DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Medicare Plan Payment Group
Innovative Healthcare Delivery Systems Group

DATE: **August 12, 2014**

TO: All Medicare Advantage, Prescription Drug Plan, Cost, PACE, and Demonstration Organizations Systems Staff

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SUBJECT: **Announcement of the November 2014 Software Release**

The Centers for Medicare and Medicaid Services (CMS) continues to implement software improvements to the enrollment and payment systems that support Medicare Advantage and Prescription Drug (MAPD) programs. This letter provides detailed information regarding the planned release of systems changes scheduled for November 2014. This release focuses on improving the efficiency of CMS systems as well as Plan processing.

The November 2014 Release changes are as follows and may require Plan action:

1. **Implementation of Overpayment Rules**
2. **Streamline Medicare Secondary Payer (MSP) Reports**
3. **Transaction Reply Code (TRC) for Plans Losing Members to Medicare and Medicaid Plan (MMP) Passive Enrollment (Affordable Care Act (ACA) 3021)**
4. **Changes to the Low Income Subsidy (LIS)/Late Enrollment Penalty (LEP) Report and the Late Enrollment Penalty Display in Medicare Advantage and Prescription Drug System (MARx)**
5. **Changes to the Segment Assignment Process**
6. **Define Compensation Past Year 6-cycle of Broker's Compensation Report**

1. Implementation of Overpayment Rules

CMS will implement a new overpayment process based on Section 6402(a) of the Affordable Care Act. The overpayment process for MA and Part D plans was finalized in a final rule published by CMS in the Federal Register on May 23, 2014 (79 FR 29843). CMS will make a number of changes to the Risk Adjustment Processing System (RAPS) and Medicare Advantage and Prescription Drug System (MARx) to accommodate the overpayment process. Those system changes, which are effective for Plans on January 1, 2015, are included in the November 2014 software release.

Detailed guidance for reporting and returning of overpayments to CMS will be provided in an upcoming Health Plan Management System (HPMS) Memo.

RAPS Overpayment File

A new RAPS File Layout and new Error Codes are being implemented specifically for the overpayment process. The following guidelines must be followed when submitting the RAPS overpayment file:

1. The file must only contain deletes.
2. Only one payment year can be submitted per file.
3. The PROD-TEST-IND in the AAA record must be populated with OPMT.
4. The assigned Remedy ticket number must be placed in the OVERPAYMENT-ID field in the BBB record (CMS will provide more information about the Remedy ticket process in the upcoming HPMS memorandum). The Plan number that is in the BBB record must match the Plan number that is assigned the Remedy ticket.
5. The payment year of the deletes that are being processed must be populated in the PAYMENT-YEAR field on the BBB record.
6. The DELETE-IND field in the CCC record must be populated with a 'D' for each diagnosis code on the file.

- ***See New RAPS Layout, Attachment A, Figure 1***
- ***See RAPS Error Codes, Attachment A, Figure 2***

New Adjustment Reason Code (ARC)

The overpayment adjustments for the RAPS delete submissions will be processed through MARx and associated with the following new Monthly Membership Report (MMR) Adjustment Reason Codes (ARCs):

ARC	Description & Notes
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

The MMR will include a Cleanup ID to identify all MARx Part C and D overpayment adjustments processed in the RAS overpayment file. CMS will disclose the Cleanup IDs in the monthly Plan payment letters. Because RAPS deletes cause changes in a beneficiary's Risk Adjustment Factor, adjustments may also be seen by a Plan that did not report the overpayment.

- ***See the updated Monthly Membership Detailed (MMDR) Data File, Attachment A, Figure 3***
- ***See the updated Monthly Membership Summary (MMSR) Data File, Attachment A, Figure 4***

Look-Back Period for MARx Adjustments

Beginning January 1, 2015, MARx will replace the system parameter that prohibits a retroactive payment adjustment from occurring if it is more than 36 months from the current month. The parameter is being updated in order to comply with the new overpayment process.

MA organizations and Part D sponsors are required to report and return any overpayment that they identify within the six most recently completed payment years. The obligation to report an identified overpayment begins on the day after an applicable reconciliation has occurred. Please note that "applicable reconciliation" as used in the Affordable Care Act is unique to the overpayment requirements, and we define this term in regulation as the annual final data submission deadlines. The Part C applicable reconciliation occurs on the date of the annual final deadline for risk adjustment data submission described at § 422.310(g), which is announced by CMS each year (see § 422.326). The Part D applicable reconciliation means the later of the annual deadline for submitting either (1) PDE data for the annual Part D payment reconciliations referred to in § 423.343(c) and (d), or (2) direct and indirect remuneration data (see § 423.360).

If an overpayment involves risk adjustment data, the deadline for submitting the data generally occurs at the end of January in the year directly following the payment year. If an overpayment involves prescription drug event (PDE) or direct and indirect remuneration (DIR) data, the deadline for submitting the data generally occurs towards the end of June in the year directly following the payment year.

Example: In 2015, the look-back period would consist of payment years 2009 through and including 2014. MA organizations and Part D sponsors are responsible for reporting and returning overpayments that they identify which impact payments in this six year timeframe. Note that, in 2015, Plans would not begin reporting overpayments for the 2014 payment year until the deadline for submitting data for the applicable reconciliation for either Part C or Part D has passed.

Calendar Year	Look-back Period
2015	2014-2009
2016	2015-2010
2017	2016-2011
2018	2017-2012
2019	2018-2013
2020	2019-2014

2. Streamline Medicare Secondary Payer (MSP) Reports

Two Medicare Secondary Payer files, the Monthly MSP Information Data File (MSPI) and the Other Health Coverage Information Data File (OHCI), are sent monthly to reflect MSP information about beneficiaries that have had Medicare as their secondary payer sometime during the last 37 months while they were also enrolled in Medicare Advantage Plans.

Starting in December 2014, the two reports will be combined into one report (the MSPI report) which will be sent to the Plans monthly after MARx month-end processing. The report will include data to populate the source code field to help Plans identify the source of the insurance information in the report. Please note that Plans will receive the two current MSP reports in November and will not receive the new combined report until December after month-end processing for the January payment.

Language in Transaction Reply Code (TRC) 280 is also being updated in the November 2014 release. The date shown in the TRC will be the actual termination date of the MSP coverage.

- ***See updated MSP Information Data File, Attachment B, Figure 1***
- ***See updated TRC 280 – Member MSP Period Ended, Attachment B, Figure 2***

3. Transaction Reply Code (TRC) for Plans Losing Members to Medicare and Medicaid Plan (MMP) Passive Enrollment (Affordable Care Act (ACA) 3021)

Currently, States passively enroll dual eligible beneficiaries into Medicare Medicaid Plans (MMP) 60 days in advance of the passive enrollment effective date. This results in an auto-disenrollment from their existing Plan, and the Plan sending a disenrollment notice within 10 days of receiving the Daily Transaction Reply Report (DTRR) with the TRC 014 (Disenrollment Due to Enrollment in Another Plan) disenrollment. As a result, the beneficiary receives a passive enrollment notice 60 days before the enrollment effective date, and a Medicare Plan disenrollment notice at day 50 (i.e., 10 days after receiving the passive enrollment notice). This scenario is very confusing for beneficiaries.

With the implementation of this update, a new TRC will be generated to notify a Plan when the beneficiary was disenrolled due to MMP passive enrollment so the Plan may take the appropriate actions. This TRC will replace the existing TRC sent to the Plans when disenrollment is due to the MMP passive enrollment.

- ***See new TRC 340, Disenrollment Due to MMP Passive Enrollment, Attachment C***

4. Changes to the Low Income Subsidy (LIS)/Late Enrollment Penalty (LEP) Report and the Late Enrollment Penalty Display in Medicare Advantage and Prescription Drug System (MARx)

CMS will implement the following changes to the Late Enrollment Penalty (LEP) reporting process:

- The Low Income Subsidy (LIS) information will be removed from the LIS/LEP report and it will be renamed the LEP Report. Other changes to the report include expanding the date fields and adding the Number of Uncovered Months (NUNCMO).

    - ***See LEP File Names, Attachment D, Figure 1***
    - ***See LEP Data File Layout, Attachment D, Figure 2***

- The reporting of LEP on the LEP report will be corrected to ensure all retroactive months for which the penalty was applicable are captured and displayed. Note that CMS will continue reporting LEP information on this report for direct bill beneficiaries only.

- LEP period information for direct bill and Social Security Administration (SSA)/Railroad Retirement Board (RRB) withhold beneficiaries will now be displayed in the MARx user interface.

    - ***See LEP View (M258) Screen: Attachment D, Figure 3***

The user interface change will be effective after the November 2014 release is installed over the November 8-9, 2014 weekend. The report changes will be effective on the January 1, 2015 reports.

5. Changes to the Segment Assignment Process

As part of end of year activities last year, CMS implemented an automated segment assignment process that placed beneficiaries into segments based on the State and County Codes (SCCs) of their effective address (SSA or residence). If a beneficiary's SCC was outside of the Plan Benefit Package (PBP) service area, MARx assigned the beneficiary to a default segment. If, in the subsequent year, the Plan's service area expanded to include the previously out of area SCC, the Plan had to move the beneficiary to the appropriate segment using a transaction type 77 – Segment ID Change.

CMS will enhance this process in the November 2014 release. If a Plan expands the service area of a PBP, MARx will detect this change. If applicable, MARx will move impacted beneficiaries assigned to the default segment to segments that now contain the SCCs of their addresses and the Plans will receive TRC 317 – Segment ID Reassigned and TRC 140 – Segment ID Change Accepted. The transaction replies will be sent to Plans after Termination/Rollover processing is completed in November. Payment, and premium changes associated with segment changes will appear on the January 1, 2015 payment reports.

6. Define Compensation Past Year 6-cycle of Broker's Compensation Report

The Brokers' Compensation Data File was implemented in 2009, stating that after a beneficiary is enrolled in an MA Plan or PDP by an agent or broker, a renewal compensation would be paid for five additional years after the initial compensation year. If any agent or broker enrolled the beneficiary in a different Plan of a 'like Plan type' during those five years, the renewal compensation would be paid as well. The initial compensation year would be indicated on the Brokers' Compensation Data File as a '1' beginning in 2009 and then increment by one every year afterwards in January. For example, January 2009 the broker compensation period would begin with '1' and then January 2010 would continue with '2' and so forth.

This update was initiated to continue incrementing the compensation period past year six. For example, for an MAPD member whose cycle year was "6" in 2014, the Brokers' Compensation Data File will display a "7" in January 2015, an "8" in January 2016, and so forth.

The Broker's Compensation Report Data File is attached:

- ***Broker's Compensation Report Data File Layout, Attachment E***

Plans are encouraged to contact the MAPD Help Desk for any issues encountered during the systems update process. Please direct any questions or concerns to the MAPD Help Desk at 1-800-927-8069 or e-mail at mapdhelp@cms.hhs.gov.

Attachment A

Figure 1: RAPS Record Layout

AAA RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'AAA'
2	SUBMITTER-ID	4 – 9	X(6)	'Shnnnn'
3	FILE-ID	10 – 19	X(10)	
4	TRANSACTION-DATE	20 – 27	9(8)	'CCYYMMDD'
5	PROD-TEST-IND	28 – 31	X(4)	'PROD' Or 'TEST' Or 'OPMT'
6	FILE-DIAG-TYPE	32 – 36	X(5)	'ICD9' Or 'ICD10'
7	FILLER	37 – 512	X(476)	SPACES

BBB RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'BBB'
2	SEQ-NO	4 – 10	9(7)	Must begin with '0000001'
3	PLAN-NO	11 – 15	X(5)	'Hnnnn'
4	OVERPAYMENT-ID	16 –27	X(12)	Remedy Ticket # if PROD-TEST- IND=OPMT
5	OVERPAYMENT-ID-ERROR CODE	28-30	X(3)	SPACES
6	PAYMENT-YEAR	31-34	9(4)	Payment Year if PROD-TEST-ID=OPMT
7	PAYMENT-YEAR-ERROR-CODE	35-37	X(3)	SPACES
8	FILLER	38-512	X(475)	SPACES

CCC RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'CCC'
2	SEQ-NO	4 – 10	9(7)	Must begin with '0000001'
3	SEQ-ERROR-CODE	11 – 13	X(3)	SPACES
4	PATIENT-CONTROL-NO	14 – 53	X(40)	Optional
5	HIC-NO	54 – 78	X(25)	
6	HIC-ERROR-CODE	79 – 81	X(3)	SPACES
7	PATIENT-DOB	82 – 89	X(8)	'CCYYMMDD'
8	DOB-ERROR-CODE	90 – 92	X(3)	SPACES
9 – 15	DIAGNOSIS-CLUSTER (10 OCCURRENCES)	93 – 412		
9.0	PROVIDER-TYPE		X(2)	HOSPITAL IP PRINCIPAL = 01 HOSPITAL IP OTHER = 02 HOSPITAL OP = 10 PHYSICIAN = 20
9.1	FROM-DATE		9(8)	'CCYYMMDD'
9.2	THRU-DATE		9(8)	'CCYYMMDD'
9.3	DELETE-IND		X(1)	SPACE or 'D'
9.4	DIAGNOSIS-CODE		X(7)	ICD-9 or ICD-10
9.5	DIAG-CLSTR-ERROR-1		X(3)	SPACES
9.6	DIAG-CLSTR-ERROR-2		X(3)	SPACES
16	CORRECTED-HIC-NO	413 – 437	X(25)	SPACES

17 – 18	RISK ASSESSMENT-CODE-CLUSTER (10 OCCURRENCES)	438 – 477		
17.0	RISK ASSESSMENT-CODE		X(1)	'A', 'B', or 'C'
17.1	RISK ASSESSMENT-CODE-ERROR		X(3)	SPACES
19	FILLER	478 - 512	X(35)	SPACES

YYY RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'YYY'
2	SEQ-NO	4 – 10	9(7)	Must begin with '0000001'
3	PLAN-NO	11 – 15	X(5)	'Hnnnn'
4	CCC-RECORD-TOTAL	16 – 22	9(7)	
5	FILLER	23 – 512	X(490)	SPACES

ZZZ RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'ZZZ'
2	SUBMITTER-ID	4 – 9	X(6)	'SHnnnn'
3	FILE-ID	10 – 19	X(10)	
4	BBB-RECORD-TOTAL	20 – 26	9(7)	
5	FILLER	27 – 512	X(486)	SPACES

Figure 2: RAPS Error Codes

ERROR CODE	ERROR DESCRIPTION	RECORD TYPE
100	INVALID RECORD TYPE	AAA
101	AAA RECORD MISSING FROM TRANSACTION	AAA
102	MISSING / INVALID SUBMITTER-ID ON AAA RECORD	AAA
103	MISSING FILE-ID ON AAA RECORD	AAA
104	MISSING / INVALID TRANSACTION DATE ON AAA RECORD	AAA
105	MISSING / INVALID PROD-TEST-OPMT-INDICATOR ON AAA RECORD	AAA
106	MISSING / INVALID FILE-DIAG-INDICATOR ON AAA RECORD	AAA
107	SUBMITTER ID IS NOT VALIDATED TO SEND PRODUCTION DATA	AAA
112	SUBMITTER ID NOT ON FILE	AAA
113	FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS	AAA
114	TRANSACTION DATE IS GREATER THAN CURRENT DATE	AAA
151	ZZZ RECORD MISSING FROM TRANSACTION	ZZZ
152	MISSING / INVALID SUBMITTER-ID ON ZZZ RECORD	ZZZ
153	MISSING / INVALID FILE-ID ON ZZZ RECORD	ZZZ
154	MISSING / INVALID BBB-RECORD-TOTAL;	ZZZ
162	ZZZ SUBMITTER-ID DOES NOT MATCH SUBMITTER-ID ON AAA RECORD	ZZZ
163	FILE ID DOES NOT MATCH FILE ID ON AAA RECORD	ZZZ
164	ZZZ VALUE IS NOT EQUAL TO THE NUMBER OF BBB RECORDS	ZZZ
165	FERAS/RAPS EDI AGREEMENT NOT ON FILE.	NA
177	ZZZ TEST FILE CANNOT EXCEED 3,000 CCC RECORDS	ZZZ
201	BBB RECORD MISSING FROM TRANSACTION	BBB
202	MISSING / INVALID SEQUENCE NUMBER ON BBB RECORD	BBB
203	MISSING / INVALID PLAN NUMBER ON BBB RECORD	BBB
212	SEQUENCE NUMBER ON BBB RECORD IS OUT OF SEQUENCE	BBB
213	SUBMITTER ID NOT AUTHORIZED TO SUBMIT FOR THIS PLAN ID	BBB
214*	OVERPAYMENT-ID IS NOT GREATER THAN SPACES FOR OPMT FILE	BBB
215*	PAYMENT-YEAR IS NOT GREATER THAN SPACES FOR OPMT FILE	BBB
216*	OVERPAYMENT-ID MUST BE SPACES FOR NON OPMT FILE	BBB
217*	PAYMENT-YEAR MUST BE SPACES FOR NON OPMT FILE	BBB
227	ICD9/ICD10 FILE TYPE IN HEADER DOES NOT MATCH TYPE DIAGNOSIS CODE ENTERED IN DETAIL RECORD	AAA
251	YYY RECORD MISSING FROM TRANSACTION	YYY
252	MISSING / INVALID SEQUENCE NUMBER ON YYY RECORD	YYY
253	MISSING / INVALID PLAN NUMBER ON YYY RECORD	YYY
254	MISSING / INVALID DETAIL-RECORD-TOTAL	YYY
262	LAST YYY SEQUENCE NUMBER IS NOT EQUAL TO NUMBER OF YYY RECORDS	YYY
263	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD	YYY
264	YYY VALUE IS NOT EQUAL TO THE NUMBER OF DETAIL RECORDS	YYY

Attachment A

ERROR CODE	ERROR DESCRIPTION	RECORD TYPE
272	SEQUENCE NUMBER ON YYY RECORD IS OUT OF SEQUENCE	YYY
301	DETAIL RECORD MISSING FROM TRANSACTION	CCC
302	MISSING / INVALID SEQUENCE NUMBER ON DETAIL RECORD	CCC
303	SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES	CCC
304	HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES	CCC
305	DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES	CCC
307	DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES	CCC
308	DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES	CCC
309	SEQUENCE-NUMBER ON DETAIL RECORD IS OUT OF SEQUENCE	CCC
310	MISSING / INVALID HIC-NO ON DETAIL RECORD	CCC
311	AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION	CCC
313	DELETE-INDICATOR MUST BE EQUAL TO A SPACE OR "D" FOR DELETE	CCC
314	INVALID DIAGNOSIS CODE FORMAT ON DETAIL RECORD	CCC
315	CORRECTED HIC NOT EQUAL TO SPACES	CCC
316	RISK ASSESSMENT CODE ERROR NOT EQUAL TO SPACES	CCC
317*	INVALID OVERPAYMENT-ID ON BBB RECORD	BBB
318*	INVALID PAYMENT-YEAR ON BBB RECORD	BBB
319*	INPUT PLAN NO ON BBB RECORD DOES NOT MATCH PLAN NO ON REMEDY TICKET	BBB
353	HIC NUMBER DOES NOT EXIST ON CME	CCC
400	MISSING / INVALID PROVIDER-TYPE ON DETAIL RECORD	CCC
401	INVALID SERVICE FROM-DATE ON DETAIL RECORD	CCC
402	INVALID SERVICE THRU-DATE ON DETAIL RECORD	CCC
403	SERVICE THRU-DATE IS OUTSIDE THE RISK ADJUSTMENT PROCESSING RANGE	CCC
404	SERVICE FROM-DATE MUST BE LESS THAN OR EQUAL TO THRU-DATE	CCC
405	DOB IS GREATER THAN SERVICE FROM-DATE	CCC
406	SERVICE FROM-DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD	CCC
407	SERVICE THRU-DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD	CCC
408	SERVICE FROM-DATE IS NOT WITHIN MA ORG ENROLLMENT PERIOD	CCC
409	SERVICE THRU-DATE IS NOT WITHIN MA ORG ENROLLMENT PERIOD	CCC
410	BENEFICIARY IS NOT ENROLLED IN ANY PLAN ON OR AFTER SERVICE FROM-DATE	CCC
411	SERVICE THRU-DATE IS GREATER THAN DATE OF DEATH	CCC
412	SERVICE FROM-DATE GREATER THAN TRANSACTION DATE	CCC
413	SERVICE THRU-DATE GREATER THAN TRANSACTION DATE	CCC
414	SERVICE THRU-DATE GREATER THAN 09/30/2014 FOR ICD-9 DIAGNOSIS	CCC
415	SERVICE THRU-DATE BEFORE 10/01/2014 FOR ICD-10 DIAGNOSIS	CCC
416	RISK ASSESSMENT CODE MUST BE EQUAL TO A VALID CODE	CCC
417	DIAGNOSIS CODE IS REQUIRED IF RISK ASSESSMENT CODE PRESENT	CCC
418	SERVICE YEAR IS CLOSED FOR DIAGNOSIS SUBMISSIONS	CCC
419	DIAGNOSIS CODE PRESENT IN THE CLUSTER, RISK ASSESSMENT CODE IS MISSING	CCC
420*	DIAGNOSIS CLUSTER SUBMITTED FOR RESTRICTED SERVICE YEAR	CCC

421*	DELETE-IND MUST BE EQUAL TO D FOR DELETE ON OPMT FILE	CCC
422*	SERVICE THRU-DATE IS NOT WITHIN THE REPORTED PAYMENT YEAR	CCC
423*	DELETE IS NOT ALLOWED WITHOUT AN OPMT FILE AFTER FINAL SWEEP DATE	CCC
ERROR CODE	**ERROR DESCRIPTION**	**RECORD TYPE**
450	DIAGNOSIS DOES NOT EXIST FOR THIS SERVICE THRUDATE	CCC
451	SERVICE THRU-DATE IS GREATER THAN DIAGNOSIS END DATE	CCC
453	DIAGNOSIS CODE IS NOT APPROPRIATE FOR PATIENT SEX	CCC
454	DIAGNOSIS IS VALID, BUT IS NOT SUFFICIENTLY SPECIFIC FOR RISK ADJUSTMENT GROUPING	CCC
455	DIAGNOSIS CLUSTER NOT EDITED DUE TO RECORD FORMAT ERROR	CCC
460	SERVICE FROM- AND THRU-DATE SPAN IS GREATER THAN 31 DAYS	CCC
490	COULD NOT DELETE; DIAGNOSIS CLUSTER NOT IN RAPS DATABASE BENEFICIARY RECORD	CCC
491	DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED	CCC
492	DIAGNOSIS CLUSTER WAS NOT SUCCESSFULLY DELETED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES WAS ALREADY DELETED FROM THE RAPS DATABASE ON THIS DATE	CCC
500	BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR THE FUTURE SUBMISSIONS	CCC
502	DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE.	CCC

Figure 3: Monthly Membership Detailed (MMDR) Data File

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

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

#	Field Name	Len	Pos	Description
22.	PIP-DCG	2	69-70	PIP-DCG Category - Only on pre-2004 adjustments
23.	Default Risk Factor Code	1	71-71	• Prior to 2004, 'Y' indicates a new enrollee risk adjustment (RA) factor was in use. • In the period 2004 through 2008, 'Y' indicates that a default factor was generated by the system due to lack of a RA factor. • For 2009 and after, for payments and payment adjustments and regardless of the effective date of the adjustment, the following applies: '1' = Default Enrollee- Aged/Disabled '2' = Default Enrollee- ESRD dialysis '3' = Default Enrollee- ESRD Transplant Kidney, Month 1 '4' = Default Enrollee- ESRD Transplant Kidney, Months 2-3 '5' = Default Enrollee- ESRD Post Graft, Months 4-9 '6' = Default Enrollee- ESRD Post Graft, 10+Months '7' = Default Enrollee Chronic Care SNP Blank = The beneficiary is not a default enrollee.
24.	Risk Adjuster Factor A	7	72-78	NN.DDDD Part A Risk Factor used for the Payment Calculation
25.	Risk Adjuster Factor B	7	79-85	NN.DDDD Part B Risk Factor used for the Payment Calculation
26.	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27.	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28.	Adjustment Reason Code	2	90-91	FORMAT: 99 Always Spaces on Payment and MSA Deposit or Recovery Records
29.	Paymt/Adjustment/MSA Start Date	8	92-99	FORMAT: YYYYMMDD
30.	Paymt/Adjustment/MSA End Date	8	100-107	FORMAT: YYYYMMDD

#	Field Name	Len	Pos	Description
31.	Demographic Paymt/Adjustmt Rate A	9	108-116	FORMAT: -99999.99 Prior to 2008, Demographic Paymt/Adjustmt Rate A is displayed. In 2008 and beyond, Demographic Paymt/Adjustmt Rate A is displayed as 0.00.
32.	Demographic Paymt/Adjustmt Rate B	9	117-125	FORMAT: -99999.99 Prior to 2008, Demographic Paymt/Adjustmt Rate B is displayed. In 2008 and beyond, Demographic Paymt/Adjustmt Rate B is displayed as 0.00.
33.	Monthly Paymt/Adjustmt Amount Rate A	9	126-134	Part A portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
34.	Monthly Paymt/Adjustmt Amount Rate B	9	135-143	Part B portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
35.	LIS Premium Subsidy	8	144-151	FORMAT: -9999.99
36.	ESRD MSP Flag	1	152-152	As of January 2011: T = Transplant/Dialysis P = Post Graft Blank = ESRD MSP not applicable Prior to 2011: Format X. Values = 'Y' or 'N'(default) Indicates if Medicare is the Secondary Payer
37.	MSA Part A Deposit/Recovery Amount	8	153-160	Medicare Savings Account (MSA) lump sum Part A dollars to be deposited/recovered. Deposits are positive values and recoveries are negative. FORMAT: -9999.99
38.	MSA Part B Deposit/Recovery Amount	8	161-168	Medicare Savings Account (MSA) lump sum Part B dollars to be deposited/recovered. Deposits are positive values and recoveries are negative. FORMAT: -9999.99
39.	MSA Deposit/Recovery Months	2	169-170	Number of months associated with MSA deposit or recovery dollars

#	Field Name	Len	Pos	Description
40.	Current Medicaid Status	1	171-171	Beginning in mid-2008, this field reports the beneficiary's current Medicaid status. (Prior to 11/07, Medicaid status was reported in field #19.) '1' = Beneficiary was determined to be Medicaid as of current payment month minus two (CPM –2) or minus one (CPM – 1), '0' = Beneficiary was not determined to be Medicaid as of current payment month minus two (CPM – 2) or minus one (CPM – 1), Blank = This is a retroactive transaction and Medicaid status is not reported. The four sources to determine Current Medicaid Status are: 1. MMA State files or Dual Medicare Table 2. Low Income Territory Table 3. Medicaid Eligibility Table (Only valid records with a Medicaid source code of "003U" and "003C" shall be used.) 4. Point of Sale Table
41.	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age Beginning in 2011, if the risk adjuster factor is from RAS, the Risk Adjuster Age Group reported will be the one used by RAS in calculating the risk factor
42.	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – Only on pre-2004 adjustments
43.	De Minimis	1	183-183	Prior to 2008, flag will be spaces. Beginning 2008: 'N' = "de minimis" does not apply, 'Y' = "de minimis" applies.
44.	Beneficiary Dual and Part D Enrollment Status Flag	1	184-184	'0' – 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.
45.	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999

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

#	Field Name	Len	Pos	Description
53.	EGHP Flag	1	198	Employer Group flag; Y = member of employer group, N = member is not in an employer group
54.	Part C Basic Premium – Part A Amount	8	199-206	The premium amount for determining the MA payment attributable to Part A. It is subtracted from the MA Plan payment for Plans that bid above the benchmark. -9999.99
55.	Part C Basic Premium – Part B Amount	8	207-214	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA Plan payment for Plans that bid above the benchmark. -9999.99
56.	Rebate for Part A Cost Sharing Reduction	8	215-222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. This amount is added to the MA Plan payment for Plans that bid below the benchmark. -9999.99
57.	Rebate for Part B Cost Sharing Reduction	8	223-230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. This amount is added to the MA Plan payment for Plans that bid below the benchmark. -9999.99
58.	Rebate for Other Part A Mandatory Supplemental Benefits	8	231-238	The amount of the rebate allocated to providing Part A supplemental benefits. This amount is added to the MA Plan payment for Plans that bid below the benchmark. -9999.99
59.	Rebate for Other Part B Mandatory Supplemental Benefits	8	239-246	The amount of the rebate allocated to providing Part B supplemental benefits. This amount is added to the MA Plan payment for Plans that bid below the benchmark. -9999.99
60.	Rebate for Part B Premium Reduction – Part A Amount	8	247-254	The Part A amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -9999.99
61.	Rebate for Part B Premium Reduction – Part B Amount	8	255-262	The Part B amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -9999.99

#	Field Name	Len	Pos	Description
62.	Rebate for Part D Supplemental Benefits – Part A Amount	8	263–270	Part A Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
63.	Rebate for Part D Supplemental Benefits – Part B Amount	8	271–278	Part B Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
64.	Total Part A MA Payment	10	279–288	The total Part A MA payment. -999999.99
65.	Total Part B MA Payment	10	289–298	The total Part B MA payment. -999999.99
66.	Total MA Payment Amount	11	299-309	The total MA A/B payment including MMA adjustments. This also includes the Rebate Amount for Part D Supplemental Benefits -9999999.99
67.	Part D RA Factor	7	310-316	The member's Part D risk adjustment factor. NN.DDDD Part D Risk Factor used for the Payment Calculation
68.	Part D Low-Income Indicator	1	317	From 2006 through 2010, an indicator to identify if the Part D Low-Income multiplier is included in the Part D payment. Values are 1 (subset 1), 2 (subset 2) or blank. Beginning 2011, value 'Y' indicates the beneficiary is Low Income, value 'N' indicates the beneficiary is not Low Income for the payment/adjustment being made.
69.	Part D Low-Income Multiplier	7	318-324	The member's Part D low-income multiplier. NN.DDDD For payment months 2011 and beyond, this field will be zero.
70.	Part D Long Term Institutional Indicator	1	325	From 2006 through 2010, an indicator to identify if the Part D Long-Term Institutional multiplier is included in the Part D payment. Values are A (aged), D (disabled) or blank. For payment months 2011 and beyond, this field will be blank.
71.	Part D Long Term Institutional Multiplier	7	326-332	The member's Part D institutional multiplier. NN.DDDD For payment months 2011 and beyond, this field will be zero.
72.	Rebate for Part D Basic Premium Reduction	8	333-340	Amount of the rebate allocated to reducing the member's basic Part D premium. -9999.99

#	Field Name	Len	Pos	Description
73.	Part D Basic Premium Amount	8	341-348	The Plan's Part D premium amount. -9999.99
74.	Part D Direct Subsidy Monthly Payment Amount	10	349-358	The total Part D Direct subsidy payment for the member. When POS contract (X is first character of contract number), then it is total POS Direct Subsidy for the member. -999999.99
75.	Reinsurance Subsidy Amount	10	359-368	The amount of the reinsurance subsidy included in the payment. -999999.99
76.	Low-Income Subsidy Cost-Sharing Amount	10	369-378	The amount of the low-income subsidy cost-sharing amount included in the payment. -999999.99
77.	Total Part D Payment	11	379-389	The total Part D payment for the member -9999999.99.
78.	Number of Paymt/Adjustmt Months Part D	2	390-391	99
79.	PACE Premium Add On	10	392-401	Total Part D Pace Premium Add-on amount -999999.99
80.	PACE Cost Sharing Add-on	10	402-411	Total Part D Pace Cost Sharing Add-on amount -999999.99
81.	Part C Frailty Score Factor	7	412-418	Beneficiary's Part C frailty score factor, NN.DDDD; otherwise, spaces
82.	MSP Factor	7	419-425	Beneficiary's MSP secondary payer reduction factor, NN.DDDD; otherwise, spaces
83.	MSP Reduction/Reduction Adjustment Amount – Part A	10	426-435	Net MSP reduction or reduction adjustment dollar amount– Part A, SSSSSS9.99
84.	MSP Reduction/Reduction Adjustment Amount – Part B	10	436-445	Net MSP reduction or reduction adjustment dollar amount – Part B, SSSSSS9.99

#	Field Name	Len	Pos	Description
85.	Medicaid Dual Status Code	2	446-447	Entitlement status for the dual eligible beneficiary. The valid values when Field 40 = 1 are: 01 = Eligible is entitled to Medicare- QMB only 02 = Eligible is entitled to Medicare- QMB AND Medicaid coverage 03 = Eligible is entitled to Medicare- SLMB only 04 = Eligible is entitled to Medicare- SLMB AND Medicaid coverage 05 = Eligible is entitled to Medicare- QDWI 06 = Eligible is entitled to Medicare- Qualifying individuals 08 = Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB,QDWI or QI) with Medicaid coverage 09 = Eligible is entitled to Medicare – Other Dual Eligibles but without Medicaid coverage 99=Unknown The valid value when Field 40 = 0 is: 00 = No Medicaid Status The valid value when Field 40 is blank is: Blank
86.	Part D Coverage Gap Discount Amount	8	448-455	The amount of the Coverage Gap Discount Amount included in the payment. -9999.99
87.	Part D RA Factor Type	2	456-457	Beginning with January 2011 payment, type of factors in use (see Field 67): D1 = Community Non-Low Income Continuing Enrollee, D2 = Community Low Income Continuing Enrollee, D3 = Institutional Continuing Enrollee, D4 = New Enrollee Community Non-Low Income Non-ESRD, D5 = New Enrollee Community Non-Low Income ESRD, D6 = New Enrollee Community Low Income Non-ESRD, D7 = New Enrollee Community Low Income ESRD, D8 = New Enrollee Institutional Non-ESRD, D9 = New Enrollee Institutional ESRD, Blank when it does not apply.

#	Field Name	Len	Pos	Description
88.	Default Part D Risk Factor Code	1	458	Beginning with January 2011 payment : 1=Not ESRD, Not Low Income, Not Originally Disabled, 2=Not ESRD, Not Low Income, Originally Disabled, 3=Not ESRD, Low Income, Not Originally Disabled, 4=Not ESRD, Low Income, Originally Disabled, 5= ESRD, Not Low Income, Not Originally Disabled, 6= ESRD, Low Income, Not Originally Disabled, 7= ESRD, Not Low Income, Originally Disabled, 8= ESRD, Low Income, Originally Disabled, Blank when it does not apply.
89.	Part A Risk Adjusted Monthly Rate Amount for Pymt/Adj	9	459-467	Beginning August 2011: Payments = Rate amount in effect for payment period Adjustments = Rate amount in effect for adjustment period Format: -99999.99
90.	Part B Risk Adjusted Monthly Rate Amount for Pymt/Adj	9	468-476	Beginning August 2011: Payments = Rate amount in effect for payment period Adjustments = Rate amount in effect for adjustment period Format: -99999.99
91.	Part D Direct Subsidy Monthly Rate Amount for Pymt/Adj	9	477-485	Beginning August 2011: Payments = Rate amount in effect for payment period Adjustments = Rate amount in effect for adjustment period Format: -99999.99
92.	Cleanup ID	10	486-495	If adjustment is the result of a cleanup = ID assigned to the cleanup. (For an overpayment run, this will be the RT # associated with the overpayment run.) If payment or non-cleanup adjustment = Blank. For all payments and adjustments prior to August 2011 = Blank ARC 94 will be used to identify clean-ups.

Figure 4: Monthly Membership Summary (MMSR) Data File

#	Field Name	Len	Position	Description
1.	MCO Contract Number	5	1-5	MCO Contract Number
2.	Run Date of the File	8	6-13	YYYYMMDD
3.	Payment Date	6	14-19	YYYYMM
4.	Adjustment Reason Code	2	20-21	Adjustment Reason Code (ARC) *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. See Appendix A for the table of record types for all possible values.
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	13	74-86	PART A Amount
13.	Part B Payment / Adjustment Amount	13	87-99	PART B Amount
14.	Total Amount	13	100-112	Total Payment/Adjustment Amount
15.	Part A Average	9	113-121	Average Part A Amount per Part A Member
16.	Part B Average	9	122-130	Average Part B Amount per Part B Member
17.	Payment /Adjustment Indicator	1	131-131	'P' for Payments and 'A' for Adjustments
18.	PBP Number	3	132-134	Plan Benefit Package Number *On records in a Contract Level summarization, this will be set to "PBP".*

#	Field Name	Len	Position	Description
19.	Segment Number	3	135-137	Segment Number *On records in a PBP Level summarization, this will be set to "000".* *On records in a Contract Level summarization, this will be set to "SEG".*
20.	Part D Member Count	7	138-144	**Payment Record:** Beneficiary count for Part D **Adjustment records:** Spaces
21.	Part D Month Count	7	145-151	**Payment Record:** 1 for each member with Part D **Adjustment record:** The number of months adjusted for Part D
22.	Part D Amount	13	152-164	Part D Amount
23.	Part D Average	9	165-173	Average Part D Amount per Part D Member
24.	LIS Band 25% Member Count	7	174-180	Count of Beneficiaries in the 25% LIS band
25.	LIS Band 50% Member Count	7	181-187	Count of Beneficiaries in the 50% LIS band
26.	LIS Band 75% Member Count	7	188-194	Count of Beneficiaries in the 75% LIS band
27.	LIS Band 100% Member Count	7	195-201	Count of Beneficiaries in the 100% LIS band

Figure 1: MSP Information Data File

MSP data files are sent to each Plan once a month after the MARx month-end process completes. The data files contain MSP information that has occurred within the past 37 month timeframe. Each beneficiary's record on the data file can contain up to 17 MSP occurrences for that beneficiary. Each of the MSP occurrences on the beneficiary's record overlaps with enrollment in the Plan at some time during the past 37 months.

Header Record

Item	Field Name	Size	Position	Type	Comments
1	Header Code	X(08)	1-8	Value 'CMSMSPDH'.	File/record identification purposes only
2	Sending Entity	X(04)	9-12	Value 'MARX'.	changed from 'MBD'
3	File Creation Date	9(08)	13-20	CCYYMMDD – Format	
4	Filler	X(10980)	21-11000	spaces	

Detail Record

Item	Field Name	Size	Position	Type	Comments
1	RRB-HIC-NUM	12	1-12	CHAR	Use RRB_HIC_NUM if available; else, use first 9 bytes mapped to BENE_CAN_NUM; next 2 bytes mapped to BIC_CD ; 12th byte is a space
2	OCC-COUNT	2	13-14	CHAR	The number of MSP occurrences with data. There are always 17 MSP occurrences in the file, but there may not be data in each occurrence.
The following information will have 17 occurrences. Each occurrence consists of Item 3 through Item 89. If there is no information available, the items will be blank.					
3	Delete Indicator	1	15	CHAR	D or blank
4	Validity Ind	1	16	CHAR	I = FI/Carrier added occurrence N=Beneficiary does not have MSP coverage Y=COBC added occurrence.
5	MSP Code	1	17	CHAR	A=Working Aged B=ESRD D=No Fault E=Worker comp F=Federal(public health) H=Black Lung I=Veterans G=Disabled L=Liability
6	COB Contractor Number	5	18-22	CHAR	Direct Mapping
7	Data Entry Added	8	23-30	INT	CCYYMMDD FORMAT
8	Update Contractor Number	5	31-35	CHAR	Direct Mapping
9	Maintenance Date	8	36-43	INT	CCYYMMDD FORMAT

10	Filler	6	44-49	CHAR	
11	Insurer Type	1	50	CHAR	Direct Mapping
12	Insurer Name	32	51-82	CHAR	Direct Mapping
13	Insurer Address 1	32	83-114	CHAR	Direct Mapping
14	Insurer Address 2	32	115-146	CHAR	Direct Mapping
15	Insurer City	15	147-161	CHAR	Direct Mapping
16	Insurer State Code	2	162-163	CHAR	Direct Mapping
17	Insurer Zip Code	9	164-172	CHAR	Direct Mapping
18	Policy Number	17	173-189	CHAR	Direct Mapping
19	MSP Effective Date	8	190-197	INT	CCYYMMDD FORMAT
20	MSP Termination Date	8	198-205	INT	CCYYMMDD FORMAT
21	Patient Relationship Code	2	206-207	INT	01 through 20
22	Subscriber First Name	9	208-216	CHAR	Direct Mapping
23	Subscriber Last Name	16	217-232	CHAR	Direct Mapping
24	Employee ID Number	12	233-244	CHAR	Direct Mapping
25	Source Code	2	245-246	CHAR	Direct Mapping
26	Employee INFO Data	1	247	CHAR	P, S, M, F
27	Employee Name	32	248-279	CHAR	Direct Mapping
28	Employee Address 1	32	280-311	CHAR	Direct Mapping
29	Employee Address 2	32	312-343	CHAR	Direct Mapping
30	Employee City	15	344-358	CHAR	Direct Mapping
31	Employee State	2	359-360	CHAR	Direct Mapping
32	Employee Zip Cd	9	361-369	CHAR	Direct Mapping
33	Insurer Group Number	20	370-389	CHAR	Direct Mapping
34	Insurer Group Name	17	390-406	CHAR	Direct Mapping
35	Prepaid Health Plan Date	8	407-414	CHAR	Direct Mapping
36	Remarks Code 1	2	415-416	CHAR	Direct Mapping
37	Remarks Code 2	2	417-418	CHAR	Direct Mapping
38	Remarks Code 3	2	419-420	CHAR	Direct Mapping
39	Diagnosis Code Ind 1	1	421	CHAR	0=ICD 10, 9=ICD 9
40	Diagnosis Code 1	7	422-428	CHAR	Direct Mapping
41	Diagnosis Code Ind 2	1	429	CHAR	0=ICD 10, 9=ICD 9
42	Diagnosis Code 2	7	430-436	CHAR	Direct Mapping
43	Diagnosis Code Ind 3	1	437	CHAR	0=ICD 10, 9=ICD 9
44	Diagnosis Code 3	7	438-444	CHAR	Direct Mapping
45	Diagnosis Code Ind 4	1	445	CHAR	0=ICD 10, 9=ICD 9
46	Diagnosis Code 4	7	446-452	CHAR	Direct Mapping

47	Diagnosis Code Ind 5	1	453	CHAR	0=ICD 10, 9=ICD 9
48	Diagnosis Code 5	7	454-460	CHAR	Direct Mapping
49	Diagnosis Code Ind 6	1	461	CHAR	0=ICD 10, 9=ICD 9
50	Diagnosis Code 6	7	462-468	CHAR	Direct Mapping
51	Diagnosis Code Ind 7	1	469	CHAR	0=ICD 10, 9=ICD 9
52	Diagnosis Code 7	7	470-476	CHAR	Direct Mapping
53	Diagnosis Code Ind 8	1	477	CHAR	0=ICD 10, 9=ICD 9
54	Diagnosis Code 8	7	478-484	CHAR	Direct Mapping
55	Diagnosis Code Ind 9	1	485	CHAR	0=ICD 10, 9=ICD 9
56	Diagnosis Code 9	7	486-492	CHAR	Direct Mapping
57	Diagnosis Code Ind 10	1	493	CHAR	0=ICD 10, 9=ICD 9
58	Diagnosis Code 10	7	494-500	CHAR	Direct Mapping
59	Diagnosis Code Ind 11	1	501	CHAR	0=ICD 10, 9=ICD 9
60	Diagnosis Code 11	7	502-508	CHAR	Direct Mapping
61	Diagnosis Code Ind 12	1	509	CHAR	0=ICD 10, 9=ICD 9
62	Diagnosis Code 12	7	510-516	CHAR	Direct Mapping
63	Diagnosis Code Ind 13	1	517	CHAR	0=ICD 10, 9=ICD 9
64	Diagnosis Code 13	7	518-524	CHAR	Direct Mapping
65	Diagnosis Code Ind 14	1	525	CHAR	0=ICD 10, 9=ICD 9
66	Diagnosis Code 14	7	526-532	CHAR	Direct Mapping
67	Diagnosis Code Ind 15	1	533	CHAR	0=ICD 10, 9=ICD 9
68	Diagnosis Code 15	7	534-540	CHAR	Direct Mapping
69	Diagnosis Code Ind 16	1	541	CHAR	0=ICD 10, 9=ICD 9
70	Diagnosis Code 16	7	542-548	CHAR	Direct Mapping
71	Diagnosis Code Ind 17	1	549	CHAR	0=ICD 10, 9=ICD 9
72	Diagnosis Code 17	7	550-556	CHAR	Direct Mapping
73	Diagnosis Code Ind 18	1	557	CHAR	0=ICD 10, 9=ICD 9
74	Diagnosis Code 18	7	558-564	CHAR	Direct Mapping
75	Diagnosis Code Ind 19	1	565	CHAR	0=ICD 10, 9=ICD 9
76	Diagnosis Code 19	7	566-572	CHAR	Direct Mapping
77	Diagnosis Code Ind 20	1	573	CHAR	0=ICD 10, 9=ICD 9
78	Diagnosis Code 20	7	574-580	CHAR	Direct Mapping
79	Diagnosis Code Ind 21	1	581	CHAR	0=ICD 10, 9=ICD 9
80	Diagnosis Code 21	7	582-588	CHAR	Direct Mapping
81	Diagnosis Code Ind 22	1	589	CHAR	0=ICD 10, 9=ICD 9
82	Diagnosis Code 22	7	590-596	CHAR	Direct Mapping

83	Diagnosis Code Ind 23	1	597	CHAR	0=ICD 10, 9=ICD 9
84	Diagnosis Code 23	7	598-604	CHAR	Direct Mapping
85	Diagnosis Code Ind 24	1	605	CHAR	0=ICD 10, 9=ICD 9
86	Diagnosis Code 24	7	606-612	CHAR	Direct Mapping
87	Diagnosis Code Ind 25	1	613	CHAR	0=ICD 10, 9=ICD 9
88	Diagnosis Code 25	7	614-620	CHAR	Direct Mapping
89	Payer ID	10	621-630	CHAR	Direct Mapping
End of the first occurrence. The displacements for the next 16 occurrences are: (Occurrence 2: 631-1246) (Occurrence 3: 1247–1862) (Occurrence 4: 1863- 2478) (Occurrence 5: 2478-3094) (Occurrence 6: 3095- 3710) (Occurrence 7: 3711-4326) (Occurrence 8: 4327-4942) (Occurrence 9: 4943-5558) (Occurrence 10: 5559-6174) (Occurrence 11: 6175-6790) (Occurrence 12: 6791-7406) (Occurrence 13: 7407-8022) (Occurrence 14: 8023-8638) (Occurrence 15: 8639-9254) (Occurrence 16: 9255-9870) (Occurrence 17: 9871-10486) The remaining 16 occurrence will cover Items 90 – 1481.					
1482	Date of Birth	8	10487-10494	INT	Direct Mapping
1483	Sex Code	1	10495	CHAR	Direct Mapping
1484	MSP Plan	5	10496-10500	CHAR	Direct Mapping
1485	MSP PBP	3	10501-10503	CHAR	Direct Mapping
1486	MSP Factor	7	10504-10510	INT	Direct Mapping
1487	PTA RDAMT SIGN	1	10511	CHAR	"-" = Negative blank = Positive
1488	PTA RDAMT	9	10512-10520	CHAR	Layout (999999.99)
1489	PTB RDAMT SIGN	1	10521	CHAR	"-" = Negative blank = Positive
1490	PTB RDAMT	9	10522-10530	CHAR	Layout (999999.99)
1491	PAID FLAG	1	10531	CHAR	Direct Mapping
1492	MSP Factor ADJ1	7	10532-10538	INT	Direct Mapping
1493	PTA RDAMT SIGN ADJ1	1	10539	CHAR	"-" = Negative blank = Positive
1494	PTA RDAMT ADJ1	9	10540-10548	CHAR	Layout (999999.99)
1495	PTB RDAMT SIGN ADJ1	1	10549	CHAR	"-" = Negative blank = Positive
1496	PTB RDAMT ADJ1	9	10550-10558	CHAR	Layout (999999.99)
1497	PAID FLAG ADJ1	1	10559	CHAR	Direct Mapping
1498	MSP Factor ADJ2	7	10560-10566	INT	Direct Mapping
1499	PTA RDAMT SIGN ADJ2	1	10567	CHAR	"-" = Negative blank = Positive
1500	PTA RDAMT	9	10568-	CHAR	Layout (999999.99)

	ADJ2		10576		
1501	PTB RDAMT SIGN ADJ2	1	10577	CHAR	"-" = Negative blank = Positive
1502	PTB RDAMT ADJ2	9	10578-10586	CHAR	Layout (999999.99)
1503	PAID FLAG ADJ2	1	10587	CHAR	Direct Mapping
1504	MSP Factor ADJ3	7	10588-10594	INT	Direct Mapping
1505	PTA RDAMT SIGN ADJ3	1	10595	CHAR	"-" = Negative blank = Positive
1506	PTA RDAMT ADJ3	9	10596-10604	CHAR	Layout (999999.99)
1507	PTB RDAMT SIGN ADJ3	1	10605	CHAR	"-" = Negative blank = Positive
1508	PTB RDAMT ADJ3	9	10606-10614	CHAR	Layout (999999.99)
1509	PAID FLAG ADJ3	1	10615	CHAR	Direct Mapping
1510	MSP Factor ADJ4	7	10616-10622	INT	Direct Mapping
1511	PTA RDAMT SIGN ADJ4	1	10623	CHAR	"-" = Negative blank = Positive
1512	PTA RDAMT ADJ4	9	10624-10632	CHAR	Layout (999999.99)
1513	PTB RDAMT SIGN ADJ4	1	10633	CHAR	"-" = Negative blank = Positive
1514	PTB RDAMT ADJ4	9	10634-10642	CHAR	Layout (999999.99)
1515	PAID FLAG ADJ4	1	10643	CHAR	Direct Mapping
1516	Filler	357	10644-11000	CHAR	space

Trailer Record

Item	Field Name	Size	Position	Type	Comments
1	Trailer Code	X(08)	1-8	Value 'CMSMSPDT'.	File/record identification purposes only
2	Sending Entity	X(04)	9-12	Value 'MARX'	changed from 'MBD'
3	File Creation Date	9(08)	13-20	CCYYMMDD – Format	
4	Detail Record Count	9(08)	21-28		Number of detail records, excluding header and trailer
5	Filler	X(10972)	29-11000	spaces	

Figure 2: Updated TRC 280 – Member MSP Period Ended

Code	Type	Title	Short Definition	Definition
280	M	Member MSP Period Ended	MEMBER NOT MSP	The beneficiary's Medicare as Secondary Payer period has ended. All Plans whose payments are impacted by the change in MSP status will receive the TRC. Field 18 will display the beginning date of the period for which the Plan will see payment impact. If the MSP period began prior to the beginning of the Plan's enrollment, this date will usually be the effective date of the enrollment. Field 24 (cc) will display the MSP coverage termination date. Note: When the date in field 24 is earlier than the date in field 18, it means that the MSP period was changed to end prior to the start of the beneficiary's enrollment in the Plan. **Plan Action**: Update the Plan's records accordingly.

New TRC 340 – Disenrollment Due to MMP Passive Enrollment

Code	Type	Title	Short Definition	Description
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.

Figure 1: LEP File Names

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

System	Type	Frequency	Dataset Naming Convention
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.Dyymm01.Thhmmsst [directory]Rxxxxx.LEPD.Dyymm01.Thhmmsst

Figure 2: LEP Data File Layout

Header Record

Item	Field	Size	Position	Description
1.	Record Type	3	1-3	H = Header Record PIC XXX
2.	MCO Contract Number	5	4-8	MCO Contract Number PIC X(5)
3.	Payment/Payment Adjustment Date	8	9-16	YYYYMMDD
4.	Data file Date	8	17-24	YYYYMMDD Date this data file created PIC 9(8)
5.	Filler	141	25-165	Spaces

Total Length = 165

Detail Record

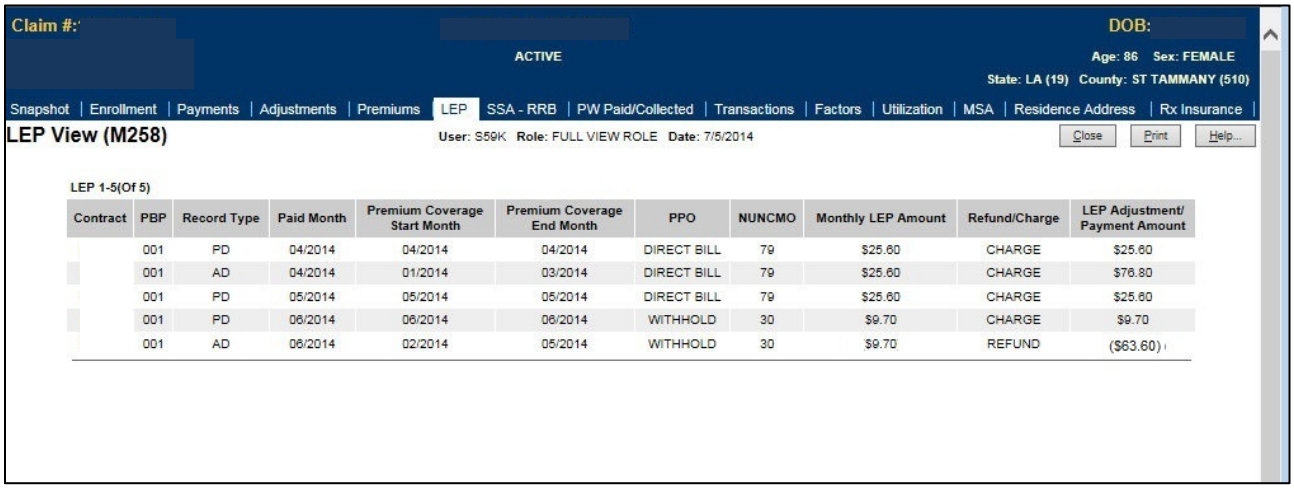
Item	Field	Size	Position	Description
1.	Record Type	3	1-3	PD = Prospective Detail Record "Prospective" means Premium Period equals Payment Month reflected in Header Record AD = Adjustment Detail Record "Adjustment" means all Premium Periods other than Prospective PIC XXX

Item	Field	Size	Position	Description
2.	MCO Contract Number	5	4-8	MCO Contract Number PIC X(5)
3.	PBP Number	3	9-11	PBP Number PIC X(3)
4.	Plan Segment Number	3	12-14	Plan Segment Number PIC X(3)
5.	HIC Number	12	15-26	Member's HIC # PIC X(12)
6.	Surname	7	27-33	PIC X(7)
7.	First Initial	1	34	PIC X
8.	Sex	1	35	M = Male, F = Female PIC X
9.	DOB	8	36-43	YYYYMMDD PIC 9(8)
10.	Filler	1	44	Space
11.	Premium/Adjustment Period Start Date	8	45-52	PD: current processing month. AD: adjustment period. YYYYMMDD PIC 9(6)
12.	Premium/Adjustment Period End Date	8	53-60	PD: current processing month. AD: adjustment period. YYYYMMDD PIC 9(6)
13.	Number of Months in Premium/Adjustment Period	2	61-62	PIC 99
14.	Number of Uncovered Months (NUNCMO)	2	63-64	PIC 99
15.	LEP Amount for Direct Billed Members	8	65-72	PD: LEP Amount for Direct Billed Members owed by Beneficiary for premium period. AD: For adjustments, compute the adjustment for each month in the (affected) payment period if the payment was already made. PIC -9999.99 NOTE: A refund will be reported as a negative amount. A charge will be reported as a positive amount
16.	Filler	93	73-165	Spaces

Trailer Record

Item	Field	Size	Position	Description
1.	Record Type	3	1-3	Trailer Record PIC XXX
2.	MCO Contract Number	5	4-8	MCO Contract Number PIC X(5)
3.	MCO PBP Number	3	9-11	MCO PBP Number PIC X(3)
4.	MCO Segment Number	3	12-14	MCO Segment Number PIC X(3)
5.	Total LEP Amount	14	15-28	Total LEP Amount PIC X(14)
6.	Record Count	14	29-42	Count of records on the data file for combination of contract/PBP/segments

Figure 3: 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
	001	PD	04/2014	04/2014	04/2014	DIRECT BILL	79	$25.60	CHARGE	$25.60
	001	AD	04/2014	01/2014	03/2014	DIRECT BILL	79	$25.60	CHARGE	$76.80
	001	PD	05/2014	05/2014	05/2014	DIRECT BILL	79	$25.60	CHARGE	$25.60
	001	PD	06/2014	06/2014	06/2014	WITHHOLD	30	$9.70	CHARGE	$9.70
	001	AD	06/2014	02/2014	05/2014	WITHHOLD	30	$9.70	REFUND	($63.60)

Attachment E

Broker Compensation Report Data File Layout

Item	Field	Length	Position	Description
1	Contract Number**	5	1-5	Contract identification
2	PBP	3	6-8	Plan Benefit Package
3	HICN	12	9-20	HICN, composed of CAN and BIC
4	First Name	30	21-50	Beneficiary first name
5	Middle Name	15	51-65	Beneficiary middle name
6	Last Name	40	66-105	Beneficiary last name
7	Filler	173	106-278	Spaces
8	Enrollment Effective Start Date	8	279-286	Date Beneficiary's Plan enrollment starts, YYYYMMDD – Format.
9	Cycle-Year as of Enrollment Effective Start Date	3	287-289	Numeric value representing the broker compensation cycle-year count as of enrollment effective start date. Cycle years start with 1 as the initial year. '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.
10	Report Generation Date	8	290-297	Date data file created YYYYMMDD – Format
11	Cycle-Year as of Report Generation Date	3	298-300	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 does not fall within the enrollment period. This occurs for both the prospective and retroactive enrollments. '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.
12	Prior Plan Type	7	301-307	Broad classification of Beneficiary's immediately prior Plan-type: "None" = no prior Plan, "MA" = non-drug MA Plan, "MAPD" = MA Plan offering prescription drugs, "COST" = Non-drug Medicare COST Plan, "COST/PD" = Medicare COST Plan providing prescription drugs, "PDP" = PDP and sometimes representative of a POS transaction,
13	Filler	79	308-386	Spaces