resident.
16	Provider Address	50	217-266	CHAR	Address of Nursing Home associated with the last assessment for the resident.
17	Provider City	20	267-286	CHAR	City of Nursing Home associated with the last assessment for the resident.
18	Provider State Code	2	287-288	CHAR	State Code of Nursing Home associated with the last assessment for the resident.
19	Provider Zip Code	11	289-299	CHAR	Zip Code of Nursing Home associated with the last assessment for the resident.

7.9 HICN to Medicare Beneficiary Identifier (MBI) Crosswalk File

To assist MAOs and Part D sponsors with the ability to determine or match their beneficiary population between HICN and MBI, MARx will generate and distribute a monthly crosswalk data file. Each crosswalk data file will be created at the MAO/PDP Contract level. The crosswalk files will be sent monthly during the transition period.

- In March 2018, Plans will receive an "initial" (one-time only) HICN to MBI Crosswalk File. The initial file will include all beneficiaries who have had valid enrollments in the Contract at any point from 2006 to present.
- After the initial Crosswalk file, a monthly file will be sent to Plans to include any new enrollment changes.

System	Type	Frequency	File Length	HICN to MBI Crosswalk File Dataset Naming Conventions
MARx	Data File	Monthly	106	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.CROSSWLK.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.CROSSWLK.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.CROSSWLK.Dyymm01.Thhmmsst

Layout 7-26: HICN to MBI Crosswalk File

HICN to MBI Crosswalk File				
Item	**Field**	**Size**	**Position**	**Description**
1	Contract	5	1 – 5	Plan Contract Number.
2	PBP	3	6 – 8	Plan Benefit Package ID.
3	HICN	12	9 – 20	Health Insurance Claim Number.
4	MBI	11	21 – 31	Medicare Beneficiary Identifier.
5	Surname	30	32 – 61	Beneficiary's last name.
6	First Name	12	62 – 73	Beneficiary's first name.
7	Date of Birth	8	74 – 81	CCYYMMDD
8	Date of Death	8	82 – 89	CCYYMMDD
9	Gender	1	90	Beneficiary Gender Identification Code. 0 = Unknown. 1 = Male. 2 = Female.
10	Recent Enrollment Date	8	91 – 98	CCYYMMDD The effective date of the beneficiary's most recent enrollment in the contract.
11	Recent Disenrollment Date	8	99 – 106	CCYYMMDD The disenrollment date (if present) for the beneficiary's most recent enrollment in the contract.

7.10 Other

This section provides a description and sample snapshot of other reports sent to Plans. Note that the examples provided for the reports do not identify any person living or dead; all Beneficiary, contract, and user information is fictional.

The **All Transmission Overview** lists the naming conventions for all reports. A user will need the dataset name to request a report through the MAPD Help Desk.

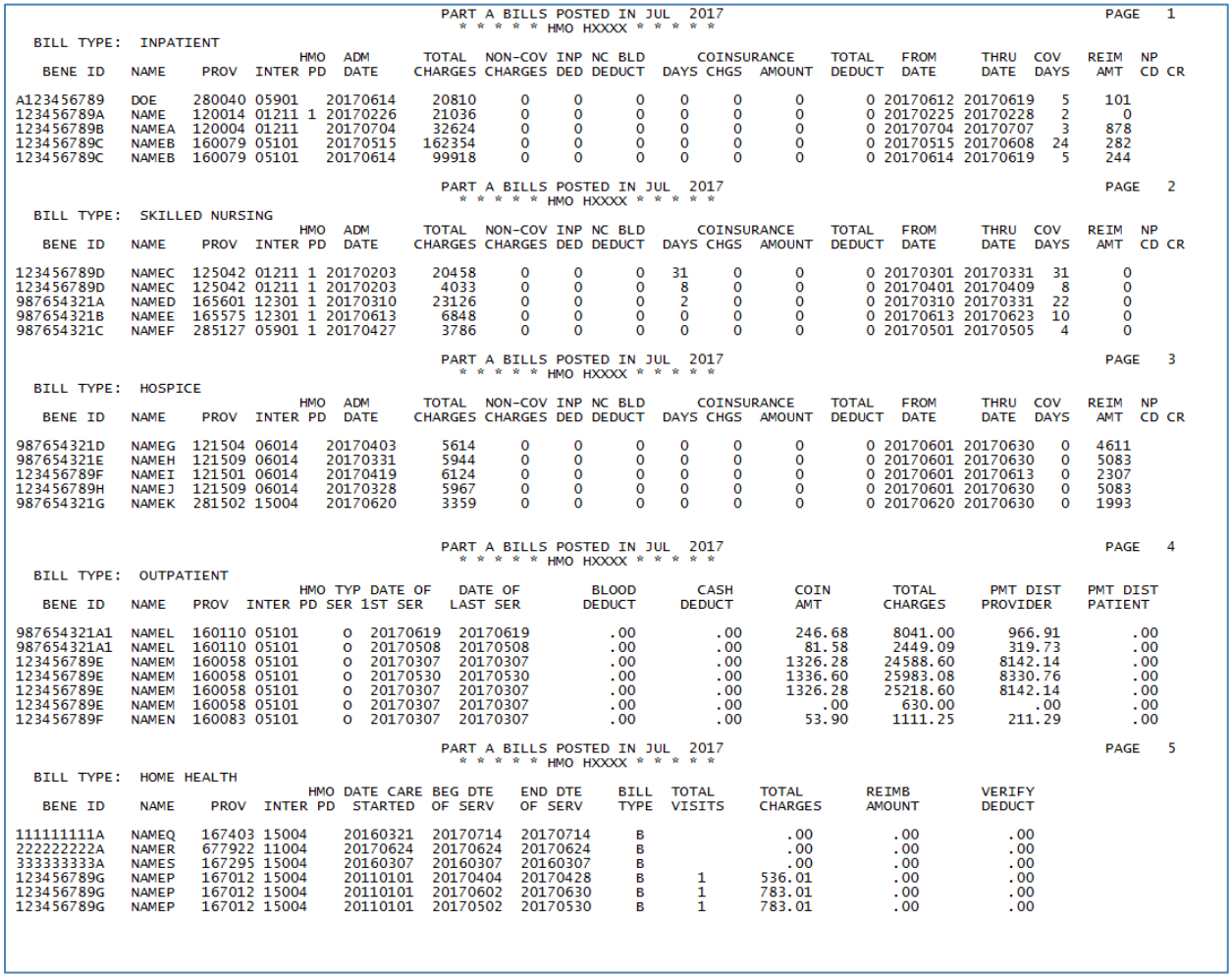
The following reports are included in this section:

- **HMO Bill Itemization Report**
- **Part C Risk Adjustment Model Output Report**
- **RAS RxHCC Model Output Report**

7.10.1 *HMO Bill Itemization Report*

This report lists the Part A bills processed under Medicare fee-for-service for beneficiaries enrolled in the contract.

Report 7-1: HMO Bill Itemization Report



PART A BILLS POSTED IN JUL 2017 PAGE 1
* * * * * HMO HXXXX * * * * *

BILL TYPE: INPATIENT

BENE ID	NAME	PROV	INTER	HMO PD	ADM DATE	TOTAL CHARGES	NON-COV CHARGES	INP DED	NC BLD DEDUCT	COINSURANCE DAYS	COINSURANCE CHGS	COINSURANCE AMOUNT	TOTAL DEDUCT	FROM DATE	THRU DATE	COV DAYS	REIM AMT	NP CD CR
A123456789	DOE	280040	05901		20170614	20810	0	0	0	0	0	0	0	20170612	20170619	5	101	
123456789A	NAME	120014	01211	1	20170226	21036	0	0	0	0	0	0	0	20170225	20170228	2	0	
123456789B	NAMEA	120004	01211		20170704	32624	0	0	0	0	0	0	0	20170704	20170707	3	878	
123456789C	NAMEB	160079	05101		20170515	162354	0	0	0	0	0	0	0	20170515	20170608	24	282	
123456789C	NAMEB	160079	05101		20170614	99918	0	0	0	0	0	0	0	20170614	20170619	5	244	

PART A BILLS POSTED IN JUL 2017 PAGE 2
* * * * * HMO HXXXX * * * * *

BILL TYPE: SKILLED NURSING

BENE ID	NAME	PROV	INTER	HMO PD	ADM DATE	TOTAL CHARGES	NON-COV CHARGES	INP DED	NC BLD DEDUCT	COINSURANCE DAYS	COINSURANCE CHGS	COINSURANCE AMOUNT	TOTAL DEDUCT	FROM DATE	THRU DATE	COV DAYS	REIM AMT	NP CD CR
123456789D	NAMEC	125042	01211	1	20170203	20458	0	0	0	31	0	0	0	20170301	20170331	31	0	
123456789D	NAMEC	125042	01211	1	20170203	4033	0	0	0	8	0	0	0	20170401	20170409	8	0	
987654321A	NAMED	165601	12301	1	20170310	23126	0	0	0	2	0	0	0	20170310	20170331	22	0	
987654321B	NAMEE	165575	12301	1	20170613	6848	0	0	0	0	0	0	0	20170613	20170623	10	0	
987654321C	NAMEF	285127	05901	1	20170427	3786	0	0	0	0	0	0	0	20170501	20170505	4	0	

PART A BILLS POSTED IN JUL 2017 PAGE 3
* * * * * HMO HXXXX * * * * *

BILL TYPE: HOSPICE

BENE ID	NAME	PROV	INTER	HMO PD	ADM DATE	TOTAL CHARGES	NON-COV CHARGES	INP DED	NC BLD DEDUCT	COINSURANCE DAYS	COINSURANCE CHGS	COINSURANCE AMOUNT	TOTAL DEDUCT	FROM DATE	THRU DATE	COV DAYS	REIM AMT	NP CD CR
987654321D	NAMEG	121504	06014		20170403	5614	0	0	0	0	0	0	0	20170601	20170630	0	4611	
987654321E	NAMEH	121509	06014		20170331	5944	0	0	0	0	0	0	0	20170601	20170630	0	5083	
123456789F	NAMEI	121501	06014		20170419	6124	0	0	0	0	0	0	0	20170601	20170613	0	2307	
123456789H	NAMEJ	121509	06014		20170328	5967	0	0	0	0	0	0	0	20170601	20170630	0	5083	
987654321G	NAMEK	281502	15004		20170620	3359	0	0	0	0	0	0	0	20170620	20170630	0	1993	

PART A BILLS POSTED IN JUL 2017 PAGE 4
* * * * * HMO HXXXX * * * * *

BILL TYPE: OUTPATIENT

BENE ID	NAME	PROV	INTER	HMO PD	TYP SER	DATE OF 1ST SER	DATE OF LAST SER	BLOOD DEDUCT	CASH DEDUCT	COIN AMT	TOTAL CHARGES	PMT DIST PROVIDER	PMT DIST PATIENT
987654321A1	NAMEL	160110	05101		O	20170619	20170619	.00	.00	246.68	8041.00	966.91	.00
987654321A1	NAMEL	160110	05101		O	20170508	20170508	.00	.00	81.58	2449.09	319.73	.00
123456789E	NAMEM	160058	05101		O	20170307	20170307	.00	.00	1326.28	24588.60	8142.14	.00
123456789E	NAMEM	160058	05101		O	20170530	20170530	.00	.00	1336.60	25983.08	8330.76	.00
123456789E	NAMEM	160058	05101		O	20170307	20170307	.00	.00	1326.28	25218.60	8142.14	.00
123456789E	NAMEM	160058	05101		O	20170307	20170307	.00	.00	.00	630.00	.00	.00
123456789F	NAMEN	160083	05101		O	20170307	20170307	.00	.00	53.90	1111.25	211.29	.00

PART A BILLS POSTED IN JUL 2017 PAGE 5
* * * * * HMO HXXXX * * * * *

BILL TYPE: HOME HEALTH

BENE ID	NAME	PROV	INTER	HMO PD	DATE CARE STARTED	BEG DTE OF SERV	END DTE OF SERV	BILL TYPE	TOTAL VISITS	TOTAL CHARGES	REIMB AMOUNT	VERIFY DEDUCT
111111111A	NAMEQ	167403	15004		20160321	20170714	20170714	B		.00	.00	.00
222222222A	NAMER	677922	11004		20170624	20170624	20170624	B		.00	.00	.00
333333333A	NAMES	167295	15004		20160307	20160307	20160307	B		.00	.00	.00
123456789G	NAMEP	167012	15004		20110101	20170404	20170428	B	1	536.01	.00	.00
123456789G	NAMEP	167012	15004		20110101	20170602	20170630	B	1	783.01	.00	.00
123456789G	NAMEP	167012	15004		20110101	20170502	20170530	B	1	783.01	.00	.00

7.10.2 *Part C Risk Adjustment Model Output Report*

This report shows the Hierarchical Condition Codes (HCCs) used by RAS to calculate risk adjustment factors for each beneficiary.

Report 7-2: Part C Risk Adjustment Model Output Report

```
RUN DATE: 20170813                    RISK ADJUSTMENT MODEL OUTPUT REPORT                                    PAGE:     1
PAYMENT MONTH: 201709                 PLAN: HXXXX PLAN NAME                                                   RAPMOSEA
                LAST            FIRST                                          DATE OF
HIC             NAME            NAME            I                              BIRTH    SEX & AGE GROUP  ESRD
------------ --------------- --------------- -                                 -------- ---------------  ----

123456789A   DOE              JANE                                           19200627 Female95-GT      N
V22 HCC DISEASE GROUPS: HCC018 Diabetes with Chronic Complications
                        HCC021 Protein-Calorie Malnutrition
                        HCC058 Major Depressive, Bipolar, and Paranoid Disorders
                        HCC108 Vascular Disease

987654321A   DOE              JOHN            E                              19390917 Male75-79        N
V22 HCC DISEASE GROUPS: HCC021 Protein-Calorie Malnutrition
                        HCC022 Morbid Obesity
                        HCC058 Major Depressive, Bipolar, and Paranoid Disorders
                        HCC084 Cardio-Respiratory Failure and Shock
                        HCC085 Congestive Heart Failure
                        HCC108 Vascular Disease
                        HCC161 Chronic Ulcer of Skin, Except Pressure
                        HCC169 Vertebral Fractures without Spinal Cord Injury

111111111A   DOEA             JOHN            M                              19350422 Male80-84        N
V22 HCC DISEASE GROUPS: HCC018 Diabetes with Chronic Complications
                        HCC033 Intestinal Obstruction/Perforation
                        HCC084 Cardio-Respiratory Failure and Shock
                        HCC085 Congestive Heart Failure
                        HCC108 Vascular Disease
                        HCC137 Chronic Kidney Disease, Severe (Stage 4)
                        HCC189 Amputation Status, Lower Limb/Amputation Complications
V22 INTERACTIONS:       INTI26 HCC85 and Diabetes Mellitus
                        INTI28 HCC85 and Renal

222222222A   DOEB             JON             L                              19270923 Male85-89        N
V22 HCC DISEASE GROUPS: HCC010 Lymphoma and Other Cancers
                        HCC019 Diabetes without Complication
                        HCC085 Congestive Heart Failure
                        HCC108 Vascular Disease
                        HCC111 Chronic Obstructive Pulmonary Disease
V22 INTERACTIONS:       INTI26 HCC85 and Diabetes Mellitus
                        INTI27 HCC85 and Chronic Obstructive Pulmonary Disease

333333333A   DOEC             JANEA           L                              19390921 Female75-79      N
Originally Disabled Female Aged (Age>=65)
Originally Disabled Aged (Age>=65)
V22 HCC DISEASE GROUPS: HCC058 Major Depressive, Bipolar, and Paranoid Disorders
                        HCC077 Multiple Sclerosis
                        HCC108 Vascular Disease

444444444A   DOED             JANEB           M                              19351126 Female80-84      N
Originally Disabled Female Aged (Age>=65)
Originally Disabled Aged (Age>=65)
V22 HCC DISEASE GROUPS: HCC018 Diabetes with Chronic Complications
                        HCC079 Seizure Disorders and Convulsions
```

7.10.3 *RAS RxHCC Model Output Report*

This report shows the Rx Hierarchical Condition Codes (HCCs) used by RAS to calculate risk adjustment factors for each beneficiary.

Report 7-3: RAS RxHCC Model Output Report

```
RUN DATE: 20170813                    RISK ADJUSTMENT MODEL OUTPUT REPORT                                                    PAGE:     1
PAYMENT MONTH: 201709                 PLAN: HXXXX PLAN NAME                                                                    RAPMODEA
            LAST                                    FIRST                                 DATE OF
HIC         NAME                                    NAME                               I  BIRTH    SEX & AGE GROUP
----------- --------------------------------------- ---------------------------------- - -------- ---------------

123456789A   DOE                                    JANE                               J 19300920 Female85-89
RXHCC DISEASE GROUPS:   RXHCC216 Peripheral Vascular Disease

123456789B   DOE                                    JANEA                                19380227 Female75-79
RXHCC DISEASE GROUPS:   RXHCC042 Thyroid Disorders
                        RXHCC045 Disorders of Lipoid Metabolism
                        RXHCC087 Osteoporosis, Vertebral and Pathological Fractures

987654321A   DOE                                    JANEB                              E 19421014 Female70-74
Originally Disabled Female Aged (Age>=65)
Originally Disabled Aged (Age>=65)
RXHCC DISEASE GROUPS:   RXHCC068 Esophageal Reflux and Other Disorders of Esophagus
                        RXHCC132 Major Depression
                        RXHCC187 Hypertension

987654321C   DOE                                    JOHN                                 19440925 Male70-74
Originally Disabled Male Aged (Age>=65)
Originally Disabled Aged (Age>=65)
RXHCC DISEASE GROUPS:   RXHCC042 Thyroid Disorders
                        RXHCC045 Disorders of Lipoid Metabolism
                        RXHCC068 Esophageal Reflux and Other Disorders of Esophagus
                        RXHCC186 Congestive Heart Failure
                        RXHCC188 Coronary Artery Disease
                        RXHCC216 Peripheral Vascular Disease

123456789C   DOE                                    JON                                E 19410429 Male75-79
RXHCC DISEASE GROUPS:   RXHCC042 Thyroid Disorders
                        RXHCC045 Disorders of Lipoid Metabolism
                        RXHCC068 Esophageal Reflux and Other Disorders of Esophagus
                        RXHCC187 Hypertension
```

7.11 All Transmission Overview

Provided in this section is a comprehensive list of file and report information exchanged between CMS and the Plans. Provided in the following tables is a list with the Dataset Naming Convention Key, and a list of the Transmission information for all reports and files, some of which are not explicitly covered in this User Guide.

Table 7-1: Dataset Naming Convention Key

Dataset Naming Convention Key	
Code	**Definition**
[GUID]	7 character EIDM User ID.
P	Production Data.
[.ZIP]	Appended if the file is compressed.
[directory]	Optional directory specification from non-mainframe C:D clients (if present, may consist of up to 60 characters). If none exists, directory defaults to the constant **EFTO** for Production files and **EFTT** for Test files.
PN	Processing number of varying length assigned to the file by Gentran.
CCCCC or XXXXX	Contract number.
PCCCCC	Plan Contract Number for C:D.
UUUU-UUUUUUU	4-7 character transmitter RACF ID.
CCYYMMDD	Year, month, and day.
YYMMDD	Two digit year, month, and day.
ZZZZZZZZ	Plan-provided high level qualifier.
EEEE	Year for which final yearly RAS file was produced.
VVVVV	Sequence counter for final yearly RAS files.
ANNNNN & BNNNNN	MARx batch transaction ID.
NNNNNNNNNN	Split into two nodes, A and B, with leading zeroes as necessary to complete ten-character batch ID.
HHMM	Hour and minute.
SSSSSS	Sequentially assigned number.
MMCCYY	Month and year.
HLQ	High Level Qualifier or Directory per VSAM File.
FREQ	Frequency code of file.

Table 7-2: File Transmission Details

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
Plan Submittals to CMS						
1	**MARx Batch Input Transaction Data File** Header Record Correction (01) Disenrollment (51/54) Enrollment (61) 4Rx Data Change (72) NUNCMO (73) EGHP (74) PPO (75) Residence Address (76) Segment ID (77) Part C Premium (78) Part D Opt-Out (79) Cancellation of Enrollment (80) Cancellation of Disenrollment (81) MMP Enrollment Cancellation (82) MMP Opt-Out (83) POS Drug Edit (90) IC Model Participation (91)	Plan Transaction file to CMS MARx system requesting new enrollment, disenrollment, changes, etc.	MARx	Data File	Daily PRN	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].MARX.D.xxxxx.FUTURE.[P/T][.ZIP] **Note:** FUTURE is part of the filename and does not change. **Connect:Direct (Mainframe):** P#EFT.IN.uuuuuuu.MARXTR.DYYMMDD.THHMMSST **Note:** DYYMMDD.THHMMSST must be coded as shown, as it is a literal
2	**Batch Eligibility Query (BEQ) Request File** Header Record Detail Record Trailer Record	File of transactions submitted by Plans to request eligibility information for prospective Plan enrollees.	MBD	Data File	PRN (Plans can send multiple files in a day)	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].MBD.D.xxxxx.BEQ.[P/T][.ZIP] **Connect:Direct (Mainframe):** P#EFT.IN.PLxxxxx.BEQ4RX.DYYMMDD.THHMMSST **Note:** DYYMMDD.THHMMSST must be coded as shown, as it is a literal
3	**Electronic Correspondence Referral System (ECRS) Batch Submittal File**	File used by Plans to submit other healthcare information (OHI) to CMS (*rather than submittal through the ECRS online system)*	ECRS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].ECRS.D.ccccc.FUTURE.[P/T][.ZIP] **Connect:Direct:** TRANSMITTED TO GHI

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
4	**Prescription Drug Event (PDE) Submittal File**	File of transactions submitted by the Plans with Prescription Drug Events.	PDE	Data File	Can be Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].PDE.D.ccccc.FUTURE.[P/T] [.ZIP] **Connect:Direct:** TRANSMITTED TO PALMETTO
5	**RAPS Submittal File**	File of transactions submitted by the Plans with diagnoses for FFS Beneficiaries.	RAPS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].RAPS.D.ccccc.FUTURE.[P/T] [.ZIP] **Connect:Direct:** TRANSMITTED TO PALMETTO
6	**Encounter Data Services (EDS) Submittal File**	File of transactions submitted by the Plans with EDS.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACF].EDS.D.xxxxx.FUTURE.[P/T][.ZIP] **Connect:Direct:** TRANSMITTED TO PALMETTO

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
CMS Transmittals to the Plans						
7	**Batch Completion Status Summary (BCSS) Data File** Summary Record Failed Records	Data file sent to the submitter once a batch of submitted transactions has been processed. Provides a count of all transactions within the batch and details the number of rejected and accepted transactions. It provides an image of the rejected and accepted transactions.	MARx	Data File	Once batch is processed	**Gentran Mailbox/TIBCO MFT Internet Server:** P.uuuuuuu.BCSSD.Annnnn.Bnnnnn.Thhmmss **Connect:Direct (Mainframe):** zzzzzzzz.uuuuuuu.BCSSD.Annnnn.Bnnnnn.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]uuuuuuu.BCSSD.Annnnn.Bnnnnn.Thhmmss
8	**Coordination of Benefits (COB) – Validated Other Insurer Information (OHI) Data File** Detail Record Primary Record Supplemental Record	File containing members' primary and secondary drug coverage that has been validated through COB processing. MARx forwards this report whenever a Plan's enrollees are affected. It may be as often as daily. The enrollees included on the report are those newly enrolled who have known OHI for drugs and those Plan enrollees with changes to their OHI.	MBD (MARx)	Data File	As Needed (can be daily)	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MARXCOB.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MARXCOB.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MARXCOB.Dyymmdd.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
9	**MA Full Dual Auto Assignment Notification File** Header Record Detail Record Trailer Record	Monthly file of Full Dual Beneficiaries in an existing Plan.	MBD	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#ADUA4.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#ADUA4.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#ADUA4.Dyymmdd.Thhmmsst
10	**Auto Assignment Address Notification File** Header Record Detail Record(s) Trailer Record	Monthly file of addresses of Beneficiaries who have been either Auto Assigned or Facilitated Assigned to PDPs.	MBD	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#APDP4.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#APDP4.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#APDP4.Dyymmdd.Thhmmsst
11	**NoRx File** Header Record Detail Record Trailer Record	File containing records identifying those enrollees that do not currently have 4Rx information stored in CMS files.	MBD	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#NORX.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#NORX.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#NORX.Dyymmdd.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
12	**Batch Eligibility Query (BEQ) Request File Pass and Fail Acknowledgment**	MBD will determine if a BEQ Request File is Accepted or Rejected. MBD will issue an e-mail acknowledgment of receipt and status to the Sending Entity.	MBD	E-mail	Response to BEQ	Email to submitter.
13	**Batch Eligibility Query (BEQ) Response File** Header Record Detail Record (Transaction) Trailer Record	File containing records produced as a result of processing the transactions of accepted BEQ Request files.	MBD	Data File	Response to BEQ	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#BQN4.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#BQN4.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#BQN4.Dyymmdd.Thhmmsst
14	**ECRS Data File**	File containing errors and statuses of ECRS submissions.	ECRS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** PCOB.BA.ECRS.ccccc.RESPONSE.ssssss **Connect:Direct:** TRANSMITTED FROM GHI
15	**Prescription Drug Event (PDE) PDFS Response Data File**	File containing responses if files are accepted or rejected.	PDE	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RSP.PDFS_RESP_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
16	**Prescription Drug Event (PDE) Drug Data Processing System (DDPS) Return Data File**	File provides feedback on every record processed in a batch. Up to 10 specific errors are reported for each PDE in the file.	PDE	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS_TRANS_VALIDATION_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
17	**Prescription Drug Event (PDE) DDPS Transaction Error Summary Data File**	File provides frequency of occurrence for each error code encountered during the processing of a PDE file. The percentage to the total errors is also computed and displayed for each error code.	PDE	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS_ERROR_SUMMARY_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
18	**Front-End Risk Adjustment System (FERAS) Response Reports**	Report indicates that the file was accepted or rejected by the Front-End Risk Adjustment System.	FERAS	Report	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RSP.FERAS_RESP_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
19	**Front-End Risk Adjustment System (FERAS) Response Data Files**	File contains all of the submitted transactions whether or not the file contains errors.	FERAS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_RETURN_FLAT_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
20	**Front-End Risk Adjustment System (FERAS) Response Reports Transaction Error Report**	Report lists the transactions that contained errors and identifies the errors found.	FERAS	Report	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_ERRORRPT_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
21	**Front-End Risk Adjustment System (FERAS) Response Reports Transaction Summary Report**	Report contains all of the transactions submitted, whether accepted or rejected.	FERAS	Report	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_SUMMARY_sssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
22	**Front-End Risk Adjustment System (FERAS) Response Reports Duplicate Diagnosis Cluster Report**	Report identifies diagnosis clusters with 502 error message, clusters accepted, but not stored.	FERAS	Report	Daily	Gentran Mailbox/TIBCO MFT Internet Server: RPT.RAPS_DUPDX_RPT_sssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
23	**Daily Transaction Reply Report (DTRR)** Detail Record Verbatim Plan Submitted Transaction	Report identifies whether a beneficiary submission was accepted or rejected and provides additional information about Plan membership.	MARx	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.DTRRD.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.DTRRD.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.DTRRD.Dyymmdd.Thhmmsst
24	**Encounter Data Services (EDS) Response Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_RESPONSE **Connect:Direct:** TRANSMITTED FROM PALMETTO
25	**Encounter Data Services (EDS) Reject IC ISAIEA Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_REJT_IC_ISAIEA.pn **Connect:Direct:** TRANSMITTED FROM PALMETTO

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
26	**Encounter Data Services (EDS) Reject Function Transaction Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_REJT_FUNCT_TRANS **Connect:Direct:** TRANSMITTED FROM PALMETTO
27	**Encounter Data Services (EDS) Accept Function Transaction Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_ACCPT_FUNCT_TRANS **Connect:Direct:** TRANSMITTED FROM PALMETTO
28	**Encounter Data Services (EDS) Response Claim Number Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_RESP_CLAIM_NUM **Connect:Direct:** TRANSMITTED FROM PALMETTO
Weekly Transmittals						
29	**LIS/Part D Premium Data File**	The data in the report reflects LIS info, premium subsidy levels, Low-income co-pay levels, etc. for all beneficiaries who have a low-income designation enrolled in a Plan. It is not automatically transmitted to the Plans. Through the MARx UI Plans can request or reorder this data file.	MARx	Data File	Biweekly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LISPRMD.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LISPRMD.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LISPRMD.Dyymmdd.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
Monthly Transmittals						
30	**Monthly Membership Report (MMR) Data File**	Data file version of the Monthly Membership Detail Reports. This file contains the data for both Part C and Part D members.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMD.Dyymm01.Thhmmsst P.Rxxxxx.MONMEMD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMD.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEMD.Dyymm01.Thhmmsst [directory]Rxxxxx.MONMEMD.Dyymm01.Thhmmsst
31	**Monthly Membership Summary Report (MMSR)**	Report summarizing payments to a Plan for the month, in several categories, and adjustments, by all adjustment categories. This report contains data for both Part C and Part D members.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMSR.Dyymm01.Thhmmsst P.Rxxxxx.MONMEMSR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMSR.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMSR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEMSR.Dyymm01.Thhmmsst [directory]Rxxxxx.MONMEMSR.Dyymm01.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
32	**Monthly Membership Summary Report (MMSR) Data File**	Data file version of the Monthly Membership Summary Report for both Part C and Part D members.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMSD.Dymm01.Thhmmsst P.Rxxxxx.MONMEMSD.Dymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMSD.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMSD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEMSD.Dyymm01.Thhmmsst [directory]Rxxxxx.MONMEMSD.Dyymm01.Thhmmsst
33	**RAS RxHCC Model Output Report** AKA: Part D Risk Adjustment Model Output Report	Report showing the Part D risk adjustment factors for each beneficiary. MARx forwards this report that is produced by RAS to Plans as part of the month-end processing.	RAS (MARx)	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMODR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMODR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMODR.Dyymm01.Thhmmsst
34	**RAS RxHCC Model Output Data File – PY2016** AKA: Part D Risk Adjustment Model Output Data File Header Record Detail / Beneficiary Record Trailer Record	Data file version of the RAS RxHCC Model Output Report. MARx forwards this report that is produced by RAS to Plans as part of the month-end processing.	RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMODD.Dyymm01.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
35	**RAS RxHCC Model Output Data File – PY2017 and PY2018** AKA: Part D Risk Adjustment Model Output Data File Header Record Detail / Beneficiary Record Trailer Record	Data file version of the RAS RxHCC Model Output Report. MARx forwards this report that is produced by RAS to Plans as part of the month-end processing.	RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMODD.Dyymm01.Thhmmsst
36	**Part C Risk Adjustment Model Output Report**	Report showing the Hierarchical Condition Codes (HCCs) used by the Risk Adjustment System (RAS) to calculate Part C risk adjustment factors for each beneficiary. MARx forwards this report that is produced by RAS to Plans as part of the month-end processing.	RAS (MARx)	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.HCCMODR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.HCCMODR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.HCCMODR.Dyymm01.Thhmmsst
37	**Part C Risk Adjustment Model Output Data File** Header Record. Detail Record Type B, E, and G (PY2012 through PY2018). Detail Record Type C and F (PY2014 through PY2016). Detail Record Type D (PY2017 through PY2018). Trailer Record.	Data file version of the Risk Adjustment Model Output Report.	RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.HCCMODD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.HCCMODD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.HCCMODD.Dyymm01.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
38	**Monthly Summary of Bills Report**	Report summarizing all Medicare fee-for-service activity, both Part A and Part B, for Beneficiaries enrolled in the contract.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.SUMBILLS.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.SUMBILLS.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.SUMBILLS.Dyymm01.Thhmmsst
39	**HMO Bill Itemization Report**	Report listing the Part A bills that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.BILLITEM.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.BILLITEM.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.BILLITEM.Dyymm01.Thhmmsst
40	**Part B Claims Data File** Record Type 1 Record Type 2	Data file listing the Part B physician and supplier claims and Part B home health claims that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.CLAIMDAT.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.CLAIMDAT.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.CLAIMDAT.Dyymm01.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
41	**Payment Record Report**	Report listing the Part B physician and supplier claims that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PAYRECDS.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PAYRECDS.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PAYRECDS.Dyymm01.Thhmmsst
42	**Monthly Premium Withholding Report (MPWR) Data File** Header Record Detail Record Trailer - T1 - Total at segment level Trailer - T2 - Total at PBP level Trailer - T3 - Total at contract level	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. This file is produced by the Premium Withhold System (PWS). MARx makes this report available to Plans as part of the month-end processing.	PWS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MPWRD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MPWRD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MPWRD.Dyymm01.Thhmmsst
43	**Failed Payment Reply Report (FPRR) Data File** Detail Record	Data file reporting payment actions which failed to complete.	MARx	Data File	Monthly Payment Cycle	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.FPRRD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx FPRRD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx. FPRRD.Dyymm01.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
44	**Plan Payment Report (PPR) – APPS Payment Letter**	Report itemizing the final monthly payment to the Plan. This report is produced by the APPS when final payments are calculated. CMS makes this report available to Plans as part of the month-end processing.	APPS	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.PLANPAY.Dyymm01.Thhmmsst P.Rxxxxx.PLANPAY.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.PLANPAY.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.PLANPAY.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.PLANPAY.Dyymm01.Thhmmsst [directory]Rxxxxx.PLANPAY.Dyymm01.Thhmmsst
45	**Plan Payment Report (PPR)/Interim Plan Payment Report (IPPR) Data File** Header Record Capitated Payment – Current Activity Record Premium Settlement Record Fees Record Special Adjustments Record Previous Cycle Balance Summary Record Payment Balance Carried Forward Record Payment Summary Record	This data file itemizes the final monthly payment to the MCO. This data file and subsequent report are produced by the APPS when final payments are calculated. CMS makes this report available to MCO's as part of month-end processing.	APPS	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PPRD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PPRD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory].Rxxxxx.PPRD.Dyymm01.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
46	**Interim Plan Payment Report (IPPR)**	When a Plan is approved for an interim payment outside of the normal monthly process, an interim Plan Payment Report is distributed to that Plan. The report contains the amount and reason for the interim payment. Plans can also request these reports via the MARx user interface under the weekly report section of the menu.	APPS	Report	As needed	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PLNPAYI.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PLNPAYI.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PLNPAYI.Dyymm01.Thhmmsst
47	**Interim Plan Payment Report (IPPR) Data File**	The Interim APPS Plan Payment Data File and Report is provided when a Plan is approved for an interim payment outside of the normal monthly process. The data file / report contains the amount and reason for the interim payment to the Plan.	APPS	Data File	As needed	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PPRID.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PPRID.Dymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory].Rxxxxx.PPRID.Dyymmdd.Thhmmsst
48	**820 Format Payment Advice Data File** Header Record Detail Record Trailer Record	HIPAA-Compliant version of the Plan Payment Report. This data file itemizes the final monthly payment to the Plan. This data file is not available through MARx.	APPS	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PLAN820D.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PLAN820D.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PLAN820D.Dyymm01.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
49	**Full Enrollment Data File**	File includes all active Plan membership on the date the file is run. This file is considered a definitive statement of current Plan enrollment. The file is distributed on or about the first of the month.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.FEFD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.FEFD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.FEFD.Dymm01.Thhmmsst
50	**Prescription Drug Event (PDE) DBC Cumulative Beneficiary Summary Report**	File includes summary for the beneficiary of accumulated overall totals in PDE amount fields with accumulated totals for covered drugs.	PDE	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS.CUM_BENE_ACT_COV_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
51	**Prescription Drug Event (PDE) DBC Cumulative Beneficiary Summary Report**	File includes summary for the beneficiary of accumulated overall totals in PDE amount fields with accumulated totals for enhanced drugs.	PDE	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS_CUM_BENE_ACT_ENH_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
52	**Prescription Drug Event (PDE) DBC Cumulative Beneficiary Summary Report**	File includes summary for the beneficiary of accumulated overall totals in PDE amount fields with accumulated totals for over-the-counter drugs.	PDE	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS_CUM_BENE_ACT_OTC_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
53	**Front-End Risk Adjustment System (FERAS) Response Reports** **Monthly Plan Activity Report**	Report provides monthly summary of the status of submissions by submitter and Plan number.	FERAS	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_MONTHLY_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
54	**Front-End Risk Adjustment System (FERAS) Response Reports** **Cumulative Plan Activity Report**	Report provides cumulative summary of the status of submissions by Submitter ID and Plan number.	FERAS	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_CUMULATIVE_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
55	**Front-End Risk Adjustment System (FERAS) Response Reports** **Frequency Report Monthly Report**	Report provides monthly summary of all errors on all file submissions within the month.	FERAS	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RAPS_ERRORFREQ_MNTH_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
56	**Late Enrollment Penalty (LEP) Data File** Header Record Detail Record Trailer Record	This data file provides information on low-income subsidized Beneficiaries and on direct-billed Beneficiaries with late enrollment penalties.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.LEPD.Dyymm01.Thhmmsst P.Rxxxxx.LEPD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.LEPD.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.LEPD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.LEPD.Dymm01.Thhmmsst [directory]Rxxxxx.LEPD.Dymm01.Thhmmsst
57	**LIS History Data File (LISHIST)** Header Record Detail Record Trailer Record	This data file supplements existing files that provide LIS notifications. It provides a complete picture of a beneficiary's LIS eligibility over a period of time not to exceed 36 months.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LISHIST.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LISHIST.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LISHIST.Dyymmdd.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
58	**Agent Broker Compensation Data File** Detail Record Trailer Record	This data file provides the broker compensation cycle-year counts. Data is sent to Plans 1) when a beneficiary enrolls, 2) each January when the cycle-year count increments and 3) as necessary when retroactive change affects the compensation cycle. Plans may re-order the Broker Compensation Report Data File via the MARx UI.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rnnnnn.COMPRPT.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rnnnnn.COMPRPT.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rnnnnn.COMPRPT.Dyymmdd.Thhmmsst
59	**Monthly Medicare Secondary Payer (MSP) Information Data File** Header Record Primary Record Detail Record Trailer Record	This data file is sent directly to Part C Plans on the first Monday after the MARx month-end processing completes. This file contains MSP details for all Part beneficiaries in the Part C Plan. It covers MSP periods for the previous 48 months.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory].Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst
60	**Medicare Advantage Organization (MAO) 004 Report** Header Record Detail Record Trailer Record	This report contains the diagnoses that meet the risk adjustment rules and are, therefore, eligible for risk adjustment.	RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MAO004PV.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MAO004PV.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MAO004PV.Dyymmdd.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
61	**Medicare Advantage Medicaid Status Data File** Header Record. Beneficiary Identification Record. Beneficiary Detail Record. Trailer Record.	This data file provides the monthly dual statuses and corresponding dual status codes for their beneficiaries who are full or partial duals.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MCMD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MCMD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MCMD.Dyymm01.Thhmmsst
62	**MSA Deposit-Recovery Data File** Header Record Detail Record Trailer Record	The data file includes MSA lump sum deposit and recovery amounts for the CPM at the beneficiary level. The file is used by MSA participating Plans to reconcile and identify MSA deposit amounts.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MSA.Dyymm01.Thhmmsst P.Rxxxxx.MSA.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MSA.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MSA.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MSA.Dyymm01.Thhmmsst [directory]Rxxxxx.MSA.Dyymm01.Thhmmsst
63	**HICN to MBI Crosswalk File**	To assist MAOs and Part D sponsors with the ability to determine or match their beneficiary population between HICN and MBI, MARx will generate and distribute a monthly crosswalk data file. Each crosswalk data file will be created at the MAO/PDP Contract level. The crosswalk files will be sent monthly during the transition period.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.CROSSWLK.Dyymm01.Thhmmsst P.Rxxxxx.CROSSWLK.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.CROSSWLK.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.CROSSWLK.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.CROSSWLK.Dyymm01.Thhmmsst [directory]Rxxxxx.CROSSWLK.Dyymm01.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
Quarterly Report						
64	**Front-End Risk Adjustment System (FERAS) Response Reports** **Frequency Report Quarterly Report**	Report provides quarterly summary of all errors on all file submissions within the three-month quarter.	FERAS	Report	Quarterly	**Gentran Mailbox/TIBCO MFT Internet Server:** RAPS_ERRORFREQ_QTR_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
Yearly Reports						
65	**RAS Final Yearly Model Output Report, Part D**	Report indicates the year-end Part D risk adjustment factors for each beneficiary. MARx forwards this report, produced by RAS, to Plans as part of the month-end processing.	RAS (MARx)	Report (.pdf)	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMOFR.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMOFR.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMOFR. Yeeee.Cvvvvv.Thhmmss
66	**RAS Final Yearly Model Output Data File, Part D**	Data file version of the year end Part D RAS Model Output Report. MARx forwards this report, produced by RAS, to Plans as part of the month-end processing.	RAS (MARx)	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMOFD.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMOFD.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMOFD.Yeeee.Cvvvvv.Thhmmss

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
67	**RAS Final Yearly Model Output Report, Part C**	Report indicates the year end Part C risk adjustment factors for each beneficiary. MARx forwards this report, produced by RAS, to Plans as part of the month-end processing.	RAS (MARx)	Report (.pdf)	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.HCCMOFR.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.HCCMOFR.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.HCCMOFR.Yeeee.Cvvvvv.Thhmmss
68	**RAS Final Yearly Model Output Data File, Part C**	Data file version of the year end Part C RAS Model Output Report. MARx forwards this report, produced by RAS, to Plans as part of the month-end processing.	RAS (MARx)	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.HCCMOFD.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.HCCMOFD.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.HCCMOFD.Yeeee.Cvvvvv.Thhmmss

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
69	**Loss of Subsidy Data File**	The first file is sent in September and identifies members receiving a joint CMS and SSA letter informing them they will not have Deemed status for the following year. The second file is sent in December and is an updated version of the September file, indicating those Beneficiaries who still do not have Deemed status for the following year. TRC 996 indicates the loss of Deeming which means the Beneficiary will not be redeemed for the upcoming period.	MARx	Data File	Twice Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst
70	**PDP Loss Data File**	This file provides a preliminary listing of LIS-eligible beneficiaries whom CMS reassigns to a new PDP or to a new PBP within the same Plan sponsor effective January 1, 2008. The Loss file notifies PDPs of the members they will lose as a result of reassignment to other Plans. These members are classified as losing members.	MBD	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.APDP5.LOSS.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.APDP5.LOSS.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.APDP5.LOSS.Dyymmdd.Thhmmsst

File Transmission Details						
Item	**Transmittal**	**Description**	**System**	**Type**	**Freq.**	**Dataset Naming Conventions**
71	**PDP Gain Data File**	This file provides a preliminary listing of LIS-eligible beneficiaries whom CMS reassigns to a new PDP or to a new PBP within the same Plan sponsor effective January 1, 2008. The Gain file notifies PDPs of members they will gain as a result of the yearly reassignment. These members are classified as gaining members.	MBD	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.APDP5.GAIN.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.APDP5.GAIN.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.APDP5.GAIN.Dyymmdd.Thhmmsst
72	**Long-Term Institutionalized Resident Report File**	This file provides Part D sponsors a list of their Beneficiaries who are LTI residents during July and January of each year.	MDS	Report	Quarterly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst
73	**No Premium Due Data File**	This data file reports members that had a Part C premium, but will no longer have the Part C premium in the upcoming year. This data file is produced during MARx end of year processing.	MARx	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.SPCLPEX.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.SPCLPEX.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.SPCLPEX.Dyymmdd.Thhmmsst

8 Medicare Advantage Prescription Drug User Interface – MARx UI

The Medicare Advantage Prescription Drug (MARx) System User Interface (UI) enables access to enrollment, eligibility, payment, premium withhold, and 4Rx information for beneficiaries.

The MARx UI accommodates online and batch processing. Online capabilities enable viewing of beneficiary or contract information. Batch capabilities allow submission of data, such as enrollment and disenrollment transactions.

This section covers the following topics:

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

All of the beneficiary, contract, and user information in the screen snapshots in this document are fictional. The names and beneficiary IDs do not identify any person living or dead.

On certain screens, if no end date displays for the subsidy period, this does not mean the beneficiary's status terminated; rather a blank Subsidy End date means that the status rolled over to the current year.

8.1 Getting Started

This section provides some basic information necessary to conduct online operations:

- **Workstation Requirements.**
- **Logging into the MARx UI.**
- **Viewing the MARx Operational Calendar.**
- **Logging out of the MARx UI.**

8.1.1 *Workstation Requirements*

MARx UI users must have the following software installed on their workstation:

- Windows XP or higher.
- Microsoft Internet Explorer with Web browser, Version 5.5 or higher.
- Adobe Acrobat Reader, Version 4 or higher, for report viewing and display of online help. If the user does not have Adobe Acrobat Reader Version 4 or higher, the user can download a free version at (www.adobe.com).

Also, the user must:

- Enable JavaScript in the browser.
- Allow pop-ups from the UI site.
- Disable script debugging in the Internet Explorer's Internet Options under the Advanced tab.

8.1.2 *Logging into the MARx UI*

The MARx UI is accessed via the CMS Enterprise Portal URL: https://portal.cms.gov. The user is presented with the Enterprise Portal login page where they will enter their User ID, Password, click the *Agree to our Terms and Conditions* option, and click the *Login* button. Next, the user will see the **My Portal** screen. Select the **MARx UI** tile and then select the **MARx UI *Application*** link.

The *User Security Role Selection (M002)* screen displays the role(s) available to the user. Typically, a user has only one role available. If the user has more than one role available, the user may change from the default to another role. The selected role shows on the title line of subsequent screens. Once a role is selected, the user clicks on the [Logon with Selected Role] button.

Figure 8-1: Security Role Selection (M002) Screen

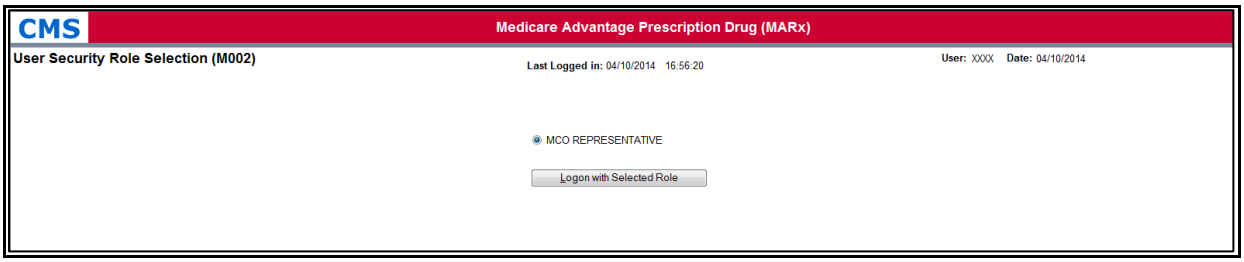
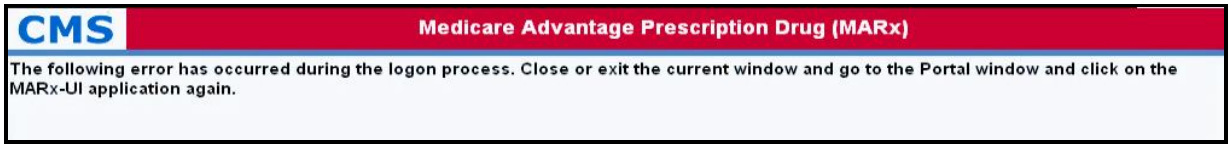


Table 8-1: User Security Role Selection (M002) Screen Field Descriptions

User Security Role Section (M002) Screen Field Descriptions		
Item	**Input/Output**	**Description**
Role selection	Required radio button	Click on one of the buttons to indicate under which role the user will log on.
[Log on with Selected Role]	Button	Click on this button to complete the logon with the selected role.

MARx UI only allows a one active session. If a user attempts to login with a 2nd session, the first session will be automatically terminated and the new session will be the only active session. If the system is up and logon is unsuccessful, the *Logon Error (M009)* screen displays an error message describing why logon failed.

Figure 8-2: Logon Error (M009) Screen



After a role is selected, the *Welcome (M101)* screen appears. Broadcast messages display for all users and provide information about system-wide events, such as the start or completion of month-end processing. These messages expire without any user action.

Figure 8-3: Welcome (M101) Screen

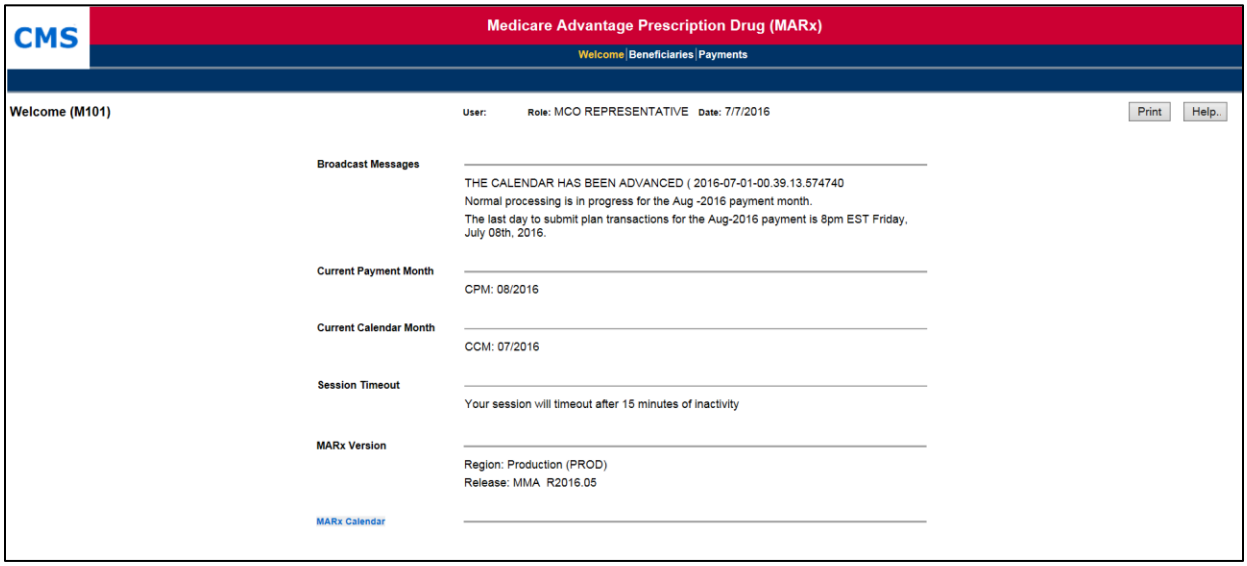


Table 8-2: Welcome (M101) Screen Field Descriptions

Welcome (M101) Field Descriptions		
Item	**Input/Output**	**Description**
Broadcast Messages	Output	Provides general information about the system's actions, e.g. month-end processing started. The list of messages refreshes every time the user returns to the screen.
Current Payment Month (CPM)	Output	The month/year currently in process by the system.
MARx Version	Output	The region and release information of the MARx UI display.
MARx Calendar	Link	Provides general information about what is happening in the system, e.g. month-end processing started. The list of messages refreshes every time the user returns to the screen.

8.1.3 *Viewing the MARx Operational Calendar*

The user may click on the MARx Calendar link to display the *Calendar (M105)* screen.

The top part of the screen shows a pictorial calendar for one month. When the screen first displays, the current month shows with the current day highlighted in blue. The bottom part of the screen, i.e., the operational calendar, shows the calendar events scheduled for that month, with the date and description of each event.

To view a different month, select a different month and/or year in the pictorial calendar. The calendar for the new month is then displayed. To view the operational calendar for the newly selected month, click on the [Re-display] button in the bottom part of the screen.

Figure 8-4: MARx Calendar (M105) Screen

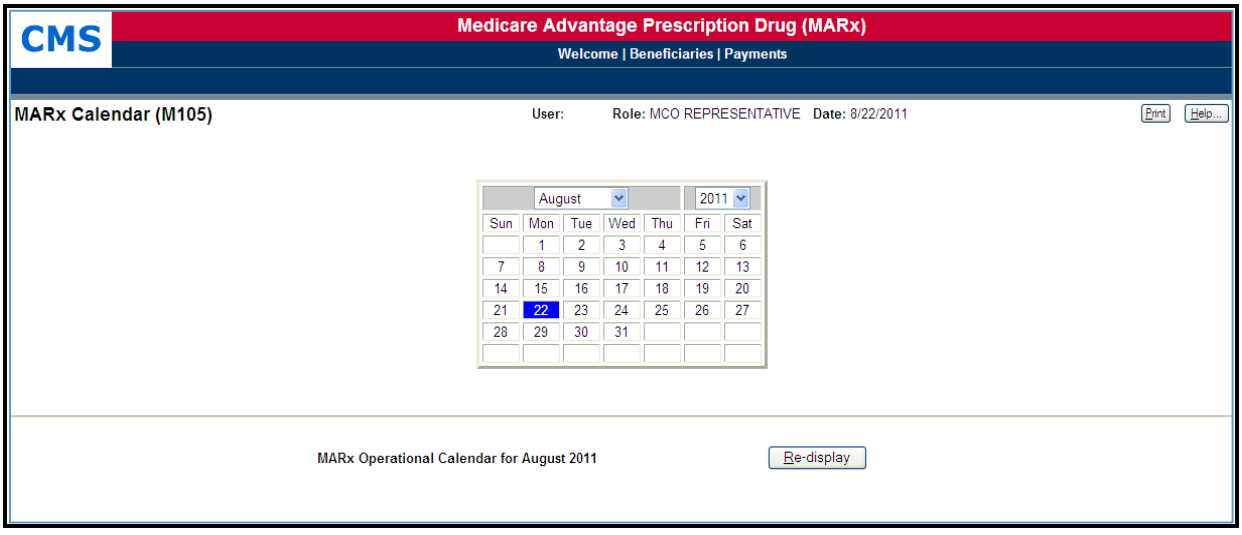


Table 8-3: MARx Calendar (M105) Field Descriptions

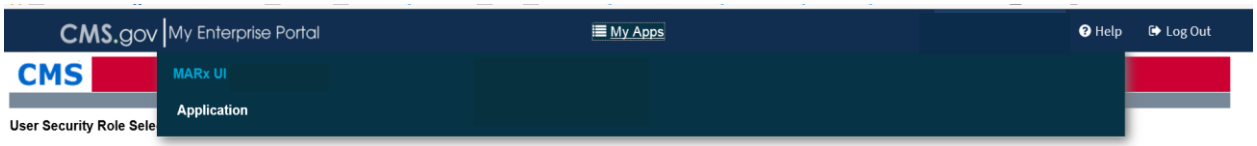
MARx Calendar (M105) Field Descriptions		
Item	**Input/Output**	**Description**
Above Line		
Month	Required dropdown list	Defaults to current calendar month. When this changes, the pictorial calendar automatically updates to the selected month and year.
Year	Required dropdown list	Defaults to current calendar year. When this changes, the pictorial calendar automatically updates to the selected month and year.
Calendar	Output	Pictorial calendar for selected month and year. When in the current month, the current day is highlighted in blue.
Below Line		
MARx Operational Calendar	Output	List of events scheduled for the selected month and year.
[Re-display]	Button	After changing the month or year, the user clicks on this button to display the operational calendar for the newly selected month.

8.1.4 Logging out of the MARx UI

When the user is finished with all activities, the user should log out. If the user does not log completely out, the session eventually times out; however, logging out as soon as the user is finished with the system is a more secure process to follow and is therefore recommended.

To log out, the user will select the **Log Out** option in the top right corner of the Enterprise Portal banner.

Figure 8-5: Logging out of the MARx UI



8.2 Navigating and Using the System

8.2.1 How Do I Find Specific Information?

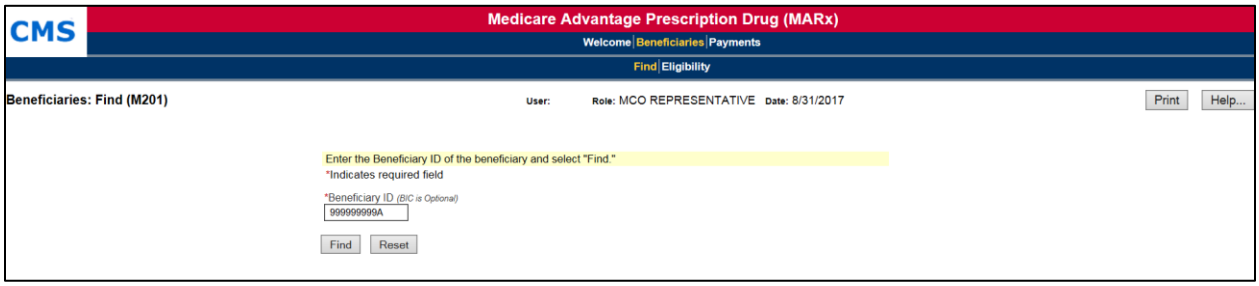
The MARx UI uses the drill-down system. This means that the user starts at a very high level, and drills down to more specific detailed information. The menus and submenus all work in the same way, as follows: the first screen of the MARx UI main menu appears with the |Welcome| menu item highlighted on the screen.

Figure 8-6: Main Menu with Welcome Selected

When the user selects an item from the MARx UI main menu by clicking on the general area, e.g., the |Beneficiaries| menu item, the screen changes.

- The selected menu item is highlighted in yellow on the screen.
- The associated submenu is displayed just below the main menu; the first item in the submenu is selected and highlighted in yellow.
- To view any of the other selections, click the menu or submenu item, e.g. the |Payment| menu item, to see the associated screen.

Figure 8-7: Example of Main Menu Selection



The first level screen names are comprised of the names of the Menu: Submenu selection. This assists with navigating to a particular screen.

After accessing a screen, the user may conduct a search to find information about a particular beneficiary or month. After narrowing the search to this more specific level, the user may find even more detail by clicking on links and/or buttons that lead to additional screens.

Access Beneficiaries: Find (M201) Screen

Consider a scenario where the user wants to determine the reason a specific beneficiary has a particular adjustment. Starting at the top level on the MARx main menu, the user selects their general area of interest, in this case, the |Beneficiaries| menu item. *The Beneficiaries: Find (M201)* screen is displayed. The Beneficiaries: Find (M201) screen also will allow a user to find information about a beneficiary who is enrolled in a contract; either currently, in the past, or in the future.

Use the Beneficiaries: Find (M201) Screen

To find a specific beneficiary, the user will enter the Health Insurance Claim Number (HICN) or the Medicare Beneficiary ID (MBI) and click on the [Find] button.

During the MBI transition period (April 2018 – December 2019), the HICN or the MBI can be entered in this field.

Figure 8-8: Beneficiaries: Find (M201) Screen

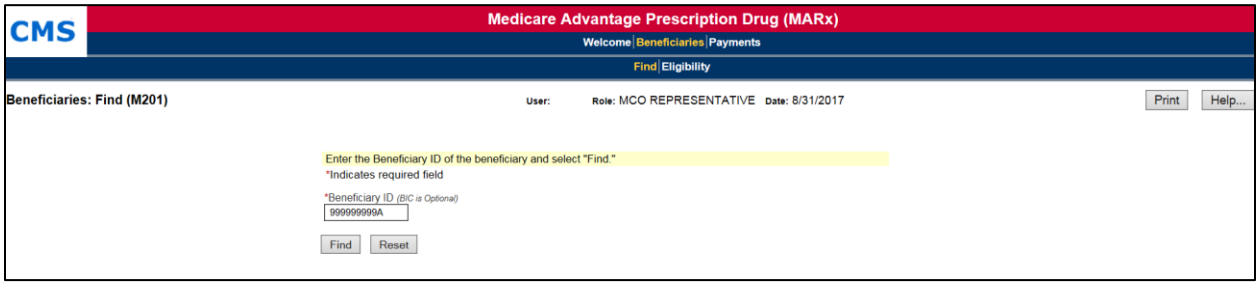


Table 8-4: Beneficiaries: Find (M201) Field Descriptions

Beneficiaries: Find (M201) Field Descriptions		
Item	**Input/Output**	**Description**
Beneficiary ID	Required data entry field	The user finds beneficiaries with the beneficiary ID.
[Find]	Button	After entering a beneficiary ID, the user clicks on this button to initiate the search for beneficiaries.

8.2.2 View Beneficiary Summary Information

Beneficiaries meeting search criteria display on the *Beneficiaries: Search Results (M202)* screen.

Use the Beneficiaries: Search Results (M202) Screen

If the search is successful, the *Beneficiaries: Search Results (M202)* screen is displayed. Any error associated with the search would display on the *Beneficiaries: Find (M201)* screen. If a user enters an inactive Beneficiary ID for the beneficiary, a message displays to that effect.

During the MBI transition period (April 2018 – December 2019):

- **The Search Criteria returns the MBI in the *Search Criteria: Beneficiary ID*, regardless of whether the MBI or HICN is entered.**
- **The user can either click the hyperlink for Update Enrollment or <Beneficiary ID>.**

Figure 8-9: Beneficiaries: Search Results (M202) Screen

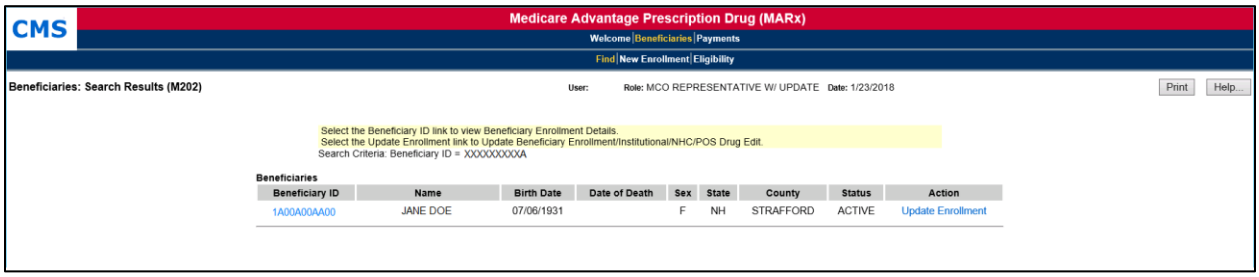


Table 8-5: Beneficiaries: Search Results (M202) Field Descriptions

Beneficiaries: Search Results (M202) Field Descriptions		
Item	**Input/Output**	**Description**
Beneficiary ID column heading	Sorter	Sorts the results by claim numbers.
Beneficiary ID in the Beneficiary ID column	Link	The user clicks on a Beneficiary ID link to display the *Beneficiary Detail: Snapshot (M203)* screen.
Name column heading	Sorter	Sorts the results by beneficiary name.
Birth Date column	Output	DOB of each beneficiary.
Date of Death column	Output	DOD, if applicable, of each beneficiary.
Sex column	Output	Sex of each beneficiary.
State column	Output	State of residence of each beneficiary.
County column	Output	County of residence of each beneficiary.
Status column	Output	Status of the searched beneficiary.
Action column	Link	Action that can be taken for the searched beneficiary.

Tip: Returning to the previous screen to add other selection criteria may narrow search results.

From this screen, the user sees summary information about each beneficiary that meets the search criteria. The user can sort the list by beneficiary ID or by name by clicking on the column heading. To see more details about any particular beneficiary in this list, the user clicks on a beneficiary ID link in the *Beneficiary ID* column. This displays the *Beneficiary Detail: Snapshot (M203)* screen in a pop-up window with a menu to get to various screens. Each screen provides specific details about the beneficiary's enrollment or payment history. These screens are described in more detail later in this section.

8.2.3 View Beneficiary Detailed Information

The user finds the beneficiary on the *Beneficiaries: Search Results (M202)* screen and drills down for more information.

View Detailed Information for a Beneficiary

To see detailed information about any of the beneficiaries listed in the *Beneficiaries: Search Results (M202)* screen, the user clicks on the associated beneficiary ID.

Note: Instead of seeing a screen in the same area as previously displayed, a new window with a new screen and new header appears. This is a pop-up window, with its own header information specific to the selected beneficiary. The beneficiary's latest mailing address is displayed, along with the current State and County Code (SCC). The header, by itself, is shown below.

Figure 8-10: Sample Header for the Beneficiary Detail Screens

To improve system performance, CMS began archiving inactive beneficiaries as of February 2013. By reducing the volume of data in the operational databases, the overall performance of the systems is enhanced.

Beneficiaries that meet both of the following criteria are selected for archiving:

- Are deceased for at least 15 years or, are at least 120 years old with a BIC of M or T.
- Have had no activity for at least two years.

However, the business owners may decide to exclude moving a population of beneficiaries to the archived database.

All beneficiaries, whether in the active or the archived database, are available for view.

To identify whether a beneficiary is archived, the MARx UI displays either an "Active" or "Archived" status on the Banner appearing at the top of the screen. Update capability is only available for beneficiary records in the active database.

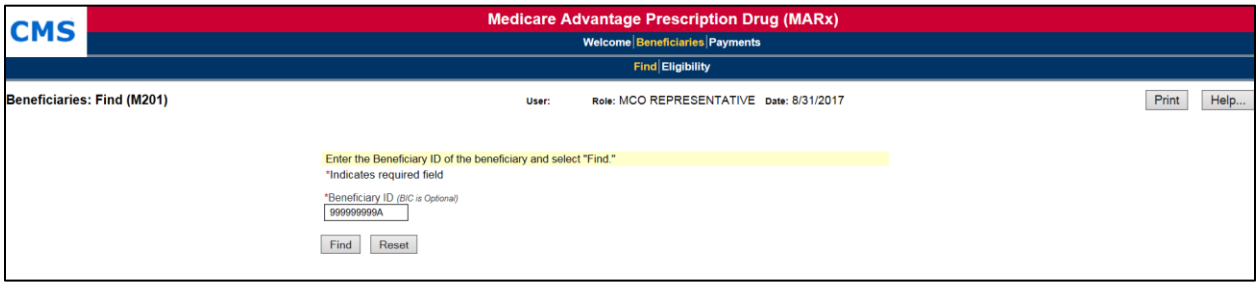
Archiving of data for the selected beneficiaries crosses all MAPD systems. CMS has the capability to recall beneficiaries from the archived database into the active database. If a Plan wishes to recall an archived beneficiary, the Plan should discuss it with CMS.
In addition, just below the header is a set of menu items, described in the table below. The user can switch back and forth among the different screens by clicking the menu items. Each screen pertains to the beneficiary selected from the *Beneficiaries: Search Results (M202)* screen.

Table 8-6: Menu Items for Viewing Beneficiary Detail Information

Menu Items for Viewing Beneficiary Detail Information		
Menu Item	**Screen Name**	**Description**
|Snapshot|	*Beneficiary Detail: Snapshot (M203)*	Displays an overall summary of payment information for the beneficiary as of the date specified. If the beneficiary is not currently enrolled, the summary of last available payments and adjustments information displays. When the screen first displays, the date defaults to the current date.
|Enrollment|	*Beneficiary Detail: Enrollment (M204)*	Displays a summary list of enrollment information, by contract, for the enrollments to which the user has access. It also provides links to drill down to more detailed payment, adjustment, and enrollment information for the beneficiary on a selected contract.
|Status|	*Beneficiary Detail: Status (M205)*	Displays a summary list of enrollment and health status, by contract, for the enrollments to which the user has access.
|Payments|	*Beneficiary Detail: Payments (M206)*	Displays a list, ordered by month as of the specified payment date, of payment and adjustment information, broken down by Part A, Part B, and Part D. The payment date defaults to the current month. It also provides links to drill down to more detailed payment and adjustment information for the beneficiary on a selected contract.
|Adjustments|	*Beneficiary Detail: Adjustments (M207)*	Displays a list, ordered by adjustment month as of the specified payment month, of adjustment information, broken down by Part A, Part B, and Part D, for months up through a specified date. The payment month defaults to the current month. It also provides links to drill down to more detailed payment and adjustment information for the beneficiary on a selected contract.
|Premiums|	*Beneficiary Detail: Premiums (M231)*	Displays a list of premium information for the specified month. The payment month defaults to the current month.
|Premium Withhold|	*Beneficiary Detail: Premium Withhold Transactions (M237)*	Displays a list of premium withhold transaction information for the beneficiary. The initial display defaults to the information for Current Processing Month
|Factors|	*Beneficiary Detail: Factors (M220)*	Displays the factors, beneficiary-specific or default, used in payment calculation.
|Utilization|	*Beneficiary Detail: Utilization (M233)*	Displays information on the beneficiary's use of Medicare services.
|MSA|	*Beneficiary Detail: MSA Lump Sum (M235)*	Displays Medical Savings Account Lump Sum information for a beneficiary for which the user has access.
|Medicaid|	*Beneficiary Detail: Medicaid (M236)*	Displays a summary list of Medicaid information for a beneficiary for which the user has access.

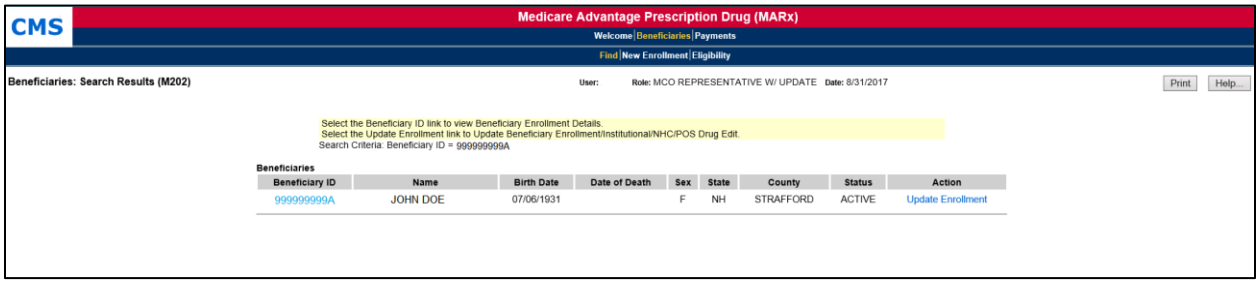
To view information for other beneficiaries, the user can either select another beneficiary from the *Beneficiaries: Search Results (M202)* screen or perform a new search on the *Beneficiaries: Find (M201)* screen.

Figure 8-11: Example of a Find Screen



The *Beneficiaries: Search Results (M202)* screen is displayed. In this example, there is only one beneficiary who meets the selection criteria; however, it is possible to have more than one beneficiary who meets the selection criteria.

Figure 8-12: Example of Search Results Screen

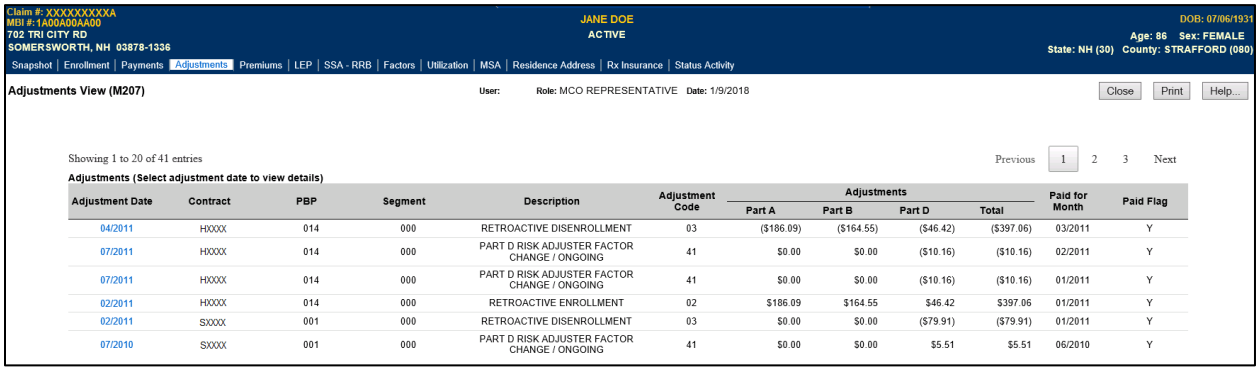


From here, the user can view beneficiary summary information or drill down to find more detailed information about the selected beneficiary. To view adjustment information, click on the linked Beneficiary ID associated with the beneficiary, **999999999A** . The *Beneficiary Detail: Snapshot (M203)* screen is displayed. This is a secondary screen which has a different header with the Beneficiary's name, claim number, MBI, DOB, street address, age, sex, state, and county. Because this is a pop-up window, there is a [Close] button in the upper right-hand corner of the body of the window.

Figure 8-13: Example of Drill Down from Search Results

To view adjustment information, the user selects the |Adjustments| menu item, located just below the header.

Figure 8-14: Example of using Secondary Screen Menu



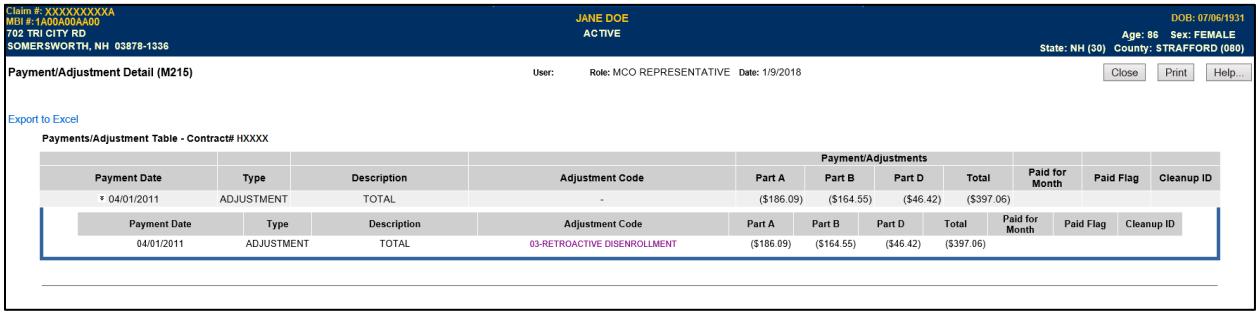
Adjustment Date	Contract	PBP	Segment	Description	Adjustment Code	Adjustments				Paid for Month	Paid Flag
						Part A	Part B	Part D	Total		
04/2011	HXXXX	014	000	RETROACTIVE DISENROLLMENT	03	($186.09)	($164.55)	($46.42)	($397.06)	03/2011	Y
07/2011	HXXXX	014	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	($10.16)	($10.16)	02/2011	Y
07/2011	HXXXX	014	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	($10.16)	($10.16)	01/2011	Y
02/2011	HXXXX	014	000	RETROACTIVE ENROLLMENT	02	$186.09	$164.55	$46.42	$397.06	01/2011	Y
02/2011	SXXXX	001	000	RETROACTIVE DISENROLLMENT	03	$0.00	$0.00	($79.91)	($79.91)	01/2011	Y
07/2010	SXXXX	001	000	PART D RISK ADJUSTER FACTOR CHANGE / ONGOING	41	$0.00	$0.00	$5.51	$5.51	06/2010	Y

To view details of an Adjustment Date, the user selects a particular adjustment by clicking on the month/year link in the Adjustment Date column, in this case, 04/2011.

At this point, a display-only screen appears.

Again, the drill-down method enables the user to navigate from very general information to very specific information just by following a path of menu and submenu items, links, and searches.

Figure 8-15: Example of Drilling into a list of items



8.2.4 *Validation Messages*

The table below lists validation messages that appear directly on the screen during data entry/processing in the status line just below the title line, as shown below.

Figure 8-16: Validation Message Placement on Screen

These are common validation messages, not specific to a single screen but related to the fields that appear on many screens. Note that screen/function-specific messages appear in the section related to the specific function and are associated with the specific screen.

Table 8-7: Validation Messages

Validation Messages	
Error Messages	**Suggested Action**
User must enter <kind of date>	Enter the field specified by the message.
A contract number must start with an ‘E’, ‘H’, ‘R’, ‘S’, ‘X,’ or ‘9’, followed by four characters	Re-enter the field and follow the format indicated in the message.
Invalid Contract/PBP combination	Check the combination and re-enter.
Invalid Contract/PBP/segment combination	Check the combination and re-enter.
<kind-of-date> is invalid. Must have format (M)M/(D)D/CCYY	Re-enter the field and follow the format indicated in the message.
PBP number must have three alphanumeric characters	Re-enter the field and follow the format indicated in the message.
Please enter at least one of the required fields	Make sure to enter all the required fields.
Segment number must have three digits	Re-enter the field and follow the format indicated in the message.
The beneficiary ID is not a valid SSA or RRB number, or CMS Internal number	Re-enter the field in SSA, RRB, or CMS Internal format.

Validation Messages	
Error Messages	**Suggested Action**
The last name contains invalid characters	Re-enter the field using only letters, apostrophes, hyphens, or blanks.
You do not have access rights to this contract	First, make sure that the Contract # is entered correctly. If not, re-enter it. If the user did, he/she should have rights to this contract; see the MARx System Administrator who can update the user profile for these rights.

8.3 MCO Representative Role

8.3.1 *View Beneficiary Snapshot Information*

A snapshot shows a summary of membership, health status, and payment/adjustment information for the beneficiary as of a specified month. If payments are unavailable for the specified month, the last available payments and adjustments information is shown.

View the Beneficiary Detail: Snapshot (M203) Screen

The *Beneficiary Detail: Snapshot (M203)* screen provides payment, health status, adjustment, entitlement, eligibility, enrollment, and premium information for the beneficiary as of the date the user specifics. When the beneficiary enrolls in two contracts, one for Part A and/or Part B and the other for Part D, information is displayed on both the contracts. On the initial display, the current date is used. To view the details as of a different date, the user updates the date in the *As Of* data entry area and clicks on the [Find] button. If the beneficiary is enrolled with an effective date in the future, no status information is available. The user changes the *As Of* date to the future date to view the snapshot information. If the beneficiary is not currently enrolled, a status message states that "*the latest available snapshot information is for a payment month in the past and last available payments and adjustments are displayed*."

Special note: Users with update capabilities will also see an "Update" button available on the M203 screen. Users without update capabilities will not see this button when viewing the screen.

During the MBI transition period (April 2018 – December 2019), the HICN and the MBI will be displayed in the Banner for all Beneficiary screens.

Figure 8-17: Beneficiary Detail: Snapshot (M203) Screen

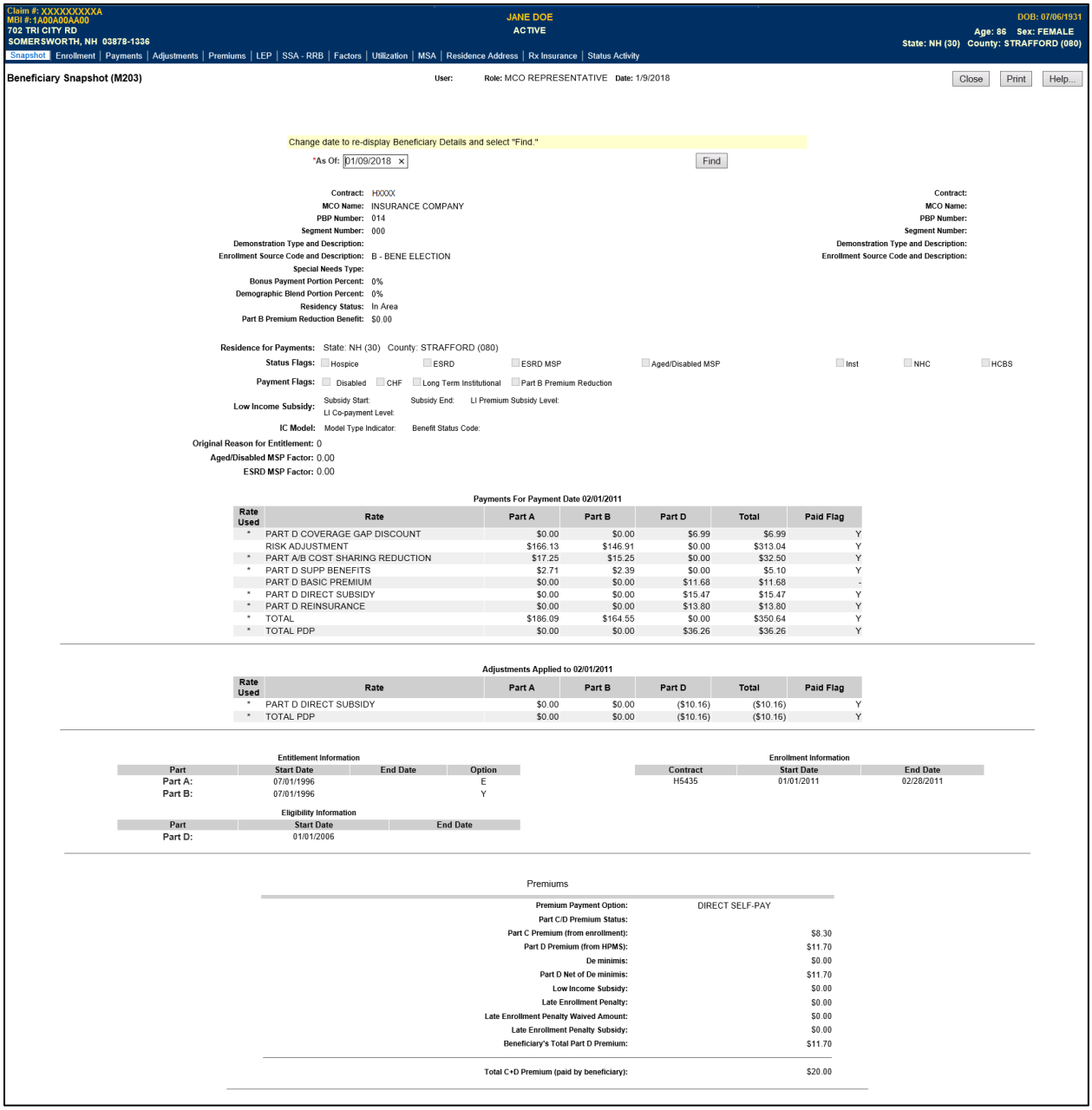
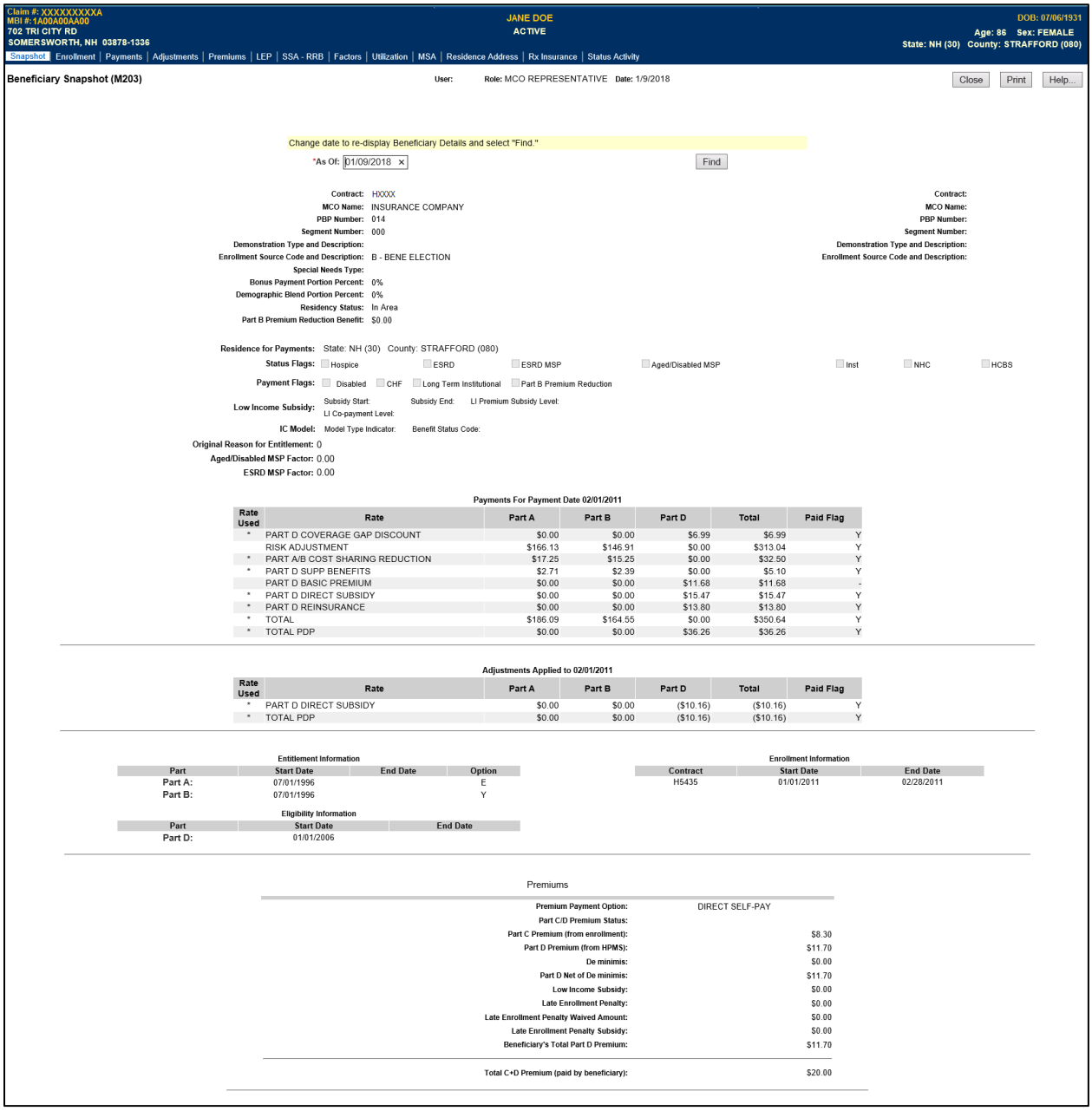


Figure 8-18: Beneficiary Detail: Snapshot (M203) Screen with Payments and Adjustments for Past Payment Month



Claim #: XXXXXXXXXA
MBI #: 1A00A00AA00
702 TRI CITY RD
SOMERSWORTH, NH 03878-1336

JANE DOE
ACTIVE

DOB: 07/06/1931
Age: 86 Sex: FEMALE
State: NH (30) County: STRAFFORD (080)

Snapshot | Enrollment | Payments | Adjustments | Premiums | LEP | SSA - RRB | Factors | Utilization | MSA | Residence Address | Rx Insurance | Status Activity

Beneficiary Snapshot (M203) User: Role: MCO REPRESENTATIVE Date: 1/9/2018 Close Print Help...

Change date to re-display Beneficiary Details and select "Find."

*As Of: 01/09/2018 Find

Contract: HXXXX
MCO Name: INSURANCE COMPANY
PBP Number: 014
Segment Number: 000
Demonstration Type and Description:
Enrollment Source Code and Description: B - BENE ELECTION
Special Needs Type:
Bonus Payment Portion Percent: 0%
Demographic Blend Portion Percent: 0%
Residency Status: In Area
Part B Premium Reduction Benefit: $0.00

Contract:
MCO Name:
PBP Number:
Segment Number:
Demonstration Type and Description:
Enrollment Source Code and Description:

Residence for Payments: State: NH (30) County: STRAFFORD (080)
Status Flags: Hospice ESRD ESRD MSP Aged/Disabled MSP Inst NHC HCBS
Payment Flags: Disabled CHF Long Term Institutional Part B Premium Reduction
Low Income Subsidy: Subsidy Start: Subsidy End: LI Premium Subsidy Level: LI Co-payment Level:
IC Model: Model Type Indicator: Benefit Status Code:
Original Reason for Entitlement: 0
Aged/Disabled MSP Factor: 0.00
ESRD MSP Factor: 0.00

Payments For Payment Date 02/01/2011

Rate Used	Rate	Part A	Part B	Part D	Total	Paid Flag
*	PART D COVERAGE GAP DISCOUNT	$0.00	$0.00	$6.99	$6.99	Y
	RISK ADJUSTMENT	$166.13	$146.91	$0.00	$313.04	Y
*	PART A/B COST SHARING REDUCTION	$17.25	$15.25	$0.00	$32.50	Y
*	PART D SUPP BENEFITS	$2.71	$2.39	$0.00	$5.10	Y
	PART D BASIC PREMIUM	$0.00	$0.00	$11.68	$11.68	-
*	PART D DIRECT SUBSIDY	$0.00	$0.00	$15.47	$15.47	Y
*	PART D REINSURANCE	$0.00	$0.00	$13.80	$13.80	Y
*	TOTAL	$186.09	$164.55	$0.00	$350.64	Y
*	TOTAL PDP	$0.00	$0.00	$36.26	$36.26	Y

Adjustments Applied to 02/01/2011

Rate Used	Rate	Part A	Part B	Part D	Total	Paid Flag
*	PART D DIRECT SUBSIDY	$0.00	$0.00	($10.16)	($10.16)	Y
*	TOTAL PDP	$0.00	$0.00	($10.16)	($10.16)	Y

Entitlement Information

Part	Start Date	End Date	Option
Part A:	07/01/1996		E
Part B:	07/01/1996		Y

Enrollment Information

Contract	Start Date	End Date
H5435	01/01/2011	02/28/2011

Eligibility Information

Part	Start Date	End Date
Part D:	01/01/2006	

Premiums

Premium Payment Option:	DIRECT SELF-PAY
Part C/D Premium Status:	
Part C Premium (from enrollment):	$8.30
Part D Premium (from HPMS):	$11.70
De minimis:	$0.00
Part D Net of De minimis:	$11.70
Low Income Subsidy:	$0.00
Late Enrollment Penalty:	$0.00
Late Enrollment Penalty Waived Amount:	$0.00
Late Enrollment Penalty Subsidy:	$0.00
Beneficiary's Total Part D Premium:	$11.70
Total C+D Premium (paid by beneficiary):	$20.00

Table 8-8: Beneficiary Detail: Snapshot (M203) Field Descriptions

Beneficiary Detail: Snapshot (M203) Field Descriptions		
Item	**Input/Output**	**Description**
As Of	Optional data entry field	Enter a valid date in the form (M)M/(D)D/CCYY. The user may change the As Of date. After changing the date, the user clicks on the [Find] button to bring up the information for that date.
[Find]	Button	Displays the information for the specified As Of date.
The following fields are repeated for each contract, up to two, in which the beneficiary is enrolled		
Contract	Output	Contract number for this beneficiary on the As Of date.
MCO Name	Output	Contract name for this beneficiary on the As Of date.
PBP Number	Output	PBP number on the contract for this beneficiary on the As Of date.
Segment Number	Output	Segment number on the contract and PBP for this beneficiary on the As Of date.
Special Needs Type	Output	Indicates the special needs population that the contract serves, if applicable.
Bonus Payment Portion Percent	Output	The percentage applied to the payment to determine the bonus amount to pay the MCO. This is not applicable to a PDP.
Residency Status	Output	The residency status for this beneficiary on the As Of date.
Part B Premium Reduction Benefit	Output	The Part B Premium Reduction Benefit amount is shown only for a non-drug contractor. For the Pre-2006 Part B Premium Reduction Benefit, multiply the Benefits Improvement & Protection Act of 2000 (BIPA) amount by 0.80.
Residence for Payments: State	Output	State used for payment calculation, which may differ from the state in the mailing address in the screen header.
Residence for Payments: County	Output	County used for payment calculation, which may differ from the county in the mailing address in the screen header.
Status Flags	Output	The flags set for the beneficiary on the As Of date.
Payment Flags	Output	The flags set for the beneficiary on the As Of date.
Low-Income Subsidy	Output	Date range; subsidy start date and end date, co-payment level, and amount of the LIS on the As Of date.
IC Model	Output	Innovation Center (IC) Model Type Indicator and Benefit Status Code
Original Reason for Entitlement	Output	The reason for the beneficiary's original entitlement to Medicare; disabled or aged.
Aged/Disabled Medicare Secondary Payer (MSP) Factor	Output	Beneficiary's aged/disabled reduction factor.
End State Renal Disease (ESRD) MSP Factor	Output	Beneficiary's ESRD Medicare Secondary Payer reduction factor.
The lines in the Payments section define each component used in the calculation of the Plan's payment for this beneficiary for the payment month associated with the As Of date. These may include Demographic, Risk Adjustment, Blended, ESRD, Part D Basic Premium, Part D Direct Subsidy, Part D Reinsurance, etc. Each line is broken into the columns below. ***When there are no payments to display, "No Payments for MM/DD/CCYY for CONTRACT/PBP/SEG" displays.***		
Rate Used	Output	Payments have asterisks, but components used in the payment calculation do not have an asterisk.
Part A	Output	The amount of the payment line that is categorized as Medicare Part A.
Part B	Output	The amount of the payment line that is categorized as Medicare Part B.

Beneficiary Detail: Snapshot (M203) Field Descriptions		
Item	**Input/Output**	**Description**
Part D	Output	The amount of the payment line that is categorized as Medicare Part D.
Total	Output	The Net Payments amount includes additions and subtractions based on rebates, subsidies, and bonuses. Payments are made in the As Of month.
Paid Flag	***Output***	***The Paid Flag indicates whether the Plan received this payment or adjustment. Following PAP, some payments or adjustments are calculated but not included in an actual payment.***
The lines in the Adjustments section define each component used in the calculation of any Plan payment adjustments for this beneficiary for the payment month associated with the As Of date. These may include Demographic, Risk Adjustment, Blended, ESRD, Part D Basic Premium, Part D Direct Subsidy, Part D Reinsurance, etc. Each line is broken into the columns below. ***When there are no adjustments to display, "No Adjustments for MM/DD/CCYY for CONTRACT/PBP/SEG" displays.***		
Rate Used	Output	Adjustments have asterisks, but components used in the adjustment calculation do not, have an asterisk, but the demographic and risk-adjusted components used in the blend do not have an asterisk.
Part A	Output	The amount of the adjustment line that is categorized as Medicare Part A.
Part B	Output	The amount of the adjustment line that is categorized as Medicare Part B.
Part D	Output	The amount of the adjustment line that is categorized as Medicare Part D.
Total	Output	The Net Adjustment amount includes additions and subtractions based on rebates, subsidies, and bonuses. Adjustments are made in the As Of month.
Paid Flag	***Output***	***The Paid Flag indicates whether the Plan received this payment or adjustment. Following the PAP, some payments or adjustments are calculated but not included in an actual payment.***
Entitlement, Eligibility, and Enrollment Information		
Entitlement Information	Output	Entitlement Start Date and End Date, as well as Option for Part A and Part B for this beneficiary on the As Of date.
Eligibility Information	Output	Eligibility Start Date and End Date for Part D for this beneficiary on the As Of date.
Enrollment Information	Output	Provides the Start Date and the End Date for this beneficiary's enrollment under the user's contract on the As Of date.
Premium Information – This section provides information on the beneficiary's premiums on the As Of date. ***When there are no premiums to display, "No Premiums found for MM/DD/CCYY for CONTRACT/PBP" displays.***		
Premium Withholding Option	Output	The Premium Withholding Option on the As Of date.
Premium Withholding Option Pending	Output	When a withholding request is submitted but not yet accepted by the withholding agency, the request is "Pending". This indicates whether this withholding request is "Pending".
Part C Premium (from enrollment)	Output	The amount of the beneficiary's premium that represents their Part C premium. This is provided by the Plan on the enrollment transaction.
Part D Premium from the Health Plan Management System (HPMS)	Output	The amount of the beneficiary's premium that represents their Part D premium. This amount is contracted with the Plan and maintained by HPMS.

Beneficiary Detail: Snapshot (M203) Field Descriptions		
Item	**Input/Output**	**Description**
De Minimis	Output	The De Minimis adjustment included in the beneficiary's premium.
Part D Net of De Minimis	Output	The Part D premium with any De Minimis adjustment.
LIS	Output	The amount of the beneficiary's premium that is subsidized due to low-income status.
Late Enrollment Penalty (LEP)	Output	The penalty amount that is added to the beneficiary's premium due to uncovered months.
LEP Waived Amount	Output	The amount of the LEP that is waived for the beneficiary.
LEP Subsidy	Output	The amount of the LEP that is subsidized.
Beneficiary's Total Part D Premium	Output	The total Part D premium for the month associated with the As Of date. This incorporates all of the Part D components that are detailed in this section.
Total C+D Premium (paid by beneficiary)	Output	The total premium paid by the beneficiary for Part C and Part D coverage.

8.3.2 *View Beneficiary Eligibility*

Beneficiary eligibility provides information regarding a beneficiary's entitlement for Part A, Part B, and eligibility for Part D, as applicable and relevant to the Plan. If the beneficiary is eligible for the Part D LIS, then the number of uncovered months is indicated, as are then the details of that subsidy. Periods when a beneficiary is covered in a Plan that qualifies for the Retiree Drug Subsidy (RDS) are shown. Periods when a beneficiary was covered in a Part D Plan are also shown. Display of all beneficiary enrollments are shown in the Enrollment Information section of the screen with the most recent enrollment as the top row. Plans may also submit a batch Beneficiary Eligibility Query (BEQ) Request File as described in Section 3.

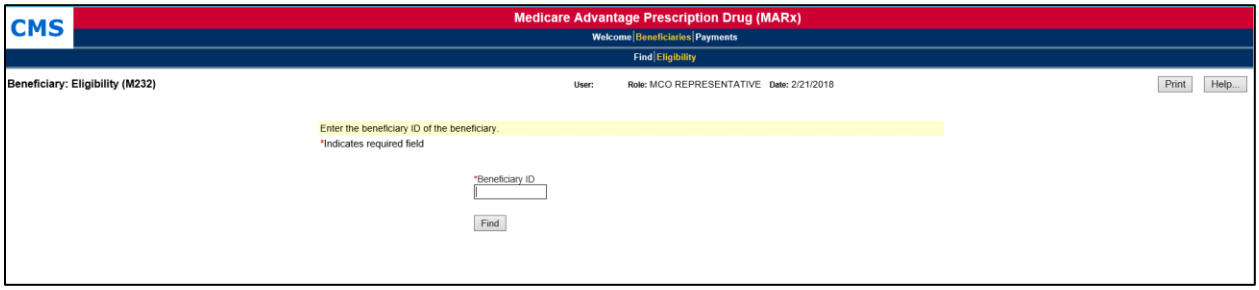
Drug Plan information is shown as a column in the Enrollment Information section. Please note that multiple lines do not necessarily mean there were multiple periods of enrollment. The lines denote the timeframes during which the contract provided drug coverage.

View the Beneficiary Eligibility (M232) Screen

From the main menu, the user clicks on the |Beneficiaries| menu item, and then clicks on the |Eligibility| submenu item to view the *Beneficiary: Eligibility (M232)* screen.

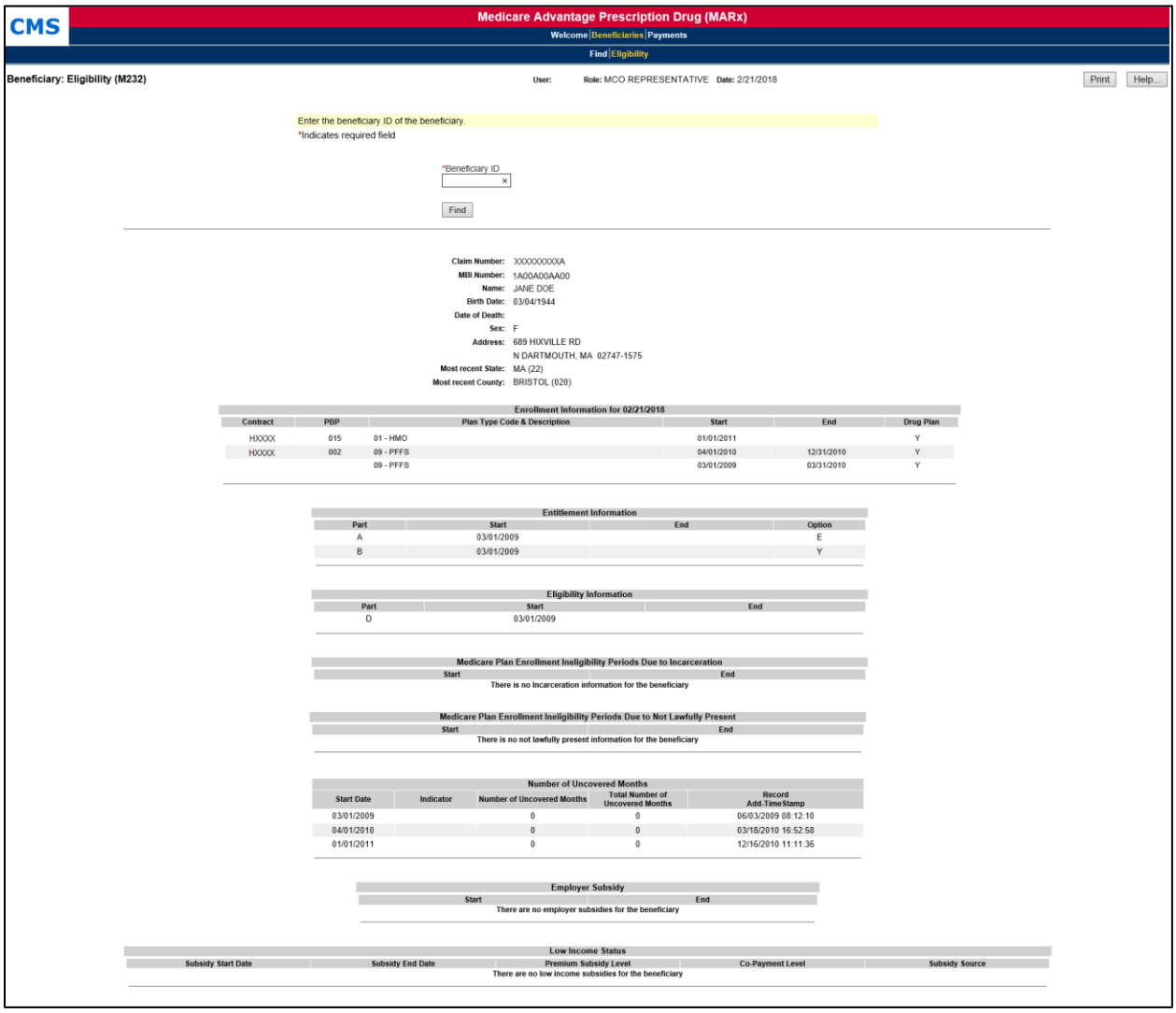
The next step is to identify the beneficiary by Beneficiary ID # on the *Beneficiary: Eligibility (M232)* screen.

Figure 8-19: Beneficiary: Eligibility (M232) Screen (Initial)



After the Beneficiary ID # is entered, the user clicks the [Find] button to show the beneficiary's identification to verify that the correct Beneficiary ID was entered, followed by the beneficiary's entitlement and eligibility information past periods of RDS and/or Part D enrollment, and low-income status.

Figure 8-20: Beneficiary: Eligibility (M232) Screen (with Eligibility Information)



Entitlement, Eligibility, Employer Subsidy, and Low Income Status display as follows:

- If a date is entered, then only the information for that date is shown.
- If a date is not entered and the beneficiary is enrolled in one of the user's Plans, then current, historical, and future information is shown.
- If the beneficiary is not enrolled in one of the user's Plans, then only the current information is shown.
- When the beneficiary was not covered by a Plan that received the RDS, a message is displayed in the Employer Subsidy section.
- When the beneficiary does not receive a Part D LIS, message displays in the LIS section.

Number of Uncovered Months section displays as follows:

Part D enrollments display as follows:

- The 10 most recent periods of Part D enrollment are shown, including Plans with employer subsidies.
- If there are several Part D enrollments back to back, the screen displays the start date of the first enrollment and the end date of the last enrollment.
- When the beneficiary does not have Part D Enrollment information, a message displays in the Part D Enrollment section.

Enrollment Information displays as follows:

- The Contract number, start and end date, and Drug Plan indicator of the beneficiary's current enrollment in the PBP is displayed.
- If the beneficiary is dual enrolled, the system displays the drug and non-drug Contract information for both of the beneficiary's current enrollments in PBPs.
- If the beneficiary is enrolled in a Plan that does not have PBPs, the Contract, Drug Plan indicator and the start and end date of the beneficiary's current enrollment is displayed.
- If the user enters a date in the "Date" field, the system considers the entered date as the current date when displaying the beneficiary's current enrollment information.

Table 8-9: Beneficiary: Eligibility (M232) Field Descriptions

Beneficiary: Eligibility (M232) Field Descriptions		
Item	**Inputs/Outputs**	**Description**
Search Criteria		
Beneficiary ID	Required data entry field	Identifies the beneficiary whose eligibility information displays.
Date	Date field	Provide eligibility information as of this date.
[Find]	Button	The user clicks on this button after entering the claim number of the beneficiary. If the beneficiary is found, eligibility information for the beneficiary is displayed.
Beneficiary Identification		
Claim Number	Output	Claim number of beneficiary.
MBI Number	Output	Medicare Beneficiary ID of beneficiary.
Name	Output	Name of beneficiary.
Birth Date	Output	Date of birth of beneficiary.
Date of Death	Output	Date of death of beneficiary.
Sex	Output	Sex of beneficiary.
Address	Output	Street address, city, state, and zip code of beneficiary.
Most recent State	Output	The most recent state on record for the beneficiary.
Most recent County	Output	The most recent county on record for the beneficiary.
Enrollment Information		
Contract	Output	Contract number for the beneficiary's enrollment(s).
PBP	Output	PBP number for the beneficiary's enrollment(s).
Plan Type Code & Description	Output	Plan Type code and the description for the beneficiary's enrollment(s).

Beneficiary: Eligibility (M232) Field Descriptions		
Item	**Inputs/Outputs**	**Description**
Start	Output	Start date of the beneficiary's enrollment(s).
End	Output	End date of the beneficiary's enrollment(s).
Drug Plan	Output	Drug Plan indicator for the beneficiary's enrollment(s).
Entitlement Information		
Part column	Output	Entitlement information that applies to the Part A and Part B of Medicare.
Start column	Output	When the entitlement period began.
End column	Output	When the entitlement period ended, as applicable.
Option column	Output	Option selected for this part.
Eligibility Information		
Part column	Output	Eligibility information that applies to this Part D of Medicare.
Start column	Output	When the eligibility period began.
End column	Output	When the eligibility period ended, as applicable.
Medicare Plan Enrollment Ineligibility Periods Due to Incarceration		
Start column	Output	When the incarceration period began.
End column	Output	When the incarceration period ended, as applicable.
Medicare Plan Enrollment Ineligibility Periods Due to Not Lawfully Present		
Start column	Output	When the not lawfully present period began.
End column	Output	When the not lawfully present period ended, as applicable.
NUNCMO		
Start Date	Output	Start Date for uncovered month's period.
Indicator	Output	Indicator showing record type.
NUNCMO	Output	NUNCMO.
Total NUNCMO	Output	Total NUNCMO based on the Indicator.
Record Add-Timestamp	Output	Timestamp for when the record was added.
Record Type	Output	Indicator showing a valid or audit record
Employer Subsidy		
Start Date column	Output	When a Retiree Drub Subsidy coverage period began.
End Date column	Output	When an RDS coverage period ended.
Part D Enrollment		
Start Date column	Output	When a Part D enrollment began for the beneficiary.
End Date column	Output	When a Part D enrollment ended for the beneficiary.
Low-Income Status		
Subsidy Start Date column	Output	When the subsidy of Part D premiums began.
Subsidy End Date column	Output	When the subsidy of Part D premiums ended, as applicable.
Premium Subsidy Level column	Output	Level at which the premiums are subsidized.
Co-Payment Level column	Output	Level of co-payment that the beneficiary must pay.
Subsidy Source Column	Output	The source of LIS subsidy.

8.3.3 View Enrollment Information

An enrollment history displays all of the times that the beneficiary is, was, or will have enrollment in any of the Plan's contracts.

View the Beneficiary Detail: Enrollment (M204) Screen

To access the *Beneficiary Detail: Enrollment (M204)* screen, the user clicks on the |Enrollment| menu item. This displays a summary list of enrollment information by contract, and PBP and segment numbers, as applicable. When the beneficiary enrolls in Part A and/or Part B and the other for Part D, two rows covering the same time period display.

Note: The user can only see contracts to which the user has access. Therefore, gaps may exist in the user's list where the user cannot see the enrollment information. Additionally, users with update capabilities will also see an "Update" button available on the M204 screen. Users without update capabilities will not see this button when viewing the screen.

Figure 8-21: Beneficiary Detail: Enrollment (M204) Screen (Initial Display)

To view details of the beneficiary enrollment transaction in a contract, the user clicks on a Contract link, which displays the *Enrollment Detail (M222)* screen for that contract and the beneficiary. To view a summary of payment and adjustment information for a particular contract, the user clicks on the view Payment link associated with that contract; PBP; and segment; as applicable, and start date. This expands the information on the *Beneficiary Detail: Enrollment (M204)* screen to include the Payments section; the information is listed by month, and is described in the following table.

Table 8-10: Beneficiary Detail: Enrollment (M204) Field Descriptions

Beneficiary Detail: Enrollment (M204) Field Descriptions		
Item	**Input/Output**	**Description**
Contract	Output	Contract in which the beneficiary is enrolled. The values displayed in this column link to display the *Enrollment Details (M222)* screen for the enrollment on this line.
PBP #	Output	PBP number for the enrollment on this line.
Segment #	Output	Segment number for the enrollment on this line.
Drug Plan	Output	Indicates whether the contract/PBP on this line provides drug insurance coverage. (Y or N).
Start	Output	Start date for the beneficiary's enrollment in this Contract/PBP/Segment.
End	Output	End date for the beneficiary's enrollment in this Contract/PBP/Segment.
Source	Output	The person or system that submitted the enrollment; contract number when entered by an MCO; user ID when entered at CMS, SSA, or Medicare Customer Service Center (MCSC).
Disenrollment Reason	Output	If the enrollment on this line includes an end date, this is the reason for the beneficiary's disenrollment.
Primary Drug Insurance	Link	Click the View link in the Primary Insurance Information column to display all occurrences of primary insurance information associated with the beneficiary's enrollment. This information displays in the bottom portion of the screen.
Payment	Link	Select the View link in the Payment column to display all payment information associated with the enrollment for the contract/PBP/segment.

View the Beneficiary Detail: Enrollment (M204) Screen Primary Drug Insurance

To view the Primary Drug Insurance information in the bottom portion of the screen, the user clicks the View link that is in the Primary Drug Insurance column. This displays an additional section on the screen, showing the beneficiary's primary 4Rx values. The information is listed by start and end date.

Special note: Users with update capabilities will also see an "Update" button available on the M204 Primary Drug Insurance and the M204 Payment screens. Users without update capabilities will not see this button when viewing these screens.

Figure 8-22: Beneficiary Detail: Enrollment (M204) Screen Primary Drug Insurance

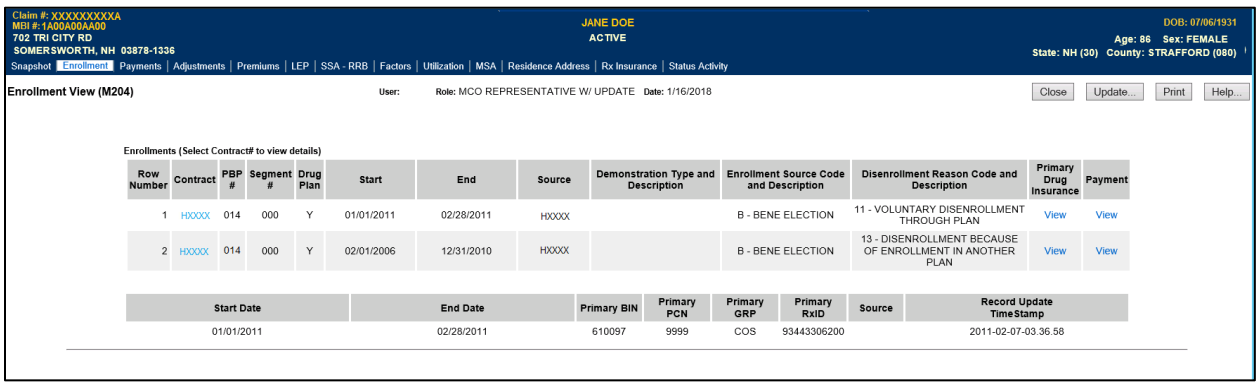


Table 8-11: Beneficiary Detail: Enrollment (M204) Drug Insurance Field Descriptions

Beneficiary Detail: Enrollment (M204) Field Descriptions		
Item	**Input/Output**	**Description**
Primary Drug Insurance Information This section contains one line per period during which the beneficiary has a unique combination of Contract, PBP, and Primary 4Rx information.		
Start Date	Output	Start date per period when the beneficiary has a unique combination of Primary Drug Insurance information (4Rx).
End Date	Output	End date per period when the beneficiary has a unique combination of Primary Drug Insurance information. This is blank for open-ended periods.
Primary Benefit Identification Number (BIN)	Output	Primary BIN for the Primary Drug Insurance period on this line.
Primary Processor Control Number (PCN)	Output	Primary PCN for the Primary Drug Insurance period on this line.
Primary Group Number (GRP)	Output	Primary GRP for the Primary Drug Insurance period on this line.
Primary Rx Identification Number (ID)	Output	Primary RxID for the Primary Drug Insurance period on this line.
Source	Output	The source of the Primary Insurance information.
Record Update Timestamp	Output	The date and time the Primary Insurance information is received.

View the Beneficiary Detail: Enrollment (M204) Screen Payment

Figure 8-23: Beneficiary Detail: Enrollment (M204) Screen Payment

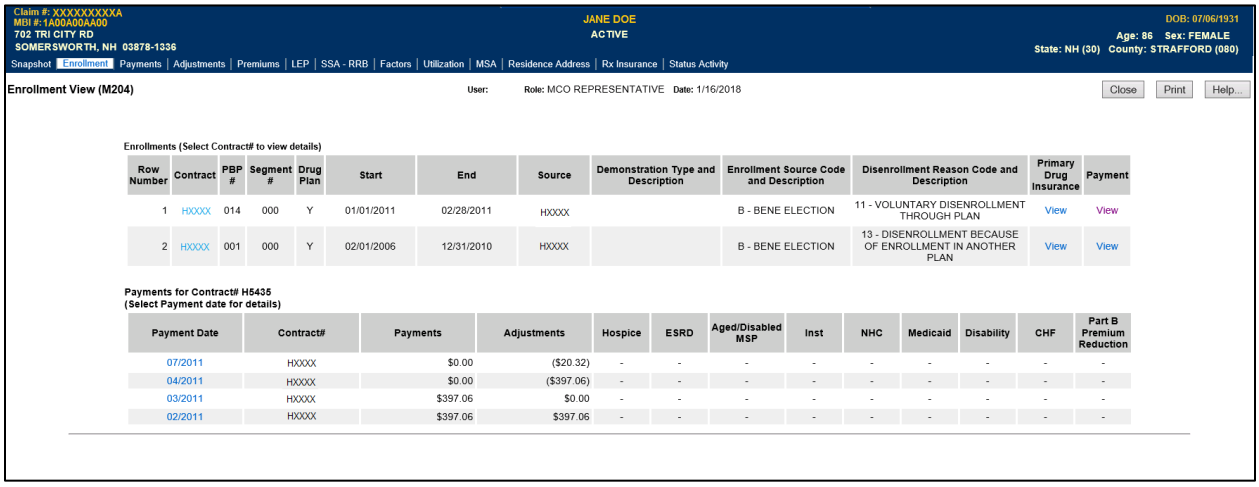


Table 8-12: Beneficiary Detail: Enrollment (M204) Payment Field Descriptions

Beneficiary Detail: Enrollment (M204) Field Descriptions		
Item	**Input/Output**	**Description**
Payments This section shows payment information for the selected enrollment line. One line displays for each month that the Plan received a payment.		
Payment Date	Output/Link	Month/year payments/adjustments made. User selects month/year on pop-up screen, which shows payment and adjustment details on payment row.
Contract #	Output	Contract associated with payment selected.
Payments	Output	Payment amounts, broken down by month, for the selected enrollment in the contract, PBP, and segment, as applicable.
Adjustments	Output	Adjustments by month for selected enrollment in contract, PBP, and segment, as applicable.
Hospice	Output	Check if beneficiary has Hospice status for month on payment row.
End Stage Renal Disease (ESRD)	Output	Check if beneficiary has ESRD status for month on payment row.
Aged/Disabled MSP	Output	Check if beneficiary has Working Aged or Disabled status for month on payment row.
Institutional (Inst)	Output	Check if beneficiary has Institutional status for month on payment row.
Nursing Home Certifiable (NHC)	Output	Check if beneficiary has NHC status for month on payment row.
Medicaid	Output	Checked if beneficiary has Medicaid status for month on payment row.
Disability	Output	Checked if beneficiary has Disability status for month on payment row.
Congestive Heart Failure (CHF)	Output	Check if beneficiary has CHF status for month on payment row.
Part B Premium Reduction	Output	Check if Part B premium reduction is applied to payment and/or adjustments for beneficiary for month on payment row.

Note: To view the payment and adjustment information in further detail, the user clicks on one of the month/year links in the Payment Date column to display the *Payment/Adjustment Detail (M215)* screen.

8.3.4 *View Beneficiary Enrollment Detail*

View the Enrollment Detail (M222) Screen

The enrollment details show the information on the enrollment, disenrollment (as applicable), and Part D insurance information for a beneficiary in a Plan.

The *Enrollment Detail (M222)* screen is accessible by selecting a Contract # link from the *Beneficiary Detail: Enrollment (M204)* screen.

Figure 8-24: Enrollment Detail (M222) Screen

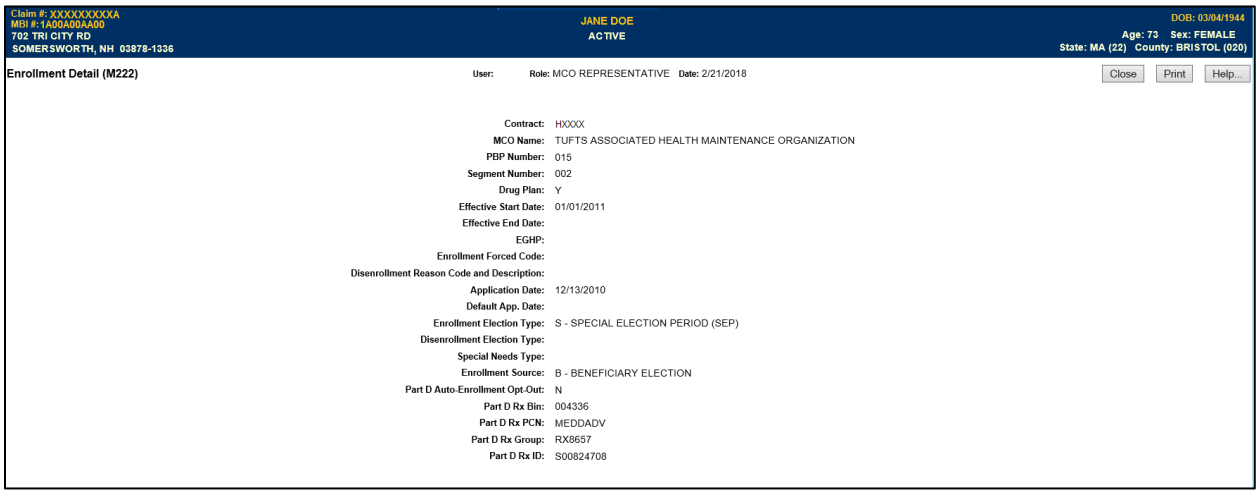


Table 8-13: Enrollment Detail (M222) Field Descriptions

Enrollment Detail (M222) Field Descriptions		
Item	**Input/Output**	**Description**
Contract	Output	Contract number in which the beneficiary is enrolled.
MCO Name	Output	Name of the contract.
PBP Number	Output	PBP in which the beneficiary is enrolled, when applicable.
Segment Number	Output	Segment in which the beneficiary is enrolled, when applicable.
Drug Plan	Output	Indicates whether the contract provides drug insurance coverage. The user sets to Y or N.
Effective Start Date	Output	Start of enrollment.
Effective End Date	Output	End of enrollment, when applicable.
EGHP	Output	Indicates whether the enrollment is an EGHP. The user sets to Y or N.
Enrollment Forced Code	Output	Reason for overriding certain membership validation rules, when applicable.
Disenrollment Reason Code	Output	Reason for disenrollment, when applicable.
Application Date	Output	The date the Plan received the beneficiary's completed enrollment application.
Enrollment Election Type	Output	Type of election period when enrollment took place.
Disenrollment Election Type	Output	Type of election period when disenrollment took place.
Special Needs Type	Output	Type of special needs population for which the Plan provides coverage, e.g., Institutional, Dual Eligible, or Chronic or Disabling Condition.
Enrollment Source	Output	The action that triggered the enrollment: automatically enrolled by CMS, beneficiary election, or facilitated enrollment by CMS.

Enrollment Detail (M222) Field Descriptions		
Item	**Input/Output**	**Description**
Part D Auto-Enrollment Opt-Out	Output	Indicates whether the beneficiary opted out of Part D coverage. Applies only to automatic enrollments by CMS. Set to Y or N.
Part D Rx Bin	Output	Card issuer identifier or a bank identifying number used for network routing.
Part D Rx PCN	Output	Identifier assigned by the processor.
Part D Rx Group	Output	Identifying number assigned to the cardholder group or employer group.
Part D Rx ID	Output	Member ID assigned to the beneficiary.

8.3.5 *View Beneficiary Payment Information*

Payment history shows the payments made for beneficiary enrolled in a particular contract.

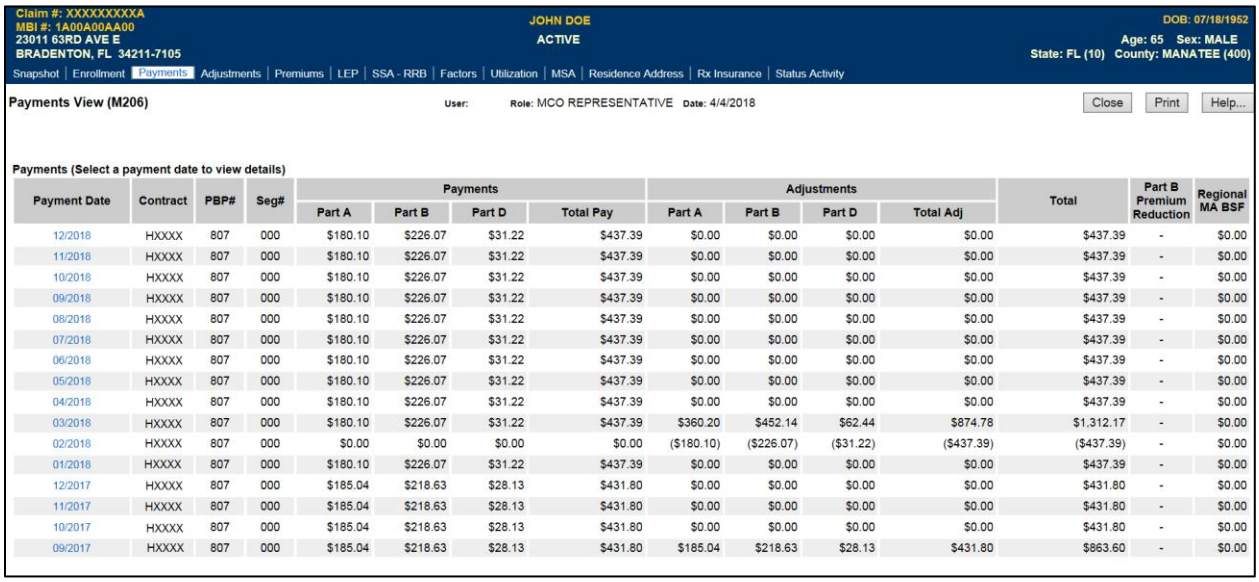
View the Beneficiary Detail: Payments View (M206) Screen

To access the *Beneficiary Detail: Payments View (M206)* screen, the user clicks on the |Payments| menu item. This displays a screen that provides a field for entering a payment month and year. When the beneficiary enrolls in two contracts; one for Part A and/or Part B and the other for Part D, two rows for the same month display. In initial display, the current month appears in that field.

The *Beneficiary Detail: Payments View (M206)* screen display a list of payments, ordered by payment month, of payment and adjustment information. The information displays by Part A, Part B, and Part D for months up through the payment date.

Note: To see the payment and adjustment information in more detail, the user clicks on one of the month/year links in the Payment Date column to display the *Payment/Adjustment Detail (M215)* screen.

Figure 8-25: Payments View (M206) Screen



Payment Date	Contract	PBP#	Seg#	Payments				Adjustments				Total	Part B Premium Reduction	Regional MA BSF
				Part A	Part B	Part D	Total Pay	Part A	Part B	Part D	Total Adj			
12/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
11/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
10/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
09/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
08/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
07/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
06/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
05/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
04/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
03/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$360.20	$452.14	$62.44	$874.78	$1,312.17	-	$0.00
02/2018	HXXXX	807	000	$0.00	$0.00	$0.00	$0.00	($180.10)	($226.07)	($31.22)	($437.39)	($437.39)	-	$0.00
01/2018	HXXXX	807	000	$180.10	$226.07	$31.22	$437.39	$0.00	$0.00	$0.00	$0.00	$437.39	-	$0.00
12/2017	HXXXX	807	000	$185.04	$218.63	$28.13	$431.80	$0.00	$0.00	$0.00	$0.00	$431.80	-	$0.00
11/2017	HXXXX	807	000	$185.04	$218.63	$28.13	$431.80	$0.00	$0.00	$0.00	$0.00	$431.80	-	$0.00
10/2017	HXXXX	807	000	$185.04	$218.63	$28.13	$431.80	$0.00	$0.00	$0.00	$0.00	$431.80	-	$0.00
09/2017	HXXXX	807	000	$185.04	$218.63	$28.13	$431.80	$185.04	$218.63	$28.13	$431.80	$863.60	-	$0.00

Table 8-14: Payments View (M206) Field Descriptions

Payments View (M206) Field Descriptions		
Item	**Input/Output**	**Description**
Search Criteria		
Payment Date	Required data entry field	The user enters a month and year in the form (M)M/CCYY.
[Find]	Button	The user clicks on this button to display payment information in the lower portion of the screen.
Payments		
Payment Date column	Output	When payment/adjustments were paid.
Month/Year in the Payment Date column	Link	The user clicks on a month/year link to display the pop-up screen *Payment/Adjustment Detail (M215)* screen.
Contract column	Output	Contracts for which payments/adjustments were made.
PBP # column	Output	PBPs for which payments/adjustments were made.
Seg # column	Output	Segments for which payments/adjustments were made.
Part A Payments column	Output	Part A payments for the beneficiary by month.
Part B Payments column	Output	Part B payments for the beneficiary by month.
Part D Payments column	Output	Part D payments for the beneficiary by month.
Total Pay column	Output	Part A, Part B, and Part D total monthly payments for beneficiary.
Part A Adjustments column	Output	Part A adjustments for the beneficiary by month.
Part B Adjustments column	Output	Part B adjustments for the beneficiary by month.
Part D Adjustments column	Output	Part D adjustments for the beneficiary by month.
Total Adj column	Output	Totals of Part A, Part B, and Part D adjustments for the beneficiary by month.
Total Pay+Adj column	Output	Payments plus adjustments for the beneficiary by month.

Payments View (M206) Field Descriptions		
Item	**Input/Output**	**Description**
Part B Premium Reduction column	Output	Indicates whether the payments/adjustments were adjusted for Part B premium reduction. Formerly known as a BIPA reduction.
Regional Medicare Advantage Benefit Stabilization Fund (MA BSF) column	Output	Lists the bonus paid from the regional MA BSF.

8.3.6 View Beneficiary Adjustment Information

An adjustment history shows the adjustments made for the beneficiary while enrolled in any of the user's contracts.

View the Beneficiary Detail: Adjustments (M207) Screen

To access the *Beneficiary Detail: Adjustments View (M207)* screen, the user clicks on the |Adjustments| menu item. When the beneficiary enrolls in two contracts, one for Part A and/or Part B and the other for Part D, two rows for the same month are displayed.

The Adjustments View (M207) screen displays a list, ordered by adjustment month, of adjustment information that occurred up through the current payment month. The Part A, Part B, and Part D adjustments are listed in adjustment.

To view the payment and adjustment information in more detail, the user clicks on one of the month/year links in the Adjustment Date column to display the *Payment/Adjustment Detail (M215)* screen.

Figure 8-26: Beneficiary Detail: Adjustments (M207) Screen

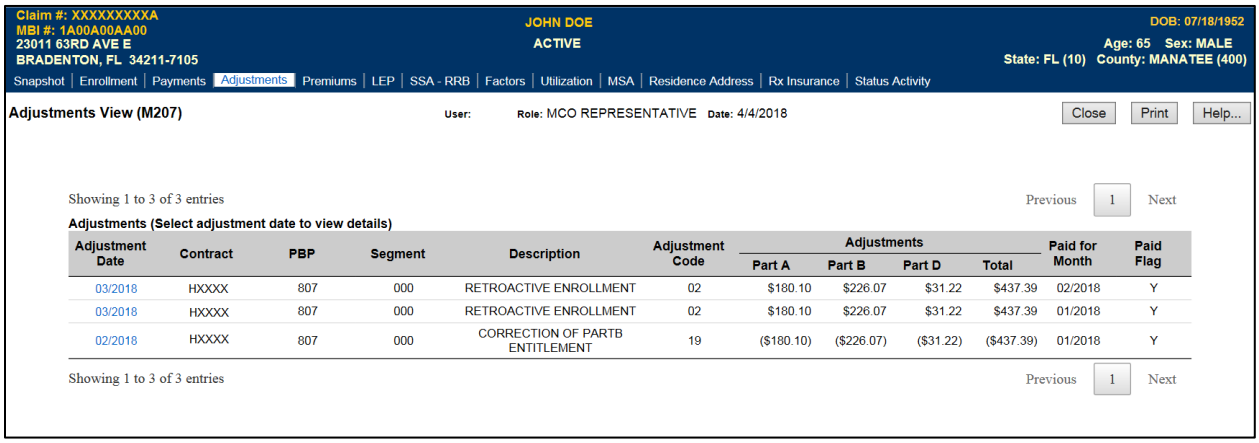


Table 8-15: Beneficiary Detail: Adjustments (M207) Field Descriptions

Beneficiary Detail: Adjustments (M207) Field Descriptions		
Item	**Input/Output**	**Description**
Adjustments		
Adjustment Date column	Output	Indicates when adjustments were paid.
Month/Year in the Adjustment Date column	Link	User clicks on month/year link to display pop-up screen *Payment/Adjustment Detail (M215).*
Contract column	Output	Contracts for which adjustments were made.
PBP column	Output	PBPs for which adjustments were made.
Segment column	Output	Segments for which adjustments were made.
Description column	Output	Description of the adjustment reason for each adjustment.
Adjustment Code column	Output	Code for the adjustment reason for each adjustment.
Part A Adjustments column	Output	Part A adjustments by Paid for Month and adjustment reason.
Part B Adjustments column	Output	Part B adjustments by Paid for Month and adjustment reason.
Part D Adjustments column	Output	Part D adjustments by Paid for Month and adjustment reason.
Total Adjustments column	Output	Total adjustments by month and adjustment reason.
Paid for Month column	Output	Indicates the month to which the adjustment applies.

8.3.7 View Payment and Adjustment Details

The *Payment/Adjustment Detail (M215)* screen shows the components that comprise the payments, adjustments, premiums, rebates, subsidies, and bonuses that apply to a beneficiary in a month.

View the Payment/Adjustment for a Beneficiary

The *Payment/Adjustment Detail (M215)* screen is accessible by clicking on a Payment Date or Adjustment Date link from the following screens:

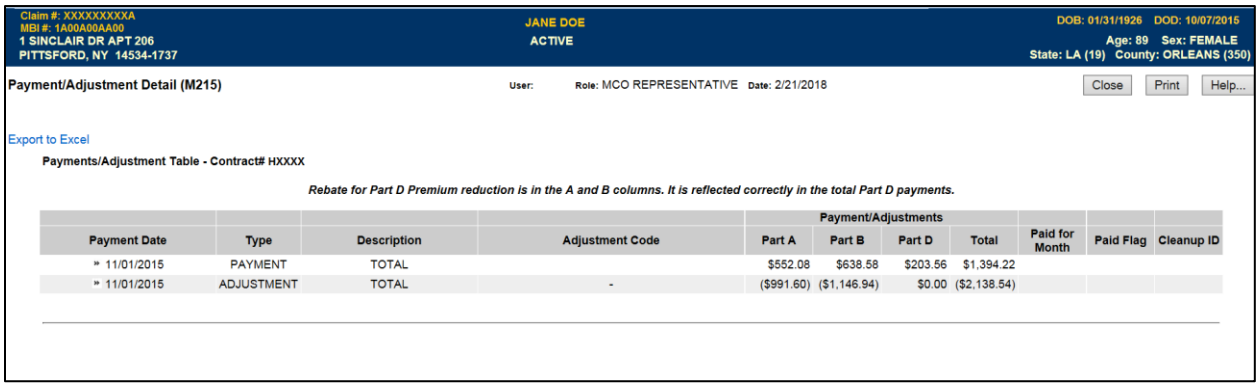
- *Beneficiary Detail: Enrollment (M204).*
- *Beneficiary Detail: Payments (M206).*
- *Beneficiary Detail: Adjustments (M207).*
- *Beneficiary Payment History (M406).*

The following screens provide payment and adjustment details for the selected month and contract. Adjustments are listed by adjustment reason code and are shown for the month in which they are paid, not the month to which they apply. When a blended rate displays, the demographic and risk-adjusted components used in the blending calculation also displays. Any additions and subtractions for bonuses, rebates, and/or subsidies are on separate lines.

View the Payment/Adjustment Detail (M215) Screen

If a beneficiary has payment/adjustment data available in MARx, the end user may click on the chevron (>>) to the left of the Payment or Adjustment line and a drop-down box displays the components that make up the payment/adjustment line.

Figure 8-27: Payment/Adjustment Detail (M215) Screen – Monthly Payment and Adjustment Totals



Adjustments will be totaled by adjustment reason code. To view all the payment adjustments associated with one of the adjustment reason codes, the user may click on the adjustment reason code and a drop-down box will display all the adjustments for that adjustment reason code.

Figure 8-28: Payment/Adjustment Detail (M215) Screen – Use Drop-Down Function

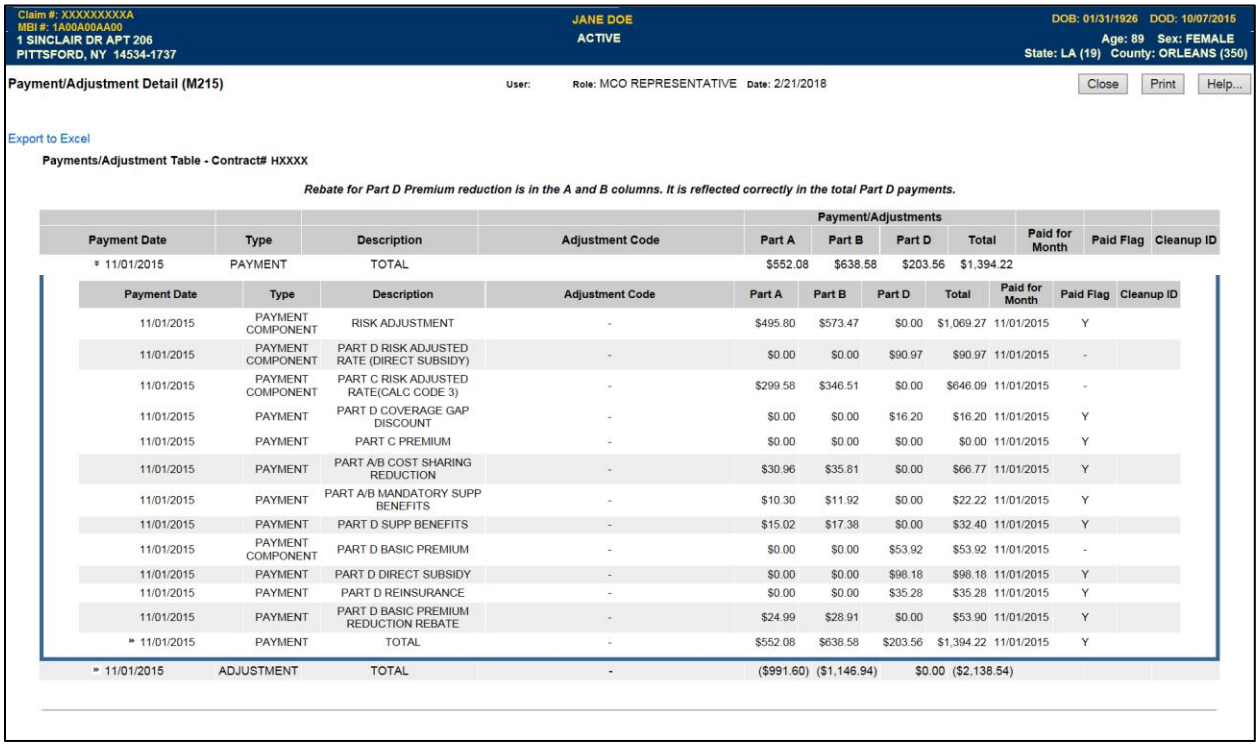
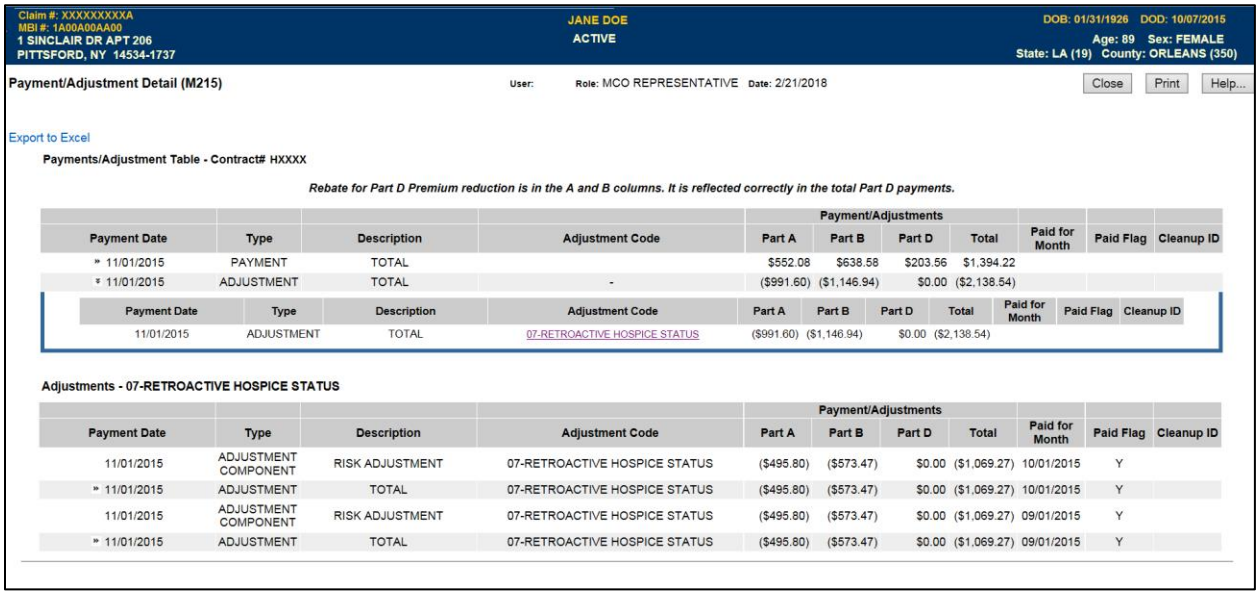


Figure 8-29: Payment/Adjustment Detail (M215) Screen – Use Drop-Down Function from the Adjustment Reason Code Detail Line



Claim #: XXXXXXXXA
MBI #: 1A00A00AA00
1 SINCLAIR DR APT 206
PITTSFORD, NY 14534-1737

JANE DOE
ACTIVE

DOB: 01/31/1926 DOD: 10/07/2015
Age: 89 Sex: FEMALE
State: LA (19) County: ORLEANS (350)

Payment/Adjustment Detail (M215) User: Role: MCO REPRESENTATIVE Date: 2/21/2018 Close Print Help...

Export to Excel

Payments/Adjustment Table - Contract# HXXXX

Rebate for Part D Premium reduction is in the A and B columns. It is reflected correctly in the total Part D payments.

				Payment/Adjustments						
Payment Date	Type	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
» 11/01/2015	PAYMENT	TOTAL		$552.08	$638.58	$203.56	$1,394.22			
» 11/01/2015	ADJUSTMENT	TOTAL	-	($991.60)	($1,146.94)	$0.00	($2,138.54)			

Payment Date	Type	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
11/01/2015	ADJUSTMENT	TOTAL	07-RETROACTIVE HOSPICE STATUS	($991.60)	($1,146.94)	$0.00	($2,138.54)			

Adjustments - 07-RETROACTIVE HOSPICE STATUS

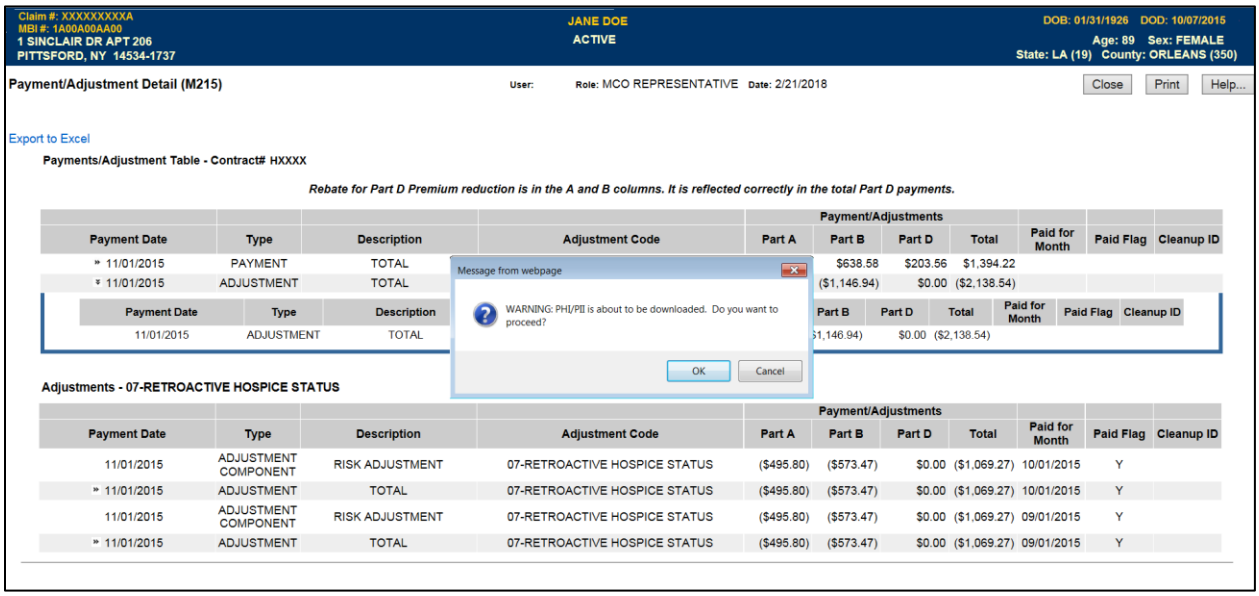
				Payment/Adjustments						
Payment Date	Type	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
11/01/2015	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	07-RETROACTIVE HOSPICE STATUS	($495.80)	($573.47)	$0.00	($1,069.27)	10/01/2015	Y	
» 11/01/2015	ADJUSTMENT	TOTAL	07-RETROACTIVE HOSPICE STATUS	($495.80)	($573.47)	$0.00	($1,069.27)	10/01/2015	Y	
11/01/2015	ADJUSTMENT COMPONENT	RISK ADJUSTMENT	07-RETROACTIVE HOSPICE STATUS	($495.80)	($573.47)	$0.00	($1,069.27)	09/01/2015	Y	
» 11/01/2015	ADJUSTMENT	TOTAL	07-RETROACTIVE HOSPICE STATUS	($495.80)	($573.47)	$0.00	($1,069.27)	09/01/2015	Y	

Payment/Adjustment Detail (M215) Screen Excel Export Function

MARx allows users to export payment/adjustment data from the *Payment/Adjustment Detail (M215)* screen in the form of a Microsoft Excel spreadsheet. The export functionality incorporates beneficiary information including Personally Identifiable Information (PII)/Protected Health Information (PHI).

When the user clicks the Export to Excel link on the *Payment/Adjustment Detail (M215)* screen, a pop-up warning message will be displayed. This pop-up message will inform the end user that PII/PHI is about to be downloaded. The pop-up message will give the authorized user the option to continue downloading the data or cancel downloading the data altogether.

Figure 8-30: Payment/Adjustment Detail (M215) Screen Pop-up Message



If the user clicks ‘OK’ to proceed, the file will be downloaded and the beneficiary identification will be added to the existing Excel export.

Figure 8-31: Example Excel Export from Payment/Adjustment Detail (M215)

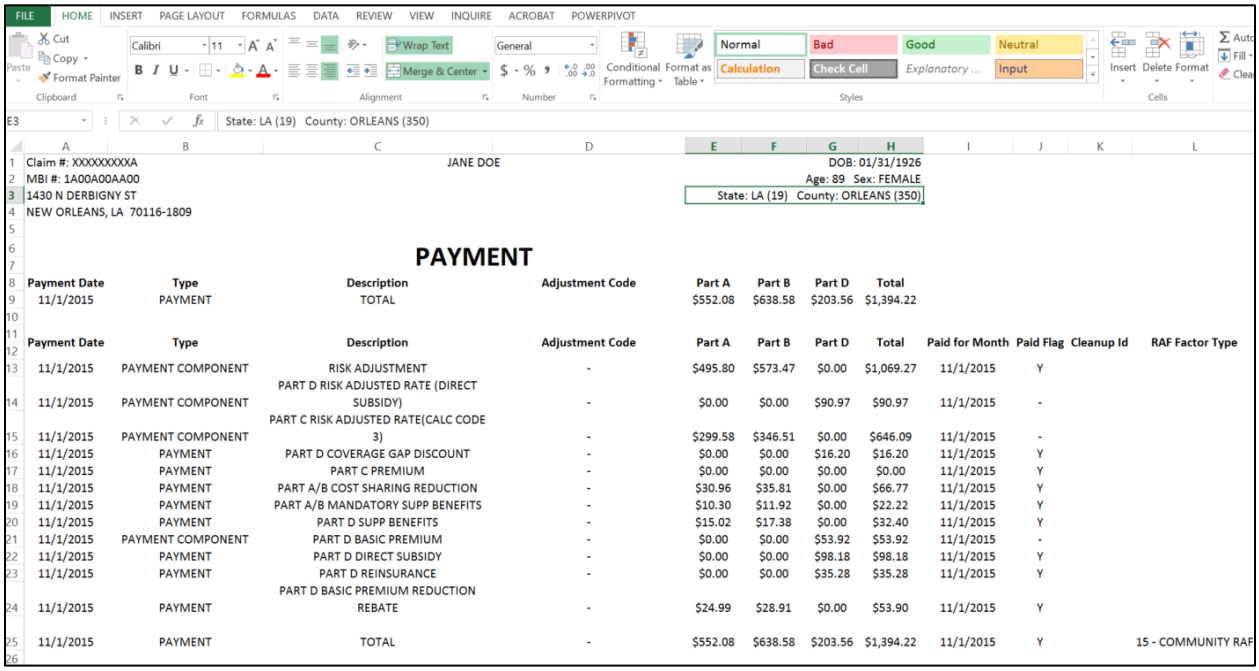


Table 8-16: Payment/Adjustment Detail (M215) Field Descriptions

Payment/Adjustment Detail (M215) Field Descriptions		
Item	**Input/Output**	**Description**
Payment Date column	Output	Date on which the payments were made.
Type column	Output	Specifies the type. These include payment, payment component, equivalent, and adjustment component.
Description column	Output	For payments or equivalent, provides description, such as demographic, risk adjusted, blended, one of the premium types, one of the rebate types, or one of the subsidy types. For adjustments, describes reason for the adjustment.
Adjustment Code column	Output	Code of adjustment reason for each adjustment. Dashes are used when it is not an adjustment.
Payment/Adjustments Part A column	Output	Part A amount of payment or adjustment, as applicable.
Payment/Adjustments Part B column	Output	Part B amount of payment or adjustment, as applicable.
Payment/Adjustments Part D column	Output	Part D amount of payment or adjustment, as applicable.
Payment/Adjustments Total column	Output	Total amount of payment or adjustment, as applicable.
Paid for Month column	Output	Month/year to which the payment applies. For adjustments, this month is being adjusted, not the month in which the adjustment is paid.

8.3.8 *View the Payment/Adjustment for Displaying Risk Adjustment Factors (RAFs) for a Beneficiary*

The Payment/Adjustment Detail (M215) screen displays the risk adjustment factor used in determining the beneficiary's payment. This information is displayed and hidden at the user's discretion. CMS added the RAF and RAF types to existing payment history lines on the MARx Payment/Adjustment Detail (M215) screen.

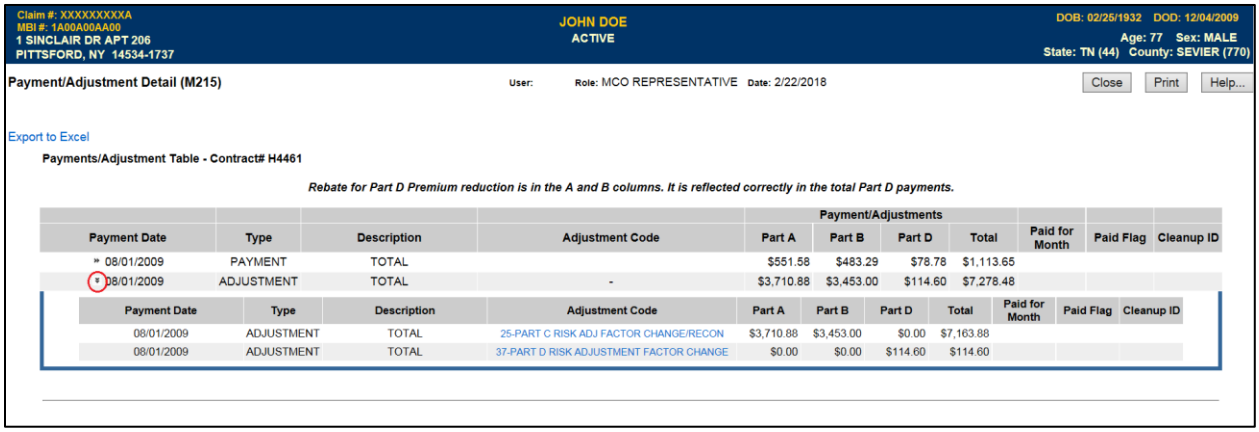
Navigate to the RAF

A chevron (>>) will appear next to each row of data on the *Payment/Adjustment Detail (M215)* screen where a risk adjustment factor is used to calculate a payment or an adjustment amount. When a user clicks the chevron (>>), a drop down display of the risk adjustment factor appears. The RAF data values on the *Payment/Adjustment Detail (M215)* screen are:

- RAF Type.
- RAF Class.
- RAF used for Part A payment calculation.
- RAF used for Part B payment calculation.
- RAF used for Part D payment calculation.
- Part C Frailty Factor used in the payment calculation.
- RAF Start and End date.

View the Payment/Adjustment for Displaying RAFs for a Beneficiary

Figure 8-32: Payment/Adjustment Detail (M215) Screen



Claim #: XXXXXXXXA
MBI #: 1A00A00AA00
1 SINCLAIR DR APT 206
PITTSFORD, NY 14534-1737

JOHN DOE
ACTIVE

DOB: 02/25/1932 DOD: 12/04/2009
Age: 77 Sex: MALE
State: TN (44) County: SEVIER (770)

Payment/Adjustment Detail (M215) User: Role: MCO REPRESENTATIVE Date: 2/22/2018 Close Print Help...

Export to Excel

Payments/Adjustment Table - Contract# H4461

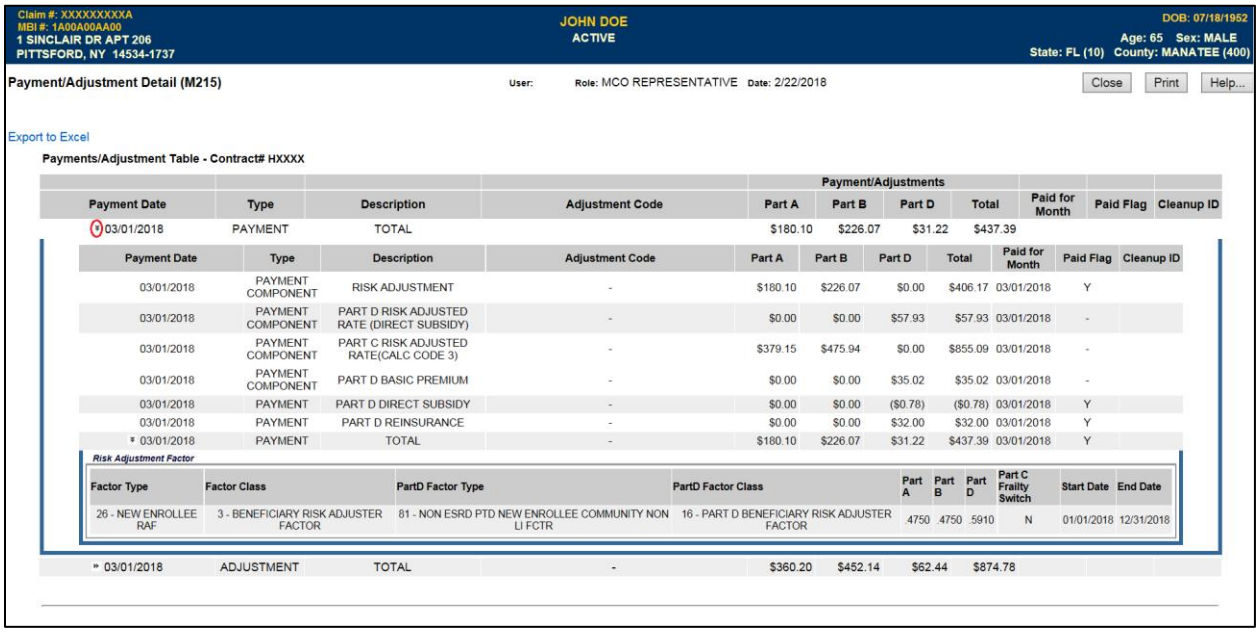
Rebate for Part D Premium reduction is in the A and B columns. It is reflected correctly in the total Part D payments.

Payment Date	Type	Description	Adjustment Code	Payment/Adjustments Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
» 08/01/2009	PAYMENT	TOTAL		$551.58	$483.29	$78.78	$1,113.65			
▾ 08/01/2009	ADJUSTMENT	TOTAL	-	$3,710.88	$3,453.00	$114.60	$7,278.48			

Payment Date	Type	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
08/01/2009	ADJUSTMENT	TOTAL	25-PART C RISK ADJ FACTOR CHANGE/RECON	$3,710.88	$3,453.00	$0.00	$7,163.88			
08/01/2009	ADJUSTMENT	TOTAL	37-PART D RISK ADJUSTMENT FACTOR CHANGE	$0.00	$0.00	$114.60	$114.60			

View the Payment/Adjustment Detail Screen with Display of RAF

Figure 8-33: Payment/Adjustment Detail (M215) Screen Display of RAF



Claim #: XXXXXXXXA
MBI #: 1A00A00AA00
1 SINCLAIR DR APT 206
PITTSFORD, NY 14534-1737

JOHN DOE
ACTIVE

DOB: 07/18/1952
Age: 65 Sex: MALE
State: FL (10) County: MANATEE (400)

Payment/Adjustment Detail (M215) User: Role: MCO REPRESENTATIVE Date: 2/22/2018 Close Print Help...

Export to Excel

Payments/Adjustment Table - Contract# HXXXX

Payment Date	Type	Description	Adjustment Code	Payment/Adjustments Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
▾ 03/01/2018	PAYMENT	TOTAL		$180.10	$226.07	$31.22	$437.39			

Payment Date	Type	Description	Adjustment Code	Part A	Part B	Part D	Total	Paid for Month	Paid Flag	Cleanup ID
03/01/2018	PAYMENT COMPONENT	RISK ADJUSTMENT	-	$180.10	$226.07	$0.00	$406.17	03/01/2018	Y	
03/01/2018	PAYMENT COMPONENT	PART D RISK ADJUSTED RATE (DIRECT SUBSIDY)	-	$0.00	$0.00	$57.93	$57.93	03/01/2018	-	
03/01/2018	PAYMENT COMPONENT	PART C RISK ADJUSTED RATE(CALC CODE 3)	-	$379.15	$475.94	$0.00	$855.09	03/01/2018	-	
03/01/2018	PAYMENT COMPONENT	PART D BASIC PREMIUM	-	$0.00	$0.00	$35.02	$35.02	03/01/2018	-	
03/01/2018	PAYMENT	PART D DIRECT SUBSIDY	-	$0.00	$0.00	($0.78)	($0.78)	03/01/2018	Y	
03/01/2018	PAYMENT	PART D REINSURANCE	-	$0.00	$0.00	$32.00	$32.00	03/01/2018	Y	
▾ 03/01/2018	PAYMENT	TOTAL	-	$180.10	$226.07	$31.22	$437.39	03/01/2018	Y	

Risk Adjustment Factor

Factor Type	Factor Class	PartD Factor Type	PartD Factor Class	Part A	Part B	Part D	Part C Frailty Switch	Start Date	End Date
26 - NEW ENROLLEE RAF	3 - BENEFICIARY RISK ADJUSTER FACTOR	81 - NON ESRD PTD NEW ENROLLEE COMMUNITY NON LI FCTR	16 - PART D BENEFICIARY RISK ADJUSTER FACTOR	.4750	.4750	.5910	N	01/01/2018	12/31/2018

» 03/01/2018	ADJUSTMENT	TOTAL	-	$360.20	$452.14	$62.44	$874.78			

8.3.9 View Beneficiary Premium Information

The premium information includes the history of basic premiums paid by the beneficiary, the penalty for late enrollment added to the premiums, and the subsidies paid by the Government that reduce the premiums.

View the Beneficiary Detail: Premiums View (M231) Screen

To access the *Beneficiary Detail: Premiums View (M231)* screen, the user clicks on the |Premiums| menu item. When the beneficiary enrolls in two contracts; one for Part A and/or Part B and the other for Part D, two rows for the same month are displayed.

The *Beneficiary Detail: Premiums View (M231)* screen displays a list of premium information. Information for the contracts in which the beneficiary was enrolled that month is displayed. The Late Enrollment Penalty (LEP) is displayed on the screen in three (3) columns:

- Direct Bill LEP Amount – The monthly LEP amount that the Plan is required to collect directly from the beneficiary.
- PW LEP Amount – The monthly LEP amount that SSA or RRB withholds from the beneficiary's benefit.
- Total LEP Amount – The Direct Bill LEP Amount plus PW LEP Amount.

Special note: Users with update capabilities will also see an "Update" button available on the M231 screen. Users without update capabilities will not see this button when viewing the screen.

Figure 8-34: Beneficiary Detail: Premiums View (M231) Screen

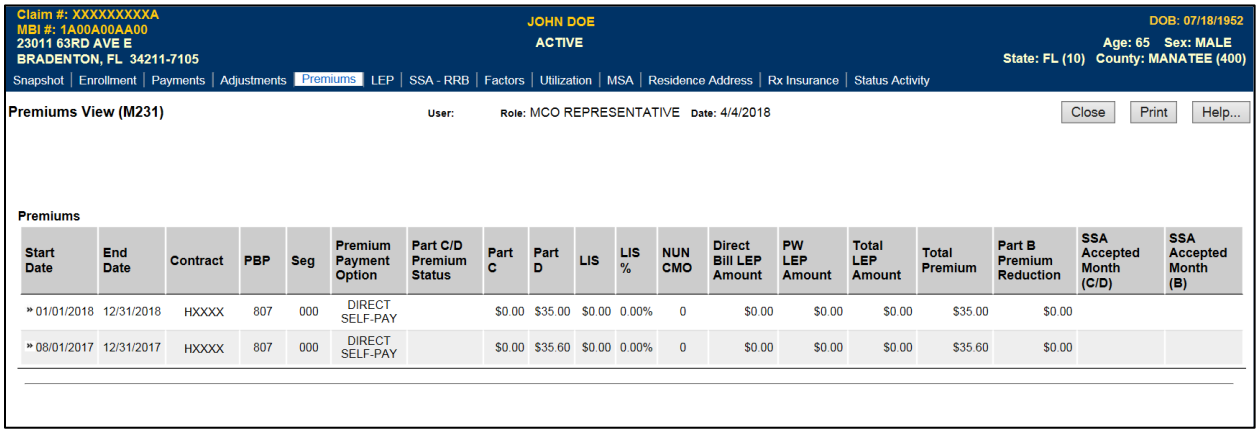


Table 8-17: Beneficiary Detail: Premiums View (M231) Field Descriptions

Beneficiary Detail: Premiums View (M231) Field Descriptions		
Item	**Input/Output**	**Description**
Search Criteria		
Payment Month	Input (Required)	Enter a month and year in the format (M)M/CCYY. This date defaults to the CPM when the screen is initially opened.
Find	Button	Displays premium information associated with the Payment Month entered.
Reset	Button	Resets the entered date to the CPM.

Beneficiary Detail: Premiums View (M231) Field Descriptions		
Item	**Input/Output**	**Description**
Premiums		
[>>]	Button	Displays additional details about the premium in a dropdown below the premium line.
[▼] [▼]	Button	Selecting this closes the already opened dropdown premium detail information view.
Start Date	Output	When the period for this row's premium began.
End Date	Output	When the period for this row's premium ended.
Contract	Output	Contract for which premiums were charged.
PBP	Output	PBP for which premiums were charged.
Seg	Output	Segment for which premiums were charged.
Premium Payment Option (PPO)	Output	The PPO that the beneficiary chose for paying the premiums; Direct Self Pay or Withholding from one of the withholding agencies (SSA or RRB).
Part C/D Premium Status	Output	'Accepted' – the withhold agency has accepted the PPO for the premium period 'Pending' – the withhold agency has not accepted the current PPO for the premium period and there was a previously accepted PPO for the premium period 'Confirmed' – the PPO matches the SSA BRI data Blank – Any premium period that cannot be identified as Accepted, Pending or Confirmed.
Part C	Output	Part C premium for the beneficiary for this period.
Part D	Output	Part D premium for the beneficiary for this period.
LIS	Output	Low-Income Subsidy - Amount of Part D premiums that were subsidized due to the beneficiary's low-income status.
LIS %	Output	Percentage level for the Part D premium subsidy due to the beneficiary's low-income status.
NUNCMO	Output	Number of months during which the beneficiary did not have creditable drug insurance coverage associated with this premium period.
Direct Bill LEP Amount	Output	Direct Bill LEP Amount - The monthly LEP amount that the Plan is required to collect directly from the beneficiary.
PW LEP Amount	Output	PW LEP Amount – The monthly LEP amount that SSA or RRB withholds from the beneficiary's benefit
Total LEP Amount	Output	The Direct Bill LEP amount plus the PW LEP Amount
Total Premium	Output	Total premium charged for Parts C and/or D, as applicable, taking into account subsidies and penalties.
Part B Premium Reduction	Output	Total Part B premium reduction, as applicable.
SSA Accepted Month (C/D)	Link	Date Parts C and/or D premium withholding request accepted by SSA. If the beneficiary did not request withholding from SSA or if the request was rejected, field is blank. Selecting this link displays the *Beneficiary Detail: Premium Withhold Transactions (M237)* screen, which shows the Parts C and/or D Premium Withhold Transactions accepted by SSA for specific premium period.
SSA Accepted Month (B)	Link	Date Part B premium reduction transaction accepted by SSA. If Part B premium reduction does not apply to beneficiary or if transaction rejected by SSA, field is blank. Selecting this link displays the *Beneficiary Detail: Premium Withhold Transactions (M237)* screen, which shows the Part B Reduction Premium Withhold Transactions accepted by SSA for specific premium period.

Beneficiary Detail: Premiums View (M231) Field Descriptions		
Item	**Input/Output**	**Description**
Premium Details This section displays when the premium line dropdown arrow is selected. It shows additional details for the line.		
Creation Date	Output	Date on which the transaction is sent to SSA.
De Minimis	Output	De Minimis amount that was applied to this premium.
Part D Net of De Minimis	Output	The Part D premium amount adjusted for De Minimis.
LEP Subsidy	Output	Amount of the LEP that was subsidized.

8.3.10 View Late Enrollment Penalty (LEP) Information

View the LEP (M258) Screen

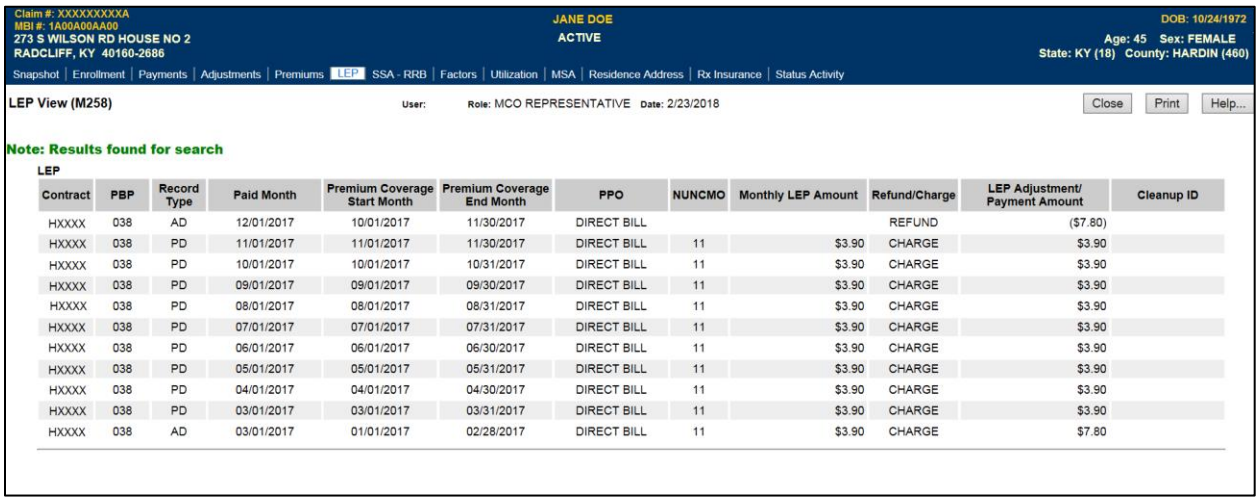
The *LEP View (M258)* screen displays information for direct bill and Social Security Administration (SSA)/Railroad Retirement Board (RRB) withholding status, including all LEP details related to premium periods and the beneficiary's entire LEP history.

Note: If more than 1,000 LEP records exist for a beneficiary, only the latest 1,000 records will be displayed on the *LEP View (M258)* screen.

The LEP records are sorted by:

- Contract number.
- PBP number.
- Segment number.
- HICN.
- Premium/Adjustment Period Start – End Date.
- Prospective record.
- Adjustment record.
- Harm detail record.

Figure 8-35: LEP View (M258) Screen



Contract	PBP	Record Type	Paid Month	Premium Coverage Start Month	Premium Coverage End Month	PPO	NUNCMO	Monthly LEP Amount	Refund/Charge	LEP Adjustment/ Payment Amount	Cleanup ID
HXXXX	038	AD	12/01/2017	10/01/2017	11/30/2017	DIRECT BILL			REFUND	($7.80)	
HXXXX	038	PD	11/01/2017	11/01/2017	11/30/2017	DIRECT BILL	11	$3.90	CHARGE	$3.90	
HXXXX	038	PD	10/01/2017	10/01/2017	10/31/2017	DIRECT BILL	11	$3.90	CHARGE	$3.90	
HXXXX	038	PD	09/01/2017	09/01/2017	09/30/2017	DIRECT BILL	11	$3.90	CHARGE	$3.90	
HXXXX	038	PD	08/01/2017	08/01/2017	08/31/2017	DIRECT BILL	11	$3.90	CHARGE	$3.90	
HXXXX	038	PD	07/01/2017	07/01/2017	07/31/2017	DIRECT BILL	11	$3.90	CHARGE	$3.90	
HXXXX	038	PD	06/01/2017	06/01/2017	06/30/2017	DIRECT BILL	11	$3.90	CHARGE	$3.90	
HXXXX	038	PD	05/01/2017	05/01/2017	05/31/2017	DIRECT BILL	11	$3.90	CHARGE	$3.90	
HXXXX	038	PD	04/01/2017	04/01/2017	04/30/2017	DIRECT BILL	11	$3.90	CHARGE	$3.90	
HXXXX	038	PD	03/01/2017	03/01/2017	03/31/2017	DIRECT BILL	11	$3.90	CHARGE	$3.90	
HXXXX	038	AD	03/01/2017	01/01/2017	02/28/2017	DIRECT BILL	11	$3.90	CHARGE	$7.80	

This screen data cannot be modified or updated, therefore only one screen message is generated when no data is found for the specified beneficiary.

Table 8-18: LEP View (M258) Field Descriptions

LEP View (M258) Field Descriptions		
Item	**Type**	**Description**
[Update]	Button	Displays the *Update Enrollment (M212)* screen, which also provides access to the following screens: *Update Institutional/NHC (M213).* *Update Medicaid (M214).* *Update Premiums (M226).* *Update Rx Insurance (M228).* The [Update] button does not show for the MCO Representative.
[Change User View]	Button	Displays the *User Security Role Selection (M002)* screen where users can mirror the view of another role. The [Change User View] button does not show for the MCO user.
Contract	Output	The Plan contract number under which the beneficiary was insured when the LEP transaction occurred.
PBP	Output	The Plan contract PBP number under which the beneficiary was insured when the LEP transaction occurred.
Record Type	Output	A 2-character code to describe the type of LEP record: PD (Prospective Detail Record) AD (Adjustment Detail Record) HD (Harm Detail Record)
Paid Month	Output	The LEP paid month and year in this format: MM/CCYY.
Premium Coverage Start Month	Output	The month and year premium coverage started in this format: MM/CCYY.
Premium Coverage End Month	Output	The month and year premium coverage ended in this format: MM/CCYY.
PPO	Output	This field designates the premium payment option as either: Direct Bill Withhold
NUNCMO	Output	Number of months during which the beneficiary is not covered by drug insurance.
Monthly LEP Amount	Output	This field displays the LEP amount monthly charged for the beneficiary.
Refund/Charge	Output	This field designates either the charge incurred for paid records or a refund when overpaid: CHARGE for positive amounts REFUND for negative amounts
LEP Adjustment/Payment Amount	Output	This field displays the LEP adjustment or payment amount.
Cleanup ID	Output	This field displays the cleanup ID.

8.3.11 View Beneficiary Premium Withhold Transactions

SSA/RRB Transaction Status (M237) screen displays the SSA/RRB processing status for the Part C/Part D premium withhold and Part B Premium Reduction transactions sent by CMS to SSA and RRB for a specific beneficiary with premium year range. Four separate views display SSA and RRB transactions:

- SSA Part C/Part D Premium Withhold.
- RRB Part C/Part D Premium Withhold.
- SSA/RRB Part B Premium Reduction.
- All SSA-RRB.

These views display whether or not SSA or RRB accepts or rejects the transaction.

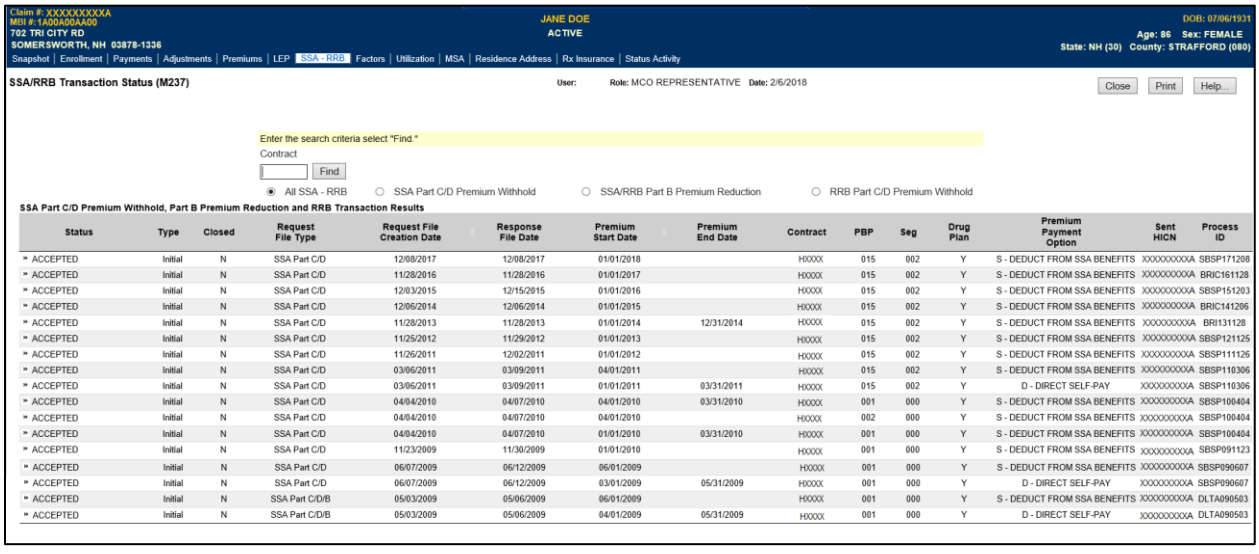
View the Beneficiary Detail: SSA/RRB Transaction Status (M237) Screen

To access the *SSA/RRB Transaction Status (M237)* screen, click on the |SSA - RRB| menu item. This displays 'All SSA-RRB' view, which provides the following Request File Type of premium withhold transactions:

- SSA Part C/Part D.
- RRB Part C/Part D.
- Historical SSA C/D/B.

By clicking the chevron (>>) to the left of the Status column, more detail transactions display, as described in the next table.

Figure 8-36: SSA/RRB Transaction Status (M237) Screen



Note: For Facilitated Direct Bill (FDB) transactions only SSA Status, Transaction Type, SSA Sent date, SSA Response File Date, and Premium Withhold Option are displayed.

Table 8-19: SSA/RRB Transaction Status (M237) Screen Transaction Details Dropdown Inputs, Outputs, and Actions

SSA/RRB Transaction Status (M237) Screen Transaction Details Dropdown Inputs, Outputs, and Actions		
Item	**Type**	**Description**
[>>]	Button	The user clicks on this button on a particular transaction status row to display dropdown premium detail transaction information view.
[^] [^]	Button	The user clicks on this button on a particular transaction status row to close the already opened dropdown premium detail transaction information view.
Reason For Reject column	Output	Reason for SSA or RRB reject of the transaction. Shown only for rejected transaction.
Part C Premium column	Output	This displays for SSA/RRB Part C/ Part D Premium Withhold; cost charged by Plan to beneficiary for Part C coverage.
Part D Premium column	Output	This displays for SSA/RRB Part C/ Part D Premium Withhold; cost to beneficiary for Basic Part D coverage.
Part D Enhanced Premium column	Output	This displays for SSA/RRB Part C and Part D Premium Withhold Cost to beneficiary for additional Part D coverage not included in the Basic coverage.
LEP column	Output	This displays for SSA/RRB Part C/ Part D Premium Withhold – Penalty charged to beneficiary for late enrollment in Part D coverage.
LEP Subsidy column	Output	This displays for SSA/RRB Part C/ Part D Premium Withhold; amount of the LEP that was subsidized.
LIS Column	Output	This displays for SSA/RRB Part C, Part D Premium Withhold; amount of Part D premiums that were subsidized by the government LIS.

Table 8-20: SSA/RRB Transaction Status (M237) Field Descriptions

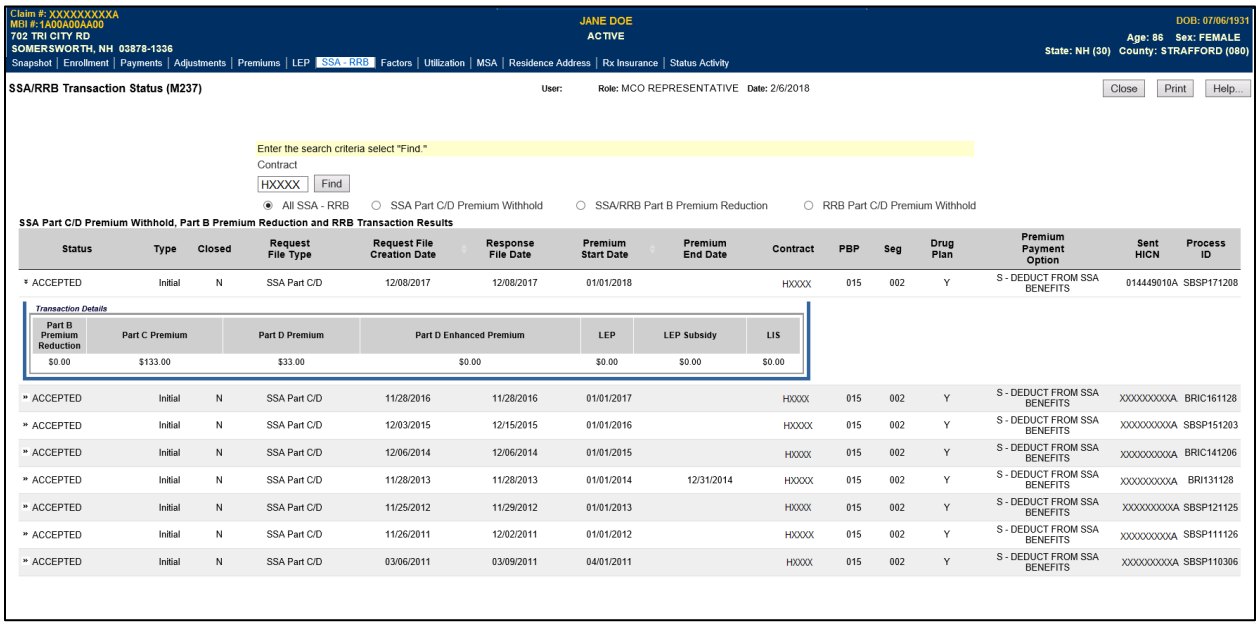
SSA/RRB Transaction Status (M237) Field Descriptions		
Item	**Input/Output**	**Description**
Premium Start Year	Optional data entry field	The user enters year in the form CCYY.
Premium End Year	Optional data entry field	The user enters year in the form CCYY.
Contract	Optional data entry field	The user enters a valid contract number
[Find]	Button	The user clicks on this button to display premium transaction information for the search criteria.
Status column	Output	SSA/RRB Transaction Status is shown as Accepted for an accepted transaction and Rejected for a rejected transaction.

SSA/RRB Transaction Status (M237) Field Descriptions		
Item	**Input/Output**	**Description**
Type column	Output	Transaction Type (Initial, Retry or FDB): **Initial** – (for both SSA and RRB) – indicates a first submission of a Premium Withhold transaction from CMS to SSA or RRB. The transaction is accepted or rejected. The rejection is because of a mismatch in demographic information between CMS and SSA or because of a new enrollment for which SSA does not yet have information. **Retry** – (for SSA only) – Indicates a transaction transmitted to SSA after the first submission was rejected by SSA. The transaction is accepted or rejected by SSA. Transactions that are rejected by SSA in 'retry' are resubmitted to SSA as a Facilitated Direct Bill (FDB) transaction. Prior Year Transaction rejects are not submitted for FDB. **FDB** – (for SSA only) – indicates a transaction was transmitted to SSA after the second attempt was rejected by SSA. The FDB transaction is accepted or rejected by SSA.
Closed	Output	Transaction Closed indicator. Shown as 'Y' for closed transactions.
Request File Creation Date column heading	Sorter	For SSA: sorts the results by SSA sent date. For RRB: sorts the results in order by Response File Creation Date, Response File Date, and Premium Start Date. Rows are sorted in ascending order by default and the order is switched between ascending and descending by clicking on column heading.
Request File Creation Date column	Output	Date transaction is sent to SSA or RRB.
Response File Date column	Output	Date on which response is received from SSA or RRB Header date on SSA Response File, date that RRB Reply File is processed.
Premium Start Date column heading	Sorter	Sorts the results by Premium Start Date Rows are sorted in ascending order by default and the order is switched between ascending and descending by clicking on column heading.
Premium Start Date column	Output	When the premium charge began.
Premium End Date column	Output	When the premium charge ended.
Contract column	Output	Contract for which premiums were charged.
PBP column	Output	PBP for which premiums were charged.
Segment Column	Output	Segment for which premiums were charged.
Drug Plan	Output	Only SSA or RRB Part C, Part D Premium Withhold. Indicates whether each contract/PBP provides drug insurance coverage. Set to Y or N.
Premium Withholding Option column	Output	Option that the beneficiary chose for paying the premiums.

SSA/RRB Transaction Status (M237) Field Descriptions		
Item	**Input/Output**	**Description**
Part B Premium Reduction column	Output	This displays the Part B premium reduction amount for SSA C/D/B types; this view only.

Additional filter options are available when you want to only display one contract at a time.

Figure 8-37: SSA/RRB Transaction Status (M237) Screen for All RRB Transaction Options



8.3.12 View Beneficiary Factors

View the Beneficiary Detail: Factors View (M220) Screen

This screen displays the factors used to calculate payments made for the beneficiary while enrolled in any of the user's contracts.

To access the *Beneficiary Detail: Factors View (M220)* screen, the user clicks on the |Factors| menu item. This displays a screen that provides the factors used to calculate payments.

Figure 8-38: Beneficiary Detail: Factors View (M220) Screen

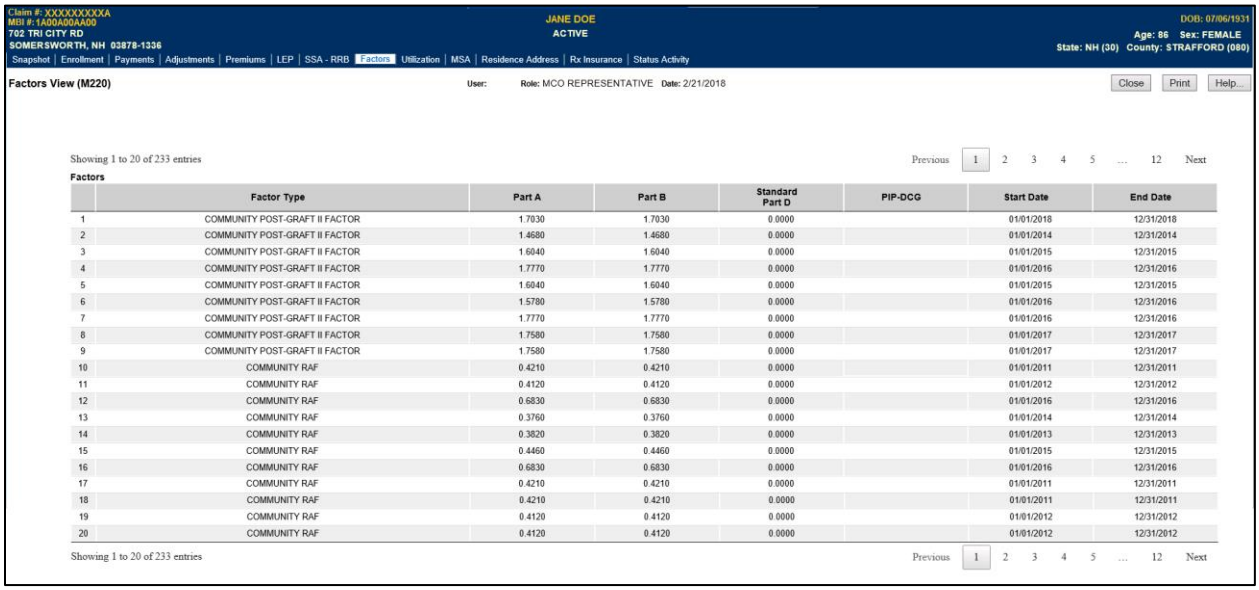


Table 8-21: Beneficiary Detail: Factors View (M220) Field Descriptions

Beneficiary Detail: Factors View (M220) Field Descriptions		
Item	**Input/Output**	**Description**
Factor Type column	Output	Type of factor calculated for the beneficiary, such as CHF.
Part A column	Output	Part A factor calculated for the beneficiary for the factor type shown.
Part B column	Output	Part B factor calculated for the beneficiary for the factor type shown.
Standard Part D	Output	Part D factor calculated for the beneficiary for the factor type shown.
PIP-DCG column	Output	Principal Inpatient Diagnosis Cost Group (PIP-DCG) score calculated for the beneficiary.
Start Date column	Output	First day the factors were effective.
End Date column	Output	Last day the factors were effective.

8.3.13 View Beneficiary Utilization

The beneficiary's utilization information indicates the beneficiary's use of Medicare, including home health care, billings, deductibles, remaining days of coverage, and additional coverage by Medicaid. When a beneficiary's Medicare coverage is under different claim numbers, these numbers are listed.

View the Beneficiary Detail: Utilization (M233) Screen

To access the *Beneficiary Detail: Utilization (M233)* screen, the user clicks on the |Utilization| menu item.

Figure 8-39: Beneficiary Detail: Utilization (M233) Screen

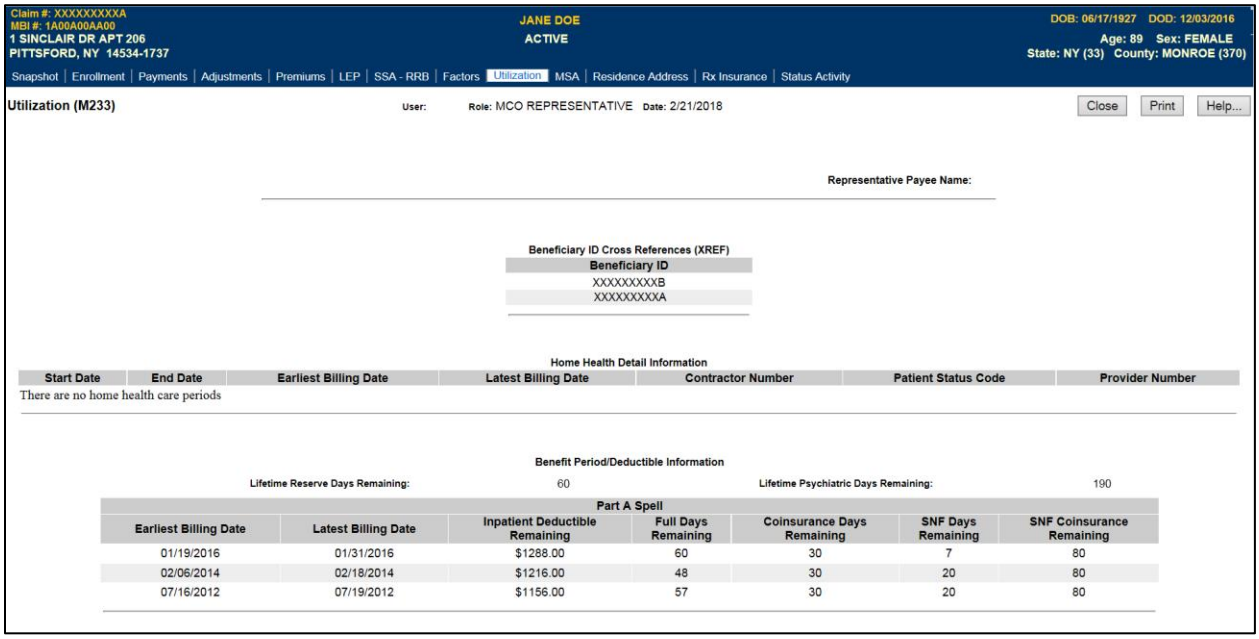


Table 8-22: Beneficiary Detail: Utilization (M233) Field Descriptions

Beneficiary Detail: Utilization (M233) Field Descriptions		
Item	**Input/Output**	**Description**
Representative Payee Name	Output	Name of most recent representative for payment.
History of Beneficiary ID Cross References (XREF)		
Beneficiary ID column	Output	Beneficiary ID previously used by the beneficiary.
History of Home Health Care Information		
Start Date column	Output	Start of home health care period.
End Date column	Output	End of home health care period.
Earliest Billing Date column	Output	When billing began for this home health care period.
Latest Billing Date column	Output	When last bill was sent for this home health care period.

Beneficiary Detail: Utilization (M233) Field Descriptions		
Item	**Input/Output**	**Description**
Contractor Number column	Output	Identifier of contractor for this home health care period.
Patient Status Code column	Output	Status of home health care for this home health care period.
Provider Number column	Output	Identifier of home health care provider for this home health care period.
History of Benefit Period/Deductible Information		
Lifetime Reserve Days Remaining	Output	Remaining reserve days left which Medicare will pay over beneficiary's lifetime.
Lifetime Psychiatric Days Remaining	Output	Remaining days of psychiatric care coverage.
Earliest Billing Date column	Output	When billing began for this benefit period.
Latest Billing Date column	Output	When last bill was sent for this benefit period.
Patient Deductible Remaining column	Output	Deductible balance for inpatient, e.g., hospital care that is remaining in the benefit period.
Full Days Remaining column	Output	Number of full days of inpatient care that are remaining in the benefit period.
Coinsurance Days Remaining column	Output	Number of coinsurance covered days of inpatient that are remaining in the benefit period.
Skilled Nursing Facilities (SNF) Days Remaining	Output	Number of days of SNF remaining in the benefit period.
SNF Coinsurance Remaining	Output	Number of coinsurance covered days of SNF remaining in the benefit period.

8.3.14 View Beneficiary Medical Savings Account (MSA) Lump Sum

The beneficiary's MSA Lump Sum screen indicates the MSA enrollment and payment information effective January 1, 2008.

View the Beneficiary Detail: MSA Lump Sum View (M235) Screen

To access the *Beneficiary Detail: MSA Lump Sum View (M235)* screen, the user clicks on the |MSA| menu item.

Figure 8-40: Beneficiary Detail: MSA Lump Sum View (M235) Screen

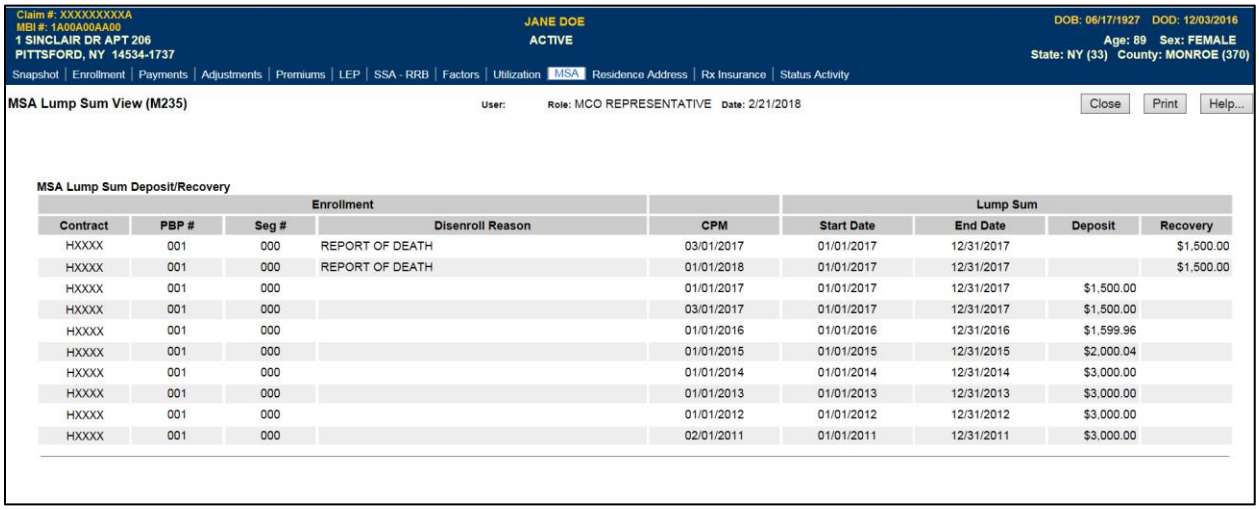


Table 8-23: Beneficiary Detail: MSA Lump Sum View (M235) Field Descriptions

Beneficiary Detail: MSA Lump Sum View (M235) Field Descriptions		
Item	**Input/Output**	**Description**
Search Criteria		
Year	Required data entry field	The user enters a year in the form CCYY.
[Find]	Button	The user clicks on this button to display MSA Lump Sum information in the lower portion of the screen.
MSA Lump Sum Deposit/Recovery		
Contract column	Output	Contracts for MSA Lump Sum record
PBP column	Output	PBPs for MSA Lump Sum record
Segment column	Output	Segments for MSA Lump Sum record
Disenroll Reason	Output	Description of the disenroll reason for MSA
Current Processing Month	Output	Current Processing Month for MSA Lump Sum record
Start Date	Output	Start date for Lump Sum
End Date	Output	End date for Lump Sum
Deposit	Output	Lump Sum deposit dollar amount
Recovery	Output	Lump Sum recovery dollar amount

8.3.15 View Beneficiary Rx Insurance

View the Rx Insurance for a Beneficiary (M244) Screen

A Plan can use the *Rx Insurance View (M244)* screen to view the Rx insurance history, both primary and secondary, for beneficiaries enrolled in their Plans. The screen displays the beneficiary's 4Rx information as it has changed over time. The Plan only sees 4Rx information for periods during which the beneficiary is enrolled in any of their Part D Plans.

Special note: Users with update capabilities will also see an "Update" button available on the M244 screen. Users without update capabilities will not see this button when viewing the screen.

To access the *Rx Insurance View (M244)* screen, select the |Rx Insurance| tab.

Figure 8-41: Rx Insurance View (M244) Screen

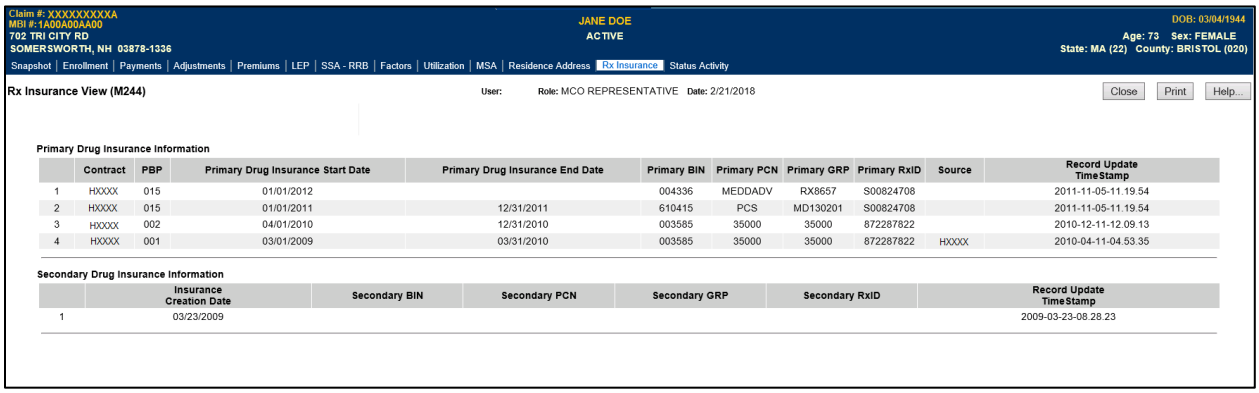


Table 8-24: Rx Insurance View (M244) Field Descriptions

Rx Insurance View (M244) Field Descriptions		
Item	**Input/Output**	**Description**
Primary Drug Insurance Information This section contains one line for each period during which the beneficiary had a unique combination of Contract, PBP and Primary 4Rx information.		
Contract	Output	The contract for the applicable period.
PBP #	Output	The PBP for the applicable period.
Primary Drug Insurance Start Date	Output	Start date for Primary 4Rx information on this line.
Primary Drug Insurance End Date	Output	End date for the Primary 4Rx information on this line.
Primary BIN	Output	Part D insurance Plan's BIN for the primary contract, PBP, and period specified.
Primary PCN	Output	Part D insurance Plan's PCN for the primary contract, PBP, and period specified.
Primary GRP	Output	Part D insurance Plan's group number for the primary contract, PBP, and period specified.
Primary RxID	Output	Identifier assigned to the beneficiary by the primary Part D insurance Plan for drug coverage.

Rx Insurance View (M244) Field Descriptions		
Item	**Input/Output**	**Description**
Source	Output	Source of the enrollment into the contract and PBP for the period specified.
Record Update Timestamp	Output	Date that this Rx insurance information was added or updated.
Secondary Drug Insurance Information This section contains one line for each period during which the beneficiary had a unique combination of Contract, PBP and Secondary 4Rx information.		
Insurance Creation Date	Output	Date that was reported for the initiation of this secondary insurance period.
Secondary BIN	Output	Secondary drug insurance Plan's BIN number.
Secondary PCN	Output	Secondary drug insurance Plan's PCN number.
Secondary GRP	Output	Identifier for the group providing secondary drug insurance coverage.
Secondary RxID	Output	Identifier assigned to the beneficiary by the secondary drug insurance.
Record Update Timestamp	Output	Date this row was added or updated.

8.3.16 *Status Activity (M256)*

The *Status Activity (M256)* screen displays a beneficiary's current health status information, as well as current values for eligibility, uncovered months, low income subsidy, not lawfully present status, and state and county codes.

The following special status categories display on the screen:

- SSA State and County Codes.
- Low Income Subsidy.
- Number of Uncovered Months.
- Health Status Flags (ESRD, MSP, Home Community Based Services (HCBS), Medicaid, etc.).
- Eligibility Status Flags (Part A, Part B, and Part D).
- Incarceration.
- Not Lawfully Present.
- Employer Subsidy.
- Innovation Center (IC) Model Status.
- Opt-Out Part D.
- Opt-Out MMP.

View the Status Activity Screen (M256)

Figure 8-42: Status Activity (M256) Screen

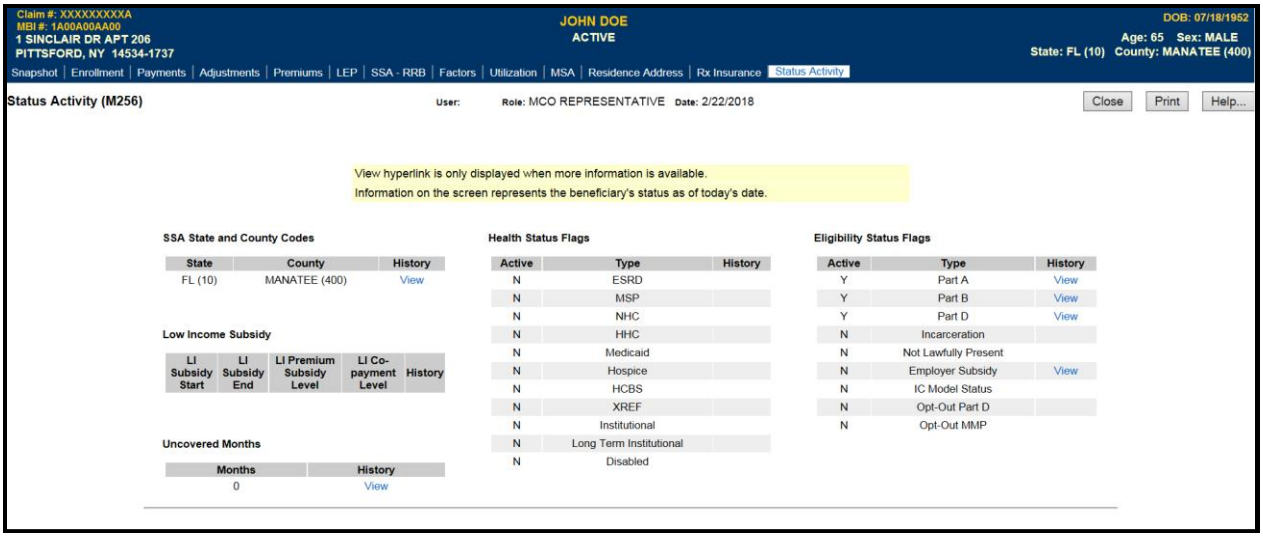


Table 8-25: Status Activity (M256) Field Descriptions

Status Activity (M256) Field Descriptions		
Item	**Type**	**Description**
[Close]	Button	Click this button to exit the active window.
[Update]	Button	Displays the *Update Enrollment (M212)* screen, which also provides access to the following screens: Update Institutional/NHC (M213) screen Update Medicaid (M214) screen Update Premiums (M226) screen Update Rx Insurance (M228) screen Update Beneficiary Enrollment Information Updating Institutional/NHC Information for a Beneficiary Updating Medicaid Information for a Beneficiary Updating Premium Information for a Beneficiary Updating Rx Insurance Information for a Beneficiary Updating the Premium Withhold Collection Detail Records for a Beneficiary
[Change User View]	Button	Displays the *Change User View (M002)* screen where users can mirror the view of another role.
SSA State and County Codes-State	Output	Current state of residence abbreviation and number as provided by SSA.
SSA State and County Codes-County	Output	Current county of residence abbreviation and number as provided by SSA.
SSA State and County Codes-History	Link	View link appears for user to access the *Status Detail: [status category] (M257)* screen, when detailed information exists for a specific beneficiary's status. Otherwise, this field is blank.
Health Status Flags-Active	Output	A yes or no indicator to show that the status is either active or audit information for the beneficiary as of today. Y = status active. N = status is not active.
Health Status Flags-Type	Output	Current health status information for these special status subcategories: • ESRD (End Stage Renal Disease) • MSP (Medicare Secondary Payer) • NHC (Nursing Home Certifiable) • HHC (Home Health Care) • Medicaid • Hospice • HCBS (Home and Community Based Services) • XREF (Cross Reference) • Institutional • Long Term Institutional • Disabled

Status Activity (M256) Field Descriptions		
Item	**Type**	**Description**
Health Status Flags-History	Output	View link appears for user to access the *Status Detail: [status category] (M257)* screen, when detailed information exists for a specific beneficiary's status. Otherwise, this field is blank.
Eligibility Status Flags-Active	Output	A yes or no indicator to show that the status is either active or audit information for the beneficiary as of today. Y = status active. N = status is not active.
Eligibility Status Flags-Type	Output	Current active or audit eligibility status listed for each of these eligibility subcategories: • Part A • Part B • Part D • Incarceration • Employer Subsidy • Opt-Out Part D • Opt-Out MMP • Not Lawfully Present • Employer Subsidy • IC Model Status • Opt-Out Part D • Opt-Out MMP
Eligibility Status Flags-History	Output	View link appears for user to access the *Status Detail: [status category] (M257)* screen, when detailed information exists for an eligibility type. Otherwise, this field is blank.
Low Income Subsidy-LI Subsidy Start	Output	The effective date (MM/DD/CCYY) when this LIS event began.
Low Income Subsidy-LI Subsidy End	Output	The effective date (MM/DD/CCYY) when this LIS event stopped.
Low Income Subsidy-LI Premium Subsidy Level	Output	Percentage of LI subsidy for this LIS event, expressed as ###%.
Low Income Subsidy-Co-payment Level	Output	The number to indicate the co-payment level assigned to the beneficiary.
Low Income Subsidy-History	Link	View link appears for user to access the *Status Detail: [status category] (M257)* screen, when detailed information exists for an eligibility type. Otherwise, this field is blank.
Uncovered Months-Months	Output	The current and cumulative total number of months that a beneficiary was without creditable coverage.
Uncovered Months-History	Link	View link appears for user to access the *Status Detail: [status category] (M257)* screen, when detailed information exists for an eligibility type. Otherwise, this field is blank.

8.3.17 View MCO Payment Information

Total payments to MCOs are calculated as part of month-end processing. This section describes how to view the MCO payment information. These payment amounts are based on the beneficiary capitation amounts and may differ from the actual payment to the MCO due to contract-level payment adjustments, such as the Balanced Budget Act (BBA) User Fee adjustment. For the Current Payment Month, the payments reflect the transactions processed to date.

Access the Payments: MCO (M401) Screen

From the main menu, the user clicks on the |Payments| menu item. The |MCO| submenu item is already selected and displays the *Payments: MCO (M401)* screen.

View payment summary information by MCO

The *Payments: MCO (401)* screen is used for entering selection criteria.

The user enters the month and year for the payments along with the contract number that the user wishes to view. Another option is for the user to break down the payments by PBP. If that option is not selected, the payments for a contract are summarized at the contract level. If breakdown by PBP is selected, contracts without PBPs are included on the display but summarized at the contract level. Similarly, there is an option to break down the payments by segment. If that option is not selected, the payments for a contract are summarized at the contract or PBP level, based on whether the breakdown by PBP option was selected. If breakdown by segment is selected, PBPs without segments are included but summarized at the PBP level. The user clicks on the [Find] button to access the *Payments: MCO Payments (M402)* screen showing all of the contracts that meet the criteria.

Figure 8-43: Payments: MCO (M401) Screen

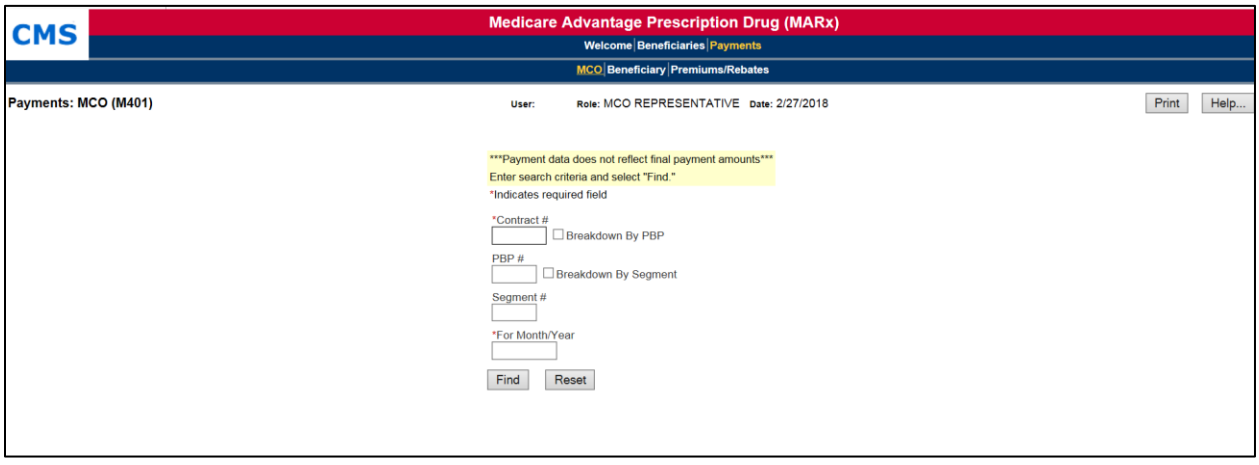


Table 8-26: Payments: MCO (M401) Field Descriptions

Payments: MCO (M401) Field Descriptions		
Item	**Input/Output**	**Description**
Contract #	Required data entry field	Request is for contract. The user enters the contract number.
Breakdown By PBP	Checkbox	If checked, the payment information is listed by PBP within each contract. Otherwise, the payment information is summarized at the contract level. **Note:** When Breakdown By Segment is checked, payments are shown by PBP, whether or not this option is checked.
PBP #	Data entry field	The user may specify a PBP to request the payment information for this PBP only. If a PBP is not entered, then payment information for all PBPs in a contract, if applicable, is displayed, either at the contract or PBP level, depending on whether Breakdown By PBP is checked. The user must specify a contract number when a PBP number is specified.
Breakdown By Segment	Checkbox	If checked, the payment information is listed by segment within the PBP. If not checked, the payment information is summarized at the PBP level when Breakdown by PBP is checked and summarized at the contract level otherwise.
Segment #	Data entry field	The user may specify a segment to request the payment information for this segment only. If a segment is not entered, then payment information for all segments in a PBP, if applicable, are displayed, at the contract, PBP, or segment level, depending on whether Breakdown By PBP and Breakdown by Segment is checked. The user must specify a contract number when a PBP number is specified.
For Month/Year	Required data entry field	Request is for payments made in this month. The user enters the date in the form (M)M/CCYY.
[Find]	Button	After the search criteria are entered, the user clicks on this button to display the list of reports.

Example 1: Multiple contracts and no PBP breakdown

Below is an example of the *Payments: MCO Payments (M402)* screen, which results when only a month/year and contract number are entered on the *Payments: MCO (M401)* screen, PBP is not entered, and Breakdown by PBP is not specified. Note that only the Contracts section is displayed on the screen; the Current Payments and Adjustment Payments sections are displayed in STEP 3. There are no error messages for the initial display of the screen, as any messages are displayed on *Payments: MCO (M401)* screen.

Note: To avoid possible internal server or database manager errors that can result when large Plans submit a query request that takes too long to execute or runs out of resources, it is recommended that users input information in the Contract #, PBP # and the Month/Year fields on the *Payments: MCO (M401)* screen. Once this information is submitted, the *Payments: MCO Payments (M402)* displays and the user can then click on the Contract # to display the details.

Figure 8-44: Payments: MCO Payments (M402) Screen for Single Contract and No PBP or Segment Breakdown (Initial Display, Example 1)

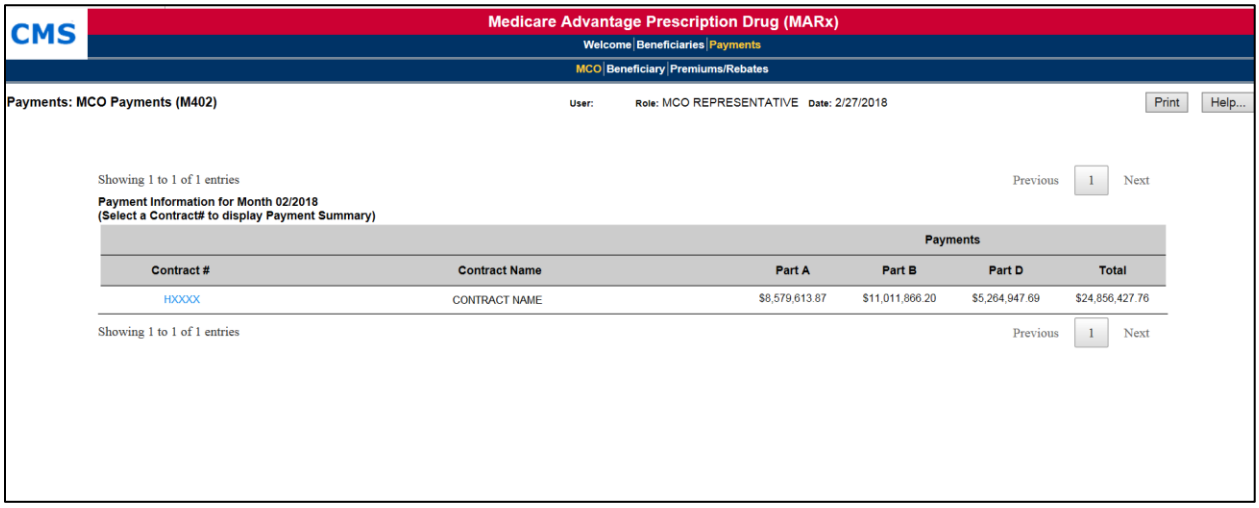


Table 8-27: Payments: MCO Payments (M402) Field Descriptions

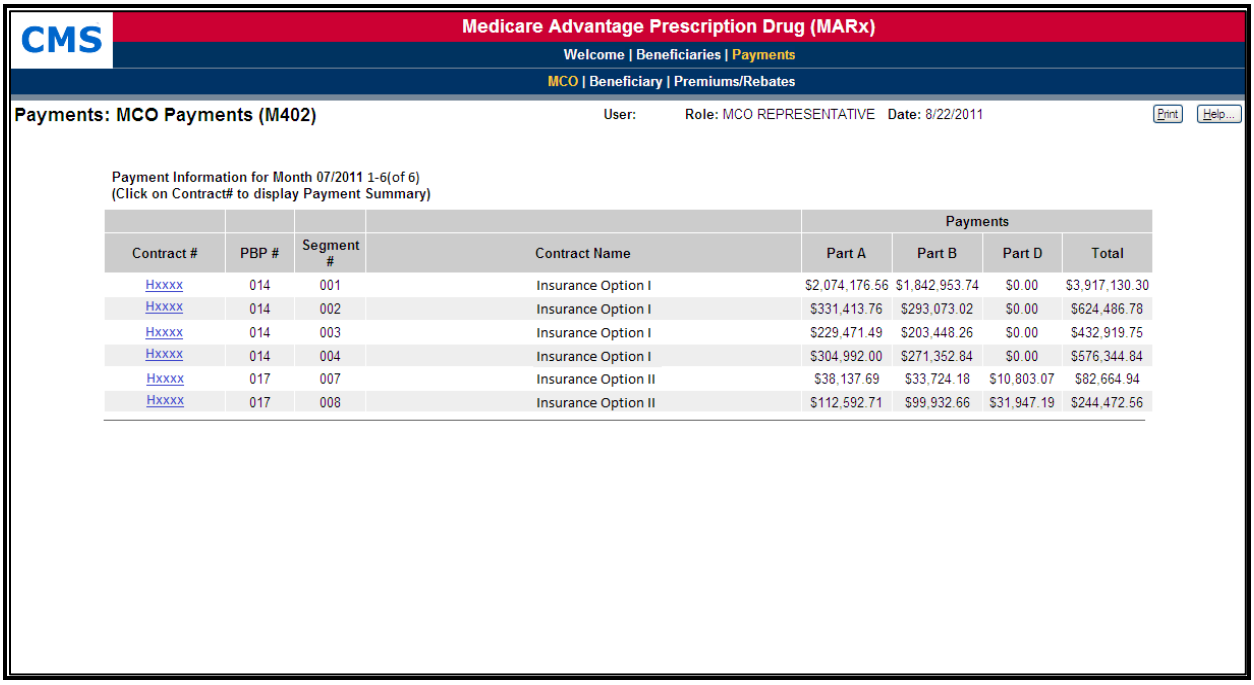
Payments: MCO Payments (M402) Field Descriptions		
Item	**Input/Output**	**Description**
Contracts		
Contract # in the Contract # column	Link	Expands this screen to show the breakdown for the selected contract.
PBP # column	Output	When selected, information displays for this PBP in the contract.
Segment # column	Output	When selected, information displays for this segment in the contract and PBP.
Payments Part A column	Output	Part A payments for the contract.
Payments Part B column	Output	Part B payments for the contract.
Payments Part D column	Output	Part D payments for the contract.
Payments Total column	Output	Part A, Part B, and Part D payment totals for the contract.
Current Payments		
Amount shown in parentheses after Part A Total Payments row heading	Output	Average Part A payment this month.
Amount shown in parentheses after Part B Total Payments row heading	Output	Average Part B payment this month.
Amount shown in parentheses after Part D Total Payments row heading	Output	Average Part D payment this month.
Payments Part A Members column	Output	Number of members in the contract with Part A payments this month; provides total plus breakdown by status.

Payments: MCO Payments (M402) Field Descriptions		
Item	**Input/Output**	**Description**
Payments Part A Total Amount column	Output	Payments and adjustments, for all beneficiaries, in the contract for Part A this month; provides total plus breakdown by status.
Payments Part B Members column	Output	Number of members in the contract with Part B payments this month; provides total plus breakdown by status.
Payments Part B Total Amount column	Output	Payments and adjustments, for all beneficiaries, in the contract for Part B this month; provides total plus breakdown by status.
Payments Part D Members column	Output	Number of members in the contract with Part D payments this month; provides total plus breakdown by status.
Payments Part D Total Amount column	Output	Payments and adjustments, for all beneficiaries, in the contract for Part D this month; provides total plus breakdown by status.
Total Out of Area	Output	Number of beneficiaries living out of the service area for the contract this month.
Adjustment Payments (only displayed if there are any adjustments)		
Code column	Output	Adjustment reason code.
Code in the Code Column	Link	Opens the *Adjustment Detail (M408)* screen to display a breakdown of the adjustments for the contract/PBP and month by beneficiary.
Adjustment Reason column	Output	Description of the adjustment reason code.
# column	Output	Number of adjustments by adjustment reason for the contract this month.
Months A column	Output	Total months over all beneficiaries for which adjustments are made for Part A by adjustment reason.
Months B column	Output	Total months over all beneficiaries for which adjustments are made for Part B by adjustment reason.
Months D column	Output	Total months over all beneficiaries for which adjustments are made for Part D by adjustment reason.
Part A column	Output	Total amount of Part A adjustments by adjustment reason.
Part B column	Output	Total amount of Part B adjustments by adjustment reason.
Part D column	Output	Total amount of Part D adjustments by adjustment reason.
Total Amount column	Output	Total amount of Part A, Part B, and Part D adjustments by adjustment reason.

Example 2: Single Contract with Segment Breakdown

Below is an example of the *Payments: MCO Payments (M402)* screen that results when a contract number is entered and Breakdown by Segment is specified. Only one contract displays and the payments are shown at the Segment level. Only the Contracts section displays on the screen. The inputs, outputs, and actions are described previously in the table above**.**

Figure 8-45: Payments: MCO Payments (M402) Screen for Single Contract and Segment Breakdown (Initial Display, Example 2)



View detailed payment information for a selected MCO

From the *Payments: MCO Payments (M402)* screen, the user finds the contract or contract/PBP that they wish to view. If the list does not fit on the screen, finding the contract/PBP may require scrolling through the list using the screen navigation arrows. The user selects the contract/PBP by clicking on the Contract # link. The following information displays for the selected contract and, when applicable, PBP. The information is shown below the contract summary information:

- Part A, Part B, Part D, and total payments.
- Breakdown by health status, separated into Part A, Part B, and Part D, with both the number of members and the payment amounts.
- Breakdown by adjustment reason, separated into Part A, Part B, and Part D, with both the number of members and the payment amounts. Note that this section of the screen is only included when there are adjustments.

Figure 8-46: Payments: MCO Payments (M402) Screen with Details for MCO

CMS

Medicare Advantage Prescription Drug (MARx)

Welcome | Beneficiaries | Payments

MCO | Beneficiary | Premiums/Rebates

Payments: MCO Payments (M402) User: Role: MCO REPRESENTATIVE Date: 2/27/2018 Print Help...

Showing 1 to 1 of 1 entries Previous 1 Next

Payment Information for Month 02/2018
(Select a Contract# to display Payment Summary)

		Payments			
Contract #	Contract Name	Part A	Part B	Part D	Total
HXXXX	CONTRACT NAME	$18,997,725.26	$23,961,394.51	$7,631,181.05	$50,590,300.82

Showing 1 to 1 of 1 entries Previous 1 Next

Payments to plan HXXXX, CONTRACT NAME for 02/2018

Part A :	$18,997,725.26
Part B :	$23,961,394.51
Part D :	$7,631,181.05
Total :	$50,590,300.82

Current Payments for 02/2018

Part A	Members	Total Amount	Part B	Members	Total Amount	Part D	Members	Total Amount
Total Payments ($339.89)	55893	$18,997,725.26	Total Payments ($428.70)	55893	$23,961,394.51	Total Payments ($136.53)	55893	$7,631,181.05
Total Hospice	146	$6,187.44	Total Hospice	146	$7,769.32	Total Hospice	146	$26,252.88
Total ESRD	260	$650,498.25	Total ESRD	260	$929,727.77	Total ESRD	260	$66,400.03
Total WA	0	$0.00	Total WA	0	$0.00	Total WA	0	$0.00
Total Institutional	0	$0.00	Total Institutional	0	$0.00	Total Institutional	0	$0.00
Total NHC	0	$0.00	Total NHC	0	$0.00	Total NHC	0	$0.00
Total CHF	0	$0.00	Total CHF	0	$0.00	Total CHF	0	$0.00
Total Medicaid	4725	$1,978,883.64	Total Medicaid	4725	$2,484,114.30	Total Medicaid	4725	$1,337,242.75
Total Out of Area	1159							

Adjustment Payments for 02/2018

Code	Adjustment Reason	#	Months A	Months B	Months D	Part A	Part B	Part D	Total Amount
01	NOTIFICATION OF DEATH	201	208	208	208	($83,956.27)	($105,663.20)	($37,763.30)	($227,382.77)
02	RETROACTIVE ENROLLMENT	522	526	526	526	$169,111.91	$211,964.11	$80,834.79	$461,910.81
03	RETROACTIVE DISENROLLMENT	1240	1243	1243	1243	($420,045.62)	($527,315.62)	($190,871.61)	($1,138,232.88)
07	RETROACTIVE HOSPICE STATUS	277	286	286	0	($151,186.16)	($187,165.33)	$0.00	($338,351.50)
08	RETROACTIVE ESRD STATUS	12	23	23	0	$25,726.64	$44,060.85	$0.00	$69,787.49
10	RETROACTIVE MEDICAID STATUS	3	3	3	0	($102.37)	($135.56)	$0.00	($237.93)
11	RETROACTIVE SCC CHANGE	79	83	83	0	$8.56	$10.04	$0.00	$18.60
19	CORRECTION OF PARTB ENTITLEMENT	14	7	7	14	($861.84)	($1,077.26)	($655.87)	($2,594.97)
31	RETROACTIVE PART D LOW-INCOME PREMIUM SUB CHNG	145	0	0	239	$0.00	$0.00	$23,567.77	$23,567.77
42	RETROACTIVE MSP STATUS	191	559	559	0	$7,453.96	$9,152.22	$0.00	$16,606.18
	Total Adjustments	2684	2938	2938	2230	($453,851.21)	($556,169.76)	($124,888.22)	($1,134,909.19)

View adjustment information for a selected MCO

To see further details about adjustments, the user clicks on an adjustment reason Code link at the bottom of the *Payments: MCO Payments (M402)* screen. The *Adjustment Detail (M408)* screen is displayed, listing all adjustments by beneficiary to show how the adjustment amount was calculated.

Figure 8-47: Adjustment Detail (M408) Screen

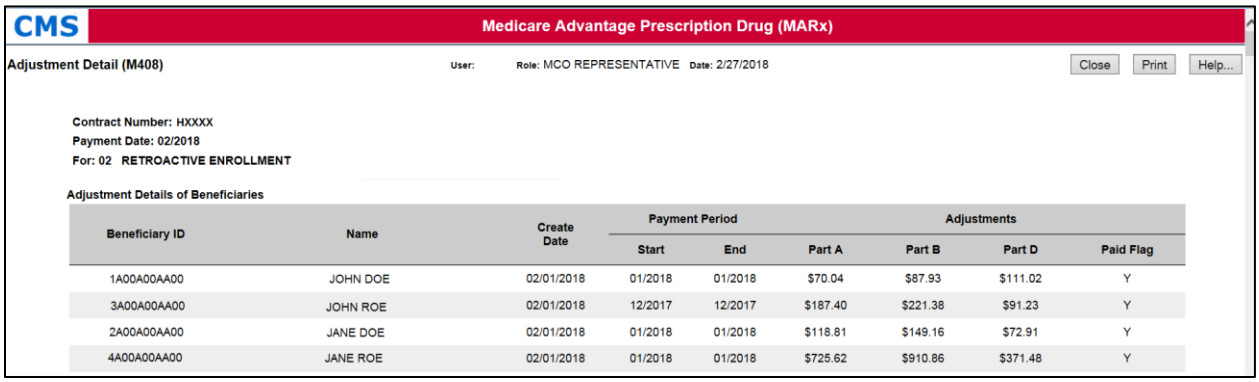


Table 8-28: Adjustment Detail (M408) Field Descriptions

Adjustment Detail (M408) Field Descriptions		
Item	**Input/Output**	**Description**
Beneficiary ID column heading	Sorter	Sorts adjustment information by beneficiary ID.
Name column heading	Sorter	Sorts adjustment information by beneficiary name.
Create Date column	Output	Date adjustment was created for beneficiary.
Payment Period Start column	Output	Start of period to which adjustment was made for beneficiary.
Payment Period End column	Output	End of period to which adjustment was made for beneficiary.
Adjustments Part A column	Output	Part A adjustment amount for beneficiary.
Adjustments Part B column	Output	Part B adjustment amount for beneficiary.
Adjustments Part D column	Output	Part D adjustment amount for beneficiary.

8.3.18 View Beneficiary Payment Information

Payments are calculated or recalculated for a beneficiary when there is a change in enrollment, demographics, health status, factors, or other information used in the calculation. Adjustments are made to previously made payments that require changes.

The steps below show how to find these payments and adjustments for a particular beneficiary. After the user finds that information, they can view the complete history of payments and adjustments.

Access the Payments: Beneficiary (M403) screen

From the main menu, the user clicks on the |Payments| menu item. If not already selected, the user clicks on the |Beneficiary| submenu item to view the *Payments: Beneficiary (M403)* screen.

Get a List of Beneficiaries

The user accesses the *Payments: Beneficiary (M403)* screen for entering search criteria.

Figure 8-48: Payments: Beneficiary (M403) Screen

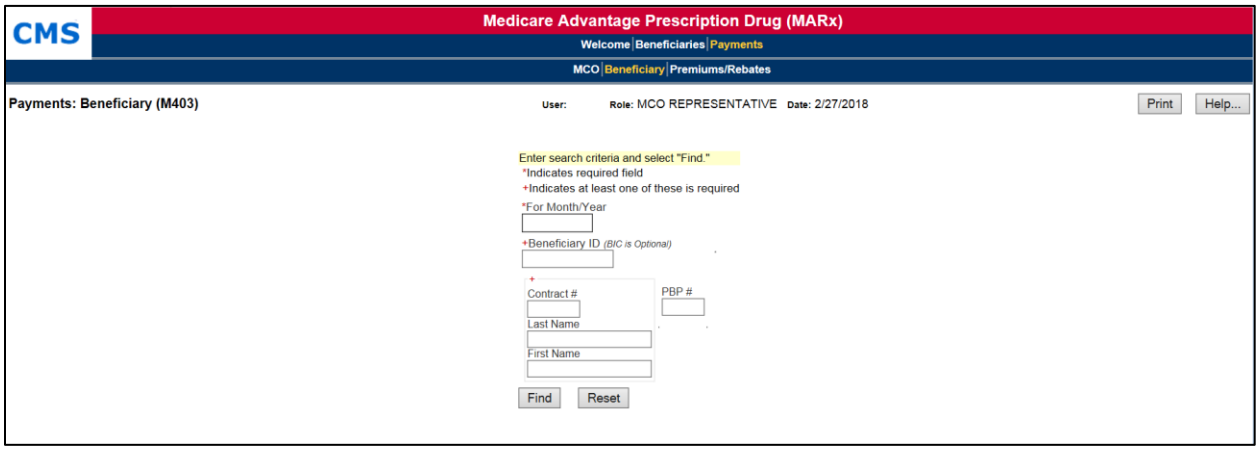


Table 8-29: Payments: Beneficiary (M403) Field Descriptions

Payments: Beneficiary (M403) Field Descriptions		
Item	**Input/Output**	**Description**
For Month/Year	Required data entry field	The user finds beneficiaries with payments/adjustments in this month. The user enters the date in the form (M)M/CCYY.
Beneficiary ID	Required data entry field	If entered, the user finds Beneficiary ID. **Note:** At least one of these is required: Beneficiary ID *or* combination of Contract #, Last Name, and First Name.
Contract #(s)	Required data entry field	If entered, the user finds beneficiaries enrolled in this contract in a past, current, or future enrollment. **Note:** At least one of these is required: Beneficiary ID *or* combination of Contract #, Last Name, and First Name.
PBP #	Data entry field	If entered, the user finds beneficiaries currently enrolled in this PBP. The PBP is applicable only when a contract number is entered.

Payments: Beneficiary (M403) Field Descriptions		
Item	**Input/Output**	**Description**
Last Name	Required data entry field	If entered, the user finds beneficiaries who currently have this last name. **Note:** At least one of these is required: Beneficiary ID *or* combination of Contract #, Last Name, and First Name.
First Name	Required data entry field	If entered, the user finds beneficiaries who currently have this first name. **Note:** At least one of these is required: Beneficiary ID *or* combination of Contract #, Last Name, and First Name.
[Find]	Button	The user clicks on this button to find the beneficiaries meeting the search criteria with payments/adjustments in the month/year indicated in the For Month/Year field.

The user enters the search criteria to find the beneficiary or beneficiaries and the payment month/year in which the user is interested, and then clicks on the [Find] button. The beneficiaries that meet the search criteria and have payments and/or adjustments calculated for that month then display on the *Payments: Beneficiary Search Results (M404)* screen. When the beneficiary is enrolled in two contracts; one for Part A and/or Part B and the other for Part D, two rows for the same month are displayed.

Figure 8-49: Payments: Beneficiary Search Results (M404) Screen

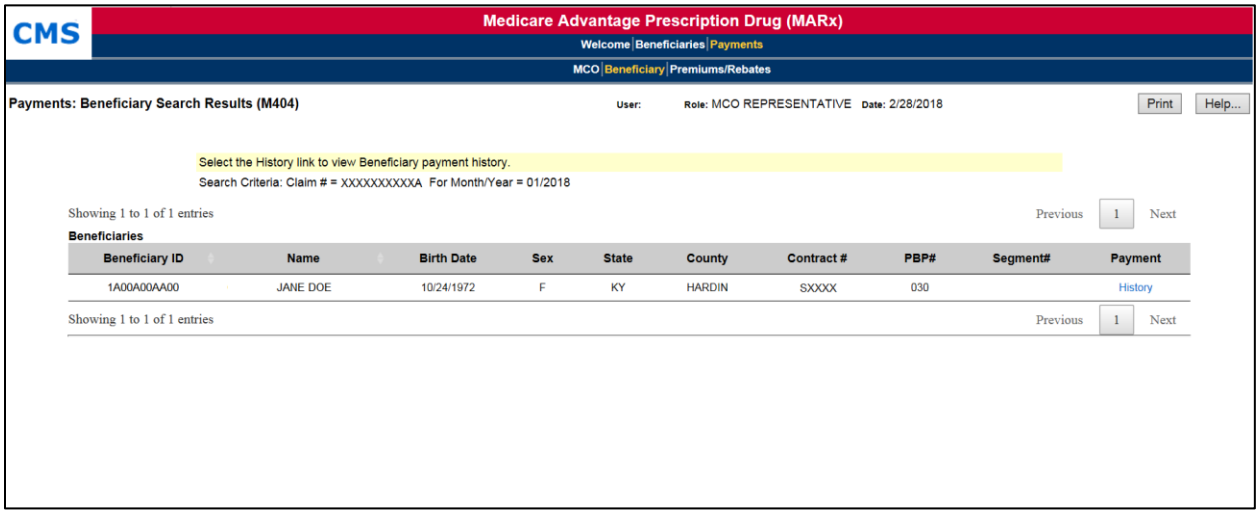


Table 8-30: Payments: Beneficiary Search Results (M404) Field Descriptions

Payments: Beneficiary Search Results (M404) Field Descriptions		
Item	**Input/Output**	**Description**
Claim # column heading	Sorter	Sorts beneficiaries by their beneficiary IDs.
Name column heading	Sorter	Sorts beneficiaries by their names.
Birth Date column	Output	Date beneficiary was born.
Sex column	Output	Sex of beneficiary.
State column	Output	State where beneficiary lived that month.
County column	Output	County where beneficiary lived that month.
Contract # column	Output	Payment is made for enrollment in this contract.
PBP# column	Output	Payment is made for enrollment in this PBP.
Segment# column	Output	Payment is made for enrollment in this segment.
History in the Payment column	Link	The user clicks on a History link to open the *Beneficiary Payment History (M406)* screen and views payments for the beneficiary up through the month/year indicated in the For Month/Year field.

From this list of beneficiaries, the user can see how the rate calculations were made, investigate how the payments would change if information about the beneficiary changed, and review the payment history, as discussed in the sections below.

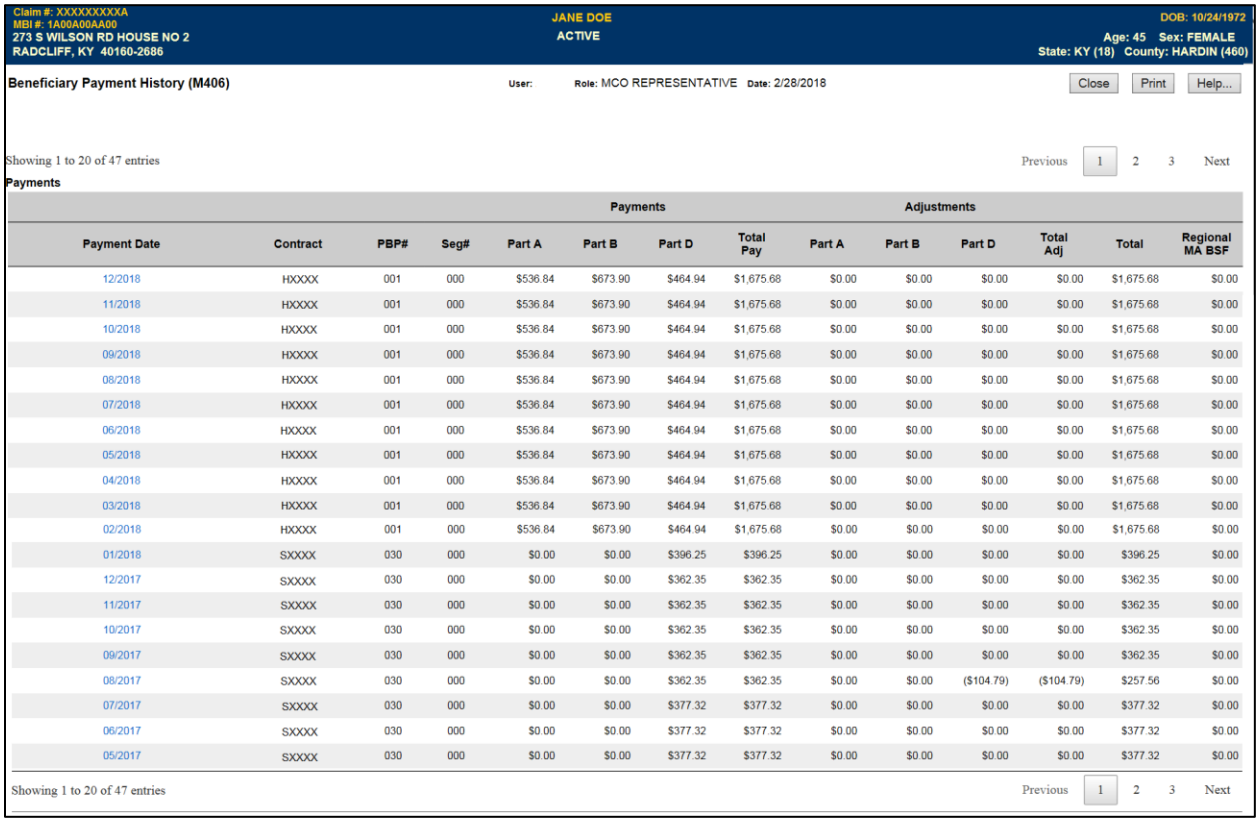
8.3.19 View Beneficiary Payment History

This section discusses how to view the payment and adjustment history for a beneficiary. From the history, the user can view the details of the payments and adjustments for a particular month.

Access the Beneficiary Payment History (M406) screen

From the *Payments: Beneficiary Search Results (M404)* screen the user clicks on the beneficiary's History link to open the *Beneficiary Payment History (M406)* screen. When the beneficiary is enrolled in two contracts; one for Part A and/or Part B and the other for Part D, two rows for the same month are displayed.

Figure 8-50: Beneficiary Payment History (M406) Screen



Claim #: XXXXXXXXXA
MBI #: 1A00A00AA00
273 S WILSON RD HOUSE NO 2
RADCLIFF, KY 40160-2686

JANE DOE
ACTIVE

DOB: 10/24/1972
Age: 45 Sex: FEMALE
State: KY (18) County: HARDIN (460)

Beneficiary Payment History (M406) User: Role: MCO REPRESENTATIVE Date: 2/28/2018 Close Print Help...

Showing 1 to 20 of 47 entries Previous 1 2 3 Next

Payments

				Payments				Adjustments					
Payment Date	Contract	PBP#	Seg#	Part A	Part B	Part D	Total Pay	Part A	Part B	Part D	Total Adj	Total	Regional MA BSF
12/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
11/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
10/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
09/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
08/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
07/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
06/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
05/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
04/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
03/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
02/2018	HXXXX	001	000	$536.84	$673.90	$464.94	$1,675.68	$0.00	$0.00	$0.00	$0.00	$1,675.68	$0.00
01/2018	SXXXX	030	000	$0.00	$0.00	$396.25	$396.25	$0.00	$0.00	$0.00	$0.00	$396.25	$0.00
12/2017	SXXXX	030	000	$0.00	$0.00	$362.35	$362.35	$0.00	$0.00	$0.00	$0.00	$362.35	$0.00
11/2017	SXXXX	030	000	$0.00	$0.00	$362.35	$362.35	$0.00	$0.00	$0.00	$0.00	$362.35	$0.00
10/2017	SXXXX	030	000	$0.00	$0.00	$362.35	$362.35	$0.00	$0.00	$0.00	$0.00	$362.35	$0.00
09/2017	SXXXX	030	000	$0.00	$0.00	$362.35	$362.35	$0.00	$0.00	$0.00	$0.00	$362.35	$0.00
08/2017	SXXXX	030	000	$0.00	$0.00	$362.35	$362.35	$0.00	$0.00	($104.79)	($104.79)	$257.56	$0.00
07/2017	SXXXX	030	000	$0.00	$0.00	$377.32	$377.32	$0.00	$0.00	$0.00	$0.00	$377.32	$0.00
06/2017	SXXXX	030	000	$0.00	$0.00	$377.32	$377.32	$0.00	$0.00	$0.00	$0.00	$377.32	$0.00
05/2017	SXXXX	030	000	$0.00	$0.00	$377.32	$377.32	$0.00	$0.00	$0.00	$0.00	$377.32	$0.00

Showing 1 to 20 of 47 entries Previous 1 2 3 Next

Table 8-31: Beneficiary Payment History (M406) Field Descriptions

Beneficiary Payment History (M406) Field Descriptions		
Item	**Input/ Output**	**Description**
Payment Date column	Output	Indicates when payment/adjustments were paid.
Month/Year in Payment Date column	Link	The user clicks on a month/year link to open the *Payment/Adjustment Detail (M215)* screen.
Contract column	Output	Contracts for which payments/adjustments were made.
PBP # column	Output	PBPs for which payments/adjustments were made.
Seg # column	Output	Segments for which payments/adjustments were made.
Part A Payments column	Output	Part A payments for the beneficiary by month.

Beneficiary Payment History (M406) Field Descriptions		
Item	**Input/ Output**	**Description**
Part B Payments column	Output	Part B payments for the beneficiary by month.
Part D Payments column	Output	Part D payments for the beneficiary by month.
Total Pay column	Output	Totals of Part A, Part B, and Part D payments for the beneficiary by month.
Part A Adjustments column	Output	Part A adjustments for the beneficiary by month.
Part B Adjustments column	Output	Part B adjustments for the beneficiary by month.
Part D Adjustments column	Output	Part D adjustments for the beneficiary by month.
Total Adj column	Output	Totals of Part A, Part B, and Part D adjustments for the beneficiary by month.
Total Pay+Adj column	Output	Payments plus adjustments for the beneficiary by month.
Part B Premium Reduction column	Output	Is checked if a Part B premium, formerly called BIPA, reduction was applied to the payment and/or adjustments for the beneficiary that month.
Regional MA BSF column	Output	Lists the bonus paid from the regional MA BSF.

Understand the Payment History

The *Beneficiary Payment History (M406)* screen lists the payments and adjustments for the beneficiary, starting with the month selected on the *Payments: Beneficiary (M403)* screen and going back in time. Each entry in the history includes:

- Month in which the payments/adjustments were made.
- Enrollment contract and, as applicable, PBP, and segment.
- Payments made that month, itemized by Part A, Part B, Part D, and combined.
- Adjustments made that month for previous months, itemized by Part A, Part B, Part D, and combined.
- Total amount paid in the month.
- Indicator of whether a Part B premium reduction was taken.
- Payment from the regional MA BSF.

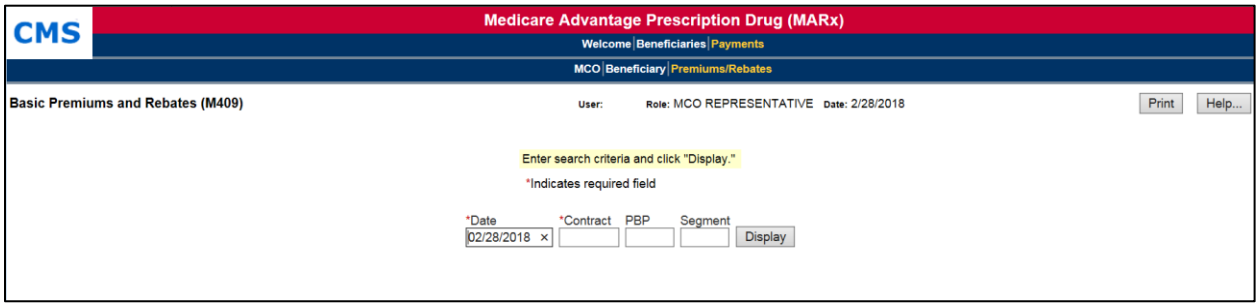
To view a further breakdown of the payments and adjustments, the user clicks on the month/year link, which opens the *Payment/Adjustment Detail (M215)* screen.

8.3.20 View Basic MCO Premiums and Rebates

This section describes how to view the basic premiums and rebates for a contract, contract/PBP, or contract/PBP/segment combination. These are the premiums and rebates negotiated with an MCO, not the premiums and rebates calculated for a beneficiary.

From the main menu, the user clicks on the |Payments| menu item. If not already selected, the user clicks on the |Premiums/Rebates| submenu item to view the *Basic Premiums and Rebates (M409)* screen.

Figure 8-51: Basic Premiums and Rebates (M409) Screen, Before Search Criteria Entered



After entering the criteria, the user clicks on the [Display] button to show the premiums and rebates, which display on the same screen, below the criteria. To view different premiums and rebates, the user changes the search criteria and clicks on the [Display] button.

Figure 8-52: Basic Premiums and Rebates (M409) Screen, After Search Criteria Entered

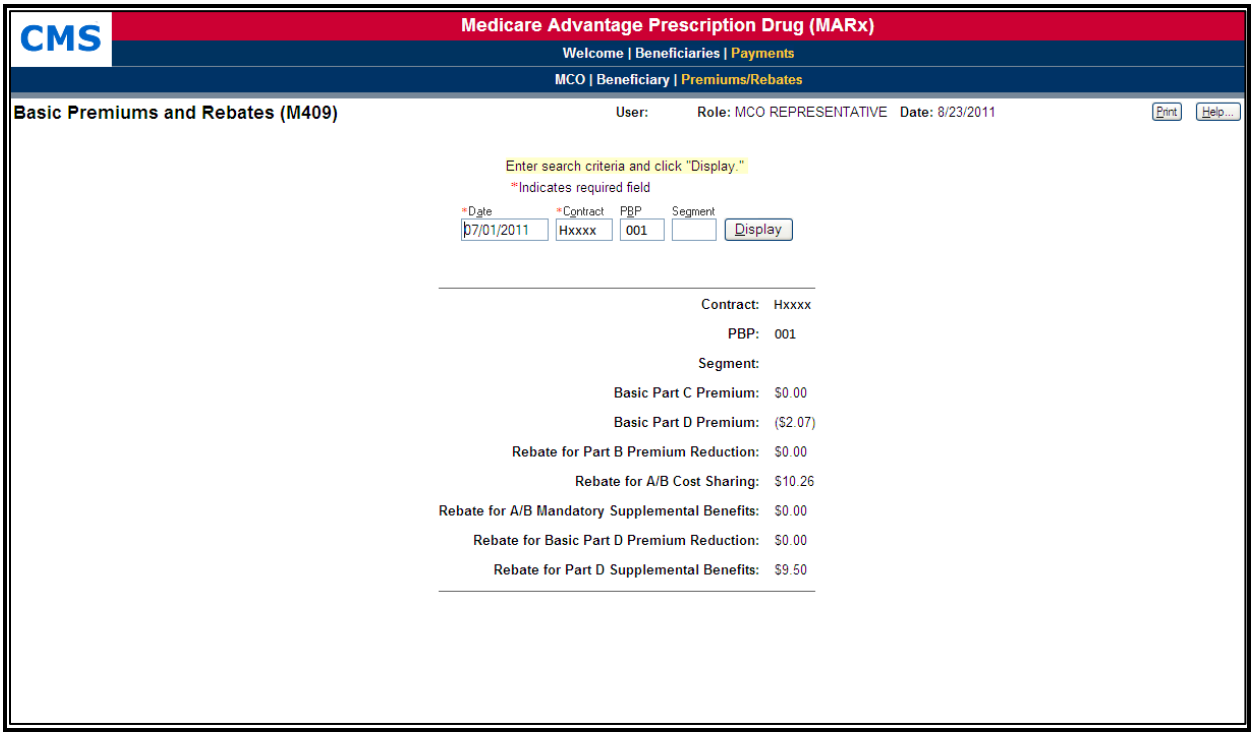


Table 8-32: Basic Premiums and Rebates (M409) Field Descriptions

Basic Premiums and Rebates (M409) Field Descriptions		
Item	**Input/Output**	**Description**
Date	Required data entry field	Premiums and rebates are effective during this month; enter the date in the form (M)M/CCYY.
Contract	Required data entry field	Displays premiums and rebates that apply to this contract.
PBP	Data entry field	If entered, displays premiums and rebates that apply to this contract and PBP. Otherwise, displays the premiums and rebates at the contract level.
Segment	Data entry field	If entered, displays premiums and rebates that apply to this contract, PBP, and segment. Otherwise, displays the premiums and rebates at the contract or contract/PBP level.
[Display]	Button	The user clicks on this button to display the premiums and rebates for the contract and, if provided, PBP and segment.
Basic Part C Premium	Output	Part C premium in MCO contract.
Basic Part D Premium	Output	Part D premium in MCO contract.
Rebate for Part B Premium Reduction	Output	Rebate paid to MCO for reduction in Part B premium.
Rebate for A/B Cost Sharing	Output	Rebate paid to MCO for Part A/Plan B cost sharing.
Rebate for A/B Mandatory Supplemental Benefits	Output	Rebate paid to MCO for providing Part A/Part B mandatory supplemental benefits.
Rebate for Basic Part D Premium Reduction	Output	Rebate paid to MCO for reduction in basic Part D premium.
Rebate for Part D Supplemental Benefits	Output	Rebate paid to MCO for providing Part D supplemental benefits.

8.4 MCO Representative with Update Role

8.4.1 *Update the Beneficiaries: Update Enrollment (M212) Screen*

The following screen is accessible only by users with update authorization. The *Update Enrollment (M212)* screen allows the user to add an end date to an existing enrollment or change the end date to an earlier date. This screen also cancels enrollments or disenrollments. To update enrollment information, such as the EGHP Flag, select the [More] button, which takes the user to the *Additional Update Enrollment Information (M230)* screen. To navigate to the *Update Enrollment (M212)* screen, select the [Update] button from the *Enrollment (M204)* screen or select the [Update Enrollment] button from the *Search Results (M202)* screen after finding a beneficiary.

Figure 8-53: Update Enrollment (M212) Screen

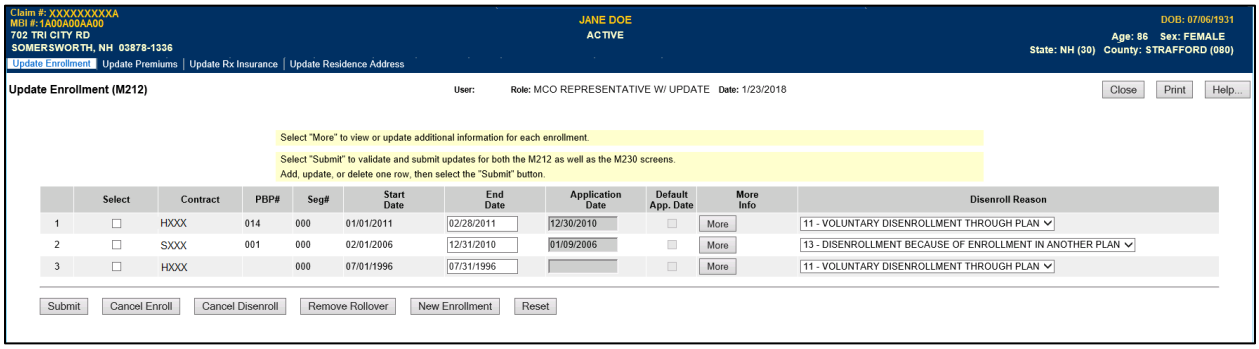


Table 8-33: Update Enrollment (M212) Field Descriptions

Update Enrollment (M212) Field Descriptions		
Item	**Input/Output**	**Description**
Updating Enrollment Information This section contains one line for each period during which the beneficiary was enrolled in the contracts to which the user has access. The user can work with each line to update the enrollment end date, to cancel an enrollment, or to cancel a disenrollment.		
Select	Input (checkbox)	Check this box to select a row to either cancel an existing enrollment or to cancel an existing disenrollment.
Contract	Output	The contract for the applicable period. *The user cannot update this field.*
PBP#	Output	The PBP for the applicable period. *The user cannot update this field.*
Seg#	Output	The segment for the applicable period. *The user cannot update this field.*
Start Date	Output	Start date for the enrollment on this line. *The user cannot update this field.*
End Date	Update	User can add or update an earlier date for the enrollment on this line.
Application Date	Output	Application date for the enrollment period on this line. *The user cannot update this field.*
More Info	Button	This takes the user to the M230 screen, where they may view or update additional information about the enrollment on this line.

Update Enrollment (M212) Field Descriptions		
Item	**Input/Output**	**Description**
Disenroll Reason	Input (dropdown)	The user must select a disenrollment reason code from the drop down box when entering or updating a disenrollment date.
Action Buttons These buttons operate on any lines that are selected by checking the Select checkbox.		
Submit	Button	Any enrollment changes are submitted for processing. After processing, the new enrollment information is displayed for the beneficiary.
Cancel Enroll	Button	Selecting Cancel Enroll cancels a selected enrollment. Users must cancel enroll within the timeframe defined by CMS policy and follow normal Enrollment Cancellation rules.
Cancel Disenroll	Button	Selecting Cancel Disenroll cancels a selected disenrollment. Users must cancel disenroll within the timeframe defined by CMS policy and follow normal Disenrollment Cancellation rules.
Reset	Button	Selecting the reset button resets any entered values that were not submitted to their original values.

8.4.2 *Update the Beneficiaries: New Enrollment (M221) Screen*

The *New Enrollment (M221)* screen is accessible only by users with update authorization. A beneficiary may enroll only into one of the contracts to which the user has access. Once an enrollment is submitted by selecting the [Enter] button, it is processed by MARx and the Plan sees the resultant Transaction Reply Codes (TRCs) on the Plan's Daily Transaction Reply Report (DTRR).

To navigate to the *New Enrollment (M221)* screen from the main menu, the user selects the |Beneficiaries| tab to display the three tabs Find, New Enrollment, and Eligibility. Selecting the |New Enrollment| tab displays the *Beneficiary: New Enrollment (M221)* screen. This screen allows the user to enter all values needed to enroll the beneficiary in a Plan. Required fields are marked with a red asterisk. Selecting the [New Enrollment] button from the *Update Enrollment (M212)* screen also takes the user to the *New Enrollment (M221)* screen.

Figure 8-54: Beneficiaries: New Enrollment (M221) Screen

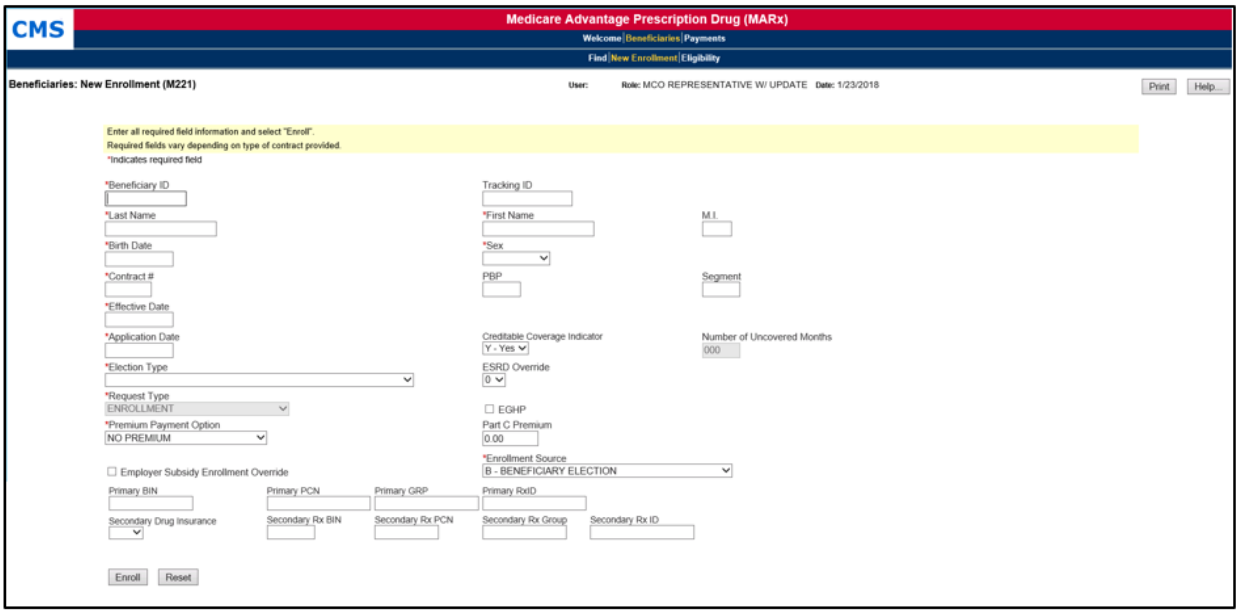


Table 8-34: Beneficiaries: New Enrollment (M221) Field Descriptions

Beneficiaries: New Enrollment (M221) Field Descriptions		
Item	**Input/Output**	**Description**
Beneficiary identification fields		
Beneficiary ID	Required input	Beneficiary ID associated with the enrolled beneficiary**.** This input field accepts an RRB number, which then converts to a corresponding Beneficiary ID.
Tracking ID	Input	The Tracking ID is an optional unique identifier provided by the Plan for its use in transaction tracking. This tracking ID is stored in the MARx system, associated with the transaction submitted, and returned to the Plan with the TRCs. Data format is alpha-numeric with a maximum of 15 characters.
Last Name	Required input	Last name of enrolled beneficiary.
First Name	Required input	First name of enrolled beneficiary.
M.I.	Input	Middle initial of enrolled beneficiary enrolled.
Birth Date	Required input	The date of birth of the enrolled beneficiary. Required format is (M)M/(D)D/YYYY.
Sex	Required input (dropdown list)	The gender of the enrolled beneficiary. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field.
Enrollment fields		
Contract #	Required input	Contract number associated with the Plan into which the beneficiary is enrolled.
PBP	Input	PBP number for this enrollment. It is required for MA contracts and applies to some non-MA contracts.
Segment	Input	Segment number for this enrollment. This is applicable only when a contract number and PBP number are entered. It applies to MA and MAPD contracts.

Beneficiaries: New Enrollment (M221) Field Descriptions		
Item	**Input/Output**	**Description**
Effective Date	Required input	Date that coverage in this Plan begins. Required format is (M)M/(D)D/YYYY.
Application Date	Input	Application Date associated with this enrollment. This is the date when the beneficiary signed the enrollment request (if available) or the date when the enrollment request was received by the Plan. Required format is (M)M/(D)D/YYYY.
Creditable Coverage	Required input (dropdown list)	Indicator of whether the beneficiary had creditable coverage between the end of their previous enrollment and the beginning of this enrollment. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field. All values except "No" render the Number of Uncovered months to zero and disable that field.
NUNCMO	Input	Number of months between the end of their previous enrollment and the beginning of this enrollment when the beneficiary did not have Creditable Coverage as defined by CMS policy. This field is available for entry only if the Creditable Coverage field is set to No, indicating that they did not have Creditable Coverage prior to this enrollment.
Election Type	Input (dropdown list)	Type of election period used for this enrollment. The input value is selected from a dropdown list which is accessed by selecting the arrow at the right end of the field.
ESRD Override	Input (dropdown list)	This field is only used when a beneficiary with ESRD status meets any of the exception criteria for enrollment into an MA or 1876 Cost based Plan as defined in the CMS Enrollment Guidance applicable to the Plan type. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field. Valid values are A through F; select any value.
Request Type	Input (dropdown list)	The type of request for this enrollment. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field. Select one of the types of enrollment from the list: • Enrollment (EMPLOYER GROUP) • Enrollment • Enrollment (2 MTHS RETRO) • Enrollment (WITH GAP END DATE)
EGHP	Input (Checkbox)	Indicates whether the enrollment is an EGHP. Automatically checked when Request Type is Enrollment (EGHP).
Enrollment Premium Part C	Input	The amount of the beneficiary's premium for Part C coverage that is part of this enrollment.
Employer Subsidy Enrollment Override	Input (Checkbox)	Indicates whether the beneficiary chose to enroll in a Part D Plan despite having employer coverage. Only if a user receives a TRC 127 can they select this override feature.
Enrollment Source	Input (dropdown list)	The initiating event that triggered this enrollment. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field. • Automatically enrolled by CMS • Beneficiary election • Facilitated enrollment by CMS

Beneficiaries: New Enrollment (M221) Field Descriptions		
Item	**Input/Output**	**Description**
Primary BIN	Input	The BIN number for the Part D insurance Plan associated with this enrollment.
Primary PCN	Input	The PCN number for the Part D insurance Plan associated with this enrollment.
Primary Group	Input	Group ID for the Part D insurance Plan associated with this enrollment.
Primary RxID	Input	Identifier assigned to the beneficiary by the Part D insurance Plan for drug coverage.
Secondary Drug Insurance	Input (dropdown list)	Indicates whether the beneficiary has drug insurance coverage other than through Part D. The input value is selected from a dropdown list, which is accessed by selecting the arrow at the right end of the field.
Secondary Rx Group	Input	Identifier for the group providing secondary drug insurance coverage. Not applicable unless the Secondary Drug Insurance indicator is Yes.
Secondary RxID	Input	Identifier assigned to beneficiary by the secondary insurance company for drug coverage. Not applicable unless the Secondary Drug Insurance indicator is Yes.
Buttons		
[Enroll]	Button	Submits the request to enroll the beneficiary.
[Reset]	Button	Resets all screen fields to original values prior to data entry.

8.4.3 Update Premiums for the Number of Uncovered Months (NUNCMO)

The Plan user who has MCO Representative with Update role can change the beneficiary's incremental uncovered months from the *Update Premiums (M226)* screen. Plan users cannot update the Part C premium amount(s) and the premium payment options via the MARx UI.

Update the Beneficiary Detail: Update Premiums (M226) Screen NUNCMO

To navigate to the *Update Premiums (M226)* screen, select the [Update] button from the *Premiums View (M231)* screen and then select the |Update Premiums| tab.

Figure 8-55: Update Premiums (M226) Screen

Claim #: XXXXXXXXXA
MBI #: 1A00A00AA00
702 TRI CITY RD
SOMERSWORTH, NH 03878-1336

JANE DOE
ACTIVE

Update Enrollment | Update Premiums | Update Rx Insurance | Update Residence Address

Update Premiums (M226)

User: Role: MCO REPRESENTATIVE W/ UPDATE Date: 2/6/2018

	Contract	PBP	Segment	Premium Start Date	Premium End Date	Premium Payment Option	Part C/D Premium Status
1	HXXXX	014	000	01/01/2011	02/28/2011	DIRECT SELF-PAY	
2	HXXXX	001	000	01/01/2010	12/31/2010	DIRECT SELF-PAY	
3	HXXXX	001	000	01/01/2009	12/31/2009	DIRECT SELF-PAY	
4	HXXXX	001	000	01/01/2008	12/31/2008	DIRECT SELF-PAY	
5	HXXXX	001	000	01/01/2007	12/31/2007	DIRECT SELF-PAY	
6	HXXXX	001	000	04/01/2006	12/31/2006	DIRECT SELF-PAY	
7	HXXXX	001	000	02/01/2006	03/31/2006	DIRECT SELF-PAY	

Number of Uncovered Months (Current Total NUNCMO : 0)

	Contract	PBP	Start Date	Incremental Uncovered Months	Total Uncovered Months
1	HXXXX	014	01/01/2011	0	0
2	HXXXX	001	02/01/2006	0	0

Submit Reset

Table 8-35: Update Premiums (M226) Field Descriptions

Update Premiums (M226) Field Descriptions		
Item	**Input/Output**	**Description**
Part C/D Premium Information This section contains one line for each premium period during which the beneficiary was enrolled in the contracts to which the user has access. *The user cannot update this information.*		
Contract	Output	Contract number of the enrollment for the premium period.
PBP	Output	PBP number associated with this enrollment.
Segment	Output	Segment number associated with this enrollment.
Premium Start Date	Output	The effective date for the Part C and/or D premiums on this line.
Premium End Date	Output	The last effective date for Part C and/or D premiums on this line. If no value is displayed, the premium period is open-ended.
PPO	Output	PPO for this beneficiary for this premium period.
PPO Pending	Output	A value of 'Y' means that a request for withholding was transmitted to the withholding agency but the agency has not yet returned an approval. Otherwise, this field is blank.
Part C Premium	Output	The cost charged by the Plan to the beneficiary for Part C coverage.
Part D Premium	Output	The cost charged by the Plan to the beneficiary for Part D coverage.
Late Enrollment Penalty	Output	The penalty amount that is added to the premium when the beneficiary has an uncovered period without creditable coverage. This amount is calculated based on the uncovered months.
Updating NUNCMO Information Uncovered months are associated with the first day of each enrollment. This section contains one line for each of the beneficiary's enrollment periods along with the associated NUNCMO. It also displays any NUNCMO resets that may have occurred. NUNCMO values for all enrollment are shown but the associated contract number is displayed only for contracts to which the user has access. The user can update the NUNCMO associated with any contract to which they have access. A user with access to the contract in which the beneficiary is currently enrolled can update that NUNCMO value or the value for any preceding enrollment.		
Current Cumulative NUNCMO	Output	The total NUNCMO used when calculating the LEP for a current enrollment period. This total includes uncovered months associated with all previous enrollments as well as any NUNCMO Resets.
Contract	Output	Contract number of the enrollment associated with this uncovered month period.
PBP #	Output	PBP number of the enrollment associated with this uncovered month period.
Start Date	Output	The start date of the enrollment associated with this uncovered month value or the date of the reset.
Incremental Uncovered Months	Update	Number of months that the beneficiary did not have creditable coverage in the period immediately prior to the enrollment on this line. The field is either left blank or set to zero when there are no uncovered months.
Cumulative Uncovered Months	Output	The running total of uncovered months. Uncovered months accumulate over time unless a NUNCMO reset is in place. Accumulation begins again at zero after a NUNCMO reset.

Update Premiums (M226) Field Descriptions		
Item	**Input/Output**	**Description**
Indicator	Output	This indicates the type of uncovered months – • Reset (R) – This line represents a NUNCMO reset. It is a point in time where the accumulation of uncovered months is set back to zero. • L- LIS Reset: This beneficiary's NUNCMO were reset because of an LIS status as of the effective date shown on the table. • A- IEP Reset: This beneficiary's NUNCMO were reset because their 2nd Initial Enrollment Period (IEP) for Part D started as of the effective date shown on the table

8.4.4 *Update the Rx Insurance View (M228) Screen*

The following screen is accessible only by users with update authorization.

Plans can use the *Update Rx Insurance (M228)* screen to view, update, and add new Rx insurance information, both primary and secondary, for beneficiaries enrolled in its Plan. The screen displays the beneficiary's 4Rx history. The Plan only views 4Rx information for periods during which the beneficiary is enrolled in any of its Part D Plans.

To access the *Update Rx Insurance (M228)* screen, select the [Update] button from the *Rx Insurance View (M244)* screen.

Figure 8-56: Update Rx Insurance (M228) Screen

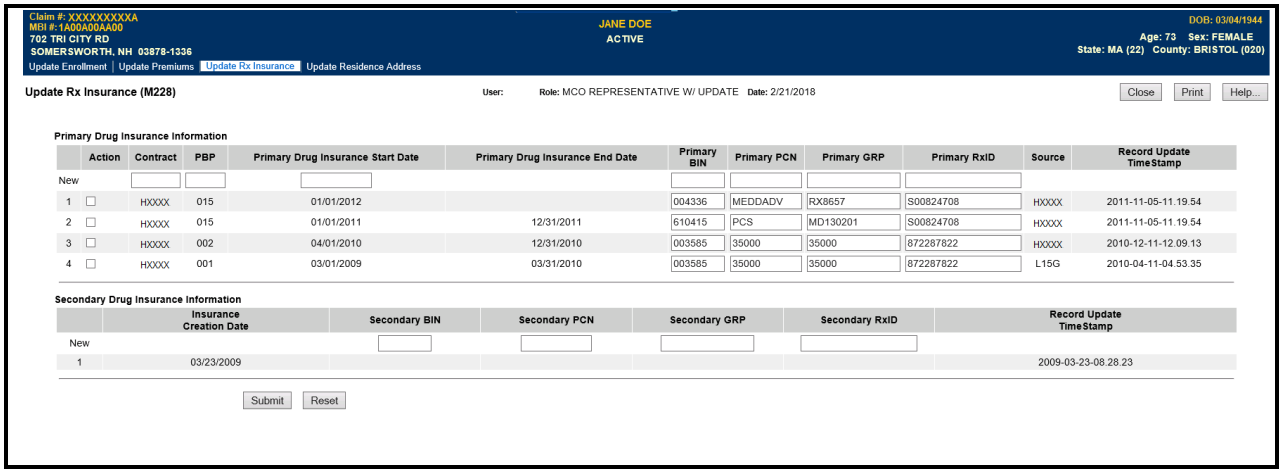


Table 8-36: Update Rx Insurance (M228) Field Descriptions

Update Rx Insurance (M228) Field Descriptions		
Item	**Input/Output**	**Description**
The *New* Line for Primary Rx Insurance This line is used to enter new Primary Rx Insurance information, along with the effective time period, and the contract and PBP that the beneficiary is enrolled in during the applicable time period. The user may only add Primary Rx Insurance for periods during which the beneficiary's enrollment is in a contract to which the user has access.		
Contract	Input	Contract in which the beneficiary was enrolled during the period on this line.
PBP	Input	The PBP in which the beneficiary was enrolled during the period on this line.
Primary Rx Insurance Start Date	Input	Start date for the Primary Rx Insurance listed on this line. This date must fall during an enrollment that the user can view on the Enrollment (M203) screen.
Primary Rx Insurance End Date	Input	End date for the Primary Rx Insurance listed on this line.
Primary BIN	Input	BIN for the Primary Rx Insurance period on this line.
Primary PCN	Input	PCN for the Primary Rx Insurance period on this line.
Primary GRP	Input	GRP for the Primary Rx Insurance period on this line.
Primary RxID	Input	RxID for the Primary Rx Insurance period on this line.
The *New* Line for Secondary Rx Insurance This line is used to enter new Secondary Rx Insurance information.		
Secondary Rx Insurance	Input (dropdown)	Select "Yes" from the dropdown list to indicate that this is a Secondary Rx Insurance entry.
Secondary BIN	Input	BIN for the Secondary Rx Insurance period on this line.
Secondary PCN	Input	PCN for the Secondary Rx Insurance period on this line.
Secondary GRP	Input	GRP for the Secondary Rx Insurance period on this line.
Secondary RxID	Input	RxID for the Secondary Rx Insurance period on this line.
Update or Delete Primary Rx Insurance Information This section contains one line for each period that the beneficiary had a unique Primary Rx Insurance period. The user can mark each line to delete or to update the available fields.		
Action	Input (Checkbox)	Check this box, and then use the buttons at the bottom of the screen to select the desired action (i.e. Submit, Delete, or Reset) for this line.
Contract	Output	Contract in which the beneficiary was enrolled during the period on this line. *The user cannot update this field.*
PBP	Output	The PBP in which the beneficiary was enrolled during the period on this line. *The user cannot update this field.*
Primary Rx Insurance Start Date	Output	Start date for the Primary Rx Insurance listed on this line. *The user cannot update this field.*
Primary Rx Insurance End Date	Update	The user can add or update an end date for the Primary Rx Insurance on this line.
Primary BIN	Update	The user can update the BIN for the Primary Rx Insurance on this line.
Primary PCN	Update	The user can update the PCN for the Primary Rx Insurance on this line.
Primary GRP	Update	The user can update the GRP for the Primary Rx Insurance on this line.
Primary RxID	Update	The user can update the RxID for the Primary Rx Insurance on this line.

Update Rx Insurance (M228) Field Descriptions		
Item	**Input/Output**	**Description**
Source	Output	Source of the Rx insurance information for the period specified. The Rx Information is submitted on an enrollment transaction code (TC 61), a Plan change transaction (TC 72), or through a UI update. If the update is completed through the UI, the source is the user's ID. *The user cannot update this field as it will automatically update when the Primary Rx Change is processed.*
Record Update Timestamp	Output	Date that this Rx insurance information was added or updated. *The user cannot update this field as it will automatically update when the Primary Rx Change is processed.*
Update or Delete Secondary Rx Insurance Information This section contains one line for each period that the beneficiary had a unique Secondary Rx Insurance period. The user can mark each line to delete or to update the available fields.		
Action	Input (Checkbox)	Check this box, then select the *delete* button to delete this line of existing Secondary Insurance information.
Secondary Rx Insurance	Output	Yes indicates that the line represents Secondary Insurance Information.
Insurance Creation Date	Output	Date that was reported for the initiation of this secondary insurance period. *The user cannot update this field.*
Secondary BIN	Update	The user can update the BIN for the Secondary Rx Insurance period on this line.
Secondary PCN	Update	The user can update the PCN for the Secondary Rx Insurance period on this line.
Secondary GRP	Update	The user can update the GRP for the Secondary Rx Insurance period on this line.
Secondary RxID	Update	The user can update the RxID for the Secondary Rx Insurance period on this line.
Source	Output	Source of the Rx insurance information for the period specified. The Rx Information is submitted on an enrollment transaction (TC 61), a Plan change transaction (TC 72), or through a UI update. If the update is conducted through the UI, the source is the user's ID. *The user cannot update this field as it will automatically update when the Primary Rx Change is processed.*
Record Update Timestamp	Output	Date that this Rx insurance information was added or updated.
Action Buttons These buttons operate on any lines that are selected by checking the Action checkbox.		
Submit	Button	Any Rx Insurance Information entered on the New line or Rx Information changes in a selected line are submitted for processing. After processing, a new line of Rx Insurance Information is displayed for the beneficiary.
Reset	Button	Any updated, or changed, values that are not submitted are reset to their original values.
Delete	Button	The Rx Insurance Information on the selected line is deleted from the beneficiary's record.

8.4.5 View/Update Beneficiary Residence Address

SSA provides CMS with a beneficiary address. This is not always the address through which the Plan interfaces with the beneficiary. A Plan user with update authority may enter an address. These addresses are associated with the period of time during which each is effective. The *Residence Address View (M243)* screen gives the Plan user an historical view of a beneficiary's residence addresses during the time they were enrolled in one of the Plans to which the user has access. The screen displays the beneficiary's historical residence address information, with the most recent address periods shown first. The Plan will only see residence address information for periods during which the beneficiary is enrolled in any of their Plans.

Users with the MCO Representative with Update role may select the [Update] button to update this beneficiary's enrollment information.

View/Update the Residence Address View (M243) Screen

Figure 8-57: Residence Address View (M243) Screen

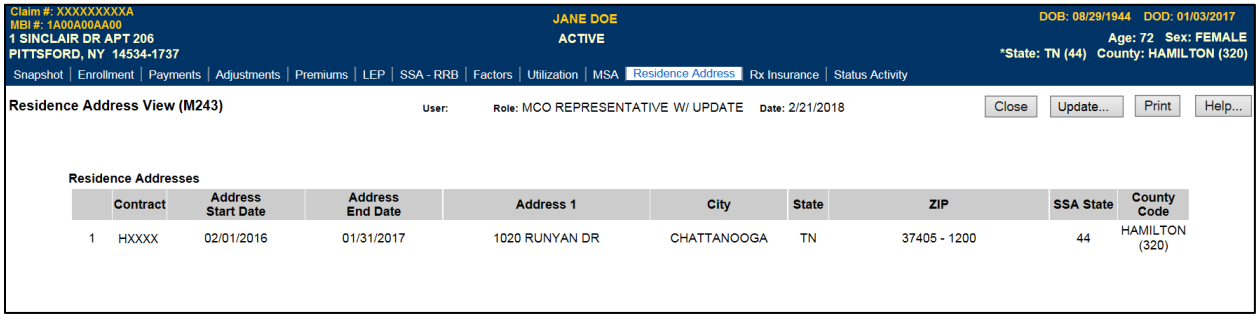


Table 8-37: Residence Address View (M243) Field Descriptions

Residence Address View (M243) Update Screen Field Descriptions		
Item	**Input/Output**	**Description**
Beneficiary's Residence Address Information This section contains one line for each period during which the beneficiary had a unique residence address, i.e., address where the beneficiary resides.		
[Update]	Button	This button takes the user to the Update Residence Address screen.
Contract	Output	The contract for the applicable period.
Address Start Date	Output	Start date for the residence address listed on this line.
Address End Date	Output	End date for the residence address listed on this line.
Address 1	Output	Residence Street Address (Line 1) for the period on this line.
Address 2	Output	Residence Street Address (Line 2) for the period on this line.
City	Output	Residence City for the period on this line.
State	Output	Residence State for the period on this line.
Zip	Output	Residence Zip for the period on this line.
SSA State Code	Output	The State Code assigned by SSA for the state on this line.
SSA County Code	Output	The county where this residence is located, along with the County Code assigned by SSA for the county.

Update the Update Residence Address (M242) Screen

The following screen is accessible only by users with update authorization.

The *Update Residence Address (M242)* screen allows the user to change or delete any address that is in the current list of residence address information and for periods where the user has access to those Plans. The screen also includes a blank line, labeled *New*, which allows the user to enter a new address for the beneficiary.

To open the *Update Residence Address (M242)* screen, click the [Update] button from the *Residence Address (M243)* screen.

Figure 8-58: Update Residence Address (M242) Screen

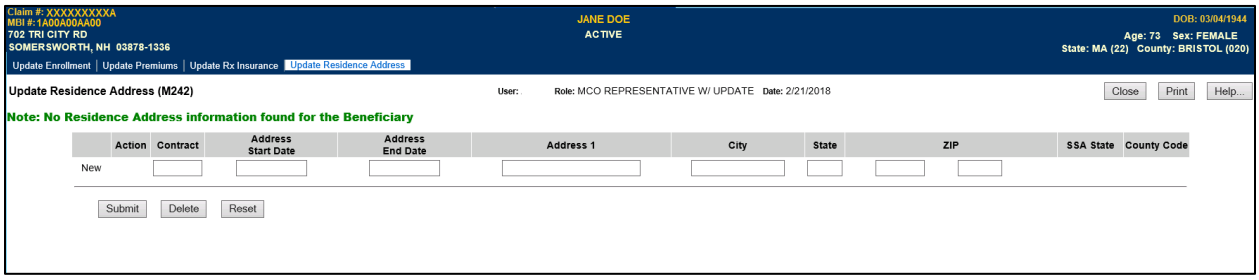


Table 8-38: Update Residence Address (M242) Field Descriptions

Update Residence Address (M242) Field Descriptions		
Item	**Input/Output**	**Description**
The *New* Line This line is used to enter a new residence address, along with the effective time period. Users can only add addresses for periods during the beneficiary's enrollment in a contract to which the user has access.		
Contract	Input	The contract for the applicable period.
Address Start Date	Input	Start date for the residence address listed on this line. This date must occur during an enrollment that the user can view on the Enrollment (M203) screen.
Address End Date	Input	End date for the residence address listed on this line.
Address 1	Input	Residence Street Address (Line 1) for the period on this line.
Address 2	Input	Residence Street Address (Line 2, if applicable) for the period on this line.
City	Input	Residence City for the period on this line
State	Input	Residence State for the period on this line
Zip	Input	Residence Zip for the period on this line
Updating or Deleting Residence Address Information This section contains one line for each period that the beneficiary has a unique residence address (address where the beneficiary resides). The user can edit each line to mark it for delete or update the available fields.		
Action	Input	Check this box, then select the desired action (i.e. Submit, Delete, or Reset) when updating, deleting, or resetting information for an existing residence address period.
Contract	Output	The contract for the applicable period. *The user cannot update this field.*
Address Start Date	Output	Start date for the residence address listed on this line. *The user cannot update this field.*

Update Residence Address (M242) Field Descriptions		
Item	**Input/Output**	**Description**
Address End Date	Update	The user can add or update an End date for the residence address on this line.
Address 1	Update	Residence Street Address (Line 1) for the period on this line.
Address 2	Update	The user can add or update the Residence Street Address (Line 2) for the period on this line.
City	Update	Residence City for the address on this line.
State	Update	Residence State for the address on this line.
Zip	Update	Residence Zip for the address on this line.
SSA State Code	Output	The State Code assigned by SSA for the state on this line. The user cannot update this field as it automatically updates when the address is processed.
SSA County Code	Output	The county where this residence is located, along with the County Code assigned by SSA for the county. The user cannot update this field as it automatically updates when the address is processed.
Action Buttons These buttons operate on any selected lines by checking the Action checkbox.		
Submit	Button	Any address entered on the New line or address changes in a selected line is submitted for processing. After processing, the new addresses are viewable in the list of addresses for the beneficiary.
Reset	Button	On a selected line, any non-submitted values are reset to their original values.
Delete	Button	The address on the selected line is deleted from the beneficiary's addresses.

8.4.6 Beneficiary Opt Out Screen (M234)

Update the Beneficiary Opt-Out (M234) Screen

The following screen is accessible only by users with update authorization.

The *Beneficiary: Opt-Out (M234)* screen displays beneficiary's Part D AE-FE Opt-Out or MMP Opt-Out information. The Plan uses this screen to view, verify, and update beneficiary's Part D AE-FE/MMP Opt-Out election. To navigate to the Part D Opt-Out (M234) screen, select the Opt-Out tab.

Figure 8-59: Beneficiary: Opt-Out (M234) Screen

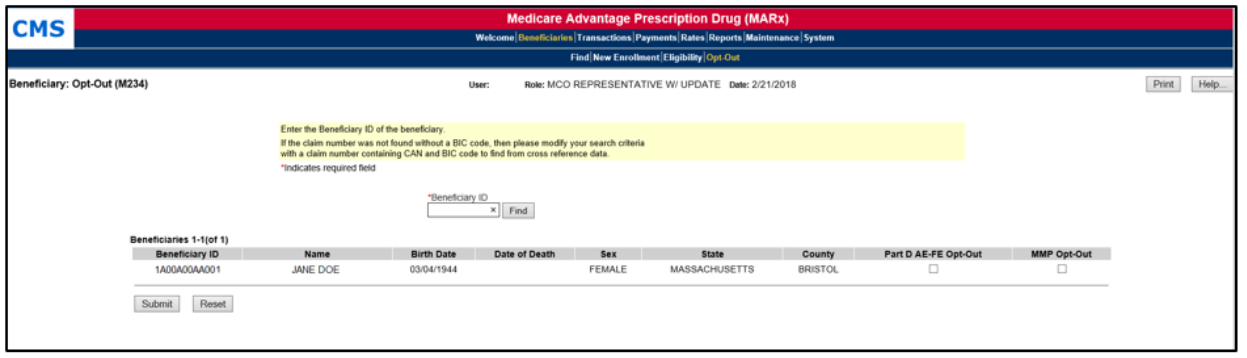


Table 8-39: Beneficiary: Opt-Out (M234) Field Descriptions

Beneficiary: Opt-Out (M234) Field Descriptions		
Item	**Input/Output**	**Description**
Beneficiary ID	Required Input	Identifies the beneficiary whose eligibility information displays.
[Find]	Button	Select after entering the beneficiary claim number. If beneficiary is found, Part D AE-FE Opt-Out displays and user may update it.
Beneficiary ID	Output	Beneficiary ID of beneficiary.
Name	Output	Name of beneficiary.
Birth Date	Output	Date of birth of beneficiary.
Date of Death	Output	Date of death of beneficiary.
Sex	Output	Sex of beneficiary.
State	Output	State of beneficiary's address.
County	Output	County of beneficiary's address.
Part D AE-FE Opt-Out	Input	Indicates if beneficiary opted-out of AE-FE.
MMP Opt-Out	Input	Indicates if beneficiary opted-out of MMP.
Action Buttons		
Submit	Button	Changes to Part D AE-FE/MMP Opt-Out indicator submitted for processing.
Reset	Button	Updated (or changed) values not submitted are reset to original values.

8.5 MCO Submitter Role

When a transactions batch file is submitted, the user may track its progress through the enrollment processing. This progress information includes:

- Dates and times when the file was received, when the file was processed, and when the Batch Completion Status Summary (BCSS) Report was generated for the file.
- Counts of transactions by status.
- Counts of transactions by transaction type.

There are three possible batch transaction statuses:

- **Successful**: Transaction was processed with no errors.
- **Rejected**: An error occurred when the transaction was processed. The rejected transactions are also saved in the Rejected Transactions File.
- **Failed**: A failed transaction is one that has an error that is so severe the transaction is not saved.

The *Transactions: Batch Status (M307)* screen displays the status of transaction batch files that were submitted by the user. Additional information about a selected batch is shown in the *Batch File Details (M314)* screen.

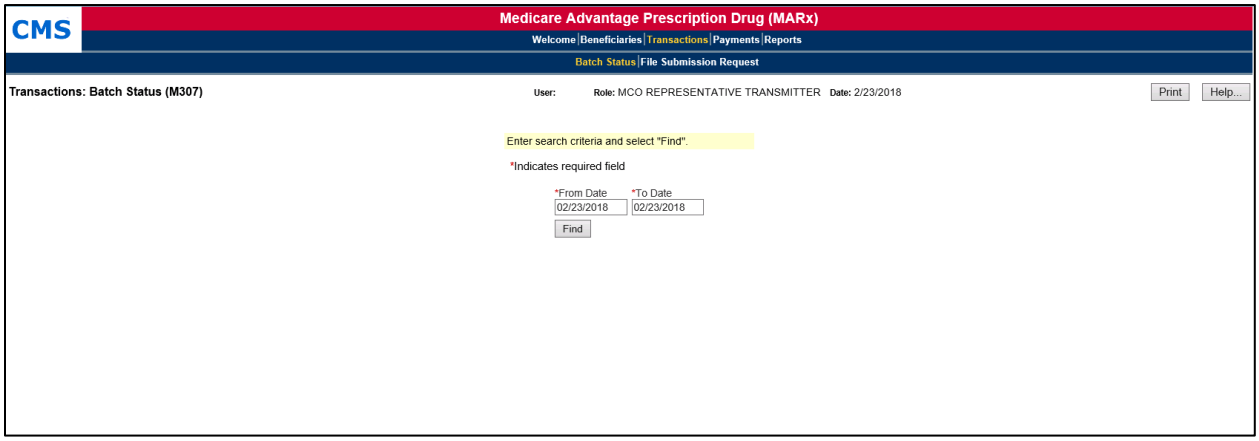
8.5.1 *Access the Transactions: Batch Status (M307) Screen*

From the main menu, the user clicks on the |Transactions| menu item to view the *Transactions: Batch Status (M307)* screen.

View the Transactions Batch Status (M307) Screen

The *Transactions: Batch Status (M307)* screen is used for entering the selection criterion.

Figure 8-60: Batch Status (M307) Screen, Before Search Criteria Entered



After the search criteria are entered, the user clicks on the [Find] button to display the transaction batch files. If there are no batches that satisfy the search criteria, the *Transactions: Batch Status (M307)* screen is re-displayed with the search criteria and a message indicating that no batches were found. The batches that meet the selection criteria are displayed on the same screen below

the selection criteria. To view different transaction batches, the user changes the search criteria and clicks on the [Find] button.

Figure 8-61: Batch Status (M307) Screen, After Search Criteria Entered

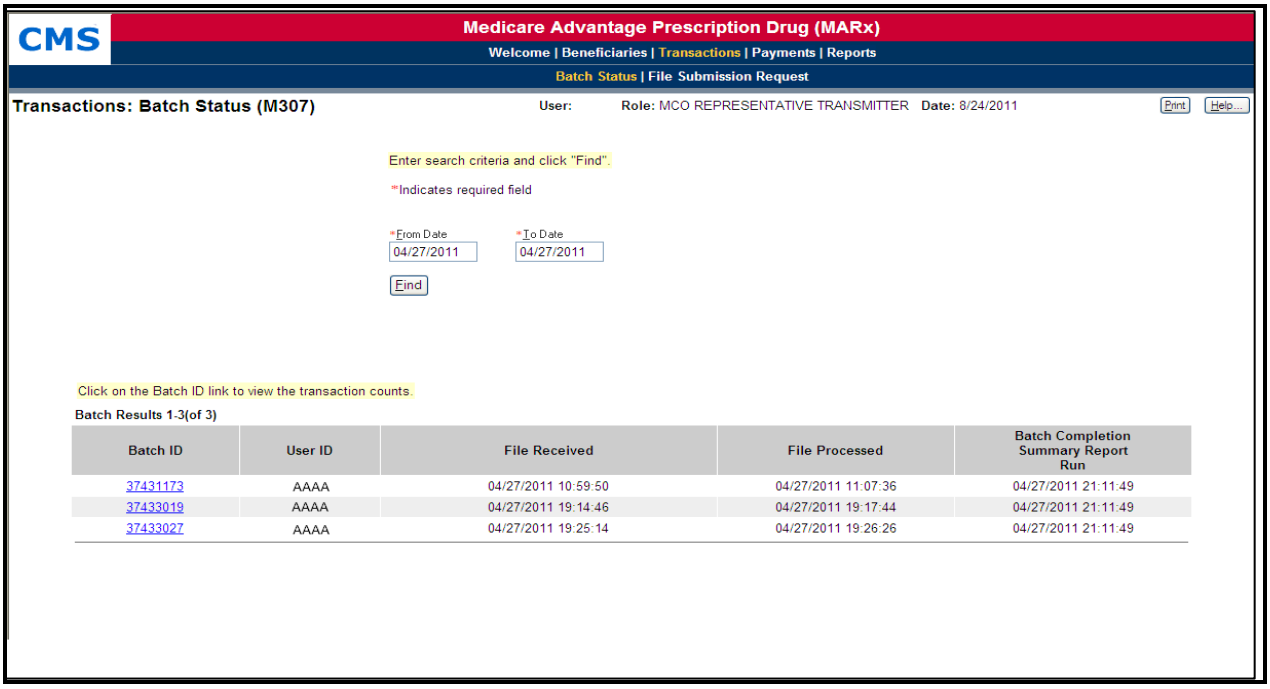


Table 8-40: Batch Status (M307) Field Descriptions

Batch Status (M307) Field Descriptions		
Item	**Input/Output**	**Description**
From Date	Required data entry field	Searches for batches that were entered on or after this date. Enter as (M)M/(D)D/CCYY. Defaults to current date.
To Date	Required data entry field	Searches for batches that were entered before or after this date. Enter as (M)M/(D)D/CCYY. Defaults to current date.
[Find]	Button	After the search criteria have been entered, the user clicks on this button to display the list of batch files.
Batch ID in the Batch ID column	Link	The user clicks on a Batch ID link to display the *Batch File Details (M314)* screen for that batch file.
User ID	Output	Identifier of user who submitted the batch file.
File Received	Output	Date and time when batch file was received.
File Processed	Output	Date and time when batch file was processed.
Batch Completion Summary Run	Output	Date and time a BCSS report was run for the batch file.

8.5.2 View the Batch File Details

The user clicks on a Batch ID link on the *Transactions: Batch Status (M307)* screen to bring up the *Batch File Details (M314)* screen.

Figure 8-62: Batch File Details (M314) Screen

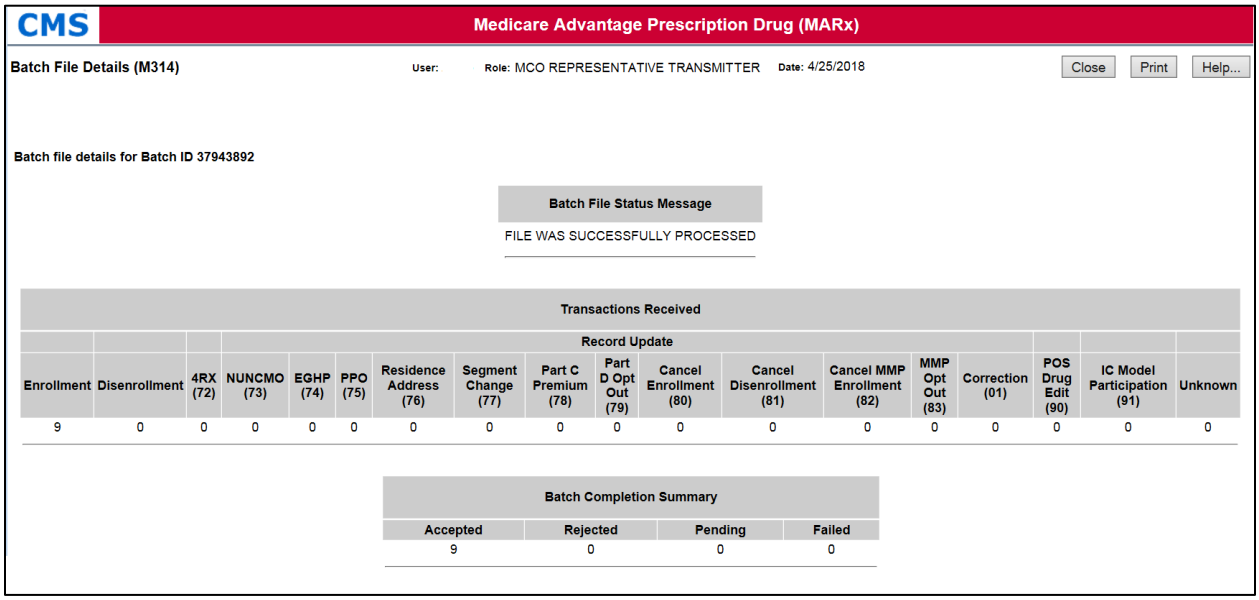


Table 8-41: Batch File Details (M314) Field Descriptions

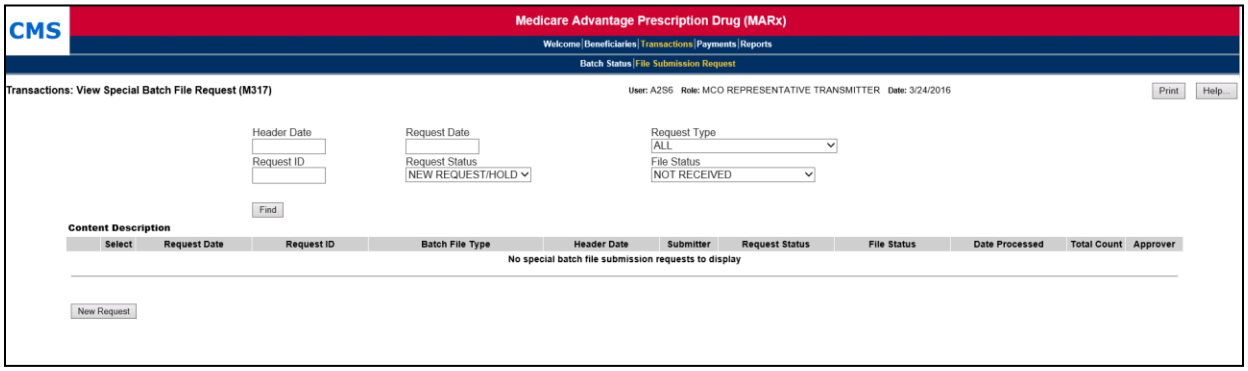
Batch File Details (M314) Field Descriptions		
Item	**Input/Output**	**Description**
Batch File Status Message	Output	Describes the status of file processing.
Enrollment	Output	Count of enrollment transactions in the batch file.
Disenrollment	Output	Count of disenrollment transactions in the batch file.
PBP Change	Output	Count of PBP change (TC 71) transactions in the batch file.
4Rx	Output	Count of 4Rx data update (TC 72) transactions in batch file.
NUNCMO	Output	Count of NUNCMO data update (TC 73) transactions in batch file.
Premium Withhold	Output	Count of Premium Payment data update (TC 75) transactions in the batch file.
EGHP	Output	Count of EGHP data update (TC 74) transactions in the batch file.
Correction	Output	Count of correction (TC 01) transactions in the batch file.
Unknown	Output	Count of transactions of unknown type in the batch file.
Accepted	Output	Count of accepted transactions in the batch file.
Rejected	Output	Count of rejected transactions in the batch file.
Pending	Output	Count of transactions in the batch file with incomplete processing.
Failed	Output	Count of transactions in the batch file that failed.

8.5.3 View Special Batch File Requests (M317) Screen

A Plan user with the MCO Representative Transmitter role may submit Special Batch Files for CMS to review and approve through the MARx UI. The MCO Representative Transmitter user submits the Special Batch File by selecting the |*Transactions*| tab followed by the |*File Submission Request*| tab from the *Welcome* screen.

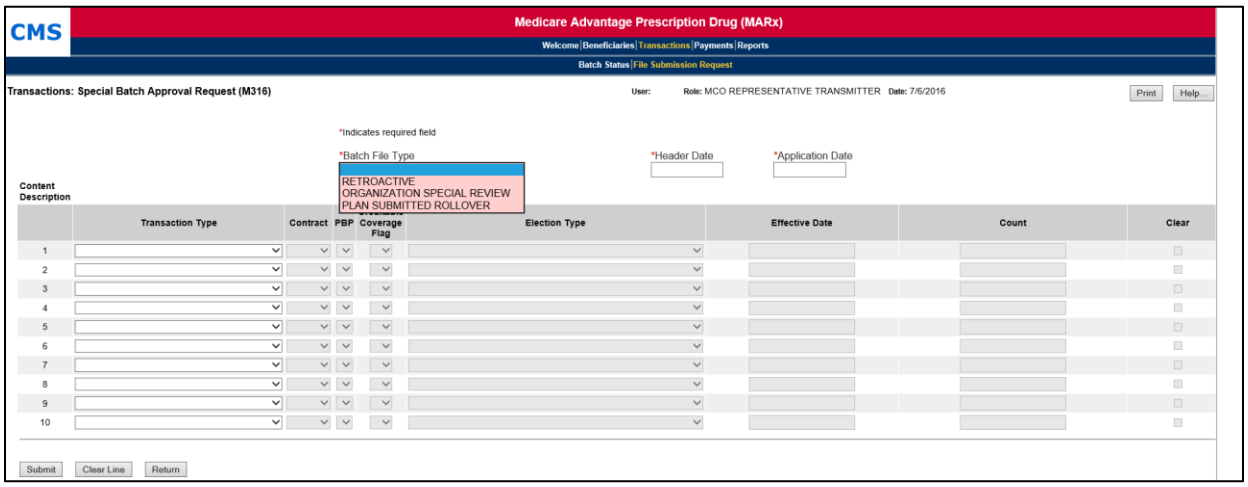
This opens the *View Special Batch File Request (M317)* screen where the user may enter the details of the special batch file when the *New Request* button is selected or the user may search for previously submitted requests when a specific Request ID is entered on the screen.

Figure 8-63: View Special Batch File Request (M317) Screen



When the MCO Representative Transmitter user selects the New Request button, the *Special Batch Approval Request (M316)* screen opens to allow the user to enter the details for batch files that requires special approval. These special batch files include Plan Submitted Rollover files, Retroactive files, and Organization Special Review.

Figure 8-64: Special Batch Approval Request (M316) Screen



When selecting a **Plan Submitted Rollover** for the Batch File Type, the user must enter the following:

- The date the special batch file should run in the *Header Date* field.
- A date in the *Application Date* field.
- For each Plan receiving a rollover transaction the user enters the following information:
  - Transaction Type: 61-Enrollment
  - Contract: The new contract the beneficiary is being rolled into.
  - PBP: The new PBP the beneficiary is being rolled into.
  - Creditable Coverage Flag: Y if applicable otherwise N.
  - Election Type: C – SEP for Plan-submitted rollovers.
  - Effective Date: The date the new enrollment takes effect.
  - Count: The number of beneficiaries being rolled over to the new plan.
  - Clear checkbox: Check this box then select the [Clear Line] button only if the line should not be submitted as part of the special batch file request.
- When all transactions have been entered, the user selects the [Submit] button.

Figure 8-65: Special Batch Approval Request (M316) Screen (Plan Submitted Rollover version)

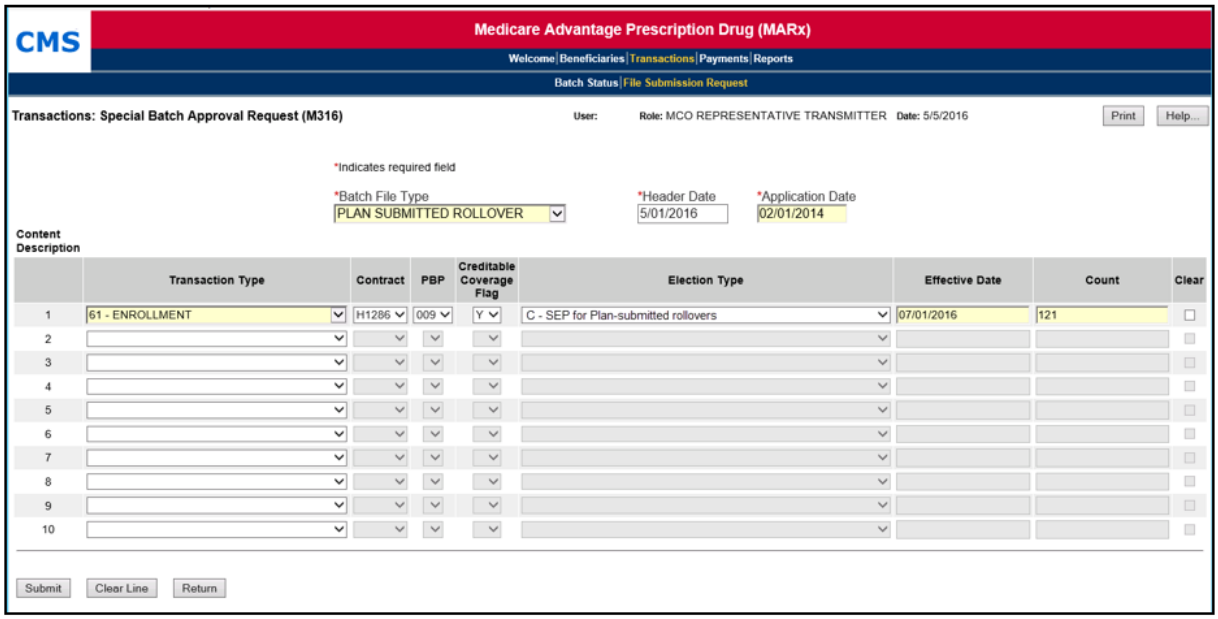


Table 8-42: Special Batch Approval Request (M316) Field Descriptions

Special Batch Approval Request (M316) Field Descriptions		
Item	**Input/Output**	**Description**
Batch File Type	Required Input	Indicate the type of special file: • Retroactive. • Plan Submitted Rollover. • Organization Special Review.
Header Date	Required Input	Enter the header date on the special file.
Application Date	Required Input for Plan Submitted Rollover requests	Enter the application date for all file transactions. **Note:** This field does not display for Organization Special Review or Retroactive requests.
Content Description: Transactions in the file are grouped by Transaction Type, Contract, PBP, Creditable Coverage Flag, Election Type, and Effective Date. Each line represents one unique combination of these. Additional lines are populated until all transactions are submitted in the special file described. The user must populate at least one line.		
Transaction Type	Input (Dropdown)	The type of transactions on this line.
Contract	Input (Dropdown)	The contract number for transactions on this line.
PBP	Input (Dropdown)	The PBP number for the transactions on this line.
Creditable Coverage Flag	Input (Dropdown)	The Creditable Coverage Flag (Y or N) for the transactions on this line.
Election Type	Input (Dropdown)	The Election Type for transactions on this line.
Effective Date	Input (For Plan Submitted Rollover requests only)	The Effective Date for transactions on this line.
Count	Input	The number of transactions with the unique combination represented on the line.
Clear	Input	Selects lines to clear with the Clear Line button.
Buttons		
Clear Line	Button	When selected, clears input from selected lines
Submit	Button	Submits the request for approval for the special file described in the Content Description lines.
Return	Button	Returns the user to the View Special Batch File Request (M317) screen.

The MCO Representative Transmitter user can then review the status of the special batch file request through the *Special Batch File Request (M317)* screen. Once the request is submitted an automated email is sent to CMS to review and approve.

Figure 8-66: View Special Batch File Request (M317) Screen

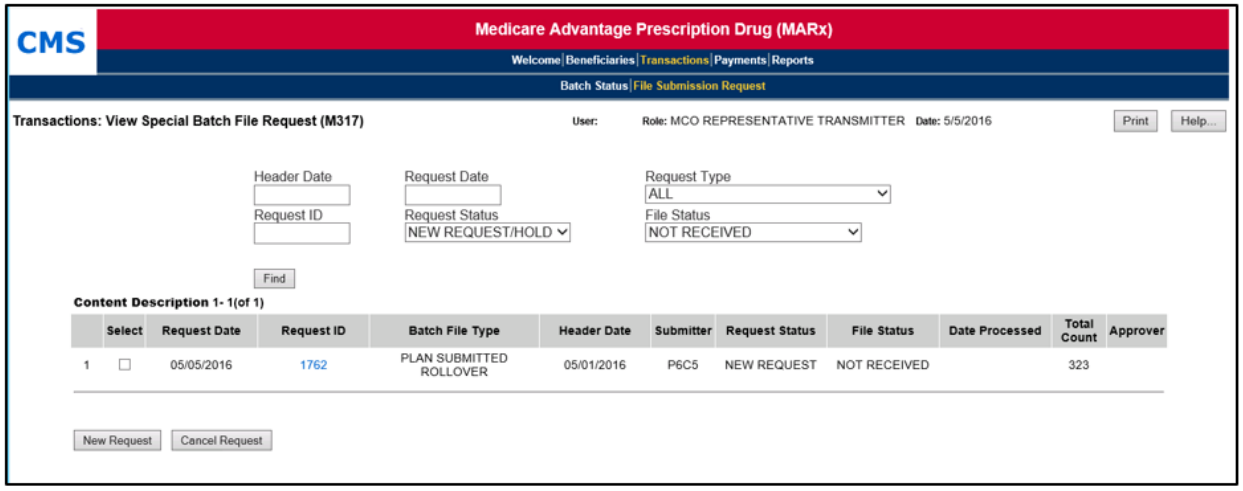


Table 8-43: View Special Batch File Request (M317) Field Descriptions

View Special Batch File Request (M317) Field Descriptions		
Item	**Input/Output**	**Description**
Find Criteria – These fields are used to find previously submitted Special Batch File Requests		
Header Date	Input (optional)	Header date in a file.
Request Date	Input (optional)	Date a request was submitted.
Request Type	Input (optional)	Type of special file for the request: • Retroactive. • Plan Submitted Rollover. • Organization Special Review.
Request Status	Input (optional – drop down)	Status of the requests to find: • New Request/Hold. • New Request. • Approved. • Disapproved. • Cancelled.
Request ID	Input (optional)	ID of a request.
File Status	Input (optional)	Status of file processing to use in the search.
Find	Button	Finds all requests that meet the above search criteria.
Content Description: The following fields are repeated for each request that meets the Find criteria.		
Select	Input	Check box to select a line. This is usually used in coordination with the *Cancel Request* button.
Request Date	Output	Date the request was submitted.
Request ID	Output (Link)	Unique Request ID Clicking on a Request ID takes the user to the *Special Batch Approval Request (M316)* screen, which displays the details of the selected request.
Batch File Type	Output	Type of special file for the request: • Retroactive. • Plan Submitted Rollover. • Organization Special Review.
Header Date	Output	Header date for the special file.

View Special Batch File Request (M317) Field Descriptions		
Item	**Input/Output**	**Description**
Submitter	Output	ID and Name of the person who submitted the Special Batch File Request.
Request Status	Output	Status of the request: • Approved. • Disapproved. • Hold. • New Request.
File Status	Output	Processing status of the special file associated with this request: • Received. • Processed. • Received/Pending Review.
Date Processed	Output	For processed special files, date of processing.
Total Count	Output	Total count of transactions in the special file.
Approver	Output	For an approved request, the ID and name of the person who approved the request.
Selection Buttons		
New Request	Button	This button navigates to the *Special Batch Approval Request (M316)* screen where the user may enter a special request.
Cancel Request	Button	This button cancels the request on the line indicated by a selected checkbox.

8.6 Request Reports

This section describes how to order copies of reports and data files generated for previous months. The ordered reports deliver via Connect:Direct NDM; Sterling Electronic Mailbox, Gentran; or TIBCO MFT Internet Server. There are various types of reports in MARx:

- Daily or randomly occurring reports and data files generate each day for events that occurred that day, including batch transaction file processing or report receipt.
- Weekly reports and data files are scheduled and automatically generate to reflect transactions processed that week for a contract.
- Month-end reports and data files are scheduled and automatically generate as part of monthly payment processing.
- Year-end reports and data files are scheduled and automatically generate as part of monthly payment processing.

Note: Only MCO Representative Transmitters may order reports.

8.6.1 *Request Reports and Data Files*

From the main menu, the user clicks on the |Reports| menu item.

From the *Reports: Find (M601)* screen, the user chooses the report frequency; monthly, weekly, daily or yearly. The selection criteria displayed is affected by the frequency chosen. The user enters the selection criteria that characterize the reports requested. The user clicks on the [Find] button to bring up the *Reports: Search Results (M602)* screen showing all of the reports that meet the criteria.

Figure 8-67: Reports: Find (M601) Screen

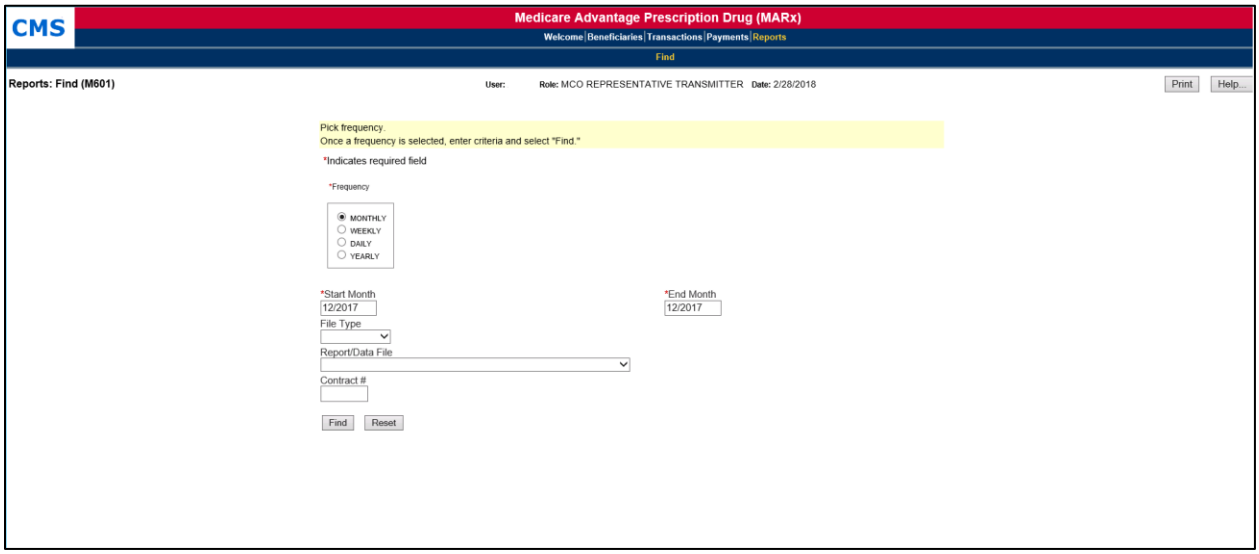


Table 8-44: Reports: Find (M601) Field Descriptions for Monthly and Weekly Reports

Reports: Find (M601) Field Descriptions for Monthly and Weekly Reports		
Item	**Input/Output**	**Description**
Frequency	Required radio button	Select MONTHLY, WEEKLY, DAILY, or YEARLY.
Start Payment Month	Required data entry field	Search for reports for this payment Start month through End Payment Month. Enter as (M)M/CCYY. For monthly reports, defaults to the previous processing month. For daily and weekly reports, defaults to Current Processing Month.
End Payment Month	Required data entry field	Searches for reports for the Start Payment Month through this Payment End month. Enter as (M)M/CCYY. For monthly reports, defaults to the previous processing month. For daily and weekly reports, defaults to Current Processing Month.
File Type	Dropdown list	The user clicks on arrow and selects value to narrow search to report or data file. **Note:** When the File Type is selected, the user does not select the Report/Data File. If both are selected, an error message is displayed and the Find does not proceed.
Report/Data File	Dropdown list	The user clicks on arrow and selects value to narrow search to type of report or data file. **Note:** When the File Type is selected, the user does not select the Report/Data File. If both are selected, an error message is displayed and the Find does not proceed.
Contract #	Data entry field	The user enters to narrow search to a particular contract
[Find]	Button	After entering the search criteria, the user clicks on this button to display the list of reports.

From this list, the user can select a report or data file and click the [Order] button. The user receives a message that the order was submitted.

8.6.2 Daily Reports

The *Reports: Find (601)* screen with selection criteria for daily reports is shown below.

Figure 8-68: Find (M601) Screen for Daily Reports

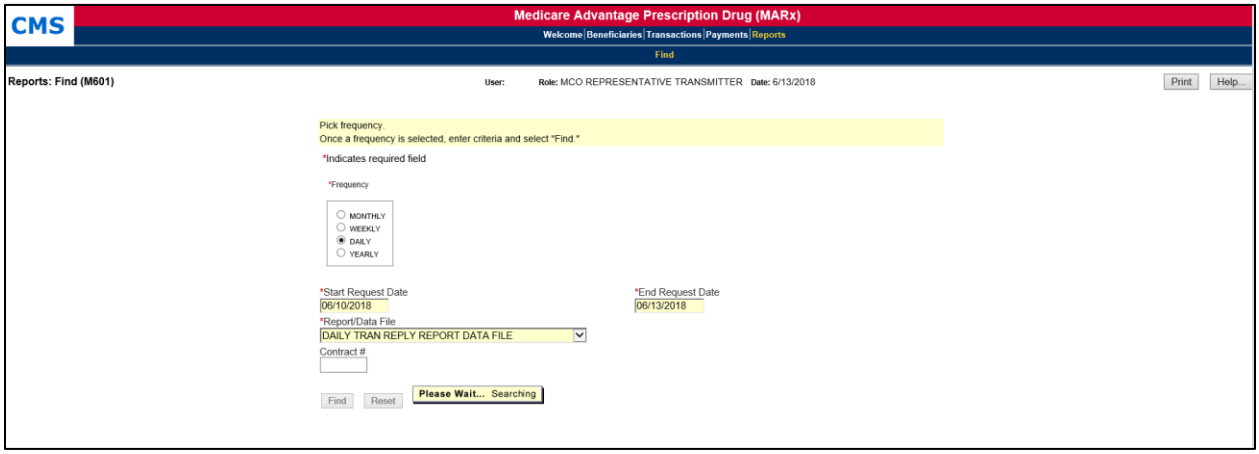


Table 8-45: Reports: Find (M601) Field Descriptions for Daily Reports

Reports: Find (M601) Field Descriptions for Daily Reports		
Item	**Input/Output**	**Description**
Frequency	Required radio button	The user selects DAILY.
Start Request Date	Required data entry field	Search for reports generated on or after this date. The user enters as (M)M/(D)D/CCYY. Defaults to current date.
End Request Date	Required data entry field	Search for reports generated on or before this date. The user enters as (M)M/(D)D/CCYY. Defaults to current date.
Report/Data File	Required dropdown list	The user clicks on arrow and selects value to narrow search to type of report or data file.
Contract #	Data entry field	The user enters to narrow search to a particular contract.
[Find]	Button	After entering the search criteria, the user clicks on this button to display the list of reports.

8.6.3 Yearly Reports

The *Reports: Find (M601)* screen with selection criteria for yearly reports is shown below.

Figure 8-69: Reports: Find (M601) Screen for Yearly Reports

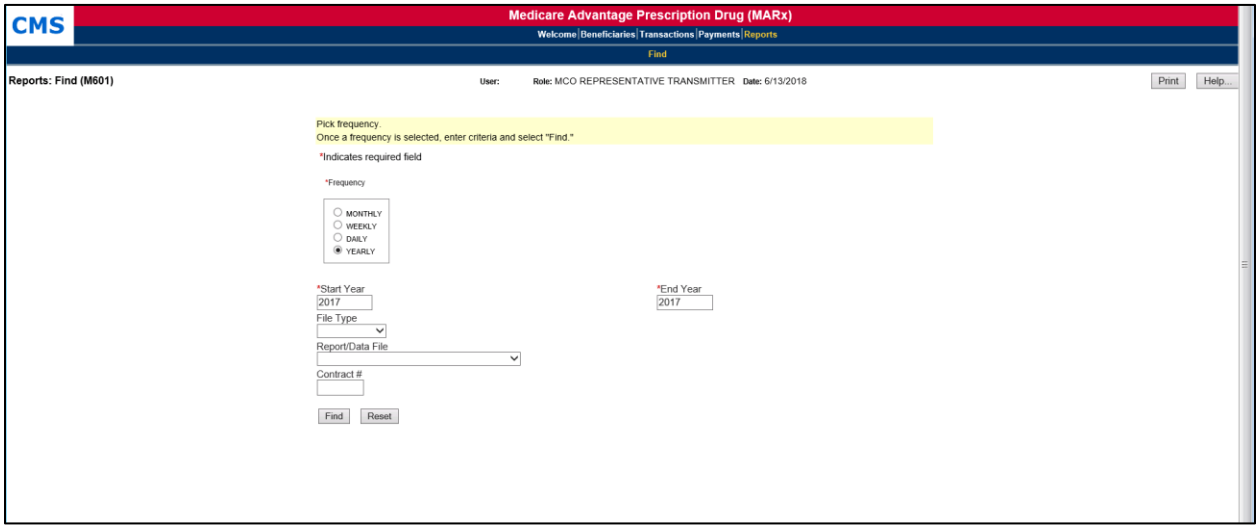


Table 8-46: Reports: Find (M601) Field Descriptions for Yearly Reports

Reports: Find (M601) Field Descriptions for Yearly Reports		
Item	**Input/Output**	**Description**
Frequency	Required radio button	The user selects YEARLY
Start Year	Required data entry field	Searches for report for this year to End year. Enter as (CCYY). For yearly reports, defaults to the previous processing year.
End Year	Required data entry field	Searches for Start Year to this Year report. Enter as (CCYY). For yearly reports, defaults to previous processing year.
File Type	Dropdown list	The user clicks on arrow and selects value to narrow search to report, data file, or combined. **Note:** When the File Type is selected, do not select the Report/Data File. If both are selected, an error message is displayed and the Find does not proceed.
Report/Data File	Dropdown list	The user clicks on arrow and selects value to narrow search to type of report or data file. **Note:** When the File Type is selected, the user does not select the Report/Data File. If both are selected, an error message is displayed and the Find does not proceed.
Contract #	Data entry field	The user enters to narrow search to a particular contract.
[Find]	Button	After the search criteria are entered, the user clicks on this button to display the list of reports.

If a report was not accessed for several years, the user must first retrieve it before accessing it. The screen is divided into two sections: reports immediately available and reports that need retrieval. If no files meet the criteria for a section, that section is not displayed.

Figure 8-70: Reports: Search Results (M602) Screen for Yearly Reports

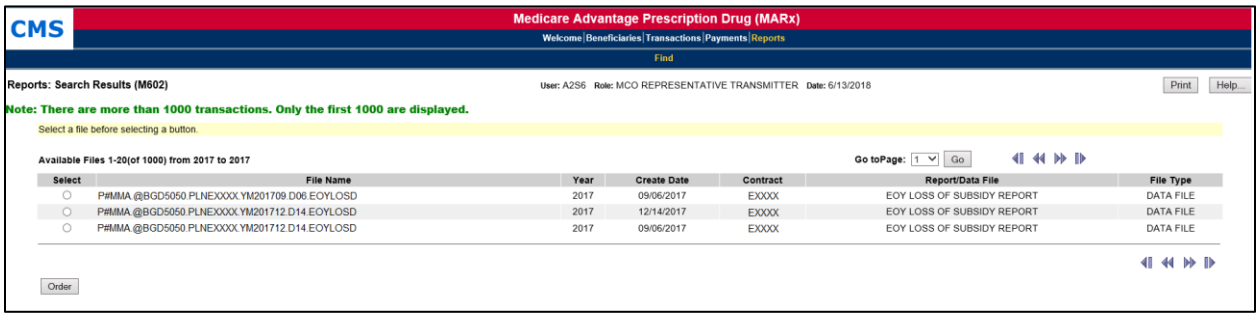


Table 8-47: Reports: Search Results (M602) Field Descriptions for Yearly Reports

Reports: Search Results (M602) Field Descriptions for Yearly Reports		
Item	**Input/Output**	**Description**
Select column	Radio button	The user clicks on one of the buttons to indicate which file to order.
File Name column heading	Sorter	Sorts all files by file name.
Year column heading	Sorter	Sorts all files by year.
Create Date column heading	Sorter	Sorts all files by create date.
Contract column heading	Sorter	Sorts all files by contract number.
Report/Data File column heading	Sorter	Sorts all files by type of report or data file.
File Type column heading	Sorter	Sorts all files by file type, either report or data.
[Order]	Button	After selecting a file, the user clicks on this button to request placement of the file in the mailbox.
www.Adobe.com	Link	A Web link to the Adobe website, where the user can download a free copy of the Adobe Acrobat Reader, required for viewing or local printing. **Note:** The user must connect to the Internet to download Acrobat.

8.7 Reporting Identified Drug Overutilizers

In the section entitled, "Improving Drug Utilization Review Controls in Part D" of the Final Contract Year (CY) 2013 Call Letter issued on April 2, 2012 and in supplemental guidance issued on September 6, 2012, CMS described how Medicare Part D sponsors can comply with drug utilization management (DUM) requirements of 42 C.F.R §423.153 et seq. to prevent overutilization of opioids.[3] In general, the guidance addressed the following expectations for sponsors to address overutilization of opioids effective January 1, 2013:

- Appropriate controls at point of sale (POS), including beneficiary-level claim edits.
- Improved retrospective drug utilization review (DUR) to identify at-risk beneficiaries.
- Case management with the beneficiaries' prescribers.
- Data-sharing between Part D sponsors regarding beneficiary overutilization.

This chapter provides instructions for sponsors to submit beneficiary-level POS drug edit information to CMS, which will automate the current process of providing this information to CMS as well as data-sharing regarding such edits between Part D sponsors.

8.7.1 *CMS Notification of Identified Drug Overutilizers with a POS Drug Edit by Sponsors*

Sponsors will submit beneficiary-level POS drug edit information for Identified Drug Overutilizers to CMS using the MARx UI or the existing batch process, Transaction Code (TC) 90. Sponsors should continue to provide a copy of the notification letter and beneficiary data to their CMS account manager per previous CMS guidance (HPMS memorandum entitled 'Beneficiary-Level Point-of-Sale Edits and Other Overutilization Issues,' August 25, 2014). If the Drug Class is non-opioids, sponsors need to submit a copy of the notification letter and beneficiary data to the CMS Part D OM mailbox (PartD_OM@cms.hhs.gov).

If the batch process is used, POS Drug Edit transactions are submitted in the same way enrollment transactions are submitted to MARx using the MARx Batch Input Transaction Data File. They can be incorporated into batches of enrollment transactions or submitted as a separate batch file. Transaction Reply Codes (TRCs) are returned in the Daily Transaction Reply Report (DTRR) data file to relay the results of the transaction processing. For an overview of transaction processing see **Section 3**.

The *Update POS Drug Edit (M254)* screen is used to submit POS Drug Edit transactions using the MARx UI. TRCs are returned in the Daily Transaction Reply Report (DTRR) data file to relay the results of the transaction processing. For further information on using the *Update POS Drug Edit (M254)* screen, see **Section 8.7.7**.

Sponsors should submit POS Drug Edit data to MARx when any of the following occurs:

- The sponsor notifies the beneficiary of a POS Drug Edit implementation (Notification).
- The sponsor implements the POS Drug Edit (Implementation).
- The sponsor terminates the POS Drug Edit (Termination).

[3] Additional information about the CMS overutilization policy is available on the CMS website at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html.

- The sponsor modifies the POS Drug Edit (i.e., code) after Notification or Implementation.

Section 3 provides the POS Drug Edit (TC 90) Detailed Record Layout.

POS Drug Edits are at the contract level (not contract/PBP). Contract-level users (Contract users) are only allowed to access or modify beneficiary POS Drug Edit information during periods of the beneficiary's enrollment within that contract with a drug Plan. If a beneficiary changes from a PBP with a drug Plan to a PBP without a drug Plan and the contract remains the same, the Contract user is only allowed to submit POS Drug Edit records for the time period when the beneficiary is enrolled in the PBP with a drug Plan. A Contract user can submit a TC 90 record or make modifications through the MARx UI after the beneficiary disenrolls, as long as the notification, implementation and/or termination dates occur during the beneficiary's enrollment within the contract with a drug Plan.

Contract Notification of Active POS Drug Edit

MARx associates an Active POS Drug Edit indicator with a beneficiary-contract enrollment if the latest POS Drug Edit status for at least one drug class is either Notification (Status = 'N') or Implementation (Status = 'I'). When a beneficiary enrolls in a new contract, the new contract ("gaining") is notified if a newly enrolled beneficiary had an Active POS Drug Edit indicator while enrolled in the immediately preceding Part D contract ("losing"). This notification is provided to the new contract via the DTRR with TRC 322, New Enrollee POS Drug Edit Notification. The reply with TRC 322 accompanies the TRCs associated with the enrollment acceptance and has an Enrollment TC 61.

Once the New Enrollee POS Drug Edit Notification (TRC 322) is provided to the new contract, an Active POS Drug Edit indicator is no longer associated with the beneficiary. Since the reply does not include the drug class or real-time status of the POS Drug Edit, identification of the prior contract is provided in the DTRR to facilitate communication between the contracts. The contract is advised to contact the previous contract's Medicare Part D overutilization contact for more information about the beneficiary's POS opioid edit and overutilization case file. The 'gaining' contract can use this information to determine if the same or a modified beneficiary-specific POS drug edit is appropriate per previous CMS guidance. If so, the contract should notify the beneficiary, however, a 30-day advance notice is not required. The Contract user should submit the information through MARx to CMS per the instructions above. The notification and implementation dates may be the same date, and as early as the first day of enrollment in the new contract.

LiNet or retrospective short-enrollments are not considered a 'losing' contract or new enrollment for purposes of the New Enrollee POS Drug Edit Notification, and are therefore excluded, i.e., they will not receive TRC 322.

Section 3 provides the DTRR layout and lists the current TRCs.

CMS and Contract Communications

CMS users have the ability to flag information that is possibly erroneous. After the CMS user flags the information, the contract is notified via the DTRR with TRC 720, CMS Audit Review POS Drug Edit. If the contract has questions after receiving TRC720, they should contact CMS

via e-mail at PartD_OM@cms.hhs.gov with subject "POS Edit Reporting" to discuss the POS Drug Edit information.

An example of a situation that may be flagged by CMS is receipt of two notification records for the same contract, beneficiary, POS Drug Edit Class and Code but neither notification is implemented or terminated.

8.7.2 General Rules for Batch and MARx UI POS Drug Edit Records

POS Drug Edit Event Definition

It is important to note that Notification, Implementation, and Termination records are associated with each other in the MARx system. A POS Drug Edit Event consists of a POS Drug Edit Notification and any POS Drug Edit Implementation and Termination records that are associated with that POS Drug Edit Notification. Below is a list of rules for submitting updated records:

- A POS Drug Edit Notification record can only be associated with one Implementation and Termination record at a time.
- An Implementation record must contain the POS Drug Edit Notification Date of the associated POS Drug Edit Notification record.
- An Implementation record must have the same or less restrictive POS Drug Edit Code as the associated POS Drug Edit Notification record.
- PS2 is less restrictive than PS1.
- A POS Drug Edit Termination record must contain the POS Drug Edit Notification Date and Implementation Date (if it exists) of the associated POS Drug Edit Notification and POS Drug Edit Implementation (if it exists) records.

POS Drug Edit Date Rules

- A POS Drug Edit Notification (status = 'N') record must have blank POS Drug Edit Implementation and Termination dates.
- A POS Drug Edit Implementation (status = 'I') record must have a blank POS Drug Edit Termination date.
- The POS Drug Edit Notification, Implementation and Termination dates must be within the beneficiary's contract enrollment period of an applicable drug Plan.
- The POS Drug Edit Notification date should be the date on the Beneficiary's POS Edit Notification letter unless the POS Drug Edit is a continuation of a POS Drug Edit from a prior Contract, then the Notification Date can be as early as the Beneficiary's enrollment date within the new contract.
- A POS Drug Edit Implementation (status = 'I') record's Implementation date must be on or after the associated POS Drug Edit Notification record's notification date.
- A POS Drug Edit Termination (status = 'T') record's Termination date must be on or after the associated POS Drug Edit Notification record's notification date if there is not an associated POS Drug Edit Implementation record.
- A POS Drug Edit Termination (status = 'T') record's Termination date must be on or after the associated POS Drug Edit Implementation record's Implementation date.
- "Future Dated" Notification, Implementation or Termination records are allowed (but not recommended) and limited to the current and upcoming calendar month.

For example, if the current date is 12/19/2013, a notification date that is between 12/20/2013 and 1/31/2014 is accepted but a notification date of 2/1/2014 would be rejected. Similarly, if the current date and notification date are 1/20/2014, the "future-dated" implementation date must be between 2/20/2014 and 2/28/2014.

Beneficiary Disenrollment and Re-enrollment Rules:

- If a beneficiary disenrolls from the contract that notified the beneficiary of the POS Drug Edit, the Contract user should not submit a POS Drug Edit Termination record. If a Termination record is submitted, the "gaining" contract will not receive the Active POS Drug Edit indicator. In addition, if the beneficiary dies it is un-necessary for the Contract user to submit a termination record.
- If there is an enrollment gap between Notification and Implementation or after Implementation, the Contract user must submit a new notification record to MARx. The sponsor should re-notify the beneficiary and the Contract user may use the enrollment start date for the Notification and/or Implementation date, if applicable.

POS Drug Edit Notification Record Deletion

A POS Drug Edit Notification record should not be deleted from MARx if a POS Drug Edit determination was made by the sponsor and the beneficiary was notified, unless the notification record was submitted for the wrong beneficiary. If the sponsor decides not to implement the POS Drug edit, the POS Drug edit should be terminated.

Inserting an Implementation Record after POS Edit Termination

If a POS Drug Edit Event contains POS Drug Edit Notification and Termination records without a POS Drug Edit Implementation record, it is not possible to add a POS Drug Edit Implementation record without first deleting the existing POS Drug Edit Termination record. After adding the POS Drug Edit Implementation record, the POS Drug Edit Termination record can be re-submitted, if appropriate.

8.7.3 *Batch Submission of POS Drug Edit Records: Notification, Implementation, and Termination*

The Contract user should submit the POS Drug Edit Notification, Implementation, and Termination records to MARx when issuing the written notification of a POS Drug Edit to the beneficiary, implementing such an edit, and deciding that a termination record is warranted, respectively. (Deletion of POS Drug Edits Records and Modified POS Drug Edit Code Implementations are covered in Sections 11.4 and 11.5, respectively).

Notification Status 'N'

The required POS Drug Edit Notification record (status = 'N') may be submitted to MARx using a POS Drug Edit transaction (TC 90). In addition to beneficiary and contract information, the following details are required for a notification record:

- POS Drug Edit Status = 'N'.
- POS Drug Edit Drug Class = Three letter drug class abbreviation i.e. 'OPI' (opioids).
- POS Drug Edit Code.
    - PS1 = No drugs in this class are approved by the Contract.
    - PS2 = Selected drugs in this class are approved by the Contract.

- POS Drug Edit Notification Date.
    - Actual date of the POS Drug Edit Notification written notice that was sent to the beneficiary.
- POS Drug Edit Update/Delete Flag = 'U'.

Sponsors are expected to take action following a notification:

- Implement the POS Drug Edit as stated in the POS Drug Edit Notification provided to the beneficiary.
- Implement a modified POS Drug Edit.
- Terminate a POS Drug Edit that is not implemented.

Therefore, the Contract user should submit a POS Drug Edit Implementation (status = 'I') or Termination (status = 'T') record to MARx using a POS Drug Edit transaction (TC 90), or through the MARx UI.

POS Drug Edit Status "I"

A Contract user should submit a POS Drug Edit Implementation (status 'I') if the edit is implemented as stated in the POS Drug Edit Notification provided to the beneficiary. In addition to beneficiary and contract information, the following details are required for an Implementation record:

- POS Drug Edit Status = 'I'.
- POS Drug Edit Drug Class = Three letter drug class abbreviation i.e. 'OPI' (opioids).
- POS Drug Edit Code must be the same or less restrictive than the POS Drug Edit Notification Record.
    - PS1 = No drugs in this class are approved by the Contract.
    - PS2= Selected drugs in this class are approved by the Contract.
      Note: PS2 is less restrictive than PS1.
- POS Drug Edit Notification Date.
    - Notification date that was previously submitted to MARx on the Notification Record.
- POS Drug Edit Implementation Date.
    - Actual date the POS Drug Edit was implemented.
- POS Drug Edit Update/Delete Flag = 'U'.

POS Drug Edit Status 'T'

A Contract user should submit a POS Drug Edit Termination (status = 'T') record if a determination was made not to implement a POS Drug Edit for a beneficiary who was notified of a potential POS Drug Edit. A Contract user may also terminate a POS Drug Edit that was implemented if determined at any point that it is no longer appropriate. In addition to beneficiary and contract information, the following details are required for a termination record:

- POS Drug Edit Status = 'T'.
- POS Drug Edit Drug Class = Three letter drug class abbreviation i.e. 'OPI' (opioids).
- POS Drug Edit Code must be the same as an existing notification or implementation (if it exists) record(s).
    - PS1 = No drugs in this class are approved by the Contract.
    - PS2 = Selected drugs in this class are approved by the Contract.

- POS Drug Edit Notification Date.
    - Notification date that was previously submitted to MARx on the Notification Record.
- POS Drug Edit Implementation Date (if it exists).
    - Implementation date that was previously submitted to MARx on the Notification Record.
- POS Drug Edit Termination Date.
    - Actual date the POS Drug Edit was terminated.
- POS Drug Edit Update/Delete Flag = 'U'.

8.7.4 *Batch Deletion of POS Drug Edit Records*

There are instances when an existing POS Drug Edit record must be removed from the MARx system. A deletion record may be submitted via batch.

Examples of scenarios when the deletion of a POS Drug Edit record is appropriate:

- Date, Class, or Code corrections following a data-entry error.
    - The Contract user must then submit the correct record AFTER deleting the record.
- "Future-dated" (Status 'I') records that are determined to be incorrect.
- A record is erroneously submitted.

The deletion of a POS edit record is not appropriate in order to modify the POS Drug Edit after Notification or Implementation. A record should not be deleted if a POS Drug Edit determination was made by the sponsor, the beneficiary was notified, and the edit was or was not implemented.

For example, if a beneficiary is notified of a potential POS Drug Edit and the sponsor subsequently decides not to implement the POS Drug Edit, then the notification record should NOT be deleted. The Contract user should terminate the POS Drug Edit by submitting a termination record as described above. However, if the Notification record is erroneous, such as a notification record for the wrong beneficiary was submitted, then that Notification record should be deleted.

For the record to be deleted using a TC 90, a deletion record is submitted by providing all of the applicable fields with matching values to the original record with a POS Drug Edit Update/Delete Flag = 'D'. For example, if a future-dated 'Implementation' record was submitted to MARx but the POS edit was never implemented, the Contract user should provide the following information in addition to beneficiary and contract information:

- POS Drug Edit Status = 'I'.
- POS Drug Edit Drug Class = Three letter drug class abbreviation i.e. 'OPI (opioids).
- POS Drug Edit Code.
    - MUST match an existing POS Drug Edit Implementation record.
- POS Drug Edit Notification and Implementation Dates.
    - MUST match an existing POS Drug Edit Notification and Implementation record.
- POS Drug Edit Update/Delete Flag = 'D'.

A deletion record must have the same beneficiary data, contract, POS Drug Edit Class, Code, Status and Dates as an existing POS Drug Edit record.

The system will automatically perform deletes for POS Drug Edit Notification and Implementation Records as detailed below:

- If a delete (update/delete flag = 'D') transaction is received for a POS Drug Edit Notification (status = 'N') record with associated POS Drug Edit Implementation and/or Termination records, the associated POS Drug Edit Implementation and/or Termination records are also deleted.
- If a delete transaction (update/delete flag = 'D') is received for a POS Drug Edit Implementation (status = 'I') record with an associated POS Drug Edit Termination record, the associated POS Drug Edit Termination record will also be deleted.

8.7.5 *Batch Modified POS Drug Edit Code Implementations*

This section discusses situations where the modifications to records would be appropriate.

Situation 1: A sponsor determines that a more restrictive POS Drug Edit (PS1) is appropriate, provides written notice to the beneficiary, but before or after implementation, determines that a less restrictive POS Drug Edit (PS2) is appropriate.

If the sponsor determines that a less restrictive POS Drug Edit (PS2) is appropriate than was stated in the original submitted POS Drug Edit (PS1) Notification record, and the POS Drug Edit (PS1) Implementation record was not submitted, the Contract user should provide the following information in addition to beneficiary and contract information:

- POS Drug Edit Status = 'I'.
- POS Drug Edit Drug Class = Three letter drug class abbreviation i.e. 'OPI' (opioids).
- POS Drug Edit Code = PS2.
- POS Drug Edit Notification Date.
    - MUST match the original notification date submitted with PS1 Drug Edit Code.
- POS Drug Edit Update/Delete Flag = 'U'.

In the scenario above, if the POS Drug Edit (PS1) Implementation record was submitted, the Contract user should submit a POS Drug Edit Termination record with the following information in addition to beneficiary and contract information:

- POS Drug Edit Status = 'T'.
- POS Drug Edit Drug Class = Three letter drug class abbreviation i.e. 'OPI' (opioids).
- POS Drug Edit Code = PS1.
- POS Drug Edit Notification Date.
    - MUST match the existing POS Drug Edit Notification record for the beneficiary and contract.
- POS Drug Edit Implementation Date.
    - MUST match the existing POS Drug Edit Implementation record for the beneficiary and contract.
- POS Drug Edit Termination date.
    - Actual date the POS Drug Edit was terminated.
- POS Drug Edit Update/Delete Flag = 'U'.

Next, the Contract user should submit a new POS Drug Edit Implementation record with the less restrictive POS Drug Edit Code (PS2) and the original POS Drug Edit Notification date (same as above example implementation).

Situation 2: A sponsor determines that a more restrictive POS Drug Edit (PS1) is appropriate after providing written notice to the beneficiary that a less restrictive POS Drug Edit (PS2) would be implemented. The less restrictive POS Drug Edit (PS2) may or may not have been implemented.

If a sponsor notified the beneficiary that a less restrictive POS Drug Edit (PS2) would be implemented, the sponsor **cannot** implement a more restrictive POS Drug Edit (PS1) than was stated in the notice without notifying the beneficiary. In this instance, the sponsor has two options after sending the beneficiary a new notification letter and submitting a new POS Drug Edit Notification record with the **new** notification date and the more restrictive POS Drug Edit Code (PS1):

- Implement the less restrictive POS Drug Edit (PS2) on the date noted in the original notification letter to the beneficiary which overlaps with the 30-day advance notice for the more restrictive POS Drug Edit.
    - When the more restrictive POS Drug Edit (PS1) is implemented and the implementation record is submitted to MARx, the Contract user must terminate the less restrictive POS Drug Edit record by submitting a POS Drug Edit Termination record with the Notification and Implementation dates of the less restrictive POS Drug Edit (PS2).
- Terminate the less restrictive POS Drug Edit Notification (PS2) by submitting a POS Drug Edit Termination record with the Notification date of the less restrictive POS Drug Edit Notification (PS2). Then, implement the more restrictive POS Drug Edit (PS1) following the 30-day advance notice.

If the less restrictive POS Drug Edit (PS2) was implemented following the 30-day notification, the sponsor can keep the less restrictive POS Drug Edit (PS2) in place while the new 30 day notification period is in effect. Once the sponsor implements the more restrictive POS Drug Edit (PS1), the less restrictive POS Drug Edit (PS2) Implementation record must be terminated by submitting a POS Drug Edit Termination record with the Notification and Implementation dates of the less restrictive POS Drug Edit (PS2). This action is the same as described in the first bullet.

Contract users should only submit POS Drug Edit changes that result in either a more or less restrictive POS Drug Edit code. Modifications that only modify the condition (e.g., quantity, strengths) of a current active POS edit that would result in the same POS Drug Edit code should not be submitted.

8.7.6 Batch Submission Records Sort

POS Drug Edit records received on a batch file are sorted in the following order by the MARx system:

- Delete records are sorted before update (add) records and are sorted in the following order:
  - POS Drug Edit Termination records.
  - POS Drug Edit Implementation records.
  - POS Drug Edit Notification records.
- Update (add) records are sorted in the following order:
  - POS Drug Edit Notification records.
  - POS Drug Edit Implementation records.
  - POS Drug Edit Termination records.

8.7.7 POS Drug Edit Screens

Part D contracts and CMS users may enter and update beneficiary POS Drug Edit information through the MARx UI. The *Update POS Drug Edit (M254)* screen as shown below, allows users with the MDBG POS Edit User and MCO POS Edit User roles to change or delete any POS Drug Edit Event that was submitted to CMS.

The Contracts will only see POS Drug Edit information for periods during which the beneficiary is enrolled in any of their Contracts. The screen also includes a blank line, labelled *New*, which allows the user to enter a new POS Drug Edit Event for the Beneficiary.

To navigate to the *Update POS Drug Edit (M254)* screen select the Update Enrollment link from the *Beneficiaries: Search Results (M202)* screen.

Figure 8-71: Update POS Drug Edit Screen (M254)

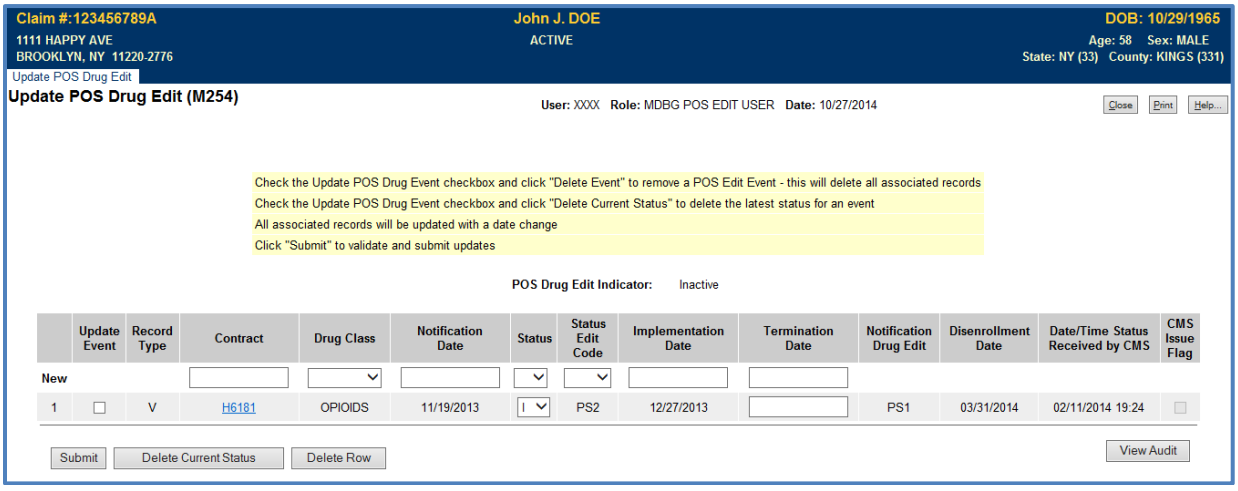


Table 8-48: Update POS Drug Edit Screen (M254) Field Descriptions

Update POS Drug Edit Screen (M254) Field Descriptions		
Item	**Input/Output**	**Description**
The *New* Line This line is used to enter new POS Drug Edit information. Users can only add POS Drug Edit information for periods during the beneficiary's enrollment in a contract to which the user has access.		
Contract	Input	Contract in which the beneficiary was enrolled during the period on this line.
Drug Class	Input (Dropdown list)	Drug Class for the POS Drug Edit on this line.
Notification Date	Input	Notification Date for the POS Drug Edit on this line.
Status	Input (Dropdown list)	Status for the POS Drug Edit on this line.
Status Edit Code	Input	Status Edit Code for the POS Drug Edit on this line.
Implementation Date	Input	Implementation Date for the POS Drug Edit on this line.
Termination Date	Input	Termination Date for the POS Drug Edit on this line.
Updating or Deleting POS Drug Edit Information This section contains one line for each POS Drug Edit Event. The user can edit each line to mark it for delete or update the available fields.		
Update Event	Input	Check this box, then select the desired action (i.e. Submit, Delete Current Status, Delete Row) when updating or deleting information for a POS Drug Edit Event
Record Type	Output	'V' denotes a valid record. 'A' denotes an audited record. *The user cannot update this field.*
Contract	Link	Select the Contract link in the Contract column to display the POS Drug Edit Detail (M255) screen. *The user cannot update this field.*
Drug Class	Output	Drug Class for POS Drug Edit Event on this line. *The user cannot update this field.*
Notification Date	Output	Notification Date for the POS Drug Edit Event on this line. *The user cannot update this field.*
Status	Input (Dropdown list)	The user can update the Status when the corresponding dates (implementation and/or termination) are entered.
Status Edit Code	Input (Dropdown list)	The user can update the Status Edit Code when an implementation record is being entered that is less restrictive than the notification record on this line.
Implementation Date	Output, Input	The user can enter an Implementation Date if the previous Status was 'N'. *If the implementation date was previously submitted, the user cannot update this field.*
Termination Date	Output, Input	The user can enter a Termination Date if the field is blank. *If the termination date was previously submitted, the user cannot update this field.*
Notification Drug Edit	Output	The POS Drug Edit Code that was submitted on the notification record that is associated with the POS Drug Edit Event on this line. *The user cannot update this field.*
Disenrollment Date	Output	The Disenrollment Date for the Contract enrollment period of the Contract that submitted the POS Drug Edit information.
Date/Time Status Received by CMS	Output	The time and date of the latest update for this row. *The user cannot update this field.*

Update POS Drug Edit Screen (M254) Field Descriptions		
Item	**Input/Output**	**Description**
CMS Issue Flag	Output	Checkbox that denotes a CMS user has flagged this row for further review by the Contract. *The user cannot update this field.*
Action Buttons These buttons operate on any selected lines by checking the Update Event checkbox.		
Submit	Button	Any POS Drug Edit information entered on the New line or POS Drug Edit changes in a selected line is submitted for processing. After processing, the updated information is viewable in the list of POS Drug Edit Events for the beneficiary.
Delete Current Status	Button	The latest status and corresponding date is deleted from the beneficiary's record.
Delete Row	Button	All records for the row are deleted. If the Notification record was associated with more than one POS Drug Edit Event then that Notification record will not be deleted.
Audit Button		
View Audit	Button	Displays both valid and audited event information in the following order: • Notification Date in descending order • Record type in descending order (V-valid before A-Audited) • Received date and time in descending order
Hide Audit	Button	Only displayed when viewing audit records.

From the *Update POS Drug Edit Screen (M254)*, users with MCO POS Edit User or MDBG POS Edit user roles may select the Contract Link to view the *POS Drug Edit Detail (M255)* screen as shown below. The *POS Drug Edit Detail (M255)* screen provides the user with information about when each transaction for a POS Drug Edit Event was received by CMS. This screen is view only; no updates can be made using this screen.

Figure 8-72: POS Drug Edit Detail Screen (M255)

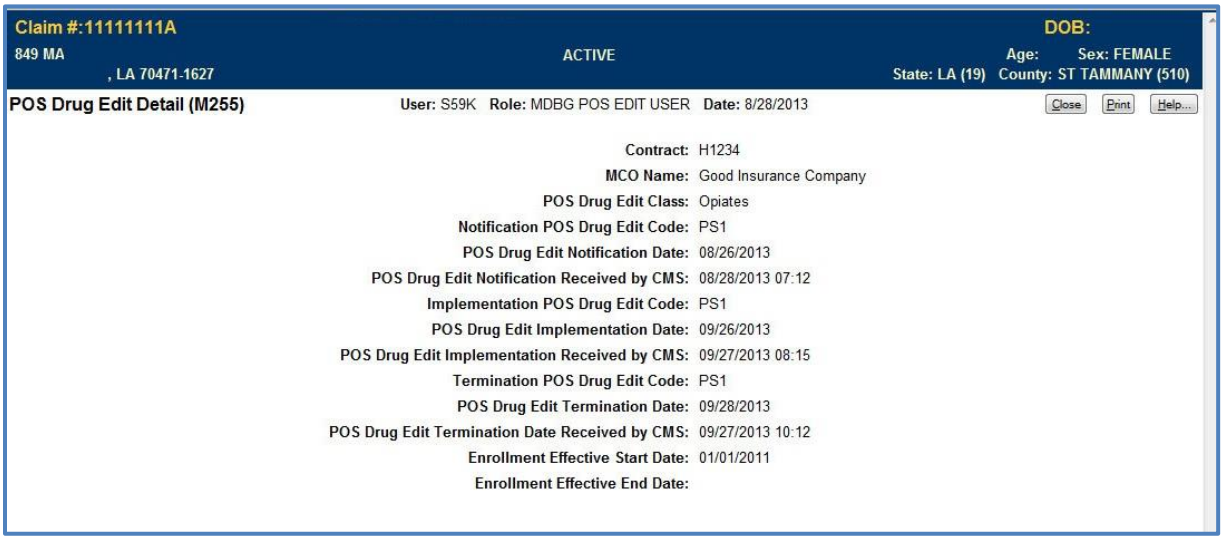


Table 8-49: POS Drug Edit Detail Screen (M255) Field Descriptions

POS Drug Edit Detail Screen (M255) Field Descriptions		
Item	**Input/Output**	**Description**
POS Drug Edit Event Information This section provides further details about the Contract, Enrollment and when information was received by CMS.		
Contract	Output	Contract that submitted the POS Drug Edit information.
MCO Name	Output	Name of the Contract.
POS Drug Edit Class	Output	Drug Class for POS Drug Edit Event.
Notification POS Drug Edit Code	Output	The POS Drug Edit Code that was submitted on the notification record that is associated with the POS Drug Edit Event.
POS Drug Edit Notification Date	Output	Notification Date for the POS Drug Edit Event.
POS Drug Edit Notification Received by CMS	Output	System date and time that the notification record was received by CMS either via batch transaction or the MARx UI.
Implementation POS Drug Edit Code	Output	The POS Drug Edit Code that was submitted on the implementation record that is associated with the POS Drug Edit Event.
POS Drug Edit Implementation Date	Output	Implementation Date for the POS Drug Edit Event.
POS Drug Edit Implementation Received by CMS	Output	System date and time that the implementation record was received by CMS either via batch transaction or the MARx UI.
Termination POS Drug Edit Code	Output	The POS Drug Edit Code that was submitted on the termination record that is associated with the POS Drug Edit Event.
POS Drug Edit Termination Date	Output	Termination Date for the POS Drug Edit Event.
POS Drug Edit Termination Received by CMS	Output	System date and time that the termination record was received by CMS either via batch transaction or the MARx UI.
Enrollment Effective Start Date	Output	When the Part D Enrollment began for the beneficiary.
Enrollment Effective End Date	Output	When the Part D Enrollment ended for the beneficiary.
Button		
Close	Button	Returns user to the Update POS Drug Edit Screen (M254)

8.7.8 MARx UI Deletion of POS Drug Edit Records

There are instances when an existing POS Drug Edit record must be removed from the MARx system. A deletion record can be submitted via the MARx UI using the *Update POS Drug Edit (M254)* screen.

Section 8.7.4, Batch Deletion of POS Drug Edit Records provides details about when it is appropriate to delete a POS Drug Edit Record.

It is not possible to change a date or edit code without first deleting the incorrect record.

There are two Delete Buttons on the *Update POS Drug Edit (M254)* screen:

- Delete Current Status
- Delete Row

If the Contract user determines that the latest record submitted for the event should be deleted:

- Check the Update Event Checkbox of the row with the record to be deleted
- Select the Delete Current Status Button

If a termination record has been submitted for the event and the implementation record should be deleted, the above steps can be executed two times. The first time will delete the termination record and the second time will delete the implementation record. If appropriate the POS Drug Edit Event can then be updated. After deleting the current status the previous status for the event will now be the current status. For example, if a POS Drug Edit event was implemented but not terminated and the Delete Current Status Button is used, the POS Drug Edit event will have an 'N' (notification) status.

If the Contract user determines the entire event should be deleted:

- Check the Update Event Checkbox of the row to be deleted.
- Select the Delete Current Status Button

The Notification, Implementation (if existed), and Termination (if existed) records will all be deleted. If appropriate, correct records can be submitted.

There are scenarios where multiple implementation records can be associated with one notification record when one implementation record was terminated. If the Delete Row is used on a row with this scenario, he notification record will not be deleted but will remain associated with the non-deleted implementation record. The row that was deleted will not appear on the *Update POS Drug Edit (M254)* screen unless the view audit button is selected.

Section 8.7.5, Batch Modified POS Drug Edit Code Implementations provides further information.

8.7.9 MARx UI Modified Implementation records from PS1 to PS2

If a sponsor determines that a more restrictive POS Drug Edit (PS1) is appropriate, provides written notice to the beneficiary, but before or after implementation, determines that a less restrictive POS Drug Edit (PS2) is appropriate, the MARx UI can be used by the Contract user to submit these records.

If a POS Drug Edit has not been implemented but the beneficiary was notified:

- Check the Update Event checkbox for the row with the notification record.
- Change the Status from 'N' to 'I'.
- Change the Status Edit Code to the less restrictive Edit Code (e.g. change from PS1 to PS2).
- Enter the Implementation Date.
- Select Submit.
- The new row will be visible with a more restrictive "Notification Drug Edit" and a less restrictive "Status Edit Code".

If the POS Drug Edit was implemented:

- Check the Update Event checkbox for the row with the implementation record.
- Change the Status from 'I' to 'T'.
- Enter the Termination Date.
- Select Submit.
- On the New line enter the Contract, Drug Class, Notification Date (will be the same as the terminated record i.e. the original Notification Date), Status of 'I', less restrictive Status Edit Code and Implementation Date.
- Select Submit.
- The new row will be visible with a more restrictive "Notification Drug Edit" and a less restrictive "Status Edit Code".

8.7.10 Future Enhancements

Other Drug Classes and Edit Codes may be implemented in the future. Normal Plan Communications will be used to alert the Part D sponsors when this occurs.

If you have any questions, please contact the new CMS Part D OM mailbox at PartD_OM@cms.hhs.gov and put "User Guide" in the subject line.

9 Glossary and Acronyms

9.1 Glossary

Glossary	
Term	**Definition**
Accepted Transaction	The successful application of a requested action that was processed by MARx.
Account Number	A number obtained from the Resource Access Control Facility (RACF) or system administrator.
Application Date	The date that the beneficiary applies to enroll in a Plan. Enrollments submitted by CMS or its contractors, such as the Medicare Beneficiary Contact Center, do not need application dates.
Batch Transaction	An automated systems approach to processing in which data items to process must be grouped and processed in bulk.
Beneficiary Identification Code (BIC)	The portion of the Medicare Health Insurance Claim Number (HICN) that identifies a specific beneficiary.
Benefit Stabilization Fund (BSF)	Established by CMS upon request of an HMO or CMP, when the HMO or CMP must provide its Medicare enrollees with additional benefits, to prevent excessive fluctuation in the provision of those benefits in subsequent contract periods.
Button	A rectangular icon on a screen which, when clicked, engages an action. The button is labeled with word(s) that describe the action, such as Find or Update.
Cancellation Transaction	A cancellation may result from an action by the beneficiary, CMS, or another Plan before the effective date of the election. A cancelled enrollment restores the beneficiary to his/her prior enrollment state.
Checkbox	A field that is part of a group of options, for which the user may select any number of options. Each option is represented with a small box, where 'x' means "on" and an empty box means "off." When a checkbox is clicked, an 'x' appears in the box. When the checkbox is clicked again, the 'x' is removed.
Connect:Direct	The proprietary software that transfers files between systems.
Correction	A record submitted by a Plan or CMS office to correct or update existing Beneficiary data.
Cost Plan	A type of contract under which a Plan is reimbursed by CMS for its reasonable costs.
Current Calendar Month (CCM)	Represents the calendar month and year at the time of transaction submission. For batch, the current month is derived from the batch file transmission date. For MARx UI transactions, the current month is derived from the system data at the time of transaction submission.
Current Processing Month	The calendar month in which processing occurs to generate payments. The Current Processing Month is distinguished from the CPM, the month in which Plans receive payment from CMS.
Current Payment Month (CPM)	The month for which Plans receive payment from CMS, not the current calendar month.
Creditable Coverage	Prescription drug coverage, generally from an employer or union, that is equivalent to, or better than, Medicare standard prescription drug coverage.
Data entry field	A field that requires the user to enter information.
Deductible	The amount a Beneficiary must pay for medical services or prescription drugs before a Plan starts paying benefits.
Disenrollment	A record submitted by a Plan, Social Security Administration District Office (SSA DO), Medicare Customer Service Center (MCSC), or CMS when a beneficiary discontinues membership in the Plan.

Glossary	
Term	**Definition**
Dropdown list	A field that contains a list of values from which the user chooses. Clicking on the down arrow on the right of the field enables the user to view the list of values, and then click on a value to select it.
Dual Eligible	Individuals entitled to both Medicare and Medicaid benefits.
Election Period	Time periods during which a Beneficiary may elect to join, change, or leave Medicare Part C and/or Part D Plans. These periods are fully defined in CMS Enrollment and Disenrollment guidance for Part C and D Plans.
Enrollment	A record submitted when a Beneficiary joins an MCO or a drug Plan.
Enrollment Process	A process in which a Plan submits a request to enroll in a Plan, change enrollment, or disenroll.
Exception	A transaction that is unprocessed due to errors or internal inconsistencies.
Failed Payment Reply Codes	Codes used for the Failed Payment Reply Report that identify incomplete payment calculations for a beneficiary.
Failed Transaction	A transaction that did not complete due to problems with the format of the transaction or internal system problems.
Formulary	The medications covered by an MA organization or Prescription Drug Plan.
Gentran	The Gentran servers provide Electronic Data Interchange (EDI) capabilities between CMS and CMS business partners. These servers provide CMS with transaction files from the Plans, and provide the Plans with CMS reports.
Hospice	A health facility for the terminally ill.
Logoff	The method of exiting an online system.
Logon	The method for gaining entry to an online system.
Lookup field	A field that provides a list of possible values. When the user clicks on the "binocular" button next to the field, a window pops up with a list of values for that field. Clicking on one of those values closes the pop-up window and the field is filled with the value chosen.
Medicaid	A jointly funded, Federal-State health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people eligible to receive Federally assisted income maintenance payments.
Managed Care Organization (MCO)	A type of contract under which CMS pays for each member, based on demographic characteristics and health status; also referred to as Risk. In a Risk contract, the MCO accepts the risk if the payment does not cover the cost of services, but keeps the difference if the payment is greater than the cost of services. Risk is managed through a membership where the high costs for very sick members are balanced by the lower cost for a larger number of relatively healthy members.
Menu	A horizontal list of items at the top of a screen. Clicking on a menu item displays a screen and may display a submenu of items corresponding to the selected menu item.
Nursing Home Certifiable (NHC)	A code that reflects the relative frailty of an individual. NHC Beneficiaries are those whose condition would ordinarily require nursing home care. The code is only acceptable for certain social health maintenance organization (SHMO)-type Plans.
Off-cycle	A retroactive transaction awaiting CMS approval because its effective date is too old for automatic acceptance.
Online	An automated systems approach that processes data in an interactive manner, normally through computer input.
Premium	The monthly payment a Beneficiary makes to Medicare, an insurance company, or a healthcare Plan.
Premium Payment Option (PPO)	The method selected by the beneficiary to pay the premium owed to the Plan. PPO choices are: (1) withhold from SSA (S) or RRB (R) benefit check or (2) Direct self-pay (D) to the Plan.

Glossary	
Term	**Definition**
Program for All Inclusive. Care for the Elderly (PACE) Plans	PACE is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity that features a comprehensive medical and social service delivery system. It uses a multidisciplinary team approach in an adult day health center supplemented by in-home and referral service in accordance with participants' needs.
Radio button	A field that is part of a group of options, of which the user may only select one option. A radio button is represented with a small circle; a filled circle indicates the button is selected, and an empty circle means it is not selected. Clicking a radio button selects that option and deselects the existing selection.
Required field	A field that the user must complete before a button is clicked to engage an action. If the button is clicked and the field is not filled in, an error message displays and the action does not occur. There are two types of required fields: • Always required, which are marked with an asterisk (*). • Conditionally required, where the user must fill in at least one or only one of the conditionally required fields. These are marked with a plus sign (+).
Risk	A contract under which Beneficiaries are "locked in" to network providers and a payment is received from CMS for each member, based on demographic characteristics and health status. In a Risk contract, the MCO accepts the risk if the payment does not cover the cost of services, but keeps the difference if the payment is greater than the cost of services. Risk is managed through a membership where the high costs for very sick members are balanced by the lower costs for a larger number of relatively healthy members.
Special Needs Plan (SNP)	A certain type of MA Plan that serves a limited population of individuals in CMS special-needs categories, as defined in CMS Part C Enrollment and Eligibility Guidance. This Plan is fully defined on the CMS website at the following link: http://www.cms.gov/home/medicare.asp under "Health Plans."
Submenu	A horizontal list of items below the screen's menu. Clicking on a submenu item displays a screen.
TIBCO MFT Internet Server	The TIBCO MFT Internet Servers provide Electronic Data Interchange (EDI) capabilities between CMS and CMS business partners. These servers provide CMS with transaction files from the Plans, and provide the Plans with CMS reports.
Transaction Code (TC)	Identifies batch transactions submitted by the Plans or CMS.
Transaction Reply Code (TRC)	The code that explains the action taken by the system in response to new information from CMS systems or in response to input from MCOs, CMS, or other users.
User ID	Valid user identification code for accessing the CMS Data Center and the Medicare Data Communications Network.
User Interface	The screens, forms, and menus that display to a user logged on to an automated system.

9.2 Acronyms

Acronyms Used in this Guide	
Acronym	**Definition**
AAPCC	Adjusted Average Per Capita Cost
ADAP	AIDS Drug Assistance Program
AE-FE	Automated Enrollment-Facilitated Enrollment
AEP	Annual Enrollment Period
APPS	Automated Plan Payment System
BBA	Balanced Budget Act of 1997
BCRC	Benefits Coordination & Recovery Center
BCSS	Batch Completion Status Summary
BEQ	Beneficiary Eligibility Query
BIC	Beneficiary Identification Code
BIN	Beneficiary Identification Number
BIPA	Benefits Improvement & Protection Act of 2000
BSF	Benefit Stabilization Fund
CAN	Claim Account Number
CCIP/FFS	Chronic Care Improvement Program/Fee-for-Service
CCM	Current Calendar Month
C:D	Connect:Direct
CHF	Congestive Heart Failure
CM	Center for Medicare
CMP	Civil Monetary Penalty
CMP	Competitive Medical Plan
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
COB	Close of Business
COB	Coordination of Benefits
COBA	Coordination of Benefits Agreement
COM	Current Operation Month
CPM	Current Payment Month
CR	Change Request
CSR	Customer Service Representative
CWF	Common Working File database (CMS' beneficiary database)
DCG	Diagnostic Cost Group
DDPS	Drug Data Processing System
DO	District Office
DOB	Date of Birth
DOD	Date of Death
DOS	Date of Service
DPO	Division of Payment Operations
DSA	Data Sharing Agreement

Acronyms Used in this Guide	
Acronym	**Definition**
DTL	Detail
DTRR	Daily Transaction Reply Report
ECRS	Electronic Correspondence Referral System
EDB	Enrollment Database
EFT	Electronic Funds Transfer
EFT	Enterprise File Transfer
EGHP	Employer Group Health Plan
EIN	Employee Identification Number
EIDM	Enterprise Identity Management
EOY	End of Year
EPOC	External Point of Contact
ESRD	End Stage Renal Disease
FDB	Facilitated Direct Bill
FERAS	Front End Risk Adjustment System
FFS	Fee-For-Service
FTR	Failed Transaction Report
GHP	Group Health Plan
HCC	Hierarchical Condition Category
HCPP	Health Care Prepayment Plan
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HPMS	Health Plan Management System
HTML	Hypertext Markup Language
HTTPS	Hypertext Transfer Protocol Secure ICD
IC	Innovation Center
ICD-9-CM	International Classification of Diseases, 9th Edition
ICEP	Initial Coverage Election Period
ID	Identification
IEP	Initial Enrollment Period
IPPR	Interim Plan Payment Report
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
LEP	Late Enrollment Penalty
LICS	Low-Income Cost Sharing
LIPS	Low-Income Premium Subsidy
LIS	Low-Income Subsidy
LISHIST	LIS History Data File
LISPRM	LIS Premium Data File
LTC	Long-Term Care
LTI	Long-Term Institutional
MA	Medicare Advantage

Acronyms Used in this Guide	
Acronym	**Definition**
MA BSF	Medicare Advantage Benefit Stabilization Fund
MADP	Medicare Advantage Disenrollment Period
MAPD	Medicare Advantage Prescription Drug
MARx	Medicare Advantage Prescription Drug System
MARx UI	Medicare Advantage Prescription Drug System User Interface
MBD	Medicare Beneficiary Database
MBI	Medicare Beneficiary Identifier
MCO	Managed Care Organization
MDS	Minimum Data Set
MCSC	Medicare Customer Service Center (1-800-MEDICARE)
MMA	Medicare Modernization Act
MMCM	Medicare Managed Care Manual
MMDR	Monthly Membership Detail Report
MMP	Medicare and Medicaid Plan
MMR	Monthly Membership Report
MMSR	Monthly Membership Summary Report
MPWE	Monthly Premium Withhold Extract
MPWR	Monthly Premium Withholding Report Data File
MSA	Medical Savings Account
MSHO	Minnesota Senior Health Options
MSP	Medicare Secondary Payer
MTM	Medication Therapy Management
NCPDP	National Council of Prescriptions Drug Programs
NMEC	National Medicare Education Campaign
NHC	Nursing Home Certifiable
NUNCMO	Number of Uncovered Months
OEPI	Open Enrollment Period for Institutionalized Individuals
OHI	Other Health Insurance
OMB	Office of Management and Budget
OPM	Office of Personnel Management
PACE	Program of All-Inclusive Care for the Elderly
PAP	Patient Assistance Program
PBM	Pharmacy Benefit Manager
PBO	Payment Bill Option
PBP	Plan Benefit Package
PCN	Pharmacy Control Number
PCN	Processor Control Number
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PFFS	Private Fee-for-Service
PIP	Principal Inpatient Diagnostic Cost Group
POS	Point-of-Sale

Acronyms Used in this Guide	
Acronym	**Definition**
PPO	Premium Payment Option
PPR	Plan Payment Report
PPS	Prospective Payment System
PRM	Primary Record
PWS	Premium Withhold System
QMB	Qualified Medicare Beneficiary Program
RA	Risk Adjustment/Risk Adjusted
RACF	Resource Access Control Facility
RAS	Risk Adjustment System
RDS	Retiree Drug Subsidy
REMIS	Renal Management Information System
RO	CMS Regional Office
RRB	Railroad Retirement Board
RRE	Responsible Reporting Entity
RxHCC	Prescription Drug Hierarchical Condition Category
SCC	State and County Code
SEP	Special Election Period
SFTP	Secure Shell File Transfer Protocol
SHMO	Social Health Maintenance Organization
SIMS	Standard Information Management System
SLMB	Specified Low-Income Medicare Beneficiary Program
SNP	Special Needs Plan
SPAP	State Pharmaceutical Assistance Program
SSA	Social Security Administration
SSA DO	Social Security Administration District Office
SSN	Social Security Number
SUP	Supplemental Record
TC	Transaction Code
TIN	Tax Identification Number
TRC	Transaction Reply Code
TrOOP	True Out-of-Pocket
TRR	Transaction Reply Report
UI	User Interface
VBID	Value-Based Insurance Design
WC	Workers Compensation
WCSA	Workers Compensation Set-Aside