DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
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Medicare Plan Accountability Group

DATE: May 31, 2005

 TO: **A**ll Medicare Advantage (MA) Plans, Part D Plans (PDPs), Cost-
               Based Organizations and Demonstrations

FROM: Cynthia E. Moreno /s/
               Acting Director

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

The purpose of this letter is to provide more operational details of the enrollment and
payment system changes related to the implementation of the Medicare Modernization
Act (MMA). It re-issues the transaction layouts which have increased in size due to
changes in the RXID and RXGROUP field formats and the Monthly Membership Report
(MMR) to address dollar field format changes and to add two PACE payment addon
fields. New adjustment reason codes are defined. In addition, this letter addresses
changes in the following areas:

- The revised Transaction Reply layout,
- Data Communications Requirements
- New Transaction Reply Codes,
- A draft of the new Premium Report,
- Process to populate Premium information for current MA plan members,
- Cost Plan Transaction Requirements and the
- CMS auto-enrollment process.

Transaction Changes
The transaction layouts have been re-issued to address the increase in size of the RXID
(from 11 to 20 bytes) and of the RXGROUP (from 12 to 15 bytes). There is a proposal to
have the RXID, RXGRP, PCNBIN and other routing information submitted after
enrollment rather than with the enrollment transaction. We will be sending final
information and instructions about these data elements in the next few weeks. More
information addressing TrOOP and coordination of benefits is also forthcoming in the
near future. We are adding 17 spaces as filler to the end of these transactions to
accommodate any future additions. Please note that all transactions, including the 01
Correction Transaction are now 224 in length. See Attachment A for the revised layouts
and notes containing the valid values for the fields.

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MMR Changes
The MMR format has been re-issued to expand the MMA dollar fields and to add 2 new fields for the PACE payment addons and 1 new field for the number of Part D payment/adjustment months. We have also noted which fields are applicable to PDPs as we are using the same format for PDPs and MA/MA-PDs**.** See Attachment B for the updated layout.

The new adjustment reason codes are:

28 - Retroactive change to Part B premium reduction amount - affects Part C

29 - Retroactive change to Hospice rate - affects Part C

30 - Retroactive change to basic Part D premium - affects Part D

31 - Retroactive change to Part D low-income premium subsidy amount - affects Part D.
NOTE – This code may not be needed based on the final design of the Premium Report. Premium-related payments to plans were all going to be included on the premium report; however a CMS decision regarding this is pending. .

32 - Retroactive change to estimated LIS cost sharing amount - affects Part D
NOTE – There **will be no** retroactive adjustments to LIS cost-sharing amounts in cases that would negatively impact the beneficiary; i.e., CMS will not hold the beneficiary liable if their cost-sharing level is retroactively reduced. There **will** be adjustments to LIS cost-sharing amounts when a beneficiary is determined to be eligible for the LIS retroactively. The appropriate cost-sharing amounts are to be applied back to the date that the beneficiary was determined to be eligible.

33 - Retroactive change to estimated reinsurance amount - affects Part D

34 - Retroactive change to basic Part C premium - affects Part C

35 - Retroactive change to rebate amount - affects Part C

36 – Part D rate change – affects Part D

37 – Retroactive change to Part D risk adjustment factor – affects Part D

Data Communications Requirements

The Office of Information Services within CMS has developed a "Concept of Operations" for data communications with the CMS Datacenter. The new telecommunication requirements were developed in response to the Medicare Modernization Act and the expected increase in the number of plans who will be in operation on January 1, 2006. These requirements apply to all Medicare Advantage Organizations (MAO) regardless of their type of contract with CMS, all cost based organizations and to all Prescription Drug Plans. The data communication options are described in the attached 'Concept of Operations' document.

All current contracting Medicare Advantage plans, Cost plans, HCPPs, and demonstrations will be allowed to transition during 2006 from their current mode of data exchange to these new requirements. Current contractors are certainly encouraged to switch over during 2005 if at all possible. All organizations not currently enrolling members will be required to communicate with CMS using one of the prescribed methods based on the size of your organization. Please contact the Medicare Modernization Customer Service Center at 1-800-927-8069 for assistance.

The changes in data communication could possibly result in changes to the transaction and monthly report file names. Information regarding any impacts to file names will be sent in the next few weeks.

Transaction Reply Data File
The revised layout of the transaction reply report (TRR) is expanding from 133 to 254 bytes in length to accommodate the new data elements. (See Attachment C.) Some items to note:

- Enrollment Source – This field will be set to B (for Beneficiary Election) for all plan-submitted enrollments. However, when CMS auto-enrolls beneficiaries into your plan, this value will be set to A (Auto-enrolled by CMS) or C (Facilitated enrollment by CMS).
- Premium Withhold Option – This field will reflect the value submitted on the transaction by the plan in most cases. However, if the premium cannot be withheld from benefits, this value will reflect a D (direct billing). The plan must bill the member for the premiums going forward until the member is able to change the premium withhold option again. (Beneficiaries can change this option during the annual election period or upon enrollment into another organization.)
- RXID/RXGroup – These fields can be reported after enrollment using a transaction type 72. More information and instructions will be sent in the near future.
- Part D Subsidy Level – This is the subsidy level applicable to low-income members. The values are 0 (CMS subsidized $0), 25 (CMS subsidized 25%), 50, 75 and 100. If this value changes, you will receive a reply code and the new value will be contained in this field.

- Part D Low-income Co-payment Level – the co-payment level associated with the low-income member. The cost-sharing level field will be populated as follows:

CODE ON MMR	DESCRIPTION	CO-PAY PRIOR TO TROOP BEGINS	CO-PAY AFTER TROOP IS REACHED	DESCRIPTION
1	Zero	0	0	Institutionalized Full-benefit Dual Eligibles
2	Low	$1/$3	0	Full-benefit Dual Eligibles $\leq$ 100% FPL
3	High	$2/$5	0	Other full subsidy eligibles (including Full-benefit Dual Eligibles > 100% FPL)
4	15%	15%	$2/$5	Partial Subsidy Eligibles (100% - 25% premium subsidy)

NOTE: Codes 1-3 identify beneficiaries for which CMS will subsidize a late enrollment penalty (@ 80%).

New Transaction Reply Codes
New reply codes have been added (see Attachment D). Some codes to note:

- The limited enrollment provisions (lock-in) go into effect January 2006. Previously defined codes 103, 104, 105 and 108 will now become active.

- When CMS auto-enrolls beneficiaries into your plan, you will be notified with code 117 or 118.

- CMS notifies you of changes in a member's low-income status by code 121.

- There are several new codes that reflect consistency edit checks involving the new data elements that you will now be submitting; e.g., 123, 124, 126, 130.

- There are a series of codes (#s127 – 129) that deal with processing enrollments for beneficiaries with employer subsidy status. The system will edit for this status and, if the beneficiary has employer coverage, the enrollment will be rejected. The plan must ensure that the beneficiary understands he may lose his

employer coverage if he enrolls in the Part D plan. If the beneficiary still wants to enroll, submit the enrollment with the employer subsidy override flag set to Y.

- CMS notifies you when the beneficiary's premium payment option changes with a code 144. In most cases, this will occur when SSA, RRB or OPM are unable to withhold the premium. The plan must then directly bill the beneficiary.

Monthly Premium Report (MPR) – PROPOSED DRAFT
CMS is proposing new beneficiary-level report(s) that will track low-income payments, withheld premiums and eventually, late enrollment penalties associated with a plan's members (See attachment E). CMS is considering; however, reporting the LIS premium amounts separately on the MMR or a different report. We will provide the final format to you in two weeks. We recognize the urgency of providing the final requirements ASAP. The plans will receive the Monthly Premium Report (MPR) at the same time as the other monthly reports. Initially the MPR will only include premium withhold activity for your members who elected the withhold option. The withheld premiums will be paid to your organization at the same time as the monthly capitation payment
See the draft table below for components of the payment that will be included each month.

PAYMENT #	ESTIMATED DATE	CONTAINS….
1	January 1, 2006	January Part D capitated and low-income subsidy (LIS) payments from CMS
2	February 1, 2006	February Part D capitated and low-income subsidy (LIS) payments from CMS + **January Withheld premiums from SSA, RRB & OPM**
3	March 1, 2006	March Part D capitated and low-income subsidy (LIS) payments from CMS + February Withheld premiums from SSA, RRB & OPM
4	April 1, 2006	April Part D capitated and low-income subsidy (LIS) payments from CMS + March Withheld premiums from SSA, RRB & OPM

The MPR will be a monthly report; however, beneficiaries' withheld plan premium payments may be included a month after the enrollments are processed due to the processing cycles of the withholding agencies. (See the table above.)

The current **draft** report includes the opening balance, activity since the last report and the closing balance for the member for the month. Trailers provide totals for each iteration of the MPR. Trailer 6, Net Settlement, should match the amount of the wire transfer to the plan's account.

CMS will continue to receive updates to member premium information from the withholding agencies after the system cut-off day. Because we want to provide a basis for the plans to reconcile their data, only transactions received by the time the monthly payments are computed will be contained on the Premium Report. This may result in differences that will be reported to you by the next month's report. We expect the process to flow as follows.

PROCESS FLOW

MARX cut-off day for plan data submittal/processing other agency withhold transactions for inclusion on June 2006 reports…………May 15, 2006

MARX continues to process other agency withhold transactions for inclusion on July 2006 reports…………May 16 – June 16, 2006

JUNE 2006 MMR/MPR…………………………..May 26, 2006

MARX cut-off day for plan data submittal/processing other agency withhold transactions for inclusion on July 2006 reports…………June 15, 2006, etc.

Each month's reports will synch up to what was processed by the MARX cut-off date, both enrollments and withhold transactions. Other agency updates will continue to be received that CMS will report to you on the next month's report.

Submitting Premium Information for Current Members
Information to CMS
The critical data elements listed below must be reported to CMS via a **72 change transaction** between **October 19 – December 6, 2005.** The non-critical elements can be submitted later in 2006. The highest priority is that this data be submitted for your dual-eligible members and for members that elect to have their premiums withheld from SSA, RRB or OPM benefits.

ELEMENT	PRIORITY
Segment ID Number	Critical
Premium Withhold Option	Critical
Part C Premium	Critical
Part D Premium	Critical
RX ID	
RX Group	
Secondary Drug Insurance Flag	
Secondary Insurer RX ID	
Secondary Insurer RX Group	

<u>Information to the Plans</u>
CMS will report the LIS premium and cost-sharing levels to you for your current members via the December 2005 Transaction Reply Report. This will allow you to apply the appropriate amounts to your members. CMS will update any premium information that you have submitted for impacted members that are eligible for the low-income premium subsidy, so you need not resubmit this information.

Cost Plan Transaction Requirements
Cost plans can offer the Part D drug benefit as an optional supplemental benefit to their members. Similar to MA plans, members can elect this coverage or not. What is different, however, is that members of cost plans can either elect the cost plan's benefit or enroll in a free-standing PDP. In the latter case, the beneficiary remains enrolled in both the cost plan and the PDP. (MA plan enrollees can only elect the Part D benefit offered by their MA plan.)

The other difference with cost plans is that since they are not MA plans, they continue to directly bill their members for the cost plan's medical premium. Only the Part D premium can be subject to the withhold option.

The required fields in the 2 enrollment situations applicable to cost plans follows.

<u>Enroll in cost plan only</u>
If the beneficiary is enrolling in the cost plan only, the following data is required.
NOTE: DO NOT SUBMIT A PBP# IF THE BENEFICIARY IS ENROLLING ONLY IN THE COST PLAN.

ELEMENT
HIC#, Name, Sex and Date of Birth
EGHP Flag
Contract #
Application Date
Transaction Code
Effective Date

<u>Enroll in cost plan and Part D plan</u>
If the beneficiary is enrolling in the cost plan and the cost plan's Part D drug plan, the following data is required.
NOTE: SEND IN THE PBP# AND PART D PREMIUM AMOUNT IF THE BENEFICIARY IS ENROLLING IN THE PART D BENEFIT OFFERED BY YOUR ORGANIZATION.

ELEMENT	NOTES
HIC#, Name, Sex and Date of Birth	
EGHP Flag	
PBP #	This is only needed if the beneficiary is enrolling in the Part D Plan.
Election Type	
Contract #	
Application Date	
Transaction Code	
Effective Date	
Premium Withhold Option	This is applicable only to the Part D premium. The cost plan continues to directly bill for the medical premium.
Part D Premium Amount	
Creditable Coverage Flag	If applicable
# of Uncovered Months	If applicable
Employer Subsidy Enrollment Override Flag	If applicable
RX ID	
RX Group	
Secondary Drug Insurance Flag	If applicable
Secondary RX ID	If applicable
Secondary RX Group	If applicable

Auto-Enrollment Process

Auto-Enrollment of Full-Benefit Dual Eligible Individuals

Auto-enrollment of full-benefit dual eligibles will start in the fall of 2005. These beneficiaries lose Medicaid prescription drug coverage 12/31/05, so auto-enrollment must be started in time to be effective 1/1/06.

The Part D plan into which a full dual eligible will be auto-enrolled is based on where the person currently gets Parts A and B benefits, and whether the Part D premium is at or below the low-income premium subsidy amount. Specifically:

MA plan $\rightarrow$ MA-PD in same MA organization with the lowest Part D premium
MA-Private Fee-for-Service (PFFS) with Part D $\rightarrow$ Same PFFS for Part D
Cost plan with Part D optional supplemental benefit $\rightarrow$ Same cost plan for Part D
Original Medicare $\rightarrow$ PDP*
PFFS with no Part D $\rightarrow$ PDP*
Cost plan with no Part D $\rightarrow$ PDP*
MSA/Health Care Prepayment Plans (HCPPs) $\rightarrow$ PDP*

* If there is more than one PDP with Part D premium at or below low-income premium subsidy amount, beneficiaries will be auto-enrolled on random basis among available plans.

CMS will delegate auto-enrollment of full-benefit dual eligibles who are current MA enrollees to MA organizations. The population here includes those full-benefit dual eligibles who are not deemed into an MA-PD plan for 2006 (i.e., because their MA plan in 2005 did not have any prescription drug coverage, or did not convert to an MA-PD plan in 2006), as well as individuals who newly enroll in an MA-only plan effective January 1, 2006 or thereafter. CMS will also delegate auto-enrollment of full-benefit dual eligibles who are current enrollees of cost plans that offer a Part D optional supplemental benefit to those cost plans. PACE enrollees automatically get their Part D benefits through their PACE organization, so no auto-enrollment is necessary.

Auto-enrollment will begin in the Fall of 2005, and continue on a monthly basis thereafter. The key dates and steps for the first round of auto-enrollment in 2005 are:

<u>August</u> - CMS will identify the initial pool of existing full-benefit dual eligibles (based on state data submitted the end of July)
<u>Mid-September</u> – CMS finalizes contracts with Part D plans
<u>Mid- September</u> – CMS creates auto-enrollment transactions with effective date of 1/1/06 (to ensure no coverage gap after Medicaid ends 12/31/05). If the beneficiary chooses another plan before the auto-enrollment effective date, the beneficiary's choice will prevail.
<u>Late October</u> – CMS notifies beneficiaries, plans, and state Medicaid agencies of plans into which beneficiary will be auto-enrolled if they do not choose on their own
<u>December 31</u> -- Last chance for beneficiary to choose another plan before auto-enrollment takes effect
<u>January 1, 2006</u> – Auto-enrollment takes effect (if person has not chosen another plan). Full-benefit dual eligibles may still change plans at any time after auto-enrollment is effective.

The notice to beneficiaries will remind them Medicaid ends 12/31/05; let them know how to choose a Part D plan; remind them they have the low-income subsidy; tell them if they don't choose a plan by 12/31/05, they will be auto-enrolled with Plan "ABC" (will provide plan's member services number and website); inform them they can change plans at anytime (since full-benefit dual eligibles have a Special Enrollment Period); clarify they can affirmatively decline Part D altogether; and direct them to call 1-800-MEDICARE for questions.

<u>Facilitated Enrollment of Others Eligible for the Low-Income Subsidy</u>

CMS will facilitate enrollment of others eligible for the low-income subsidy (LIS) starting in July of 2005. This includes QMB-only (no Medicaid; only payment for Medicare premiums, coinsurance, and deductibles); SLMB-only and Qualifying Individual (no Medicaid; only payment for Medicare Part B premium); SSI-only

(Medicare and SSI, but no Medicaid); and those who apply at SSA or State and are determined eligible for low-income subsidy.

This population is not eligible for, and therefore not losing, Medicaid prescription drug coverage. To give this population time to choose a plan that meets their needs and enroll on their own, CMS will wait until near the end of the Initial Enrollment Period (which ends 5/15/06) to facilitate their enrollment.

Generally, the process will be the same one as used for auto-enrollment, including delgating facilitated enrollment to MA organizations and cost plans. The primary difference is when the process first commences. Other LIS eligibles who do not choose a Part D plan will have their enrollment facilitated effective June 1, 2006. In addition, other LIS eligibles who have their enrollment facilitated will have one Special Enrollment Period, which CMS will authorize in operational guidance. This means they have one chance to change after facilitated enrollment (outside of the normal opportunities in which any beneficiary can change plans).

Upcoming Systems Letters
CMS will continue to provide technical information to the plans via these system letters. Another letter will be released in June with information relating to

- Final Monthly Premium Report and instructions
- Auto-enrollment address information file layout
- TROOP balance reporting
- Accessing CMS systems for eligibility checks and obtaining reply and membership reports
- Plan payment report layouts
- Enrollment response file layouts
- Reporting of RXID/RXGROUP data.

Final layout information will be sent by mid June. Future letters will address submittal of multiple transactions for a member in the same file, additional transaction reply codes and testing procedures.

Contact Information
If you have questions regarding the information contained in this letter, please contact the health insurance specialist assigned to your region, Kim Miegel on 410-786-3311, or Bill Bucksten on 410-786-7477.

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ATTACHMENT A – TRANSACTION LAYOUTS

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (EMPLOYER & MCO) 60/61			DISENROLLMENT 51			PLAN ELECTION (PBP CHANGE) 71			PLAN CHANGE 72*		
				MA	MA-PD	PDP	MA	MA-PD	PDP	MA	MA-PD	PDP	MA	MA-PD	PDP
1	HIC#	12	1 – 12	R	R	R	R	R	R	R	R	R	R	R	R
2	Surname	12	13 – 24	R	R	R	R	R	R	R	R	R	R	R	R
3	First Name	7	25 – 31	R	R	R	R	R	R	R	R	R	R	R	R
4	M. Initial	1	32												
5	Sex	1	33	R	R	R	R	R	R	R	R	R	R	R	R
6	Birth Date (YYYYMMDD)	8	34 – 41	R	R	R	R	R	R	R	R	R	R	R	R
7	EGHP Flag	1	42	blank field has a meaning	blank field has a meaning	blank field has a meaning	N/A	N/A	N/A	blank field has a meaning	blank field has a meaning	blank field has a meaning	blank = no change	blank = no change	blank = no change
8	PBP #	3	43 – 45	R	R	R	N/A	N/A	N/A	R (Change-to value)	R (Change-to value)	R (Change-to value)			
9	Election Type	1	46	R	R	R	R	R	R	R	R	R	R for premium withhold option changes; otherwise, N/A	R for premium withhold option changes; otherwise, N/A	R for premium withhold option changes; otherwise, N/A
10	Contract #	5	47 – 51	R	R	R	R	R	R	R	R	R	R	R	R
11	Application Date	8	52 – 59	R	R	R	N/A	N/A	N/A	R	R	R	N/A	N/A	N/A
12	Transaction Code	2	60 – 61	R	R	R	R	R	R	R	R	R	R	R	R
13	Disenrollment Reason (Future Use)	2	62 – 63	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	Effective Date (YYYYMMDD)	8	64 – 71	R	R	R	R	R	R	R	R	R	R	R	R
15	Segment ID	3	72-74	R, blank for non-segmented organizations; otherwise, 3-digits	R, blank for non-segmented organizations; otherwise, 3-digits	N/A	N/A	N/A	N/A	R, blank for non-segmented organizations; otherwise, 3-digits	R, blank for non-segmented organizations; otherwise, 3-digits	N/A	Blank or change-to value for local plans; otherwise, N/A	Blank or change-to value for local plans; otherwise, N/A	N/A
16	Filler	5	75-79	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
17	Prior Commercial Override	1	80	If applies; otherwise, zero or blank	If applies; otherwise, zero or blank	N/A	N/A	N/A	N/A	If applies; otherwise, zero or blank	If applies; otherwise, zero or blank	N/A	N/A	N/A	N/A
18	Premium Withhold Option/ Parts C-D	1	81	R	R	R	N/A	N/A	N/A	R	R	R	blank or change-to value	blank or change-to value	blank or change-to value
19	Part C Premium Amount (XXXXvXX)	6	82 – 87	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value	N/A
20	Part D Premium Amount (XXXXvXX)	6	88 – 93	N/A	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
21	Creditable Coverage Flag	1	94	N/A	R	R				N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
22	Number of Uncovered Months	3	95-97	N/A	R, blank = zero, meaning no uncovered months	R, blank = zero, meaning no uncovered months				N/A	R, blank = zero, meaning no uncovered months	R, blank = zero, meaning no uncovered months	N/A	Blank or change-to value	Blank or change-to value
23	Employer Subsidy Enrollment Override Flag	1	98	N/A	R if beneficiary has Employer Subsidy status; otherwise blank	R if beneficiary has Employer Subsidy status; otherwise blank	N/A	N/A	N/A	N/A	R if beneficiary has Employer Subsidy status; otherwise blank	R if beneficiary has Employer Subsidy status; otherwise blank	N/A	N/A	N/A
24	Part D Opt-Out Flag	1	99	N/A	N/A	N/A	N/A	R for auto-enrollees only; otherwise, N/A	R for auto-enrollees only; otherwise, N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	Rx ID	20	100-119	N/A	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
26	Rx Group	15	120-134	N/A	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
27	Secondary Drug Insurance Flag	1	135	N/A	R (Blank if auto-enroll)	R (Blank if auto-enroll)	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
28	Secondary Rx ID	20	136-155	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	N/A	N/A	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	R if secondary insurance change-to value is Y	R if secondary insurance change-to value is Y
29	Secondary Rx Group	15	156-170	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	N/A	N/A	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	R if secondary insurance change-to value is Y	R if secondary insurance change-to value is Y
30	Enrollment Source	1	171	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER
31	SSN	9	172-180	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	FILLER	FILLER	FILLER
32	Trustee Routing Number	9	181-189	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	Blank or change-to value	FILLER	FILLER
33	Bank Account Number	17	190-206	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	Blank or change-to value	FILLER	FILLER
34	Bank Account Type	1	207	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	Blank or change-to value	FILLER	FILLER
35	Filler	17	208-224	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

NOTE: *Type 72-Plan Change transactions are prospective, meaning the current month plus three months. Said another way, current month plus payment month plus two months.

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NOTES

ITEM	FIELDS	DESCRIPTION
1	HIC#	Claim Account Number (CAN) plus Beneficiary Idenfication Code (BIC)
2	Surname	No comment.
3	First Name	No comment.
4	M. Initial	No comment.
5	Sex	1 = male, 2 = female, 0 = unknown
6	Birth Date (YYYYMMDD)	YYYYMMDD
7	EGHP Flag	Y if EGHP; otherwise, blank = not EGHP for type 60, 61, and 71 transactions. For type 72 transactions, Y if EGHP, N if not EGHP, and blank indicates no change.
8	PBP #	3-blanks = non-PBP organizations, COST (if non-PBP), PACE, HCPP, and non-MA Demos; 3-character numeric = PBP number, zero-padded, 001-999 valid for MA, MA-PD, and PDP plans.
9	Election Type	A = AEP; E = IEP, I = ICEP; S = SEP; O = OEP; N = OEPNEW; T = OEPI. MA and MA-PDs have I, A, O, S, N, and T. PDPs have E, A, and S.
10	Contract #	Hxxxx = identifies local MAs and MA-PDs. Rxxxx = identifies regional MAs and MA-PDs. Sxxxx = identifies PDPs. Fxxxx = identifies fallback plans.
11	Application Date	YYYYMMDD -- Either the date the plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper).
12	Transaction Code	51 = disenrollment; 60/61 = enrollment; 71 =plan election (PBP change); and 72 = plan change.
13	Disenrollment Reason	Future use.
14	Effective Date (YYYYMMDD)	YYYYMMDD
15	Segment ID	3-blanks = non-segmented organization transaction; for segmented organization transactions, 3-character numeric = segment number, zero padded, 001-999 valid plan Segment ID range. Only local plans (Hxxxx) may have segments.
16	Filler	N/A
17	Prior Commercial Override	Required if beneficiary is ESRD and wants to enroll in a MA, MA-PD, Cost, HCPP plans. Not required if plan is special-needs-plan (SNP). Alpha-numeric, 0-9 and A-F. Zero (0) and blank = no override.
18	Premium Withhold Option/Parts C-D	D = direct self-pay; S = deduct from SSA benefits; R = deduct from RRB benefits; O = deduct from OPM benefits. The option applies to both Part C and D premiums.
19	Part C Premium Amount (XXXXvXX)	6-digits with leading zeroes, or blank if premium does not apply. Decimal point assumed 2-digits from right, XXXXvXX. Any value other than a blank on a type 72 transaction indicates a change-to value. That is, 000000 is an acceptable change-to value meaning $0.00.
20	Part D Premium Amount (XXXXvXX)	6-digits with leading zeroes, or blank if premium does not apply. Decimal point assumed 2-digits from right, XXXXvXX. Any value other than a blank on a type 72 transaction indicates a change-to value. That is, 000000 is an acceptable change-to value meaning $0.00.
21	Creditable Coverage Flag	Y if covered, N if not covered.
22	Number of Uncovered Months	Count of total months without drug coverage.
23	Employer Subsidy Override Flag	If the beneficiary is in a plan receiving an employer subsidy, but still wants to enroll in a Part D plan, submit the enrollment with the override = Y; otherwise blank.
24	Part D Opt-Out Flag	Applies to full benefit dual eligible and facilitated enrolled beneficiaries. Y = opt-out of auto enrollment; N = do not opt-out of auto-enrollment; blank = no change to opt-out status.
25	Rx ID	Part D plan's ID number for beneficiary. Alphanumeric, upper case when alpha; left justified; space padded. Upper case printable characters and default value of spaces.
26	Rx Group	Part D plan's group ID number for beneficiary. Alphanumeric, upper case when alpha; left justified; space padded. Upper case printable characters and default value of spaces.
27	Secondary Drug Insurance Flag	For type 61 and 71 MA-PD and PDP transactions, Y = beneficiary has secondary drug insurance; N = beneficiary does not have secondary drug insurance available; blank = do not know whether beneficiary has secondary drug insurance. For type 72 MA-PD and PDP transactions, Y = secondary drug insurance available; N = no secondary drug insurance available; blank = no change.
28	Secondary Rx ID	Secondary insurance plan's ID number for beneficiary. Alphanumeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces.
29	Secondary Rx Group	Secondary insurance plan's group ID number for beneficiary. Alphanumeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces.
30	Enrollment Source	A = auto-enrolled by CMS; B = beneficiary election; C = facilitated enrollment by CMS
31	SSN	Social Security Number as it will appear on the MSA beneficiary's trustee bank account. Field valid only for MA MSA plans; otherwise, filler.
32	Trustee Routing Number	Automated Clearing House (ACH) Routing Number for the trustee institution where the beneficiary maintains an MSA account. Field valid only for MA plans; otherwise, filler.
33	Bank Account Number	Medical Savings Account (MSA) Number, bank account number where CMS will deposit the annual MSA contribution. Field valid only for MA plans; otherwise, filler.
34	Bank Account Type	Type of bank account where CMS will deposit the annual MSA contribution. C = checking; S = savings. Field valid only for MA plans; otherwise, filler.
35	Filler	N/A

ITEM	FIELDS	SIZE	POSITION	DESCRIPTION		
CORRECTION TRANSACTION						
1	HIC#	12	1 – 12	Nine-byte SSN of primary beneficiary (Beneficiary Claim Account Number); two-byte BIC (Beneficiary Identification Code); one-byte filler (except RRB)		
2	Surname	12	13 – 24	Beneficiary Surname		
3	First Name	7	25 – 31	Beneficiary Given Name		
4	M. Initial	1	32	Beneficiary Middle Initial		
5	Action Code	1	33	D = Institutional ON E = Medicaid ON F = Medicaid OFF G = Nursing Home Certifiable (NHC) ON		
6	Filler	13	34 – 41	Spaces		
10	Contract #	5	47 – 51	Contract Number		
11	Filler	8	52 – 59	Spaces		
12	Transaction Code	2	60 – 61	"01"		
13	Filler	163	62 – 224	Spaces		

ATTACHMENT B – MMR DATA FORMAT
* - Fields applicable to PDPs

#	Field Name	Len	Pos	Description
1*	Contract Number	5	1-5	The organization's Contract Number
2*	Run Date of the File	8	6-13	YYYYMMDD
3*	Payment Date	6	14-19	YYYYMM
4*	HIC Number	12	20-31	Member's HIC #
5*	Surname	7	32-38	
6*	First Initial	1	39-39	
7*	Sex	1	40-40	M = Male, F = Female
8*	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10*	State & County Code	5	53-57	
11*	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12*	Part A Entitlement	1	59-59	Y = Entitled to Part A
13*	Part B Entitlement	1	60-60	Y = Entitled to Part B
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD
16	Working Aged	1	63-63	Y = Working Aged
17	Institutional	1	64-64	Y = Institutional
18	NHC	1	65-65	Y = Nursing Home Certifiable

#	Field Name	Len	Pos	Description
19	Medicaid	1	66-66	Y = Medicaid Status
20	FILLER	1	67-67	SPACES
21	Medicaid Indicator	1	68-68	Y = Medicaid Addon
22	PIP-DCG	2	69-70	PIP-DCG Category - **Only on pre-2004 adjustments**
23	Default Indicator	1	71-71	Y = default RA factor in use • For pre-2004 adjustments, a "Y" indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a "Y" indicates that a default factor was generated by the system due to lack of a RA factor.
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28*	Adjustment Reason Code	2	90-91	99 Always Spaces on Payment
29*	Paymt/Adjustmt Start Date	8	92-99	YYYYMMDD
30*	Paymt/Adjustmt End Date	8	100-107	YYYYMMDD
31	Demographic Paymt/Adjustmt Rate A	9	108-116	-$$$$$.99
32	Demographic Paymt/Adjustmt Rate B	9	117-125	-$$$$$.99
33	Risk Adjuster Paymt/Adjustmt Rate A	9	126-134	-$$$$$.99

#	Field Name	Len	Pos	Description
34	Risk Adjuster Paymt/Adjustmt Rate B	9	135-143	-$$$$$.99
35	FILLER	28	144-171	SPACES
36	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
37	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – **Only on pre-2004 adjustments**
38	FILLER	2	183-184	SPACES
39*	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999
40	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
41	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) E1 = New Enrollee Post-Graft I (ESRD) E2 = New Enrollee Post-Graft II (ESRD) G1 = Graft I (ESRD) G2 = Graft II (ESRD) I = Institutional I1 = Institutional Post-Graft I (ESRD) I2 = Institutional Post-Graft II (ESRD)
42	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
43	Previously Disabled Indicator	1	192-192	Y = Previously Disabled – **Only on post-2003 payments/adjustments**
44	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months

#	Field Name	Len	Pos	Description
45	Segment ID	3	194 – 196	Identification number of the segment of the PBP. Blank if there are no segments.
46*	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)
47*	EGHP Flag	1	198	Employer Group flag; Y = member of employer group, N = member is not in an employer group
48	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. -$$$.99
49	Part C Basic Premium – Part B Amount	8	207 - 214	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA plan payment for plans that bid above the benchmark. -$$$.99
50	Rebate for Part A Cost Sharing Reduction	8	215 - 222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -$$$.99
51	Rebate for Part B Cost Sharing Reduction	8	223 - 230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -$$$.99
52	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. -$$$.99
53	Rebate for Other Part B Mandatory Supplemental Benefits	8	239 - 246	The amount of the rebate allocated to providing Part B supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -$$$.99

#	Field Name	Len	Pos	Description
54	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. -$$$.99
55	Rebate for Part B Premium Reduction – Part B Amount	8	255 - 262	The Part B amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -$$$.99
56	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. -$$$.99
57	Rebate for Part D Supplemental Benefits – Part B Amount	8	271 - 278	Part B Amount of the rebate allocated to providing Part D supplemental benefits. -$$$.99
58	Total Part A MA Payment	10	279- 288	The total Part A MA payment. -$$$.99
59	Total Part B MA Payment	10	289 - 298	The total Part B MA payment. -$$$.99
60	Total MA Payment Amount	11	299 - 309	The total MA A/B payment including MMA adjustments. This also includes the Rebate Amount for Part D Supplemental Benefits -$$$$$.99
61*	Part D RA Factor	7	310 - 316	The member's Part D risk adjustment factor. NN.DDDD
62*	Part D Low-Income Indicator	1	317	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.
63*	Part D Low-Income Multiplier	7	318 - 324	The member's low-income multiplier. NN.DDDD
64*	Part D Long Term Institutional Indicator	1	325	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.
65*	Part D Long Term Institutional Multiplier	7	326 - 332	The member's long term institutional multiplier. NN.DDDD

#	Field Name	Len	Pos	Description
66	Rebate for Part D Basic Premium Reduction	8	333 - 340	Amount of the rebate allocated to reducing the member's basic Part D premium. -$$$.99
67*	Part D Basic Premium Amount	8	341 - 348	The plan's Part D premium amount. -$$$.99
68*	Part D Direct Subsidy Payment Amount	10	349 - 358	The total Part D Direct subsidy payment for the member. -$$$.99 Applies to all members.
69*	Reinsurance Subsidy Amount	10	359 - 368	The amount of the reinsurance subsidy included in the payment. -$$$.99 Applies to all members.
70*	Low-Income Subsidy Cost-Sharing Amount	10	369 - 378	The amount of the low-income subsidy cost-sharing amount included in the payment. -$$$.99 Applies to LIS members only
71*	Total Part D Payment	11	379 - 389	The total Part D payment for the member. -$$$$$.99
72*	Number of payment/adjustment months Part D	2	390 - 391	Total number of months covered by the payment/adjustment 99
73	PACE Premium Add-On	10	392 - 401	Total Part D PACE Premium Add-on amount -$$$.99
74	PACE Cost Sharing Add-On	10	–402 - 411	Total Part D PACE Cost Sharing Add-on amount -$$$.99

Attachment C
Transaction Reply Data File

Note: Field 30 reused as application date, other MMA elements begin with Field 32.

Field	Size	Position	Description
1. Claim Number	12	1 – 12	Claim Account Number
2. Surname	12	13 – 24	Beneficiary Surname
3. First Name	7	25 – 31	Beneficiary Given Name
4. Middle Name	1	32	Beneficiary Middle Initial
5. Sex Code	1	33	Beneficiary Sex Identification Code 0 = Unknown 1 = Male 2 = Female
6. Date of Birth	8	34 – 41	YYYYMMDD Format
7. Medicaid Indicator	1	42	1 = Medicaid 0 = No Medicaid
8. Contract Number	5	43 – 47	Plan Contract Number
9. State Code	2	48 – 49	Beneficiary Residence State Code
10. County Code	3	50 – 52	Beneficiary Residence County Code
11. Disability Indicator	1	53	1 = Disabled 0 = No Disability
12. Hospice Indicator	1	54	1 = Hospice 0 = No Hospice
13. Institutional/NHC Indicator	1	55	1 = Institutional 2 = NHC 0 = No Institutional
14. ESRD Indicator	1	56	1 = End-Stage Renal Disease 0 = No End-Stage Renal Disease
15. Transaction Reply Code	3	57 – 59	Transaction Reply Code
16. Transaction Type Code	2	60 – 61	Transaction Type Code
17. Entitlement Type Code	1	62	Beneficiary Entitlement Type Code
18. Effective Date	8	63 – 70	YYYYMMDD Format; Present only when the Transaction Reply Code is one of the following: 11, 12, 16, 17, 21 – 23, 38, 52, 80, 82 – 84, 100, 109 and 112
19. WA Indicator	1	71	1 = Working Aged 0 = No Working Aged
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
23. Filler	1	84	Space

Field	Size	Position	Description
24. Positions 85 – 96 are dependent upon the value of the TRANSACTION REPLY CODE. There are spaces for all codes except where indicated below.			
a. Disenrollment Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 14, 18, 84
b. Enrollment Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 83
c. Claim Number (new)	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: 36, 90, 91, 92
e. Hospice Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 35, 71
f. Hospice End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 72
g. ESRD Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 45, 73
h. ESRD End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 74
i. Institutional/ NHC Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 48, 75
j. Institutional/ NHC End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 49, 76
k. Medicaid Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 77
l. Medicaid End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 78
m. Part A End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 79
n. WA Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 66
o. WA End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 67
p. Part A Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 80
q. Part B End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 81
r. Part B Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is the following: 82
s. SCC	5	85 – 89	Beneficiary Residence State and County Code; Present only when Transaction Reply Code is the following: 85
25. District Office Code	3	97 – 99	Code of the originating district office; Present only when Transaction Type Code is 53

Field	Size	Position	Description
26. Filler	8	100 – 107	Part A Payments are no longer part of the TR data file, this field is now fill space.
27. Filler	8	108 – 115	Part B Payments are no longer part of the TR data file, this field is now fill space.
28. Source ID	5	116 – 120	Transaction Source Identifier
29. Prior Plan Benefit Package ID	3	121 – 123	Prior PBP number; present only when transaction type code is 71
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 **Note: This field was previously filler in MMCS**
31. Filler	2	132 – 133	Spaces
MMA fields start here			**MMCS Data file ended with position 133**
32. Out of Area Flag	1	134 – 134	Out of Area Indicator
33. Segment Number	3	135 – 137	Further definition of PBP by geographic boundaries
34. Part C Beneficiary Premium	8	138 – 145	Cost to beneficiary for Part C benefits
35. Part D Beneficiary Premium	8	146 – 153	Cost to beneficiary for Part D benefits
36. Election Type	1	154 – 154	A = AEP; E = IEP; I = ICEP; S=SEP; O = OEP; N = OEPNEW; T = OEPI

MA/MA-PDs have I, A, O, S, N, T PDPs have E, A, and S |
37. Enrollment Source	1	155 – 155	A = Auto enrolled by CMS B = Beneficiary Election C = Facilitated enrollment by CMS D = CMS Annual Rollover
38. Part D Opt-Out Flag	1	156 – 156	Y = Opt-out of auto enrollment Blank = No change to opt-out status
39. Premium Withhold Option/Parts C-D	1	157 – 157	D = Direct self-pay S = Deduct from SSA benefits R = Deduct from RRB benefits O = Deduct from OPM benefits N = No premium applicable Option applies to both Part C and D Premiums
40. Number of Uncovered Months	3	158 – 160	Count of Total Months without drug coverage
41. Creditable Coverage Flag	1	161 – 161	Y = Covered N = Not Covered
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.

Field	Size	Position	Description
43. Rx ID	20	163 – 182	Part D plan's ID number for beneficiary
44. Rx Group	15	183 – 197	Part D plan's group ID number for beneficiary
45. Secondary Drug Insurance Flag	1	198-198	Type 61 & 71 MA-PD and PDP transactions: Y = Beneficiary has secondary drug insurance N = Beneficiary does not have secondary drug insurance available Blank – Do not know whether beneficiary has secondary drug insurance Type 72 MA-PD and PDP transactions: Y = Secondary drug insurance available N = No secondary drug insurance available Blank = no change
46. Secondary Rx ID	20	199 – 218	Secondary Insurance plan's ID number for beneficiary
47. Secondary Rx Group	15	219 – 233	Secondary Insurance plan's Group ID number for beneficiary
48. EGHP	1	234 - 234	Type 60, 61, 71 transactions: Y = EGHP Blank = not EGHP Type 72 transactions: Y = EGHP N = Not EGHP Blank = no change
49. Part D Subsidy Level	3	235 – 237	LIS percentage
50. Co-Pay Category	1	238 – 238	Definitions of the 4 Categories: 1. $0 Full duals that are institutionalized 2. $1/$3 Full duals with income equal to or less than 100% FPL 3. $2/$5 Other full subsidy eligibles 4. 15% Partial subsidy eligibles
51. Co-Pay Effective Date	8	239 - 246	Date co-pay category become effective.

Attachment D
Transaction Reply Codes

Code/Type *	Title	Short Definition	Definition
001 R	Invalid Transaction Code	BAD TRANS CODE	A transaction attempted to process. The transaction was rejected, because the supplied input transaction code was an invalid value. The valid transaction code values are 01, 51, 60, 61, and 71. The transaction should be resubmitted with a valid transaction code.. *NOTE: Tran Codes 30 & 31 are valid for pre-2004 adjustments*
002 R	Invalid Correction Action Code	BAD ACTION CODE	A correction transaction attempted to process. The transaction was rejected, because the supplied action code was an invalid value. The valid action code values are D, E, F and G. The transaction should be resubmitted with a valid action code.
003 R	Invalid Contract Number	BAD CONTRACT #	An enrollment, disenrollment, correction, or demonstration factor update transaction attempted to process. The transaction was rejected because no current record was found in the contract file for the input contract number. *NOTE: Description is not on CMS website. Based on input from iCORP.*
004 R	Beneficiary Name Required	NEED MEMB NAME	An enrollment, disenrollment, or PBP change transaction attempted to process. The transaction was rejected, because a match could not be found for the beneficiary and the beneficiary name was not included on the transaction record. The transaction should be resubmitted with beneficiary name included.
005 R	Invalid Sex Code	BAD SEX CODE	A demonstration factor update transaction attempted to process (trans code 30 or 31). The transaction was rejected because the value in the sex field was not 0, 1 or 2.
006 R	Invalid Birth Date	BAD BIRTH DATE	A demonstration factor update, enrollment, disenrollment, or PBP change transaction attempted to process. The transaction was rejected because a match could not be found for the beneficiary and the value in the date of birth field was not a valid date in the format YYYYMMDD.

Code/Type *	Title	Short Definition	Definition
007 R	Invalid Claim Number	NO MATCH—HICN	An enrollment, disenrollment, PBP change, or correction transaction attempted to process. The transaction was rejected, because the claim number was not in a valid format. The valid format for a claim number could take one of two forms: 1. HICN is an 11 position value, with the first 9 positions numeric and the last 2 positions alphanumeric. 2. RRB is a 7 to 12 position value, with the first 1 to 3 positions alpha and the last 6 or 9 positions numeric. The transaction should be resubmitted with a valid claim number (HICN) or RRB.
008 R	Beneficiary Not Found on GHP	NOT ENROLLED	A disenrollment or correction transaction attempted to process. The transaction was rejected, because the claim number was not found in the MARX System. The transaction should be resubmitted with a valid claim number. NOTE: In these cases, the incoming transaction is intended to update a record that was previously established on the managed care databases, that is, the beneficiary has already been enrolled in an MCO. The incoming transaction is attempting to add new information about status, applying a payment factor, or ending the enrollment period. The error code means that the original enrollment record is not found. NOTE: This TR code also applies to demonstration factor updates.
009 R	No Match on Name	NO MATCH—NAME	A transaction attempted to process. The transaction was rejected because the name on the incoming record did not match a record on the database. The transaction should be resubmitted with the correct name. NOTE: This label is not precise. This reply code indicates that the managed care system was not able to find a unique beneficiary that matched on 3 of 4 of the following: surname, first initial, date of birth, and sex code.
010 R	Invalid Medicaid Transaction	INVALID MCAID	A correction transaction attempted to process with an action code of 'F' (turn Medicaid OFF). The transaction was rejected, because the Medicaid status was not set by the MCO and for that reason, could not be turned off by the MCO. NOTE: Edit suspended in 2004 by CMS.
011 A	Enrollment Accepted as Submitted	ENROLL ACCEPTED	The new enrollment has been successfully processed. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.
012 A	Enrollment Accepted, with SCC Override	[obsolete]	This transaction code is obsolete.

Code/Type *	Title	Short Definition	Definition
013 A	Disenrollment Accepted as Submitted	DISENROL ACCEPT	The disenrollment has been successfully processed. The effective date of the disenrollment is shown in field 24 (see codes 18-28) of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.
014 A	Disenrollment Due to Enrollment in Another Plan	DISNROL-NEW MCO	A new enrollment was successfully processed for the beneficiary, which placed them in another MCO. As a result, the beneficiary was disenrolled from the MCO receiving this message. The effective date of the disenrollment is shown in field 24 of the Transaction Reply record. In field 27 the Contract number of the source is shown. On the printed report, the disenrollment date is shown in the EFF DATE column, and the MCO causing the disenrollment is shown in the SOURCE ID column.
015 A	Enrollment Canceled	ENROLL CANCELED	An enrollment was canceled due to one of the following reasons: a MCO's disenrollment request dated the month prior to enrollment; a loss of Part A or B Entitlement; or the beneficiary is in the ESRD health status prior to enrollment.
016 A	Enrollment Accepted, Out Of Area	ENROLL-OUT AREA	A new enrollment was processed, but the beneficiary's residence state and county codes place the beneficiary outside of the MCO's approved service area. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column. If the SCC shown on the printed report differs from your records prompt the beneficiary to visit the Social Security Administration Field Office (SSAFO) to change their address. This will enable a more accurate payment for this beneficiary to be made. *NOTE: The 'conditional' aspect no longer applies; this TR code is now merely an alert that the beneficiary's SCC in CMS records is not within the service area.*
017 A	Enrollment Accepted, Payment Default Rate	ENROLL—BAD SCC	A new Part C enrollment was processed, but valid residence state and county codes were not available and could not be derived from the zip code. The enrollment is considered valid by the system; however, since there is no valid residence state and county codes, Part C payment is made for this beneficiary at the plan bid rate with no geographic adjustment. When valid residence information is provided to the system, payment will be made using the updated residence information. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.

Code/ Type *	Title	Short Definition	Definition
018 A	Automatic Disenrollment	AUTO DISENROLL	An action occurred which caused an automatic disenrollment of this beneficiary. A disenrollment action was not submitted by CMS or the plan. This action could result from a change in the beneficiary's personal characteristics. For example, a death notice, or loss of Part A or Part B Entitlement would cause an enrolled beneficiary to be automatically disenrolled. The effective date of the disenrollment is shown in field 24 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column, and the reason for disenrollment is shown in the REMARKS column.
019 R	Enrollment Rejected - PACE Loss Of Part A And B Entitlement	NO ENROLL-NO A B	An enrollment attempted to process for a PACE plan or a Medicare + Choice (M+C) MCO. The enrollment failed because the beneficiary is not entitled to both Part A and Part B of Medicare.
020 R	Enrollment Rejected - PACE Under 55	NO ENROLL-NOT 55	An enrollment attempted to process for a PACE plan. The enrollment failed because the beneficiary is not yet 55 years of age
021 A	Enrollment Accepted, Date Modified	[Obsolete]	This transaction code is obsolete. .
022 A	Enrollment Accepted, Claim Number Change	ENROLL-NEW HICN	A new enrollment was successfully processed for a beneficiary whose claim number has changed. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. The new claim number is shown in field 24. The old claim number will appear in field 1. On the printed report the enrollment date is shown in the EFF DATE column, and the new claim number is shown in the REMARKS column. Any further actions submitted for this beneficiary must use the new claim number.
023 A	Enrollment Accepted, Name Change	ENROLL-NEW NAME	A new enrollment was successfully processed for a beneficiary whose name has changed. The effective date of the new enrollment is shown in field 18 of the Transaction Reply record. The new name will appear in fields 2, 3 and 4. On the printed report, the enrollment date is shown in the EFF DATE column, and the new name is shown in the SURNAME, FIRST NAME and MI columns.
024 A	Disenrollment Accepted, Date Modified	[Obsolete]	This transaction reply code is obsolete.

Code/ Type *	Title	Short Definition	Definition
025 A	Disenrollment Accepted, Claim Number Change	DISROL-NEW HICN	A disenrollment was successfully processed for a beneficiary whose claim number has changed. The effective date of the disenrollment is shown in field 21 of the Transaction Reply record. The new claim number is shown in field 24. The old claim number will appear in field 1. On the printed report the disenrollment date is shown in the EFF DATE column, and the new claim number is shown in the REMARKS column. Any further actions submitted for this beneficiary should use the new claim number.
026 A	Disenrollment Accepted, Name Change	DISROL-NEW NAME	A disenrollment was successfully processed for a beneficiary whose name has changed. The effective date of the disenrollment is shown in field 21 of the Transaction Reply record. The new name will appear in fields 2, 3 and 4. On the printed report, the disenrollment date is shown in the EFF DATE column, and the new name is shown in the SURNAME, FIRST NAME and MI columns.
027 A	Demonstration Beneficiary Factor Set	DEMO FACTOR ON	A demonstration factor was successfully processed for a beneficiary. The effective start date of the factor is shown in field 24 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column. NOTE: This reply code is only applicable to transactions that update beneficiary-specific risk adjustment factors for certain demonstration MCO contracts, i.e., GHP_TRAN_CD 30 and 31.
028 A	Demonstration Beneficiary Factor Terminated	DEMO FACTOR OFF	A demonstration factor with an end date was successfully processed for a beneficiary. The effective end date of the factor is show in field 24 of the Transaction Reply record. On the printed report the value is shown in the EFF DATE column. NOTE: This reply code is only applicable to transactions that update beneficiary-specific risk adjustment factors for certain demonstration MCO contracts, i.e., GHP_TRAN_CD 30 and 31.
029 A	Demo Beneficiary Factor Cancellation	DEMO FACTOR CAN	A demonstration factor was successfully processed for a beneficiary. A factor originally established has been cancelled, and is no longer valid. NOTE: This reply code is only applicable to transactions that update beneficiary-specific risk adjustment factors for certain demonstration MCO contracts, i.e., GHP_TRAN_CD 30 and 31

Code/ Type *	Title	Short Definition	Definition
030 P	Enrollment Held, Pending Medicare Entitlement Confirmation	PENDING MCARE	An enrollment attempted to process, but the beneficiary does not appear on the Medicare Beneficiary database (MBD) or does not have Part A or Part B entitlement. Very infrequently, Medicare enrollments may not be posted in a timely fashion. In these cases, MARX will hold the enrollment for a period of time (3 months), to allow for the completion of the MBD record keeping. This code is obsolete.
031 R	Enrollment Rejected, Data Not In Enrollment Database	MEMB NOT MCARE	An enrollment transaction attempted to process. The enrollment was rejected because the beneficiary could not be located in the MBD. Verify the claim number and name and resubmit the transaction. NOTE: This transaction reply code will be generated after the orbit period has elapsed if the beneficiary is still not found in the MBD. This code is obsolete.
032 R	Enrollment Rejected, Beneficiary Not Entitled to Part B	MEMB HAS NO B	An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary did not have Medicare Part B Entitlement. Part B entitlement is required for enrollment in a managed care plan. *NOTE: Generated once the orbit period has expired.* This code is obsolete.
033 R	Enrollment Rejected, Beneficiary Not Entitled to Part A	MEMB HAS NO A	An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary did not have Medicare Part A Entitlement. Part A entitlement is required for enrollment in a managed care plans. *NOTE: Generated once the orbit period has expired.* This code is obsolete.
034 R	Enrollment Rejected, Beneficiary is Not Age 65	MEMB NOT AGE 65	An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary was not age 65 or older. The age requirement is MCO-specific.
035 R	Enrollment Rejected, Beneficiary is in Hospice Status	MEMB IN HOSPICE	An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary was in Hospice status. The Hospice requirement is MCO specific (e.g., applies only to 1876 Cost Plans). The attempted enrollment date is shown in field 24 of the Transaction Reply record.

Code/Type*	Title	Short Definition	Definition
036 R	Enrollment Rejected, Beneficiary is Deceased	MEMB DECEASED	An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary is deceased. The attempted enrollment date is shown in field 24 of the Transaction Reply record. On the printed report, the value is shown in the REMARKS column.
037 R	Enrollment Rejected, Invalid Date	BAD ENROLL DATE	An enrollment transaction attempted to process. The enrollment was rejected, because the submitted enrollment effective date was either an invalid numeric value; a date more than 3 months in the future; a date not the first of the month; or a code 60 was with a future date or a date more than 3 months before the prospective payment month. Retroactive PBP change requests are also rejected with this transaction reply code. The transaction should be resubmitted with a valid date.
038 D	Enrollment Rejected, Duplicate Transaction	DUPLICATE	An enrollment transaction attempted to process. The enrollment was rejected, because another enrollment transaction submitted by the same plan, with the same effective date, was already processed. No action is required by the plan.
039 R	Enrollment Rejected, Currently Enrolled in Same Plan	ALREADY ENROLL	An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary was already enrolled in this plan. No action is required by the plan.
040 R	Enrollment Rejected, Multiple Enrollment Transactions	MULTIPLES	An enrollment transaction attempted to process. The enrollment was rejected, because the transaction was one of several that were submitted with the same effective date and application date.
041 R	Invalid Demonstration Beneficiary Factor Date	BAD FACTOR DATE	A beneficiary factor update request attempted to process. The transaction 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 effective end date.
042 R	Enrollment Rejected, Blocked	ENROLL BLOCKED	An enrollment transaction attempted to process. The enrollment was rejected, because the MCO is currently blocked from enrolling new beneficiaries.
043 R	Invalid Demonstration Beneficiary Factor	BAD FACTOR	A beneficiary factor update request attempted to process. The transaction was rejected, because the factor was not in a valid format; or the factor was larger than allowed. NOTE: the factor must be 7 positions long, with the 3rd position being '.' and the other 6 positions numeric.

Code/Type *	Title	Short Definition	Definition
044 R	Enrollment Rejected, Outside Contracted Period	NO CONTRACT	An enrollment transaction attempted to process. The enrollment was rejected, because the submitted enrollment date is outside the contracted period with CMS.
045 R	Enrollment Rejected, Beneficiary is in ESRD Status	MEMB HAS ESRD	An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary is in ESRD (end-stage renal disease) status. The attempted enrollment effective date is shown in field 24 of the Transaction Reply record. On the printed report, the value is shown in the REMARKS column.
046 R	Enrollment Rejected; No response from HI Master	[obsolete]	This transaction reply code is obsolete.
047 R	Enrollment Rejected, Retroactive Effective Date	RETRO ENROLL DT	An enrollment transaction attempted to process. The enrollment was rejected, because the enrollment effective date submitted was not within the acceptable retroactive period. The enrollment should be resubmitted with an effective date which is not less than one month before the prospective payment month.
048 A	Nursing Home Certifiable Set	NHC ON	A transaction has been processed placing the beneficiary in Nursing Home Certifiable (NHC) status. The NHC health status is MCO specific (e.g., applies only to SHMO plans). The NHC effective start date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.
049 A	Nursing Home Certifiable Terminated	NHC OFF	This transaction code is obsolete. *NOTE: NHC periods always have an end date. TR code 159 is used to acknowledge online changes to NHC periods.*
050 R	Disenrollment Rejected, Not Enrolled	NOT ENROLLED	A disenrollment transaction attempted to process. The disenrollment was rejected, because the beneficiary was not currently enrolled in the plan.
051 R	Disenrollment Rejected, Invalid Date	BAD DISENR DATE	A disenrollment transaction attempted to process. The disenrollment was rejected, because the effective date was one of invalid numeric value or a date outside the allowable time frame. The transaction should be resubmitted with a valid date.
052 D	Disenrollment Rejected, Duplicate Transaction	DUPLICATE	A second disenrollment transaction attempted to process. The disenrollment was rejected, duplicate transaction, no process necessary. No action is required by the plan.
053 R	Disenrollment Rejected, Before Current Enrollment	DATE LT ENROLL	A disenrollment transaction attempted to process. The disenrollment was rejected, because the disenrollment effective date submitted was earlier than the effective enrollment date on record. The transaction should be resubmitted with a valid date.

Code/Type *	Title	Short Definition	Definition
054 R	Disenrollment Rejected, Retroactive Date	RETRO DISN DATE	A disenrollment transaction attempted to process. The disenrollment was rejected, because the effective date was outside the allowable time frame. The disenrollment should be resubmitted with a valid date.
055 M	ESRD Status Canceled	ESRD CANCELED	The ESRD status information which was previously set has been canceled. The effective date of the status period canceled is shown in field 24 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.
056 R	Demonstration Enrollment Rejected	FAILS DEMO REQ	An enrollment transaction attempted to process. The enrollment was rejected, because the beneficiary did not meet the Demonstration requirements. For example, the beneficiary is currently known to be Working Aged or not known to be ESRD. These requirements are MCO specific. The attempted enrollment effective date is shown in field 24 of the Transaction Reply record. On the print report, the value is shown is the EFF DATE column.
057 M	Risk Adjuster Factor Change	RA FACTOR CHG	The Risk Adjuster System (RAS) has created new factors for this beneficiary, which may result in payment adjustments.
058 R	SSA Disenrollment Rejected, Cancel New Enrollment	CANNOT CANCEL	A disenrollment transaction from an SSAFO attempted to process. The disenrollment was rejected because the effective date of the disenrollment if applied would result in a cancellation of the enrollment period. The attempted disenrollment effective date is shown on the printed report under the EFF DATE column.
059 M	Working Aged Status Canceled	WA CANCEL	The working aged status information which was previously set has been canceled. The effective date of the status period canceled is shown in field 24 of the Transaction Reply record. On the printed report, the value is shown in the EFF DATE column.
060 R	Correction Rejected, Not Enrolled in Plan	NOT ENROLLED	A correction transaction attempted to process. The correction was rejected, because the beneficiary is no longer enrolled under the incoming contract number. MCOs are not permitted to process transactions against beneficiaries that are not enrolled in their plan.
061 R	Correction Rejected, Retroactive Change	[Obsolete]	This transaction reply code is obsolete. .

Code/ Type *	Title	Short Definition	Definition
062 R	Correction Rejected, Overlaps Other Period	INS-NHC OVERLAP	A correction transaction attempted to process. The correction was rejected, because another correction transaction submitted by the same plan, with the same effective date, was already processed. No action is required by the MCO. NOTE: Currently, this transaction reply refers to the overlap of an institutional period and an NHC period. These two types of periods are mutually exclusive.
063 R	Correction Rejected, Extend Past Death Date	[Obsolete]	This transaction code is obsolete.
064 R	Correction Rejected, Invalid Date	[Obsolete]	This transaction code is obsolete.
065 A	WA Accepted, Not Yet Posted	WA OK/NOT POST	A Working Aged (HUSP) transaction has been received by CMS. The transaction was sent on for further processing. This reply is to confirm that the request has been received and forwarded to the COB contractor. This does not mean acceptance by COB or CWF. *NOTE: This code became obsolete in 2004 with the new working aged adjustment process and retirement of the HUSP process.*
066 M	WA Status Set	WA ON	A Working Aged status has been set for a beneficiary. The effective Working Aged start date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column. *NOTE: This code became obsolete in 2005 with the new working aged adjustment process.*
067 M	WA Status Terminated	WA OFF	A Working Aged status has been terminated for a beneficiary. The effective Working Aged termination date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column. *NOTE: This code became obsolete in 2005 with the new working aged adjustment process.*
068 R	Working Aged Status Rejected	WA REJECT	A Working Aged transaction attempted to process. The transaction was rejected because the supplied input did not pass all required edits. The failed edits are noted by the SP Error Code, which can be found in the Plan Communications User's Guide under the appendix marked "MSP Maintenance Transaction Error Codes". *NOTE: This code became obsolete in 2004 with the new working aged adjustment process and retirement of the HUSP process.*

Code/ Type *	Title	Short Definition	Definition
069 P	Working Aged Status Pending	WA PENDING	A Working Aged transaction has been received by CMS, but is pending because it has not completed processing. *NOTE: This code became obsolete in 2004 with the new working aged adjustment process and retirement of the HUSP process.*
070 A	Prior Commercial Enr Changed	COMM ENROL CHG	An online transaction changed the length of a previously reported period of commercial enrollment.
071 M	Hospice Status Set	HOSPICE ON	A notification has been received from CMS's Hospice system placing the beneficiary in Hospice status. The effective Hospice start date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.
072 M	Hospice Status Terminated	HOSPICE OFF	A notification has been received from CMS's Hospice system terminating the beneficiary's Hospice status. The effective Hospice end date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.
073 M	ESRD Status Set	ESRD ON	A notification has been received from CMS's ESRD system placing the beneficiary in ESRD status. The effective ESRD start date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.
074 M	ESRD Status Terminated	ESRD OFF	A notification has been received from CMS's ESRD system terminating the beneficiary's ESRD status. The effective ESRD end date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.
075 A	Institutional Status Set	INSTITUTION ON	A transaction has been received placing the beneficiary in Institutional status. The effective Institutional start date is shown in field 21 and 23 of the Transaction Reply record. On the printed report this value is shown in the EFF DATE column. Institutional automatically ends each month; therefore, there is no termination status transaction.
076 A	Institutional Status Terminated	INSTITUTION OFF	This transaction reply code is obsolete. *NOTE: Institutional periods always have an end date. TR code 158 is used to acknowledge online changes to institutional periods dates.*
077 A/M	Medicaid Status Set	MEDICAID ON	A transaction has been received placing the beneficiary in Medicaid Status. The effective Medicaid start date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.

Code/ Type *	Title	Short Definition	Definition
078 A/M	Medicaid Status Terminated	MEDICAID OFF	A transaction has been received terminating the beneficiary Medicaid status. The effective Medicaid end date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.
079 M	Part A Termination	MEDICARE A OFF	A notification has been received terminating the beneficiary's Part A Entitlement. The effective Part A Entitlement end date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.
080 M	Part A Reinstatement	MEDICARE A ON	A notification has been received reinstating the beneficiary's Part A Entitlement. The effective Part A Entitlement start date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column. NOTE: This reply code is only prepared if the beneficiary is still enrolled in some managed care contract. If the beneficiary has been disenrolled, but not re-enrolled, the reply code is not issued.
081 M	Part B Termination	MEDICARE B OFF	A notification has been received terminating the beneficiary's Part B Entitlement. The effective Part B Entitlement end date is shown in field 24 of the Transaction Reply record. On the printed report, this value is shown in the EFF DATE column.
082 M	Part B Reinstatement	MEDICARE B ON	A notification has been received reinstating the beneficiary's Part B Entitlement. The effective Part B Entitlement start date is shown in field 24 of the Transaction Reply Record. On the printed report, this value is shown in the EFF DATE column. NOTE: This reply code is only prepared if the beneficiary is still enrolled in some managed care contract. If the beneficiary has been disenrolled, but not re-enrolled, the reply code is not issued.
083 A	Enrollment Date Change	NEW ENROLL DATE	CMS staff changed the effective date for an enrollment. The new effective date of the enrollment is shown in field 24 of the Transaction Reply record. This value is also present in field 18. On the printed report, this value is shown in the EFF DATE column.
084 A	Disenrollment Date Change	NEW DISROL DATE	CMS staff changed the effective date for a disenrollment. The new effective date of the disenrollment is shown in field 24 of the Transaction Reply record. The effective enrollment date is shown in field 18. On the printed report, the effective disenrollment date is shown in the EFF DATE column.
085 M	State and County Code Change	NEW SCC	A notification has been received indicating that the beneficiary's State and County Code (SCC) information has changed. The new SCC is shown in field 9 and 23 of the Transaction Reply record. On the printed report, the new SCC is shown in the REMARKS column.

Code/Type *	Title	Short Definition	Definition
086 M	Claim Number Change	NEW HICN	A notification has been received indicating that the beneficiary's claim number has changed. The new claim number is shown in field 24 of the Transaction Reply record. On the printed report, the new claim number is shown in the REMARKS column.
087 M	Name Change	NEW NAME	A notification has been received indicating that the beneficiary's name has changed. The new name is shown in fields, 2, 3 and 4 of the Transaction Reply record. On the printed report, the new name is shown in fields 2, 3 and 4 of the Transaction Reply record. On the printed report, the new name is shown in the SURNAME, FIRST NAME and MI columns.
088 M	Sex Code Change	NEW SEX CODE	A notification has been received indicating that the beneficiary's sex code has changed. The new Sex code is shown in field 5 of the Transaction Reply record. On the printed report, the new Sex code is in the SEX column.
089 M	Date of Birth Change	NEW BIRTH DATE	A notification has been received indicating that the beneficiary's date of birth has changed. The new date of birth is shown in field 6 of the Transaction Reply record. On the printed report, the new birth date is shown in the DATE OF BIRTH and EFF DATE columns.
090 M	Date of Death Established	MEMB DECEASED	A notification has been received indicating that the beneficiary is deceased. The date of death is shown in field 24 of the Transaction Reply record. On the printed report, the date of death is shown in the EFF DATE column.
091 M	Date Of Death Removed	DEATH DATE OFF	Previously, the Medicare Beneficiary Database reported a date of death for this beneficiary. That date has been removed, as the beneficiary is still alive. NOTE: This reply code is not issued if the beneficiary is no longer enrolled in any MCO.
092 M	Date of Death Corrected	NEW DEATH DATE	A notification has been received indicating that the beneficiary's date of death has been corrected. The corrected date of death is shown in field 24 of the Transaction Reply record. On the printed report, the corrected date of death is shown in the EFF DATE column.
093	SCC Exemption Code Change	[Obsolete]	This transaction reply code is obsolete.
094 R	No Match on Name	[Obsolete]	This transaction reply code is obsolete.

Code/Type *	Title	Short Definition	Definition
095 R	Invalid State, County Or Zip Code	BAD ADDRESS	The State, County or ZIP code received from the MBD is invalid. If these codes differ from your records, prompt the beneficiary to visit the Social Security Administration Field Office (SSAFO) to change their address. This will enable MARX to make a more accurate payment for this enrollment.
096	SCC Already Exists	[Obsolete]	This transaction reply code is obsolete.
097 R	Medicaid Previously Turned On	MCAID PREV ON	A transaction attempted to process the start of a Medicaid period and was rejected because the Medicaid status for the beneficiary was already on for the month in question. No action required by the plan.
098 R	Medicaid Status Previously Turned Off	MCAID PREV OFF	A transaction attempted to process the end of a Medicaid period and was rejected because the Medicaid status was already off for the month in question. No action required by the plan.
099 M	Medicaid Period Change/Cancellation	MCAID CHANGE	A change has been made to a period of Medicaid status information for the beneficiary. No action required by the plan.
100 A	Election Change Accepted as Submitted	ELECTION OK	An M+CO has submitted a transaction type 71 to move a member from one benefit package to another. All applicable edits have been passed; the transaction has successfully processed. The effective date of the PBP election is shown in field 24 of the Transaction Reply record.
101 R	Rejected; Invalid Institutional Flag	BAD INST FLAG	Code is for transaction types 71/61/60/51. Must be Y or spaces.. *NOTE: Made obsolete by the August 2002 Plan Communications Guide.*
102 R	Rejected; Invalid or Missing Application Date	BAD SIGN DATE	A transaction was rejected (60/61/71) because it was submitted with an invalid or missing application date. The application date must be present, represent a valid date and precede the effective date on the transaction (effective date of the enrollment or PBP change). Note that the application date is not a required field on transaction type 51, nor is it required for any enrollment submitted online by CMS. The transaction should be resubmitted with a valid date.
103 P	Transaction Orbiting; ICEP/IEP Election with Missing A/B Entitlement Date	ICEP/IEP ORBIT	Beneficiary does not have entitlement on record. Transaction will be held (orbited) for 3 months maximum waiting for entitlement. Code is for transaction type 61 and election types I and E only, orbit is 3 months maximum. This code is obsolete.

Code/ Type *	Title	Short Definition	Definition
104 R	Rejected; Invalid or Missing Election Type	BAD ELECT TYPE	Election type is either missing, not valid for plan or transaction type, or not valid for the current time. Code is for transaction types 71/61/60/51 and election types A, I, E, N, S, O, and T; except that I and E are not valid for 51 or 71. *NOTE: Election types are on hold until 11/15/2005.*
105 R	Rejected; Invalid Effective Date for Election Type	BAD ELECT DATE	Effective date specified is not valid for the election type. Code is for transaction types 71/61/60/51; applies only to election types A, I, E, N, O, and T. *NOTE: Election types are on hold until 11/15/2005.*
106 R	Rejected; Another Transaction Received with a Later Application Date	LATER APPLIC	The transaction was rejected (60/61/71) because a transaction with a more recent application date was received for the same effective date. When multiple transactions are received for the same beneficiary with the same effective date but with different contract/PBP #s, the application date will be used to determine which election to accept. Note that this code does not apply to transaction type 51, nor does it apply to an enrollment submitted online by CMS. If the application dates are different, the system will accept the election containing the most recent date. If the application dates are the same, they will all be rejected with a code of 040.
107 R	Rejected; Invalid or Missing PBP Number	BAD PBP NUMBER	The transaction was rejected (60/61/71) because the PBP # was missing or invalid. Note that the PBP # is not required on transaction type 51. The PBP # submitted on the 60/61/71 must be valid for the contract number on the transaction. The transaction should be resubmitted with a valid PBP #.
108 R	Rejected; Election Limits Exceeded	NO MORE ELECTS	Election limit exceeded for this election type. Code is for transaction types 71/61/60/51 and election types A, I, E, N, and O. *NOTE: Election types are on hold until 11/15/2005.*
109 D	Rejected; Duplicate PBP Number	DUPLICATE	The transaction was rejected (71) because the member was already enrolled in the PBP # on the transaction. This code only applies to transaction type 71.
110 R	Rejected; No Part A and No EGHP Enrollment Waiver	NO PART A/EGHP	The transactions was rejected (60/61/71) because the beneficiary lacks Part A and there was no EGHP Part B-only waiver in place. MCOs can offer PBP for EGHP members only, and, if the MCO chooses, it can define such PBPs for individuals who do not have Part A.

Code/Type *	Title	Short Definition	Definition
111 R	PBP Rejected; Invalid Contract Number	BAD CONTRACT #	The transaction was rejected (71) because the contract number on the transaction does not match the member's enrollment record. This code applies only to transaction type 71. The transaction should be resubmitted with the correct contract number.
112 R	Rejected; Conflicting Effective Dates	CNFLT EFF DATE	For a 71 or 71-X transaction (Note: 71X transactions have been discontinued starting with the February 2003 run), no current enrollment record is found for the beneficiary that has an effective start date before or on the effective date on the transaction. Also, for 71-X, the effective date on the transaction is after the PBP startup cutoff date.
113 M	Part B Premium Reduction Rate Change	PARTB REDUCT CH	Acknowledgement that the Part B premium reduction amount has been changed (Formerly related to the "BIPA 606" legislation; for 2006 and forward, part of the MMA legislation.)
114 R	Drug Coverage Change Rejected; Not AEP or OEPI	RX NOT AEP/OEPI	Existing plan members cannot add or drop drug coverage except during an AEP or OEPI. Code is for transaction types 71/61/60/51 and election types N, O or S.
115 R	Enrollment Rejected; Plan Not Open	PLAN NOT OPEN	An OEP, OEPNEW, or OEPI enrollment was rejected because the plan is closed to such enrollments.
116 R	Enrollment or Change Rejected; Invalid or Missing Segment number	BAD SEGMENT NUM	The transaction (60/61/71/72) was rejected because the enrollment is for a PBP that has been segmented, and segment number on the transaction was missing or invalid. The Segment number submitted on transaction type 60/61/71/72 must be valid for the PBP and contract number. The transaction should be resubmitted with a valid Segment number. *NOTE: Segment number is not required for transaction type 51.*
117 A	FBD Auto Enrollment Accepted	FBD AUTO ENROLL	CMS has performed an auto-enrollment of a full-benefit dual eligible beneficiary into a Part D plan.
118 A	LIS Facilitated Enrollment Accepted	LIS FAC ENROLL	CMS has performed a facilitated enrollment of a low-income subsidy beneficiary into a Part D plan.
119 A	Premium Amount Change Accepted	PREM AMT CHG	Plan has submitted a change transaction to update the Part D or Part C premium amount. The transaction was successful.

Code/ Type *	Title	Short Definition	Definition
120 A	Premium Withholding Option Change Accepted	WHOLD UPDATE	Plan or CMS submitted a change transaction to update the premium withholding option. The transaction was successful.
121 M	Beneficiary Low Income Status Updated	LIS UPDATE	The beneficiary's Part D low-income subsidy status has changed.
122 R	Enrollment or Change Rejected, Invalid Premium Amount	BAD PREMIUM AMT	The transaction (60/61/71) was rejected because the Part C or Part D premium amount was not numeric. A code 72 correction transaction was rejected because a non-blank Part C or Part D premium amount was not numeric. Transaction should be resubmitted with corrected premium amount.
123 R	Enrollment or Change Rejected, Invalid Premium Withholding Option Code	BAD W/HOLD OPT	The transaction (60/61/71) was rejected because the Part C or Part D premium amount was greater than zero and the Premium Withholding Option code contained an invalid value (valid values are D, S, R, and O). A code 72 correction transaction was rejected because a non-blank Premium Withholding Option code contained an invalid value. Transactions should be resubmitted with corrected option codes.
124 R	Enrollment or Change Rejected; Invalid Uncovered Months Field	BAD UNCOV MNTHS	The transaction (60/61/71) was rejected because the "Number of Uncovered Months" field contained a non-numeric value. A code 72 correction transaction was rejected because a non-blank "Number of Uncovered Months" field contained a non-numeric value. Transactions should be resubmitted with corrected fields.
125 R	MSA Enrollment or Change Rejected, Invalid MSA Fields	BAD MSA DATA	The transaction (60/61/71) for Medical Savings Account (MSA) was rejected because one or more of these required fields was missing: beneficiary's social security number, bank account number, bank routing number, or bank account type code.
126 R	Enrollment or Change Rejected; Invalid Creditable Coverage Flag	BAD CRED COV FL	The transaction (60/61/71) was rejected because the "Creditable Coverage Flag" field contained an invalid value. A code 72 correction transaction was rejected because a non-blank "Creditable Coverage Flag" field contained an invalid value. Transactions should be resubmitted with corrected fields.
127 R	Part D Enrollment Rejected; Employer Subsidy Status	EMP SUB REJ	The Enrollment was rejected because the beneficiary has employer subsidy status. The plan should contact the beneficiary to explain the 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
128 R	Part D Enrollment Rejected; Employer Subsidy Flag set; No Prior Transaction	EMP SUB OVR REJ	The Enrollment was rejected because the beneficiary has employer subsidy status and the Employer Subsidy Override Flag was set, but the override is not valid because there is no record that the enrollment was previously submitted and rejected due to employer subsidy status. MARX enforces this two-step process to ensure that the plan discusses the consequences of the Part D enrollment (i.e., possible loss of employer health coverage) with the beneficiary before MARX accepts the employer subsidy override.
129 A	Part D Enrollment Accepted; Employer Subsidy Flag set; Prior Transaction Rejected	EMP SUB ACC	The Enrollment was accepted. A prior transaction was rejected because the beneficiary has employer subsidy status. This transaction (with employer subsidy override flag set) indicates that the plan has contacted the beneficiary to explain the consequences of this enrollment, and that the beneficiary elects to join the Part D plan anyway. [These three scenarios—126, 127 and 128—are outlined in the CMS/DEPO letter to the plans dated March 8, 2005.]
130 R	Part D Opt-Out Rejected, Opt-Out Indicator Not Valid	BAD OPT OUT CD	The Part D Opt-Out Flag submitted by the plan has an invalid value.
131 A	Part D Opt-Out Accepted	OPT OUT OK	A valid disenrollment transaction was received with a Part D Opt-Out Flag set to Y. The beneficiary will not be subject to auto-enrollment into Part D by CMS in the future.
132 A	Part D Enrollment Accepted; Missing RxID and/or Rx Group	NO RXID NUMBERS	Plans submitting Part D transactions (60/61/71/72) must provide their RxID and RxGroup information. Although the transaction was accepted, plan should follow up with RxID and RxGroup numbers on a change transaction (72).
133 R	Part D Enrollment Rejected; Invalid Secondary Insurance Flag	BAD 2 INS FLAG	Plans submitting Part D transactions (60/61/71/72) must provide a valid value for the secondary drug coverage flag.
134 A	Part D Enrollment Accepted; Invalid Secondary Insurance	NO 2 INS INFO	Plans submitting Part D transactions (60/61/71/72) must indicate when a beneficiary has secondary drug coverage. This transaction reply indicates that the secondary insurance flag was set, but the secondary insurance RxID and RxGroup were not supplied. Plan should follow up with secondary insurance RxID and RxGroup ID information on a change transaction (72).
135 M	Beneficiary Has Started Dialysis Treatments	DIALYSIS START	A notification has been received that a beneficiary has ESRD and has begun dialysis treatments.

Code/ Type *	Title	Short Definition	Definition
136 M	Beneficiary Has Ended Dialysis Treatments	DIALYSIS END	A notification has been received that a beneficiary has ESRD and is no longer receiving dialysis treatments.
137 M	Beneficiary Has Received a Kidney Transplant	TRANSPLANT	A notification has been received that a beneficiary has ESRD and has received a transplanted kidney.
138 M	Beneficiary Address Change to Outside the U.S.	ADDR NOT U.S.	A notification has been received that the beneficiary's address is now outside of the U.S.
139 A	EGHP Flag Change Accepted	EGHP FLAG CHG	A change (72) transaction has been successfully processed to change the EGHP Flag for the beneficiary.
140 A	Segment ID Change Accepted	SEGMENT ID CHG	A change (72) transaction has been successfully processed to change the Segment ID for the beneficiary.
141 A	Creditable Coverage Change Accepted	CRED COV CHG	A change (72) transaction has been successfully processed to change the creditable coverage information (Creditable Coverage Flag, Number of Uncovered Months) for the beneficiary.
142 A	Part D Rx Number Change Accepted	PARTD Rx # CHG	A change (72) transaction has been successfully processed to change the Part D plan RxID and/or RxGroup numbers for the beneficiary.

This code is obsolete. |
143 A	Secondary Insurance Rx Number Change Accepted	2 INS Rx # CHG	A change (72) transaction has been successfully processed to change the Secondary Insurance RxID and/or RxGroup numbers for the beneficiary.
144 M	Premium withhold option change from retirement system	PREM WHOLD CHG	Notice has been received from the beneficiary's retirement system (SSA, RRB or OPM) that it was unable to withhold the entire premium amount from the beneficiary's monthly check, as requested. In these cases, the premium withhold option will be changed to 'direct bill'.
146 A	Rollover successful	ROLLOVER	A termination-rollover action was processed. These actions allow all members of a terminating organization (contract, plan or segment) to be 'rolled over' (automatically enrolled) in a new organization. No action is required by the plan, unless the action is in error, and results in beneficiaries being moved incorrectly. In this case, contract your CMS plan representative.

Code/Type *	Title	Short Definition	Definition
147 A	Rollover successful, RxID and RxGroup update required	ROLLOVR NEED RX	A termination-rollover action involving a PDP or MA-PD was processed, and CMS needs updated RxID and RxGroup IDs for this member. Plan should submit a change transaction '72' for this member, supplying the new information.
148 A	Rollover successful, Secondary RxID and RxGroup update required	RLLOVR NEED 2RX	A termination-rollover action involving a PDP or MA-PD was processed, and CMS needs updated secondary insurance RxID and RxGroup IDs for this member. Plan should submit a change transaction '72' for the member, supplying the new information. *NOTE: This TR code is only created when a 'rolled over' member previously had secondary Rx insurance information on file.*
150 A	Enrollment accepted, Exceeds Capacity Limit	OVER CAP LIMIT	An enrollment has been accepted, but the resulting enrollment count exceeds the capacity limit for the contract or PBP. *NOTE: Capacity limits do not apply to PDPs.*
151 A	Disenrollment Accepted, Invalid Disenrollment Reason Code	DISROL-BAD RC [future use]	A disenrollment was successfully processed for a beneficiary but the disenrollment reason code was invalid. *NOTE: This code is for FUTURE use.*
152 M	Race Code Change	NEW RACE CODE	A notification has been received indicating that the beneficiary's race code has changed.
153 M	Expiration of Temporary Address	TEMP ADR EXPIRE	Beneficiary's temporary address has expired.
154 M	Out of Area Status	OUT OF AREA	Beneficiary's address has changed and is no longer in the service area; or, service area has been reduced, and the beneficiary's county is no longer in the service area.
155 M	Incarceration	INCARCERATED	A notification has been received, indicating that the beneficiary is incarcerated.
156 R	Batch Transaction Rejected, User Not Authorized for Contract	BAD USR FOR PLN	A batch transaction has been submitted by a user who is not authorized to submit transactions for the contract in question.
157 R	Contract Not Authorized for Transaction Code	UNAUT REQUEST	An enrollment, disenrollment, change, correction, or demonstration factor update transaction attempted to process. The transaction was rejected because the plan is not authorized to submit that type of transaction.

Code/Type *	Title	Short Definition	Definition
158 M	Institutional Period Change/Cancellation	INST CHANGE	CMS staff changed or cancelled an Institutional period for the beneficiary. No action required by the plan.
159 M	NHC Period Change/Cancellation	NHC CHANGE	CMS staff changed or cancelled a NHC period for the beneficiary. No action required by the plan.
160 R	Batch Transaction Rejected, User Not Authorized for Batch Submission	UNAUT BATCH SUB	A batch transaction has been submitted by a user who is not authorized to submit batch transactions.
161 M	Beneficiary Record Deleted from MBD	MBD DELETE	This unusual reply code indicates a problem with the Medicare enrollee rosters. If you receive this reply, please contact your central office support analyst for advice about how to proceed.
165 R	Processing Delayed	SYSTEM DELAY	Processing of this transaction has been delayed due to MARX system conditions. No action is required by the user. MARX will process the transaction as soon as possible.

Attachment E
Draft Monthly Premium Report

#	Field Name	Len	Pos	Description
	*** FILE CONTROL			
	Record Type	2		H = Header Record(s), TBD D = Detail Record for each beneficiary included on the report *Add to T6 Total Refunds included in Net Settlement* T1 = PlanTrailer, Direct Bill Totals T2 = PlanTrailer, Withheld Totals T3 = PlanTrailer, Premium Totals T4 = PlanTrailer, Govt Owes Plan T5 = PlanTrailer, Plan Owes Govt T6 = PlanTrailer, Net Settlement T1 – T6 are sums based on the "Activity" fields on this report; they are not cumulative.
	DETAIL RECORD (Record Type = "D")			
	*** PLAN IDENTIFICATION			
	MCO Contract Number	5		MCO Contract Number
	Plan Benefit Package Id	3		Plan Benefit Package Id FORMAT 999
	Plan Segment Id	3		
	*** FILE IDENTIFICATION			
	Payment Date	8		YYYYMMDD First 6 digits contain Payment Month
	Run Date of This File	8		There can be up to 4 Run Dates for a given Payment Month (1st of month "prospective" payment run plus 3 runs for monthly withholding files) YYYYMMDD
	Run Date of Previous File	8		Date of Previous File for this Pay Month SPACES = First File for this Pay Month YYYYMMDD

#	Field Name	Len	Pos	Description
	*** BENEFICIARY IDENTIFICATION & PREMIUM SETTINGS			
	HIC Number	12		Member's HIC #
	Surname	7		
	First Initial	1		
	Sex	1		M = Male, F = Female
	Date of Birth	8		YYYYMMDD
	Premium Payment Option	3		Premium Payment Option in effect for this Pay Month 1st report file for this Pay Month determines Premium Payment Option setting for remaining iterations of report file for this Pay Month. "DIR" = Direct Billing of Premiums "SSA" = Withholding by SSA "RRB" = Withholding by RRB "OPM" = Withholding by OPM *Premium Periods where Direct Billing is in Effect – must be reported if a penalty or LIS amount is involved (or for reporting a fallback plan), otherwise they are optional as far as this accounting report is concerned.*
	Payment Option Change Flag	1		*Idea behind flag is to alert plan that the Payment Option has been changed during the month from original withholding request to "DIR", and that the plan should bill the enrollee for the premium period described in this record.*

#	Field Name	Len	Pos	Description
	LIS Premium Indicator	1		Indicates whether beneficiary entitled to LIS of premium and/or penalty amounts for premium period reflected on this record. 1 = 100% level LIS (also determines penalty LIS) 2 = 75% level LIS 3 = 50% level LIS 4 = 25% level LIS 0 = 0% level LIS (Not Entitled)
	*** PREMIUM PERIOD			
	Premium Period Start Date	8		Starting Date of Period Premium Payment Covers YYYYMMDD
	Premium Period End Date	8		Ending Date of Period Premium Payment Covers YYYYMMDD
	Number of Months in Premium Period	2		99
	*** MONTHLY RATES			These are the "expected" rates for the premium period identified above.
	Part C Premium Rate			Cannot be negative
	Part D Premium Rate			Cannot be negative
	Part D Penalty Rate			Cannot be negative
	Premium LIS Rate			Cannot be negative
	Penalty LIS Rate			Cannot be negative
	*** OPENING BALANCE COLLECTED PREMIUMS			
	Opening Balance Date	8		Reflects the date of last collection report for this premium period, SPACES for 1st report. YYYYMMDD

#	Field Name	Len	Pos	Description
	Total Opening Balance			If this is the first report for the premium period, Total Opening Balance = $0.00. Total Opening Balance = + Part C Premiums Collected Opening Balance + Part D Premiums Collected Opening Balance + Part D Penalties Collected Opening Balance + Premium LIS Collected Opening Balance + Penalty LIS Collected Opening Balance
	Part C Premiums Collected Opening Balance			If this is the first report for the premium period, Part C Premiums Collected Opening Balance = $0.00. For a normal plan, if the payment option = "DIR", this field = $0.00.
	Part D Premiums Collected Opening Balance			If this is the first report for the premium period, Part D Premiums Collected Opening Balance = $0.00. For a normal plan, if the payment option = "DIR", this field = $0.00.
	Part D Penalties Collected Opening Balance			If this is the first report for the premium period, Part D Penalties Collected Opening Balance = $0.00.
	Premium LIS Collected Opening Balance			If this is the first report for the premium period, Premium LIS Collected Opening Balance = $0.00.
	Penalty LIS Collected Opening Balance			If this is the first report for the premium period, Penalty LIS Collected Opening Balance = $0.00.
	*** ACTIVITY SINCE LAST REPORT			
	Part C Premiums Collected Since Last Report			For a normal plan, if the payment option = "DIR", this field = $0.00.
	Part D Premiums Collected Since Last Report			For a normal plan, if the payment option = "DIR", this field = $0.00.

#	Field Name	Len	Pos	Description
	Part D Penalties Collected Since Last Report			
	Premium LIS Collected Since Last Report			
	Penalty LIS Collected Since Last Report			
	*** CLOSING BALANCE COLLECTED PREMIUMS			
	Total Closing Balance			Total Closing Balance = + Total Opening Balance + Part C Premiums Collected Since Last Report + Part D Premiums Collected Since Last Report + Part D Penalties Collected Since Last Report + Premium LIS Collected Since Last Report + Penalty LIS Collected Since Last Report
	Part C Premiums Collected Closing Balance			Part C Premiums Collected Closing Balance = + Part C Premiums Collected Opening Balance + Part C Premiums Collected Since Last Report For a normal plan, if the payment option = "DIR", this field = $0.00.
	Part D Premiums Collected Closing Balance			Part D Premiums Collected Closing Balance = + Part D Premiums Collected Opening Balance + Part D Premiums Collected Since Last Report For a normal plan, if the payment option = "DIR", this field = $0.00.

#	Field Name	Len	Pos	Description
	Part D Penalties Collected Closing Balance			Part D Penalties Collected Closing Balance = + Part D Penalties Collected Opening Balance + Part D Penalties Collected Since Last Report
	Premium LIS Collected Closing Balance			Premium LIS Collected Closing Balance = + Premium LIS Collected Opening Balance + Premium LIS Collected Since Last Report
	Penalty LIS Collected Closing Balance			Penalty LIS Collected Closing Balance = + Penalty LIS Collected Opening Balance + Penalty LIS Collected Since Last Report
	Plan's Share Closing Balance			Plan's Share Closing Balance (for 2006) = + Part C Premiums Collected Closing Balance + Part D Premiums Collected Closing Balance + Premium LIS Collected Closing Balance Does not apply to a Fallback Plan
	Govt's Share Closing Balance			Govt's Share Closing Balance (for 2006) = + Part D Penalties Collected Closing Balance + Penalty LIS Collected Closing Balance
	Enrollee's Share Closing Balance			Enrollee's Share Closing Balance Normally zero, a non-zero amount represents an overpayment by the enrollee. This amount will be included in the net premium settlement the Plan receives, but is to be refunded to the enrollee. Plan's Share Closing Balance will be reduced by this amount. (See also Trailer T6).
	*** DISCREPANCY REPORTING			

#	Field Name	Len	Pos	Description
	Amt Discrepancy Flag	1		"*" = Amount Discrepancy Indicates "expected" total does not equal the "collected" total. For <u>prospective</u> premium period (i.e., premium period matches Payment Month of Report file), set Flag to "*" if the monthly withholding file corresponding to the beneficiary's Premium Payment Option has been received) AND (Part C Premium Rate + Part D Premium Rate + Part D Penalty Rate <> Total Closing Balance) For retroactive premium periods, set Flag to "*" if ((Number of Months in Premium Period) X (Part C Premium Rate + Part D Premium Rate + Part D Penalty Rate)) <> Total Closing Balance If the payment option = "DIR", this field is left blank.
	Discrepancy Amt			Discrepancy Amt is non-zero only if Amt Discrepancy Flag = "*" Discrepancy Amt = + ((Number of Months in Premium Period) X (Part C Premium Rate + Part D Premium Rate + Part D Penalty Rate)) - Total Closing Balance A positive Discrepancy Amt represents an amount in arrears. If the payment option = "DIR", this field is left blank.