MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLANS

Plan Communications User Guide

Appendices

May 27, 2016

Version 10.1

DEPARTMENT OF HEALTH & HUMAN SERVICES - USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Change Log
May 27, 2016 Updates

Section	Changes
Global Changes	Updated the version to 10.1 Updated the publication date to May 27, 2016 Updated Table, Section, and Appendix references
Appendix A	No Change
Appendix B	No Change
Appendix C	No Change
Appendix D	No Change
Appendix E	No Change
Appendix F	Removed Bonus Payment Data File (obsolete) Updated fields 28, 29, and 30 in the Monthly Membership Detail Data File
Appendix G	No Change
Appendix H	No Change
Appendix I	Updated description for TRC 126 Revision to I.6 MMR Adjustment Reason Codes
Appendix J	Removed Bonus Payment Report (obsolete)
Appendix K	Removed references to Bonus Payment Report and Bonus Payment Report Data File
Appendix L	No Change
Appendix M	No Change

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A: *Glossary and List of Abbreviations and Acronyms*

Table A-1: 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 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 User Interface 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.
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.

Term	Definition
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 available on the Web at: http://www.cms.gov/home/medicare.asp under "Eligibility and Enrollment."
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 MARx with transaction files from the Plans, and provide the Plans with MARx 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.
Network Data Mover (NDM)	Software used for transmitting and receiving data; replaced by Connect:Direct.
MicroStrategy	A tool used for generating and viewing standard and ad hoc reports.
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.

Term	Definition
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.
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 Web at: 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 MARx and MBD with transaction files from the Plans, and provide the Plans with MARx and MBD 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.

A.1 List of Abbreviations and Acronyms

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
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	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
COBC	Coordination of Benefits Contractor
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
DPO	Division of Payment Operations

DSA	Data Sharing Agreement
DTL	Detail
DTRR	Daily Transaction Reply Report
ECRS	Electronic Correspondence Referral System
EDB	Enrollment Database
EFT	Electronic File Transfer
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
FAQ	Frequently Asked Question
FEFD	Full Enrollment File Data
FERAS	Front End Risk Adjustment System
FFS	Fee-For-Service
FTR	Failed Transaction Report
GHP	Group Health Plan
GUIDE	Plan Communications User Guide
HCC	Hierarchical Condition Category
HCFA	Health Care Financing Administration (renamed to CMS)
HCPP	Health Care Prepayment Plan
HIC	Health Insurance Claim
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 Interface Control Document
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
IT	Information Technology
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
MA BSF	Medicare Advantage Benefit Stabilization Fund
MADP	Medicare Advantage Disenrollment Period
MAPD	Medicare Advantage and Part D
MARx	Medicare Advantage and Prescription Drug System
MARx UI	Medicare Advantage and Prescription Drug System User Interface
MBD	Medicare Beneficiary Database
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
NCPDP	National Council of Prescriptions Drug Programs
NDM	Network Data Mover
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	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
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
WC	Workers Compensation
WCSA	Workers Compensation Set-Aside
WPP	Wisconsin Partnership Program

B: *CMS Payment Information*

B.1 Payment Information Form

Plans receive monthly payments from CMS for the medical services and/or prescription drugs that they provide to Medicare beneficiaries. In order to receive payment, a Plan's bank account information and Employee Identification Number (EIN)/Tax Identification Number (TIN) must be submitted to CMS. The Payment Information Form is used to provide this information.

ORGANIZATION INFORMATION

NAME OF ORGANIZATION: _____
DBA, if any: _____

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

CONTACT PERSON NAME: _____
TELEPHONE NUMBER: _____

CONTRACT NO's.: 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

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C: *Monthly Schedule*

The following pages contain the 2016 Plan Medicare Advantage and Prescription Drug System (MARx) Monthly Schedule, which provides dates for the following:

- Plan Data Due
- Down Days
- Availability of Monthly Reports
- Due Date for Certification of Enrollment, Payment, and Premium Reports
- Payments Due to Plans
- Holidays

Note: The Daily Transaction Reply Report (DTRR) is not indicated on this schedule because it is a daily report.

This calendar is also available as a single document in the Medicare Advantage and Prescription Drug (MAPD) Help Desk Web site downloads section: http://www.cms.gov/mapdhelpdesk/. Both color and text 508 compliant versions of this schedule are available at the above link.

C.1 MARx Plan Payment Processing Schedule Description - Calendar Year 2016

It is vital that everyone involved in the Medicare enrollment and payment operations of the contract is aware of target dates schedule attached to this description. The schedule includes:

(1) **PLAN DATA DUE** - This is the last day for Plans to transmit records to the CMS Data Center for processing in the month. Plans must complete the transmission by the close of business (8 p.m. ET) on the date noted.

(2) **PAYMENT DUE PLANS** - This is the date that CMS deposits the CMS 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.

Note: The January deposit is the first business day of the month.

(3) **MONTHLY REPORTS AVAIL** - This is the date all the CMS monthly reports are available for downloading from the mailbox or received in the system.

Note: These reports are not mailed; the Plan must download them to receive them!

(3) **ANNUAL ELECTION PERIOD BEGINS AND ENDS** - 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.

(4) **CERTIFICATION DUE** - 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).

(5) **APPROVED RETROS TO CMS** - Any records processed as batch retroactive files must arrive at CMS by noon on the date shown, along with the appropriate paperwork approved by CMS.

Yearly Schedule of Events

YEAR 2016 MARx MONTHLY CALENDAR

January 2016						
Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

January	
January 1, 2016	New Year's Day
January 4, 2016	January Payment Due to Plan
January 4, 2016	Certification of Enrollment for November 20, 2015- Monthly Reports
January 8, 2016	Plan Data Due (8pm Eastern Time)
January 18, 2016	Martin Luther King Day
January 22, 2016	Monthly Reports Available

February 2016						
Su	M	Tu	W	Th	F	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29					

February	
February 1, 2016	February Payment Due to Plan
February 5, 2016	Plan Data Due (8pm Eastern Time)
February 8, 2016	Certification of Enrollment for December 23, 2015 - Monthly Reports
February 15, 2016	Washingtons Birthday (Observed)
February 18, 2016	Monthly Reports Available

March 2016						
Su	M	Tu	W	Th	F	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

March	
March 1, 2016	March Payment Due to Plan
March 7, 2016	Certification of Enrollment for January 22, 2016 -Monthly Reports
March 11, 2016	Plan Data Due (8pm Eastern Time)
March 24, 2016	Monthly Reports Available

Yearly Schedule of Events

YEAR 2016 MARx MONTHLY CALENDAR

April 2016						
Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24`	25	26	27	28	29	30

April	
April 1, 2016	April Payment Due to Plan
April 3, 2016	Certification of Enrollment for February 18, 2016 - Monthly Reports
April 8, 2016	Plan Data Due (8pm Eastern Time)
April 22, 2016	Monthly Reports Available
April 29, 2016	May Payment Due to Plan - April 29, 2016

May 2016						
Su	M	Tu	W	Th	F	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

May	
May 8, 2016	Certification of Enrollment for March 24, 2016 - Monthly Reports
May 13, 2016	Plan Data Due (8pm Eastern Time)
May 23, 2016	Monthly Reports Available
May 30, 2016	Memorial Day

June 2016						
Su	M	Tu	W	Th	F	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

June	
June 1, 2016	June Payment Due to Plan
June 6, 2016	Certification of Enrollment for April 22, 2016 - Monthly Reports
June 10, 2016	Plan Data Due (8pm Eastern Time)
June 23, 2016	Monthly Reports Available

Yearly Schedule of Events

YEAR 2016 MARx MONTHLY CALENDAR

July 2016						
Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

July	
July 1, 2016	July Payment Due to Plan
July 4, 2016	Independence Day
July 8, 2016	Certification of Enrollment for May 24, 2016 - Monthly Reports
July 8, 2016	Plan Data Due (8pm Eastern Time)
July 22, 2016	Monthly Reports Available

August 2016						
Su	M	Tu	W	Th	F	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August	
August 1, 2016	August Payment Due to Plan
August 7, 2016	Certification of Enrollment for June 23, 2016 - Monthly Reports
August 12, 2016	Plan Data Due (8pm Eastern Time)
August 24, 2016	Monthly Reports Available

September 2016						
Su	M	Tu	W	Th	F	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

September	
September 1, 2016	September Payment Due to Plan
September 5, 2016	Labor Day
September 5, 2016	Certification of Enrollment for July 22, 2016 - Monthly Reports
September 9, 2016	Plan Data Due (8pm Eastern Time)
September 22, 2016	Monthly Reports Available
September 30, 2016	October Payment Due Plan

Yearly Schedule of Events

YEAR 2016 MARx MONTHLY CALENDAR

October 2016						
Su	M	Tu	W	Th	F	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

October	
October 7, 2016	Plan Data Due (8pm Eastern Time)
October 8, 2016	Certification of Enrollment for August 24, 2016 - Monthly Reports
October 10, 2016	Columbus Day
October 15, 2016	Annual Enrollment Period - BEGINS
October 24, 2016	Monthly Reports Available

November 2016						
Su	M	Tu	W	Th	F	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

November	
November 1, 2016	November Payment Due to Plan
November 6, 2016	Certification of Enrollment for September 22, 2016 -Monthly Reports
November 11, 2016	Plan Data Due (8pm Eastern Time)
November 11, 2016	Veteran's Day
November 22, 2016	Monthly Reports Available
November 24, 2016	Thanksgiving

December 2016						
Su	M	Tu	W	Th	F	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

December	
December 1, 2016	December Payment Due to Plan
December 7, 2016	Annual Election Period - ENDS
December 8, 2016	Certification of Enrollment for October 24, 2016 - Monthly Reports
December 9, 2016	Plan Data Due (8pm Eastern Time)
December 22, 2016	Monthly Reports Available
December 26, 2016	Christmas Holiday (Observed)
January 2, 2017	New Year's Day (Observed)
January 3, 2017	January Payment Due Plan
January 6, 2017	Plan Data Due (8pm Eastern Time)

D: *Enrollment Data Transmission Schedule*

The following is a recommendation for the best time to transmit data:

- Monday through Friday - 24 hours.
  Data **IS** received for monthly processing.

- Saturday, Sunday, and system down days.

  Data **IS RECEIVED AND HELD** for monthly processing.
  Refer to the Plan Monthly Schedule. (Appendix C)

- Enrollment Data Cutoff Day - Data is due by 8 p.m. ET.

The Plan Monthly Schedule in Appendix C lists cutoff dates for each month.

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E: *ESRD Network Contact Information Table*

Network	Region	States	Name & Address	Contact Information
1	1	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	ESRD Network of New England Jaya Bhargava, Data Manager 30 Hazel Terrace. Woodbridge, Connecticut 06525	Phone: (203) 387-9332 Fax: (203) 389-9902
2	2	New York	IPRO/CKD Network for New York Bernadette Cobb, Data Manager 1979 Marcus Avenue Lake Success, New York 11042-1002	Phone: (516) 209-5619 Fax: (516) 326-8929
3	2	New Jersey Puerto Rico Virgin Islands	Trans-Atlantic Renal Council Chris Milkosky, Data Manager Cranbury Gate Office Park 109 S. Main St., Suite 21 Cranbury, New Jersey 08512-9595	Phone: (609) 490-0310 Fax: (609) 490-0835
4	3	Delaware Pennsylvania	ESRD Network 4 Inc. Rhonda Lockett, Data Manager 40 24th Street, Suite 410 Pittsburgh, Pennsylvania 15222	Phone: (412) 325-2250 Fax: (412) 325-1811
5	3	D of Columbia Maryland Virginia West Virginia	Mid-Atlantic Renal Coalition Jason Robins, Data Manager 1527 Huguenot Road Midlothian, Virginia 23113	Phone: (804) 794-3757 Fax: (804) 794-3793
6	4	Georgia North Carolina South Carolina	Southeastern Kidney Council, Inc. Margo Clay, Data Manager 1000 St. Albans Drive, Suite 270 Raleigh, North Carolina 27609	Phone: (919) 855-0882 Fax: (919) 855-0753
7	4	Florida	ESRD Network of Florida, Inc. LeChrystal Williams, Data Manager 5201 W Kennedy Boulevard, Suite 900 Tampa, Florida 33606	Phone: (813) 383-1530 Fax: (813) 354-1514
8	4	Alabama Mississippi Tennessee	ESRD Network Eight, Inc. Robert Bain, Data Manager 1755 Lelia Drive, Suite 400 Jackson, Mississippi 39210	Phone: (601) 936-9260 Fax: (601) 932-4446
9	5	Kentucky Indiana Ohio	The Renal Network, Inc. Christy Harper, Data Manager 911 East 86th Street, Suite 202 Indianapolis, Indiana 46240	Phone: (317) 257-8265 Fax: (317) 257-8291
10	5	Illinois	The Renal Network, Inc. Christy Harper, Data Manager 911 E 86th Street, Suite 202 Indianapolis, Indiana 46240	Phone: (317) 257-8265 Fax: (317) 257-8291
11	5	Michigan Minnesota North Dakota South Dakota Wisconsin	Renal Network of the Upper Midwest Tom Kysilko, Data Manager 1360 Energy Park Drive, Suite 200 St. Paul, Minnesota 55108	Phone: (651) 644-9877 Fax: (651) 644-9853
12	7	Iowa Kansas Missouri Nebraska	ESRD Network 12 Jeff Arnell, Data Manager 7306 NW Tiffany Springs Parkway Suite 230 Kansas City, Missouri 64153	Phone: (816) 880-9990 Fax: (816) 880-9088

Network	Region	States	Name & Address	Contact Information
13	6	Arkansas Louisiana Oklahoma	ESRD Network 13 Cindy Smith, Data Manager 4200 Perimeter Center Drive, Suite 102 Oklahoma City, Oklahoma 73112	Phone: (405) 942-6000 Fax: (405) 942-6884
14	6	Texas	ESRD Network of Texas, Inc. Nathan Muzos, Data Manager 4040 McEwen, Suite 350 Dallas, Texas 75244	Phone: (972) 503-3215 Fax: (972) 503-3219
15	10	Arizona Colorado Nevada New Mexico Utah Wyoming	Intermountain ESRD Network, Inc. Matt Howard, Data Manager 165 S. Union Blvd Suite 466 Lakewood, Colorado 80228	Phone: (303) 831-8818 Fax: (303) 860-8392
16	10	Alaska Idaho Montana Oregon Washington	Northwest Renal Network Donna Swenson, Data Manager 4702 42nd Avenue, SW Seattle, Washington 98116	Phone: (206) 923-0714 Fax: (206) 923-0716
17	10	Amer Samoa Hawaii N. California Pacific Islands	Western Pacific Renal Network Susan Tanner, Data Manager 505 San Marin Drive, Bldg A, Suite 300 Novata, California 94945	Phone: (415) 897-2400 Fax: (415) 897-2422
18	10	S. California	Southern California Renal Disease Council Svetlana Lyulkin, Data Manager 6255 Sunset Boulevard, Suite 2211 Los Angeles, California 90028	Phone: (323) 962-2020 Fax: (323) 962-2891

F: *Record Layouts*

This appendix provides record layouts for data files exchanged with Plans. Field lengths, formats, and descriptions are included along with expected values where applicable. Table F-1 below lists the names of all the layouts and on which page of Appendix F to find them. Appendix K identifies the naming conventions of for all files exchanged between CMS and the Plans.

Table F-1: Record Layouts Lookup Table

Section	Name	Page
Daily Record Layouts		
F.1	Batch Completion Status Summary (BCSS) Data File	F-3
F.2	Coordination of Benefits (COB); Validated Other Health Insurance (OHI) Data File	F-8
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F.3.2	Disenrollment Transaction (TC 51/54)	F-19
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F.3.4.1	4RX Change (TC 72)	F-22
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Weekly Record Layouts		
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Monthly Record Layouts		
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Section	Name	Page
F.12	Monthly Membership Summary Data File	F-78
F.13	Monthly Premium Withholding Report Data File (MPWR)	F-80
F.14	Part B Claims Data File	F-83
F.15	Part C Risk Adjustment Model Output Data File	F-85
F.16	RAS RxHCC Model Output Data File aka Part D Risk Adjustment Model Output Data File	F-109
F.17	Medicare Advantage Organization (MAO) 004 Report	F-121
F.18	Monthly Full Enrollment Data File	F-125
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F.21	NoRx File	F-135
F.22	MA Full Dual Auto Assignment Notification File	F-139
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F.24	Plan Payment Report (PPR) / Interim Plan Payment Report (IPRR) Data File	F-146
F.25	Agent Broker Compensation Report Data File	F-155
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F.27	Failed Payment Reply Report Data File	F-169
F.28	MSA Deposit-Recovery Data File Layout	F-171
Yearly Record Layouts		
F.29	Loss of Subsidy Data File	F-175
F.30	Long-Term Institutionalized Resident Report Data File	F-177
F.31	No Premium Due Data File Layout	F-179

Daily Record Layouts

F.1 Batch Completion Status Summary (BCSS) Data File

As of the April 2011 release, the Batch Completion Status Summary (BCSS) file is a hybrid file that communicates the status of file transmissions, as well as reporting and reports on submitted transaction records that failed due to formatting issues. Previously, this file also returned the processing results of accepted and rejected transactions, but as of the April 2011 release, those are reported only on the Daily Transaction Reply Report (DTRR) Data file. Note: The Enrollment Transmission Message File (STATUS) discontinued as of the April 2011 Release. 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 details the number of rejected and accepted transactions. It also provides an image of each failed transaction.

System	Type	Frequency	Dataset Naming Conventions
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

F.1.1 Failed Record

Below, the example of a BCSS report displays the format of the file transmission status. Plans get a sense of how the file status incorporates the new Transaction Codes (TCs) 76 through 83 and how the counts for accepted, rejected and failed transactions are displayed.

Beginning of Message Text

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 = 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……

End of Message Text

All BCSS records begin with a two-character record type identifier. The first character designates the type of data reported in that section.

Please note that the first count on the C1 Tran CNTS1 record is the total number of transactions received in the file.

F.1.2 BCSS 'Failed Transaction' Layout

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	Transaction Reply Codes (TRCs)	3	309-311	First TRC
6	TRCs	3	312- 314	Second TRC; otherwise, spaces
7	TRCs	3	315 - 317	Third TRC; otherwise, spaces
8	TRCs	3	318-320	Fourth TRC; otherwise, spaces
9	TRCs	3	321-323	Fifth TRC; otherwise, spaces

Total Length = 323

F.1.3 BCSS Error Condition

The six following STATUS file messages generate when an **error** condition prevents the transaction from processing.

1. Invalid User Id

```
********************************** Top of Data ******************************
H1 TRANSACTIONS RECEIVED ON 2006-01-27 AT 16.59.49
H2 PROCESSING STOPPED    ON 2006-01-27 AT 17.00.39
H3 USER ID (aaaa) NOT AUTHENTICATED: INACTIVE USER
H4 HEADER CODE= AAAAAAHEADER
H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
H7 BATCH ID   = <nnnnnnnnn>
H8 USER ID    = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 =         T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 =         T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 =         T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
********************************* Bottom of Data ****************************
```

OR

```
********************************** Top of Data ******************************
H1 TRANSACTIONS RECEIVED ON 2006-01-27 AT 16.59.49
H2 PROCESSING STOPPED    ON 2006-01-27 AT 17.00.39
H3 USER ID (aaaa) NOT AUTHENTICATED: USER ID NOT FOUND
H4 HEADER CODE= AAAAAAHEADER
H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
```

```
H7 BATCH ID   = <nnnnnnnnn>
H8 USER ID    = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 =         T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 =         T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 =         T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
******************************** Bottom of Data ***************************
```

2. Invalid Header Date

```
********************************* Top of Data*****************************
H1 TRANSACTIONS RECEIVED ON 2006-01-27 AT 16.23.22
H2 PROCESSING STOPPED    ON 2006-01-27 AT 16.23.42
H3 HEADER RECORD IS MISSING OR INVALID
H4 HEADER CODE= AAAAAAHEADER
H5 HEADER DATE= <NNNNNN>
H6 REQUEST ID =
H7 BATCH ID   = <nnnnnnnnn>
H8 USER ID    = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 =         T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 =         T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 =         T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
******************************** Bottom of Data ***************************
```

3. Missing Header Record

```
********************************* Top of Data *****************************
H1 TRANSACTIONS RECEIVED ON           AT
H2 PROCESSING STOPPED    ON 2006-01-25 AT 18.11.38
H3 HEADER RECORD IS MISSING OR INVALID
H4 HEADER CODE= XXXXXXXXXXXXXXXXXXXXXX
H5 HEADER DATE= XXXXXX
H6 REQUEST ID = XXXXXXXXXX
H7 BATCH ID   = XXXXXXXXXX
H8 USER ID    =   XXXXXX
C1 TRAN CNTS1 =
C2 TRAN CNTS2 =
C3 TRAN CNTS3 =
C4 TRAN CNTS4 =
C5 TRAN CNTS5 =
******************************** Bottom of Data ***************************
```

4. Future Header Date

```
********************************* Top of Data *****************************
H1 TRANSACTIONS RECEIVED ON 2006-01-30 AT 16.48.37
H2 PROCESSING STOPPED    ON 2006-01-30 AT 16.48.55
H3 HEADER RECORD DATE IS A FUTURE CALENDAR MONTH
H4 HEADER CODE= AAAAAAHEADER
H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
H7 BATCH ID   = <nnnnnnnnn>
H8 USER ID    = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
```

C2 TRAN CNTS2 = T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 = T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 = T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
********** Bottom of Data **********

5. Header Date earlier than CCM

********** Top of Data **********
H1 TRANSACTIONS RECEIVED ON 2013-09-25 AT 16.08.20
H2 PROCESSING STOPPED ON 2013-09-25 AT 16.08.22
H3 HEADER RECORD DATE IS EARLIER THAN CURRENT CALENDAR MONTH
H4 HEADER CODE= AAAAAAHEADER
H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
H7 BATCH ID = <nnnnnnnnn>
H8 USER ID = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 = T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 = T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 = T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
********** Bottom of Data **********

6. Transaction File Rejection Reason

After a Specialty file is reviewed by CMS, the following STATUS messages are generated upon rejection:

********** Top of Data **********
H1 TRANSACTIONS RECEIVED ON 2010-03-23 AT 13.55.15
H2 TRANSACTIONS REJECTED ON 24 Mar 2010 AT 14:39:33
H3 THIS <RETRO/ROLLOVER/REVIEW> FILE WAS REJECTED BY <CMS Approver Name>
REJECTION REASONS: <text of reason
H4 HEADER CODE= AAAAAAHEADER RETRO
H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
H7 BATCH ID = <nnnnnnnnn>
H8 USER ID = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 = T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 = T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 = T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
********** Bottom of Data **********

F.1.4 BCSS Specialty Files

If the file is a Specialty file, the following STATUS messages generate upon initial receipt:

Retro File Detected

********** Top of Data **********
H1 TRANSACTIONS RECEIVED ON 2006-01-27 AT 14.23.05
H2 PROCESSING STOPPED ON 2006-01-27 AT 14:23:39
H3 RETRO FILE DETECTED FOR USERID <aaaa>
H4 HEADER CODE= AAAAAAHEADER RETRO

H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
H7 BATCH ID = <nnnnnnnnn>
H8 USER ID = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 = T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 = T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 = T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
********** Bottom of Data **********

Rollover File Detected

********** Top of Data **********
H1 TRANSACTIONS RECEIVED ON 2006-01-27 AT 14.23.05
H2 PROCESSING STOPPED ON 2006-01-27 AT 14:23:39
H3 ROLLOVER FILE DETECTED FOR USERID <aaaa>
H4 HEADER CODE= AAAAAAHEADER POVER
H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
H7 BATCH ID = <nnnnnnnnn>
H8USER ID = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 = T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 = T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 = T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
********** Bottom of Data **********

Review File Detected

********** Top of Data **********
H1 TRANSACTIONS RECEIVED ON 2006-01-27 AT 14.23.05
H2 PROCESSING STOPPED ON 2006-01-27 AT 14:23:39
H3 REVIEW FILE DETECTED FOR USERID <aaaa>
H4 HEADER CODE= AAAAAAHEADER SVIEW
H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
H7 BATCH ID = <nnnnnnnnn>
H8 USER ID = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 = T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 = T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 = T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn

********** Bottom of Data **********

F.2 Coordination of Benefits (COB); Validated Other Health Insurance (OHI) Data File

This file contains members' primary and secondary coverage, validated through COB processing. MARx forwards this report whenever a Plan's enrollees are affected, which may occur as often as daily. The enrollees included on the report are those newly enrolled who have known Other Health Insurance (OHI) and those Plan enrollees with changes to their OHI.

System	Type	Frequency	Dataset Naming Conventions
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

The following records are included in this file:

- Detail Record
- Primary Record
- Supplemental Record

F.2.1 General 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

F.2.2 Detail Records: Indicates the Beginning of a Series of Beneficiary Subordinate Detail Records

Item	Field	Size	Position	Format	Valid Values/Description
1	Record Type	3	1-3	CHAR	"DTL"
2	HICN/RRB Number	12	4-15	CHAR	Spaces if unknown
3	SSN	9	16-24	ZD	000000000 if unknown
4	Date of Birth (DOB)	8	25-32	CHAR	YYYYMMDD
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

Note: Total Length = 1100

F.2.3 *Primary Records: Subordinate to Detail Record (Unlimited Occurrences)*

Item	Field	Size	Position	Format	Valid Values/Description
1	Record Type	3	1-3	CHAR	"PRM"
2	HICN/RRB Number	12	4-15	CHAR	Spaces if unknown
3	SSN	9	16-24	ZD	000000000 if unknown
4	Date of Birth (DOB)	8	25-32	CHAR	YYYYMMDD
5	Gender Code	1	33	CHAR	0=unknown, 1 = male, 2 = female
6	RxID Number*	20	34-53	CHAR	
7	RxGroup Number*	15	54-68	CHAR	
8	RxBIN Number*	6	69-74	ZD	
9	RxPCN Number*	10	75-84	CHAR	
10	Rx Plan Toll Free Number*	18	85-102	CHAR	
11	Sequence Number*	3	103-105	CHAR	
12	COB Source Code* **Note:** There may be instances where an unknown COB Source Code will be provided. Plans should contact COBC for clarification on any unknown Source Codes.	5	106-110	CHAR	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 Office of Personnel Management (OPM) Data Match 11114 Workers' Compensation Data Match 11118 Pharmacy Benefit Manager (PBM) 11120 COBA 11125 Recovery Audit Contractor (RAC) 1 (April Release) 11126 RAC 2 (April Release) 11127 RAC 3 (April Release) P0000 PBM S0000 Assistance Program Note: Contractor numbers 11100 - 11199 are reserved for COB

Item	Field	Size	Position	Format	Valid Values/Description
13	MSP Reason (Entitlement Reason from COB)	1	111	CHAR	A=Working Aged B=ESRD C=Conditional Payment D=Automobile Insurance, No fault E=Workers Compensation F=Federal (public) G=Disabled H=Black Lung I=Veterans L=Liability
14	Coverage Code*	1	112	CHAR	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	
16	Insurer's Address-1*	32	145-176	CHAR	
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	
22	Individual Policy Number*	17	245-261	CHAR	
23	Group Policy Number*	20	262-281	CHAR	
24	COB Effective Date*	8	282-289	ZD	YYYYMMDD
25	Termination Date*	8	290-297	ZD	YYYYMMDD
26	Relationship Code*	2	298-299	CHAR	01=Bene 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	
29	Payer Order*	3	313-315	ZD	
30	Policy Holder's First Name	9	316-324	CHAR	
31	Policy Holder's Last Name	16	325-340	CHAR	
32	Policy Holder's SSN	12	341-352	CHAR	
33	Employee Information Code	1	353	CHAR	P=Patient S=Spouse M=Mother F=Father
34	Employer's Name	32	354-385	CHAR	
35	Employer's Address 1	32	386-417	CHAR	
36	Employer's Address 2	32	418-449	CHAR	

Item	Field	Size	Position	Format	Valid Values/Description
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	
44	Attorney's Address 1	32	608-639	CHAR	
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	
50	Class Action Type	2	707-708	CHAR	
51	Administrator Name	32	709-740	CHAR	
52	Administrator Address 1	32	741-772	CHAR	
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	WCSA Amount	12	831-842	ZD	Integer value
58	WCSA Indicator	2	843-844	CHAR	
59	WCMSA Settlement Date	8	845-852	ZD	YYYYMMDD
60	Administrator's Telephone Number	18	853-870	CHAR	
61	Total Rx Settlement Amount	12	871-882	CHAR	Includes decimal point: 9999999999.99
62	Rx $ included in the WCMSA Settlement Amount	1	883	CHAR	Y = Yes N = No
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

Item	Field	Size	Position	Format	Valid Values/Description
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	
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	
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	
114	Filler	9	1092-1100	CHAR	Spaces

Total Length = 1100

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

F.2.4 *Supplemental Records: Subordinate to DTL (Unlimited Occurrences)*

Item	Field	Size	Position	Format	Valid Values/Description
1	Record Type	3	1-3	CHAR	"SUP"
2	HICN/RRB Number	12	4-15	CHAR	Spaces if unknown
3	SSN	9	16-24	ZD	000000000 if unknown
4	Date of Birth (DOB)	8	25-32	CHAR	YYYYMMDD
5	Gender Code	1	33	CHAR	0=unknown, 1 = male, 2 = female
6	RxID Number*	20	34-53	ZD	
7	RxGroup Number*	15	54-68	CHAR	
8	RxBIN Number*	6	69-74	ZD	
9	RxPCN Number*	10	75-84	CHAR	
10	Rx Plan Toll Free Number*	18	85-102	CHAR	
11	Sequence Number*	3	103-105	CHAR	
12	COB Source Code*	5	106-110	CHAR	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 Office of Personnel Management (OPM) Data Match 11114 Workers' Compensation Data Match 11118 Pharmacy Benefit Manager (PBM) 11120 COBA 11125 Recovery Audit Contractor (RAC) 1 (April Release) 11126 RAC 2 (April Release) 11127 RAC 3 (April Release) P0000 PBM S0000 Assistance Program Note: Contractor numbers 11100 - 11199 are reserved for COB

Item	Field	Size	Position	Format	Valid Values/Description
13	Supplemental Type Code	1	111	CHAR	L=Supplemental M=Medigap N=State Program (Non-Qualified SPAP) O=Other P=Patient Assistance Program Q=Qualified State Pharmaceutical Assistance Program (SPAP) R=Charity S=AIDS Drug Assistance Program T=Federal Health Program 1=Medicaid 2=Tricare 3 = Major Medical
14	Coverage Code*	1	112	CHAR	U=Drug (network benefit) V=Drug with Major Medical (non-network benefit)
15	Insurer's Name*	32	113-144	CHAR	
16	Insurer's Address-1*	32	145-176	CHAR	
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	
23	Group Policy Number*	20	262-281	CHAR	
24	COB Effective Date*	8	282-289	ZD	YYYYMMDD
25	Termination Date*	8	290-297	ZD	YYYYMMDD
26	Relationship Code*	2	298-299	CHAR	01=Bene is Policy Holder 02=Spouse 03=Child 04=Other
27	Payer ID*	10	300-309	CHAR	
28	Person Code*	3	310-312	CHAR	
29	Payer Order*	3	313-315	ZD	
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	

Item	Field	Size	Position	Format	Valid Values/Description
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	
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	

Item	Field	Size	Position	Format	Valid Values/Description
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
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	
81	Filler	577	524-1100	CHAR	Spaces

Total Length = 1100

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

F.3 MARx Batch Input Transaction Data File

A transaction file is submitted to CMS by a Plan, and consists of a header record followed by individual transaction records. The Transaction Code (TC) identifies the type of transaction record. This section details the contents and format that each record type may include in the transaction file.

System	Type	Frequency	Dataset Naming Conventions
MARx	Data File	Batch - 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:** P#EFT.IN.uuuuuuu.MARXTR.DYYMMDD.THHMMSST Note: DYYMMDD.THHMMSST must be coded as shown, as it is a literal

This file may include the following records:

- Header Record
- Disenrollment (51/54) Detail Record
- Enrollment (61) Detail Record
- Miscellaneous Change Detail Records:
  - Correction (01) Record
  - 4Rx Data Change (72)
  - Number of Uncovered Months (NUNCMO) Change (73)
  - Employer Group Health Plan (EGHP) Change (74)
  - Premium Payment Option (PPO) Change (75)
  - Residence Address Change (76)
  - Segment ID Change (77)
  - Part C Premium Change (78)
  - Part D Opt-Out (79)
  - MMP Opt-Out Update (TC83)
- Cancellation of Enrollment (80) and Cancellation of Disenrollment (81) Detail Records
  - MMP Enrollment Cancellation (TC82)
- POS Drug Edit (TC90)

F.3.1 *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" = used for batch files that do not require special approval for submission; “RETRO” = retroactive batch file submission; “POVER” = Plan rollover batch file submission; “SVIEW” = Special organization review batch file 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.

Item	Field	Size	Position	Description
6	Filler	4	30-33	Spaces
7	Current Calendar Month (CCM)	6	34-39	Reference month for enrollment processing formatted MMYYYY. The CCM date determines whether to accept a file and evaluates the appropriate effective date for submitted transactions.
8	Filler	261	40-300	Spaces

Total Length = 300

F.3.2 *Disenrollment Transaction (TC 51/54) Detailed Record Layout*

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	Required
8	PBP	3	43-45	Optional
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, and PACE National Plans
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	Transaction Codes (TCs)*	2	60-61	“51” or “54”
13	DRC	2	62-63	Required for Involuntary Disenrollments. Optional for Voluntary Disenrollments.
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Segment ID	3	72-74	Optional
16	Filler	24	75-98	N/A
17	Part D Opt-Out Flag	1	99	Optional for all Part D Plans; otherwise blank.
18	MMP Opt-Out Flag	1	100	Optional for all Plans.
19	Filler	109	101-209	N/A
20	Plan Transaction Tracking ID**	15	210-224	Optional
21	Filler	76	225-300	N/A

Total Length = 300

*The “51” transaction is Plan submitted. The “54” is submitted by 1-800-Medicare without a header record.

**Plan Transaction Tracking ID field is not used by 1-800-Medicare.

F.3.3 *Enrollment Transaction (TC 61) Detailed Record Layout*

Item	Fields	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	EGHP Flag	1	42	Blank field has a meaning.
8	PBP #	3	43-45	Required
9	Election Type	1	46	Required: for all Plan types when Note 3 is true; otherwise not required for HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MDHO demo, MSHO demo, and PACE National Plans.
10	Contract #	5	47-51	Required
11	Application Date	8	52-59	Required
12	Transaction Code	2	60-61	Required
13	Disenrollment Reason	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Segment ID	3	72-74	Optional: if provided, must have three digits and a valid Segment for the Contract/PBP.
16	Filler	5	75-79	N/A
17	ESRD Override	1	80	Required: for MA Plans to successfully enroll ESRD exceptions.
18	Premium Withhold Option/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 and MSA/demo Plans.
19	Part C Premium Amount (XXXXvXX)	6	82-87	Required: for all Plan types except HCPP, COST 1, COST 2, CCIP/FFS demo, MSA/MA and MSA/demo Plans.
20	Filler	6	88-93	N/A
21	Creditable Coverage Flag	1	94	Required: for all Part D Plans; otherwise blank.
22	Number of Uncovered Months	3	95-97	Required: for all Part D Plans; otherwise blank. Blank = zero, meaning no uncovered months.
23	Employer Subsidy Enrollment Override Flag	1	98	Required: if beneficiary has Employer Subsidy status for Part D; otherwise blank.
24	Part D Opt-Out Flag	1	99	Required: when changing PBPs; 'Y' when Opting Out of Part D; 'N' when Opting in for Part D; otherwise, blank.
25	Filler	35	100-134	N/A
26	Secondary Drug Insurance Flag	1	135	Required: for Part D Plans. Value is 'Y' or 'N' or blank. For auto/facilitated enrollments and rollovers, value is blank. For non-Part D Plans, value is blank.

Item	Fields	Size	Position	Required/Optional
27	Secondary Rx ID	20	136-155	Required: if secondary insurance; otherwise, blank.
28	Secondary Rx Group	15	156-170	Required: if secondary insurance; otherwise, blank.
29	Enrollment Source	1	171	Required: for Point of Service (POS) submitted enrollment transactions; otherwise, optional.
30	Filler	38	172-209	N/A
31	Plan Assigned Transaction Tracking ID	15	210-224	Optional
32	Part D Rx BIN	6	225-230	Required: for all Part D Plans except PACE National and MMP; otherwise, blank.
33	Part D Rx PCN	10	231-240	Change-to value for all Part D Plans, otherwise blank.
34	Part D Rx Group	15	241-255	Change-to value for all Part D Plans, otherwise blank.
35	Part D Rx ID	20	256-275	Required: for all Part D Plans except PACE National and MMP; otherwise, blank.
36	Secondary Drug BIN	6	276-281	Required: if secondary insurance; otherwise, blank.
37	Secondary Drug PCN	10	282-291	Required: if secondary insurance; otherwise, blank.
38	Filler	9	292-300	N/A

Total Length = 300

*The “51” transaction is Plan submitted. The “54” is submitted by 1-800-Medicare without a header record.
**Plan Transaction Tracking ID field is not used by 1-800-Medicare.

Note: Election type rules do apply to HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demos, MDHO demo, MSHO demo, and PACE National enrollments in cases where such an enrollment would cause an automatic disenrollment from another Plan requiring an election type. It is important that the election type for the Plan on the enrollment request is consistent with the election type required for automatic disenrollment.

Note: MA organizations and cost Plans that auto/facilitate enroll LIS Beneficiaries on behalf of CMS should use the appropriate newly-designated enrollment source code when submitting auto-enrollments or facilitated enrollments: E = Plan-submitted auto-enrollment, F = Plan-submitted facilitated enrollment, G = Point-of-Sale (POS) submitted enrollment; for use by POS contractor only, H = CMS reassignment enrollment, I = Assigned to Plan-submitted enrollment with enrollment source other than any of the following: B, E, F, G, H and blank.

F.3.4 *Miscellaneous Change Transactions – Detailed Record Layouts*

F.3.4.1 4RX Change (TC 72) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1 – 12	Required
2	Surname	12	13 – 24	Required
3	First Name	7	25 – 31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34 – 41	Required
7	Filler	1	42	N/A
8	PBP #	3	43 – 45	Required
9	Filler	1	46	N/A
10	Contract #	5	47 – 51	Required
11	Filler	8	52 – 59	N/A
12	Transaction Code (TC)	2	60 – 61	Required
13	Filler	2	62 – 63	N/A
14	Effective Date (YYYYMMDD)	8	64 – 71	Required
15	Filler	63	72-134	N/A
16	Secondary Drug Insurance Flag	1	135	Blank or new value. Blank does not remove or replace existing data.
17	Secondary Rx ID	20	136-155	Blank or new additional value. Blank does not remove or replace existing data.
18	Secondary Rx Group	15	156-170	Blank or new additional value. Blank does not remove or replace existing data.
19	Filler	54	171-209	N/A
20	Transaction Tracking ID	15	210-224	Optional
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. Blank is 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 a blank. Blank removes the beneficiary's existing value.
23	Part D Rx Group	15	241-255	Change-to value, either a new value or a blank. Blank removes the beneficiary's existing value.
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. Blank is appropriate when not changing a beneficiary's 4Rx primary insurance information.
25	Secondary Drug BIN	6	276-281	Blank or new additional value. Blank does not remove or replace existing data.
26	Secondary Drug PCN	10	282-291	Blank or new additional value. Blank does not remove or replace existing data.

Item	Field	Size	Position	Required/Optional
27	Filler	9	292-300	N/A

Total Length = 300

F.3.4.2 NUNCMO Change (TC 73) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	22	72-93	N/A
16	Creditable Coverage Flag	1	94	Required
17	NUNCMO	3	95-97	Blank or change-to value
18	Filler	112	98-209	N/A
19	Transaction Tracking ID	15	210-224	Optional
20	Filler	76	225-300	N/A

Total Length = 300

F.3.4.3 EGHP Change (TC 74) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	EGHP Flag	1	42	Required change-to value
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	138	72-209	N/A
16	Transaction Tracking ID	15	210-224	Optional
17	Filler	76	225-300	N/A

Total Length = 300

F.3.4.4 Premium Payment Option (PPO) Change (TC 75) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60- 61	Required
13	Filler	2	62- 63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	9	72-80	N/A
16	PPO/ Parts C-D	1	81	Required change-to value

Item	Field	Size	Position	Required/Optional
17	Filler	128	82-209	N/A
18	Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225- 300	N/A

Total Length = 300

F.3.4.5 Residence Address Change (TC 76) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	5	42-46	N/A
8	Contract #	5	47-51	Required
9	Filler	8	52-59	N/A
10	TC	2	60-61	76
11	Filler	2	62-63	N/A
12	Effective Date (YYYYMMDD)	8	64-71	Required
13	Filler	3	72-74	N/A
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	N/A
17	Address Update/Delete Flag	1	209-209	Required
18	Transaction Tracking ID	15	210-224	Optional
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

Total Length = 300

F.3.4.6 Segment ID Change (TC 77) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Segment ID	3	72-74	Required
16	Filler	135	75-209	N/A
17	Transaction Tracking ID	15	210-224	Optional
18	Filler	76	225-300	N/A

Total Length = 300

F.3.4.7 Part C Premium Change (TC 78) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HIC#	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Sex	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	10	72-81	N/A

Item	Field	Size	Position	Required/Optional
16	Part C Premium Amount (XXXXvXX)	6	82-87	Required
17	Filler	122	88-209	N/A
18	Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225-300	N/A

Total Length = 300

F.3.4.8 Part D Opt-Out Change (TC 79) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	27	72-98	N/A
16	Part D Opt-Out Flag	1	99	Required
17	Filler	110	100-209	N/A
18	Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225-300	N/A

Total Length = 300

F.3.5 *Cancellation Transactions – Detailed Record Layouts*

F.3.5.1 Cancel Enrollment (TC 80) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HIC#	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Sex	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required: if Plan has PBPs
9	Filler	1		N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	Transaction Code (TC)	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	138	72-209	N/A
16	Transaction Tracking ID	15	210-224	Optional
17	Filler	76	225-300	N/A

Total Length = 300

F.3.5.2 Cancel Disenrollment Transaction (TC 81) Detailed Record Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP	3	43-45	Required
9	Filler	1	46	
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	Transaction Code	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Segment ID	3	72-74	Optional
16	Filler	135	75-209	N/A
17	Transaction Tracking ID	15	210-224	Optional

Item	Field	Size	Position	Required/Optional
18	Filler	76	225– 300	N/A

Total Length = 300

F.3.5.3 MMP Enrollment Cancellation (TC 82) Detail Record Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP	3	43-45	Required for PBP contracts; otherwise, spaces
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	Transaction Code (TC)	2	60-61	Required
13	DRC	2	62-63	Optional
14	Effective Date (YYYYMMDD)	8	64-71	Required (must equal the enrollment date)
15	Filler	28	72-99	N/A
16	MMP Opt-Out Flag	1	100	Optional
17	Filler	109	101-209	N/A
18	Plan Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225-300	N/A

Total Length = 300

F.3.5.4 MMP Opt-Out Update (TC 83) Layout

Item	Field	Size	Position	Required/Optional
1	HICN	12	1-12	Required
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	28	72-99	N/A
16	MMP Opt-Out Flag	1	100	Required
17	Filler	109	101-209	N/A
18	Plan Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225-300	N/A

Total Length = 300

F.3.5.5 POS Drug Edit (TC 90) Layout

Item	Field	Size	Position	Required/Optional
1	HIC#	12	1 – 12	Required
2	Surname	12	13 – 24	Required
3	First Name	7	25 – 31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34 – 41	Required
7	Filler	5	42 - 46	N/A
8	Contract #	5	47 – 51	Required
9	Filler	8	52 – 59	N/A
10	Transaction Code	2	60 – 61	Required
11	Filler	13	62 – 74	N/A
12	Update/Delete Flag	1	75	Required
13	POS Drug Edit Status	1	76	Required
14	POS Drug Edit Class	3	77 - 79	Required
15	POS Drug Edit Code	3	80 - 82	Required
16	Notification Date	8	83 - 90	Required
17	Implementation Date	8	91 - 98	Required if Status is I or Status is T and an Implementation record exists.
18	Termination Date	8	99 - 106	Required if Status is T
19	Filler	103	107 - 209	N/A
20	Plan Assigned Transaction Tracking ID	15	210 - 224	Optional
21	Filler	76	225 - 300	N/A

Total Length = 300

F.3.6 *Correction Record*

Note: The effective date for ‘01’ transactions comes from the file header.

tem	Field	Size	Position	Correction	Description
1	HICN	12	1-12	R	Nine-byte SSN of primary Beneficiary Claim Account Number (CAN); two-byte Beneficiary Identification Code (BIC) one-byte filler (except RRB)
2	Surname	12	13-24	R	Beneficiary’s last name
3	First Name	7	25-31	R	Beneficiary’s first name
4	M. Initial	1	32		Beneficiary’s middle initial
5	Action Code	1	33	R	D = Institutional ON E = Medicaid ON F = Medicaid OFF G = Nursing Home Certifiable (NHC) ON
6	Filler	13	34-41	N/A	Spaces
7	Contract #	5	47-51	R	Contract Number
8	Filler	8	52-59	N/A	Spaces
9	Transaction Code (TC)	2	60-61	R	‘01’ = Correction
10	Filler	239	62-300	N/A	Spaces

Total Length = 300

F.3.7 *Notes for All Plan-Submitted Transaction Types*

Item	Field	Description
1	HICN	Health Insurance Claim Number - CAN plus BIC
2	Surname	Beneficiary's last name
3	First Name	Beneficiary's first name
4	M. Initial	Beneficiary's middle initial
5	Gender Code	• 1 = male • 2 = female • 0 = unknown
6	Birth Date (YYYYMMDD)	The date of the beneficiary's birth • YYYYMMDD
7	EGHP Flag	This flag indicates whether the Plan associated with this transaction is an Employer Group Health Plan (EGHP). For an Enrollment (TC 61) Transaction: • Y = EGHP • blank for all others For an EGHP Change (TC 74) Transaction: • Y = EGHP • N = not EGHP • blank = no change
8	PBP #	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded), for the Plan associated with this transaction. PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with blanks.
9	Election Type	The election type associated with the enrollment or disenrollment associated with this transaction. • 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 #	The contract number associated with the transaction. • Hxxxx = local Plans • Rxxxx = regional Plans • Sxxxx = PDPs • Fxxxx = fallback Plans • Exxxx = employer sponsored MA/MAPD and PDP Plans.

Item	Field	Description
11	Application Date	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. • YYYYMMDD
12	TC	This identifies the type of transaction submitted on this record. • 01 = Internal corrections or cleanups • 41 = Part D Opt-Out Change (Submitted by CMS) • 42 = MMP Opt-Out Update • 51 = Disenrollment (MCO or CMS) • 54 = Disenrollment (Submitted by 1-800-MEDICARE) • 61 = Single Enrollment • 72 = 4Rx Record Update • 73 = NUNCMO Update • 74 = Employer Group Health Plan (EGHP) Update • 75 = Premium Payment Option (PPO) Update • 76 = Residence Address Update • 77 = Segment ID Update • 78 = Part C Premium Update • 79 = Part D Opt-Out Update • 80 = Cancellation of Enrollment • 81= Cancellation of Disenrollment • 82 = MMP Enrollment Cancellation • 83 = MMP Opt-Out Update • 90= POS Drug Edit
13	Disenrollment Reason	The reason the beneficiary is disenrolled from the Plan. This is required for all Plan submitted Disenrollment transactions. Refer to the published Disenrollment Reason Code (DRC) list and the appropriate CMS Plan enrollment manual instructions.
14	Effective Date (YYYYMMDD)	The effective date for the action taken by the submitted transaction. • YYYYMMDD
15	Segment ID	The three character segment identifier, 001-999 (zero-padded), associated with this transaction. Only required for segmented Plans. Only local MA/MAPD Plans (Hxxxx) may have segments. For non-segmented Plans, this field is populated with blanks.
16	Filler	Blank
17	ESRD Override	This is populated to enroll an End Stage Renal Disease (ESRD) beneficiary into a non-PDP Plan. • Any alpha-numeric value (1-9 and A-F) indicates an override. • Zero (0) or blank indicates no override.
18	PPO/Parts C-D	This indicates the premium payment option (PPO) requested by the beneficiary on this transaction. • D = Direct self-pay • S = Deduct from SSA benefits • N = No Premium • R = RRB benefits The option applies to both Part C and D premiums.
19	Part C Premium Amount (XXXXvXX)	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 transaction, this field is treated as blank.
20	Filler	Blank

Item	Field	Description
21	Creditable Coverage Flag	This indicates whether the beneficiary has creditable drug coverage in the period prior to this enrollment in a Part D Prescription Plan. • For enrollment (TC 61) transactions, valid values are Y, N, and blank. • For NUNCMO change (TC 73), valid values are Y, N. • Y = the beneficiary has creditable coverage. • N = the beneficiary does not have creditable coverage. **Note:** R and U are not valid values for this field on submitted transactions. To set a beneficiary's NUNCMO to zero for a particular date, the plans should use Creditable Coverage Flag = Y and NUNCMO = 0.
22	Number of Uncovered Months (NUNCMO)	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 zero if the Creditable Coverage Flag is Y.
23	Employer Subsidy Enrollment Override Flag	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 • Blank = No override
24	Part D Opt-Out Flag	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. • Blank = no change to opt-out status
25	MMP Opt-Out Flag	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. • Blank = no change to opt-out status
26	Secondary Drug Insurance Flag	This flag indicates whether that beneficiary has secondary drug insurance. • Y = beneficiary has secondary drug insurance • N = beneficiary does not have secondary drug insurance • blank = status of beneficiary's secondary drug insurance is unknown
27	Secondary Rx ID	Secondary insurance Plan's Identifier for a Beneficiary. It can consist of any combination of alphanumeric characters.
28	Secondary Rx Group	Secondary insurance Plan's Group ID for a Beneficiary. It can consist of any combination of alphanumeric characters.
29	Enrollment Source	Indicates the source of the enrollment. • A = AE by CMS • B = Beneficiary election (Default when a blank enrollment source is submitted). • C = FE by CMS • D = System generated rollover • E = Plan submitted AE • F = Plan submitted FE • G = Point of Sale (POS) submitted enrollment • H = Re-assignment submitted by CMS or Plan • J = State-submitted passive enrollment • K = CMS-submitted passive enrollment • L = MMP beneficiary election • M= Default for MMP enrollments submitted without an Enrollment Source Code *(M is not submitted on an enrollment)*
30	Filler	Blank
31	Transaction Tracking ID	Optional value created and used by the Plan to track the replies of the transaction.

Item	Field	Description
32	Part D Rx BIN	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).
33	Part D Rx PCN	Part D insurance Plan's Pharmacy Control Number (PCN) for the Beneficiary. • Alphanumeric (upper case and/or numeric) and left justified • Default value = spaces
34	Part D Rx Group	Part D insurance Plan's group identifier for the Beneficiary. • Alphanumeric (upper case and/or numeric) and left justified • Default value = spaces
35	Part D Rx ID	Part D insurance Plan's ID for the Beneficiary. • Alphanumeric (upper case and/or numeric) and left justified • Default value = spaces
36	Secondary Rx BIN	Secondary insurance Plan's BIN number for the Beneficiary. • Numeric and right justified
37	Secondary Rx PCN	Secondary insurance Plan's PCN identifier for a Beneficiary. • Alphanumeric (upper case and/or numeric) and left justified • Default value = spaces
38	Update/Delete Flag	This flag indicates whether the POS Drug Edit Record is an update or delete. • U = Update (add) • D = Delete
39	POS Drug Edit Status	The POS Drug Edit Status for the Beneficiary. • N = Notification • I = Implementation • T = Termination
40	POS Drug Edit Class	The restricted class of drugs. • OPI = Opioids
41	POS Drug Edit Code	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)
42	Notification Date	The date of the POS Drug Edit Notification to the beneficiary. • YYYYMMDD
43	Implementation Date	The date of the POS Drug Edit Implementation. • YYYYMMDD
44	Termination Date	The date of the POS Drug Edit Termination. • YYYYMMDD
45	Filler	Blank

F.4 Failed Transaction Data File - OBSOLETE

Effective with the April 2011 Software Release, CMS no longer generates the Failed Transaction Data File. Failed records reporting was incorporated into the BCSS Data file.

The Failed Transaction data file details transactions that CMS cannot load into MARx for processing due to formatting errors with the file header, user authentication, transaction format or incorrect data types for transaction data elements. It is sent to the user who submitted the batch.

System	Type	Frequency	Dataset Naming Conventions
MARx	Data File	Response to transaction batch file	Obsolete

F.5 Daily Transaction Reply Report (DTRR) Data File

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 file also contains records that report the submitted transactions verbatim back to the Plans.

System	Type	Frequency	Dataset Naming Conventions
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

F.5.1 DTRR Data File Detailed Record Layout

Field	Size	Position	Description
1. HICN	12	1 – 12	Health Insurance Claim Number
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	YYYYMMDD Format
7. Record Type	1	42	‘T’ = TRC record
8. Contract Number	5	43 – 47	Plan Contract Number
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	‘1’ = Disabled without ESRD (disability insurance benefits (DIB); ‘2’ = ESRD Only (end stage renal disease (ESRD)); ‘3’ = Disabled with ESRD (both DIB and ESRD); ‘0’ = No Disability; Space = not applicable.

Field	Size	Position	Description
12. Hospice Indicator	1	54	'1' = Hospice; '0' = No Hospice; Space = not applicable.
13. Institutional/NHC/HCBS Indicator	1	55	'3' = HCBS; '1' = Institutional; '2' = NHC; '0' = No Institutional; Space = not applicable
14. ESRD Indicator	1	56	'1' = End-Stage Renal Disease; '0' = No End-Stage Renal Disease; Space = not applicable.
15. Transaction Reply Code	3	57 – 59	TRC, see TRC list for values
16. Transaction Type Code	2	60 – 61	Transaction Type Code
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.
18. Effective Date	8	63 – 70	YYYYMMDD Format; Effective date is present for all TRCs. Field content is TRC dependent for the following TRCs: 071 & 072 – the effective date of the hospice period 091 – Previously reported incorrect death date, 121, 194, and 223 – PBP enrollment effective date. 280 - 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 293 – Enrollment End Date; Last day of the month 305 – New ZIP Code 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, For Transaction Type Code 90 the current calendar month will be populated

Field	Size	Position	Description
19. WA Indicator	1	71	'1' = Working Aged; '0' = No Working Aged; Space = not applicable.
20. Plan Benefit Package ID	3	72 – 74	PBP number
21. Filler	1	75	Spaces
22. Transaction Date	8	76 – 83	YYYYMMDD Format; Present for all transaction reply codes. For TRCs 121, 194, and 223, the report generation date.
23. UI Initiated Change Flag	1	84	'1' = transaction created through user interface; '0' = transaction from source other than user interface; Space = not applicable.
24. Positions 85 – 96 are dependent upon the value of the TRANSACTION REPLY CODE. There are spaces for all codes except where indicated below.	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 13, 14, 18
a. Effective Date of the Disenrollment	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 13, 14, 18, 293
b. New Enrollment Effective Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 17
c. Claim Number (old)	12	85 – 96	Present only when Transaction Reply Code is one of the following: 22, 25, 86
d. Date of Death	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 90 (with transaction type 01), 92
e. Hospice End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 71 or 72. If blank for TRC 71, then the Hospice Period is open ended.
f. ESRD Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 73
g. ESRD End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 74
h. Institutional/ NHC Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 48, 75, 158, 159
i. Medicaid Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 77
j. Medicaid End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 78
k. Part A End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 79

Field	Size	Position	Description
l. WA Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 66
m. WA End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 67
n. Part A Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 80
o. Part B End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 81
p. Part B Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 82
q. Old State and County Codes	5	85 – 89	Beneficiary's prior state and county code; Present only when Transaction Reply Code is 85
r. Attempted Enroll Effective Date	8	85 - 92	The effective date of an enrollment transaction that was submitted but rejected. Present only when Transaction Reply code is the following: 35, 36, 45, 56
s. PBP Effective Date	8	85 – 92	YYYYMMDD Format. Effective date of a beneficiary's PBP change. Present only when Transaction Reply Code is 100.
t. Correct Part D Premium Rate	12	85 – 96	ZZZZZZZZ9.99 Format; Part D premium amount reported by HPMS for the Plan. Present only when the Transaction Reply Code is 181.
u. Date Identifying Information Changed by UI User	8	85 – 92	YYYYMMDD Format; Field content is dependent on Transaction Reply Code: 702 – Fill-in enrollment period end date, 705 – End date of enrollment period for corrected PBP, blank when end date not provided by user, 707 – End date of enrollment period for corrected segment, blank when end date not provided by user, 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 Format; Part C premium amount reported by HPMS for the Plan. Present only when the Transaction Reply Code is 182.
w. Date of Death Removed	8	85 – 92	YYYYMMDD Format; Previously reported erroneous date of death. Present only when Transaction Reply Code is 091.
x. Dialysis End Date	8	85 – 92	YYYYMMDD Format; Will be present when Transaction Reply Code is 268 and the dialysis period has an end date.
y. Transplant Failure Date	8	85 – 92	YYYYMMDD Format; Will be present when Transaction Reply Code is 269 and the transplant has an end date.

Field	Size	Position	Description
z. New ZIP Code	10	85 - 94	#####-#### Format; Will be present when Transaction Reply Code is 305
aa. Previous Contract for POS Drug Edit Active Indicator	5	85-89	Will be present when Transaction Reply Code is 322
bb. MSP Coverage Termination Date	8	85 – 92	YYYYMMDD Format: Will be present when Transaction Reply Code is 280 and contain the Adjusted Coverage Termination 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 Transaction Reply Code is the following: 216, 300, 341
25. District Office Code	3	97 – 99	Code of the originating district office; Present only when Transaction Type Code 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 OR submitted LINET Plan PBP changed to PBP corresponding to enrollment processing date; present only when transaction type code is 61; otherwise, spaces if not applicable.
30. Application Date	8	124 – 131	The date the Plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper). Format: YYYYMMDD; otherwise, spaces if not applicable.
31. UI User Organization Designation	2	132 – 133	'01' = Plan '02' = Regional Office; '03' = Central Office; Spaces = not UI transaction
32. Out of Area Flag	1	134 – 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.

Field	Size	Position	Description
36. Election Type	1	154 – 154	‘A’ = AEP; ‘E’ = IEP; ’I’ = ICEP; ‘O’ = OEP; ‘N’ = OEPNEW; ‘T’ = OEPI; ‘R’=5 Star SEP; ‘S’= Other SEP; ‘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 I, A, N, O, R, S, T, U, V, W, X, and Y. MAPDs use I, A, E, N, O, R, S, T, U, V, W, X, Y. PDPs use A, E, R, S, U, V, W, X, and Y.)
37. Enrollment Source	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 Space = not applicable.
38. Part D Opt-Out Flag	1	156 – 156	‘Y’ = Opt-out of auto-enrollment; ‘N’ = Opted out of auto-enrollment; Space = No change to opt-out status

Field	Size	Position	Description
39. Premium Withhold Option/Parts C-D	1	157 – 157	'D' = Direct self-pay; 'S' = Deduct from SSA benefits; 'R' = Deduct from RRB benefits; 'N' = No premium applicable; 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 & 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 Transaction Reply Code is the following: 141, 216, 300, 341
41. Creditable Coverage Flag	1	161 – 161	'Y' = Covered; 'N' = Not Covered; 'R' = Setting uncovered months to zero due to a new IEP; 'U' = Setting uncovered months to the value prior to using R; Space = not applicable.
42. Employer Subsidy Override Flag	1	162 – 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.
43. Processing Timestamp	15	163 – 177	Transaction processing time, or, for TRCs 121, 194, and 223, the report generation time. Format: HH.MM.SS.SSSSSS
44. End Date	8	178 - 185	YYYMMDD format End Date associated with the Transaction Reply Code when applicable. Currently present only for TRCs that report a Premium Payment Option (PPO) value that is not open-ended.
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 Transaction Reply Code is the following: 141, 216, 300, 341
46. Filler	9	189 – 197	Spaces

Field	Size	Position	Description
47. Secondary Drug Insurance Flag	1	198-198	Type 61 MAP and PDP transactions: 'Y' = Beneficiary has secondary drug insurance; 'N' = Beneficiary does not have secondary drug insurance available; Space = No flag submitted by Plan. Type 72 MAP and PDP transactions: 'Y' = Secondary drug insurance available 'N' = No secondary drug insurance available Space = no change. Space returned with any other transaction type has no meaning.
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 type.
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 type.
50. EGHP	1	234 - 234	Type 61 transactions: 'Y' = EGHP; Space = not EGHP. Type 74 transactions: 'Y' = EGHP; 'N' = Not EGHP; Space = no change. Space reported with any other transaction type has no meaning.
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 – 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.
53. Low-Income Period Effective Date	8	239 - 246	Date low income period starts. Format: YYYYMMDD Spaces if not applicable.

Field	Size	Position	Description
54. Part D Late Enrollment Penalty Amount	8	247 - 254	Calculated Part D late enrollment penalty, not including adjustments indicated by items (53) and (54). Format: -9999.99; otherwise, spaces if not applicable.
55. Part D Late Enrollment Penalty Waived Amount	8	255 - 262	Amount of Part D late enrollment penalty waived. Format: -9999.99; otherwise, spaces if not applicable.
56. Part D Late Enrollment Penalty Subsidy Amount	8	263 - 270	Amount of Part D late enrollment penalty low-income subsidy. Format: -9999.99; otherwise, spaces if not applicable.
57. Low-Income Part D Premium Subsidy Amount	8	271- 278	Amount of Part D low-income premium subsidy as of the enrollment period start date. Format: -9999.99; otherwise, spaces if not applicable.
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 type.
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 type.
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 type.
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 type.
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 type.
64. De Minimis Differential Amount	8	346 - 353	Amount by which a Part D de minimis Plan's beneficiary premium exceeds the applicable regional low-income premium subsidy benchmark. Format: -9999.99; otherwise, spaces if not applicable.
65. MSP Status Flag	1	354 - 354	'P' = Medicare primary payor; 'S' = Medicare secondary payor; 'N' = Non-respondent beneficiary; Space = not applicable.
66. Low Income Period End Date	8	355 - 362	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 blank for LIS applicants with an open ended award or when the TRC is not one of the LIS TRCs 121, 194, 223. FORMAT: YYYYMMDD; otherwise, spaces if not applicable.
67. Low Income Subsidy Source Code	1	363 - 363	'A' = Approved SSA applicant; 'D' = Deemed eligible by CMS; Space = not applicable.

Field	Size	Position	Description
68. Enrollee Type Flag, PBP Level	1	364 - 364	Designation relative to the report generation date (Transaction Date, field #22) 'C' = Current PBP enrollee; 'P' = Prospective PBP enrollee; 'Y' = Previous PBP enrollee; Spaces = not applicable.
69. Application Date Indicator	1	365 – 365	Identifies whether the application date associated with a UI submitted enrollment has a system generated default value: 'Y' = Default value for 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, see DRC list for values
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 Clean-Up ID associated with the transaction. Used to identify transactions that were created to correct payment data. Spaces if no value exists.
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	Three character drug class identifier. Spaces = Not applicable Present only when Transaction Type Code is 90 and POS Drug Edit Class is provided, otherwise blank
77. POS Drug Edit Code	3	399-401	Three character POS Drug Edit Code Spaces = Not applicable Present only when Transaction Type Code is 90 and POS Drug Edit Code is provided, otherwise blank
78. Notification Date	8	402--409	YYYYMMDD format, Date beneficiary is notified of a POS Drug Edit Present only when Transaction Type Code is 90 and notification date is provided, otherwise blank
79. Implementation Date	8	410-417	YYYYMMDD format Date POS Drug Edit is implemented Present only when Transaction Type Code is 90 and implementation date is provided, otherwise blank

Field	Size	Position	Description
80. Termination Date	8	418-425	YYYYMMDD format Date POS Drug Edit is terminated Present only when Transaction Type Code is 90 and termination date is provided, otherwise blank
81. Hospice Provider Number	13	426 – 438	Hospice Medicare Provider Number Present only for Transaction Reply Codes 71 or 72
82. Filler	36	439 - 474	Spaces
83. System Assigned Transaction Tracking ID	11	475 – 485	System assigned transaction tracking ID.
84. Plan Assigned Transaction Tracking ID	15	486 – 500	Plan submitted batch input transaction tracking ID.

Total Length = 500

F.5.2 Verbatim Plan Submitted Transaction on DTRR

Item	Field	Size	Position	Description
1	HICN	12	1-12	HICN
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	YYYYMMDD Format
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 or ‘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.

Total Length = 500

F.6 Batch Eligibility Query (BEQ) Request File

The BEQ Request File includes transactions submitted by Plans to request eligibility information for prospective Plan enrollees. The file is used to conduct initial eligibility checks against CMS MBD system to verify member is Part A / B eligible.

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

System	Type	Frequency	Dataset Naming Conventions
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:** 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:

- Header Record
- Detail Record
- Trailer Record

F.6.1 *Header Record*

Field	Size	Position	Format	Valid Values	Description
File ID Name	8	1- 8	X(8)	"MMABEQRH"	Critical Field: This field is always set to the value "MMABEQRH." This code identifies the file as a BEQ Request File and this record as the Header Record of the file.
Sending Entity: CMS	8	9-16	X(8)	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. The Sending Entity may participate in Part D.
File Creation Date	8	17-24	X(8)	YYYYMMDD	Critical Field: The date that the Sending Entity created the BEQ Request File. This value's format is YYYYMMDD. For example, January 3 2010 is the value 20100103. This value should agree with the corresponding value in the Trailer Record. CMS returns this information to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File.

Field	Size	Position	Format	Valid Values	Description
File Control Number	9	25-33	X(9)	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 Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Trailer Record.
Filler	717	34-750	X(717)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.

Total Length = 750

F.6.2 *Detail Record (Transaction)*

Field	Size	Position	Format	Valid Values	Description
Record Type	5	1-5	X(5)	"DTL01" = BEQ Transaction Note: The value above is DTL-zero-one.	Critical Field This field is set to the value "DTL01," which indicates that this detail record is a BEQ Transaction. This code identifies the record as a detail record for processing specifically for BEQ Service.
HICN/RRB Number	12	6-17	X(12)	HICN Or RRB	Critical Field This field provides either the HICN or the RRB Number for identification of the individual. The Plan should provide either the HICN or the RRB Number, whichever the Plan has available and active for the individual. The value is left justified in the field and does not include dashes, decimals, or commas.
Filler	9	18-26	X(9)	Spaces	
DOB	8	27-34	X(8)	YYYYMMDD	Critical Field The date of the individual's birth; value format is YYYYMMDD. The value should not include dashes, decimals, or commas. The value should include only numbers.
Gender Code	1	35	X(1)	0 (Zero) = Unknown; 1 = Male; 2 = Female	Not Critical Field The gender of the individual. The acceptable values include 0 (Zero) = Unknown, 1 = Male, 2 = Female.
Detail Record Sequence Number	7	36-42	9(7)	Seven-byte number unique within the BEQ Request File	Critical Field A unique number assigned by the Sending Entity to the Transaction (Detail Record). This number should uniquely identify the Transactions (Detail Record) within the BEQ Request File.
Filler	708	43-750	X(708)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for or used to store meaningful information, unless specifically documented otherwise.

Total Length = 750

F.6.3 *Trailer Record*

Field	Size	Position	Format	Valid Values	Description
File ID Name	8	1-8	X(8)	"MMABEQRT"	Critical Field This field is always set to the value "MMABEQRT." This code identifies the record as the Trailer Record of a BEQ Request File.
Sending Entity (CMS)	8	9-16	X(8)	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. The Sending Entity may participate in Part D.
File Creation Date	8	17-24	X(8)	YYYYMMDD	Critical Field The date when the Sending Entity created the BEQ Request File. This value's format is YYYYMMDD. For example, January 3, 2010 is the value 20100103. This value should agree with the corresponding value in the Header Record. CMS will pass this information back to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File.
File Control Number	9	25-33	X(9)	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 Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Header Record.
Record Count	7	34-40	9(7)	Numeric value greater than Zero.	Critical Field The total number of Transactions (Detail Records) supplied on the BEQ Request File. This value is right-justified in the field, with leading zeroes. This value should not include non-numeric characters, such as commas, spaces, dashes, decimals.
Filler	710	41-750	X(710)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.

Total Length = 750

F.6.4 Sample BEQ Request File Pass and Fail Acknowledgments

Description

The Enrollment Processing 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.

Example

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

Example of BEQ Request File "Pass" Acknowledgment

TO: Jim.Doe@xxs.net

TO: Chris.Doe@dxxx.org

TO: Falcon.Doe@xxxx.org

TO: eevs.helpdesk@ngc.com

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 20070306F20070306

INPUT TRAILER RECORD

MMABEQRTS0094 20070306F200703060000074

Example of BEQ Request File "Fail" Acknowledgment

TO: Jim.Doe@xxs.net

TO: Chris.Doe@dxxx.org

TO: Falcon.Doe@xxxx.org

TO: eevs.helpdesk@ngc.com

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 20070228 84433346

INPUT TRAILER RECORD

MMABEQRTH0030 20070221 844333460074065

THE TRAILER RECORD IS INVALID

F.7 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.

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

System	Type	Frequency	Dataset Naming Conventions
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

The following records are included in this file:

- Header Record
- Detail Record
- Trailer Record

F.7.1 *Header Record*

Data Field	Length	Position	Format	Valid Values
Header Code	8	1 – 8	CHAR	‘CMSBEQRH’
Sending Entity	8	9 – 16	CHAR	‘MBD ’ (MBD + five spaces)
File Creation Date	8	17 – 24	CHAR	CCYYMMDD
File Control Number	9	25 – 33	CHAR	
Filler	1467	34 – 1500	CHAR	Spaces

Total Length = 1500

F.7.2 *Detail Record (Transaction)*

Data Field	Length	Position	Format	Valid Values
Record Type	3	1 – 3	CHAR	'DTL'
Start of Original Detail Record				
Record Type	5	4 – 8	CHAR	
Beneficiary's Health Insurance Claim/Railroad Board Number	12	9 – 20	CHAR	
Filler	9	21 –29	CHAR	
Beneficiary's Date of Birth	8	30 – 37	CHAR	
Beneficiary's Gender Code	1	38	CHAR	
Detail Record Sequence Number	7	39 – 45	ZD	
End of Original Detail Record				
Processed Flag	1	46	CHAR	'Y' or 'N'
Beneficiary Match Flag	1	47	CHAR	'Y' or 'N'
Medicare Part A Entitlement Start Date	8	48 – 55	CHAR	CCYYMMDD
Medicare Part A Entitlement End Date	8	56 – 63	CHAR	CCYYMMDD
Medicare Part B Entitlement Start Date	8	64 – 71	CHAR	CCYYMMDD
Medicare Part B Entitlement End Date	8	72 – 79	CHAR	CCYYMMDD
Medicaid Indicator	1	80	CHAR	'0' or '1'
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence one)	8	81 – 88	CHAR	CCYYMMDD
Part D Disenrollment Date or Employer Subsidy End Date (occurrence one)	8	89 – 96	CHAR	CCYYMMDD
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence two)	8	97 – 104	CHAR	CCYYMMDD
Part D Disenrollment Date or Employer Subsidy End Date (occurrence two)	8	105 – 112	CHAR	CCYYMMDD
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence three)	8	113 – 120	CHAR	CCYYMMDD
Part D Disenrollment Date or Employer Subsidy End Date (occurrence three)	8	121 – 128	CHAR	CCYYMMDD
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence four)	8	129 – 136	CHAR	CCYYMMDD
Part D Disenrollment Date or Employer Subsidy End Date (occurrence four)	8	137 – 144	CHAR	CCYYMMDD
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence five)	8	145 – 152	CHAR	CCYYMMDD
Part D Disenrollment Date or Employer Subsidy End Date (occurrence five)	8	153 – 160	CHAR	CCYYMMDD
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence six)	8	161 – 168	CHAR	CCYYMMDD
Part D Disenrollment Date or Employer Subsidy End Date (occurrence six)	8	169 – 176	CHAR	CCYYMMDD
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence seven)	8	177 – 184	CHAR	CCYYMMDD
Part D Disenrollment Date or Employer Subsidy End Date (occurrence seven)	8	185 – 192	CHAR	CCYYMMDD
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence eight)	8	193 – 200	CHAR	CCYYMMDD
Part D Disenrollment Date or Employer Subsidy End Date (occurrence eight)	8	201 – 208	CHAR	CCYYMMDD
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence nine)	8	209 – 216	CHAR	CCYYMMDD

Data Field	Length	Position	Format	Valid Values
Part D Disenrollment Date or Employer Subsidy End Date (occurrence nine)	8	217 – 224	CHAR	CCYYMMDD
Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence 10)	8	225 – 232	CHAR	CCYYMMDD
Part D Disenrollment Date or Employer Subsidy End Date (occurrence 10)	8	233 – 240	CHAR	CCYYMMDD
Sending Entity	8	241 – 248	CHAR	
File Control Number	9	249 – 257	CHAR	
File Creation Date	8	258 – 265	CHAR	CCYYMMDD
Part D Eligibility Start Date	8	266 – 273	CHAR	
Deemed / Low-Income Subsidy Effective Date (occurrence one)	8	274 – 281	CHAR	CCYYMMDD
Deemed / Low-Income Subsidy End Date (occurrence one)	8	282 – 289	CHAR	CCYYMMDD
Co-Payment Level Identifier (occurrence one)	1	290	CHAR	‘1’, ‘2’, ‘3’, ‘4’ or ‘5’
Part D Premium Subsidy Percent (occurrence one)	3	291 – 293	CHAR	‘100’, ‘075’, ‘050’, or ‘025’
Deemed / Low-Income Subsidy Effective Date (occurrence two)	8	294 – 301	CHAR	CCYYMMDD
Deemed / Low-Income Subsidy End Date (occurrence two)	8	302 – 309	CHAR	CCYYMMDD
Co-Payment Level Identifier (occurrence two)	1	310	CHAR	1’, ‘2’, ‘3’, ‘4’ or ‘5’
Part D Premium Subsidy Percent (occurrence two)	3	311 – 313	CHAR	‘100’, ‘075’, ‘050’, or ‘025’
Part D/RDS Indicator (10 occurrences)				
RDS/Part D Indicator (occurrence one)	1	314	CHAR	‘D’ or ‘R’
RDS/Part D Indicator (occurrence two)	1	315	CHAR	‘D’ or ‘R’
RDS/Part D Indicator (occurrence three)	1	316	CHAR	‘D’ or ‘R’
RDS/Part D Indicator (occurrence four)	1	317	CHAR	‘D’ or ‘R’
RDS/Part D Indicator (occurrence five)	1	318	CHAR	‘D’ or ‘R’
RDS/Part D Indicator (occurrence six)	1	319	CHAR	‘D’ or ‘R’
RDS/Part D Indicator (occurrence seven)	1	320	CHAR	‘D’ or ‘R’
RDS/Part D Indicator (occurrence eight)	1	321	CHAR	‘D’ or ‘R’
RDS/Part D Indicator (occurrence nine)	1	322	CHAR	‘D’ or ‘R’
RDS/Part D Indicator (occurrence 10)	1	323	CHAR	‘D’ or ‘R’
Uncovered Months Data (20 occurrences)				
Start Date (occurrence one)	8	324 – 331	CHAR	CCYYMMDD
Number of Uncovered Months (occurrence one)	3	332 – 334	ZD	
Number of Uncovered Months Status Indicator (occurrence one)	1	335	CHAR	
Total Number of Uncovered Months (occurrence one)	3	336 – 338	ZD	
Uncovered Months (occurrence two)	15	339 – 353		
Uncovered Months (occurrence three)	15	354 – 368		
Uncovered Months (occurrence four)	15	369 – 383		
Uncovered Months (occurrence five)	15	384 – 398		
Uncovered Months (occurrence six)	15	399 – 413		
Uncovered Months (occurrence seven)	15	414 – 428		
Uncovered Months (occurrence eight)	15	429 – 443		
Uncovered Months (occurrence nine)	15	444 – 458		

Data Field	Length	Position	Format	Valid Values
Uncovered Months (occurrence 10)	15	459 – 473		
Uncovered Months (occurrence 11)	15	474 – 488		
Uncovered Months (occurrence 12)	15	489 – 503		
Uncovered Months (occurrence 13)	15	504 – 518		
Uncovered Months (occurrence 14)	15	519 – 533		
Uncovered Months (occurrence 15)	15	534 – 548		
Uncovered Months (occurrence 16)	15	549 – 563		
Uncovered Months (occurrence 17)	15	564 – 578		
Uncovered Months (occurrence 18)	15	579 – 593		
Uncovered Months (occurrence 19)	15	594 – 608		
Uncovered Months (occurrence 20)	15	609 – 623		
Beneficiary's Retrieved Date of Birth (as retrieved from CMS database for matching beneficiary)	8	624 – 631	CHAR	CCYYMMDD
Beneficiary's Retrieved Gender Code (as retrieved from CMS database for matching beneficiary)	1	632	CHAR	0 = Unknown 1 = Male 2 = Female
Last Name	40	633 – 672	CHAR	
First Name	30	673 – 702	CHAR	
Middle Initial	1	703	CHAR	
Current State Code	2	704 – 705	CHAR	
Current County Code	3	706 – 708	CHAR	
Date of Death	8	709 – 716	CHAR	CCYYMMDD
Part C/D Contract Number (if available)	5	717 – 721	CHAR	
Part C/D Enrollment Start Date (if available)	8	722 – 729	CHAR	CCYYMMDD
Part D Indicator (if available)	1	730	CHAR	Y = Yes, N = No Space
Part C Contract Number (if available)	5	731 – 735	CHAR	
Part C Enrollment Start Date (if available)	8	736 – 743	CHAR	
Part D Indicator (if available)	1	744	CHAR	N = No Space
ESRD Indicator	1	745	CHAR	End Stage Renal Disease Indicator 0 = No ESRD 1 = ESRD
PBP Number (associated with contract number in positions 717 – 721)	3	746 – 748	CHAR	Plan Benefit Package number

Data Field	Length	Position	Format	Valid Values
Plan Type Code (associated with PBP number in 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 32 = Fallback 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
Plan Type Code (cont.)				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
EGHP Indicator (associated with PBP number in positions 746 – 748)	1	751	CHAR	Employer Group Health Plan Switch Y = EGHP N = not EGHP
PBP Number (associated with contract number in positions 731 – 735)	3	752 – 754	CHAR	Plan Benefit Package number
Plan Type Code (associated with PBP number in positions 752 – 754)	2	755 – 756	CHAR	See values for positions 1167–1168.
EGHP Indicator (associated with PBP number in positions 752 – 754)	1	757	CHAR	Employer Group Health Plan Switch Y = EGHP N = not EGHP
Mailing Address Line 1	40	758 – 797	CHAR	
Mailing Address Line 2	40	798 – 837	CHAR	
Mailing Address Line 3	40	838 – 877	CHAR	
Mailing Address Line 4	40	878 – 917	CHAR	
Mailing Address Line 5	40	918 – 957	CHAR	

Data Field	Length	Position	Format	Valid Values
Mailing Address Line 6	40	958 – 997	CHAR	
Mailing Address City	40	998 – 1037	CHAR	
Mailing Address Postal State Code	2	1038 – 1039	CHAR	
Mailing Address ZIP Code	9	1040 – 1048	CHAR	
Mailing Address Start Date	8	1049 – 1056	CHAR	CCYYMMDD
Residence Address Line 1	60	1057 – 1116	CHAR	
Residence Address City	40	1117 – 1156	CHAR	
Residence Address Postal State Code	2	1157 – 1158	CHAR	
Residence Address ZIP Code	9	1159 – 1167	CHAR	
Residence Address Start Date	8	1168 – 1175	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(1)	8	1176 – 1183	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration End Date(1)	8	1184 – 1191	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(2)	8	1192 – 1199	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration End Date(2)	8	1200 – 1207	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(3)	8	1208 – 1215	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration End Date(3)	8	1216 – 1223	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(4)	8	1224 – 1231	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration End Date(4)	8	1232 – 1239	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(5)	8	1240 – 1247	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration End Date(5)	8	1248 – 1255	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(6)	8	1256 – 1263	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration End Date(6)	8	1264 – 1271	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(7)	8	1272 – 1279	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration End Date(7)	8	1280 – 1287	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(8)	8	1288 – 1295	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration End Date(8)	8	1296 – 1303	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(9)	8	1304 – 1311	CHAR	CCYYMMDD

Data Field	Length	Position	Format	Valid Values
Medicare Plan Ineligibility Due to Incarceration End Date(9)	8	1312 – 1319	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration Start Date(10)	8	1320 – 1327	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Incarceration End Date(10)	8	1328 – 1335	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(1)	8	1336-1343	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (1)	8	1344-1351	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(2)	8	1352-1359	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (2)	8	1360-1367	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(3)	8	1368-1375	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (3)	8	1376-1383	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(4)	8	1384-1391	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (4)	8	1392-1399	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(5)	8	1400-1407	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (5)	8	1408-1415	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(6)	8	1416-1423	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (6)	8	1424-1431	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(7)	8	1432-1439	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (7)	8	1440-1447	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(8)	8	1448-1455	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (8)	8	1456-1463	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(9)	8	1464-1471	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (9)	8	1472-1479	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(10)	8	1480-1487	CHAR	CCYYMMDD
Medicare Plan Ineligibility Due to Not Lawful Presence End Date (10)	8	1488-1495	CHAR	CCYYMMDD
Filler	5	1496-1500	CHAR	Spaces

F.7.3 *Trailer Record*

Data Field	Length	Position	Format	Valid Values
Trailer Code	8	1 – 8	CHAR	‘CMSBEQRT’
Sending Entity	8	9 – 16	CHAR	‘MBD ‘ (MBD + five spaces)
File Creation Date	8	17 – 24	CHAR	CCYYMMDD
File Control Number	9	25 – 33	CHAR	
Record Count	7	34 – 40	ZD	Right justified
Filler	1460	41 – 1500	CHAR	Spaces

Total Length = 1500

Weekly Record Layouts

F.8 LIS/Part D Premium Data File

System	Type	Frequency	Dataset Naming Conventions
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

Item	Field	Size	Position	Description
1	Claim Number	12	1-12	Beneficiary's CAN
2	Contract Number	5	13-17	Contract Identification Number
3	PBP Number	3	18-20	Beneficiary's PBP ID, blank if none
4	Segment Number	3	21-23	Beneficiary's Segment Identification Number, blank if none
5	Run Date	8	24-31	Data File Generation Date YYYYMMDD – Format
6	Subsidy Start Date	8	32-39	Beneficiary's Subsidy Start Date YYYYMMDD – Format
7	Subsidy End Date	8	40-47	Beneficiary's Subsidy End Date YYYYMMDD – Format
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, YYYYMMDD – Format
11	Beneficiary Enrollment End Date	8	60-67	Beneficiary's Enrollment End Date YYYYMMDD – Format Space can remain blank
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)

Item	Field	Size	Position	Description
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	Filler

Total Length = 278

Monthly Record Layouts

F.9 820 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 Automated Plan Payment System (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 Medicare Advantage and Prescription Drug System (MARx).

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

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

The following records are included in this file:

- Header Record (numbers 1-6 below)
- Detail Record (numbers 7-10 below)
- Summary Record (number 11 below)

The segments are listed in a required order:

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 (data element) 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[1]

Following are two balancing rules:

1. BPR02 = total of all RMR04
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.

F.9.1 Header Record

Item	Segment	Data Element	Description	Length	Type	Contents
			820 Header Segment ID	2	AN	"ST"
		ST01	Transaction Set ID Code	3/3	ID	"820"
		ST02	Transaction Set Control Number	4/9	AN	Begin with "00001" Increment each Run
			Beginning Segment For Payment Order/Remittance Advice	3	AN	"BPR"
	BPR	BPR01	Transaction Handling Code	1/2	ID	"I"(Remittance Information Only)
	BPR	BPR02	Total Premium Payment Amount	1/18	R	Payment Letter – Net Payment See discussion on Balancing.
	BPR	BPR03	Credit/Debit Flag Code	1/1	ID	"C" (Credit)
	BPR	BPR04	Payment Method Code	3/3	ID	"BOP" (Financial Institution Option)
	BPR	BPR16	Check Issue or EFT Effective Date	8/8	DT	Use Payment Letter – Payment Date in YYYYMMDD format

[1] See pp.16 in National EDI Transaction Set Implementation Guide for 820, ASCX12N, 820 (004010X061), dated May 2000

Item	Segment	Data Element	Description	Length	Type	Contents
			Re-Association Key	3	AN	"TRN"
	TRN	TRN01	Trace Type Code	1/2	ID	"3" (Financial Re-association Trace Number)
	TRN	TRN02	Check or EFT Trace Number	1/30	AN	"USTREASURY"
			Coverage Period	3	AN	"DTM"
	DTM	DTM01	Date/Time Qualifier	3/3	ID	"582" (Report Period)
	DTM	DTM05	Date/Time Period Format Qualifier	2/3	ID	"RD8"(Range of dates expressed in format YYYYMMDD – YYYYMMDD)
	DTM	DTM06	Date/Time Period	1/35	AN	Range of Dates for Payment Month. See DTM05.
			Premium Receiver's Name	2	AN	"N1"
	1000A	N101	Entity Identifier Code	2/3	ID	"PE" (Payee)
	1000A	N102	Name	1/60	AN	Contract Name
	1000A	N103	Identification Code Qualifier	1/2	ID	"EQ" Insurance Company Assigned ID Number
	1000A	N104	Identification Code	2/80	AN	Contract Number
			Premium Payer's Name	2	AN	"N1"
	1000B	N101	Entity Identifier Code	2/3	ID	"PR" (Payer)
	1000B	N102	Name	1/60	AN	"CMS"
	1000B	N103	Identification Code Qualifier	1/2	ID	"EQ" Insurance Company Assigned ID Number
	1000B	N104	Identification Code	2/80	AN	"CMS"

F.9.2 Detail Record

Item	Segment	Data Element	Description	Length	Type	Contents
			Organization Summary Remittance Detail	3	AN	"RMR"
	2300A	RMR01	Reference Identification Qualifier	2/3	ID	"CT"
	2300A	RMR02	Contract Number	1/30	AN	Payment Letter – Contract #
	2300A	RMR04	Detail Premium Payment Amount	1/18	R	Payment Letter – Net Payment See discussion on Balancing.
	2300A	RMR05	Billed Premium Amount	1/18	R	Payment Letter – Capitated Payment. See discussion on Balancing.
			Summary Line Item	3	AN	"IT1"
	2310A	IT101	Line Item Control Number	1/20	AN	"1" (Assigned for uniqueness)
			Member Count	3	AN	"SLN"
	2315A	SLN01	Line Item Control Number	1/20	AN	"1" (Assigned for uniqueness)
	2315A	SLN03	Information Only Indicator	1/1	ID	"O" (For Information only)

Item	Segment	Data Element	Description	Length	Type	Contents
	2315A	SLN04	Head Count	1/15	R	Payment Letter – Total Members
	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
			Organization Summary Remittance Level Adjustment	3	AN	"ADX"
	2320A	ADX01	Adjustment Amount	1/18	R	Payment Letter – Total Adjustments is the difference between Capitated Payment and Net Payment. See discussion on Balancing.
	2320A	ADX02	Adjustment Reason Code	2/2	ID	"H1" - Information forthcoming – detailed information related to the adjustment is provided through a separate mechanism

F.9.3 Trailer Record

Item	Segment	Data Element	Description	Length	Type	Contents
Summary			**820 Trailer**	3	AN	"SE"
		SE01	Number of Included Segments	1/10	N0	"11"
		SE02	Transaction Set Control Number	4/9	AN	Use control number, same as in 820 Header.

F.10 BIPA 606 Payment Reduction Data File

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

System	Type	Frequency	Dataset Naming Conventions
MARx	Data File	Monthly, if applicable	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.BIPA606D.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.BIPA606D.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.BIPA606D.Dyymm01.Thhmmsst

Item	Field	Size	Position	Description
1	Contract Number	5	1-5	Contract Number
2	PBP Number	3	6-8	999
3	Run Date	8	9-16	YYYYMMDD
4	Payment Month	6	17-22	YYYYMM
5	Adjustment Reason Code	2	23-24	99; SPACES = Payment
6	Payment/Adjustment Start Month	6	25-30	YYYYMM
7	Payment/Adjustment End Month	6	31-36	YYYYMM
8	HIC	12	37-48	External Format
9	Surname First 7	7	49-55	
10	First Initial	1	56	
11	Sex	1	57	M = Male; F = Female
12	Date of Birth	8	58-65	YYYYMMDD
13	BIPA606 Payment Reduction Rate	6	66-71	999.99; must be GE ZERO
14	Total Net Blended Payment/Adjustment Excluding BIPA606 Reduction Amount	9	72-80	-99999.99
15	BIPA606 Net Payment Reduction Amount	8	81-88	-9999.99; Normally negative, may include positive adjustments Applies only to Part B amounts
16	Net Part A Blended Amount	9	89-97	-99999.99; Same as MMR amount
17	Net Part B Blended Amount plus BIPA606 Net Payment Reduction	9	98-106	-99999.99
18	Total Net Blended Payment/Adjustment Including BIPA606 Reduction Amount	9	107-115	-99999.99
19	Filler	18	116-133	Spaces

Total Length = 133

F.11 Monthly Membership Detail Data File

This is a data file version of the Monthly Membership Detail Report (MMDR). The report lists every Part C and Part D Medicare member of the contract and provides details about the payments and adjustments made for each. This file contains the data for both Part C and Part D members and is generated monthly.

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

System	Type	Frequency	Dataset Naming Conventions
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

#	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

#	Field Name	Len	Pos	Description
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
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

#	Field Name	Len	Pos	Description
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.
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

#	Field Name	Len	Pos	Description
28.	Adjustment Reason Code	2	90-91	FORMAT: 99 Always Spaces on Payment
29.	Paymt/Adjustment Start Date	8	92-99	FORMAT: YYYYMMDD
30.	Paymt/Adjustment End Date	8	100-107	FORMAT: YYYYMMDD
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.	Risk Adjusted Paymt/Adjustmt Amount A	9	126-134	Risk Adjusted Part A payment or payment adjustment. FORMAT: -99999.99
34.	Risk Adjusted Paymt/Adjust Amount B	9	135-143	Risk Adjusted Part B payment or payment adjustment. 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.	Filler	17	153-170	Spaces
38.	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

#	Field Name	Len	Pos	Description
				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
39.	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
40.	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – Only on pre-2004 adjustments
41.	De Minimis	1	183-183	Prior to 2008, flag will be spaces. Beginning 2008: ‘N’ = “de minimis” does not apply, ‘Y’ = “de minimis” applies.
42.	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.
43.	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999
44.	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
45.	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community C1 = Community Post-Graft I (ESRD)

#	Field Name	Len	Pos	Description
				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
46.	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
47.	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
48.	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months
49.	Segment ID	3	194-196	Identification number of the segment of the PBP. Blank if there are no segments.
50.	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)
51.	EGHP Flag	1	198	Employer Group flag; Y = member of employer group, N = member is not in an employer group
52.	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
53.	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
54.	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

#	Field Name	Len	Pos	Description
				is added to the MA Plan payment for Plans that bid below the benchmark. -9999.99
55.	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
56.	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
57.	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
58.	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
59.	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
60.	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
61.	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
62.	Total Part A Payment	10	279–288	The total Part A Payment. FORMAT: -999999.99
63.	Total Part B Payment	10	289–298	The total Part B Payment. FORMAT: -999999.99
64.	Total Part C Payment	11	299-309	The sum of Total Part A Payment and Total Part B Payment. FORMAT: -9999999.99
65.	Part D RA Factor	7	310-316	The member's Part D risk adjustment factor.

#	Field Name	Len	Pos	Description
				NN.DDDD Part D Risk Factor used for the Payment Calculation
66.	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.
67.	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.
68.	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.
69.	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.
70.	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
71.	Part D Basic Premium Amount	8	341-348	The Plan's Part D premium amount. -9999.99
72.	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
73.	Reinsurance Subsidy Amount	10	359-368	The amount of the reinsurance subsidy included in the payment. -999999.99
74.	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
75.	Total Part D Payment	11	379-389	The total Part D payment for the member -9999999.99.
76.	Number of Paymt/Adjustmt Months Part D	2	390-391	99

#	Field Name	Len	Pos	Description
77.	PACE Premium Add On	10	392-401	Total Part D Pace Premium Add-on amount - 999999.99
78.	PACE Cost Sharing Add-on	10	402-411	Total Part D Pace Cost Sharing Add-on amount -999999.99
79.	Part C Frailty Score Factor	7	412-418	Beneficiary's Part C frailty score factor, NN.DDDD; otherwise, spaces
80.	MSP Factor	7	419-425	Beneficiary's MSP secondary payer reduction factor, NN.DDDD; otherwise, spaces
81.	MSP Reduction/Reduction Adjustment Amount – Part A	10	426-435	Net MSP reduction or reduction adjustment dollar amount– Part A, SSSSSS9.99
82.	MSP Reduction/Reduction Adjustment Amount – Part B	10	436-445	Net MSP reduction or reduction adjustment dollar amount – Part B, SSSSSS9.99
83.	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
84.	Part D Coverage Gap Discount Amount	8	448-455	The amount of the Coverage Gap Discount Amount included in the payment. -9999.99
85.	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

#	Field Name	Len	Pos	Description
				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.
86.	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.
87.	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
88.	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
89.	Part D Direct Subsidy Monthly Rate Amount	9	477-485	Beginning August 2011: Payments = Rate amount in effect for payment

#	Field Name	Len	Pos	Description
	for Pymt/Adj			period Adjustments = Rate amount in effect for adjustment period Format: -99999.99
90.	Cleanup ID	10	486-495	The Cleanup ID field is used in the event of a cleanup or a RAS overpayment run. It is used to uniquely identify the cleanup with which the record is associated. It is usually the Remedy Ticket number for the cleanup or overpayment run. RAS overpayment runs are associated with an ARC 60 or ARC 61 in Field 28. ARC 94 in Field 28 is used to identify clean-ups when no other ARC codes apply. The field will be blank when the record reports: • A prospective payment • A non-cleanup adjustment • Any payment or adjustment prior to August 2011.

Total Length = 495

F.12 Monthly Membership Summary Data File

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

System	Type	Frequency	Dataset Naming Conventions
MARx	Data File	Monthly	**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

#	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

#	Field Name	Len	Position	Description
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".*
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

Total Length = 201

F.13 Monthly Premium Withholding Report (MPWR) Data File

This is a monthly reconciliation file of premiums withheld from Social Security Administration (SSA) or Railroad Retirement Board (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.

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

System	Type	Frequency	Dataset Naming Conventions
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

The file includes the following records:

- Header Record
- Detail Record
- Trailer Record

F.13.1 *Header Record*

Item	Field	Size	Position	Description
1	Record Type	2	1-2	H = Header Record PIC XX
2	MCO Contract Number	5	3-7	MCO Contract Number PIC X(5)
3	Payment Date	8	8-15	YYYYMMDD First 6 digits contain payment month PIC 9(8)
4	Report Date	8	16-23	YYYYMMDD Date this report created PIC 9(8)
5	Filler	142	24-165	Spaces

Total Length = 165

F.13.2 *Detail Record*

Item	Field	Size	Position	Description
1	Record Type	2	1-2	D = Detail Record PIC XX
2	MCO Contract Number	5	3-7	MCO Contract Number PIC X(5)
3	Plan Benefit Package Id	3	8-10	Plan Benefit Package ID PIC X(3)
4	Plan Segment Id	3	11-13	PIC X(3)
5	HIC Number	12	14-25	Member's HIC # PIC X(12)
6	Surname	7	26-32	PIC X(7)
7	First Initial	1	33	PIC X
8	Sex	1	34	M = Male, F = Female PIC X
9	Date of Birth	8	35-42	YYYYMMDD PIC 9(8)
10	PPO	3	43-45	PPO in effect for this Pay Month "SSA" = Withholding by SSA "RRB" = Withholding by RRB PIC X(3)
11	Filler	1	46	Space
12	Premium Period Start Date	8	47-54	Starting Date of Period Premium Payment Covers YYYYMMDD PIC 9(8)
13	Premium Period End Date	8	55-62	Ending Date of Period Premium Payment Covers YYYYMMDD PIC 9(8)
14	Number of Months in Premium Period	2	63-64	PIC 99
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. PIC -9999.99
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. PIC -9999.99
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. PIC -9999.99
18	Filler	77	89-165	Spaces

Total Length = 165

F.13.3 *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 PIC XX
2	MCO Contract Number	5	3-7	MCO contract number PIC X(5)
3	Plan Benefit Package (PBP) ID	3	8-10	PBP ID, not populated on T3 records PIC X(3)
4	Plan Segment Id	3	11-13	Not populated on T2 or T3 records PIC X(3)
5	Total Part C Premiums Collected	14	14-27	Total withholding collections as specified by Trailer Record type, field (1) PIC -9(10).99
6	Total Part D Premiums Collected	14	28-41	Total withholding collections as specified by Trailer Record type, field (1) PIC -9(10).99
7	Total Part D LEPs Collected	14	42-55	Total withholding collections as specified by Trailer Record type, field (1) PIC -9(10).99
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 PIC -9(10).99
9	Filler	96	70-165	Spaces

Total Length = 165

F.14 Part B Claims Data File

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

System	Type	Frequency	Dataset Naming Conventions
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

F.14.1 *Record Type 1*

Item	Field	Size	Position	Description
1	Contract Number	5	1-5	MCO contract number
2	Record Type	1	6	Record Type Number 6 – Physician/Supplier Record Type Number 7 – Durable Medical Equipment
3	CAN-BIC	12	7-18	HIC Number
4	Period From	8	19-26	Start Date – YYYYMMDD
5	Period To	8	27-34	End Date – YYYYMMDD
6	Date of Birth	8	35-42	Beneficiary's Date of Birth – YYYYMMDD
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.
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 – YYYYMM. 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

Total Length = 187

F.14.2 *Record Type 2*

Item	Field	Size	Position	Description
1	Contract Number	5	1-5	MCO contract number
2	Record Type	1	6	Record Type Number 5 – Home Health Agency
3	CAN-BIC	12	7-18	HIC Number
4	Period From	8	19-26	Start Date – YYYYMMDD
5	Period To	8	27-34	End Date – YYYYMMDD
6	Date of Birth	8	35-42	Beneficiary's Date of Birth – YYYYMMDD
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.
	Total Charges	11	62-72	Total charges on the claim.
12	Report Date	6	73-78	Claims processed through date – YYYYMM. 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

Total Length = 187

F.15 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 the 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.

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

System	Type	Frequency	Dataset Naming Conventions
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

The following records are included in this file:

- Header Record
- Detail Record
- Trailer Record

F.15.1 Header Record

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "1"	1 = Header B = Details for new V21 PTC MOR C = Details for new V22 PTC MOR 3 = Trailer
2	Contract Number	Char(5)	2	6	5		Unique identification for a Medicare Advantage Contract
3	Run Date	Char(8)	7	14	8	Format as yyyymmdd	The run date when this file was created
4	Payment Year and Month	Char(6)	15	20	6	Format as yyyymm	This identifies the risk adjustment payment year and month for the model run.
5	Filler	Char(180)	21	200	180	Spaces	Filler

Total Length = 200

F.15.2 Detail Record Type B

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "B"	1 = Header B = Details for new V21 PTC MOR C = Details for new V22 PTC MOR 3 = Trailer
2	Health Insurance Claim Account Number	Char(12)	2	13	12	Also known as HICAN	This is the Health Insurance Claim Account Number (known as HICAN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICAN, consisting of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD), uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.
3	Beneficiary Last Name	Char(12)	14	25	12	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	26	32	7	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	33	33	1	1-byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	34	41	8	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	42	42	1	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary. Examples include Male and Female.
8	Social Security Number	Char(9)	43	51	9	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration
9	RAS ESRD Indicator Switch	Char(1)	52	52	1	Y = ESRD N = not ESRD	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.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
10	Age Group Female0_34	Char(1)	53	53	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 0 and 34, inclusive
11	Age Group Female35_44	Char(1)	54	54	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 35 and 44, inclusive
12	Age Group Female45_54	Char(1)	55	55	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 45 and 54, inclusive
13	Age Group Female55_59	Char(1)	56	56	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 55 and 59, inclusive
14	Age Group Female60_64	Char(1)	57	57	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 60 and 64, inclusive
15	Age Group Female65_69	Char(1)	58	58	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 65 and 69, inclusive
16	Age Group Female70_74	Char(1)	59	59	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 70 and 74, inclusive
17	Age Group Female75_79	Char(1)	60	60	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 75 and 79, inclusive
18	Age Group Female80_84	Char(1)	61	61	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages of 80 and 84, inclusive
19	Age Group Female85_89	Char(1)	62	62	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages of 85 and 89, inclusive

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
20	Age Group Female90_94	Char(1)	63	63	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages of 90 and 94, inclusive
21	Age Group Female95_GT	Char(1)	64	64	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female, age 95 or greater
22	Age Group Male0_34	Char(1)	65	65	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 0 and 34, inclusive
23	Age Group Male35_44	Char(1)	66	66	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 35 and 44, inclusive
24	Age Group Male45_54	Char(1)	67	67	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 45 and 54, inclusive
25	Age Group Male55_59	Char(1)	68	68	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 55 and 59, inclusive
26	Age Group Male60_64	Char(1)	69	69	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 60 and 64, inclusive
27	Age Group Male65_69	Char(1)	70	70	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 65 and 69, inclusive
28	Age Group Male70_74	Char(1)	71	71	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 70 and 74, inclusive
29	Age Group Male75_79	Char(1)	72	72	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 75 and 79, inclusive

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
30	Age Group Male80_84	Char(1)	73	73	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 80 and 84, inclusive
31	Age Group Male85_89	Char(1)	74	74	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 85 and 89, inclusive
32	Age Group Male90_94	Char(1)	75	75	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 90 and 94, inclusive
33	Age Group Male95_GT	Char(1)	76	76	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male, age 95 or greater
34	Medicaid Female Disabled	Char(1)	77	77	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a female disabled and also entitled to Medicaid.
35	Medicaid Female Aged	Char(1)	78	78	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a female aged (> 64) and also entitled to Medicaid.
36	Medicaid Male Disabled	Char(1)	79	79	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a male disabled and also entitled to Medicaid.
37	Medicaid Male Aged	Char(1)	80	80	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a male aged (> 64) and also entitled to Medicaid.
38	Originally Disabled Female	Char(1)	81	81	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a female and original Medicare entitlement was due to disability.
39	Originally Disabled Male	Char(1)	82	82	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a male and original Medicare entitlement was due to disability.
40	HCC001	Char(1)	83	83	1	Set to "1" if applicable, otherwise "0"	HIV/AIDS
41	HCC002	Char(1)	84	84	1	Set to "1" if applicable, otherwise "0"	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
42	HCC006	Char(1)	85	85	1	Set to "1" if applicable, otherwise "0"	Opportunistic Infections
43	HCC008	Char(1)	86	86	1	Set to "1" if applicable, otherwise "0"	Metastatic Cancer and Acute Leukemia

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
44	HCC009	Char(1)	87	87	1	Set to "1" if applicable, otherwise "0"	Lung and Other Severe Cancers
45	HCC010	Char(1)	88	88	1	Set to "1" if applicable, otherwise "0"	Lymphoma and Other Cancers
46	HCC011	Char(1)	89	89	1	Set to "1" if applicable, otherwise "0"	Colorectal, Bladder, and Other Cancers
47	HCC012	Char(1)	90	90	1	Set to "1" if applicable, otherwise "0"	Breast, Prostate, and Other Cancers and Tumors
48	HCC017	Char(1)	91	91	1	Set to "1" if applicable, otherwise "0"	Diabetes with Acute Complications
49	HCC018	Char(1)	92	92	1	Set to "1" if applicable, otherwise "0"	Diabetes with Chronic Complications
50	HCC019	Char(1)	93	93	1	Set to "1" if applicable, otherwise "0"	Diabetes without Complication
51	HCC021	Char(1)	94	94	1	Set to "1" if applicable, otherwise "0"	Protein-Calorie Malnutrition
52	HCC022	Char(1)	95	95	1	Set to "1" if applicable, otherwise "0"	Morbid Obesity
53	HCC023	Char(1)	96	96	1	Set to "1" if applicable, otherwise "0"	Other Significant Endocrine and Metabolic Disorders
54	HCC027	Char(1)	97	97	1	Set to "1" if applicable, otherwise "0"	End-Stage Liver Disease
55	HCC028	Char(1)	98	98	1	Set to "1" if applicable, otherwise "0"	Cirrhosis of Liver
56	HCC029	Char(1)	99	99	1	Set to "1" if applicable, otherwise "0"	Chronic Hepatitis
57	HCC033	Char(1)	100	100	1	Set to "1" if applicable, otherwise "0"	Intestinal Obstruction/Perforation
58	HCC034	Char(1)	101	101	1	Set to "1" if applicable, otherwise "0"	Chronic Pancreatitis
59	HCC035	Char(1)	102	102	1	Set to "1" if applicable, otherwise "0"	Inflammatory Bowel Disease
60	HCC039	Char(1)	103	103	1	Set to "1" if applicable, otherwise "0"	Bone/Joint/Muscle Infections/Necrosis

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
61	HCC040	Char(1)	104	104	1	Set to "1" if applicable, otherwise "0"	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
62	HCC046	Char(1)	105	105	1	Set to "1" if applicable, otherwise "0"	Severe Hematological Disorders
63	HCC047	Char(1)	106	106	1	Set to "1" if applicable, otherwise "0"	Disorders of Immunity
64	HCC048	Char(1)	107	107	1	Set to "1" if applicable, otherwise "0"	Coagulation Defects and Other Specified Hematological Disorders
65	HCC051	Char(1)	108	108	1	Set to "1" if applicable, otherwise "0"	Dementia With Complications
66	HCC052	Char(1)	109	109	1	Set to "1" if applicable, otherwise "0"	Dementia Without Complication
67	HCC054	Char(1)	110	110	1	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Psychosis
68	HCC055	Char(1)	111	111	1	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Dependence
69	HCC057	Char(1)	112	112	1	Set to "1" if applicable, otherwise "0"	Schizophrenia
70	HCC058	Char(1)	113	113	1	Set to "1" if applicable, otherwise "0"	Major Depressive, Bipolar, and Paranoid Disorders
71	HCC070	Char(1)	114	114	1	Set to "1" if applicable, otherwise "0"	Quadriplegia
72	HCC071	Char(1)	115	115	1	Set to "1" if applicable, otherwise "0"	Paraplegia
73	HCC072	Char(1)	116	116	1	Set to "1" if applicable, otherwise "0"	Spinal Cord Disorders/Injuries
74	HCC073	Char(1)	117	117	1	Set to "1" if applicable, otherwise "0"	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
75	HCC074	Char(1)	118	118	1	Set to "1" if applicable, otherwise "0"	Cerebral Palsy
76	HCC075	Char(1)	119	119	1	Set to "1" if applicable, otherwise "0"	Polyneuropathy
77	HCC076	Char(1)	120	120	1	Set to "1" if applicable, otherwise "0"	Muscular Dystrophy

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
78	HCC077	Char(1)	121	121	1	Set to "1" if applicable, otherwise "0"	Multiple Sclerosis
79	HCC078	Char(1)	122	122	1	Set to "1" if applicable, otherwise "0"	Parkinsons and Huntingtons Diseases
80	HCC079	Char(1)	123	123	1	Set to "1" if applicable, otherwise "0"	Seizure Disorders and Convulsions
81	HCC080	Char(1)	124	124	1	Set to "1" if applicable, otherwise "0"	Coma, Brain Compression/Anoxic Damage
82	HCC082	Char(1)	125	125	1	Set to "1" if applicable, otherwise "0"	Respirator Dependence/Tracheostomy Status
83	HCC083	Char(1)	126	126	1	Set to "1" if applicable, otherwise "0"	Respiratory Arrest
84	HCC084	Char(1)	127	127	1	Set to "1" if applicable, otherwise "0"	Cardio-Respiratory Failure and Shock
85	HCC085	Char(1)	128	128	1	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure
86	HCC086	Char(1)	129	129	1	Set to "1" if applicable, otherwise "0"	Acute Myocardial Infarction
87	HCC087	Char(1)	130	130	1	Set to "1" if applicable, otherwise "0"	Unstable Angina and Other Acute Ischemic Heart Disease
88	HCC088	Char(1)	131	131	1	Set to "1" if applicable, otherwise "0"	Angina Pectoris
89	HCC096	Char(1)	132	132	1	Set to "1" if applicable, otherwise "0"	Specified Heart Arrhythmias
90	HCC099	Char(1)	133	133	1	Set to "1" if applicable, otherwise "0"	Cerebral Hemorrhage
91	HCC100	Char(1)	134	134	1	Set to "1" if applicable, otherwise "0"	Ischemic or Unspecified Stroke
92	HCC103	Char(1)	135	135	1	Set to "1" if applicable, otherwise "0"	Hemiplegia/Hemiparesis
93	HCC104	Char(1)	136	136	1	Set to "1" if applicable, otherwise "0"	Monoplegia, Other Paralytic Syndromes
94	HCC106	Char(1)	137	137	1	Set to "1" if applicable, otherwise "0"	Atherosclerosis of the Extremities with Ulceration or Gangrene

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
95	HCC107	Char(1)	138	138	1	Set to "1" if applicable, otherwise "0"	Vascular Disease with Complications
96	HCC108	Char(1)	139	139	1	Set to "1" if applicable, otherwise "0"	Vascular Disease
97	HCC110	Char(1)	140	140	1	Set to "1" if applicable, otherwise "0"	Cystic Fibrosis
98	HCC111	Char(1)	141	141	1	Set to "1" if applicable, otherwise "0"	Chronic Obstructive Pulmonary Disease
99	HCC112	Char(1)	142	142	1	Set to "1" if applicable, otherwise "0"	Fibrosis of Lung and Other Chronic Lung Disorders
100	HCC114	Char(1)	143	143	1	Set to "1" if applicable, otherwise "0"	Aspiration and Specified Bacterial Pneumonias
101	HCC115	Char(1)	144	144	1	Set to "1" if applicable, otherwise "0"	Pneumococcal Pneumonia, Emphysema, Lung Abscess
102	HCC122	Char(1)	145	145	1	Set to "1" if applicable, otherwise "0"	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
103	HCC124	Char(1)	146	146	1	Set to "1" if applicable, otherwise "0"	Exudative Macular Degeneration
104	HCC134	Char(1)	147	147	1	Set to "1" if applicable, otherwise "0"	Dialysis Status
105	HCC135	Char(1)	148	148	1	Set to "1" if applicable, otherwise "0"	Acute Renal Failure
106	HCC136	Char(1)	149	149	1	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Stage 5
107	HCC137	Char(1)	150	150	1	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Severe (Stage 4)
108	HCC138	Char(1)	151	151	1	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Moderate (Stage 3)
109	HCC139	Char(1)	152	152	1	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)
110	HCC140	Char(1)	153	153	1	Set to "1" if applicable, otherwise "0"	Unspecified Renal Failure
111	HCC141	Char(1)	154	154	1	Set to "1" if applicable, otherwise "0"	Nephritis

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
112	HCC157	Char(1)	155	155	1	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
113	HCC158	Char(1)	156	156	1	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Full Thickness Skin Loss
114	HCC159	Char(1)	157	157	1	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Partial Thickness Skin Loss
115	HCC160	Char(1)	158	158	1	Set to "1" if applicable, otherwise "0"	Pressure Pre-Ulcer Skin Changes or Unspecified Stage
116	HCC161	Char(1)	159	159	1	Set to "1" if applicable, otherwise "0"	Chronic Ulcer of Skin, Except Pressure
117	HCC162	Char(1)	160	160	1	Set to "1" if applicable, otherwise "0"	Severe Skin Burn or Condition
118	HCC166	Char(1)	161	161	1	Set to "1" if applicable, otherwise "0"	Severe Head Injury
119	HCC167	Char(1)	162	162	1	Set to "1" if applicable, otherwise "0"	Major Head Injury
120	HCC169	Char(1)	163	163	1	Set to "1" if applicable, otherwise "0"	Vertebral Fractures without Spinal Cord Injury
121	HCC170	Char(1)	164	164	1	Set to "1" if applicable, otherwise "0"	Hip Fracture/Dislocation
122	HCC173	Char(1)	165	165	1	Set to "1" if applicable, otherwise "0"	Traumatic Amputations and Complications
123	HCC176	Char(1)	166	166	1	Set to "1" if applicable, otherwise "0"	Complications of Specified Implanted Device or Graft
124	HCC186	Char(1)	167	167	1	Set to "1" if applicable, otherwise "0"	Major Organ Transplant or Replacement Status
125	HCC188	Char(1)	168	168	1	Set to "1" if applicable, otherwise "0"	Artificial Openings for Feeding or Elimination
126	HCC189	Char(1)	169	169	1	Set to "1" if applicable, otherwise "0"	Amputation Status, Lower Limb/Amputation Complications
127	Disabled Disease HCC006	Char(1)	170	170	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 006 Opportunistic Infections
128	Disabled Disease HCC034	Char(1)	171	171	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 034 Chronic Pancreatitis

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
129	Disabled Disease HCC046	Char(1)	172	172	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 046 Severe Hematological Disorders
130	Disabled Disease HCC054	Char(1)	173	173	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 054 Drug/Alcohol Psychosis
131	Disabled Disease HCC055	Char(1)	174	174	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 055 Drug/Alcohol Dependence
132	Disabled Disease HCC110	Char(1)	175	175	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 110 Cystic Fibrosis
133	Disabled Disease HCC176	Char(1)	176	176	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 176 Complications of Specified Implanted Device or Graft
134	CANCER_ IMMUNE	Char(1)	177	177	1	Set to "1" if applicable, otherwise "0"	CANCER_IMMUNE
135	CHF_COPD	Char(1)	178	178	1	Set to "1" if applicable, otherwise "0"	CHF_COPD
136	CHF_RENAL	Char(1)	179	179	1	Set to "1" if applicable, otherwise "0"	CHF_RENAL
137	COPD_CARD _RESP_FAIL	Char(1)	180	180	1	Set to "1" if applicable, otherwise "0"	COPD_CARD_RESP_FA IL
138	DIABETES_ CHF	Char(1)	181	181	1	Set to "1" if applicable, otherwise "0"	DIABETES_CHF
139	SEPSIS_ CARD_RESP_ FAIL	Char(1)	182	182	1	Set to "1" if applicable, otherwise "0"	SEPSIS_CARD_RESP_F AIL
140	Medicaid	Char(1)	183	183	1	Set to "1" if applicable, otherwise "0"	Beneficiary is entitled to Medicaid.
141	Originally Disabled	Char(1)	184	184	1	Set to "1" if applicable, otherwise "0"	Beneficiary original Medicare entitlement was due to disability.
142	Disabled Disease HCC039	Char(1)	185	185	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 039 Bone/Joint/Muscle Infections/Necrosis
143	Disabled Disease HCC077	Char(1)	186	186	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 077 Multiple Sclerosis
144	Disabled Disease HCC085	Char(1)	187	187	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 085 Congestive Heart Failure

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
145	Disabled Disease HCC161	Char(1)	188	188	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 161 Chronic Ulcer of Skin, Except Pressure
146	ART_ OPENINGS_ PRESSURE_ ULCER	Char(1)	189	189	1	Set to "1" if applicable	ART_OPENINGS_PRESS URE_ ULCER
147	ASP_SPEC_ BACT_ PNEUM_ PRES_ULC	Char(1)	190	190	1	Set to "1" if applicable	ASP_SPEC_BACT_PNE UM_ PRES_ULC
148	COPD_ASP_ SPEC_BACT_ PNEUM	Char(1)	191	191	1	Set to "1" if applicable	COPD_ASP_SPEC_BAC T_ PNEUM
149	DISABLED_ PRESSURE_ ULCER	Char(1)	192	192	1	Set to "1" if applicable	DISABLED_PRESSURE_ ULCER
150	SCHIZO-PHRENIA_ CHF	Char(1)	193	193	1	Set to "1" if applicable	SCHIZO-PHRENIA_CHF
151	SCHIZO-PHRENIA_ COPD	Char(1)	194	194	1	Set to "1" if applicable	SCHIZO-PHRENIA_COPD
152	SCHIZO-PHRENIA_ SEIZURES	Char(1)	195	195	1	Set to "1" if applicable	SCHIZO-PHRENIA_SEIZURES
153	SEPSIS_ ARTIF_ OPENINGS	Char(1)	196	196	1	Set to "1" if applicable	SEPSIS_ARTIF_OPENIN GS
154	SEPSIS_ ASP_SPEC_ BACT_ PNEUM	Char(1)	197	197	1	Set to "1" if applicable	SEPSIS_ASP_SPEC_BA CT_ PNEUM
155	SEPSIS_ PRESSURE_ ULCER	Char(1)	198	198	1	Set to "1" if applicable	SEPSIS_PRESSURE_UL CER
156	Filler	Char(2)	199	200	2	Spaces	Filler

Total Length = 200.
NOTE: Fields 140-155 are associated with the CMS HCC V21 Institutional Score only.

F.15.3 Detail Record Type C

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "C"	1 = Header, B = Details for new V21 PTC MOR, C = Details for new V22 PTC MOR 3 = Trailer

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
2	Health Insurance Claim Account Number	Char(12)	2	13	12	Also known as HICAN	This is the Health Insurance Claim Account Number (known as HICAN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICAN consist of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD) uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.
3	Beneficiary Last Name	Char(12)	14	25	12	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	26	32	7	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	33	33	1	1-byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	34	41	8	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	42	42	1	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary. Examples include Male and Female.
8	Social Security Number	Char(9)	43	51	9	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration.
Beneficiary Demographic Indicators:							
9	Age Group Female0_34	Char(1)	52	52	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 0 and 34, inclusive.
10	Age Group Female35_44	Char(1)	53	53	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 35 and 44, inclusive.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
11	Age Group Female45_54	Char(1)	54	54	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 45 and 54, inclusive.
12	Age Group Female55_59	Char(1)	55	55	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 55 and 59, inclusive.
13	Age Group Female60_64	Char(1)	56	56	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 60 and 64, inclusive.
14	Age Group Female65_69	Char(1)	57	57	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 65 and 69, inclusive.
15	Age Group Female70_74	Char(1)	58	58	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 70 and 74, inclusive.
16	Age Group Female75_79	Char(1)	59	59	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 75 and 79, inclusive.
17	Age Group Female80_84	Char(1)	60	60	1	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 and 84, inclusive.
18	Age Group Female85_89	Char(1)	61	61	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 and 89, inclusive.
19	Age Group Female90_94	Char(1)	62	62	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 and 94, inclusive.
20	Age Group Female95_GT	Char(1)	63	63	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female, age 95 or greater.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
21	Age Group Male0_34	Char(1)	64	64	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 and 34, inclusive.
22	Age Group Male35_44	Char(1)	65	65	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 and 44, inclusive.
23	Age Group Male45_54	Char(1)	66	66	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 and 54, inclusive.
24	Age Group Male55_59	Char(1)	67	67	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 and 59, inclusive.
25	Age Group Male60_64	Char(1)	68	68	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 and 64, inclusive.
26	Age Group Male65_69	Char(1)	69	69	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 and 69, inclusive.
27	Age Group Male70_74	Char(1)	70	70	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 and 74, inclusive.
28	Age Group Male75_79	Char(1)	71	71	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 and 79, inclusive.
29	Age Group Male80_84	Char(1)	72	72	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 and 84, inclusive.
30	Age Group Male85_89	Char(1)	73	73	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 and 89, inclusive.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
31	Age Group Male90_94	Char(1)	74	74	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 and 94, inclusive.
32	Age Group Male95_GT	Char(1)	75	75	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male, age 95 or greater.
33	Medicaid Female Disabled	Char(1)	76	76	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a female disabled and also entitled to Medicaid.
34	Medicaid Female Aged	Char(1)	77	77	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a female aged (> 64) and also entitled to Medicaid.
35	Medicaid Male Disabled	Char(1)	78	78	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a male disabled and also entitled to Medicaid.
36	Medicaid Male Aged	Char(1)	79	79	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a male aged (> 64) and also entitled to Medicaid.
37	Originally Disabled Female	Char(1)	80	80	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a female and original Medicare entitlement was due to disability.
38	Originally Disabled Male	Char(1)	81	81	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a male and original Medicare entitlement was due to disability.
HCC Indicators:							
39	HCC001	Char(1)	82	82	1	Set to "1" if applicable, otherwise "0"	HIV/AIDS
40	HCC002	Char(1)	83	83	1	Set to "1" if applicable, otherwise "0"	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
41	HCC006	Char(1)	84	84	1	Set to "1" if applicable, otherwise "0"	Opportunistic Infections
42	HCC008	Char(1)	85	85	1	Set to "1" if applicable, otherwise "0"	Metastatic Cancer and Acute Leukemia
43	HCC009	Char(1)	86	86	1	Set to "1" if applicable, otherwise "0"	Lung and Other Severe Cancers
44	HCC010	Char(1)	87	87	1	Set to "1" if applicable, otherwise "0"	Lymphoma and Other Cancers
45	HCC011	Char(1)	88	88	1	Set to "1" if applicable, otherwise "0"	Colorectal, Bladder, and Other Cancers

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
46	HCC012	Char(1)	89	89	1	Set to "1" if applicable, otherwise "0"	Breast, Prostate, and Other Cancers and Tumors
47	HCC017	Char(1)	90	90	1	Set to "1" if applicable, otherwise "0"	Diabetes with Acute Complications
48	HCC018	Char(1)	91	91	1	Set to "1" if applicable, otherwise "0"	Diabetes with Chronic Complications
49	HCC019	Char(1)	92	92	1	Set to "1" if applicable, otherwise "0"	Diabetes without Complication
50	HCC021	Char(1)	93	93	1	Set to "1" if applicable, otherwise "0"	Protein-Calorie Malnutrition
51	HCC022	Char(1)	94	94	1	Set to "1" if applicable, otherwise "0"	Morbid Obesity
52	HCC023	Char(1)	95	95	1	Set to "1" if applicable, otherwise "0"	Other Significant Endocrine and Metabolic Disorders
53	HCC027	Char(1)	96	96	1	Set to "1" if applicable, otherwise "0"	End-Stage Liver Disease
54	HCC028	Char(1)	97	97	1	Set to "1" if applicable, otherwise "0"	Cirrhosis of Liver
55	HCC029	Char(1)	98	98	1	Set to "1" if applicable, otherwise "0"	Chronic Hepatitis
56	HCC033	Char(1)	99	99	1	Set to "1" if applicable, otherwise "0"	Intestinal Obstruction/Perforation
57	HCC034	Char(1)	100	100	1	Set to "1" if applicable, otherwise "0"	Chronic Pancreatitis
58	HCC035	Char(1)	101	101	1	Set to "1" if applicable, otherwise "0"	Inflammatory Bowel Disease
59	HCC039	Char(1)	102	102	1	Set to "1" if applicable, otherwise "0"	Bone/Joint/Muscle Infections/Necrosis
60	HCC040	Char(1)	103	103	1	Set to "1" if applicable, otherwise "0"	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
61	HCC046	Char(1)	104	104	1	Set to "1" if applicable, otherwise "0"	Severe Hematological Disorders
62	HCC047	Char(1)	105	105	1	Set to "1" if applicable, otherwise "0"	Disorders of Immunity

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
63	HCC048	Char(1)	106	106	1	Set to "1" if applicable, otherwise "0"	Coagulation Defects and Other Specified Hematological Disorders
64	HCC054	Char(1)	107	107	1	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Psychosis
65	HCC055	Char(1)	108	108	1	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Dependence
66	HCC057	Char(1)	109	109	1	Set to "1" if applicable, otherwise "0"	Schizophrenia
67	HCC058	Char(1)	110	110	1	Set to "1" if applicable, otherwise "0"	Major Depressive, Bipolar, and Paranoid Disorders
68	HCC070	Char(1)	111	111	1	Set to "1" if applicable, otherwise "0"	Quadriplegia
69	HCC071	Char(1)	112	112	1	Set to "1" if applicable, otherwise "0"	Paraplegia
70	HCC072	Char(1)	113	113	1	Set to "1" if applicable, otherwise "0"	Spinal Cord Disorders/Injuries
71	HCC073	Char(1)	114	114	1	Set to "1" if applicable, otherwise "0"	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
72	HCC074	Char(1)	115	115	1	Set to "1" if applicable, otherwise "0"	Cerebral Palsy
73	HCC075	Char(1)	116	116	1	Set to "1" if applicable, otherwise "0"	Polyneuropathy
74	HCC076	Char(1)	117	117	1	Set to "1" if applicable, otherwise "0"	Muscular Dystrophy
75	HCC077	Char(1)	118	118	1	Set to "1" if applicable, otherwise "0"	Multiple Sclerosis
76	HCC078	Char(1)	119	119	1	Set to "1" if applicable, otherwise "0"	Parkinsons and Huntingtons Diseases
77	HCC079	Char(1)	120	120	1	Set to "1" if applicable, otherwise "0"	Seizure Disorders and Convulsions
78	HCC080	Char(1)	121	121	1	Set to "1" if applicable, otherwise "0"	Coma, Brain Compression/Anoxic Damage
79	HCC082	Char(1)	122	122	1	Set to "1" if applicable, otherwise "0"	Respirator Dependence/Tracheostomy Status

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
80	HCC083	Char(1)	123	123	1	Set to "1" if applicable, otherwise "0"	Respiratory Arrest
81	HCC084	Char(1)	124	124	1	Set to "1" if applicable, otherwise "0"	Cardio-Respiratory Failure and Shock
82	HCC085	Char(1)	125	125	1	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure
83	HCC086	Char(1)	126	126	1	Set to "1" if applicable, otherwise "0"	Acute Myocardial Infarction
84	HCC087	Char(1)	127	127	1	Set to "1" if applicable, otherwise "0"	Unstable Angina and Other Acute Ischemic Heart Disease
85	HCC088	Char(1)	128	128	1	Set to "1" if applicable, otherwise "0"	Angina Pectoris
86	HCC096	Char(1)	129	129	1	Set to "1" if applicable, otherwise "0"	Specified Heart Arrhythmias
87	HCC099	Char(1)	130	130	1	Set to "1" if applicable, otherwise "0"	Cerebral Hemorrhage
88	HCC100	Char(1)	131	131	1	Set to "1" if applicable, otherwise "0"	Ischemic or Unspecified Stroke
89	HCC103	Char(1)	132	132	1	Set to "1" if applicable, otherwise "0"	Hemiplegia/Hemiparesis
90	HCC104	Char(1)	133	133	1	Set to "1" if applicable, otherwise "0"	Monoplegia, Other Paralytic Syndromes
91	HCC106	Char(1)	134	134	1	Set to "1" if applicable, otherwise "0"	Atherosclerosis of the Extremities with Ulceration or Gangrene
92	HCC107	Char(1)	135	135	1	Set to "1" if applicable, otherwise "0"	Vascular Disease with Complications
93	HCC108	Char(1)	136	136	1	Set to "1" if applicable, otherwise "0"	Vascular Disease
94	HCC110	Char(1)	137	137	1	Set to "1" if applicable, otherwise "0"	Cystic Fibrosis
95	HCC111	Char(1)	138	138	1	Set to "1" if applicable, otherwise "0"	Chronic Obstructive Pulmonary Disease
96	HCC112	Char(1)	139	139	1	Set to "1" if applicable, otherwise "0"	Fibrosis of Lung and Other Chronic Lung Disorders

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
97	HCC114	Char(1)	140	140	1	Set to "1" if applicable, otherwise "0"	Aspiration and Specified Bacterial Pneumonias
98	HCC115	Char(1)	141	141	1	Set to "1" if applicable, otherwise "0"	Pneumococcal Pneumonia, Emphysema, Lung Abscess
99	HCC122	Char(1)	142	142	1	Set to "1" if applicable, otherwise "0"	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
100	HCC124	Char(1)	143	143	1	Set to "1" if applicable, otherwise "0"	Exudative Macular Degeneration
101	HCC134	Char(1)	144	144	1	Set to "1" if applicable, otherwise "0"	Dialysis Status
102	HCC135	Char(1)	145	145	1	Set to "1" if applicable, otherwise "0"	Acute Renal Failure
103	HCC136	Char(1)	146	146	1	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Stage 5
104	HCC137	Char(1)	147	147	1	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Severe (Stage 4)
105	HCC157	Char(1)	148	148	1	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
106	HCC158	Char(1)	149	149	1	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Full Thickness Skin Loss
107	HCC161	Char(1)	150	150	1	Set to "1" if applicable, otherwise "0"	Chronic Ulcer of Skin, Except Pressure
108	HCC162	Char(1)	151	151	1	Set to "1" if applicable, otherwise "0"	Severe Skin Burn or Condition
109	HCC166	Char(1)	152	152	1	Set to "1" if applicable, otherwise "0"	Severe Head Injury
110	HCC167	Char(1)	153	153	1	Set to "1" if applicable, otherwise "0"	Major Head Injury
111	HCC169	Char(1)	154	154	1	Set to "1" if applicable, otherwise "0"	Vertebral Fractures without Spinal Cord Injury
112	HCC170	Char(1)	155	155	1	Set to "1" if applicable, otherwise "0"	Hip Fracture/Dislocation
113	HCC173	Char(1)	156	156	1	Set to "1" if applicable, otherwise "0"	Traumatic Amputations and Complications

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
114	HCC176	Char(1)	157	157	1	Set to "1" if applicable, otherwise "0"	Complications of Specified Implanted Device or Graft
115	HCC186	Char(1)	158	158	1	Set to "1" if applicable, otherwise "0"	Major Organ Transplant or Replacement Status
116	HCC188	Char(1)	159	159	1	Set to "1" if applicable, otherwise "0"	Artificial Openings for Feeding or Elimination
117	HCC189	Char(1)	160	160	1	Set to "1" if applicable, otherwise "0"	Amputation Status, Lower Limb/Amputation Complications
Disabled HCCs							
118	Disabled Disease HCC006	Char(1)	161	161	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 006 Opportunistic Infections
119	Disabled Disease HCC034	Char(1)	162	162	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 034 Chronic Pancreatitis
120	Disabled Disease HCC046	Char(1)	163	163	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 046 Severe Hematological Disorders
121	Disabled Disease HCC054	Char(1)	164	164	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 054 Drug/Alcohol Psychosis
122	Disabled Disease HCC055	Char(1)	165	165	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 055 Drug/Alcohol Dependence
123	Disabled Disease HCC110	Char(1)	166	166	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 110 Cystic Fibrosis
124	Disabled Disease HCC176	Char(1)	167	167	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 176 Complications of Specified Implanted Device or Graft
Disease Interactions							
125	CANCER_ IMMUNE	Char(1)	168	168	1	Set to "1" if applicable, otherwise "0"	CANCER_IMMUNE
126	CHF_COPD	Char(1)	169	169	1	Set to "1" if applicable, otherwise "0"	CHF_COPD
127	CHF_RENAL	Char(1)	170	170	1	Set to "1" if applicable, otherwise "0"	CHF_RENAL
128	COPD_CARD _RESP_FAIL	Char(1)	171	171	1	Set to "1" if applicable, otherwise "0"	COPD_CARD_RESP_ FAIL

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
129	DIABETES_ CHF	Char(1)	172	172	1	Set to "1" if applicable, otherwise "0"	DIABETES_CHF
130	SEPSIS_CARD _RESP_FAIL	Char(1)	173	173	1	Set to "1" if applicable, otherwise "0"	SEPSIS_CARD_ RESP_FAIL
Additional Institutional Coefficients							
131	Medicaid	Char(1)	174	174	1	Set to "1" if applicable, otherwise "0"	Beneficiary is entitled to Medicaid.
132	Originally Disabled	Char(1)	175	175	1	Set to "1" if applicable, otherwise "0"	Beneficiary original Medicare entitlement was due to disability.
Disabled HCCs							
133	Disabled Disease HCC039	Char(1)	176	176	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 039 Bone/Joint/Muscle Infections/Necrosis
134	Disabled Disease HCC077	Char(1)	177	177	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 077 Multiple Sclerosis
135	Disabled Disease HCC085	Char(1)	178	178	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 085 Congestive Heart Failure
136	Disabled Disease HCC161	Char(1)	179	179	1	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 161 Chronic Ulcer of Skin, Except Pressure
137	DISABLED_P RESSURE_UL CER	Char(1)	180	180	1	Set to "1" if applicable, otherwise "0"	DISABLED_PRESSURE _ULCER
Disease Interactions							
138	ART_ OPENINGS_ PRESSURE_ ULCER	Char(1)	181	181	1	Set to "1" if applicable	ART_OPENINGS _PRESSURE_ ULCER
139	ASP_SPEC_ BACT_ PNEUM_ PRES_ULC	Char(1)	182	182	1	Set to "1" if applicable	ASP_SPEC _BACT_ PNEUM_ PRES_ULC
140	COPD_ASP_ SPEC_BACT_ PNEUM	Char(1)	183	183	1	Set to "1" if applicable	COPD_ASP_ SPEC_BACT_ PNEUM
141	SCHIZO- PHRENIA_ CHF	Char(1)	184	184	1	Set to "1" if applicable	SCHIZO- PHRENIA _CHF
142	SCHIZO- PHRENIA_ COPD	Char(1)	185	185	1	Set to "1" if applicable	SCHIZO- PHRENIA _COPD
143	SCHIZO- PHRENIA_ SEIZURES	Char(1)	186	186	1	Set to "1" if applicable	SCHIZO- PHRENIA _SEIZURES

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
144	SEPSIS_ ARTIF_ OPENINGS	Char(1)	187	187	1	Set to "1" if applicable	SEPSIS_ ARTIF_ OPENINGS
145	SEPSIS_ASP_ SPEC_BACT_ PNEUM	Char(1)	188	188	1	Set to "1" if applicable	SEPSIS_ASP_ SPEC_BACT_ PNEUM
146	SEPSIS_ PRESSURE_ ULCER	Char(1)	189	189	1	Set to "1" if applicable	SEPSIS_ PRESSURE_ ULCER
147	Filler	Char(11)	190	200	11	Spaces	Filler

The total length of this record is 200 characters.

F.15.4 Trailer Record

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "3"	1 = Header B = Details for new V21 PTC MOR C = Details for new V22 PTC MOR 3 = Trailer
2	Contract Number	Char(5)	2	6	5	Also known as MCO plan number	Unique identification for a Managed Care Organization (MCO) enabling the MCO to provide coverage to eligible beneficiaries
3	Total Record Count	Char(9)	7	15	9	Includes all header and trailer records	Record count in display format
4	Filler	Char(185)	16	200	185	Spaces	Filler

Total Length = 200

F.16 Risk Adjustment System (RAS) Prescription Drug Hierarchical Condition Category (RxHCC) Model Output Data File - aka Part D RA Model Output Data File

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

System	Type	Frequency	Dataset Naming Conventions
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

The following records are included in this file:

- Header Record
- Detail/Beneficiary Record Format
- Trailer Record

F.16.1 *Header Record*

The Contract Header Record signals the beginning of the detail/Beneficiary records for a Medicare Advantage or stand-alone PDP contract.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "1"	1 = Header 2 = Details 3 = Trailer
2	Contract Number	Char(5)	2	6	5	Also known as MCO plan number	Unique identification for a Managed Care Organization (MCO) enabling the MCO to provide coverage to eligible beneficiaries.
3	Run Date	Char(8)	7	14	8	Format as yyyymmdd	The run date when this file was created.
4	Payment Year and Month	Char(6)	15	20	6	Format as yyyymm	This identifies the risk adjustment payment year and month for the model run.
5	Filler	Char(143)	21	163	143	Spaces	Filler

Total Length = 163

F.16.2 *Detail/Beneficiary Record*

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 the current calendar/payment year.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "2"	1 = Header 2 = Details 3 = Trailer
2	Health Insurance Claim Account Number	Char(12)	2	13	12	Also known as HICAN	This is the Health Insurance Claim Account Number (known as HICAN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICAN, consisting of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD), uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.
3	Beneficiary Last Name	Char(12)	14	25	12	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	26	32	7	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	33	33	1	1 byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	34	41	8	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	42	42	1	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary.
8	Social Security Number	Char(9)	43	51	9	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female 0-34	Char(1)	52	52	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 0 and 34.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
10	Age Group Female35_44	Char(1)	53	53	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 35 and 44, inclusive.
11	Age Group Female45_54	Char(1)	54	54	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 45 and 54, inclusive.
12	Age Group Female55_59	Char(1)	55	55	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 55 and 59, inclusive.
13	Age Group Female60_64	Char(1)	56	56	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 60 and 64, inclusive.
14	Age Group Female65_69	Char(1)	57	57	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 65 and 69, inclusive.
15	Age Group Female70_74	Char(1)	58	58	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 70 and 74, inclusive.
16	Age Group Female75_79	Char(1)	59	59	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 75 and 79, inclusive.
17	Age Group Female80_84	Char(1)	60	60	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 and 84, inclusive.
18	Age Group Female85_89	Char(1)	61	61	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 and 89, inclusive.
19	Age Group Female90_94	Char(1)	62	62	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 and 94, inclusive.
20	Age Group Female95_GT	Char(1)	63	63	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female, age 95 and greater.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
21	Age Group Male0_34	Char(1)	64	64	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 and 34, inclusive.
22	Age Group Male35_44	Char(1)	65	65	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 and 44, inclusive.
23	Age Group Male45_54	Char(1)	66	66	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 and 54, inclusive.
24	Age Group Male55_59	Char(1)	67	67	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 and 59, inclusive.
25	Age Group Male60_64	Char(1)	68	68	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 and 64, inclusive.
26	Age Group Male65_69	Char(1)	69	69	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 and 69, inclusive.
27	Age Group Male70_74	Char(1)	70	70	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 and 74, inclusive.
28	Age Group Male75_79	Char(1)	71	71	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 and 79, inclusive.
29	Age Group Male80_84	Char(1)	72	72	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 and 84, inclusive.
30	Age Group Male85_89	Char(1)	73	73	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 and 89, inclusive.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
31	Age Group Male90_94	Char(1)	74	74	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 and 94, inclusive.
32	Age Group Male95_GT	Char(1)	75	75	1	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male, age 95 and greater.
33	Originally Disabled Female	Char(1)	76	76	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a female and original Medicare entitlement was due to disability.
34	Originally Disabled Male	Char(1)	77	77	1	Set to "1" if applicable, otherwise "0"	Beneficiary is a male and original Medicare entitlement was due to disability.
35	Disease Coefficients RXHCC1	Char(1)	78	78	1	Set to "1" if applicable, otherwise "0"	HIV/AIDS
36	Disease Coefficients RXHCC5	Char(1)	79	79	1	Set to "1" if applicable, otherwise "0"	Opportunistic Infections
37	Disease Coefficients RXHCC15	Char(1)	80	80	1	Set to "1" if applicable, otherwise "0"	Chronic Myeloid Leukemia
38	Disease Coefficients RXHCC16	Char(1)	81	81	1	Set to "1" if applicable, otherwise "0"	Multiple Myeloma and Other Neoplastic Disorders
39	Disease Coefficients RXHCC17	Char(1)	82	82	1	Set to "1" if applicable, otherwise "0"	Secondary Cancers of Bone, Lung, Brain, and Other Specified Sites; Liver Cancer
40	Disease Coefficients RXHCC18	Char(1)	83	83	1	Set to "1" if applicable, otherwise "0"	Lung, Kidney, and Other Cancers
41	Disease Coefficients RXHCC19	Char(1)	84	84	1	Set to "1" if applicable, otherwise "0"	Breast and Other Cancers and Tumors
42	Disease Coefficients RXHCC30	Char(1)	85	85	1	Set to "1" if applicable, otherwise "0"	Diabetes with Complications
43	Disease Coefficients RXHCC31	Char(1)	86	86	1	Set to "1" if applicable, otherwise "0"	Diabetes without Complication

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
44	Disease Coefficients RXHCC40	Char(1)	87	87	1	Set to "1" if applicable, otherwise "0"	Specified Hereditary Metabolic/Immune Disorders
45	Disease Coefficients RXHCC41	Char(1)	88	88	1	Set to "1" if applicable, otherwise "0"	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders
46	Disease Coefficients RXHCC42	Char(1)	89	89	1	Set to "1" if applicable, otherwise "0"	Thyroid Disorders
47	Disease Coefficients RXHCC43	Char(1)	90	90	1	Set to "1" if applicable, otherwise "0"	Morbid Obesity
48	Disease Coefficients RXHCC45	Char(1)	91	91	1	Set to "1" if applicable, otherwise "0"	Disorders of Lipoid Metabolism
49	Disease Coefficients RXHCC54	Char(1)	92	92	1	Set to "1" if applicable, otherwise "0"	Chronic Viral Hepatitis C
50	Disease Coefficients RXHCC55	Char(1)	93	93	1	Set to "1" if applicable, otherwise "0"	Chronic Viral Hepatitis, Except Hepatitis C
51	Disease Coefficients RXHCC65	Char(1)	94	94	1	Set to "1" if applicable, otherwise "0"	Chronic Pancreatitis
52	Disease Coefficients RXHCC66	Char(1)	95	95	1	Set to "1" if applicable, otherwise "0"	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis
53	Disease Coefficients RXHCC67	Char(1)	96	96	1	Set to "1" if applicable, otherwise "0"	Inflammatory Bowel Disease
54	Disease Coefficients RXHCC68	Char(1)	97	97	1	Set to "1" if applicable, otherwise "0"	Esophageal Reflux and Other Disorders of Esophagus
55	Disease Coefficients RXHCC80	Char(1)	98	98	1	Set to "1" if applicable, otherwise "0"	Aseptic Necrosis of Bone
56	Disease Coefficients RXHCC82	Char(1)	99	99	1	Set to "1" if applicable, otherwise "0"	Psoriatic Arthropathy and Systemic Sclerosis

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
57	Disease Coefficients RXHCC83	Char(1)	100	100	1	Set to "1" if applicable, otherwise "0"	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy
58	Disease Coefficients RXHCC84	Char(1)	101	101	1	Set to "1" if applicable, otherwise "0"	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies
59	Disease Coefficients RXHCC87	Char(1)	102	102	1	Set to "1" if applicable, otherwise "0"	Osteoporosis, Vertebral and Pathological Fractures
60	Disease Coefficients RXHCC95	Char(1)	103	103	1	Set to "1" if applicable, otherwise "0"	Sickle Cell Anemia
61	Disease Coefficients RXHCC96	Char(1)	104	104	1	Set to "1" if applicable, otherwise "0"	Myelodysplastic Syndromes and Myelofibrosis
62	Disease Coefficients RXHCC97	Char(1)	105	105	1	Set to "1" if applicable, otherwise "0"	Immune Disorders
63	Disease Coefficients RXHCC98	Char(1)	106	106	1	Set to "1" if applicable, otherwise "0"	Aplastic Anemia and Other Significant Blood Disorders
64	Disease Coefficients RXHCC111	Char(1)	107	107	1	Set to "1" if applicable, otherwise "0"	Alzheimer's Disease
65	Disease Coefficients RXHCC112	Char(1)	108	108	1	Set to "1" if applicable, otherwise "0"	Dementia, Except Alzheimer's Disease
66	Disease Coefficients RXHCC130	Char(1)	109	109	1	Set to "1" if applicable, otherwise "0"	Schizophrenia
67	Disease Coefficients RXHCC131	Char(1)	110	110	1	Set to "1" if applicable, otherwise "0"	Bipolar Disorders
68	Disease Coefficients RXHCC132	Char(1)	111	111	1	Set to "1" if applicable, otherwise "0"	Major Depression
69	Disease Coefficients RXHCC133	Char(1)	112	112	1	Set to "1" if applicable, otherwise "0"	Specified Anxiety, Personality, and Behavior Disorders

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
70	Disease Coefficients RXHCC134	Char(1)	113	113	1	Set to "1" if applicable, otherwise "0"	Depression
71	Disease Coefficients RXHCC135	Char(1)	114	114	1	Set to "1" if applicable, otherwise "0"	Anxiety Disorders
72	Disease Coefficients RXHCC145	Char(1)	115	115	1	Set to "1" if applicable, otherwise "0"	Autism
73	Disease Coefficients RXHCC146	Char(1)	116	116	1	Set to "1" if applicable, otherwise "0"	Profound or Severe Intellectual Disability/Developmental Disorder
74	Disease Coefficients RXHCC147	Char(1)	117	117	1	Set to "1" if applicable, otherwise "0"	Moderate Intellectual Disability/Developmental Disorder
75	Disease Coefficients RXHCC148	Char(1)	118	118	1	Set to "1" if applicable, otherwise "0"	Mild or Unspecified Intellectual Disability/Developmental Disorder
76	Disease Coefficients RXHCC156	Char(1)	119	119	1	Set to "1" if applicable, otherwise "0"	Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
77	Disease Coefficients RXHCC157	Char(1)	120	120	1	Set to "1" if applicable, otherwise "0"	Spinal Cord Disorders
78	Disease Coefficients RXHCC159	Char(1)	121	121	1	Set to "1" if applicable, otherwise "0"	Inflammatory and Toxic Neuropathy
79	Disease Coefficients RXHCC160	Char(1)	122	122	1	Set to "1" if applicable, otherwise "0"	Multiple Sclerosis
80	Disease Coefficients RXHCC161	Char(1)	123	123	1	Set to "1" if applicable, otherwise "0"	Parkinson's and Huntington's Diseases
81	Disease Coefficients RXHCC163	Char(1)	124	124	1	Set to "1" if applicable, otherwise "0"	Intractable Epilepsy
82	Disease Coefficients RXHCC164	Char(1)	125	125	1	Set to "1" if applicable, otherwise "0"	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
83	Disease Coefficients RXHCC165	Char(1)	126	126	1	Set to "1" if applicable, otherwise "0"	Convulsions
84	Disease Coefficients RXHCC166	Char(1)	127	127	1	Set to "1" if applicable, otherwise "0"	Migraine Headaches
85	Disease Coefficients RXHCC168	Char(1)	128	128	1	Set to "1" if applicable, otherwise "0"	Trigeminal and Postherpetic Neuralgia
86	Disease Coefficients RXHCC185	Char(1)	129	129	1	Set to "1" if applicable, otherwise "0"	Primary Pulmonary Hypertension
87	Disease Coefficients RXHCC186	Char(1)	130	130	1	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure
88	Disease Coefficients RXHCC187	Char(1)	131	131	1	Set to "1" if applicable, otherwise "0"	Hypertension
89	Disease Coefficients RXHCC188	Char(1)	132	132	1	Set to "1" if applicable, otherwise "0"	Coronary Artery Disease
90	Disease Coefficients RXHCC193	Char(1)	133	133	1	Set to "1" if applicable, otherwise "0"	Atrial Arrhythmias
91	Disease Coefficients RXHCC206	Char(1)	134	134	1	Set to "1" if applicable, otherwise "0"	Cerebrovascular Disease, Except Hemorrhage or Aneurysm
92	Disease Coefficients RXHCC207	Char(1)	135	135	1	Set to "1" if applicable, otherwise "0"	Spastic Hemiplegia
93	Disease Coefficients RXHCC215	Char(1)	136	136	1	Set to "1" if applicable, otherwise "0"	Venous Thromboembolism
94	Disease Coefficients RXHCC216	Char(1)	137	137	1	Set to "1" if applicable, otherwise "0"	Peripheral Vascular Disease
95	Disease Coefficients RXHCC225	Char(1)	138	138	1	Set to "1" if applicable, otherwise "0"	Cystic Fibrosis

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
96	Disease Coefficients RXHCC226	Char(1)	139	139	1	Set to "1" if applicable, otherwise "0"	Chronic Obstructive Pulmonary Disease and Asthma
97	Disease Coefficients RXHCC227	Char(1)	140	140	1	Set to "1" if applicable, otherwise "0"	Pulmonary Fibrosis and Other Chronic Lung Disorders
98	Disease Coefficients RXHCC241	Char(1)	141	141	1	Set to "1" if applicable, otherwise "0"	Diabetic Retinopathy
99	Disease Coefficients RXHCC243	Char(1)	142	142	1	Set to "1" if applicable, otherwise "0"	Open-Angle Glaucoma
100	Disease Coefficients RXHCC260	Char(1)	143	143	1	Set to "1" if applicable, otherwise "0"	Kidney Transplant Status
101	Disease Coefficients RXHCC261	Char(1)	144	144	1	Set to "1" if applicable, otherwise "0"	Dialysis Status
102	Disease Coefficients RXHCC262	Char(1)	145	145	1	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease Stage 5
103	Disease Coefficients RXHCC263	Char(1)	146	146	1	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease Stage 4
104	Disease Coefficients RXHCC311	Char(1)	147	147	1	Set to "1" if applicable, otherwise "0"	Chronic Ulcer of Skin, Except Pressure
105	Disease Coefficients RXHCC314	Char(1)	148	148	1	Set to "1" if applicable, otherwise "0"	Pemphigus
106	Disease Coefficients RXHCC316	Char(1)	149	149	1	Set to "1" if applicable, otherwise "0"	Psoriasis, Except with Arthropathy
107	Disease Coefficients RXHCC355	Char(1)	150	150	1	Set to "1" if applicable, otherwise "0"	Narcolepsy and Cataplexy
108	Disease Coefficients RXHCC395	Char(1)	151	151	1	Set to "1" if applicable, otherwise "0"	Lung Transplant Status

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
109	Disease Coefficients RXHCC396	Char(1)	152	152	1	Set to "1" if applicable, otherwise "0"	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas
110	Disease Coefficients RXHCC397	Char(1)	153	153	1	Set to "1" if applicable, otherwise "0"	Pancreas Transplant Status
111	Originally Disabled	Char(1)	154	154	1	Set to "1" if applicable, otherwise "0"	The original reason for Medicare entitlement was due to disability.
112	NONAGED RXHCC1	Char(1)	155	155	1	Set to "1" if applicable, otherwise "0"	Non-Aged and HIV/AIDS
113	NONAGED RXHCC130	Char(1)	156	156	1	Set to "1" if applicable, otherwise "0"	Non-Aged and Schizophrenia
114	NONAGED RXHCC131	Char(1)	157	157	1	Set to "1" if applicable, otherwise "0"	Non-Aged and Bipolar Disorders
115	NONAGED RXHCC132	Char(1)	158	158	1	Set to "1" if applicable, otherwise "0"	Non-Aged and Major Depression
116	NONAGED RXHCC133	Char(1)	159	159	1	Set to "1" if applicable, otherwise "0"	Non-Aged and Specified Anxiety, Personality, and Behavior Disorders
117	NONAGED RXHCC134	Char(1)	160	160	1	Set to "1" if applicable, otherwise "0"	Non-Aged and Depression
118	NONAGED RXHCC135	Char(1)	161	161	1	Set to "1" if applicable, otherwise "0"	Non-Aged and Anxiety Disorders
119	NONAGED RXHCC160	Char(1)	162	162	1	Set to "1" if applicable, otherwise "0"	Non-Aged and Autism
120	NONAGED RXHCC163	Char(1)	163	163	1	Set to "1" if applicable, otherwise "0"	Non-Aged and Multiple Sclerosis

Total Length = 163

NOTE: Fields 111-120 are associated with the Rx HCC Continuing Enrollee Institutional Score only.

F.16.3 *Trailer Record*

The Contract Trailer Record signals the end of the detail/Beneficiary records for a MA or stand-alone PDP contract. This record has a length of 163.

Field #	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "3"	1 = Header 2 = Details 3 = Trailer
2	Contract Number	Char(5)	2	6	5	Also known as MCO plan number	Unique identification for a Managed Care Organization (MCO) enabling the MCO to provide coverage to eligible beneficiaries.
3	Total Record Count	Char(9)	7	15	9	Includes all header and trailer records	Record count in display format 9(9).
4	Filler	Char(153)	16	163	153	Spaces	Filler

Total Length = 163

F.17 Medicare Advantage Organization (MAO) 004 Report – Encounter Data Diagnosis Eligible for Risk Adjustment

Beginning with Payment Year (PY) 2015, encounter data based diagnoses with 2014 dates of service that are valid for risk adjustment will be 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. For PY 2016 (2015 dates of service), CMS will use a blended risk score, adding 10% of the risk score calculated using diagnoses from encounter data records and FFS claims with 90% of the risk score calculated using diagnoses submitted to RAPS and FFS claims. In order to report which diagnoses CMS has extracted from the encounter data system to use in the calculation of risk scores, CMS will send a flat file report to Plan sponsors (MAOs, PACE Organizations, entities under contract to offer cost plans, and certain demonstration projects). The report will contain the diagnoses that meet the risk adjustment rules and are, therefore, eligible for risk adjustment.

This report will be distributed to MAOs by Contract Identification Number on a monthly basis via MARx. CMS will start sending the reports in December 2015, beginning with diagnoses from 2014 dates of service.

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	Dataset Naming Conventions
RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MAO004.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MAO004.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MAO004.Dyymmdd.Thhmmsst

F.17.1 *Header Record*

#	Field Name	Field Length	Starting Position	Ending position	Format and Comments
1	Record Type	1	1	1	• Numeric • 0=Header
2	Delimiter	1	2	2	• Alphanumeric • Uses the * character
3	Report ID	7	3	9	• Alphanumeric • Value is 'MAO-004'
4	Delimiter	1	10	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	16	• Alphanumeric • Uses the * character
7	Report Date	8	17	24	• Numeric • Format CCYYMMDD • Last day of encounter data submission month
8	Delimiter	1	25	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	79	• Alphanumeric • Uses the * character
11	Submission Interchange Number	30	80	109	• Alphanumeric • Interchange Sender ID (ISA06) + Interchange Control Number (ISA13) + Interchange Date (ISA09)
12	Delimiter	1	110	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	115	• Alphanumeric • Uses the * character
15	Filler	385	116	500	• Alphanumeric • Spaces

Total Length = 500

F.17.2 *Detail Record*

#	Field Name	Starting Position	Ending Position	Field Length	Format and Comments
1	Record Type	1	1	1	• Numeric • 1=Detail
2	Delimiter	1	2	2	• Alphanumeric • Uses the * character
3	Report ID	7	3	9	• Alphanumeric • Value is 'MAO-004'
4	Delimiter	1	10	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	16	• Alphanumeric • Uses the * character
7	Beneficiary HICN	12	17	28	• Alphanumeric • Beneficiary Health Insurance Claim Number

8	Delimiter	1	29	29	• Alphanumeric • Uses the * character
9	Encounter ICN	44	30	73	• Numeric • Encounter Data System (EDS) Internal Control Number. In encounter data, only 13 spaces represent the ICN; however, there are 44 spaces on the records to allow enhancement of the ICN.
10	Delimiter	1	74	74	• Alphanumeric • Uses the * character
11	Replacement Encounter Switch	1	75	75	• Alpha Numeric • Encounter Replacement switch will identify if this there was a replacement received.
12	Delimiter	1	76	76	• Alphanumeric • Uses the * character
13	Original Encounter ICN	44	77	120	• Numeric • Encounter Data System (EDS) Internal Control Number. In encounter data, only 13 spaces represent the ICN; however, there are 44 spaces on the records to allow enhancement of the ICN.
14	Delimiter	1	121	121	• Alphanumeric • Uses the * character
15	Plan Submission Date	8	122	129	• Numeric, format CCYYMMDD • Identifies MAO data submission date
16	Delimiter	1	130	130	• Alphanumeric • Uses the * character
17	Processing Date	8	131	138	• Numeric, format CCYYMMDD • Identifies Encounter Data Processing System (EDPS) processing date.
18	Delimiter	1	139	139	• Alphanumeric • Uses the * character
19	"From" Date of Service	8	140	147	• Numeric • Format CCYYMMDD • The start date for a provided service
20	Delimiter	1	148	148	• Alphanumeric • Uses the * character
21	"Through" Date of Service	8	149	156	• Numeric, • Format CCYYMMDD • The end date for a provided service.
22	Delimiter	1	157	157	• Alphanumeric • Uses the * character
23	Claim Type	1	158	158	• Alphanumeric • Type of Claim: Professional, Inpatient, or Outpatient (Values: P, I, O)
24	Delimiter	1	159	159	• Alphanumeric • Uses the * character
25	Diagnosis Code	7	160	166	• 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.

26	Diagnosis ICD	1	167	167	• Alpha Numeric • ICD code for Diagnosis (9 or 0)
27	Delimiter	1	168	168	• Alphanumeric • Uses the * character
28	Diagnosis Codes	324	169	492	• Alpha Numeric • Additional Diagnosis codes up to 36 including the ICD codes and the * delimiters
29	Filler	8	493	500	• Alphanumeric • Spaces

Total Length = 500

F.17.3 *Trailer Record*

#	Field Name	Field Length	Starting Position	Ending Position	Format and Comments
1	Record Type	1	1	1	• Numeric • 9=Trailer
2	Delimiter	1	2	2	• Alphanumeric • Uses the * character
3	Report ID	7	3	9	• Alphanumeric • Value is 'MAO-004'
4	Delimiter	1	10	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	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	35	• Alphanumeric • Uses the * character
9	Filler	465	36	500	• Alphanumeric • Spaces

Total Length = 500

F.18 Monthly Full Enrollment Data File

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 TRRs, the TRC on all records is 999.

System	Type	Frequency	Dataset Naming Conventions
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.Dyymm01.Thhmmsst

Item	Field	Size	Position	Description
1	HICN	12	1 – 12	HICN
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	YYYYMMDD – Format
7	Medicaid Indicator	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	Disability Indicator	1	53	Spaces
12	Hospice Indicator	1	54	Spaces
13	Institutional/NHC/HCBS Indicator	1	55	Spaces
14	ESRD Indicator	1	56	Spaces
15	TRC	3	57 – 59	TRC; Defaulted to '999'
16	TC	2	60 – 61	TC; Defaulted to '01' for special reports
17	Entitlement Type Code	1	62	Spaces
18	Effective Date	8	63 – 70	YYYYMMDD – Format
19	WA Indicator	1	71	Spaces
20	Plan Benefit Package (PBP) ID	3	72 – 74	PBP number
21	Filler	1	75	Spaces
22	Transaction Date	8	76 – 83	Set to Current Date (YYYYMMDD)
23	Filler	1	84	Spaces

Item	Field	Size	Position	Description
24	Subsidy End Date	12	85 – 96	End date of LIS Period (Present if Bene is deemed for the full year, or if the Bene 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	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; or Space = Not Applicable
38	Part D Opt-Out Flag	1	156 – 156	Spaces
39	Filler	1	157 – 157	Spaces
40	Number of Uncovered Months	3	158 – 160	Spaces
41	Creditable Coverage Flag	1	161 – 161	Spaces
42	Employer Subsidy Override Flag	1	162 – 162	Spaces
43	Rx ID	20	163 – 182	Spaces
44	Rx Group	15	183 – 197	Spaces
45	Secondary Drug Insurance Flag	1	198-198	Spaces
46	Secondary Rx ID	20	199 – 218	Spaces
47	Secondary Rx Group	15	219 – 233	Spaces
48	EGHP	1	234 – 234	Spaces
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

Item	Field	Size	Position	Description
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 (0) ‘4’ = 15% ‘5’ = unknown
51	Low-Income Co-Pay Effective Date	8	239 – 246	YYYYMMDD – Format
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

Total Length = 278

F.19 LEP Data File

This report provides information on direct-billed Beneficiaries with late enrollment penalties.

Note: 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

F.19.1 *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	YYYYMMDD
4.	Data file Date	8	17-24	Date this data file was created YYYYMMDD
5.	Filler	141	25-165	Spaces

Total Length = 165

F.19.2 *Detail Record*

Item	Field Name	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
2.	Contract Number	5	4-8	Contract Number
3.	PBP Number	3	9-11	PBP Number

Item	Field Name	Size	Position	Description
4.	Plan Segment Number	3	12-14	Plan Segment Number
5.	HIC Number	12	15-26	Member's HIC Number
6.	Surname	7	27-33	Surname
7.	First Initial	1	34	First Initial
8.	Sex	1	35	M = Male F = Female
9.	DOB	8	36-43	YYYYMMDD
10.	Filler	1	44	Space
11.	Premium/Adjustment Period Start Date	8	45-52	PD: current processing start date AD: adjustment period start date. YYYYMMDD
12.	Premium/Adjustment Period End Date	8	53-60	PD: current processing end date AD: adjustment period end date. YYYYMMDD
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
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). 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 = Blank.
17.	Filler	82	84-165	Spaces

Total Length = 165

F.19.3 *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 CT1 = Total for contract/PBP/segment PT2 = Prospective total for contract/PBP AT2 = Adjustment total for contract/PBP CT2 = Total for contract/PBP PT3 = Prospective total for contract AT3 = Adjustment 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

Total Length = 165

F.20 LIS History Data File (LISHIST)

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.

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

System	Type	Frequency	Dataset Naming Conventions
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

Please note the following limitations:

- The LIS History Data File displays those LIS contract history changes during active, contiguous enrollment over a period of time not to exceed 36 months.

Note: This file was updated to include a Data Activity Flag in field 16 (position 80) of the Detail Record.

F.20.2 *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 YYYYMMDD – Format
4	Calendar Month	6	15-20	CHAR	First six digits contain Calendar Month the report generated; YYYYMM – Format
5	Filler	145	21-165	CHAR	SPACES

Total Length = 165

F.20.3 *Detail Record (Transaction)*

Item	Field	Size	Position	Position	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, blank when Beneficiary premium profile is unavailable.
4	HIC Number	12	10-21	CHAR	Beneficiary's HIC #
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 YYYYMMDD – Format
10	Low Income Period Start Date	8	51-58	CHAR	Start date for beneficiary's Low Income Period Amount: YYYYMMDD – Format
11	Low Income Period End Date	8	59-66	CHAR	End date for beneficiary's Low Income Period Amount: YYYYMMDD – Format
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 here represents several possibilities: 1. There is no Plan premium and therefore no premium subsidy. 2. 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 – Format
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. In 2007, 1 = $2.15/$5.35 and 2 = $1/$3.10. In 2006 1 = $2/$5 and 2 = $1/$3.

Item	Field	Size	Position	Position	Description
15	Beneficiary Source of Subsidy Code	1	79	CHAR	Source of beneficiary subsidy. Valid values are: A = Determined Eligible for LIS by the Social Security Administration or a State Medicaid Agency D = Deemed Eligible for LIS
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 do 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: YYYYMMDD – Format
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 – Format
19	Contract Year	4	97-100	CHAR	Calendar Year associated with the low income premium subsidy amount; YYYY – Format
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: YYYYMMDD – Format
22	Filler	56	110-165	CHAR	Spaces

Total Length = 165

F.20.4 *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

Total Length = 165

F.21 NoRx File

This file contains records identifying those enrollees with no current 4Rx information stored in CMS files. A Detail Record Type containing a value of "NRX" in positions 1 – 3 of the file layout indicates that this record requests the organization to send CMS 4Rx information for the Beneficiary.

System	Type	Frequency	Dataset Naming Conventions
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

The following records are included in this file:

- Header Record
- Detail Record
- Trailer Record

F.21.1 *Header Record*

Note: A "Critical Field" must contain a value. A "Not Critical Field" may contain a value or all spaces.

Field	Size	Position	Format	Valid Values	Description
File ID Name	8	1-8	X(8)	"CMSNRX 0H"	Critical Field This field is always set to the value "CMSNRX0H." This code allows recognition of the record as the Header Record of a NoRx File.
Sending Entity	8	9-16	X(8)	"MBD" (MBD + 5 spaces)	Critical Field This field is always set to the value "MBD". The value specifically is "MBD" followed by five spaces.
File Creation Date	8	17-24	X(8)	YYYYMM DD	Critical Field The date on which the NoRx file was created by CMS. This value is formulated as YYYYMMDD.
File Control Number	9	25-33	X(9)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Filler	717	34-750	X(717)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.

Total Length = 750

F.21.3 *Detail Record*

Note: A "Critical Field" must contain a value. A "Not Critical Field" may contain a value or all spaces.

Field	Size	Position	Format	Valid Values	Description
Record Type	3	1-3	X(3)	"NRX"	Critical Field This field is set to the value "NRX," indicating that this detail record is a NoRx record. This code allows recognition of the detail record as a No Rx record from CMS.
Record Type from Original Detail	5	4-8	X(5)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
HICN or RRB Number	12	9-20	X(9)	HICN or RRB	Critical Field This field contains either the HICN or the RRB Number of the Beneficiary without 4Rx data.
SSN	9	21-29	X(9)	SSN from CMS	Not a Critical Field This field may contain the SSN of the Beneficiary that does not have 4Rx data.
Beneficiary Date of Birth from Original Detail	8	30-37	X(8)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Beneficiary Gender Code from Original Detail	1	38	X(1)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Rx BIN from Original Detail	6	39-44	X(6)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Rx PCN from Original Detail	10	45-54	X(10)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Rx ID Number from Original Detail	20	55-74	X(20)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Rx Group from Original Detail	15	75-89	X(15)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Contract Number	5	90- 94	X(5)	Contract Number from CMS	Critical Field This field contains the Contract Number of the beneficiary that does not have 4Rx data.
PBP Number	3	95- 97	X(3)	PBP Number from CMS	Critical Field This field contains the beneficiary PBP number but does not have 4Rx data.
PBP Enrollment Effective Date from Original Detail	8	98-105	X(8)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.

Field	Size	Position	Format	Valid Values	Description
Record Sequence Number from Original Detail	7	106-112	X(7)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Processed Flags	3	113-115	X(3)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Error Return Codes	36	116-151	X(36)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
Sending Entity from Original File	8	152-159	X(8)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
File Control Number from Original File	9	160-168	X(9)	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
File Creation Date	8	169-176	X(8)	YYYYMMDD	Critical Field This field contains the date the NoRx record was created.
Filler	574	177-750	X(574)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.

Total Length = 750

F.21.4 *Trailer Record*

Note: A "Critical Field" must contain a value. A "Not Critical Field" may contain a value or all spaces.

Field	Size	Position	Format	Valid Values	Description
File ID Name	8	1-8	X(8)	"CMSNRX0T"	Critical Field This field is always set to the value "CMSNRX0T." This code allows recognition of the record as the Trailer Record of a NoRx File.
Sending Entity	8	9-16	X(8)	"MBD " (MBD + 5 spaces)	Critical Field This field is always set to the value "MBD ". The value specifically is "MBD" followed by five spaces.
File Creation Date	8	17-24	X(8)	YYYYMMDD	Critical Field The date that CMS created the NoRx file. This value is formulated as YYYYMMDD.
File Control Number	9	25-33	X(9)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
File Record Count	7	34-40	9(7)	Numeric value greater than Zero.	Critical Field The total number of NoRx records on this file. This value is right-justified in the field with leading zeroes.
Filler	710	41-750	X(710)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.

Total Length = 750

F.22 MA Full Dual Auto Assignment Notification File

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

System	Type	Frequency	Dataset Naming Conventions
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

The following records are included in this file:

- Header Record — This first record of the file only occurs once.
- Detail Record (Transaction) — This record contains Beneficiary information and may occur multiple times.
- Trailer Record — This last record of the file only occurs once.

F.22.1 *Header Record*

Field	Size	Position	Format	Valid Values	Description
File ID Name	8	1-8	X(8)	"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.
Sending Entity: MBD	8	9-16	X(8)	"MBD " (MBD + 5 Spaces)	This is always set to the value "MBD ." The value specifically is MBD + 5 following Spaces. This value agrees with the corresponding value in the Trailer Record.
File Creation Date	8	17-24	X(8)	YYYYMMDD	The date on which the Full Dual File was created by CMS. This value is in the format of YYYYMMDD. For example, January 3, 2010 is the value 20100103. This value agrees with the corresponding value in the Trailer Record.
File Control Number	9	25-33	X(9)	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.
Filler	67	34-100	X(67)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for or used to store meaningful information, unless specifically documented otherwise.

Total Length = 100

F.22.2 *Detail Record (Transaction)*

Field Name	Size	Position
Contract Number (This field provides the Contract assigned to the beneficiary; CNTRCT_NUM in CME_SRVC_DEL_ELCT)	5	1-5
Run Date (This field provides the creation date of the file in YYYYMMDD format)	8	6-13
Filler (This field is all spaces)	6	14-19
Beneficiary's HICN/RRB (This field provides either the HICN or the RRB Number for identification of the individual; BENE_CAN_NUM and BIC_CD or RRB_HIC_NUM in CME_BENE)	12	20-31
Beneficiary's Surname (This field provides the last name of the individual; BENE_LAST_NAME in CME_BENE_NAME)	12	32-43
Initial of Beneficiary's First Name (This field provides the initial of the first name of the individual; BENE_1ST_NAME in CME_BENE_NAME)	1	44
Beneficiary's Gender (This field provides the gender of the individual; BENE_SEX_CD in MBD_BENE; '0', '1', or '2')	1	45
Beneficiary's Date of Birth (This field provides the date of birth of the individual in YYYYMMDD format; BENE_BIRTH_DT in CME_BENE)	8	46-53
Filler (This field is all spaces)	47	54-100

Total Length = 100

F.22.3 *Trailer Record*

Data Field	Size	Position	Format	Valid Values	Field Definition
File ID Name	8	1- 8	X(8)	"MMAADUAT"	This field is always set to the value "MMAADUAT." This code identifies the record as the Trailer Record of an Auto Assignment Full Dual Notification File.
Sending Entity MBD	8	9-16	X(8)	"MBD " (MBD + 5 Spaces)	This field is always set to the value "MBD ." The value specifically is MBD + 5 following Spaces. This value agrees with the corresponding value in the Header Record.
File Creation Date	8	17-24	X(8)	YYYYMMDD	The date on which the Full Dual Notification File was created by CMS. This value is formatted as YYYYMMDD. For example, January 3, 2010 is the value 20100103. This value agrees with the corresponding value in the Header Record.
File Control Number	9	25-33	X(9)	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.
Record Count	9	34-42	9(9)	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. This value does not include non-numeric characters, such as commas, spaces, dashes, decimals.
Filler	58	43-100	X(58)	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for or used to store meaningful information, unless specifically documented otherwise.

Total Length = 100

F.23 Auto Assignment Address Notification File

This file contains monthly addresses of Beneficiaries that are either AE, FE, or reassigned to PDPs. This file contains a header record, detail records, and a trailer record. Please see the Main Guide section 4.4.5 for details on its use.

System	Type	Frequency	Dataset Naming Conventions
MBD	Data File	Monthly	**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

- Header Record — This first record of the file only occurs once.
- Detail Record — This record contains Beneficiary information and may occur multiple times.
- Trailer Record — This last record of the file only occurs once.

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.

F.23.1 *Header Record*

Item	Field	Size	Position
1	Header Code (This field used for file/record identification purposes, 'MMAAPDPGH')	9	1-9
2	Sending Entity (This field used to identify the sending entity, 'MBD '(MBD + 5 spaces))	8	10-17
3	File Creation Date (The date the file was created in YYYYMMDD format)	8	18-25
4	File Control Number (Unique file identifier created by Sending Entity)	9	26-34
5	Filler (This field is all spaces)	581	35-615

Total Length = 615

F.23.2 *Detail Record*

Item	Field	Size	Position
1	Beneficiary's HICN (This field provides the HICN for identification of the individual)	12	1-12
2	Beneficiary's Last Name (This field provides the first twelve characters of the last name of the individual)	12	13-24
3	Beneficiary's First name (This field provides the first seven characters of the first name of the individual)	7	25-31
4	Beneficiary's Middle Initial (This field provides the middle initial of the individual)	1	32
5	Beneficiary's Gender (This field provides the gender of the individual; '0', '1', or '2')	1	33
6	Beneficiary's DOB (This field provides the date of birth of the individual in YYYYMMDD format)	8	34-41
7	Medicaid Indicator (This field indicates the beneficiary's Medicaid eligibility; this field will always contain the value of '1' to indicate 'Yes')	1	42
8	Contract Number (This field provides the Contract assigned to the beneficiary)	5	43-47
9	State Code (This field provides the beneficiary's state of residency)	2	48-49
10	County Code (This field provides the beneficiary's county of residency)	3	50-52
11	Filler (This field is all spaces)	7	53-59
12	TC (This field identifies the type of record; '61')	2	60-61
13	Filler (This field is all spaces)	1	62
14	Effective Date (The effective date of the assignment in YYYYMMDD format)	8	63-70
15	Filler (This field is all spaces)	1	71
16	PBP (This field notes the PBP of the auto-assigned contract)	3	72-74
17	Filler (This field is all spaces)	49	75-123
18	Application Date (The date of the application in YYYYMMDD format)	8	124-131
19	Filler (This field is all spaces)	30	132-161
20	Election Type (This field indicates the type of election; 'Z')	1	162
21	Enrollment Source (This field indicates the source of the enrollment; 'A' or 'C')	1	163
22	Filler (This field is all spaces)	1	164
23	Premium Withhold Option/Parts C-D (This field indicates the payment option for payment of Part C and D premiums; 'D')	1	165
24	Filler (This field is all spaces)	76	166-242
25	Part D Subsidy Level (This field identifies the portion of the Part D Premium subsidized; For monthly, value is always '100'; For Facilitated, values are either '100', '075', '050', or '025')	3	243-245
26	Co-Payment Category (This field indicates the Subsidy Co-Payment level for the beneficiary; '1' or '4')	1	246
27	Co-Payment Effective Date (This field is filler and is filled with zeroes)	8	247-254

Item	Field	Size	Position
28	Beneficiary Address Line 1 (First line in the mailing address)	40	255-294
29	Beneficiary Address Line 2 (Second line in the mailing address)	40	295-334
30	Beneficiary Address Line 3 (Third line in the mailing address)	40	335-374
31	Beneficiary Address Line 4 (Fourth line in the mailing address)	40	375-414
32	Beneficiary Address Line 5 (Fifth line in the mailing address)	40	415-454
33	Beneficiary Address Line 6 (Sixth line in the mailing address)	40	455-494
34	Beneficiary Address City (The city in the mailing address)	40	495-534
35	Beneficiary Address State (The state in the mailing address)	2	535-536
36	Beneficiary Zip Code (The zip code in the mailing address)	9	537-545
37	Full Last Name (This field provides the last name of the individual)	40	546-585
38	Full First Name (This field provides the first name of the individual)	30	586-615

Total Length = 615

F.23.3 *Trailer Record*

Item	Field	Size	Position
1	Trailer Code (This field used for file/record identification purposes, 'MMAAPDPGT')	9	1-9
2	Sending Entity (This field used to identify the sending entity, 'MBD '(MBD + 5 spaces))	8	10-17
3	File Creation Date (The date the file was created in YYYYMMDD format)	8	18-25
4	File Control Number (Unique file identifier created by Sending Entity)	9	26-34
5	Record Count (Number of Detail Records, right justified with leading zeroes)	9	35-43
6	Filler This field is all spaces	572	44-615

Total Length = 615

F.24 Plan Payment Report (PPR)/Interim Plan Payment Report (IPPR) Data File

Also known as the APPS Payment Letter, this data file itemizes the final monthly payment to the MCO. This data file and subsequent report is produced by the APPS when final payments are calculated. CMS makes this report available to MCOs as part of month-end processing.

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.

System	Type	Frequency	Dataset Naming Conventions
APPS	Data File	As needed	**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

F.24.1 *Header Record*

Item	Field	Position	Length	Type	Definition
1	Contract Number	1-5	5	Character	Contract Number
2	Record Identification Code	6-6	1	Character	Record Type Identifier H = Header Record
3	Contract Name	7-56	50	Character	Name of the Contract
4	Payment Cycle Date	57-62	6	Character	Identified the month and year of payment: Format = YYYYMM
5	Run Date	63-70	8	Character	Identifies the date file was created: Format = YYYYMMDD
6	Filler	71-200	130	Character	Spaces

Total Length = 200

F.24.2 *Capitated Payment – Current Activity*

Item	Field	Position	Length	Type	Description
7	Contract Number	1-5	5		Contract Number
8	Record Identification Code	6	1		Record Type Identifier C = Capitated Payment
9	Table ID Number	7	1		1
10	Adjustment Reason Code	8-9	2		Blank = for prospective pay **For list of adjustment reasons codes consult section H.3 of the Medicare Advantage and Prescription Drug Plan Communication Guide.**
11	Part A Total Members	10-17	8	Numeric	Number of beneficiaries Part A payments is being made prospectively. Format: ZZZZZZZ9
12	Part B Total Members	18-25	8	Numeric	Number of beneficiaries Part B payments is being made prospectively. Format: ZZZZZZZ9
13	Part D Total Members	26-33	8	Numeric	Number of beneficiaries Part D payments is being made prospectively. Format: ZZZZZZZ9
14	Part A Payment Amount	34-46	13	Numeric	Total Part A Amount Format: SSSSSSSSS9.99
15	Part B Payment Amount	47-59	13	Numeric	Total Part B Amount Format: SSSSSSSSS9.99
16	Part D Payment Amount	60-72	13	Numeric	Total Part D Amount Format: SSSSSSSSS9.99
17	Coverage Gap Discount Amount	73-85	13	Numeric	The Coverage Gap Discount included in Part D Payment. Format: SSSSSSSSS9.99
18	Total Payment	86- 98	13	Numeric	Total Payment Format: SSSSSSSSS9.99
19	Filler	99-200	102	Character	Spaces

Total Length = 200

F.24.3 *Premium Settlement*

Item	Field	Position	Length	Type	Description
20	Contract Number	1-5	5	Character	Contract Number
21	Record Identification Code	6	1	Character	Record Type Identifier P = Premium Settlement
22	Table ID Number	7	1	Character	2
23	Part C Premium Withholding Amount	8-20	13	Numeric	Total Part C Premium Amount Format: SSSSSSSSS9.99
24	Part D Premium Withholding Amount	21-33	13	Numeric	Total Part D Premium Amount Format: SSSSSSSSS9.99
25	Part D Low Income Premium Subsidy	34-46	13	Numeric	Total Low Income Premium Subsidy Format: SSSSSSSSS9.99
26	Part D Late Enrollment Penalty	47-59	13	Numeric	Total Late Enrollment Penalty Format: SSSSSSSSS9.99
27	Total Premium Settlement Amount	60-72	13	Numeric	Total Premium Settlement Format: SSSSSSSSS9.99
28	Filler	73-200	128	Character	Spaces

Total Length = 200

F.24.4 *Fees*

Item	**Field**	**Position**	**Length**	**Type**	**Description**
29	Contract Number	1-5	5	Character	Contract Number
30	Record Identification Code	6	1	Character	Record Type Identifier F = FEES
31	Table ID Number	7	1	Character	3
32	NMEC Part A Subject to Fee	8-20	13	Numeric	Part A amount subject to National Medicare Educational Campaign fees. Format:ZZZZZZZZZ9.99
33	NMEC Part A Rate	21-27	7	Numeric	Rate used to calculate the fees for Part A. Format: 0.99999
34	Part A Fee Amount	28-40	13	Numeric	Fee Assessed for Part A Format:SSSSSSSSS9.99
35	NMEC Part B Subject to Fee	41-53	13	Numeric	Part B amount subject to National Medicare Educational Campaign fees. Format: ZZZZZZZZZ9.99
36	NMEC Part B Rate	54-60	7	Numeric	Rate used to calculate the fees for Part B. Format: 0.99999
37	Part B Fee Amount	61-73	13	Numeric	Fee Assessed for Part B Format: SSSSSSSSS9.99

Item	Field	Position	Length	Type	Description
38	NMEC Part D Subject to Fee	74-86	13	Numeric	Part D amount subject to National Medicare Educational Campaign fees. Format: ZZZZZZZZZ9.99
39	NMEC Part D Rate	87-93	7	Numeric	Rate used to calculate the fees for Part D. Format: 0.99999
40	Part D Fee Amount	94-106	13	Numeric	Fee Assessed for Part D Format: SSSSSSSSS9.99
41	Total NMEC Fee Assessed	107- 119	13	Numeric	Total NMEC Fee Assessed for Part A, B and D Format: SSSSSSSSS9.99
42	Total Prospective Part D Members	120- 127	8	Numeric	Total members for Part D Format: ZZZZZZZ9
43	Rate for COB Fees	128- 131	4	Numeric	Rate used to calculate the COB fees. Format: 0.99
44	Amount of COB Fees	132- 144	13	Numeric	COB Fee Format: SSSSSSSSS9.99
45	Total of Assessed Fees	145- 157	13	Numeric	Total of all Fees Assessments Format: SSSSSSSSS9.99
46	Filler	158- 200	43	Character	Spaces

Total Length = 200

F.24.5 *Special Adjustments*

Item	Field	Position	Length	Type	Description
47	Contract Number	1 – 5	5	Character	Contract Number
48	Record Identification Code	6 – 6	1	Character	Record Type Identifier S = Special Adjustments
49	Table ID Number	7 – 7	1	Character	4
50	Document ID	8 – 15	8	Numeric	The document ID for identifying the adjustment.
51	Source	16-20	5	Character	The CMS division responsible for initiating the adjustments.
52	Description	21 – 70	50	Character	The reason the adjustment was made.
53	Type	71 – 90	20	Character	The payment component the adjustment is for: • CGD=Coverage Gap Discount Invoice • CMP=Civil Monetary Penalty • CST=Cost Plan Adjustment • PTD=Part D Risk Adjustment • PRS=Annual Part D Reconciliation • RAC=Recovery Audit Contract Adjustment • RSK=Risk Adjustment • HTC=HITECH Incentive Payment • OTH=default non-specific group.
54	Adjustment to Part A	91 – 103	13	Numeric	Adjustment amount for Part A Format: SSSSSSSSS9.99
55	Adjustment to Part B	104 – 116	13	Numeric	Adjustment amount for Part B Format: SSSSSSSSS9.99

Item	Field	Position	Length	Type	Description
56	Adjustment to Part D or Adjustment to HITECH Incentive Payment	117 – 129	13	Numeric	Adjustment amount for HITECH Incentive Payment when the adjustment type in data item 53 is "HTC". The adjustment amount is for Part D for the rest of the types. Format: SSSSSSSSS9.99
57	Premium C Withholding Part A	130 – 142	13	Numeric	Adjustment amount for Premium Withholding Part A. Format: SSSSSSSSS9.99
58	Premium C Withholding Part B	143 – 155	13	Numeric	Adjustment amount for Premium Withholding Part B. Format: SSSSSSSSS9.99
59	Premium D Withholding	156 – 168	13	Numeric	Adjustment amount for Premium D Withholding. Format: SSSSSSSSS9.99
60	Part D Low Income Premium Subsidy	169 – 181	13	Numeric	Adjustment amount for Low Income Subsidy. Format: SSSSSSSSS9.99
61	Total Adjustment Amount	182 – 194	13	Numeric	Total Adjustments Format: SSSSSSSSS9.99
62	Filler	195 – 200	6	Character	Spaces

Total Length = 200

F.24.6 *Previous Cycle Balance Summary*

Item	Field	Position	Length	Type	Description
63	Contract Number	1 – 5	5	Character	Contract Number
64	Record Identification Code	6 – 6	1	Character	Record Type Identifier L = Last Period Carry Over Amounts carried over to this month from previous months
65	Table ID Number	7 – 7	1	Character	5
66	Part A Carry Over Amount	8 – 20	13	Numeric	Part A Carry Over Amount from Table 5**- Previous Balance Column. Format: SSSSSSSSS9.99
67	Part B Carry Over Amount	21 – 33	13	Numeric	Part B Carry Over Amount from Table 5**- Previous Balance Column. Format: SSSSSSSSS9.99
68	Part D Carry Over Amount	34 – 46	13	Numeric	Part D Carry Over Amount from Table 5**- Previous Balance Column. Format: SSSSSSSSS9.99
69	Part C Premium Withholding Carry Over Amount	47 – 59	13	Numeric	Part C Premium Withholding Carry Over Amount from Table 5**- Previous Balance Column. Format: SSSSSSSSS9.99
70	Part D Premium Withholding Carry Over Amount	60 – 72	13	Numeric	Part D Premium Withholding Carry Over Amount from Table 5**- Previous Balance Column. Format: SSSSSSSSS9.99

Item	Field	Position	Length	Type	Description
71	Part D Low Income Premium Subsidy Carry Over Amount	73 – 85	13	Numeric	Part D Low Income Premium Subsidy Carry Over Amount from Table 5**- Previous Balance Column. Format: SSSSSSSSS9.99
72	Part D Late Enrollment Penalty Carry Over Amount	86 – 98	13	Numeric	Part D Late Enrollment Penalty Carry Over Amount from Table 5**- Previous Balance Column. Format: SSSSSSSSS9.99
73	Education User Fee Carry Over Amount	99 – 111	13	Numeric	Education User Fee Carry Over Amount from Table 5**- Previous Balance Column. Format: SSSSSSSSS9.99
74	Part D COB User Fee Carry Over Amount	112 – 124	13	Numeric	Part D COB User Fee Carry Over Amount from Table 5**- Previous Balance Column. Format:SSSSSSSSS9.99
75	CMS Special Adjustments Carry Over Amount	125 – 137	13	Numeric	CMS Special Adjustments Carry Over Amount from Table 5**- Previous Balance Column. Format: SSSSSSSSS9.99
76	Total Carry Over Amount	138 – 150	13	Numeric	Sum of amounts in Previous Balance Column Format: SSSSSSSSS9.99
77	Filler	151 – 200	50	Character	Spaces.

Total Length = 200

F.24.7 *Payment Summary*

Item	Field	Position	Length	Type	Description
78	Contract Number	1 – 5	5	Character	Contract Number
79	Record Identification Code	6 – 6	1	Character	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).
80	Table ID Number	7 – 7	1	Character	5
81	Part A Amount	8 – 20	13	Numeric	Part A amount from Table 5**-Net Payment Column. Format: ZZZZZZZZZ9.99
82	Part B Amount	21 – 33	13	Numeric	Part B amount from Table 5**-Net Payment Column. Format: ZZZZZZZZZ9.99
83	Part D Amount	34 – 46	13	Numeric	Part D amount from Table 5**-Net Payment Column. Format: ZZZZZZZZZ9.99
84	Part C Premium Withholding Amount	47 – 59	13	Numeric	Part C Premium Withholding Amount from Table 5**-Net Payment Column. Format: ZZZZZZZZZ9.99

Item	Field	Position	Length	Type	Description
85	Part D Premium Withholding Amount	60 – 72	13	Numeric	Part D Premium Withholding Amount from Table 5**-Net Payment Column. Format: ZZZZZZZZZ9.99
86	Part D Low Income Premium Subsidy Amount	73 – 85	13	Numeric	Part D Low Income Subsidy Amount from Table 5**-Net Payment Column. Format: ZZZZZZZZZ9.99
87	Part D Late Enrollment Penalty Amount	86 – 98	13	Numeric	Part D Late Enrollment Penalty Amount from Table 5**-Net Payment Column. Format: SSSSSSSSS9.99
88	Education User Fee Amount	99 – 111	13	Numeric	Education User Fee Amount from Table 5**-Net Payment Column. Format: SSSSSSSSS9.99
89	Part D COB User Fee Amount	112 – 124	13	Numeric	Part B COB Fee Amount from Table 5**-Net Payment Column. Format: SSSSSSSSS9.99
90	CMS Special Adjustments Amount	125 – 137	13	Numeric	CMS Special Adjustments Amount from Table 5**-Net Payment Column. Format: SSSSSSSSS9.99
91	Total Net Payment	138 – 150	13	Numeric	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 is carried forward. Format: SSSSSSSSS9.99
92	Filler	151 – 200	50	Character	Spaces.

Total Length = 200

F.24.8 *Payment Balance Carried Forward*

Item	Data Element	Position	Length	Type	Description
93	Contract Number	1 – 5	5	Character	Contract Number
94	Record Identification Code	6 – 6	1	Character	Record Type Identifier N = Balance Carried Forward to Next Cycle. Amounts carried forward (and not paid) to next month from this month
95	Table ID Number	7 – 7	1	Character	5
96	Part A Amount Carry Forward to Next Cycle	8 – 20	13	Numeric	Part A Amount Carry Forward from Table 5**-Balance Forward Column. Format: SSSSSSSSS9.99
97	Part B Amount Carry Forward to Next Cycle	21 – 33	13	Numeric	Part B Amount Carry Forward from Table 5**-Balance Forward Column. Format: SSSSSSSSS9.99
98	Part D Amount Carry Forward to Next Cycle	34 – 46	13	Numeric	Part D Amount Carry Forward from Table 5**-Balance Forward Column. Format: SSSSSSSSS9.99
99	Part C Premium Withholding Amount Carry Forward to Next Cycle	47 – 59	13	Numeric	Part C Premium Withholding Amount Carry Forward from Table 5**-Balance Forward Column. Format: SSSSSSSSS9.99
100	Part D Premium Withholding Amount Carry Forward to Next Cycle	60 – 72	13	Numeric	Part D Premium Withholding Amount Carry Forward from Table 5**-Balance Forward Column. Format: SSSSSSSSS9.99
101	Part D Low Income Premium Subsidy Amount Carry Forward to Next Cycle	73 – 85	13	Numeric	Part D Low Income Subsidy Amount Carry Forward from Table 5**-Balance Forward Column. Format: SSSSSSSSS9.99
102	Part D Late Enrollment Penalty Amount Carry Forward to Next Cycle	86 – 98	13	Numeric	Part D Late Enrollment Penalty Amount Carry Forward from Table 5**-Balance Forward Column. Format: SSSSSSSSS9.99
103	Education User Fee Amount Carry Forward to Next Cycle	99 – 111	13	Numeric	Education User Fee Amount Carry Forward from Table 5**-Balance Forward Column. Format: SSSSSSSSS9.99
104	Part D COB User Fee Amount Carry Forward to Next Cycle	112 – 124	13	Numeric	Part B COB Fee Amount Carry Forward from Table 5**-Balance Forward Column. Format:SSSSSSSSS9.99

Item	Data Element	Position	Length	Type	Description
105	CMS Special Adjustments Amount Carry Forward to Next Cycle	125 – 137	13	Numeric	CMS Special Adjustments Amount Carry Forward from Table 5**-Balance Forward Column. Format: SSSSSSSSS9.99
106	Total Carry Forward Amount	138 – 150	13	Numeric	Sum of amounts in Balance Forward Column Format: SSSSSSSSS9.99
107	Filler	151 – 200	50	Character	Spaces.

Total Length = 200

F.25 Agent Broker Compensation Report Data File

For Plan enrollments, MARx establishes a status of initial or renewal as well as a compensation cycle, which provides Plans with the information necessary to determine how to pay agents for specific Beneficiary enrollments. Plans can 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 on are the renewal years. Plans are responsible for using this information in conjunction with their internal payment and enrollment tracking systems to determine an agent's use and how much to pay the agent.

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

System	Type	Frequency	Dataset Naming Conventions
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

Item	Field	Length	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	HICN	12	10-21	Health Insurance Claim Number
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 YYYYMMDD Format
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). Format: YYYYMMDD;

Item	Field	Length	Position	Description
				otherwise, spaces if not applicable.
11	Enrollment Effective Start Date	8	59-66	Date Beneficiary's Plan enrollment starts, YYYYMMDD – Format.
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' – Initial 'R' – Renewal Blank -
13	Report Generation Date	8	68-75	Date data file created YYYYMMDD – Format
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.
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

Item	Field	Length	Position	Description
				"COST/PD" = Medicare COST Plan providing prescription drugs "PDP" = Prescription Drug Plan
17	Correction Indicator	2	89-90	'R' – Retroactive enrollment ○ Any enrollment processed by MARx after the effective date of the enrollment 'ER' – Enrollment reinstated ○ An disenrollment cancellation was processed by MARx ○ A cancelled enrollment reinstated a previous enrollment 'IR' – Change in Initial or Renewal ○ 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 Blank – the enrollment does not have a corrected field
18	Filler	60	91-150	Spaces

Total Length = 150

Agent Broker Compensation Data File - Trailer Record

Item	Field	Length	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

Total Length = 150

F.26 Monthly Medicare Secondary Payer (MSP) Information Data File

A Medicare Secondary Payment (MSP) data 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.

In the August 2015 release, the file layout was modified so that it is easier for the Plans to process. The record length was reduced from 11000 characters to 700 characters in length for each record. The file has four record types:

- A Header Record
- A Trailer Record
- A PRIMARY Record
- A DETAIL 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	Dataset Naming Conventions
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

F.26.1 *Header Record*

Item	Field Name	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

Total Length = 700

F.26.2 *Primary Record*

Item	Field Name	Size	Position	Description
1.	Record Type	3	1-3	"PRM"
2.	HICN	12	4-15	RRB # or HICN
3.	Detail Count	2	16-17	This is the count of MSP DET records that exist for each beneficiary
4.	Date of Birth	8	18-25	CCYYMMDD
5.	Sex 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.

Item	Field Name	Size	Position	Description
8.	MSP Factor	7	35-41	Layout (00.0000)
9.	PTA RDAMT SIGN	1	42	"-" = Negative blank = Positive
10.	PTA RDAMT	9	43-51	Layout (999999.99)
11.	PTB RDAMT SIGN	1	52	"-" = Negative blank = Positive
12.	PTB RDAMT	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.

Item	Field Name	Size	Position	Description
14.	MSP Factor ADJ1	7	63-69	Layout (00.0000)
15.	PTA RDAMT SIGN ADJ1	1	70	"-" = Negative blank = Positive
16.	PTA RDAMT ADJ1	9	71-79	Layout (999999.99)
17.	PTB RDAMT SIGN ADJ1	1	80	"-" = Negative blank = Positive
18.	PTB RDAMT ADJ1	9	81-89	Layout (999999.99)
19.	PAID FLAG ADJ1	1	90	Y = Yes, it was paid N = No, it was not paid
20.	MSP Factor ADJ2	7	91-97	Layout (00.0000)

Item	Field Name	Size	Position	Description
21.	PTA RDAMT SIGN ADJ2	1	98	"-" = Negative blank = Positive
22.	PTA RDAMT ADJ2	9	99-107	Layout (999999.99)
23.	PTB RDAMT SIGN ADJ2	1	108	"-" = Negative blank = Positive
24.	PTB RDAMT ADJ2	9	109-117	Layout (999999.99)
25.	PAID FLAG ADJ2	1	118	Y = Yes, it was paid N = No, it was not paid
26.	MSP Factor ADJ3	7	119-125	Layout (00.0000)
27.	PTA RDAMT SIGN ADJ3	1	126	"-" = Negative blank = Positive
28.	PTA RDAMT ADJ3	9	127-135	Layout (999999.99)
29.	PTB RDAMT SIGN ADJ3	1	136	"-" = Negative blank = Positive
30.	PTB RDAMT ADJ3	9	137-145	Layout (999999.99)
31.	PAID FLAG ADJ3	1	146	Y = Yes, it was paid N = No, it was not paid
32.	MSP Factor ADJ4	7	147-153	Layout (00.0000)
33.	PTA RDAMT SIGN ADJ4	1	154	"-" = Negative blank = Positive
34.	PTA RDAMT ADJ4	9	155-163	Layout (999999.99)
35.	PTB RDAMT SIGN ADJ4	1	164	"-" = Negative blank = Positive
36.	PTB RDAMT ADJ4	9	165-173	Layout (999999.99)
37.	PAID FLAG ADJ4	1	174	Y = Yes, it was paid N = No, it was not paid
38.	Filler	526	175-700	Spaces

Total Length = 700

F.26.3 Detail Record

Item	Field Name	Size	Position	Description
1.	Record Type	5	1-5	Value: DET## (## = number of the MSP occurrence. 01 through 17)
2.	HICN	12	6-17	RRB # or HICN
3.	Delete Ind	1	18	D = occurrence to be deleted or audited
4.	Validity Ind	1	19	I = FI/Carrier added occurrence N = Beneficiary does not have MSP coverage Y = COBC 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

Item	Field Name	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
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	The first line of the insurer's mailing street address.
15.	Insurer Address 2	32	118-149	The second line of the insurer's mailing street address.
16.	Insurer City	15	150-164	The name of the city for the insurer's mailing address.
17.	Insurer State Code	2	165-166	The postal state code for the insurer's mailing address.
18.	Insurer Zip Code	9	167-175	The zip code associated with the address.
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

Item	Field Name	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

Item	Field Name	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

Item	Field Name	Size	Position	Description
31.	Employer City	15	347-361	The name of employer's city
32.	Employer State	2	362-363	Employer's state code
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

Item	Field Name	Size	Position	Description
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
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
68.	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

Item	Field Name	Size	Position	Description
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

Total Length = 700

F.26.4 *Trailer Record*

Item	Field Name	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

Total Length = 700

F.27 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. The records in this file are the same length as those in the DTRR and contain their own unique Payment Reply Codes (PRCs) found in Table I-5.

System	Type	Frequency	Dataset Naming Conventions
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

Field	Size	Position	Description
1.HICN	12	1-12	Beneficiary's HICN, included with PRC 264
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, formatted YYYYMMDD, included with PRC 264
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, formatted YYYYMMDD and included with PRC 264
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, formatted YYYYMMDD and included with both PRC 000 and PRC 264
19. FILLER	1	84	Spaces
20. CPM	12	85- 96	CPM, formatted YYYYMM, left justified with six spaces completing the field, and included with both PRC 000 and PRC 264, and PRC 299
21. FILLER	38	97-134	Spaces
22. Segment Number	3	135-137	Segment in PBP, included with PRC 264

Field	Size	Position	Description
23. FILLER	25	138-162	Spaces
24. Processing Timestamp	15	163-177	Report generation time, formatted HH.MM.SS.SSSSSS and included with both PRC 000 and PRC 264
25. FILLER	188	178-365	Spaces
26. PRC Short Name	15	366-380	PRC short name associated with PRC 000 is “NO REPORT,” with PRC 264 is “NO PAYMENT,” and with PRC 299 is “RESTORED PYMT.” Text is left justified with following spaces completing the field.
27. FILLER	120	381-500	Spaces

Total Length = 500

F.28 MSA Deposit-Recovery Data File Layout

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.

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.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

There are three types of records on the MSA Deposit data file: Header, Detail and Trailer.

- Header Record –
  - Record ID = 'HDR', provides Contract number and pertinent dates for the file
- 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
- 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).

F.28.1 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 YYYYMMDD
4.	Payment Date	6	17-22	YYYYMM
5.	Filler	143	23-165	Spaces

Total Length = 165

F.28.2 Detail Record

Item	Field	Size	Position	Description
	Record ID	3	1-3	DPT = MSA Deposit Record RCV = MSA Recovery Record
	MCO Contract Number	5	4-8	MCO Contract Number
	Plan Benefit Package ID	3	9-11	Plan Benefit Package ID Format: 999
	HIC Number	12	12-23	Member's HIC Number
	Surname	7	24-30	Surname
	First Initial	1	31	First Initial
	Sex	1	32	M = Male F = Female
	Date of Birth	8	33-40	YYYYMMDD
	Filler	1	41	Blank
	Disenrollment Reason Code	2	42-43	Disenrollment Reason Code associated with the Recovery Blank for a Deposit record
	MSA Deposit or Recovery Start Date	8	44-51	Start Date for Deposit or Recovery entry YYYYMMDD

Item	Field	Size	Position	Description
	MSA Deposit or Recovery End Date	8	52-59	End Date for Deposit or Recovery entry YYYYMMDD
	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. Format: 99
	Part A Monthly Deposit Rate	7	62-68	The Medicare Part A dollar amount that is deposited monthly into the beneficiaries MSA Account. Format: 9999.99
	Part B Monthly Deposit Rate	7	69-75	The Medicare Part B dollar amount that is deposited monthly into the beneficiaries MSA Account. Format: 9999.99
	Lump-Sum MSA Deposit or Recovery Part A amount	9	76-84	Part A Lump Sum Amount provided to plan for bene's MSA enrollment. For disenrollment, Part A Lump Sum amount to be recovered from Plan Format: -99999.99 **NOTE**: A Recovery will be reported as a negative amount. A Deposit will be reported as a positive amount
	Lump-Sum MSA Deposit or Recovery Part B amount	9	85-93	Part B Lump Sum Amount provided to plan for bene's MSA enrollment. For disenrollment, Part A Lump Sum amount to be recovered from Plan. Format: -99999.99 **NOTE**: A Recovery will be reported as a negative amount. A Deposit will be reported as a positive amount
	Filler	72	94-165	Blanks

Total Length = 165

F.28.3 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 Blank on TR2
4.	Beneficiary Count	7	12-18	TR1 - Distinct count of beneficiaries based on HICNs reported this month for the PBP TR2 – Sum of beneficiaries reported TR1 records Format: 9999999
5.	Detail Record Count	7	19-25	Count of Deposit and Recovery records for the PBP (TR1) or all PBPs (TR2) Format: 9999999
6.	PBP Count	4	26-29	Blank on TR1 Count of TR1 records for the contract Format: 9999
7.	Filler	2	30-31	Spaces
8.	Part A Total Deposit Amount	13	32-44	Total Part A Lump-Sum MSA Deposit amount Format: 9999999999.99
9.	Part B Total Deposit Amount	13	45-57	Total Part B Lump-Sum MSA Deposit amount Format: 9999999999.99
10.	Part A Total Recovery Amount	14	59-71	Total Part A Lump-Sum MSA Recovery amount Format: -9999999999.99
11.	Part B Total Recovery Amount	14	72-85	Total Part B Lump-Sum MSA Recovery amount Format: -9999999999.99
12.	Total Amount	15	86-100	Sum of all amounts on record Format: -99999999999.99
13.	Filler	69	101-165	Spaces

Total Length = 165

Yearly Record Layouts

F.29 Loss of Subsidy Data 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	Dataset Naming Conventions
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

F.29.1 *LIS Data File Detail Record*

Item	Field	Size	Position	Description
1	HICN	12	1-12	Health Insurance Claim Number
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	YYYYMMDD – Format
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	TRC '996'

13	Transaction Type Code	2	60-61	Transaction Type Code '01'
14	Filler	1	62	Spaces
15	Effective Date	8	63-70	YYYYMMDD – Format is 01/01 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 (YYYYMMDD), is the run date.
20	Filler	1	84	Spaces
21	Low-Income Subsidy End Date	8	85-92	End Date of Beneficiary's LIS Period (YYYYMMDD), is 12/31 of the current year.
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

Total Length = 500

F.30 Long-Term Institutionalized (LTI) Resident Report Data 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 will release the LTI report twice yearly. 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.

This report is distributed to each Part D sponsor through the secure CMS Enterprise File Transfer (EFT) process. The report is retrieved using Gentran or Connect:Direct service.

System	Type	Frequency	Dataset Naming Conventions
MDS	Report	Twice Yearly	**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

Item	Field	Type	Length	Position	Description
1	Part D Contract Number	CHAR	5	1-5	Part D Contract Number associated with the resident during the month of the last nursing home assessment date.
2	Part D Plan Number	CHAR	3	6-8	Part D Plan Number associated with the resident during the month of the last nursing home assessment date.
3	Part D Plan Name	CHAR	50	9-58	Part D Plan Name associated with the resident during the month of the last nursing home assessment date.
4	Last Name	CHAR	24	59-82	Beneficiary Last Name
5	First Name	CHAR	15	83-97	Beneficiary First Name
6	HICN	CHAR	12	98-109	HICN associated with the resident.
7	Date of Birth	DATE	8	110-117	Beneficiary's Date of Birth YYYYMMDD – Format
8	Gender	CHAR	1	118	Beneficiary Gender Code 1 = Male 2 = Female 0 = Unknown
9	Nursing Home Length of Stay	CHAR	6	119-124	Nursing Home Length of Stay in days (0 – 999999) at the time of the last Nursing Home assessment.

Item	Field	Type	Length	Position	Description
10	Nursing Home Admission Date	DATE	8	125-132	Admission date associated with the last assessment for the resident. YYYYMMDD – Format
11	Last Nursing Home Assessment Date	DATE	8	133-140	Target date of the last assessment for the resident. YYYYMMDD – Format
12	Prospective Payment System (PPS) Indicator	CHAR	1	141	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	CHAR	50	142-191	Name of Nursing Home associated with the last assessment for the resident.
14	Medicare Provider ID	CHAR	12	192-203	Medicare Provider ID of Nursing Home associated with the last assessment for the resident.
15	Provider Telephone Number	CHAR	13	204-216	Telephone Number of Nursing Home associated with the last assessment for the resident.
16	Provider Address	CHAR	50	217-266	Address of Nursing Home associated with the last assessment for the resident.
17	Provider City	CHAR	20	267-286	City of Nursing Home associated with the last assessment for the resident.
18	Provider State Code	CHAR	2	287-288	State Code of Nursing Home associated with the last assessment for the resident.
19	Provider Zip Code	CHAR	11	289-299	Zip Code of Nursing Home associated with the last assessment for the resident.

Total Length = 299

F.31 No Premium Due Data File Layout

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 Update (TC 78) to update the Part C premium Amount, and a PPO Update (TC 75) to request SSA Withholding Status, for enrollees who are renewing both elections for the next year.

System	Type	Frequency	Dataset Naming Conventions
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

Field	Size	Position	Description
HICN	12	1-12	Health Insurance Claim Number
Surname	12	13-24	Beneficiary Surname
First Name	7	25-31	Beneficiary Given Name
Middle Initial	1	32	Beneficiary Middle Initial
Gender Code	1	33	Beneficiary Gender Identification Code '0' = Unknown; '1' = Male; '2' = Female.
Date of Birth	8	34-41	YYYYMMDD – Format
Filler	1	42	Space
Contract Number	5	43-47	Plan Contract Number
State Code	2	48-49	Spaces
County Code	3	50-52	Spaces
Disability Indicator	1	53	Space
Hospice Indicator	1	54	Space
Institutional/NHC Indicator	1	55	Space
ESRD Indicator	1	56	Space
TRC	3	57-59	TRC Defaulted to '267'
Transaction Code	2	60-61	TC Defaulted to '01' for special reports
Entitlement Type Code	1	62	Space
Effective Date	8	63-70	YYYYMMDD – Format; Example: 20110101 (set to first of January of the upcoming year)
WA Indicator	1	71	Space

Field	Size	Position	Description
PBP ID	3	72-74	PBP number
Filler	1	75	Space
Transaction Date	8	76-83	YYYYMMDD – Format; Set to the report generation date.
UI Initiated Change Flag	1	84	Space
FILLER	12	85-96	Spaces
District Office Code	3	97-99	Spaces
Previous Part D Contract/PBP for TrOOP Transfer.	8	100-107	Spaces
End Date	8	108-115	Spaces
Source ID	5	116-120	Spaces
Prior PBP ID	3	121-123	Spaces
Application Date	8	124-131	Spaces
UI User Organization Designation	2	132-133	Spaces
Out of Area Flag	1	134	Space
Segment Number	3	135-137	Further definition of PBP by geographic boundaries; Default to '000' when blank.
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
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
Election Type	1	154	Space
Enrollment Source	1	155	Space
Part D Opt-Out Flag	1	156	Space
Premium Withhold Option/Parts C-D	1	157	'N' = No premium applicable;
Number of Uncovered Months	3	158-160	Spaces
Creditable Coverage Flag	1	161	Space
Employer Subsidy Override Flag	1	162	Space
Processing Timestamp	15	163-177	The report generation time. Format: HH.MM.SS.SSSSSS
Filler	20	178-197	Spaces
Secondary Drug Insurance Flag	1	198	Space
Secondary Rx ID	20	199-218	Spaces
Secondary Rx Group	15	219-233	Spaces
EGHP	1	234	Space
Part D LIPS Level	3	235-237	Spaces
Low-Income Co-Pay Category	1	238	Space
Low-Income Period Effective Date	8	239-246	Spaces
Part D LEP Amount	8	247-254	Spaces
Part D LEP Waived Amount	8	255-262	Spaces
Part D LEP Subsidy Amount	8	263-270	Spaces
Low-Income Part D Premium Subsidy Amount	8	271-278	Spaces
Part D Rx BIN	6	279-284	Spaces
Part D Rx PCN	10	285-294	Spaces
Part D Rx Group	15	295-309	Spaces

Field	Size	Position	Description
Part D Rx ID	20	310-329	Spaces
Secondary Rx BIN	6	330-335	Spaces
Secondary Rx PCN	10	336-345	Spaces
De Minimis Differential Amount	8	346-353	Spaces
MSP Status Flag	1	354	Space
Low Income Period End Date	8	355-362	Spaces
LIS Source Code	1	363	Space
Enrollee Type Flag, PBP Level	1	364	Space
Application Date Indicator	1	365	Space
Filler	135	366-500	Spaces

Total Length = 500

G: *Screen Hierarchy*

The Common User Interface (UI) screens are accessed via the drill-down method of navigation. Functions are grouped together under a common menu item. For example, most of the Beneficiary-specific information is found under the Beneficiary menu item. **Table G-1** lists the names of the Common UI screens accessible to Managed Care Organizations (MCOs) and their screen numbers, for reference only.

Table G-1: Screen Lookup Table

Screen Name	Screen Number
Logon, Logoff, and Welcome Screens	
MARx Logout	
User Security Role Selection	M002
Welcome	M101
MARx Calendar	M105
Beneficiaries Screens	
Beneficiaries: Find	M201
Beneficiaries: Search Results	M202
Beneficiary Detail: Snapshot	M203
Beneficiary Detail: Enrollment	M204
Beneficiary Detail: Payments	M206
Beneficiary Detail: Adjustments	M207
Beneficiaries: New Enrollment	M212
Payment/Adjustment Detail	M215
Beneficiary Detail: Factors	M220
Beneficiaries: Update Enrollment	M221
Enrollment Detail	M222
Beneficiary Detail: Update Premiums	M226
Rx Insurance View	M228
Beneficiaries: Additional Update Enrollment	M230
Beneficiary Detail: Premiums	M231
Beneficiaries: Eligibility	M232
Beneficiary Detail: Utilization	M233
Part D AE-FE Opt-Out	M234
Beneficiary Detail: MSA Lump Sum	M235
Beneficiary Detail: SSA/RRB Transaction Status	M237
Update Premium Withhold Collection	M240
Update SSA R&R	M241
Update Residence Address View	M242
Residence Address View	M243
Rx Insurance View	M244
Update POS Drug Edit	M254
Status Activity	M256

Screen Name	Screen Number
Status Activity Detail	M257
Transactions Screens	
Transactions: Batch Status	M307
Batch File Details	M314
Special Batch Approval Request	M316
View Special Batch File Request	M317
Payments Screens	
Payments: MCO	M401
Payments: MCO Payments	M402
Payments: Beneficiary	M403
Payments: Beneficiary Search Results	M404
Beneficiary Payment History	M406
Adjustment Detail	M408
Payments: Premiums and Rebates	M409
Reports Screens	
Reports: Find	M601
Reports: Search Results	M602

H: *Validation Messages*

Table H-1 lists validation messages that appear directly on the screen during data entry/processing in the status line (the line just below the title line, as in **Figure H-1**).

Figure H-1: 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 H-1: Validation Messages

Error Messages	Suggested Action
User must enter a contract number	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.
User must enter a sex	Enter the field specified by the message.
User must select a state	Enter the field specified by 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/YYYY	Re-enter the field and follow the format indicated in the message.
User must enter <kind of date>	Enter the field specified by 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.
Please enter user ID or password	Make sure to enter one of the fields specified by the message.
Segment number must have three digits	Re-enter the field and follow the format indicated in the message.
The claim number is not a valid SSA or RRB number, or CMS Internal number	Re-enter the field in SSA, RRB, or CMS Internal format.
The last name contains invalid characters	Re-enter the field using only letters, apostrophes, hyphens, or blanks.
The user ID contains invalid characters	Re-enter the field and follow the format indicated in the message.
You do not have access rights to this contract	First, make sure that the Contract # correctly is entered correctly. If not, re-enter it. If the user did, he/she should have rights to this contract; see the Security Administrator who can update the user profile for these rights.

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I: *Codes*

This appendix lists the numerical value and descriptions for codes that are highly visible to users.

I.1 Transaction Codes

Table I-1 lists the Medicare Advantage and Prescription Drug System (MARx) Transaction Codes and the description of each code.

Table I-1: Transaction Codes

Code	Description
01	MCO Correction
30	Turn Bene-Level Demonstration Factor On (Demos Only)
31	Turn Bene-Level Demonstration Factor Off (Demos Only)
41	Update to Opt-Out Flag (Submitted by CMS)
42	MMP Opt-Out Change (Submitted by 1-800 MEDICARE)
51	Disenrollment (MCO or CMS)
54	Disenrollment (Submitted by 1-800-MEDICARE)
61	Enrollment
72	4Rx Record Update
73	NUNCMO Record Update
74	EGHP s Record Update
75	Premium Payment Option (PPO) Update
76	Residence Address Record Update
77	Segment ID Record Update
78	Part C Premium Record Update
79	Part D Opt-Out Record Update
80	Cancellation of Enrollment
81	Cancellation of Disenrollment
82	MMP Enrollment Cancellation
83	MMP Opt-Out Update
90	POS Drug Edit

I.2 Transaction Reply Codes (TRCs)

Table I-2 lists the reply codes returned for transactions found in Table I-1.

TRC Types:

A -	Accepted -	A transaction is accepted and the requested action is applied (Example: enrollment or disenrollment)
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 claim number, a reply is included in the Plan's TRR with TRC 086, giving the Plan the new claim number.
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.

Legend for Type: A = Accepted R = Rejected I = Informational
M = Maintenance F = Failed

Table I-2: 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 and 90. 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 and 90) 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.

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, and 90) 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 and 90) 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 Claim Number	BAD HICN FORMAT	A transaction (Transaction Types 01, 51, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83 and 90) was rejected, because the beneficiary claim number was not in a valid format. The valid format for a claim number could take one of two forms: • 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 alpha and the last 6 or 9 positions numeric. **Plan Action:** Determine the correct claim number (HICN or RRB) for the beneficiary and resubmit the transaction if appropriate.
008	R	Beneficiary Claim Number Not Found	CLAIM NOT FOUND	A transaction (Transaction Types 01, 51, 61, 72**,** 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, and 83) was rejected, because a beneficiary with this claim number was not found. The Plan must resubmit the transaction with a valid claim number. **Plan Action:** Determine the correct claim number (HICN or RRB) for the beneficiary and resubmit the transaction if appropriate.
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 and 90) attempted to process but the system was unable to find the beneficiary based on the identifying information submitted in the transaction. A match on claim number (HICN) 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.

Code	Type	Title	Short Definition	Definition
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.
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.

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:
				  • The beneficiary disenrolled from the original plan with an effective date before the rollover enrollment began.
				  • 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.

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.

Code	Type	Title	Short Definition	Definition
022	A	Transaction Accepted, Claim Number Change	NEW HICN	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 claim number for this beneficiary has changed. The new claim number is in DTRR field 1 and the old claim number 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's claim number in the Plan's records. Any future submitted transactions for this beneficiary must use the new claim number.
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.

Code	Type	Title	Short Definition	Definition
025	A	Disenrollment Accepted, Claim Number Change	DISROL-NEW HICN	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 claim number for this beneficiary has changed. The new claim number is in DTRR field 1 and the old claim number 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's claim number in the Plan's records. Future submitted transactions for this beneficiary must use the new claim number.
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.

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.

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

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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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.
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 (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.

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.

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	INSTITUTIO N 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.

Code	Type	Title	Short Definition	Definition
077	M	Medicaid Status Set	MEDICAID ON	A reply with this TRC is seen for Plan submitted retroactive Transaction Type 01 and 30 transactions and occasionally Transaction Type 61 enrollment transactions. In the case of Transaction Type 01, this beneficiary has been placed in Medicaid Status by the Plan. The effective date of the Medicaid Status is reported in field 18 of the DTRR. This date is always the first of the month and is retroactive. **Note:** Plans do not submit Transaction Type 01 with any effective dates later than 12/31/2007. 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 having a Medicaid status. 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. Transaction Type 30, when provided with the request type 22, is a rate recalculation for a Medicaid status change. **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 in response to a Transaction Type 01 transaction submitted by the Plan. This beneficiary's Medicaid Status has been terminated. The effective date of the termination Medicaid Status is reported in DTRR fields 18 and 24 of the DTRR. This date is always the last day of the month. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.

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 fields DTRR data file 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.

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 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 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.
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.

Code	Type	Title	Short Definition	Definition
086	M	Claim Number Change	NEW HICN	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 HICN has changed. The new claim number is reported in DTRR field 1 and the old claim number is in Field 24. **Plan Action:** Update the Plan's records. The new claim number 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.
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.

Code	Type	Title	Short Definition	Definition
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.*

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.
097	R	Medicaid Previously Turned On	MCAID PREV ON	A correction transaction (Transaction Type 01) was rejected because this transaction attempted to set the Medicaid status for the beneficiary to ON. The Medicaid status for the beneficiary was already ON for the month in question. ***Note:*** *This TRC is only applicable for submitted correction transactions (01) with effective dates prior to 1/1/2008.* **Plan Action:** None required. Verify the Plan records.

Code	Type	Title	Short Definition	Definition
098	R	Medicaid Previously Turned Off	MCAID PREV OFF	A correction transaction (Transaction Type 01) was rejected because this transaction attempted to set the Medicaid status for the beneficiary to OFF. The Medicaid status for the beneficiary was already OFF for the month in question. ***Note:*** *This TRC is only applicable for submitted correction transactions (Transaction Type 01) with effective dates prior to 1/1/2008.* **Plan Action:** None required. Verify the Plan records.
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.
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.

Code	Type	Title	Short Definition	Definition
103	R	ICEP/IEP Election, Missing A/B Entitlement Date	ICEP/IEP NO 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 is only returned on enrollment transactions submitted with election type I (Initial Coverage Election Period) or E (Initial Enrollment Period for Part D). **Plan Action:** Verify the beneficiary's Part A / Part B entitlement / enrollment. Take the appropriate actions as per CMS enrollment guidance.
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 is either missing, contains an invalid value, or is not appropriate for the Plan or for the transaction type. The valid Election Type 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) 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** U - SEP for Loss of Dual Eligibility or for Loss of LIS V - SEP for Changes in Residence W - SEP EGHP (Employer/Union Group Health Plan) Y - SEP for CMS Casework Exceptional Conditions X - SEP for Administrative Change • Plan Submitted "Rollover" • Involuntary Disenrollment • PPO Change • Plan-submitted "Canceling" Transaction

Code	Type	Title	Short Definition	Definition
104 Con't	R	Rejected; Invalid or Missing Election Type	BAD ELECT TYPE	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 (must meet all conditions) • POS Enrollment (Enrollment Source Code = G) S - Special Enrollment Period (SEP) The value expected in Election Type 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 MMCM* or the *PDP Guidance on Eligibility, Enrollment and Disenrollment*. Determine the appropriate Election Type 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.*

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, and 83) 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.

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) 1 per calendar year E - Initial Enrollment Period for Part D (IEP) 1 per lifetime F - Initial Enrollment Period for Part D (IEP2) 1 per lifetime I - Initial Coverage Election Period (ICEP) 1 per lifetime **Plan Action:** Review the discussion of election type requirements in *Chapter 2 of the MMCM* 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.

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.

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.

Code	Type	Title	Short Definition	Definition
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.*
121	M	Low Income Period Status	LIS UPDATE	This TRC is returned on a reply with Transaction Type 01 or 61. It is intended to supply the Plan with additional information about the beneficiary. It is created in response to an enrollment transaction or change in a beneficiary's low income profile. Each TRC 121 returns start and end dates, premium subsidy percentage, and copayment category for one low income period affecting a PBP enrollment. There may be more than one TRC 121 returned. The effective date for the co-pay period is shown in the Transaction Reply Report Low-Income Period Effective Date field (field 51). Premium subsidy percentage and co-pay level are reported in the Part D Low-Income Premium Subsidy Level field (field 49), and Low-Income Co-Pay Category field (field 50), respectively. The Effective Date field (field 18) contains the PBP enrollment period start date. Low income subsidy TRC 194 and/or TRC 223 may accompany TRC 121. These three TRCs convey the beneficiary's low income subsidy profile at the time of report generation. They provide a full replacement set of low income subsidy data affecting the identified PBP enrollment 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.

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.

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.

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 blank **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.

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.

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.

Code	Type	Title	Short Definition	Definition
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.
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.

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**: Follow the procedures in CMS enrollment guidance and contact your CMS Central Office Health Insurance Specialist.

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.

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.
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	(Note: 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.

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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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.
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 53 (waived amount) and 54 (subsidized amount) from field 52 (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.

Code	Type	Title	Short Definition	Definition
182	I	Invalid PTC Premium Submitted Corrected, Accepted	PTC PRM OVERIDE	An Enrollment, PBP change, Enrollment Cancellation, Disenrollment Cancellation or Part C Premium Record Update transaction (Transaction Types 61, 78, 80, 81, 82) was accepted but the Part C premium submitted on the transaction did not agree with the Plan's HPMS contracted Part C premium rate. The premium has been adjusted to reflect the contracted rate. The corrected Part C premium rate is reported in Daily Transaction Reply Report (DTRR) data record fields 24 and 34. • 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. 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.

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.

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.

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.

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.

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. **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 enrollments transactions for PACE National Part D Plans. **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.

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.

Code	Type	Title	Short Definition	Definition
210	A	POS Enrollment Accepted	POS ENROLLME NT	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.
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.

Code	Type	Title	Short Definition	Definition
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.
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; or • 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.

Code	Type	Title	Short Definition	Definition
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.
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. Pl**an 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.

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 is not a reply to a submitted transaction, but is intended to supply the Plan with additional information about the beneficiary. Records with TRC 121 report low income periods that exist for a beneficiary at the time of data file generation. A record with TRC 223 reports a previously existing low income subsidy period that was removed and not replaced. Records with TRCs 121 and 223 accompany the acceptance TRC for an enrollment transaction and provide a full replacement set of low income subsidy data affecting the PBP enrollment. The following LIS information is reported on the DTRR for each period of Low Income Subsidy that was removed: • PBP Enrollment Effective Date (Field 18) • Part D Low-income Premium Subsidy Level (Field 49) for removed period • Low-income Co-Pay Category (Field 50) for removed period • Low-income Period start date (Field 51) for removed period • Low-income Period End Date (Field 64) for removed period • Low-income Period Subsidy Source (Field 65) for removed 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.
224	A	A/D MSP Beneficiary Transaction Accepted	MSP ACCEPTED	Aged/Disabled MSP Beneficiary transaction (85) accepted. **Plan Act**ion: None Required**.**
225	I	Exceeds SSA Benefit & Safety Net Amount	INSUF FUND&SNE T	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.

Code	Type	Title	Short Definition	Definition
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**.**
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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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	The beneficiary has other insurance and Medicare is secondary payer. All Plans whose payments are impacted by the MSP notification will receive the TRC. **Plan Action**: Update the Plan's records accordingly.
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.

Code	Type	Title	Short Definition	Definition
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.
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) failed because the submitted birth date was either • Not formatted as YYYYMMDD (e.g., "Aug 1940"), or • 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.

Code	Type	Title	Short Definition	Definition
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 POS drug edit cancellation (Transaction Type 90) failed because the submitted effective date was either, • Blank, • Not formatted as YYYYMMDD (e.g., "Aug 1940"), or • 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.
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, or • 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, or • The address was not a U.S. address. **Plan Action:** Correct address information and resubmit.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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.
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.

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.
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.
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/Disenroll 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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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.
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 CANCELLA TN	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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
301	M	Merged Beneficiary, Claim Number Change	BENE HICN 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 claim numbers (HICNs) which were merged under a single HICN. This DTRR reports the **VALID** HICN in field 1 and the **INVALID** HICN in field 24. **Plan Action:** Update the Plan's records to use the **VALID** HICN from field 1 for this beneficiary. The **valid** claim number must be used on all future transactions for this beneficiary.
302	M	Enrollment Cancelled, Claim Number 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 HICNs, which were merged into one. Plan enrollments for the conflicting HICNs have been combined under a valid HICN. 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.

Code	Type	Title	Short Definition	Definition
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 claim numbers (HICNs) which were merged into one. Plan enrollments for the conflicting HICNs have been combined under a valid HICN. 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.
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.

Code	Type	Title	Short Definition	Definition
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.
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 blank **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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition

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:
				  ○ A retroactive enrollment that spans more than one year and the Segment ID is not valid for both years
				  ○ 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.
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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition

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.
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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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) or D (Delete). **Plan Action:** Correct the POS Drug Edit Update/Delete flag and resubmit the transaction, if appropriate.
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.

Code	Type	Title	Short Definition	Definition
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.

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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
600	R	UI Transaction Override	UI OVERRIDE	This TRC is used for special Enrollment Reconciliation DTRRs. A discrepancy enrollment transaction (Transaction Type 61) was rejected because it attempted to change an existing enrollment record that was previously entered by a CMS User through the User Interface. **Plan Action:** Update Plan records accordingly and take the appropriate actions as per CMS enrollment guidance (send "Enrollment Status Update" notice to the beneficiary).
601	R	Casework Beneficiary	CASEWORK BENE	This TRC is used for special Enrollment Reconciliation DTRRs. A discrepancy enrollment transaction (Transaction Type 61) was rejected because the beneficiary's enrollment was updated by CMS casework. **Plan Action:** Update Plan records accordingly and take the appropriate actions as per CMS enrollment guidance (send "Enrollment Status Update" notice to the beneficiary).
602	R	No Discrepancy	NO DISCREPANCY	This TRC is used for special Enrollment Reconciliation DTRRs. A discrepancy enrollment transaction (Transaction Type 61) was rejected because the enrollment effective date and contract/PBP in the submitted transaction matches the existing enrollment on file. There is no update to the beneficiary's enrollment period. **Plan Action:** None required

Code	Type	Title	Short Definition	Definition
603	R	2007 Date is Not Valid	2007 DT INVALID	This TRC is used for special Enrollment Reconciliation DTRRs. A discrepancy enrollment transaction (Transaction Type 61) was rejected because 2007 effective dates were not considered for the 2006 enrollment reconciliation. This rejection could have been caused by one of the following reasons: • A 2007 enrollment or PBP was submitted and rejected because there was not a 2006 discrepancy submitted along with the 2007 enrollment. • A 2006 enrollment transaction AND a 2007 PBP change record attempted to process as a Rollover. The transaction rejected because the enrollment record and the PBP change record did not have the same application signature date. **Plan Action:** Update Plan records accordingly. If the Plan has a 2007 enrollment to correct, contact the MAPD HelpDesk for assistance.
604	A	Disenrollment	DISENROLL MENT	This TRC is used for special Enrollment Reconciliation DTRRs. Check dates code puts in DTRR fields 18 and 24(maybe) and update text. As a result of the Enrollment Reconciliation process, this beneficiary was disenrolled due to enrollment in another Plan. **Plan Action:** Update Plan records accordingly and take the appropriate actions as per CMS enrollment guidance (send "Enrollment Status Update" notice to the beneficiary).
605	R	Recon Transaction Denied	TRANS DENIED	This TRC is used for special Enrollment Reconciliation DTRRs. A discrepancy enrollment transaction (Transaction Type 61) was denied following reconciliation processing. **Plan Action:** Update Plan records accordingly and take the appropriate actions as per CMS enrollment guidance (send "Enrollment Status Update" notice to the beneficiary).

Code	Type	Title	Short Definition	Definition
606	I	Direct Bill	DIRECT BILL	This TRC is used for special Enrollment Reconciliation DTRRs. This beneficiary has been changed to "Direct Bill" for this enrollment period. Even though a PPO other than D was specified in the transaction, Direct Bill is the only valid option for reconciliation transactions. This transaction response will accompany the acceptance TRC for the submitted discrepancy transaction. **Plan Action:** Update the Plan's records accordingly, ensuring that the beneficiary is in direct bill status for the enrollment period. Take the appropriate actions as per CMS enrollment guidance.
607	A	Enrollment Accepted as Submitted	ENROLL OK	This TRC is used for special Enrollment Reconciliation DTRRs. The submitted discrepancy enrollment transaction (Transaction Type 61) was accepted. The effective date of the enrollment period is reported in DTRR field 18. **Plan Action:** Ensure that the Plan records correctly represent this enrollment. Take the appropriate actions as per CMS enrollment guidance.
608	A	Enrl Accepted, CMS Established Eff and End Dates	ENRLD/CMS DTS	This TRC is used for special Enrollment Reconciliation DTRRs. The submitted discrepancy enrollment transaction (Transaction Type 61) was accepted but the effective date and end date for the enrollment period were provided by CMS. The new effective date of the enrollment period is reported in DTRR field 18. **Plan Action:** Update Plan records to be consistent with the dates in fields 18 and 54(**?**). Review ALL enrollment periods in the Full Enrollment file to determine the beneficiary's status. Take the appropriate actions as per CMS enrollment guidance (send appropriate "Enrollment Status Update" notice).

Code	Type	Title	Short Definition	Definition
609	A	Enrollment Accepted with CMS established Eff date	ENRLD/CMS EFF	This TRC is used for special Enrollment Reconciliation DTRRs. The submitted discrepancy enrollment transaction (Transaction Type 61) was accepted but the effective date for the enrollment period was provided by CMS. The effective date of the new enrollment period is reported in DTRR field 18. **Plan Action:** Update Plan records to be consistent with the dates in fields 18. Review ALL enrollment periods in the Full Enrollment file to determine the beneficiary's status. Determine if a premium refund is required. Take the appropriate actions as per CMS enrollment guidance (send appropriate "Enrollment Status Update" notice).
610	A	Enrollment Accepted with CMS Established End Date	ENRLD/CMS END	This TRC is used for special Enrollment Reconciliation DTRRs. The submitted discrepancy enrollment transaction (Transaction Type 61) was accepted but the end date for the enrollment period was provided by CMS. The submitted effective date of the enrollment period is reported in DTRR field 18. **Plan Action:** Update Plan records to be consistent with the dates in fields 18. Review ALL enrollment periods in the Full Enrollment file to determine the beneficiary's status. Determine if a premium refund is required. Take the appropriate actions as per CMS enrollment guidance (send appropriate "Enrollment Status Update" notice).
611	R	No Discrepancy in 2006	NO DISCREP 2006	This TRC is used for special Enrollment Reconciliation DTRRs. A discrepancy enrollment transaction (Transaction Type 61) was rejected because the enrollment matched exactly what CMS has on file for the calendar year of the reconciliation. However, CMS has identified an enrollment discrepancy which exists in another contract or calendar year. **Plan Action:** Review ALL enrollment periods in the Full Enrollment file to confirm the status of the beneficiary. The Plan should work through the established retroactive process to correct discrepancies associated with a calendar year other than the year being reconciled.

Code	Type	Title	Short Definition	Definition
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.

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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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.
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.

Code	Type	Title	Short Definition	Definition
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).

I.3 Obsolete Transaction Reply Codes (TRCs)

Table I-3 lists the ***obsolete*** TRCs marked for deletion beginning November 2006.

Table I-3: Obsolete Transaction Reply Codes

Code	Type	Title	Short Definition	Definition
027	A	Demonstration Beneficiary Factor Set	OBSOLETE	A transaction to turn on the beneficiary-level demonstration factor (Transaction Type 30) was successfully processed. The effective start date of the factor is shown in DTRR field 24. **Note:** This reply code is only applicable to transactions that update beneficiary-specific risk adjustment factors for certain demonstration contracts. **Plan Action:** Update the Plan's records.
028	A	Demonstration Beneficiary Factor Terminated	OBSOLETE	A transaction to turn off the beneficiary-level demonstration factor (Transaction Type 31) was successfully processed. The effective end date of the factor is show in DTRR field 24. **Note:** This reply code is only applicable to transactions that update beneficiary-specific risk adjustment factors for certain demonstration contracts. **Plan Action:** Update the Plan's records.
040	R	Enrollment Rejected, Multiple Enrollment Trans	OBSOLETE	An enrollment transaction (Transaction Type 61) was rejected because it was one of several that were submitted with the same effective date and application date. **Plan Action:** None required.
041	R	Invalid Demonstration Beneficiary Factor Date	OBSOLETE	A beneficiary factor update request attempted to process. This was rejected because the effective start and/or end date was not in a valid format or the request specified an effective start date that was greater than the end date. **Plan Action:** If this TRC is included in the Plan's DTRR, call the MMA Helpdesk to request guidance.
057	M	Risk Adjuster Factor Change	OBSOLETE	This is an informational TRC. The Risk Adjuster System (RAS) has created new factors for this beneficiary, which may result in payment adjustments. **Plan Action:** Refer to the monthly RAS reports to update the Plan's records.

Code	Type	Title	Short Definition	Definition
111	R	PBP Rejected; Invalid Contract Number	OBSOLETE	A PBP enrollment change transaction (Transaction Type 61) was rejected because the contract number submitted on the transaction does not match the contract number of the Plan in which the beneficiary is currently enrolled. The requested effective date of enrollment in the new PBP is reported in DTRR field 18. **Plan Action:** If appropriate, resubmit the transaction with the correct contract number. If the Plan is attempting to move the beneficiary to a new contract number, an enrollment transaction (Transaction Type 61) must be used.
112	R	Rejected; Conflicting Effective Dates	OBSOLETE	A PBP change transaction (Transaction Type 61) was rejected because beneficiary was not enrolled in the submitted contract as of the effective date for the PBP change. A beneficiary must be enrolled in a PBP of a contract in order to change to another PBP. The effective date of the enrollment within the contract must be equal to or before the effective date of the PBP change. **Plan Action:** Correct the effective date of the PBP Change transaction and resubmit if appropriate. If the Plan is attempting to enroll a beneficiary in a different PBP with an effective date earlier than the original enrollment, the Plan must us an Enrollment transaction (Transaction Type 61).
115	R	Enrollment Rejected; Plan Not Open	OBSOLETE	An enrollment or PBP change transaction (Transaction Type 61) was rejected because this Plan is closed to enrollments using an O (OEP), N (OEPNEW) or OEPI (T) election type. **Plan Action:** Correct the enrollment type and resubmit the transaction if appropriate.
146	A	Rollover successful	OBSOLETE	A termination-rollover action was processed. These actions allow all members of a terminating Plan (contract or PBP) to be 'rolled over' (automatically enrolled) in a new Plan. This normally occurs at year end if a contract or PBP changes for the new year. The transaction is an Enrollment Transaction (Transaction Type 61) and has the new contract, PBP, and segment in DTRR fields 8, 20 and 33, respectively. The effective date of the rollover is reported in field 18 and in the EFF DATE column on the printed report. **Plan Action:** Submit a 4Rx Record Update transaction (Transaction Type 72) supplying the beneficiary's new insurance field (4Rx) values. If the move resulted in beneficiaries being moved incorrectly, contract your CMS Plan representative.

Code	Type	Title	Short Definition	Definition
148	I	Rollover successful, Secondary Drug Insurance 4Rxupdate required	OBSOLETE	A beneficiary was "rolled over" into a new Plan (Contract and/or PBP). Updated 4RX drug insurance information is needed by CMS for the primary drug coverage and the secondary if applicable. This TRC provides the Plan with additional information on a rollover transaction that was processed successfully. It will be received by Plans which offer Part D coverage (PDP, MA-PD, demonstration or other Plan with Part D). The effective date of the new rolled-over enrollment will be reported in field 18 and in the EFF DATE column on the printed report. **Plan Action:** Submit a 4Rx Change transaction (Transaction Type 72) supplying the beneficiary's new insurance field (4Rx) values.
167	M	Change in Beneficiary Low Income Premium Subsidy	OBSOLETE	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 low-income subsidy amount and/or percentage have changed. 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. Field 55 reports the beneficiary's Part D premium subsidy amount as of the effective date of the transaction. If the change affects the Part D low-income subsidy for the Current Payment Month (CPM), the new amount will be reported in field 24. Replies with TRC 167 are often accompanied by replies with TRC 168 and TRC 121. ***Note:*** *Fields 24 and 49 – 54 always represent the beneficiary's LIS and LEP values for the current CPM. If this change is retroactive, these values may not reflect the values of the period being changed. Refer to the LISHIST report to determine the correct values for retroactive changes.* ***TRC167will continue to be generated for internal purposes and will not be sent to the Plans.*** **Plan Action:** Adjust the beneficiary's Part D LIS amount and/or percentage as of the effective date in field 18. Take the appropriate actions as per CMS enrollment guidance. If the change is retroactive, refer to the LISHIST report to verify the correct amount for the affected period.

Code	Type	Title	Short Definition	Definition
168	M	Change in Beneficiary Low Income Cost Sharing Subsidy	OBSOLETE	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 low-income cost sharing level (co-pay) has changed. 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. If the change affects the Part D low-income cost sharing level for the Current Payment Month (CPM), the new level will be reported in field 24. Replies with TRC 168 are often accompanied by replies with TRC 167 and TRC 121. **Note:** Fields 24 and 49 – 54 always represent the beneficiary's LIS and LEP values for the current CPM. If this change is retroactive, these values may not reflect the values of the period being changed. Refer to the LISHIST report to determine the correct values for retroactive changes. Field 55 reports the beneficiary's Part D premium subsidy amount as of the effective date of the transaction. **Plan Action:** Adjust the beneficiary's Part D LIS cost-sharing level as of the effective date in field 18. Take the appropriate actions as per CMS enrollment guidance. If the change is retroactive, refer to the LISHIST report to verify the correct level for the affected period.
174	R	Transaction Rejected; No Data Updates Submitted	OBSOLETE	An EGHP, Segment ID, Part C premium, or Part D Opt-Out change transaction (Transaction Types 74, 77, 78, 79) was rejected because none of the change-to fields, EGHP Flag, Segment ID, Opt-Out Flag or Part C Premium, were populated in the submitted transaction. This transaction had no effect on the beneficiary's records. **Plan Action:** None required unless a change was intended. If a change was intended, populate the correct field(s) and resubmit the transaction.

Code	Type	Title	Short Definition	Definition
181	I	Invalid PTD premium submitted, corrected	OBSOLETE	The Part D premium submitted on the enrollment or PBP change transaction (Transaction Type 61) does not agree with the Plan's defined Part D premium rate. The premium has been adjusted to reflect the defined rate. The correct Part D premium rate is reported in DTRR field 24. This TRC provides additional information about an enrollment or PBP change transaction (Transaction Type 61) 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 beneficiary records with the premium information in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
192	I	No Change in Part C Premium Amount	OBSOLETE	A Part C Premium Update transaction (Transaction Type 78) was submitted, however, no data change was made to the beneficiary's record. The submitted transaction contained a Part C Premium Amount value that matched the Part C Premium Amount already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action:** None required.

Code	Type	Title	Short Definition	Definition
194	M	Deemed Correction	DEEMD CORR	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 manually added or updated a co-pay period for this beneficiary. This added or updated co-pay period occurs within a period during which the beneficiary is DEEMED by CMS. This is a correction. Each TRC 194 returns start and end dates, premium subsidy percentage, and copayment category for one low income subsidy period affecting a beneficiary's PBP enrollment. There may be more than one TRC 194 returned. The effective date for the added or updated deemed low-income subsidy period is shown in the DTRR Low-Income Period Effective Date field (field 51). The new co-pay level is reported in the Low-Income Co-Pay Category field (field 50). The Effective Date field (field 18) contains the PBP enrollment period start date. Low income scenarios TRC 121 and/or TRC 223 may accompany TRC 194. These three TRCs convey the beneficiary's low income subsidy profile at the time of report generation. They provide a full replacement set of low income subsidy data affecting the identified PBP enrollment period. This code is considered obsolete as of 1/1/2010. **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.
199	R	Rejected, Return to Plan for Additional Research	OBSOLETE	A submitted transaction (Transaction Types 51, 61, 72, 73, 74, 75, 01, 85) was rejected. This transaction was placed into a pending status due to multiple transactions that were concurrently processed for the same beneficiary. Subsequent transactions may have been processed while this transaction was pending. As a result, this transaction may no longer be valid. **Plan Action:** Research the beneficiary's current status and resubmit any appropriate transactions.

Code	Type	Title	Short Definition	Definition
207	I	Part D Premium has been corrected to zero	OBSOLETE	An enrollment or PBP change transaction (Transaction Type 61) was submitted and accepted for a Part C only Plan. This transaction contained an amount other than zero in the Part D premium field. Since a Part D premium does not apply to a Part C only Plan, the Part D premium has been corrected to be zero. This TRC provides additional information about an enrollment or PBP change transaction (Transaction Type 61) 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 D premium amount included in the DTRR record.
208	R	Plan Change Rejected Both 4Rx and non 4Rx Changes	OBSOLETE	A 4Rx Record Update transaction (Transaction Type 72) was rejected because it contained information for both 4Rx and non-4Rx record updates. If any of the 4Rx (primary and secondary drug insurance) fields are populated, no other record updates can be included on the transaction. **Plan Action:** Submit separate Record Update transactions (Transaction Type 72) for 4Rx and non-4Rx record updates.

I.4 Transaction Reply Code (TRC) Groupings

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

	BENEFICIARY CROSS REFERENCE MERGE
301M	MERGED BENEFICIARY, CLAIM NUMBER CHANGE
302M	ENROLLMENT CANCELLED, CLAIM NUMBER CHANGE (BENEFICIARY MERGE)
	CMS-ONLINE UPDATES TRC GROUPING
701A	NEW UI ENROLLMENT (OPEN ENDED)
702A	UI FILL-IN ENROLLMENT
703A	UI ENROLLMENT CANCEL (DELETE)
704A	UI ENROLLMENT CANCEL-PBP CORRECTION
705A	UI ENROLLMENT PBP CORRECTION
706A	UI ENROLLMENT CANCEL SEGMENT CORRECTION
707A	UI ENROLLMENT SEGMENT CORRECTION
708A	UI ASSIGNS END DATE
709A	UI MOVED START DATE EARLIER
710A	UI MOVED START DATE LATER
711A	UI MOVED END DATE EARLIER
712A	UI MOVED END DATE LATER
713A	UI REMOVED ENROLLMENT END DATE
714I	UI PART D OPT OUT CHANGE ACCEPTED
715M	MEDICAID CHANGE ACCEPTED
716I	UI CHANGED THE NUMBER OF UNCOVERED MONTHS
717I	UI CHANGED ONLY THE APPLICATION DATE
	DEMONSTRATION TRC GROUPING
056R	DEMONSTRATION ENROLLMENT REJECTED
169R	REINSURANCE DEMONSTRATION ENROLLMENT REJECTED
307A	MMP PASSIVE ENROLLMENT ACCEPTED
308R	MMP PASSIVE ENROLLMENT REJECTED
309I	NO CHANGE IN MMP OPT-OUT FLAG
310R	MMP OPT-OUT REJECTED; INVALID OPT-OUT CODE
311A	MMP OPT-OUT ACCEPTED
312A	MMP ENROLLMENT CANCELLATION ACCEPTED
313R	MMP ENROLLMENT CANCELLATION REJECTED
314R	INVALID CANCELLATION TRANSACTION

	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, CLAIM NUMBER CHANGE
026 A	DISENROLLMENT ACCEPTED, NAME CHANGE
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
090M	DATE OF DEATH ESTABLISHED
104R	REJECTED; INVALID OR MISSING ELECTION TYPE
105R	REJECTED; INVALID EFFECTIVE DATE FOR ELECTION TYPE
108R	REJECTED; ELECTION LIMITS EXCEEDED
114R	DRUG COVERAGE CHANGE REJECTED; NOT AEP
120A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
151 I	DISENROLLMENT ACCEPTED, INVALID DISENR REASON CODE
205 I	INVALID DISENROLLMENT REASON CODE
	DISENROLLMENT CANCELLATION TRC GROUPING
036R	TRANSACTION REJECTED BENEFICIARY IS DECEASED
042R	TRANSACTION REJECTED, BLOCKED
044R	TRANSACTION REJECTED, OUTSIDE CONTRACT PERIOD
116R	ENROLLMENT OR CHANGE REJECTED; INVALID SEGMT NUM
284R	CANCELLATION REJECTED, ENROLL/DISENROLL CANCELLATION
288A	DISENROLLMENT CANCELLATION ACCEPTED
289R	DISENROLLMENT CANCELLATION REJECTED
291I	ENROLLMENT REINSTATED, DISENROLLMENT CANCELLATION
296R	DISENROLL CANCEL REJECTED, REINSTATEMENT CONFLICT (CONFLICTS WITH AN EXISTING ENROLLMENT)
	DISENROLLMENT TRANSACTION (TC 51)
	Rejected when used to attempt an enrollment Cancellation
292R	DISENROLLMENT REJECTED, WAS CANCELLATION ATTEMPT
	EGHP TRC GROUPING
110R	REJECTED; NO PART A AND NO EGHP ENROLLMENT WAIVER
127R	PART D ENROLLMENT REJECTED, EMPLOYER SUBSIDY
128R	PART D ENROLL REJECT, EMPLYR SBSDY SET: NO PRIOR TRN
129I	PART D ENROLL ACCEPT, EMP SBSDY SET: PRIOR TURN REJECT
139A	EGHP FLAG CHANGE ACCEPTED
162R	INVALID EGHP FLAG VALUE
164R	EGHP FLAG VALUE NOT 'Y'
189A	NO CHANGE IN EGHP FLAG

	ENROLLMENT RECON TRC GROUPING
600R	UI TRANSACTION OVERRIDE
601R	CASEWORK BENEFICIARY
602R	NO DISCREPANCY
603R	2007 DATE IS NOT VALID
604A	DISENROLLMENT
605R	RECON TRANSACTION DENIED
606I	DIRECT BILL
607A	ENROLLMENT ACCEPTED AS SUBMITTED
608A	ENROLLMENT ACCEPTED WITH CMS ESTABLISHED EFFECTIVE AND CMS END DATE
609A	ENROLLMENT ACCEPTED WITH CMS ESTABLISHED EFFECTIVE
610A	ENROLLMENT ACCEPTED WITH CMS ESTABLISHED END DATE
611R	NO DISCREPANCY IN 2006

	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
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
056R	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
104R	REJECTED; INVALID OR MISSING ELECTION TYPE
105R	REJECTED; INVAILD EFFECTIVE DATE FOR ELECTION TYPE
106R	REJECTED; ANOTHER TRANSACTION RECEIVED WITH LATER APPLICATION DATE
108R	REJECTED; ELECTION LIMITS EXCEEDED
114R	DRUG COVERAGE CHANGE REJECTED; NOT AEP
116R	ENROLLMENT OR CHANGE REJECTED; INVALID SEGMT NUM
120A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
124R	ENROLLMENT/CHANGE REJECTED; INVALID UNCOVERED MONTHS
126R	ENROLLMENT/CHANGE REJECTED; INVALID CRED CVRG FLAG

127R	PART D ENROLLMENT REJECTED; EMPLOYER SUBSIDY STATUS
128R	PART D ENROLLMENT REJECT, EMPLYR SBSDY SET; NO PRIOR TRN
129I	PART D ENROLL ACCEPT; EMP SBSDY SET; PRIOR TRN REJECT
133R	PART D ENROLL REJECTED; INVALID SECNDRY INSUR FLAG
134I	MISSING SECONDARY INSURANCE INFORMATION
150I	ENROLLMENT ACCEPTED, EXCEEDS CAPACITY LIMIT
176R	TRANSACTION REJECTED, ANOTHER TRANSACTION ACCEPTED
184R	ENROLLMENT REJECTED, BENEFICIARY IS Medicaid
196R	TRANSACTION REJECTED, BENE NOT ELIGIBLE FOR PART D
211R	RE-ASSIGNMENT ENROLLMENT REJECTED
212A	RE-ASSIGNMENT ENROLLMENT ACCEPTED
246A	GAP ENROLLMENT ACCEPTED; NO CHANGE TO DATES
247A	GAP ENROLLMENT ACCEPTED; NEW END DATE
248R	GAP ENROLLMENT REJECTED; INVALID END DATE
249R	GAP ENROLLMENT OVERLAP AE, FE OR POS/LI NET PERIOD
250R	GAP ENROLLMENT DATES FALL WITHIN ANOTHER ENROLLMENT
251R	GAP ENROLLMENT NOT IN RETRO FILE
268I	BENEFICIARY HAS DIALYSIS PERIOD
269I	BENEFICIARY HAS TRANSPLANT
307A	MMP PASSIVE ENROLLMENT ACCEPTED
308R	MMP PASSIVE ENROLLMENT REJECTED
312A	MMP ENROLLMENT CANCELLATION ACCEPTED
313R	MMP ENROLLMENT CANCELLATION REJECTED

	ENROLLMENT CANCELLATION TRC GROUPING
060R	TRANSACTION REJECTED, NOT ENROLLED
285A	ENROLLMENT CANCELLATION ACCEPTED
286R	ENROLLMENT CANCELLATION REJECTED
287A	ENROLLMENT REINSTATED
292R	DISENROLLMENT REJECTED, WAS CANCELLATION ATTEMPT
312A	MMP ENROLLMENT CANCELLATION ACCEPTED
313R	MMP ENROLLMENT CANCELLATION REJECTED
314R	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
268I	BENEFICIARY HAS DIALYSIS PERIOD
269I	BENEFICIARY HAS TRANSPLANT

	FAILED PAYMENT
000I	NO DATA TO REPORT
264I	PAYMENT NOT YET COMPLETED
299I	CORRECTION TO PREVIOUSLY FAILED PAYMENT
	FAILED TRCs GROUPING
257F	FAILED; BIRTH DATE INVALID FOR DATABASE INSERTION
258F	FAILED; EFFECTIVE DATE INVALID FOR DATABASE INSERTION
259F	FAILED; END DATE INVALID FOR DATABASE INSERTION
263F	APPLICATION DATE INVALID FOR DATABASE INSERTION
	HOSPICE TRC GROUPING
071M	HOSPICE STATUS SET
072M	HOSPICE STATUS TERMINATED
	LATE ENROLLMENT PENALTY/LEP TRC GROUPING
177M	CHANGE IN LATE ENROLLMENT PENALTY
178M	LATE ENROLLMENT PENALTY RESCINDED
218M	LEP RESET UNDONE
219M	LEP RESET ACCEPTED
	LIS/AUTO/FACI TRC GROUPING
117A	FBD AUTO ENROLLMENT ACCEPTED
118A	LIS FACILITATED ENROLLMENT ACCEPTED
121M	LOW INCOME PERIOD STATUS
166R	PART D FBD AUTO ENROLLMENT OR FACILITATED ENROLLMENT REJECTED
194M	DEEMED CORRECTION
223I	LOW INCOME PERIOD CLOSED
	MEDICAID TRC GROUPING
077M	MEDICAID STATUS SET
078M	MEDICAID STATUS TERMINATED
097R	MEDICAID PREVIOUSLY TURNED ON
098R	MEDICAID PREVIOUSLY TURNED OFF
099M	MEDICAID PERIOD CHANGE/CANCELLATION
184R	ENROLLMENT REJECTED, BENEFICIARY IS IN MEDICAID
	MEDICARE SECONDARY PAYER/MSP TRC GROUPING
227R	AGED/DISABLED TRANSACTION REJECTED-INVALID TRANSACTION TYPE
245M	MEMBER HAS MSP PERIOD
280I	MEMBER MSP PERIOD HAS ENDED
	NUMBER OF UNCOVERED MONTHS/NUNCMO TRC GROUPING
120A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
124R	ENROLLMENT/CHANGE REJECTED, INVALID UNCOV MONTHS
126R	ENROLLMENT/CHANGE REJECTED, INVALID CRED CVRG FLAG
141A	UNCOVERED MONTHS CHANGE ACCEPTED
187A	NO CHANGE IN NUMBER OF UNCOVERED MONTHS INFORMATION
215R	UNCOVERED MONTHS CHANGE REJECTED, INCORRECT EFF DATE
216I	UNCOVERED MONTHS EXCEEDS MAX POSSIBLE VALUE
217R	CAN'T CHANGE NUMBER OF UNCOVERED MONTHS

290I	IEP NUNCMO RESET
295M	LOW INCOME NUNCMO RESET
300R	NUNCMO CHANGE REJECTED, EXCEEDS MAX POSSIBLE VALUE
	PLAN CHANGES TRC GROUPING
060R	TRANSACTION REJECTED, NOT ENROLLED IN PLAN
116R	ENROLLMENT OR CHANGE REJECTED; INVALID SEGMT NUM
134I	MISSING SECONDARY INSURANCE INFORMATION
140A	SEGMENT ID CHANGE ACCEPTED
171R	RECORD UPDATE REJECTED, INVALID CHG EFFECTIVE DATE
172R	CHANGE REJECTED; CREDITABLE COVERAGE//2 DRUG INFO NOT APPLICABLE
188A	NO CHANGE IN SEGMENT ID
	PART D OPT OUT TRC GROUPING
130R	PART D OPT-OUT REJECTED, OPT-OUT FLAG NOT VALID
131A	PART D OPT-OUT ACCEPTED
241I	NO CHANGE IN PART D OPT OUT FLAG
	POINT OF SALE (POS) TRC GROUPING
210A	POS ENROLLMENT ACCEPTED
220R	TRANSACTION REJECTED; INVALID POS ENROLL SOURCE CODE
	PREMIUM PAYMENT TRC GROUPING
119A	PREMIUM AMOUNT CHANGE ACCEPTED
120A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
122R	ENROLLMENT/CHANGE REJECTED, INVALID PREM AMT
123R	ENROLLMENT/CHANGE REJECTED, INVALID PREM PAY OPT CD
144M	PREMIUM PAYMENT OPTION CHANGED TO DIRECT BILL
170I	PREMIUM WITHHOLD OPTION CHANGE TO DIRECT BILL
173R	CHANGE REJECTED; PREMIUM NOT PREVIOUSLY SET
179A	TRANSACTION ACCEPTED- NO CHANGE TO PREMIUM RECORD
182I	INVALID PTC PREMIUM SUBMITTED, CORRECTED
191A	NO CHANGE IN PREMIUM WITHHOLD OPTION
206I	PART C PREMIUM HAS BEEN CORRECTED TO ZERO
213I	PREMIUM WITHHOLD OPTION CHANGE TO DIRECT BILL
222I	BENE EXCLUDED FROM TRANSMISSION TO SSA/RRB
237I	PART B PREMIUM REDUCTION SENT TO SSA
240A	TRANSACTION RECEIVED, WITHHOLDING PENDING
243R	CHANGE TO SSA WITHHOLDING REJECTED DUE TO NO SSN
252I	PREM PAYMENT OPTION CHANGED TO DIRECT BILL, NO SSN
253M	CHANGED TO DIRECT BILL; NO FUNDS WITHHELD
267M	PREMIUM PAYMENT OPTION SET TO "**N**" DUE TO NO PREMIUM

	RESIDENCE ADDRESS CHANGE TRC GROUPING
154M	OUT OF AREA STATUS
260R	REJECTED; BAD END DATE, REJECT RESIDENCE ADDRESS CHANGE
261R	REJECTED; INCOMPLETE RESIDENCE ADDRESS INFORMATION
265A	RESIDENCE ADDRESS CHANGE ACCEPTED, NEW SCC
266R	UNABLE TO RESOLVE SSA STATE COUNTY CODES
282A	RESIDENCE ADDRESS DELETED
283R	RESIDENCE ADDRESS DELETE REJECTED

	RRB TRC GROUPING
120A	PPO CHANGE SENT TO W/H AGENCY
123R	ENROLLMENT/CHANGE REJECTED, INVALID PRE PAY OPT CD
144M	PREMIUM PAYMENT OPTION CHANGED TO DIRECT BILL
185M	WITHHOLDING AGENCY ACCEPTED TRANSACTION
186I	WITHHOLDING AGENCY REJECTED TRANSACTION
191A	NO CHANGE IN PREMIUM WITHHOLD OPTION
222I	BENE EXCLUDED FROM TRANSMISSION TO SSA/RRB
252I	PRE PAYMENT OPTION CHANGED TO DIRECT BILL; NO SSN
254I	BENE SET TO DIRECT BILL, SPANS JURISDICTION
255I	PLAN SUBMITTED RRB W/H FOR SSA BENE
256I	PLAN SUBMITTED SSA W/H FOR RRB BENE
262R	BAD RRB PREMIUM WITHHOLD EFFECTIVE DATE

	SCC ADDRESS TRC GROUPING
085M	STATE AND COUNTY CODE CHANGE
138M	BENEFICIARY ADDRESS CHANGE TO OUTSIDE THE U.S.
154M	OUT OF AREA STATUS
305M	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	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
185M	WITHHOLDING AGENCY ACCEPTED TRANSACTION
186I	WITHHOLDING AGENCY REJECTED TRANSACTION
195M	SSA UNSOLICITED RESPONSE (SSA WITHHOLD UPDATE)
235I	SSA ACCEPTED PART B REDUCTION TRANSACTION
236I	SSA REJECTED PART B REDUCTION TRANSACTION
243R	CHANGE TO SSA WITHHOLDING REJECTED DUE TO NO SSN

	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	CLAIM NUMBER 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
121M	LOW INCOME PERIOD STATUS
152 M	RACE CODE CHANGE
154M	OUT OF AREA STATUS
155 M	INCARCERATION NOTIFICATION RECEIVED
158 M	INSTITUTIONAL PERIOD CHANGE/CANCELLATION
159 M	NURSING HOME CERT PERIOD CHANGE/CANCELLATION
165 R	PROCESSING DELAYED DUE TO MARX SYSTEM PROBLEMS
194M	DEEMED CORRECTION
197M	PART D ELIGIBILITY TERMINATION
198M	PART D ELIGIBILITY REINSTATEMENT
267M	PREMIUM PAYMENT OPTION SET TO **"N"** DUE TO NO PREMIUM
270M	BENEFICIARY TRANSPLANT HAS ENDED

I.5 Payment Reply Codes (PRCs)

PRC Types:

A -	Accepted -	A transaction is accepted and the requested action is applied (Example: enrollment or disenrollment)
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 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 their Beneficiaries enrolled in their Plan. They are sent in response to information received by CMS. For example: If CMS is informed of a change in a Beneficiary's claim number, a reply is included in the Plan's TRR with TRC 086, giving the Plan the new claim number.
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.*

Table I-4: Payment 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

Code/Type*	Title	Short Definition	Definition
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 required.

I.6 MMR Adjustment Reason Codes

Table I-5 lists the adjustment reasons and their associated codes.

Table I-5: Adjustment Reason Codes

Code	Description
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 Adj Factor Change/Recon
26	Mid-year Part C Risk Adj 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
32	Retroactive Change to Estimated Cost-Sharing Amount
33	Retroactive Change to Estimated Reinsurance Amount
34	Retroactive Change Basic Part C Premium

Code	Description
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 Clean-Up

I.7 State Codes

Table I-6 lists the numeric and character code for all states.

Table I-6: State Code Table

State / Territory	Numeric Code	Character Code
Alabama	01	AL
Alaska	02	AK
Arizona	03	AZ
Arkansas	04	AR
California	05	CA
Colorado	06	CO
Connecticut	07	CT
Delaware	08	DE
District of Columbia (Washington DC)	09	DC
Florida	10	FL
Georgia	11	GA
Hawaii	12	HI
Idaho	13	ID
Illinois	14	IL
Indiana	15	IN
Iowa	16	IA
Kansas	17	KS
Kentucky	18	KY
Louisiana	19	LA
Maine	20	ME
Maryland	21	MD
Massachusetts	22	MA
Michigan	23	MI
Minnesota	24	MN
Mississippi	25	MS
Missouri	26	MO
Montana	27	MT
Nebraska	28	NE
Nevada	29	NV
New Hampshire	30	NH
New Jersey	31	NJ
New Mexico	32	NM
New York	33	NY
North Carolina	34	NC
North Dakota	35	ND
Ohio	36	OH
Oklahoma	37	OK
Oregon	38	OR
Pennsylvania	39	PA
Puerto Rico	40	PR
Rhode Island	41	RI

State / Territory	Numeric Code	Character Code
South Carolina	42	SC
South Dakota	43	SD
Tennessee	44	TN
Texas	45	TX
Utah	46	UT
Vermont	47	VT
Virgin Islands	48	VI
Virginia	49	VA
Washington	50	WA
West Virginia	51	WV
Wisconsin	52	WI
Wyoming	53	WY
Africa	54	
Asia	55	
Canada	56	
Ctrl America/West Indies/Alvarado (Honduras)	57	
Himariotis (Greece) (Europe)	58	
Ibarra (Mexico)	59	
Oceania (Australia & Islands in the Pacific)	60	
Bush (Philippine Islands)	61	
South America	62	
U.S. Possessions	63	
American Samoa	64	
Gogue (Guam)	65	
Dirksz (Aruba)	78	
Lynch (APO NE)	94	
Correa (APO)	95	
St. Peter (Plaisted)	99	

I.8 Entitlement Status and Enrollment Reason Codes

The tables below list the codes for Part A and Part B Enrollment, Entitlement and Non-Entitlement

1.8.1 Entitlement Status Code Tables

Part A – Entitlement Status Codes

The following codes occur when the Part A Entitlement Date is *present* and the Part A Termination Date is *blank*:

Code	Definition
E	Free Part A Entitlement
G	Entitled due to good cause
Y	Currently entitled, premium is payable

The following codes occur when the Part A Entitlement Date is *present* and the Part A Termination Date is *also present*:

Code	Definition
C	No longer entitled due to disability cessation
S	Terminated, no longer entitled under ESRD provision
T	Terminated for non-payment of premiums
W	Voluntary withdrawal from premium Part A coverage
X	Free Part A terminated because of Title II termination

Part A – Non Entitlement Status Codes

The following codes occur when there is *no* Part A Entitlement Date and *no* Part A Termination Date:

Code	Definition
D	Coverage denied
F	Terminated due to invalid enrollment or enrollment voided
H	Ineligible for free Part A, or did not enroll for premium Part A
N	Not valid SSA HIC, used by CMS 3rd party sys for potential PTA entitled date
R	Refused benefits

Part A - Enrollment Reason Codes

Code	Definition
A	Attainment of age 65
B	Equitable relief
D	Disability – Under age 65 entitlement
G	General Enrollment Period
I	Initial Enrollment Period
J	MQGE entitlement
K	Renal disease not reason for entitled prior to 65 or 25th month of disability
L	Late filing
M	Termination based on renal entitlement but disability based on entitlement continues
N	Age 65 and uninsured
P	Potentially insured beneficiary is enrolled for Medicare coverage only
Q	Quarters of coverage requirements are involved
R	Residency requirements are involved
T	Disabled working individual
U	Unknown blank = not applicable; e.g. Part A data is generated at age 64 years, 8 months

Part B - Entitlement Status Codes

The following codes occur when the Part B Entitlement Date is *present* and the Part B Termination Date is *blank*:

Code	Definition
G	Entitled due to good cause
Y	Currently entitled, premium is payable

The following codes occur when the Part B Entitlement Date is *present* and the Part B Termination Date is also *present*:

Code	Definition
C	No longer entitled due to cessation of disability
F	Terminated due to invalid enrollment or enrollment voided
S	Terminated, no longer entitled under ESRD provision
T	Terminated for non-payment of premiums
W	Voluntary withdrawal from coverage

Part B – Non Entitlement Reason Codes

The following codes occur when there is *no* Part B Entitlement Date and *no* Part B Termination Date:

Code	Definition
D	Coverage denied
N	No Foreign/Puerto Rican Beneficiary is not entitled to SMI or dually/Technically entitled Beneficiary ID not entitled to SMI.
R	Refused benefits

Part B - Enrollment Reason Codes

Code	Definition
B	Equitable Relief
C	Good Cause
D	Deemed date of birth
F	Working aged
G	General enrollment period
I	Initial enrollment period
K	Renal disease was a reason for entitlement prior to age 65 or prior to the 25th month of disability
M	Renal entitlement terminated, but disability based entitlement continues
R	Residency requirements are involved
S	State buy-in
T	Disabled working Individual * * = future – current CMS program edits do not create this code
U	Unknown

I.9 Disenrollment Reason Codes

Table I-7 lists the reason codes for Disenrollment.

Table I-7: Disenrollment Reason Code Table

Disenrollment Reason Number	Disenrollment Reason Description	MARx UI	AUTO-DIS	PLAN SUB'D
1	FAILURE TO PAY PREMIUMS	N/A	N/A	N/A
2	RELOCATION OUT OF PLAN SERVICE AREA (NO SPECIAL PROVISIONS)	N/A	N/A	N/A
3	FAILURE TO CONVERT TO RISK PROVISIONS	N/A	N/A	N/A
4	FRAUD	N/A	N/A	N/A
5	LOSS OF PART B ENTITLEMENT	N/A	Y	N/A
6	LOSS OF PART A ENTITLEMENT (PLAN-SPECIFIC)	N/A	Y	N/A
7	FOR CAUSE	Y	N/A	N/A
8	REPORT OF DEATH	N/A	Y	N/A
9	TERMINATION OF CONTRACT (CMS-INITIATED)	N/A	Y	N/A
10	TERMINATION OF CONTRACT/PBP/SEGMENT (PLAN WITHDRAWAL)	N/A	Y	N/A
11	VOLUNTARY DISENROLLMENT THROUGH PLAN	Y	N/A	Y
12	VOLUNTARY DISENROLLMENT THROUGH DISTRICT OFFICE	N/A	N/A	N/A
13	DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	N/A	Y	N/A
14	RETROACTIVE	N/A	N/A	N/A
15	TERMINATED IN ERROR BY CMS SYSTEM	N/A	N/A	N/A
16	END OF SCC CONDITIONAL ENROLLMENT PERIOD	N/A	N/A	N/A
17	BENE DOES NOT MEET AGE CRITERION (PLAN-SPECIFIC)	N/A	N/A	N/A
18	ROLLOVER	N/A	Y	N/A
19	TERMINATED BY SSA DISTRICT OFFICE	N/A	N/A	N/A
20	INVALID ENROLLMENT WITH ESRD	N/A	Y	N/A
21	CANNOT TRAVEL/POOR HEALTH/TO HMO/PLAN DOCTORS	N/A	N/A	N/A
22	SPOUSE IS NO LONGER MEMBER OF HMO/PLAN	N/A	N/A	N/A
23	COULDN'T USE MEDICARE CARD TO SEE OTHER PLAN	N/A	N/A	N/A

Disenrollment Reason Number	Disenrollment Reason Description	MARx UI	AUTO-DIS	PLAN SUB'D
24	DID NOT KNOW I JOINED THIS HMO	N/A	N/A	N/A
25	DIFFICULTY REACHING HMO/PLAN DOCTOR BY PHONE PROBLEM	N/A	N/A	N/A
26	CALLED HMO/PLAN COULD NOT GET HELP WITH PROBLEM	N/A	N/A	N/A
27	DISSATISFIED WITH MEDICAL CARE/DOCS OR HOSPITAL	N/A	N/A	N/A
28	TOLD BY PLAN DOCTORS OR STAFF I SHOULD DISENROLL	N/A	N/A	N/A
29	PREFER TRADITIONAL MEDICARE	N/A	N/A	N/A
30	HAVE OTHER HEALTH INSURANCE BENEFITS AVAILABLE	N/A	N/A	N/A
31	FOUND HMO/PLAN TOO CONFUSING	N/A	N/A	N/A
32	MY CLAIMS/BILLS WERE NOT PAID	N/A	N/A	N/A
33	HAD LITTLE OR NO CHOICE OF SPECIALIST	N/A	N/A	N/A
34	TREATED DISCOURTEOUSLY BY DOCTOR/NURSE/STAFF	N/A	N/A	N/A
35	DOCTOR COULDN'T IMPROVE MY CONDITION	N/A	N/A	N/A
36	HMO/PLAN MEDICAL GROUP WAS LOCATED TOO FAR AWAY	N/A	N/A	N/A
37	HAD LIMITED OR NO CHOICE OF MY PRIMARY DOCTOR	N/A	N/A	N/A
41	YOU MOVED PERMANENTLY OUT OF AREA WHERE PLAN PROVIDES SERVIC	N/A	N/A	N/A
42	YOUR DOCTOR OR THE PLAN TOLD YOU TO DISENROLL	N/A	N/A	N/A
43	YOUR DOCTOR DIDN'T GIVE YOU GOOD QUALITY CARE	N/A	N/A	N/A
44	YOU USED UP THE PRESCRIPTION ALLOWANCE	N/A	N/A	N/A
45	THE PLAN COST YOU TOO MUCH	N/A	N/A	N/A
46	YOU COULDN'T GET CARE WHEN YOU NEEDED IT	N/A	N/A	N/A
47	YOUR DOCTOR ISN'T IN THE PLAN	N/A	N/A	N/A
48	YOU DIDN'T KNOW YOU SIGNED UP FOR THIS PLAN	N/A	N/A	N/A
49	YOU DIDN'T LIKE HOW THE PLAN WORKED	N/A	N/A	N/A
50	ROLLED OVER ENROLLMENT REMOVED/AUDITED	N/A	Y	N/A
54	PART A OR B START DATE CHANGE	N/A	Y	N/A

Disenrollment Reason Number	Disenrollment Reason Description	MARx UI	AUTO-DIS	PLAN SUB'D
56	BENEFICIARY MEDICAID PERIOD RECEIVED	N/A	N/A	N/A
57	BENEFICIARY HOSPICE PERIOD RECEIVED	N/A	Y	N/A
59	INVALID ENROLLMENT WITH HOSPICE	N/A	Y	N/A
60	BENEFICIARY LIVES IN USA LESS THAN 183 DAYS A YEAR	N/A	N/A	N/A
61	LOSS OF PART D ELIGIBILITY	N/A	Y	N/A
62	PART D DISENROLLMENT DUE TO FAILURE TO PAY IRMAA	N/A	Y	N/A
63**	MMP OPT-OUT AFTER ENROLLED	Y	Y	Y
64**	LOSS OF DEMONSTRATION ELIGIBILITY	Y	Y	Y
65***	LOSS OF EMPLOYER GROUP PLAN ELIGIBILITY	Y	N/A	Y
70	CONFIRMED INCARCERATION	N/A	Y	N/A
71	Not Lawfully Present	N/A	Y	N/A
88	CONVERSION	N/A	N/A	N/A
90	ENROLLMENT CANCELLED DUE TO BENEFICIARY MERGE	N/A	Y	N/A
91	FAILURE TO PAY PREMIUMS	Y	N/A	Y
92	RELOCATION OUT OF PLAN SERVICE AREA	Y	N/A	Y
93	LOST SPECIFIC PLAN ELIGIBILITY (SNP ONLY)	Y	N/A	Y
99	OTHER (NOT SUPPLIED BY BENE)	N/A	N/A	Y*

*Plan cannot submit 99; it is assigned as a default value by the system only.

**Only valid for MMP Disenrollments, Disenrollment Cancellations or Enrollment Cancellations.

***Only valid for submittal on a disenrollment from an EGWP. When a disenrollment from one of these plans results in the cancellation of subsequent contiguous enrollments in the same contract, those enrollments will receive the same DRC 65.

I.10 BEQ Response File Error Condition Table

I.10.1 *Request File Error Conditions*

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

Table I-8: File Level Error information

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 (Transactions) in the file.
File Content	The File has no Transactions.	● There are no Transactions (Detail Records) found in the file.

I.10.2 *Request Transaction Detail Record Error Conditions*

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

Table I-9: 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 or RRB; 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 or RRB; date of birth, and gender**.**

J: *Report Files*

This appendix provides a description and sample snapshot of each report file. **Table J-1** lists the names of all the accessible reports to Plans and on which page of this appendix J they are located. Note that the examples provided for the reports do not identify any person living or dead; all Beneficiary, contract, and user information is fictional. Appendix J identifies the naming conventions for all reports sent to Plans. The user needs dataset names to request a report through the mainframe.

Table J-1: Reports Lookup Table

Section	Name	Page
J.1	BIPA 606 Payment Reduction Report	J-2
J.2	HMO Bill Itemization Report	J-4
J.3	Monthly Membership Detail Report – Drug Report (Part D)	J-5
J.4	Monthly Membership Detail Report – Non Drug Report (Part C)	J-6
J.5	Monthly Membership Summary Report	J-7
J.6	Monthly Summary of Bills Report	J-9
J.7	Part C Risk Adjustment Model Output Report	J-12
J.8	RAS RxHCC Model Output Report AKA - Part D Risk Adjustment Model Output Report	J-13
J.9	Payment Records Report	J-14
J.10	Plan Payment Report (PPR) (APPS Payment Letter)	J-15
J.11	Interim Plan Payment Report (IPPR)	J-16
J.12	No Premium Due Report Format	J-19

Note: See Appendix K for complete information on Dataset Names.

J.1 BIPA 606 Payment Reduction Report

Description

This report lists members for whom the MCO is paying a portion of the Part B premium. This report only reflects data for periods prior to 2006.

Example

1 RUN DATE: 2003/12/10
PAY MONTH: 2004/01 BIPA606 PAYMENT REDUCTION REPORT PAGE: 1
CONTRACT#: H3333 REPORT DATE: 2003/12/10

0 PBP ID: 026

0 CLAIM NUMBER	SURNAME	F I	S E X	BIRTH DATE	ADJ RC	PAY/ADJ DATES	BIPA RATE	BLEND TOT W/O BIPA	BIPA AMOUNT	BLEND PT-A	BLEND PT-B PLUS BIPA	BLEND TOT PLUS BIPA
123456789A	PARR	H	F	19121128		200401-200401	31.25	609.52	-31.25	362.64	215.63	578.27
123456789A	MONET	M	F	19170402		200401-200401	31.25	677.32	-31.25	400.05	246.02	646.07
123456789D	GARRISO	M	F	19130812		200401-200401	31.25	744.55	-31.25	437.15	276.15	713.30
123456789A	GEISEL	A	M	19190407		200401-200401	31.25	687.28	-31.25	387.95	268.08	656.03
123456789A	BLAZE	H	M	19170901		200401-200401	31.25	688.39	-31.25	406.45	250.69	657.14
123456789D	AMES	E	F	19061027		200401-200401	31.25	607.62	-31.25	361.59	214.78	576.37
123456789D	KLEIN	P	F	19270531		200401-200401	31.25	459.05	-31.25	243.34	184.46	427.80
123456789A	DAVIDS	J	M	19200513		200401-200401	31.25	787.43	-31.25	444.78	311.40	756.18
123456789B	DAVIDS	E	F	19180521		200401-200401	31.25	744.30	-31.25	443.28	269.77	713.05
123456789A	MURRAY	E	F	19190614		200401-200401	31.25	724.95	-31.25	418.69	275.01	693.70
123456789A	MURDOC	P	M	19161126		200401-200401	31.25	734.80	-31.25	433.85	269.70	703.55
PBP ID:	026	TOTALS:		11				$ 7,465.21	$ -343.75		$ 7,121.46	
	AGED REDUCTION:								$ -343.75			
	DIB REDUCTION:								$ 0.00			
0 CONTRACT:	H3333	TOTALS		1				$ 7,465.21	$ 0.00		$ 7,121.46	
									$ 0.00			

1 RUN DATE: 2003/12/10
PAY MONTH: 2004/01 BIPA606 PAYMENT REDUCTION REPORT PAGE: 2
CONTRACT#: H3333 REPORT DATE: 2003/12/10

0 PBP ID: 027

0 CLAIM NUMBER	SURNAME	F I	S E X	BIRTH DATE	ADJ RC	PAY/ADJ DATES	BIPA RATE	BLEND TOT W/O BIPA	BIPA AMOUNT	BLEND PT-A	BLEND PT-B PLUS BIPA	BLEND TOT PLUS BIPA
123456789B	MARKS	E	F	19220112		200401-200401	73.38	685.30	-73.38	395.50	216.42	611.92
123456789A	MONTG	M	F	19111113		200401-200401	73.38	723.40	-73.38	430.47	219.55	650.02
123456789D	SCHREIB	A	F	19190814		200401-200401	73.38	520.09	-73.38	300.46	146.25	446.71
123456789A	BECKER	V	F	19191224		200401-200401	73.38	520.09	-73.38	300.46	146.25	446.71
123456789A	BRIDGE	H	M	19171219		200401-200401	73.38	715.74	-73.38	422.51	219.85	642.36
123456789A	EDELMA	S	M	19160825		200401-200401	73.38	765.94	-73.38	452.29	240.27	692.56
123456789A	ZEMLAC	A	F	19090715		200401-200401	73.38	640.90	-73.38	381.26	186.26	567.52
123456789A	ROSENS	L	M	19180629		200401-200401	73.38	712.25	-73.38	420.62	218.25	638.87
123456789B	ROSENS	L	F	19231014		200401-200401	73.38	558.72	-73.38	322.85	162.49	485.34
123456789D	ROLNIC	I	F	19090215		200401-200401	73.38	633.83	-73.38	377.02	183.43	560.45
123456789D	KAIN	M	F	19150907		200401-200401	73.38	831.80	-73.38	494.02	264.40	758.42

PBP ID:	027	TOTALS:	11	$ 7,380.06	$ -807.18	$ 6,500.88
	AGED REDUCTION:				$ -807.18	
	DIB REDUCTION:				$ -293.52	
0 CONTRACT:	H3333	TOTALS	22	$ 14,773.27	$ -4,049.32	$ 13622.34
	AGED REDUCTION:				$ -1,150.93	
	DIB REDUCTION:				$ -293.52	

J.2 HMO Bill Itemization Report

Description

This report lists the Part A bills processed under Medicare fee-for-service for beneficiaries enrolled in the contract.

Example

1 PART A BILLS POSTED IN OCT 2002 PAGE 1

* * * * * HMO H4444 * * * * *

BILL TYPE: INPATIENT

CL AIM NUM	NAME	PROV	INT ER	H M O PD	ADM DATE	TOTAL CHAR GES	NON-COV CHARGES	INP DED	NC BLD DEDUCT	D A Y S	COINSURANCE CHGS	COINSURANCE AMOUNT	TOTAL DEDUCT	FROM DATE	THRU DATE	COV DAY S	REIM AMT	NP CD	C R
123456789A	BAKER	10084	52280	1	20020630	7821	0	812	0	0	0	812	0	20020630	20020703	0	70090		
123456789C2	MILLER	14007	4901	1	20020819	8320	8320	0	0	0	0	0	0	20020819	20020920	0	0		

1 PART A BILLS POSTED IN OCT 2002 PAGE 2

* * * * * HMO H4444 * * * * *

BILL TYPE: HOSPICE

CL AIM NUM	NAME	PROV	INT ER	H M O PD	ADM DATE	TOTAL CHAR GES	NON-COV CHARGES	INP DED	NC BLD DEDUCT	D A Y S	COINSURANCE CHGS	COINSURANCE AMOUNT	TOTAL DEDUCT	FROM DATE	THRU DATE	COV DAY S	REIM AMT	NP CD	C R
1234567891	CANDLE	11570	380		20020826	3084	0	0	0	0	0	0	0	20020901	20020930	4	3084		
12345678946	FLICKE	11570	380		20020912	1953	0	0	0	0	0	0	0	20020912	20020930	3	1953		

'

J.3 Monthly Membership Detail Report – Drug Report (Part D)

Description

This report lists every Medicare member of the contract and provides details about the payments and adjustments made for each Beneficiary. The two Monthly Membership Detail Reports are for drugs and for non-drugs.

Example

The example below is part of a Monthly Membership Detail Report containing drug information. The full report includes all members in the contract.

```
1 RUN DATE:  20090110                                   MONTHLY MEMBERSHIP REPORT-DRUG
 PAGE:          1
 PAYMENT MONTH: 200902                          PLAN (Exxxx) PBP(xxx) SEGMENT(xxx) PLAN NAME HERE
                                                      BASIC PREMIUM | ESTIMATED REINSURANCE
                                                PART D          $30.36      |       $0.00
                          S                                  ---  FLAGS  -----    --------------- PAYMENTS/ ADJUSTMENTS --
-----------------------------
CLAIM                     E  AGE   STATE       P  P      S  L  L  D  C   ADJ   RA   FCTR      DATES       LOW-INCOME COST
LOW-INCOME COST
NUMBER                    X  GRP   CNTY        A  A  E   0  O  I  E  M   REA                START  END   SHARING
PERCENTAGE   SHARING SUBSIDY
------------------------------ -  --------   ------    O  R  R  G  U  I  N M  C  -------  ---------------------------------------------------------------
-------------------------------
        SURNAME   F       DMG  BIRTH    O  T  T  H  R  N  S  I  A   MTHS  DIRECT      SUBSIDY           PACE
                  I       RA   DATE     A  A  B  P  C  C  T  N  I   D     PAYMENT   AMT        PREMIUM ADD – ON
TOTAL PAYMENT
---------------------------- -  --------   -------    -  -  -  -  -   -  -  -  -  -  -------  ---------------------------------------------------------------
------------------------------A839389                  M  8084    10500                                    1.3900       200902
200902                    000                $0.00
        FIRST       R       8084    19280401          Y D       N N   1                    $86.86                 $0.00
$0.00             $86.86
MA839389              F   8084    10500                                        1.0880      200902   200902                 000
          $0.00
        SECOND   E          8084    19270603          Y D       N N   1                    $61.39                 $0.00
$0.00             $61.69
```

J.4 Monthly Membership Detail Report – Non-Drug Report (Part C)

Description

This report lists every Medicare member of the contract and provides details about the payments and adjustments made for each beneficiary.

Example

The example below is one page of a Monthly Membership Detail Report containing non-drug information. The full report includes all members in the contract.

(above benchmark bid)

```
RUN DATE:20090124                    MONTHLY MEMBERSHIP REPORT - NON DRUG                    PAGE:      1
PAYMENT MONTH:200902                  PLAN(Hzzzz) PBP(nnn) SEGMENT(mmm) PLAN NAME HERE

                  ------------------------------------------------ REBATES ------------------------------------------
          BASIC PREMIUM | COST SHR REDUC   MAND SUPP BENEFIT  PART D SUPP BENEFIT    PART B BAS PRM REDUC   PART D BAS PRM REDUC
PART A        $0.00     |    $22.22                $0.00                $0.00                  $0.00                  $0.00
PART B        $0.00     |    $19.46                $0.00                $0.00                  $0.00                  $0.00

                   S                    ----------- FLAGS ---------------     ------------------------------------------ PAYMENTS/ADJUSTMENTS --------------------
CLAIM              E  AGE  STATE     P  P            M F    A  D    S  A C  MTHS            DATES            LAG              FTYPE
NUMBER             X  GRP  CNTY      A  A  H  E  I   C  R  O  D  E  E  O  D M  A B          START      END
--------------------  -  -------  --------  O  R  R  O  S  N  N  A  A  R  D  F  G  U  M  C  -----    ----  ------------------------------------------------------------------------------
  SURNAME  F    DMG  BIRTH   O  T  T  S  R  S  H  I  I  E  O  A  H  R  S  A  PIP    ADJ
           I    RA   DATE    A  A  B  P  D  T  C  D  L  C  N  U  P  C  P  I  DCG    REA   FCTR-A  FCTR-B    PART A    PART B    TOTAL PAYMENT
-------------------- - -------  ----------   -  -  -  -  -  -  -  -  -  -  -  -  -  -  -  -  ------ ------------------------------------------------------------------
123456789A     F  8084  33800                                                                  200405 200405    Y         C
  FIRST      G     8084  19200206    Y  Y                 1  A     Y  D            N                 1.0650  1.0650    $385.49   $337.74   $723.23
987654321B     M  8084  33800                                                                  200405 200405    Y         C
  SECOND     H     8084  19251008    Y  Y  Y  Y           4  T     N  D            N                 1.0650  1.0650    $675.22   $591.58   $1266.80
```

(below benchmark bid)

```
RUN DATE: 20090124                MONTHLY MEMBERSHIP REPORT – NON DRUG                PAGE:      1
PAYMENT MONTH:200902               PLAN(Hzzzz) PBP(nnn) SEGMENT(mmm) PLAN NAME HERE

                    ------------------------------------------------ REBATES ------------------------------------------
        BASIC PREMIUM | COST SHR REDUC   MAND SUPP BENEFIT  PART D SUPP BENEFIT    PART B BAS PRM REDUC   PART D BAS PRM REDUC
PART A        $0.00       |    $9.99                  $0.00                  $0.00                  $0.00                  $0.00
PART B        $0.00       |    $9.99                  $0.00                  $0.00                  $0.00                  $0.00

                    S          ----------- FLAGS ---------------     ------------------ PAYMENTS/ADJUSTMENTS --------------------
CLAIM               E   AGE  STATE        P P              M F     A  D      S      C   MTHS    PAYMENT DATE     LAG    FTYPE----FACTORS--------   AMOUNT
NUMBER              X   GRP  CNTY         A A  H E I      C R O  D  E  E  O      M    A B      START   END          FRAILTY-SCORE  MSP                MSP
--------------------    -   -------- ---------    O R R O S N N A A R D  F  G U  M C    ---- --- ----------------------------------------------------------------------------
  SURNAME   F          DMG  BIRTH      O T T  S R S H I I E O  A  H R  S A    PIP      ADJ
                       I    RA    DATE      A A B P D T C D L C N  U  P C  P I    DCG      REA    FCTR-A  FCTR-B     PART A     PART B     TOTAL PAYMENT
-------------------- -      -------- -----     - - - -  -  - -  - - -  -  -  - -  - -    ---- ----------------------------------------------------------------------------------------
1234567890AB    F    8084 33800                                                                  200405 200405                Y      C  99.9999          $9.99
   FIRST        G    8084 19200206       Y Y N            1     Y Z                                   1.0650  1.0650          $9.99    $9.99              $9.99
0987654321AB   M    8084 33800                                                                  200405 200405                Y      C  99.9999          $9.99
   SECOND  H        8084 19251008       Y Y Y  Y         4     P N                                   1.0650  1.0650          $ 9.99   $9.99              $9.99
```

J.5 Monthly Membership Summary Report (MMSR)

Description

This report summarizes payments to an MCO 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.

Example

RUN DATE:20081213 MONTHLY MEMBERSHIP SUMMARY REPORT (PAGE 1)
PAYMENT MONTH:200901 PLAN: Hzzz PBP(nnn) SEG(mmm) PLAN NAME 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			
PART C PREMIUM	0	$0.00	PART C PREMIUM	0	$0.00	DIR SUBSDY	0	$0.00
A/B COST SHR	0	$0.00	A/B COST SHR	0	$0.00	LIS COST SHR	0	$0.00
A/B MAN SUP BN	0	$0.00	A/B MAN SUP BN	0	$0.00	ESTIMATD REINS	0	$0.00
D BAS PRM REDU	0	$0.00	D BAS PRM REDU	0	$0.00	PACE PRM ADDON	0	$0.00
D SUPP BENFITS	0	$0.00	D SUPP BENFITS	0	$0.00			
B BAS PRM REDU	0	$0.00	B BAS PRM REDU	0				
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	1							
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:20081213 MONTHLY MEMBERSHIP SUMMARY REPORT (PAGE 2)
PAYMENT MONTH:200901 PLAN: Hzzz PBP(nnn) SEG(mmm) PLAN NAME 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	0	0	0	0	$0.00	$0.00	$0.00	$0.00
90	HIST ALIGNMT	0	0	0	0	$0.00	$0.00	$0.00	$0.00

TOTAL ADJUSTMENT

MONTHS A :	0	PART A AMOUNT :	$0.00
MONTHS B :	0	PART B AMOUNT :	$0.00
MONTHS D :	0	PART D AMOUNT :	$000,000.00-
NUMBER OF ADJUSTMENTS :	0	TOTAL AMOUNT :	$000,000.00-

TOTAL PYMT AMT A $0.00

TOTAL PYMT AMT B	$0.00
TOTAL PYMT AMT D	$000,000.00
SUM TOTAL AMOUNT	$000,000.00

J.6 Monthly Summary of Bills Report

Description

This report summarizes all Medicare fee-for-service activity, both Part A and Part B, for Beneficiaries enrolled in the contract.

Example

1 **MONTHLY SUMMARY OF BILLS PAID BY INTERMEDIARIES FOR HMO ENROLLEES**

0 HMO NO H1234 HMO NAME ABC FOUNDATION, INC. HMO FY ENDING 12/2008 CURRENT MONTH 11/2008

BILLS THROUGH 01/30/2009

0	---------- INPATIENT BILLS ----------					-------- OUTPATIENT BILLS--------			----------HHA BILLS ----------				
	TOTAL CHARGES	NON COVERED CHARGES	REIMB AMOUNT	COVERED DAYS	TOTAL BILLS	COVERED CHARGES	REIMB AMOUNT	TOTAL BILLS	TOTAL CHARGES	REIMB AMOUNT	TOTAL VISITS	TOTAL BILLS
0INTER NO 00322 PROV NO 500054	26,845	0	199	2	1	0	0	0	0	0	0	0
INT TOTAL	26,845	0	199	2	1	0						
-HMO TOTAL	26,845	0	199	2	1	0						
FY TOTAL	$26,845	$0	$199	2	1	$0	$0	0	$0	0	$0	0

1 **MONTHLY SUMMARY OF CLAIMS PAID BY CARRIERS FOR HMO ENROLLEES**

0 HMO NO H5678 HMO NAME ABC FOUNDATION, INC. HMO FY ENDING 12/2008 CURRENT MONTH 11/2008

0 TOTALS FOR THIS MONTH

0	CARRIER NUMBER	MEDICAL CHARGES	REIMB AMOUNT	TOTAL BILLS
0	67890	50	50	3
0	12345	46	41	2
0	54321	31	25	4
0	HMO TOTAL	127	116	9
	FY TOTAL	$116,001,944	$85,570,97	374

J.7 Part C Risk Adjustment Model Output Report

Description

This report shows the Hierarchical Condition Codes (HCCs) used by RAS to calculate risk adjustment factors for each beneficiary.

Example

Below is part of a Risk Adjustment Model Output report. The full report shows all of the Beneficiaries in the contract.

```
RUN DATE: 20031219                          RISK ADJUSTMENT MODEL OUTPUT REPORT                    PAGE:    1
PAYMENT MONTH: 200401                       PLAN: H8888 PLAN NAME HERE
 RAPMORP1
                LAST        FIRST                                                  DATE OF
 HIC            NAME        NAME          I                                        BIRTH       SEX & AGE GROUP
 ---------------- ---------------- ------------------ -                            ---------   ---------------------------

 123456789A     WOOD        CHARLES       W                                        19250225    Male75-79
Originally Disabled Male Aged (Age>64)
HCC DISEASE  GROUPS:   HCC019 Diabetes without Complication
                       HCC080 Congestive Heart Failure
                       HCC092 Specified Heart Arrhythmias

123456789B     TREE        LILLIAN       L                                        19270418    Female75-79
HCC DISEASE  GROUPS:   HCC010 Breast, Prostate, Colorectal and Other Cancers and Tumors
                       HCC016 Diabetes with Neurologic or Other Specified Manifestation
                       HCC071 Polyneuropathy
                       HCC108 Chronic Obstructive Pulmonary Disease

123456789A     GRASS       ALBERT        A                                        19421213    Male60-64
HCC DISEASE  GROUPS:   HCC079 Cardio-Respiratory Failure and Shock
                       HCC080 Congestive Heart Failure
                       HCC092 Specified Heart Arrhythmias
                       HCC108 Chronic Obstructive Pulmonary Disease
                       HCC131 Renal Failure
INTERACTIONS:          INTI03 CHF_COPD
                       INTI05 RF_CHF1
```

J.8 RAS RxHCC Model Output Report - aka - Part D RA Model Output Report

Description

This report shows the Hierarchical Condition Codes (HCCs) used by RAS to calculate risk adjustment factors for each beneficiary.

Example

Below are the first few lines of a RA Model Output report. The full report shows all of the Beneficiaries in the contract.

```
RUN DATE: 20060124                          RISK ADJUSTMENT MODEL OUTPUT REPORT                    PAGE:    1
PAYMENT MONTH: 200602                       PLAN: H9999 PLAN NAME HERE
 RAPMORP2
                 LAST          FIRST                                                   DATE OF
HIC              NAME          NAME            I                                       BIRTH        SEX & AGE GROUP
----------------- ---------------- ------------------ -                                 ---------    ---------------------------

123456789A       TWO           RUTH            M                                       19181122     Female85-89
 RXHCC DISEASE  GROUPS:  RXHCC019 Disorders of Lipoid Metabolism
                         RXHCC048 Other Musculoskeletal and Connective Tissue Disorders
                         RXHCC092 Acute Myocardial Infarction and Unstable Angina
                         RXHCC098 Hypertensive Heart Disease or Hypertension
                         RXHCC159 Cellulitis, Local Skin Infection

 123456789A   BREEZE                     WINDY       T                                  19620730     Female35-44
 RXHCC DISEASE  GROUPS:  RXHCC045 Disorders of the Vertebrae and Spinal Discs
                         RXHCC085 Migraine Headaches
                         RXHCC098 Hypertensive Heart Disease or Hypertension
                         RXHCC113 Acute Bronchitis and Congenital Lung/Respiratory Anomaly
                         RXHCC129 Other Diseases of Upper Respiratory System
                         RXHCC144 Vaginal and Cervical Diseases
```

J.9 Payment Records Report

Description

This report lists the Part B physician and supplier claims that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract.

Example

1 PART B CLAIMS RECORDS POSTED IN OCT 2002 PAGE 1

0 * * * * *HMO H2222 * * * * *

0 CLAIM NUMBER	NAME FIRST	EXPENSE LAST	DATES	ALLOWED TOTAL CHARGES	REIMB AMT	COINSURANCE AMT	DED AMT	PHYS APP	PAY SUPP ID	CARRIER IND	CARRIER NUMBER	INFORMATION PAID CONTROL NUMBER
123456789A	JONES	20020917	20020917	9.72	7.78	1.94	.00	L99999	1	11111	20021014	620902283027160
123456789A	HOWARD	20020920	20020920	12.00	9.60	2.40	.00	L88888	1	11111	20021014	620902283027550
123456789A	WILLS	20020830	20020830	12.65	10.12	2.53	.00	P77777	1	11111	20021017	620902283028810
123456789A	BRILL	20020831	20020831	12.00	9.60	2.40	.00	P77777	1	11111	20021014	620902283028800
123456789A	SOMMER	20020915	20020915	12.00	9.60	2.40	.00	P77777	1	11111	20021014	620902283028820
123456789A	HOWARD	20020708	20020708	5.43	5.43	.00	.00	000000	1	22222	20021023	02262828553000

J.10 Plan Payment Report (APPS Payment Letter)

Description

Also known as the APPS Payment Letter, this report itemizes the final monthly payment to the MCO. This report is produced by APPS when final payments are calculated. CMS makes this report available to MCOs as part of month-end processing.

Plan Payment Report (PPR) - Final

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.

Following is an updated example of a PPR or APPS Payment Letter:

CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : HXXXX PAGE: 1/5
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 07/2012
RUN DATE : 06/12/2012
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	35,784	17,086,056.85			17,086,056.85
	PROSPECTIVE PART B PAYMENT	35,783		15,586,246.88		15,586,246.88
	PROSPECTIVE PART D PAYMENT	35,741			3,129,416.09	3,129,416.09
(01)	DEATH OF BENEFICIARY	78	-61,204.10	-58,211.37	-8,980.08	-128,395.55
(02)	RETROACTIVE ENROLLMENT	101	49,787.41	44,781.16	13,449.77	108,018.34
(03)	RETROACTIVE DISENROLLMENT	115	-66,532.55	-61,216.03	-14,285.83	-142,034.41
(06)	CORRECT PART A ENT	0	0.00	0.00	0.00	0.00
(07)	RETRO HOSPICE STATUS	218	-242,684.06	-219,290.39	0.00	-461,974.45
(08)	RETRO ESRD STATUS	6	32,780.71	45,180.41	63.33	78,024.45
(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	35	14.75	13.20	0.00	27.95
(12)	DATE OF DEATH CORRECTION	21	-17,285.62	-17,229.46	-2,756.17	-37,271.25
(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	8	-929.11	-839.59	-744.86	-2,513.56
(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	17,202	3,459,452.35	3,129,337.35	0.00	6,588,789.70
(27)	RETRO CHF	0	0.00	0.00	0.00	0.00
(31)	RETRO LIS STATUS	29	0.00	0.00	3,867.48	3,867.48
(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	24,321	0.00	0.00	254,021.30	254,021.30
(42)	RETRO MSP FACTOR CHG	127	117,628.03	105,380.36	0.00	223,008.39
(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
(94)	PMT ADJ DUE TO CLEANUP	0	0.00	0.00	0.00	0.00
TOTAL		149,569	20,357,084.66	18,554,152.52	3,374,051.03	42,285,288.21

** THE TOTAL PART D INCLUDES COVERAGE GAP DISCOUNT OF:

PROSPECTIVE	=	105,755.60
ADJUSTMENT	=	-517.04
TOTAL	=	105,238.56

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

CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : HXXXX
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 07/2012
RUN DATE : 06/12/2012
REPORT SECTION: PREMIUM SETTLEMENT
TABLE NUMBER : 2

PAGE: 2/5

PAYMENT CATEGORY	PART C	PART D	NET PAYMENT
PART C PREMIUM WITHOLDING	55,758.00		55,758.00
PART D PREMIUM WITHOLDING		0.00	0.00
PART D LOW INCOME PREMIUM SUBSIDY		69,579.10	69,579.10
PART D LATE ENROLL PENALTIES (DIRECT BILL)		-5,332.20	-5,332.20
TOTAL	55,758.00	64,246.90	120,004.90

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

CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : HXXXX
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 07/2012
RUN DATE : 06/12/2012
REPORT SECTION: FEES
TABLE NUMBER : 3

PAGE: 3/5

DESCRIPTION	INPUTS	PART A	PART B	PART D	NET PAYMENT
EDUCATION USER FEE:					
1) PART A AMT SUBJECT TO FEE	17,086,056.85				
2) X FEE RATE	0.00048	-8,201.31			-8,201.31
3) PART B AMT SUBJECT TO FEE	15,586,246.88				
4) X FEE RATE	0.00048		-7,481.40		-7,481.40
5) PART D AMT SUBJECT TO FEE	3,093,618.69				
6) X FEE RATE	0.00048			-1,484.94	-1,484.94
TOTAL					-17,167.65
COB USER MEMBERS:					
1) PROSP D MEMBERS	35,741.00				
2) X FEE RATE	0.18			-6,433.38	-6,433.38
TOTAL		-8,201.31	-7,481.40	-7,918.32	-23,601.03

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

CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : HXXXX
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 07/2012
RUN DATE : 06/12/2012
REPORT SECTION: SPECIAL ADJUSTMENT
TABLE NUMBER : 4

PAGE: 4/5

DOC ID	DESCRIPTION	SOURCE	TYPE	PAYMENT CATEGORY	PART A	PART B	PART D/HITECH	NET PAYMENT
2012-0067	PART D 2006 REOPENING	DPR	PRS	CAPITATED	0.00	0.00	-732.32	-732.32
				PREMIUM C	0.00	0.00		0.00
				PREMIUM D			0.00	0.00
				LIS			0.00	0.00
				HTC			0.00	0.00
TOTAL					0.00	0.00	-732.32	-732.32

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

CGD = COVERAGE GAP DISCOUNT INVOICE
CMP = CIVIL MONETARY PENALTY
CST = COST PLAN ADJUSTMENT
HTC = HITECH INCENTIVE PAYMENT
OTH = OTHER - NON SPECIFIC ADJUSTMENT GROUP
PRS = ANNUAL PART D RECONCILIATION
PTD = PART D RISK ADJUSTMENT
RAC = RECOVERY AUDIT CONTRACT ADJUSTMENT
RSK = RISK ADJUSTMENTS

CMS MONTHLY PLAN PAYMENT REPORT

PAGE: 5/5

PLAN NUMBER : HXXXX
PLAN NAME : XXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MONTH : 07/2012
RUN DATE : 06/12/2012
REPORT SECTION: PAYMENT SUMMARY
TABLE NUMBER : 5

SOURCE	PAYMENT SUMMARY	PAYMENT TYPE	PREVIOUS BALANCE	CURRENT ACTIVITY	NET PAYMENT	BALANCE FORWARD
TABLE 1	PART A	CAPITATED	0.00	20,357,084.66	20,357,084.66	0.00
TABLE 1	PART B	CAPITATED	0.00	18,554,152.52	18,554,152.52	0.00
TABLE 1	PART D	CAPITATED	0.00	3,374,051.03	3,374,051.03	0.00
TABLE 2	PART C PREMIUM WITHHOLDING	PREMIUM	0.00	55,758.00	55,758.00	0.00
TABLE 2	PART D PREMIUM WITHHOLDING	PREMIUM	0.00	0.00	0.00	0.00
TABLE 2	PART D LOW INCOME PREMIUM SUBSIDY	PREMIUM	0.00	69,579.10	69,579.10	0.00
TABLE 2	PART D LATE ENROL PENALTIES	PREMIUM	0.00	-5,332.20	-5,332.20	0.00
TABLE 3	EDUCATION USER FEE	FEES	0.00	-17,167.65	-17,167.65	0.00
TABLE 3	PART D COB USER FEE	FEES	0.00	-6,433.38	-6,433.38	0.00
TABLE 4	CMS ADJUSTMENTS	SPEC ADJ	0.00	-732.32	-732.32	0.00
TOTAL			0.00	42,380,959.76	42,380,959.76	0.00

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

J.11 Interim Plan Payment Report (IPPR)

Description

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).

IPPR

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 User Interface under the weekly reports section of the menu.

12 Plan Payment Report

Note: For a sample of this report, refer to J.11 for the file format.

J.12 No Premium Due Report Format

No Premium Due Reports are no longer generated. Only a data file is produced. The report is here for reference

```
         1         2         3         4         5         6         7         8         9         0         1         2         3
123456789012345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345678901234567890123


RUN DATE:  01/15/2005                    TRANSACTION REPLIES/MONTHLY ACTIVITY                                  REPORT ID:  10
REPORTING MONTH:  12/2004          PLAN (Hzzzz) PBP (nnn) SGMT (mmm) Health Plan Name Here                          PAGE:   1
 * * * PLAN-SUBMITTED TRANSACTIONS:  ACCEPTED * * *
---------------------------  T R A N S A C T I O N  ---------------------------------------------  R E P L Y  -----------------
                   S                  O E            L  CO-PAY
                 F E DATE OF  EFF          O L SRCE  SPECIAL I  EFF        --PREMIUMS--   RPLY
TC CLAIM NUMBER SURNAME I X BIRTH    DATE     SCC   A T ID    STATUS  S  DATE       PT C     PT D  CODE REMARKS
-------------------------------------------------------------------------------------------------------------------------------------
61 1234567890AB DAVIDSO F M 09/10/26 01/01/05 45850 Y A SYSGN HEWIN  1  01/01/05  100.00   200.00  011  ENROLL ACCEPTED
51 1234567890AB BELMORE M F 03/27/33 01/01/05 22000 N E TV6K      N  2  04/01/05     .00    85.30  014  DISNROL-NEW MCO
51 123456789A   DUGAN   D F 07/14/17 01/01/05 45180 Y I TOE8   E     3  05/01/05     .00   113.56  014  AUTO DISENROLL
```

K: *All Transmissions Overview*

Table K-1: All Transmissions Overview

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Dataset naming conventions key: [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 = Contract number Pccccc = Plan Contract Number for C:D Uuuu-uuuuuu = 4-7 character transmitter RACF ID xxxxx = 5 character Contract ID yyyymmdd = Calendar year, month & day yymmdd = two digit year, month, 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 mmyyyy = Calendar month & year hlq = High Level Qualifier or Directory per VSAM File freq = Frequency code of file	
Plan Submittals to CMS						
1	**MARx Batch Input Transaction Data File** Header Record Disenrollment (51/54) Detail Record Enrollment (61) Detail Record Miscellaneous Change Detail Records: Correction (01) Record 4Rx Data Change (72) Number of Uncovered Months (NUNCMO) Change (73) Employer Group Health Plan (EGHP) Change (74) Premium Payment Option (PPO) Change (75) Residence Address Change (76) Segment ID Change (77) Part C Premium Change (78) Part D Opt-Out (79) MMP Opt-Out Update (TC83) Cancellation of Enrollment (80) and Cancellation of Disenrollment (81) Detail Records MMP Enrollment Cancellation (TC82) POS Drug Edit (TC90) **PCUG Record Layout – F.3**	Enrollment Transaction file to CMS MARx system requesting new enrollment, disenrollment, changes, etc. Only the 1-800-Medicare group submits a Part D Opt-Out (41) transaction.	MARx	Data File	Batch - 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 **PCUG Record Layout – F.6**	File of transactions submitted by Plans to request eligibility information for prospective Plan enrollees. Used to do initial eligibility checks against CMS MBD system to verify member is Part A./B eligible.	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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
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
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
ID#	**Transmittal**	**Description**	**Responsible System**	**Type**	**Freq.**	**Dataset Naming Conventions**
		Plan Submittals to CMS				
5	**MARx Batch Input Transaction Data File** Header Record Enrollment Transaction (Employer & Plan - 61 Detail Record Disenrollment Transaction (51/54) Detail Record Plan Elections (PBP Change) Transaction (71) Detail Record 4Rx Data Update (72) NUNCMO Update (73) Other Enrollment record Update (74) Premium Withhold Option Update (75) **PCUG Record Layout – F.3**	Enrollment Transaction file to CMS MARx system requesting new enrollment, disenrollment, changes, etc. Only the 1-800-Medicare group submits a Part D Opt-Out (41) transaction.	MARx	Data File	Batch - 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
6	**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
7	**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
8	**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
9	**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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Users (Submitters)						
CMS Transmittals to the Plans						
10	**Failed Transaction Data File** Header Record Failed Record	This report is no longer generated as a result of the November 2009 software release. Failed Records are now reported on the BCSS data file.	MARx	Data File	Response to transaction batch file	Obsolete
11	**Batch Completion Status Summary Data File** Summary Record Failed Records **PCUG Record Layout – F.1**	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
12	**Enrollment Transmission Message File (STATUS)**	This message is no longer generated as a result of the April 2011 software release. This information is now incorporated into the Batch Completion Status Summary (BCSS) data file.	MARx	Report	Response to transaction batch file	Obsolete
13	**Coordination of Benefits (Validated Other Insurer Information) Data File** Detail Record Primary Record Supplemental Record **PCUG Record Layout – F.2**	File containing members' primary and secondary 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 Other Health Insurance (OHI) 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
14	**MA Full Dual Auto Assignment Notification File** Header Record Detail Record (Transaction) Trailer Record **PCUG Record Layout – F.22**	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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Plans						
15	**Auto Assignment (PDP) Address Notification File** Header Record Detail Record(s) Trailer Record **PCUG Record Layout – F.23**	Monthly file of addresses of Beneficiaries who have been either Auto Assigned or Facilitated Assigned to PDPs.	MBD	Data File	Monthly	**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
16	**NoRx File** Header Record Detail Record Trailer Record **PCUG Record Layout – F.21**	File containing records identifying those enrollees that do not currently have 4Rx information stored in CMS files. A Detail Record Type containing a value of "NRX" in positions 1 – 3 of the file layout will indicate that this record is a request for your organization to send CMS 4Rx information for the beneficiary.	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
17	**Batch Eligibility Query (BEQ) Request File Acknowledgment (Accept/Reject)** **PCUG Sample Report – F.6.4**	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. If Accepted the file will be processed. If Rejected, the e-mail shall inform the Sending Entity of the first File Error Condition that caused the BEQ Request File to be Rejected. A rejected file will not be returned.	MBD	E-mail	Response to BEQ	N/A
18	**Batch Eligibility Query (BEQ) Response File** Header Record Detail Record (Transaction) Trailer Record **PCUG Record Layout – F.7**	File containing records produced as a result of processing the transactions of accepted BEQ Request files. Detail records for all submitted records that were successfully processed will contain Processed Flag = Y. Detail records for all submitted records that were not successfully processed contain Processed Flag = N.	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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Plans						
19	**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
20	**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
21	**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 (Mainframe):**
22	**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
23	**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
24	**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
25	**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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Plans						
26	**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_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
27	**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_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
28	**Transaction Reply Daily Activity Data File** **PCUG Record Layout – F.5**	Data file version of the Transaction Reply Daily Activity Report.	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
29	**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
30	**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
31	**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
32	**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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Plans						
33	**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 (Data & Reports)						
34	**LIS/Part D Premium Data File** **PCUG Record Layout – F.8**	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. This data file is produced bi-weekly. 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
Monthly Transmittals (Data & Reports)						
35	**Part C Monthly Membership Detail Report (Non Drug Report)** aka: Monthly Membership Report (MMR) **PCUG Sample Report – J.5**	Report listing every Part C Medicare member of the contract and providing details about the payments and adjustments made for each. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMR.Dyymm01.Thhmmsst P.Rxxxxx.MONMEMR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMR.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEMR.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMR.Dyymm01.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
36	**Part D Monthly Membership Detail Report (Drug Report)** aka: Monthly Membership Report (MMR) **PCUG Sample Report – J.4**	Report listing every Part D Medicare member of the contract and provides details about the payments and adjustments made for each. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMDR.Dyymm01.Thhmmsst P.Rxxxxx.MONMEMDR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMDR.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMDR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEDR.Dyymm01.Thhmmsst [directory]Rxxxxx.MONMEDR.Dyymm01.Thhmmsst
37	**Monthly Membership Detail Data File** **PCUG Record Layout – F.12**	Data file version of the Monthly Membership Detail Reports. This file contains the data for both Part C and Part D members. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
38	**Monthly Membership Summary Report** **PCUG Sample Report – J.5**	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. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
39	**Monthly Membership Summary Data File** **PCUG Record Layout – F.12**	Data file version of the Monthly Membership Summary Report for both Part C and Part D members. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Data File	Monthly	**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
40	**RAS RxHCC Model Output Report** ***AKA: Part D Risk Adjustment Model Output Report*** **PCUG Sample Report – J.8**	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. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	RAS (MARx)	Report (.pdf)	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
41	**RAS RxHCC Model Output Data File** ***AKA: Part D Risk Adjustment Model Output Data File*** Header Record Detail / Beneficiary Record Format Trailer Record **PCUG Record Layout – F.16**	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. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
42	**Part C Risk Adjustment Model Output Report** **PCUG Sample Report – J.7**	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. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
43	**Part C Risk Adjustment Model Output Data File** Header Record Detail Record Trailer Record **PCUG Record Layout – F.15**	Data file version of the Risk Adjustment Model Output Report. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
44	**BIPA 606 Payment Reduction Report** **PCUG Sample Report – J.1**	Report listing members for whom the Plan is paying a portion of the Part B premium. Generated only if there are pre-2006 adjustments that involve BIPA 606 premium reductions. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly, if applicable	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.BIPA606R.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.BIPA606R.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.BIPA606R.Dyymm01.Thhmmsst
45	**BIPA 606 Payment Reduction Data File** **PCUG Record Layout – F.10**	Data file version of the BIPA 606 Reduction Report. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Data File	Monthly, if applicable	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.BIPA606D.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.BIPA606D.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.BIPA606D.Dyymm01.Thhmmsst
46	**Monthly Summary of Bills Report** **PCUG Sample Report – J.6**	Report summarizing all Medicare fee-for-service activity, both Part A and Part B, for Beneficiaries enrolled in the contract Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
47	**HMO Bill Itemization Report** **PCUG Sample Report – J.2**	Report listing the Part A bills that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
48	**Part B Claims Data File** **Record Type 1** **Record Type 2** **PCUG Record Layout – F.14**	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. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
49	**Payment Records Report** **PCUG Sample Report – J.9**	Report listing the Part B physician and supplier claims that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
50	**Monthly Premium Withholding Report Data File (MPWR)** **Header Record** **Detail Record** **Trailer - T1 - Total at segment level** **Trailer - T2 - Total at PBP level** **Trailer - T3 - Total at contract level** **PCUG Record Layout – F.13**	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. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
51	**Failed Payment Reply Report** **Detail Record** **PCUG Record Layout – F.27**	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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
52	**Plan Payment Report (APPS Payment Letter)** **PCUG Sample Report – J.10**	Report itemizing the final monthly payment to the Plan. This report is produced by the APPS when final payments are calculated. MARx makes this report available to Plans as part of the month-end processing. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
53	**Plan Payment Report (APPS Payment Letter) Data File** **PCUG Record Layout – F.24**	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. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
54	**Interim APPS Plan Payment Report** **PCUG Sample Report – J.11**	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
55	**Interim APPS Plan Payment Report Data File** **PCUG Sample Layout – F.24**	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.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory].Rxxxxx.PPRID.Dyymmdd.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
56	**820 Format Payment Advice Data File** **PCUG Record Layout – F.9**	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. Note: The date in the file name defaults to "01" denoting the first day of the CCM.	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
57	**Monthly Full Enrollment Data File** **PCUG Record Layout – F.18**	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.Dyymm01.Thhmmsst
58	**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
59	**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
60	**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
61	**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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
62	**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
63	**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
64	**LEP Data File** Header Record Detail Record Trailer Record **PCUG Record Layout – F.19**	This report provides information on low-income subsidized Beneficiaries and on direct-billed Beneficiaries with late enrollment penalties. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	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
65	**LIS History Data File (LISHIST)** **PCUG Record Layout – F.20**	This 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. Note: The date in the file name defaults to "dd" denoting the day of the calendar month.	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
66	**Agent Broker Compensation Data File** **PCUG Record Layout – F.25**	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 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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
67	**Monthly MSP Information Data File** **PCUG Record Layout – F.26**	This data file is sent directly to Plans on the first Monday after the MARx month-end processing completes. This file contains a subset of information to allow Plans to reconcile payment; the full monthly MSP COB file distributed at the beginning of each month contains more detail.	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
68	**Medicare Advantage Organization (MAO) 004 Report**	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.MAO004.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MAO004.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MAO004.Dyymmdd.Thhmmsst
Quarterly Report						
69	**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 Report						
70	**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
71	**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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Yearly Report						
72	**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
73	**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
74	**Loss of Subsidy Data File** **PCUG Record Layout – F.28**	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. The data file has a record length of 500 bytes. The TRC used for this special file type is 996. 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
75	**PDP Loss Data File**	Once a year notification file sent by CMS providing 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

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Yearly Report						
76	**PDP Gain Data File**	Once a year notification file, sent by CMS, 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
77	**Long-Term Institutionalized Resident Report** **PCUG Record Layout – F.30**	The Long-Term Institutionalized (LTI) Resident Report provides Part D sponsors a list of their Beneficiaries who are LTI residents during July and January of each year. This report contains basic information on the Beneficiaries and their institutions (Skilled Nursing Home or Nursing Home).	MDS	Report	Twice Yearly	**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
78	**No Premium Due Data File** **PCUG Record Layout – F.31**	The no premium due 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

L: *MA Plan Connectivity Checklist*

Getting Started				
☑ **or N/A**	**#**	**Task**	**Checkpoint**	**Notes**
☐	1.	Obtain a Contract Number from CMS/HPMS	Once completed, Task #4 may be initiated.	Contract #:
☐	2.	Enter Connectivity Data into HPMS Plan Connectivity Data Module (Plans are required to mail/fax completed forms to MAPD Help Desk)		
	3.	Complete T1/Connect:Direct information in the PCD module	Must be started at least 6 weeks prior to target connectivity testing date.	
☐ or N/A		1. CMS Connect:Direct data entry into HPMS		
☐ or N/A		2. CMS SPOE ID Request form		
Security and Access				
☑ **or N/A**	**#**	**Task**	**Checkpoint**	**Notes**
☐	4.	Submit EPOC Designation Letter to CMS	After completion of Task #1.	
☐	5.	EPOC registered in EIDM (Allow 5 business days once EPOC letter is submitted before registering in EIDM)	After completion of Task #4.	
☐	6.	EPOC approval received from CMS		
☐	7.	User/Submitter(s) registered in EIDM for Enrollment, BEQ and ECRS	After EPOC registration is complete.	
☐ or N/A	8.	User/Representative(s) registered in EIDM for Enrollment, BEQ and ECRS	After EPOC registration is complete.	
☐ or N/A	9.	User/Submitter(s) registered in EIDM for PDE/RAPS	Gentran/TIBCO MFT Submitters only. May be completed the same time as Task #7 or at a later date.	
Connectivity – Setup **Note: Plans perform either Task #10 or Task #11.**				
☐ or N/A	**#**	**Task**	**Checkpoint**	**Notes**
	10.	Each item listed in this Task is **required** by Plans submitting data via Connect:Direct. Set up T1/Connect:Direct to CMS:	Must be started at least 6 weeks prior to target connectivity testing date.	
☐ or N/A		1. Contact AT&T or an AT&T reseller to establish connectivity to CMS via AGNS.		
☐ or N/A		2. Verify access to CMS via AGNS		
☐ or N/A		3. High-level qualifier and/or security designations verified as accessible to CMS.		
☐ or N/A		4. Obtain Connect:Direct Software from Sterling Commerce.		

❑ or N/A		5. Complete installation and configuration of Connect:Direct Software.		
❑ or N/A		6. Submitter successfully registered in EIDM (see Task #8).		
❑ or N/A		7. Obtain SPOE ID from CMS (see Task #3.2).		
	11.	Each item listed in this Task is **required** by Plans submitting data via Gentran/TIBCO MFT. Set up Gentran/TIBCO MFT access:		
❑ or N/A		1. Submitter successfully registered in EIDM (see Task #7).		
❑ or N/A		2. Obtain and install SFTP Software (if not using HTTPS)		
❑ or N/A		3. Open required firewalls/ports: SFTP Port: 10022 HTTPS Port: 3443		

Connectivity – Testing
Note: Plans perform either Task #12 or Task #13. Plans submitting PDE/RAPS data must also perform Task #14.

	#	Task	Checkpoint	Notes
	12.	Each item listed in this Task is **required** by Plans submitting data via Connect:Direct. Test T1/Connect:Direct to CMS:		
❑ or N/A		1. Appropriate telecommunications and technical resources participate in conference call with appropriate CMS Resources (initiated by MAPD Help Desk).		
❑ or N/A		2. Successfully transfer data **to** CMS		
❑ or N/A		3. Successfully receive data **from** CMS		
	13.	Each item listed in this Task is **required** by Plans submitting data via Gentran/TIBCO MFT. Test Gentran/TIBCO MFT:	Task # 7 must be completed successfully before this task can be completed.	
❑ or N/A		1. Mailbox(s) established at CMS is accessible		
❑ or N/A		2. Screenshot of successful access to 1 Gentran mailbox e-mailed to the MAPD Help Desk.		
❑ or N/A		3. Send test file to Gentran mailbox/TIBCO MFT server		
❑ or N/A	14.	Contact CSSC Help Desk for assistance with Connectivity Testing of PDE/RAPS data submission.		

M: *Valid Election Types for Plan-Submitted Transactions*

Table M-1 shows the valid election types for Plan-submitted enrollment and disenrollment transactions. Plans must ensure the requirements in the CMS Enrollment and Disenrollment guidance applicable to the Plan type are followed to properly determine and report the election type.

Table M-1: Valid Election Types for Plans

Election Types						
PLANS	**AEP (A)**	**OEPI (T)**	**SEP (Note 2)**	**IEP (E/F)**	**MADP**	**ICEP (I)**
MA	**Y**	**Y**	**Y**	**N**	**Y**	**Y**
MA-PD	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
PDP	**Y**	**N (Use coordinating SEP where appropriate per CMS guidance)**	**Y**	**Y**	**N (Use coordinating SEP where appropriate per CMS guidance)**	**N**
SHMO I	**Y**	**Y**	**Y**			**Y**
SHMO II	**Y**	**Y**	**Y**			**Y**
Cost with Part D	**Y**	**N (Use coordinating SEP where appropriate per CMS guidance)**	**Y**	**Y**	**Use coordinating SEP where appropriate per CMS guidance)**	
Cost without Part D	**None required; however, if the beneficiary is currently enrolled in an MA Plan, a valid MA election period is required to leave that program and enroll in the cost Plan.**					
WPP	**Y**	**Y**	**Y**	**Y**		**Y**
ESRD I			**Y**			
ESRD II			**Y**			
PACE National	**None Required**					
CCIP / FFS Demos	**None Required**					
MDHO Demo	**None Required**					
MSHO Demo	**None Required**					

Election Types						
PLANS	**AEP (A)**	**OEPI (T)**	**SEP (Note 2)**	**IEP (E/F)**	**MADP**	**ICEP (I)**
MSA	**Y**	**N**	**Y**	**N**	**N**	**Y**
MSA Demo	**Y**		**Y**		**N**	**Y**

Note 1: For code usage, refer to the previously released MMA Guidance and PDP Guidance.

Note 2: For election type SEP, use the following values under these specific circumstances:

- U - for Duals and Individuals with LIS
- W - for EGHP
- V - for permanent moves
- Y - CMS Casework use only (not submitted by Plans)
- S - Any other SEP as provided in guidance that is not one of the above values.

Note 3: In addition to these election period identifiers, CMS provides a valid value of 'X' for use in the election period identifier field. This value is an Administrative Action and Plans may use when a submitted transaction is not reflective of an actual Beneficiary election, as follows:

- Plan submitted "rollover"- Year-end processing occasionally requires that Plans submit transactions to accomplish the Plan crosswalk from one contract year to another. When required, as defined in the CMS Call Letter instructions, Plans should use the 'X' value in the election period field of the enrollment transaction submitted for this purpose.

- Involuntary Disenrollment - In limited circumstances, Plans may involuntarily disenroll individuals for specific reasons and when meeting all of the conditions provided in CMS enrollment guidance. Since these actions are not "elections," Plans should use the value of 'X' in the election period field of the disenrollment transaction submitted for this purpose.

- Premium Option Change - Plans may submit changes to an individual's premium withholding status via a 72 transaction. When doing so, Plans should use the 'X' value in the election period field of the 72 transaction submitted for this purpose.

- Plan-submitted "canceling" Transaction - Since beneficiaries may choose to cancel an enrollment or disenrollment request prior to the effective date of the request, occasionally Plans submit "canceling" transactions to CMS to cancel an already submitted action. Plans should use the value TC 80 to cancel an enrollment or TC 81 to cancel a disenrollment transaction.