MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

Plan Communications User Guide

Appendices

February 28, 2018

Version 12.0

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Change Log
February 28, 2018 Updates

Section	Changes
Global Changes	Updated the version to 12.0 Updated the publication date to February 28, 2018 Updated Table, Section, and Appendix references
Appendix A	No Change
Appendix B	No Change
Appendix C	No Change
Appendix D	No Change
Appendix E	No Change
Appendix F	Updated BEQ Request and Response file Updated the Auto Assignment Address (PDP) Notification File Detail Record Updated the No RX File Detail Record Updated the MA Full Dual Auto Assignment Notification File Detail Record Added HICN to MBI Crosswalk Naming Conventions Updated opening paragraph to the Medicare Advantage Organization (MAO) 004 Report – Encounter Data Diagnosis Eligible for Risk Adjustment Updated item# 7 in Header Record. Updated item#s: 5,6,7,23,25 & 27 in Detail Record.
Appendix G	No Change
Appendix H	No Change
Appendix I	Added TRC 161 in Transaction Reply Code and Groupings tables.
Appendix J	No Change
Appendix K	No Change
Appendix L	No Change
Appendix M	No Change

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Table of Contents

A: *Glossary and List of Abbreviations and Acronyms*

Table A-1: Glossary

Term	Definition
Accepted Transaction	The successful application of a requested action that was processed by MARx.
Account Number	A number obtained from the Resource Access Control Facility (RACF) or system administrator.
Application Date	The date that the beneficiary applies to enroll in a Plan. Enrollments submitted by CMS or its contractors, such as the Medicare Beneficiary Contact Center, do not need application dates.
Batch Transaction	An automated systems approach to processing in which data items to process must be grouped and processed in bulk.
Beneficiary Identification Code (BIC)	The portion of the Medicare health insurance claim number that identifies a specific beneficiary.
Benefit Stabilization Fund (BSF)	Established by CMS upon request of an HMO or CMP, when the HMO or CMP must provide its Medicare enrollees with additional benefits, to prevent excessive fluctuation in the provision of those benefits in subsequent contract periods.
Button	A rectangular icon on a screen which, when clicked, engages an action. The button is labeled with word(s) that describe the action, such as Find or Update.
Cancellation Transaction	A cancellation may result from an action by the beneficiary, CMS, or another Plan before the effective date of the election. A cancelled enrollment restores the beneficiary to his/her prior enrollment state.
Checkbox	A field that is part of a group of options, for which the user may select any number of options. Each option is represented with a small box, where 'x' means "on" and an empty box means "off." When a checkbox is clicked, an 'x' appears in the box. When the checkbox is clicked again, the 'x' is removed.
Connect:Direct	The proprietary software that transfers files between systems.
Correction	A record submitted by a Plan or CMS office to correct or update existing Beneficiary data.
Cost Plan	A type of contract under which a Plan is reimbursed by CMS for its reasonable costs.
Current Calendar Month (CCM)	Represents the calendar month and year at the time of transaction submission. For batch, the current month is derived from the batch file transmission date; for User Interface transactions, the current month is derived from the system data at the time of transaction submission.
Current Processing Month	The calendar month in which processing occurs to generate payments. The Current Processing Month is distinguished from the CPM, the month in which Plans receive payment from CMS.
Current Payment Month (CPM)	The month for which Plans receive payment from CMS, not the current calendar month.
Creditable Coverage	Prescription drug coverage, generally from an employer or union, that is equivalent to, or better than, Medicare standard prescription drug coverage.
Data entry field	A field that requires the user to enter information.
Date of Service (DOS)	Date of service
Deductible	The amount a Beneficiary must pay for medical services or prescription drugs before a Plan starts paying benefits.

Term	Definition
Disenrollment	A record submitted by a Plan, Social Security Administration District Office (SSA DO), Medicare Customer Service Center (MCSC), or CMS when a beneficiary discontinues membership in the Plan.
Dropdown list	A field that contains a list of values from which the user chooses. Clicking on the down arrow on the right of the field enables the user to view the list of values, and then click on a value to select it.
Dual Eligible	Individuals entitled to both Medicare and Medicaid benefits
Election Period	Time periods during which a Beneficiary may elect to join, change, or leave Medicare Part C and/or Part D Plans. These periods are fully defined in CMS Enrollment and Disenrollment guidance for Part C and D Plans available on the Web at: http://www.cms.gov/home/medicare.asp under "Eligibility and Enrollment."
Enrollment	A record submitted when a Beneficiary joins an MCO or a drug Plan.
Enrollment Process	A process in which a Plan submits a request to enroll in a Plan, change enrollment, or disenroll.
Exception	A transaction that is unprocessed due to errors or internal inconsistencies.
Failed Payment Reply Codes	Codes used for the Failed Payment Reply Report that identify incomplete payment calculations for a beneficiary.
Failed Transaction	A transaction that did not complete due to problems with the format of the transaction or internal system problems.
Formulary	The medications covered by an MA organization or Prescription Drug Plan.
Gentran	The Gentran servers provide Electronic Data Interchange (EDI) capabilities between CMS and CMS business partners. These servers provide MARx with transaction files from the Plans, and provide the Plans with MARx reports.
Hospice	A health facility for the terminally ill.
Logoff	The method of exiting an online system.
Logon	The method for gaining entry to an online system.
Lookup field	A field that provides a list of possible values. When the user clicks on the "binocular" button next to the field, a window pops up with a list of values for that field. Clicking on one of those values closes the pop-up window and the field is filled with the value chosen.
Medicaid	A jointly funded, Federal-State health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people eligible to receive Federally assisted income maintenance payments.
Managed Care Organization (MCO)	A type of contract under which CMS pays for each member, based on demographic characteristics and health status; also referred to as Risk. In a Risk contract, the MCO accepts the risk if the payment does not cover the cost of services, but keeps the difference if the payment is greater than the cost of services. Risk is managed through a membership where the high costs for very sick members are balanced by the lower cost for a larger number of relatively healthy members.
Menu	A horizontal list of items at the top of a screen. Clicking on a menu item displays a screen and may display a submenu of items corresponding to the selected menu item.
Network Data Mover (NDM)	Software used for transmitting and receiving data; replaced by Connect: Direct.
MicroStrategy	A tool used for generating and viewing standard and ad hoc reports.
Nursing Home Certifiable (NHC)	A code that reflects the relative frailty of an individual. NHC Beneficiaries are those whose condition would ordinarily require nursing home care. The code is only acceptable for certain social health maintenance organization (SHMO)-type Plans.

Term	Definition
Off-cycle	A retroactive transaction awaiting CMS approval because its effective date is too old for automatic acceptance.
Online	An automated systems approach that processes data in an interactive manner, normally through computer input.
Premium	The monthly payment a Beneficiary makes to Medicare, an insurance company, or a healthcare Plan.
Premium Payment Option (PPO)	The method selected by the beneficiary to pay the premium owed to the Plan. PPO choices are: (1) withhold from SSA (S) or RRB (R) benefit check or (2) Direct self-pay (D) to the Plan.
Program for All Inclusive. Care for the Elderly (PACE) Plans	PACE is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity that features a comprehensive medical and social service delivery system. It uses a multidisciplinary team approach in an adult day health center supplemented by in-home and referral service in accordance with participants' needs.
Radio button	A field that is part of a group of options, of which the user may only select one option. A radio button is represented with a small circle; a filled circle indicates the button is selected, and an empty circle means it is not selected. Clicking a radio button selects that option and deselects the existing selection.
Required field	A field that the user must complete before a button is clicked to engage an action. If the button is clicked and the field is not filled in, an error message displays and the action does not occur. There are two types of required fields: • Always required, which are marked with an asterisk (*) • Conditionally required, where the user must fill in at least one or only one of the conditionally required fields. These are marked with a plus sign (+).
Risk	A contract under which Beneficiaries are “locked in” to network providers and a payment is received from CMS for each member, based on demographic characteristics and health status. In a Risk contract, the MCO accepts the risk if the payment does not cover the cost of services, but keeps the difference if the payment is greater than the cost of services. Risk is managed through a membership where the high costs for very sick members are balanced by the lower costs for a larger number of relatively healthy members.
Special Needs Plan (SNP)	A certain type of MA Plan that serves a limited population of individuals in CMS special-needs categories, as defined in CMS Part C Enrollment and Eligibility Guidance. This Plan is fully defined on the Web at: http://www.cms.gov/home/medicare.asp under “Health Plans.”
Submenu	A horizontal list of items below the screen’s menu. Clicking on a submenu item displays a screen.
TIBCO MFT Internet Server	The TIBCO MFT Internet Servers provide Electronic Data Interchange (EDI) capabilities between CMS and CMS business partners. These servers provide MARx and MBD with transaction files from the Plans, and provide the Plans with MARx and MBD reports.
Transaction Code (TC)	Identifies batch transactions submitted by the Plans or CMS.
Transaction Reply Code (TRC)	The code that explains the action taken by the system in response to new information from CMS systems or in response to input from MCOs, CMS, or other users.
User ID	Valid user identification code for accessing the CMS Data Center and the Medicare Data Communications Network.
User Interface	The screens, forms, and menus that display to a user logged on to an automated system.

A.1 List of Abbreviations and Acronyms

Acronym	Definition
AAPCC	Adjusted Average Per Capita Cost
ADAP	AIDS Drug Assistance Program
AE-FE	Automated Enrollment-Facilitated Enrollment
AEP	Annual Enrollment Period
APPS	Automated Plan Payment System
BBA	Balanced Budget Act of 1997
BCSS	Batch Completion Status Summary
BEQ	Beneficiary Eligibility Query
BIC	Beneficiary Identification Code
BIN	Beneficiary Identification Number
BIPA	Benefits Improvement & Protection Act of 2000
BSF	Benefit Stabilization Fund
CAN	Claim Account Number
CCIP/FFS	Chronic Care Improvement Program/Fee-for-Service
CCM	Current Calendar Month
C: D	Connect:Direct
CHF	Congestive Heart Failure
CM	Center for Medicare
CMP	Competitive Medical Plan
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
COB	Close of Business
COB	Coordination of Benefits
COBA	Coordination of Benefits Agreement
COBC	Coordination of Benefits Contractor
COM	Current Operation Month
CPM	Current Payment Month
CR	Change Request
CSR	Customer Service Representative
CWF	Common Working File database (CMS' beneficiary database)
DCG	Diagnostic Cost Group
DDPS	Drug Data Processing System

Acronym	Definition
DO	District Office
DOB	Date of Birth
DOD	Date of Death
DOS	Date of Service
DPO	Division of Payment Operations
DSA	Data Sharing Agreement
DTL	Detail
DTRR	Daily Transaction Reply Report
ECRS	Electronic Correspondence Referral System
EDB	Enrollment Database
EFT	Electronic File Transfer
EFT	Electronic Funds Transfer
EFT	Enterprise File Transfer
EGHP	Employer Group Health Plan
EIN	Employee Identification Number
EIDM	Enterprise Identity Management
EOY	End of Year
EPOC	External Point of Contact
ESRD	End Stage Renal Disease
FAQ	Frequently Asked Question
FEFD	Full Enrollment File Data
FERAS	Front End Risk Adjustment System
FFS	Fee-For-Service
FTR	Failed Transaction Report
GHP	Group Health Plan
GUIDE	Plan Communications User Guide
HCC	Hierarchical Condition Category
HCFA	Health Care Financing Administration (renamed to CMS)
HCPP	Health Care Prepayment Plan
HIC	Health Insurance Claim
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization

Acronym	Definition
HPMS	Health Plan Management System
HTML	Hypertext Markup Language
HTTPS	Hypertext Transfer Protocol Secure ICD
ICD-9-CM	International Classification of Diseases, 9th Edition
ICEP	Initial Coverage Election Period
ID	Identification
IEP	Initial Enrollment Period
IPPR	Interim Plan Payment Report
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
IT	Information Technology
LEP	Late Enrollment Penalty
LICS	Low-Income Cost Sharing
LIPS	Low-Income Premium Subsidy
LIS	Low-Income Subsidy
LISHIST	LIS History Data File
LISPRM	LIS Premium Data File
LTC	Long-Term Care
LTI	Long-Term Institutional
MA	Medicare Advantage
MA BSF	Medicare Advantage Benefit Stabilization Fund
MADP	Medicare Advantage Disenrollment Period
MAPD	Medicare Advantage Prescription Drug
MARx	Medicare Advantage Prescription Drug System
MARx UI	Medicare Advantage Prescription Drug System User Interface
MBD	Medicare Beneficiary Database
MBI	Medicare Beneficiary Identifier
MCO	Managed Care Organization
MDS	Minimum Data Set
MCSC	Medicare Customer Service Center (1-800-MEDICARE)
MMA	Medicare Modernization Act
MMCM	Medicare Managed Care Manual
MMDR	Monthly Membership Detail Report

Acronym	Definition
MMP	Medicare and Medicaid Plan
MMR	Monthly Membership Report
MMSR	Monthly Membership Summary Report
MPWE	Monthly Premium Withhold Extract
MPWR	Monthly Premium Withholding Report Data File
MSA	Medical Savings Account
MSHO	Minnesota Senior Health Options
MSP	Medicare Secondary Payer
NCPDP	National Council of Prescriptions Drug Programs
NDM	Network Data Mover
NMEC	National Medicare Education Campaign
NHC	Nursing Home Certifiable
NUNCMO	Number of Uncovered Months
OEPI	Open Enrollment Period for Institutionalized Individuals
OHI	Other Health Insurance
OMB	Office of Management and Budget
OPM	Office of Personnel Management
PACE	Program of All-Inclusive. Care for the Elderly
PAP	Patient Assistance Program
PBM	Pharmacy Benefit Manager
PBO	Payment Bill Option
PBP	Plan Benefit Package
PCN	Processor Control Number
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PFFS	Private Fee-for-Service
PIP	Principal Inpatient Diagnostic Cost Group
POS	Point-of-Sale
PPO	Premium Payment Option
PPR	Plan Payment Report
PPS	Prospective Payment System
PRM	Primary Record
PWS	Premium Withhold System

Acronym	Definition
QMB	Qualified Medicare Beneficiary Program
RA	Risk Adjustment/Risk Adjusted
RACF	Resource Access Control Facility
RAS	Risk Adjustment System
RDS	Retiree Drug Subsidy
REMIS	Renal Management Information System
RO	CMS Regional Office
RRB	Railroad Retirement Board
RRE	Responsible Reporting Entity
RxHCC	Prescription Drug Hierarchical Condition Category
SCC	State and County Code
SEP	Special Election Period
SFTP	Secure Shell File Transfer Protocol
SHMO	Social Health Maintenance Organization
SIMS	Standard Information Management System
SLMB	Specified Low-Income Medicare Beneficiary Program
SNP	Special Needs Plan
SPAP	State Pharmaceutical Assistance Program
SSA	Social Security Administration
SSA DO	Social Security Administration District Office
SSN	Social Security Number
SUP	Supplemental Record
TC	Transaction Code
TIN	Tax Identification Number
TRC	Transaction Reply Code
TrOOP	True Out-of-Pocket
TRR	Transaction Reply Report
UI	User Interface
WC	Workers Compensation
WCSA	Workers Compensation Set-Aside
WPP	Wisconsin Partnership Program

B: *CMS Payment Information*

B.1 Payment Information Form

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

ORGANIZATION INFORMATION

NAME OF ORGANIZATION: _____
DBA, if any: _____

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

CONTACT PERSON NAME: _____
TELEPHONE NUMBER: _____

CONTRACT NO's.: H _____; H _____; H _____; H _____
(If known)
EIN/TIN NAME of business for tax purposes (as registered with the IRS: a W-9 may be required) _____

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

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

FINANCIAL INSTITUTION

NAME OF BANK: _____
ADDRESS: _____
CITY: _____ STATE: __ ZIP CODE: _____ - _____

ACH/EFT COORDINATOR NAME: _____
TELEPHONE NUMBER: _____

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

SIGNATURE & TITLE OF ORGANIZATION'S AUTHORIZED REPRESENTATIVE:

_____DATE: _____

Signature Title

_____ _____

Print Name Phone Number

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C: *Monthly Schedule*

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

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

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

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

C.1 MARx Plan Payment Processing Schedule Description - Calendar Year 2017 and 2018

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

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

(2) **PAYMENT DUE PLANS** - This is the date that CMS deposits the CMS monthly payment to the Plans; all deposits are made to arrive on the first calendar day of the month unless the first day falls on a weekend or a Federal holiday. In this case, the deposit arrives on the last workday prior to the first of the month.

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

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

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

(3) **ANNUAL ELECTION PERIOD BEGINS AND ENDS** - The Annual Election Period (AEP) is October 15 through December 7 every year. Elections made during the AEP are effective January 1 of the following year.

(4) **CERTIFICATION DUE** - This is the date by which Plans must certify the accuracy of the enrollment information of the MARx Report. Plans must send the Certification via the Health Plan Management System (HPMS).

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

2017 MARx Monthly Calendar

JANUARY						
S	M	T	W	T	F	S
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FEBRUARY						
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MARCH						
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APRIL						
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MAY						
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28	29	30	31			

JUNE						
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11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

Legend

- CMS Holiday
- Payment to Plan
- Certification of Enrollment
- Monthly Reports Available
- Plan Data Cut-Off (8pm Eastern Time)
- Plan Data Cut-Off and Certification of Enrollment (on the same day)
- Plan Data Cut-Off and CMS Holiday (on the same day)
- Annual Elections: 10/15/17 through 12/07/17

2017 MARx Monthly Calendar

JULY

S	M	T	W	T	F	S
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23	24	25	26	27	28	29
30	31					

AUGUST

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SEPTEMBER

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OCTOBER

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29	30	31				

NOVEMBER

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DECEMBER

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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Legend

- CMS Holiday
- Payment to Plan
- Certification of Enrollment
- Monthly Reports Available
- Plan Data Cut-Off (8pm Eastern Time)
- Plan Data Cut-Off and Certification of Enrollment (on the same day)
- Plan Data Cut-Off and CMS Holiday (on the same day)
- Annual Elections: 10/15/17 through 12/07/17

Special Dates for January 2018 - Payment to Plan: 01/02/2018 & Plan Data Cut-off: 01/05/18

2018 MARx Monthly Calendar

JANUARY

S	M	T	W	T	F	S
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21	22	23	24	25	26	27
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FEBRUARY

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MARCH

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25	26	27	28	29	30	31

APRIL

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22	23	24	25	26	27	28
29	30					

MAY

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27	28	29	30	31		

JUNE

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10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Legend

- CMS Holiday
- Payment to Plan
- Certification of Enrollment
- Monthly Reports Available
- Plan Data Cut-Off (8pm Eastern Time)
- Plan Data Cut-Off and Certification of Enrollment (on the same day)
- Plan Data Cut-Off and CMS Holiday (on the same day)
- Annual Elections: 10/15/18 through 12/07/18

2018 MARx Monthly Calendar

JULY

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
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AUGUST

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SEPTEMBER

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23	24	25	26	27	28	29
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OCTOBER

S	M	T	W	T	F	S
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21	22	23	24	25	26	27
28	29	30	31			

NOVEMBER

S	M	T	W	T	F	S
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11	12	13	14	15	16	17
18	19	20	21	22	23	24
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DECEMBER

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16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	1	2	3	4	5

Legend

- **CMS Holiday**
- **Payment to Plan**
- **Certification of Enrollment**
- **Monthly Reports Available**
- **Plan Data Cut-Off (8pm Eastern Time)**
- **Plan Data Cut-Off and Certification of Enrollment (on the same day)**
- **Plan Data Cut-Off and CMS Holiday (on the same day)**
- **Annual Elections: 10/15/18 through 12/07/18**

Special Dates for January 2019 - Payment to Plan: 01/02/19, Plan Data Cut-off: 01/04/19, and Certification of Enrollment: 01/05/19

D: *Enrollment Data Transmission Schedule*

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

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

- Saturday, Sunday, and system down days.

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

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

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

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E: *ESRD Network Contact Information*

Plans may contact the appropriate Facility or Renal Network to verify specific discrepancy data by visiting: https://www.medicare.gov/people-like-me/esrd/esrd.html.

F: *Record Layouts*

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

Table F-1: Record Layouts Lookup Table

Daily Record Layouts

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

The Batch Completion Status Summary (BCSS) file is a hybrid file that communicates the status of file transmissions, as well as reporting on submitted transaction records that failed due to formatting issues. Note: The Enrollment Transmission Message File (STATUS) was discontinued as of the April 2011.

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

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

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

F.1.1 Sample BCSS Report

The example of a BCSS report below shows the format of the file. It incorporates:

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

Beginning of Message Text
H1 TRANSACTIONS RECEIVED ON 2012-03-27 AT 16.59.49
H2 TRANSACTIONS PROCESSED ON 2012-03-27 AT 17.03.50
H3 ENROLLMENT PROCESSING COMPLETED

H4 HEADER CODE= AAAAAAHEADER
H5 HEADER DATE= 032012
H6 REQUEST ID =
H7 BATCH ID = 0123456789
H8 USER ID = X7YZ
C1 TRAN CNTS1 = 00000019 T01 0000000 T51 0000000 T61 0000000 T72 0000001
C2 TRAN CNTS2 = T73 0000002 T74 0000000 T75 0000000 T76 0000000
C3 TRAN CNTS3 = T77 0000000 T78 0000000 T79 0000002 T80 0000002
C4 TRAN CNTS4 = T81 0000003 T82 0000004 T83 0000005 T90 0000000
C5 TRAN CNTS5 = T91 0000000 **TXX 0000000**
P1 TOTAL TRANSACTIONS PROCESSED = 00000019
P2 TOTAL ACCEPTED TRANSACTIONS = 00000017
P3 TOTAL REJECTED TRANSACTIONS = 0000002
P4 TOTAL FAILED TRANSACTIONS = 0000000
F……failed transaction text image……
End of Message Text

F.1.2 BCSS 'Failed Transaction' Layout

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

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

Total length = 323

F.1.3 BCSS Error Condition

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

1. Invalid User Id

********** Top of Data **********
H1 TRANSACTIONS RECEIVED ON 2006-01-27 AT 16.59.49
H2 PROCESSING STOPPED ON 2006-01-27 AT 17.00.39
H3 USER ID (aaaa) NOT AUTHENTICATED: INACTIVE USER

H4 HEADER CODE= AAAAAAHEADER
H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
H7 BATCH ID = <nnnnnnnnn>
H8 USER ID = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 = T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 = T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 = T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
********** Bottom of Data **********

OR

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

2. Invalid Header Date

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

3. Missing Header Record

********** Top of Data **********
H1 TRANSACTIONS RECEIVED ON AT
H2 PROCESSING STOPPED ON 2006-01-25 AT 18.12.08
H3 HEADER RECORD IS MISSING OR INVALID
H4 HEADER CODE= XXXXXXXXXXXXXXXXXXXXX
H5 HEADER DATE= XXXXXX
H6 REQUEST ID = XXXXXXXXXX

H7 BATCH ID = XXXXXXXXXX
H8 USER ID = XXXXXX
C1 TRAN CNTS1 =
C2 TRAN CNTS2 =
C3 TRAN CNTS3 =
C4 TRAN CNTS4 =
C5 TRAN CNTS5 =
********** Bottom of Data **********

4. Future Header Date

********** Top of Data **********
H1 TRANSACTIONS RECEIVED ON 2006-01-30 AT 16.48.37
H2 PROCESSING STOPPED ON 2006-01-30 AT 16.48.55
H3 HEADER RECORD DATE IS A FUTURE CALENDAR MONTH
H4 HEADER CODE= AAAAAAHEADER
H5 HEADER DATE= <MMCCYY>
H6 REQUEST ID =
H7 BATCH ID = <nnnnnnnnn>
H8 USER ID = <aaaa>
C1 TRAN CNTS1 = nnnnnnn T01 nnnnnnn T51 nnnnnnn T61 nnnnnnn T72 nnnnnnn
C2 TRAN CNTS2 = T73 nnnnnnn T74 nnnnnnn T75 nnnnnnn T76 nnnnnnn
C3 TRAN CNTS3 = T77 nnnnnnn T78 nnnnnnn T79 nnnnnnn T80 nnnnnnn
C4 TRAN CNTS4 = T81 nnnnnnn T82 nnnnnnn T83 nnnnnnn T90 nnnnnnn
C5 TRAN CNTS5 = TXX nnnnnnn
********** Bottom of Data **********

5. Header Date earlier than CCM

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

6. Transaction File Rejection Reason

When a submitted Special file (Retro, Rollover, Special) is reviewed by CMS and rejected, the following STATUS message is returned in the BCSS:

********** Top of Data **********
H1 TRANSACTIONS RECEIVED ON 2010-03-23 AT 13.55.15
H2 TRANSACTIONS REJECTED ON 24 Mar 2010 AT 14:39:33
H3 THIS <RETRO/ROLLOVER/REVIEW> FILE WAS REJECTED BY <CMS Approver Name>
REJECTION REASONS: <text of reason
H4 HEADER CODE= AAAAAAHEADER RETRO
H5 HEADER DATE= <MMCCYY>

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

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

F.1.4 BCSS for Special Transaction Files

When plans submit a special transaction file that requires CMS review and approval before processing, the following BCSS files are returned to the submitter to communicate the file status:

Retro File Detected – Returned when a Retro File is received by CMS

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

Rollover File Detected – Returned when a rollover file is received by CMS

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

Review File Detected – Returned when a transaction file requiring special review is received by CMS

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

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

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

Note: This file is returned to Part D Plans and covers beneficiary other drug coverage. Part C Plans receive the Monthly MSP Information Data file that reports MA MSP.

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

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

The following records are included in this file:

- Detail Record
- Primary Record
- Supplemental Record

F.2.1 General Organization of Records

Detail Record (DTL) Record 1 (Beneficiary A)
Primary (PRM) records associated with 'DTL' Record 1 (Beneficiary A)
Supplemental (SUP) records associated with 'DTL' Record 1 (Beneficiary A)
'DTL' Record 2 (Beneficiary B)
'PRM' records associated with 'DTL' Record 2 (Beneficiary B)
'SUP' records associated with 'DTL' Record 2 (Beneficiary B)
'DTL' Record 3 (Beneficiary C)
'PRM' records associated with 'DTL' Record 3 (Beneficiary C)
'SUP' records associated with 'DTL' Record 3 (Beneficiary C)
'DTL Record n
'PRM' records associated with 'DTL' Record n
'SUP' records associated with 'DTL' Record n

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

Item	Field	Size	Position	Format	Valid Values/Description
1	Record Type	3	1-3	CHAR	"DTL"
2	HICN/RRB Number	12	4-15	CHAR	• Spaces if unknown
3	SSN	9	16-24	ZD	000000000 if unknown
4	Date of Birth (DOB)	8	25-32	CHAR	YYYYMMDD
5	Gender Code	1	33	CHAR	0=unknown, 1 = male, 2 = female
6	Contract Number	5	34-38	CHAR	
7	Plan Benefit Package	3	39-41	CHAR	
8	Action Type	1	42	CHAR	2 = Full replacement
9	Filler	1058	43-1100	CHAR	Spaces

Note: Total Length = 1100

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

Item	Field	Size	Position	Format	Valid Values/Description
1	Record Type	3	1-3	CHAR	"PRM"
2	HICN/RRB Number	12	4-15	CHAR	• Spaces if unknown
3	SSN	9	16-24	ZD	000000000 if unknown
4	Date of Birth (DOB)	8	25-32	CHAR	YYYYMMDD
5	Gender Code	1	33	CHAR	0=unknown, 1 = male, 2 = female
6	RxID Number*	20	34-53	CHAR	
7	RxGroup Number*	15	54-68	CHAR	
8	RxBIN Number*	6	69-74	ZD	
9	RxPCN Number*	10	75-84	CHAR	
10	Rx Plan Toll Free Number*	18	85-102	CHAR	
11	Sequence Number*	3	103-105	CHAR	

Item	Field	Size	Position	Format	Valid Values/Description
12	COB Source Code* **Note:** There may be instances where an unknown COB Source Code will be provided. Plans should contact COBC for clarification on any unknown Source Codes.	5	106-110	CHAR	11100 Non Payment/Payment Denial 11101 IEQ 11102 Data Match 11103 HMO 11104 Litigation Settlement BCBS 11105 Employer Voluntary Reporting 11106 Insurer Voluntary Reporting 11107 First Claim Development 11108 Trauma Code Development 11109 Secondary Claims Investigation 11110 Self Report 11111 411.25 11112 BCBS Voluntary Agreements 11113 Office of Personnel Management (OPM) Data Match 11114 Workers' Compensation Data Match 11118 Pharmacy Benefit Manager (PBM) 11120 COBA 11125 Recovery Audit Contractor (RAC) 1 (April Release) 11126 RAC 2 (April Release) 11127 RAC 3 (April Release) P0000 PBM S0000 Assistance Program Note: Contractor numbers 11100 - 11199 are reserved for COB
13	MSP Reason (Entitlement Reason from COB)	1	111	CHAR	A=Working Aged B=ESRD C=Conditional Payment D=Automobile Insurance, No fault E=Workers Compensation F=Federal (public) G=Disabled H=Black Lung I=Veterans L=Liability

Item	Field	Size	Position	Format	Valid Values/Description
14	Coverage Code*	1	112	CHAR	A=Hospital and Medical U=Drug (network benefit) V=Drug with Major Medical (non-network benefit) W=Comprehensive, Hospital, Medical, Drug (network) X=Hospital and Drug (network) Y=Medical and Drug (network) Z=Health Reimbursement Account (hospital, medical, and drug)
15	Insurer's Name*	32	113-144	CHAR	
16	Insurer's Address-1*	32	145-176	CHAR	
17	Insurer's Address-2*	32	177-208	CHAR	
18	Insurer's City*	15	209-223	CHAR	
19	Insurer's State*	2	224-225	CHAR	
20	Insurer's Zip Code*	9	226-234	CHAR	
21	Insurer TIN	10	235-244	CHAR	
22	Individual Policy Number*	17	245-261	CHAR	
23	Group Policy Number*	20	262-281	CHAR	
24	COB Effective Date*	8	282-289	ZD	YYYYMMDD. This date is a manipulated date and does not reflect the actual effective date of the other coverage and therefore should not be used for purposes of Part D coordination of benefits. Part D Sponsors should use the Effective Date of Other Drug Coverage (Position 1084-1091 in Primary records and position 516-523 in Supplemental records) for coordination of benefits.
25	Termination Date*	8	290-297	ZD	YYYYMMDD
26	Relationship Code*	2	298-299	CHAR	01=Bene is Policy Holder 02=Spouse 03=Child 04=Other
27	Payer ID*	10	300-309	CHAR	*This is a future element.*
28	Person Code*	3	310-312	CHAR	
29	Payer Order*	3	313-315	ZD	
30	Policy Holder's First Name	9	316-324	CHAR	
31	Policy Holder's Last Name	16	325-340	CHAR	
32	Policy Holder's SSN	12	341-352	CHAR	
33	Employee Information Code	1	353	CHAR	P=Patient S=Spouse M=Mother F=Father
34	Employer's Name	32	354-385	CHAR	

Item	Field	Size	Position	Format	Valid Values/Description
35	Employer's Address 1	32	386-417	CHAR	
36	Employer's Address 2	32	418-449	CHAR	
37	Employer's City	15	450-464	CHAR	
38	Employer's State	2	465-466	CHAR	
39	Employer's Zip Code	9	467-475	CHAR	
40	Filler	20	476-495	CHAR	
41	Employer TIN	10	496-505	CHAR	
42	Filler	70	506-575	CHAR	
43	Attorney's Name	32	576-607	CHAR	
44	Attorney's Address 1	32	608-639	CHAR	
45	Attorney's Address 2	32	640-671	CHAR	
46	Attorney's City	15	672-686	CHAR	
47	Attorney's State	2	687-688	CHAR	
48	Attorney's Zip	9	689-697	CHAR	
49	Lead Contractor	9	698-706	CHAR	
50	Class Action Type	2	707-708	CHAR	
51	Administrator Name	32	709-740	CHAR	
52	Administrator Address 1	32	741-772	CHAR	
53	Administrator Address 2	32	773-804	CHAR	
54	Administrator City	15	805-819	CHAR	
55	Administrator State	2	820-821	CHAR	
56	Administrator Zip	9	822-830	CHAR	
57	Workers Compensation Set Aside (WCSA) Amount	12	831-842	ZD	Integer value
58	WCSA Indicator	2	843-844	CHAR	
59	Workers Compensation Medical Set Aside (WCMSA) Settlement Date	8	845-852	ZD	YYYYMMDD
60	Administrator's Telephone Number	18	853-870	CHAR	
61	Total Rx Settlement Amount	12	871-882	CHAR	Includes decimal point: 9999999999.99
62	Rx $ included in the WCMSA Settlement Amount	1	883	CHAR	Y = Yes N = No
63	Diagnosis Indicator 1	1	884	CHAR	9 = ICD-9; 0 = ICD-10
64	Claim Diagnosis Code 1	7	885-891	CHAR	
65	Diagnosis Indicator 2	1	892	CHAR	9 = ICD-9; 0 = ICD-10
66	Claim Diagnosis Code 2	7	893-899	CHAR	
67	Diagnosis Indicator 3	1	900	CHAR	9 = ICD-9; 0 = ICD-10
68	Claim Diagnosis Code 3	7	901-907	CHAR	
69	Diagnosis Indicator 4	1	908	CHAR	9 = ICD-9; 0 = ICD-10
70	Claim Diagnosis Code 4	7	909-915	CHAR	
71	Diagnosis Indicator 5	1	916	CHAR	9 = ICD-9; 0 = ICD-10

Item	Field	Size	Position	Format	Valid Values/Description
72	Claim Diagnosis Code 5	7	917-923	CHAR	
73	Diagnosis Indicator 6	1	924	CHAR	9 = ICD-9; 0 = ICD-10
74	Claim Diagnosis Code 6	7	925-931	CHAR	
75	Diagnosis Indicator 7	1	932	CHAR	9 = ICD-9; 0 = ICD-10
76	Claim Diagnosis Code 7	7	933-939	CHAR	
77	Diagnosis Indicator 8	1	940	CHAR	9 = ICD-9; 0 = ICD-10
78	Claim Diagnosis Code 8	7	941-947	CHAR	
79	Diagnosis Indicator 9	1	948	CHAR	9 = ICD-9; 0 = ICD-10
80	Claim Diagnosis Code 9	7	949-955	CHAR	
81	Diagnosis Indicator 10	1	956	CHAR	9 = ICD-9; 0 = ICD-10
82	Claim Diagnosis Code 10	7	957-963	CHAR	
83	Diagnosis Indicator 11	1	964	CHAR	9 = ICD-9; 0 = ICD-10
84	Claim Diagnosis Code 11	7	965-971	CHAR	
85	Diagnosis Indicator 12	1	972	CHAR	9 = ICD-9; 0 = ICD-10
86	Claim Diagnosis Code 12	7	973-979	CHAR	
87	Diagnosis Indicator 13	1	980	CHAR	9 = ICD-9; 0 = ICD-10
88	Claim Diagnosis Code 13	7	981-987	CHAR	
89	Diagnosis Indicator 14	1	988	CHAR	9 = ICD-9; 0 = ICD-10
90	Claim Diagnosis Code 14	7	989-995	CHAR	
91	Diagnosis Indicator 15	1	996	CHAR	9 = ICD-9; 0 = ICD-10
92	Claim Diagnosis Code 15	7	997-1003	CHAR	
93	Diagnosis Indicator 16	1	1004	CHAR	9 = ICD-9; 0 = ICD-10
94	Claim Diagnosis Code 16	7	1005-1011	CHAR	
95	Diagnosis Indicator 17	1	1012	CHAR	9 = ICD-9; 0 = ICD-10
96	Claim Diagnosis Code 17	7	1013-1019	CHAR	
97	Diagnosis Indicator 18	1	1020	CHAR	9 = ICD-9; 0 = ICD-10
98	Claim Diagnosis Code 18	7	1021-1027	CHAR	
99	Diagnosis Indicator 19	1	1028	CHAR	9 = ICD-9; 0 = ICD-10
100	Claim Diagnosis Code 19	7	1029-1035	CHAR	
101	Diagnosis Indicator 20	1	1036	CHAR	9 = ICD-9; 0 = ICD-10
102	Claim Diagnosis Code 20	7	1037-1043	CHAR	
103	Diagnosis Indicator 21	1	1044	CHAR	9 = ICD-9; 0 = ICD-10
104	Claim Diagnosis Code 21	7	1045-1051	CHAR	
105	Diagnosis Indicator 22	1	1052	CHAR	9 = ICD-9; 0 = ICD-10
106	Claim Diagnosis Code 22	7	1053-1059	CHAR	
107	Diagnosis Indicator 23	1	1060	CHAR	9 = ICD-9; 0 = ICD-10
108	Claim Diagnosis Code 23	7	1061-1067	CHAR	
109	Diagnosis Indicator 24	1	1068	CHAR	9 = ICD-9; 0 = ICD-10
110	Claim Diagnosis Code 24	7	1069-1075	CHAR	
111	Diagnosis Indicator 25	1	1076	CHAR	9 = ICD-9; 0 = ICD-10
112	Claim Diagnosis Code 25	7	1077-1083	CHAR	

Item	Field	Size	Position	Format	Valid Values/Description
113	Effective Date of Other Drug Coverage	8	1084-1091	CHAR	YYYYMMDD. This date is the actual effective date of other drug insurance coverage provided by the other insurance. This date should be used for coordination of benefits. The Part D Sponsor should compare Date of Service (DOS) to both the Part D effective period and the other coverage effective period to determine if coordination of benefits is necessary
114	Filler	9	1092-1100	CHAR	Spaces

Total Length = 1100

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

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

Item	Field	Size	Position	Format	Valid Values/Description
1	Record Type	3	1-3	CHAR	"SUP"
2	HICN/RRB Number	12	4-15	CHAR	• Spaces if unknown
3	SSN	9	16-24	ZD	000000000 if unknown
4	Date of Birth (DOB)	8	25-32	CHAR	YYYYMMDD
5	Gender Code	1	33	CHAR	0=unknown, 1 = male, 2 = female
6	RxID Number*	20	34-53	ZD	
7	RxGroup Number*	15	54-68	CHAR	
8	RxBIN Number*	6	69-74	ZD	
9	RxPCN Number*	10	75-84	CHAR	
10	Rx Plan Toll Free Number*	18	85-102	CHAR	
11	Sequence Number*	3	103-105	CHAR	
12	COB Source Code*	5	106-110	CHAR	11100 Non Payment/Payment Denial 11101 IEQ 11102 Data Match 11103 HMO 11104 Litigation Settlement BCBS 11105 Employer Voluntary Reporting 11106 Insurer Voluntary Reporting 11107 First Claim Development 11108 Trauma Code Development 11109 Secondary Claims Investigation 11110 Self Report 11111 411.25 11112 BCBS Voluntary Agreements 11113 Office of Personnel Management (OPM) Data Match 11114 Workers' Compensation Data Match 11118 Pharmacy Benefit Manager (PBM) 11120 COBA 11125 Recovery Audit Contractor (RAC) 1 (April Release) 11126 RAC 2 (April Release) 11127 RAC 3 (April Release) P0000 PBM S0000 Assistance Program Note: Contractor numbers 11100 - 11199 are reserved for COB

Item	Field	Size	Position	Format	Valid Values/Description
13	Supplemental Type Code	1	111	CHAR	L=Supplemental M=Medigap N=State Program (Non-Qualified SPAP) O=Other P=Patient Assistance Program Q=Qualified State Pharmaceutical Assistance Program (SPAP) R=Charity S=AIDS Drug Assistance Program T=Federal Health Program 1=Medicaid 2=Tricare 3 = Major Medical
14	Coverage Code*	1	112	CHAR	U=Drug (network benefit) V=Drug with Major Medical (non-network benefit)
15	Insurer's Name*	32	113-144	CHAR	
16	Insurer's Address-1*	32	145-176	CHAR	
17	Insurer's Address-2*	32	177-208	CHAR	
18	Insurer's City*	15	209-223	CHAR	
19	Insurer's State*	2	224-225	CHAR	
20	Insurer's Zip Code*	9	226-234	CHAR	
21	Filler	10	235-244	CHAR	Spaces
22	Individual Policy Number*	17	245-261	CHAR	
23	Group Policy Number*	20	262-281	CHAR	
24	COB Effective Date*	8	282-289	ZD	YYYYMMDD. This date is a manipulated date and does not reflect the actual effective date of the other coverage and therefore should not be used for purposes of Part D coordination of benefits. Part D Sponsors should use the Effective Date of Other Drug Coverage (Position 1084-1091 in Primary records and position 516-523 in Supplemental records) for coordination of benefits.
25	Termination Date*	8	290-297	ZD	YYYYMMDD
26	Relationship Code*	2	298-299	CHAR	01=Bene is Policy Holder 02=Spouse 03=Child 04=Other
27	Payer ID*	10	300-309	CHAR	
28	Person Code*	3	310-312	CHAR	
29	Payer Order*	3	313-315	ZD	
30	Diagnosis Indicator 1	1	316	CHAR	9 = ICD-9; 0 = ICD-10
31	Claim Diagnosis Code 1	7	317-323	CHAR	

Item	Field	Size	Position	Format	Valid Values/Description
32	Diagnosis Indicator 2	1	324	CHAR	9 = ICD-9; 0 = ICD-10
33	Claim Diagnosis Code 2	7	325-331	CHAR	
34	Diagnosis Indicator 3	1	332	CHAR	9 = ICD-9; 0 = ICD-10
35	Claim Diagnosis Code 3	7	333-339	CHAR	
36	Diagnosis Indicator 4	1	340	CHAR	9 = ICD-9; 0 = ICD-10
37	Claim Diagnosis Code 4	7	341-347	CHAR	
38	Diagnosis Indicator 5	1	348	CHAR	9 = ICD-9; 0 = ICD-10
39	Claim Diagnosis Code 5	7	349-355	CHAR	
40	Diagnosis Indicator 6	1	356	CHAR	9 = ICD-9; 0 = ICD-10
41	Claim Diagnosis Code 6	7	357-363	CHAR	
42	Diagnosis Indicator 7	1	364	CHAR	9 = ICD-9; 0 = ICD-10
43	Claim Diagnosis Code 7	7	365-371	CHAR	
44	Diagnosis Indicator 8	1	372	CHAR	9 = ICD-9; 0 = ICD-10
45	Claim Diagnosis Code 8	7	373-379	CHAR	
46	Diagnosis Indicator 9	1	380	CHAR	9 = ICD-9; 0 = ICD-10
47	Claim Diagnosis Code 9	7	381-387	CHAR	
48	Diagnosis Indicator 10	1	388	CHAR	9 = ICD-9; 0 = ICD-10
49	Claim Diagnosis Code 10	7	389-395	CHAR	
50	Diagnosis Indicator 11	1	396	CHAR	9 = ICD-9; 0 = ICD-10
51	Claim Diagnosis Code 11	7	397-403	CHAR	
52	Diagnosis Indicator 12	1	404	CHAR	9 = ICD-9; 0 = ICD-10
53	Claim Diagnosis Code 12	7	405-411	CHAR	
54	Diagnosis Indicator 13	1	412	CHAR	9 = ICD-9; 0 = ICD-10
55	Claim Diagnosis Code 13	7	413-419	CHAR	
56	Diagnosis Indicator 14	1	420	CHAR	9 = ICD-9; 0 = ICD-10
57	Claim Diagnosis Code 14	7	421-427	CHAR	
58	Diagnosis Indicator 15	1	428	CHAR	9 = ICD-9; 0 = ICD-10
59	Claim Diagnosis Code 15	7	429-435	CHAR	
60	Diagnosis Indicator 16	1	436	CHAR	9 = ICD-9; 0 = ICD-10
61	Claim Diagnosis Code 16	7	437-443	CHAR	
62	Diagnosis Indicator 17	1	444	CHAR	9 = ICD-9; 0 = ICD-10
63	Claim Diagnosis Code 17	7	445-451	CHAR	
64	Diagnosis Indicator 18	1	452	CHAR	9 = ICD-9; 0 = ICD-10
65	Claim Diagnosis Code 18	7	453-459	CHAR	
66	Diagnosis Indicator 19	1	460	CHAR	9 = ICD-9; 0 = ICD-10
67	Claim Diagnosis Code 19	7	461-467	CHAR	
68	Diagnosis Indicator 20	1	468	CHAR	9 = ICD-9; 0 = ICD-10
69	Claim Diagnosis Code 20	7	469-475	CHAR	
70	Diagnosis Indicator 21	1	476	CHAR	9 = ICD-9; 0 = ICD-10
71	Claim Diagnosis Code 21	7	477-483	CHAR	
72	Diagnosis Indicator 22	1	484	CHAR	9 = ICD-9; 0 = ICD-10

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

Total Length = 1100

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

F.3 MARx Batch Input Transaction Data File

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

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

This file may include the following records:

- Header Record
- Disenrollment (51/54) Detail Record
- Enrollment (61) Detail Record
- Miscellaneous Change Detail Records:
  - Correction (01) Record
  - 4Rx Data Change (72)
  - Number of Uncovered Months (NUNCMO) Change (73)
  - Employer Group Health Plan (EGHP) Change (74)
  - Premium Payment Option (PPO) Change (75)
  - Residence Address Change (76)
  - Segment ID Change (77)
  - Part C Premium Change (78)
  - Part D Opt-Out (79)
  - MMP Opt-Out Update (TC83)
- Cancellation of Enrollment (80) and Cancellation of Disenrollment (81) Detail Records
  - MMP Enrollment Cancellation (TC82)
- POS Drug Edit (TC90)
- IC Model Participation (TC91)

F.3.1 *Header Record*

Item	Field	Size	Position	Description
1	Header Message	12	1-12	"AAAAAAHEADER"
2	Filler	1	13	Spaces
3	Batch File Type	5	14-18	"Spaces" = used for batch files that do not require special approval for submission; “RETRO” = retroactive batch file submission; “POVER” = Plan rollover batch file submission; “SVIEW” = Special organization review batch file submission.
4	Filler	1	19	Spaces
5	CMS Approval Request ID	10	20-29	"Spaces" when “Batch File Type,” field #3, contains spaces; otherwise, the right justified CMS pre-approval request ID from the special batch request utility.
6	Filler	4	30-33	Spaces
7	Current Calendar Month (CCM)	6	34-39	Reference month for enrollment processing formatted MMYYYY. The CCM date determines whether to accept a file and evaluates the appropriate effective date for submitted transactions.
8	Filler	261	40-300	Spaces

Total Length = 300

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

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

Item	Field	Size	Position	Required/Optional
7	Filler	1	42	Required
8	PBP	3	43-45	Required
9	Election Type	1	46	Required for all Plan types except HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MDHO demo, MSHO demo, and PACE National Plans
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	Transaction Codes (TCs)*	2	60-61	"51" or "54"
13	DRC	2	62-63	Required for Involuntary Disenrollments. Optional for Voluntary Disenrollments.
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Segment ID	3	72-74	Optional
16	Filler	24	75-98	N/A
17	Part D Opt-Out Flag	1	99	Optional for all Part D Plans; otherwise blank.
18	MMP Opt-Out Flag	1	100	Optional for all Plans.
19	Filler	109	101-209	N/A
20	Plan Transaction Tracking ID**	15	210-224	Optional
21	Filler	76	225-300	N/A

Total Length = 300

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

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

Item	Field	Size	Position	Enrollment (61)
1	Beneficiary Identifier	12	1 – 12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13 – 24	Required
3	First Name	7	25 – 31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34 – 41	Required
7	EGHP Flag	1	42	Required
8	PBP #	3	43 – 45	Required
9	Election Type	1	46	Required Optional for: HCPP COST 1 without drug COST 2 without drug CCIP/FFS demo MDHO demo MSHO demo PACE National plans
10	Contract #	5	47 – 51	Required
11	Application Date	8	52 – 59	Required
12	Transaction Code	2	60 – 61	Required
13	Disenrollment Reason	2	62 – 63	Not populated on the enrollment transaction N/A
14	Effective Date (YYYYMMDD)	8	64 – 71	Required

Item	Field	Size	Position	Enrollment (61)
15	Segment ID	3	72 – 74	Required 3 digits for segmented organizations otherwise blank
16	Filler	5	75 – 79	N/A
17	ESRD Override	1	80	Required
18	Premium Withhold Option/Parts C-D	1	81	Required for all plan types except HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MSA/MA and MSA/demo plans
19	Part C Premium Amount (XXXXvXX)	6	82 – 87	Required for all plan types except HCPP, COST 1, COST 2, CCIP/FFS demo, MSA/MA and MSA/demo plans
20	Filler	6	88 – 93	N/A
21	Creditable Coverage Flag	1	94	Required for all Part D plans; otherwise blank
22	Number of Uncovered Months	3	95 – 97	Required for all Part D plans; otherwise blank.
23	Employer Subsidy Enrollment Override Flag	1	98	Required if beneficiary has Employer Subsidy status for Part D; otherwise blank
24	Part D Opt-Out Flag	1	99	Required when changing PBPs. ('Y' when Opting Out of Part D; 'N' when Opting In to Part D; otherwise blank)
25	Filler	35	100 – 134	N/A
26	Secondary Drug Insurance Flag	1	135	Required for Part D plans. For auto/facilitated enrollments and rollovers, value should be blank. For non-Part D plans, value should be blank.
27	Secondary Rx ID	20	136 – 155	Required when the secondary drug insurance flag = Y; otherwise blank.
28	Secondary Rx Group	15	156 – 170	Required when the secondary drug insurance flag = Y; otherwise, blank.
29	Enrollment Source	1	171	Required for POS submitted enrollment transactions; otherwise optional.
30	Rolled from Contract	5	172-176	Required for Rollover enrollment transactions submitted on a POVER special batch file; otherwise blank
31	Rolled from PBP	3	177-179	Required for Rollover enrollment transactions submitted on a POVER special batch file; otherwise blank
32	Filler	30	180 – 209	N/A

Item	Field	Size	Position	Enrollment (61)
33	Plan Assigned Transaction Tracking ID	15	210 – 224	Optional
34	Part D Rx BIN	6	225 – 230	Required for all Part D plans except PACE National and MMP; otherwise blank.
35	Part D Rx PCN	10	231 – 240	Required for all Part D plans, otherwise blank.
36	Part D Rx Group	15	241 – 255	Required for all Part D plans, otherwise blank.
37	Part D Rx ID	20	256 – 275	Required for all Part D plans except PACE National and MMP; otherwise, blank.
38	Secondary Drug BIN	6	276 – 281	Required when the secondary drug insurance flag = Y; otherwise blank.
39	Secondary Drug PCN	10	282 – 291	Required when the secondary drug insurance flag = Y; otherwise blank.
40	Filler	9	292 – 300	N/A

Total Length = 300

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

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

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

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

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1 – 12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13 – 24	Required
3	First Name	7	25 – 31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34 – 41	Required
7	Filler	1	42	N/A
8	PBP #	3	43 – 45	Required
9	Filler	1	46	N/A
10	Contract #	5	47 – 51	Required
11	Filler	8	52 – 59	N/A
12	Transaction Code (TC)	2	60 – 61	Required
13	Filler	2	62 – 63	N/A
14	Effective Date (YYYYMMDD)	8	64 – 71	Required
15	Filler	63	72-134	N/A
16	Secondary Drug Insurance Flag	1	135	Blank or new value. Blank does not remove or replace existing data.
17	Secondary Rx ID	20	136-155	Blank or new additional value. Blank does not remove or replace existing data.
18	Secondary Rx Group	15	156-170	Blank or new additional value. Blank does not remove or replace existing data.
19	Filler	54	171-209	N/A
20	Transaction Tracking ID	15	210-224	Optional

Item	Field	Size	Position	Required/Optional
21	Part D Rx BIN	6	225-230	Required together with Part D Rx ID when changing 4Rx primary insurance information. Must include either the beneficiary's current field value or the change-to value. Blank is appropriate when not changing a beneficiary's 4Rx primary insurance information.
22	Part D Rx PCN	10	231-240	Change-to value, either a new value or a blank. Blank removes the beneficiary's existing value.
23	Part D Rx Group	15	241-255	Change-to value, either a new value or a blank. Blank removes the beneficiary's existing value.
24	Part D Rx ID	20	256-275	Required together with Part D Rx ID when changing 4Rx primary insurance information. Must include either the beneficiary's current field value or the change-to value. Blank is appropriate when not changing a beneficiary's 4Rx primary insurance information.
25	Secondary Drug BIN	6	276-281	Blank or new additional value. Blank does not remove or replace existing data.
26	Secondary Drug PCN	10	282-291	Blank or new additional value. Blank does not remove or replace existing data.
27	Filler	9	292-300	N/A

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required

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

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	EGHP Flag	1	42	Required change-to value
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	138	72-209	N/A
16	Transaction Tracking ID	15	210-224	Optional
17	Filler	76	225-300	N/A

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60- 61	Required
13	Filler	2	62- 63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	9	72-80	N/A
16	PPO/ Parts C-D	1	81	Required change-to value
17	Filler	128	82-209	N/A
18	Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225- 300	N/A

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	5	42-46	N/A
8	Contract #	5	47-51	Required
9	Filler	8	52-59	N/A
10	TC	2	60-61	76
11	Filler	2	62-63	N/A
12	Effective Date (YYYYMMDD)	8	64-71	Required
13	Filler	3	72-74	N/A
14	Residence Address Line 1	65	75-139	Required when Address Update/Delete Flag indicates “Update” code
15	Residence Address Line 2	65	140-204	Optional
16	Filler	4	205-208	N/A
17	Address Update/Delete Flag	1	209-209	Required
18	Transaction Tracking ID	15	210-224	Optional
19	Residence City	57	225-281	Required when Address Update/Delete Flag indicates “Update” code
20	Residence State	2	282-283	Required when Address Update/Delete Flag indicates “Update” code

Item	Field	Size	Position	Required/Optional
21	Residence Zip Code	5	284-288	Required when Address Update/Delete Flag indicates "Update" code
22	Residence Zip Code+4	4	289-292	Optional
23	End Date	8	293-300	Optional

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Segment ID	3	72-74	Required
16	Filler	135	75-209	N/A
17	Transaction Tracking ID	15	210-224	Optional
18	Filler	76	225-300	N/A

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Sex	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	10	72-81	N/A
16	Part C Premium Amount (XXXXvXX)	6	82-87	Required
17	Filler	122	88-209	N/A
18	Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225-300	N/A

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	27	72-98	N/A
16	Part D Opt-Out Flag	1	99	Required
17	Filler	110	100-209	N/A
18	Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225-300	N/A

Total Length = 300

F.3.5 *Cancellation Transactions – Detailed Record Layouts*

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Sex	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required: if Plan has PBPs
9	Filler	1		N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	Transaction Code (TC)	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	138	72-209	N/A
16	Transaction Tracking ID	15	210-224	Optional
17	Filler	76	225-300	N/A

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP	3	43-45	Required
9	Filler	1	46	
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	Transaction Code	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Segment ID	3	72-74	Optional
16	Filler	135	75-209	N/A
17	Transaction Tracking ID	15	210-224	Optional
18	Filler	76	225– 300	N/A

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP	3	43-45	Required for PBP contracts; otherwise, spaces
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	Transaction Code (TC)	2	60-61	Required
13	DRC	2	62-63	Optional
14	Effective Date (YYYYMMDD)	8	64-71	Required (must equal the enrollment date)
15	Filler	28	72-99	N/A
16	MMP Opt-Out Flag	1	100	Optional
17	Filler	109	101-209	N/A
18	Plan Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225-300	N/A

Total Length = 300

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

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1-12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13-24	Required
3	First Name	7	25-31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34-41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47-51	Required
11	Filler	8	52-59	N/A
12	TC	2	60-61	Required
13	Filler	2	62-63	N/A
14	Effective Date (YYYYMMDD)	8	64-71	Required
15	Filler	28	72-99	N/A
16	MMP Opt-Out Flag	1	100	Required
17	Filler	109	101-209	N/A
18	Plan Transaction Tracking ID	15	210-224	Optional
19	Filler	76	225-300	N/A

Total Length = 300

F.3.5.5 POS Drug Edit (TC 90) Layout

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1 – 12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13 – 24	Required
3	First Name	7	25 – 31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34 – 41	Required
7	Filler	5	42 - 46	N/A
8	Contract #	5	47 – 51	Required
9	Filler	8	52 – 59	N/A
10	Transaction Code	2	60 – 61	Required
11	Filler	13	62 – 74	N/A
12	Update/Delete Flag	1	75	Required
13	POS Drug Edit Status	1	76	Required
14	POS Drug Edit Class	3	77 - 79	Required
15	POS Drug Edit Code	3	80 - 82	Required
16	Notification Date	8	83 - 90	Required
17	Implementation Date	8	91 - 98	Required if Status is I or Status is T and an Implementation record exists.
18	Termination Date	8	99 - 106	Required if Status is T
19	Filler	103	107 - 209	N/A
20	Plan Assigned Transaction Tracking ID	15	210 - 224	Optional
21	Filler	76	225 - 300	N/A

Total Length = 300

F.3.5.6 IC Model Participation (TC 91) Transaction Layout

Item	Field	Size	Position	Required/Optional
1	Beneficiary Identifier	12	1 – 12	Required **Reject** the transaction with TRC007 if following criteria is not met during MBI transition: 1. Format must be one of the following: • HICN is a 7 to 12 position value, with the first 1 to 3 positions possible alphas, and the last 6 or 9 positions numeric (RRB number). • HICN is an 11-position value, with the first 9 positions numeric and the last 2 positions being alpha in the first space and alpha-numeric or blank in the second (Non-RRB number). • MBI is when the 2nd, 5th, 8th and 9th positions are alphas. 2. String must contain NO embedded spaces. **Reject** the transaction with TRC008 if the beneficiary identifier is not found.
2	Surname	12	13 – 24	Required
3	First Name	7	25 – 31	Required
4	M. Initial	1	32	Optional
5	Gender Code	1	33	Required
6	Birth Date (YYYYMMDD)	8	34 – 41	Required
7	Filler	1	42	N/A
8	PBP #	3	43-45	Required
9	Filler	1	46	N/A
10	Contract #	5	47 – 51	Required
11	Filler	8	52 – 59	N/A
12	Transaction Code	2	60 – 61	Required
13	Filler	2	62 – 63	N/A
14	IC Model Start Date (YYYYMMDD)	8	64 – 71	Required
15	Filler	3	72 – 74	N/A
16	IC Model Update/Delete Flag	1	75	Required
17	IC Model Type Indicator	2	76 – 77	Required
18	IC Model Benefit Status Code	2	78 - 79	Required if IC Model Type Indicator is ‘01’; N/A for other Type Indicator
19	IC Model End Date (YYYYMMDD)	8	80 - 87	Optional
20	IC Model End Date Reason Code	2	88 – 89	Required if IC Model End Date is present
21	Filler	120	90 – 209	N/A

Item	Field	Size	Position	Required/Optional
22	Plan Assigned Transaction Tracking ID	15	210 – 224	Optional
23	Filler	76	225 – 300	N/A

Total Length = 300

F.3.6 *Correction Record*

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

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

Total Length = 300

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

Item	Field	Description
1	HICN	Health Insurance Claim Number - CAN plus BIC
2	Surname	Beneficiary's last name
3	First Name	Beneficiary's first name
4	M. Initial	Beneficiary's middle initial
5	Gender Code	• 1 = male • 2 = female • 0 = unknown
6	Birth Date (YYYYMMDD)	The date of the beneficiary's birth • YYYYMMDD
7	EGHP Flag	This flag indicates whether the Plan associated with this transaction is an Employer Group Health Plan (EGHP). For an Enrollment (TC 61) Transaction: • Y = EGHP • blank for all others For an EGHP Change (TC 74) Transaction: • Y = EGHP • N = not EGHP • blank = no change
8	PBP #	Three-character Plan Benefit Package (PBP) identifier, 001 – 999 (zero padded), for the Plan associated with this transaction. PBP is required for all organizations except HCPP and CCIP/FFS demos. For these non-PBP organizations, populate with blanks.
9	Election Type	The election type associated with the enrollment or disenrollment associated with this transaction. • A = AEP • D = MADP • E = IEP • F = IEP2 • I = ICEP • R = 5 Star Quality Rating SEP • S = Other SEP • T = OEPI • U = Dual/LIS SEP • V = Permanent Change in Residence SEP • W = EGHP SEP • X = Administrative SEP • Y = CMS/Case Worker SEP. I, A, D, O, S, N, U, V, W, X, Y and T are valid for MA only enrollments. I, A, D, O, S, U, V, W, X, Y, E, F, N, and T are valid for MAPD enrollments. A, S, U, V, W, X, Y, E and F are valid for PDP enrollments.
10	Contract #	The contract number associated with the transaction. • Hxxxx = local Plans • Rxxxx = regional Plans • Sxxxx = PDPs • Fxxxx = fallback Plans • Exxxx = employer sponsored MA/MAPD and PDP Plans.

Item	Field	Description
11	Application Date	The application date associated with this enrollment transaction. The application date is generally the date the enrollment request was initially received by the Plan, as further defined in the CMS Plan enrollment manual guidance. • YYYYMMDD
12	TC	This identifies the type of transaction submitted on this record. • 01 = Internal corrections or cleanups • 41 = Part D Opt-Out Change (Submitted by CMS) • 42 = MMP Opt-Out Update • 51 = Disenrollment (MCO or CMS) • 54 = Disenrollment (Submitted by 1-800-MEDICARE) • 61 = Single Enrollment • 72 = 4Rx Record Update • 73 = NUNCMO Update • 74 = Employer Group Health Plan (EGHP) Update • 75 = Premium Payment Option (PPO) Update • 76 = Residence Address Update • 77 = Segment ID Update • 78 = Part C Premium Update • 79 = Part D Opt-Out Update • 80 = Cancellation of Enrollment • 81= Cancellation of Disenrollment • 82 = MMP Enrollment Cancellation • 83 = MMP Opt-Out Update • 90 = POS Drug Edit • 91 = IC Model Participation
13	Disenrollment Reason	The reason the beneficiary is disenrolled from the Plan. This is required for all Plan submitted Disenrollment transactions. Refer to the published Disenrollment Reason Code (DRC) list and the appropriate CMS Plan enrollment manual instructions.
14	Effective Date (YYYYMMDD)	The effective date for the action taken by the submitted transaction. • YYYYMMDD
15	Segment ID	The three character segment identifier, 001-999 (zero-padded), associated with this transaction. Only required for segmented Plans. Only local MA/MAPD Plans (Hxxxx) may have segments. For non-segmented Plans, this field is populated with blanks.
16	Filler	Blank
17	ESRD Override	This is populated to enroll an End Stage Renal Disease (ESRD) beneficiary into a non-PDP Plan. • Any alpha-numeric value (1-9 and A-F) indicates an override. • Zero (0) or blank indicates no override.
18	PPO/Parts C-D	This indicates the premium payment option (PPO) requested by the beneficiary on this transaction. • D = Direct self-pay • S = Deduct from SSA benefits • N = No Premium • R = RRB benefits The option applies to both Part C and D premiums.
19	Part C Premium Amount (XXXXvXX)	The amount of the Part C Premium is formatted as six digits with leading zeroes. A decimal point is assumed 2-digits from right; XXXXvXX. Zero is interpreted as an actual value. If Part C premium does not apply to the transaction, this field is treated as blank.
20	Filler	Blank

Item	Field	Description
21	Creditable Coverage Flag	This indicates whether the beneficiary has creditable drug coverage in the period prior to this enrollment in a Part D Prescription Plan. • For enrollment (TC 61) transactions, valid values are Y, N, and blank. • For NUNCMO change (TC 73), valid values are Y, N. • Y = the beneficiary has creditable coverage. • N = the beneficiary does not have creditable coverage. **Note:** R and U are not valid values for this field on submitted transactions. To set a beneficiary's NUNCMO to zero for a particular date, the plans should use Creditable Coverage Flag = Y and NUNCMO = 0.
22	Number of Uncovered Months (NUNCMO)	The number of months during which the beneficiary did not have creditable coverage in the period prior to this enrollment, as determined by the Plan according to the applicable CMS policy. A NUNCMO may be greater than 0 only if the Creditable Coverage Flag is N. This field is populated with zero if the Creditable Coverage Flag is Y.
23	Employer Subsidy Enrollment Override Flag	This flag indicates that the Beneficiary is currently in a Plan receiving an employer subsidy, but still wants to enroll in a Part D Plan. • Y = override the employer subsidy check and enroll the beneficiary • Blank = No override
24	Part D Opt-Out Flag	This flag indicates that the beneficiary does not want AE in a Part D Plan. It applies to LIS beneficiaries who are subject to AE-FE into Part D. • Y = add the flag to opt-out of Part D AE-FE. • N = remove the flag to opt-out of Part D AE-FE. • Blank = no change to opt-out status
25	MMP Opt-Out Flag	This flag indicates the beneficiary does not want passive enrollment into an MMP. • Y = add the flag to opt-out of passive enrollment into MMPs. • N = remove the flag to opt-out of passive enrollment into an MMP. • Blank = no change to opt-out status
26	Secondary Drug Insurance Flag	This flag indicates whether that beneficiary has secondary drug insurance. • Y = beneficiary has secondary drug insurance • N = beneficiary does not have secondary drug insurance • blank = status of beneficiary's secondary drug insurance is unknown
27	Secondary Rx ID	Secondary insurance Plan's Identifier for a Beneficiary. It can consist of any combination of alphanumeric characters.
28	Secondary Rx Group	Secondary insurance Plan's Group ID for a Beneficiary. It can consist of any combination of alphanumeric characters.
29	Enrollment Source	Indicates the source of the enrollment. 'A' = Auto enrolled by CMS; 'B' = Beneficiary Election; 'C' = Facilitated enrollment by CMS; 'D' = CMS Annual Rollover; 'E' = Plan initiated auto-enrollment; 'F' = Plan initiated facilitated-enrollment; 'G' = Point-of-sale enrollment; 'H' = CMS or Plan reassignment; 'I' = Invalid submitted value (transaction is not rejected); 'J' = State-submitted passive enrollment 'K' = CMS-submitted passive enrollment 'L' = MMP beneficiary election 'N' = Rollover by Plan Transaction Space = not applicable.

Item	Field	Description
30	Filler	Blank
31	Transaction Tracking ID	Optional value created and used by the Plan to track the replies of the transaction.
32	Part D Rx BIN	Part D insurance Plan's Beneficiary Identification Number (BIN) • Numeric and right justified • Example: If BIN is five-position numeric (12345), the submitted BIN is a six-position numeric with zero added in the first position (012345).
33	Part D Rx PCN	Part D insurance Plan's Pharmacy Control Number (PCN) for the Beneficiary. • Alphanumeric (upper case and/or numeric) and left justified • Default value = spaces
34	Part D Rx Group	Part D insurance Plan's group identifier for the Beneficiary. • Alphanumeric (upper case and/or numeric) and left justified • Default value = spaces
35	Part D Rx ID	Part D insurance Plan's ID for the Beneficiary. • Alphanumeric (upper case and/or numeric) and left justified • Default value = spaces
36	Secondary Rx BIN	Secondary insurance Plan's BIN number for the Beneficiary. • Numeric and right justified
37	Secondary Rx PCN	Secondary insurance Plan's PCN identifier for a Beneficiary. • Alphanumeric (upper case and/or numeric) and left justified • Default value = spaces
38	Update/Delete Flag	This flag indicates whether the POS Drug Edit Record is an update or delete. • U = Update (add) • D = Delete
39	POS Drug Edit Status	The POS Drug Edit Status for the Beneficiary. • N = Notification • I = Implementation • T = Termination
40	POS Drug Edit Class	The restricted class of drugs. • OPI = Opioids
41	POS Drug Edit Code	The POS Drug Edit Code that details the level of drug usage allowed. The higher the number the less restrictive the allowance code. • PS1 = No drugs allowed in the drug class (most restrictive drug allowance code) • PS2 = One or more drugs in the class allowed (less restrictive drug allowance code)
42	Notification Date	The date of the POS Drug Edit Notification to the beneficiary. • YYYYMMDD
43	Implementation Date	The date of the POS Drug Edit Implementation. • YYYYMMDD
44	Termination Date	The date of the POS Drug Edit Termination. • YYYYMMDD
45	Filler	Blank

F.4 Daily Transaction Reply Report (DTRR) Data File

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

The DTRR contains the following types of information:

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

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

F.4.1 DTRR Data File Detailed Record Layout

Item	Field	Size	Position	Description
1	Beneficiary ID	12	1 – 12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then, • MBI during and after MBI transition. o MBI is 11 characters, left-justified with one space at the end.
2	Surname	12	13 – 24	Beneficiary Surname
3	First Name	7	25 – 31	Beneficiary Given Name
4	Middle Initial	1	32	Beneficiary Middle Initial
5	Gender Code	1	33	Beneficiary Gender Identification Code '0' = Unknown; '1' = Male; 2' = Female.
6	Date of Birth	8	34 – 41	YYYYMMDD Format
7	Record Type	1	42	'T' = TRC record
8	Contract Number	5	43 – 47	Plan Contract Number
9	State Code	2	48 – 49	Beneficiary Residence State Code; otherwise, spaces if not applicable.
10	County Code	3	50 – 52	Beneficiary Residence County Code; otherwise, spaces if not applicable.
11	Disability Indicator	1	53	'0' = No Disability; '1' = Disabled without ESRD (disability insurance benefits (DIB); '2' = ESRD Only (end stage renal disease (ESRD)); '3' = Disabled with ESRD (both DIB and ESRD); Space = not applicable.
12	Hospice Indicator	1	54	'0' = No Hospice; '1' = Hospice; Space = not applicable.
13	Institutional/NHC/HCBS Indicator	1	55	'0' = No Institutional; '1' = Institutional; '2' = NHC; '3' = HCBS; Space = not applicable
14	ESRD Indicator	1	56	'0' = No End-Stage Renal Disease; '1' = End-Stage Renal Disease; Space = not applicable.
15	Transaction Reply Code	3	57 – 59	TRC, see TRC list for values
16	Transaction Type Code	2	60 – 61	Transaction Type Code

Item	Field	Size	Position	Description
17	Entitlement Type Code	1	62	Beneficiary Entitlement Type Code: 'Y' = Entitled to Part A and B, 'Z' = Entitled to Part A or B; Space = not applicable Space reported with TRCs 121, 194, and 223, has no meaning.
18	Effective Date	8	63 – 70	YYYYMMDD Format; Effective date is present for all TRCs unless listed below. Field content is TRC dependent for the following TRCs: 071 & 072 – Effective date of the hospice period 090 – Current Calendar Month 091 – Previously reported incorrect death date 121, 194, and 223 – PBP enrollment effective date 245 – the date that payments will begin to be impacted due to the addition of the MSP period 280 – the date that payments will begin to be impacted due to the addition of the MSP period 293 – Enrollment End Date; Last day of the month 305 – New ZIP Code Start Date 366 – The effective date of the change in Medicaid status 368 – Beginning date of the period for which the Plan's payments are impacted by MSP, based on the MSP start date 701 – New enrollment period start date 702 – Fill-in enrollment period start date 703 – Start date of cancelled enrollment period 704 – Start date of enrollment period cancelled for PBP correction 705 – Start date of enrollment period for corrected PBP 706 – Start date of enrollment period cancelled for segment correction 707 – Start date of enrollment period for corrected segment 708 – Enrollment period end date assigned to existing opened ended enrollment 709 & 710 – New start date resulting from update 711 & 712 – New end date resulting from update 713 – "00000000" – End date removed. Original end date is in field 24.X

Item	Field	Size	Position	Description
19	WA Indicator	1	71	'0' = Not Working Aged; '1' = Working Aged; Space = not applicable.
20	Plan Benefit Package ID	3	72 – 74	PBP number
21	Filler	1	75	Spaces
22	Transaction Date	8	76 – 83	YYYYMMDD Format; Present for all transaction reply codes. For TRCs 121, 194, and 223, the report generation date.
23	UI Initiated Change Flag	1	84	'0' = transaction from source other than user interface; '1' = transaction created through user interface; Space = not applicable.
24	Positions 85 – 96 are dependent upon the value of the TRANSACTION REPLY CODE. There are spaces for all codes except where indicated below.	8	85 – 92	YYYYMMDD Format; Present only when the Transaction Reply Code is one of the following: 13, 14, 18
a	Effective Date of the Disenrollment	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 13, 14, 18, 293
b	New Enrollment Effective Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 17
c	Claim Number (old)	12	85 – 96	Present only when Transaction Reply Code is one of the following: 22, 25, 86, 301
d	Date of Death	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 90 (with transaction type 01), 92
e	Hospice End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 71 or 72. If blank for TRC 71, then the Hospice Period is open ended.
f	ESRD Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 73
g	ESRD End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 74
h	Institutional/ NHC Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 48, 75, 158, 159
i	Medicaid Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 77
j	Medicaid End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 78

Item	Field	Size	Position	Description
k	Part A End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 79
l	WA Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 66
m	WA End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 67
n	Part A Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 80
o	Part B End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 81
p	Part B Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 82
q	Old State and County Codes	5	85 – 89	Beneficiary's prior state and county code; Present only when Transaction Reply Code is 85
r	Attempted Enroll Effective Date	8	85 - 92	The effective date of an enrollment transaction that was submitted but rejected. Present only when Transaction Reply code is the following: 35, 36, 45, 56
s	PBP Effective Date	8	85 – 92	YYYYMMDD Format. Effective date of a beneficiary's PBP change. Present only when Transaction Reply Code is 100.
t	Correct Part D Premium Rate	12	85 – 96	ZZZZZZZZ9.99 Format; Part D premium amount reported by HPMS for the Plan. Present only when the Transaction Reply Code is 181.
u	Date Identifying Information Changed by UI User	8	85 – 92	YYYYMMDD Format; Field content is dependent on Transaction Reply Code: 702 – Fill-in enrollment period end date, 705 – End date of enrollment period for corrected PBP, blank when end date not provided by user, 707 – End date of enrollment period for corrected segment, blank when end date not provided by user, 709 & 710 – Enrollment period start date prior to start date change, 711, 712, & 713 – Enrollment period end date prior to end date change.
v	Modified Part C Premium Amount	12	85 – 96	ZZZZZZZZ9.99 Format; Part C premium amount reported by HPMS for the Plan. Present only when the Transaction Reply Code is 182.

Item	Field	Size	Position	Description
w	Date of Death Removed	8	85 – 92	YYYYMMDD Format; Previously reported erroneous date of death. Present only when Transaction Reply Code is 091.
x	Dialysis End Date	8	85 – 92	YYYYMMDD Format; Will be present when Transaction Reply Code is 268 and the dialysis period has an end date.
y	Transplant Failure Date	8	85 – 92	YYYYMMDD Format; Will be present when Transaction Reply Code is 269 and the transplant has an end date.
z	New ZIP Code	10	85 - 94	#####-#### Format; Will be present when Transaction Reply Code is 305
aa	Previous Contract for POS Drug Edit Active Indicator	5	85-89	Will be present when Transaction Reply Code is 322
bb	MSP Period Start Date	8	85 – 92	YYYYMMDD Format: Will be present when Transaction Reply Code is 245, 280, or 368 and will contain the MSP Period Start Date.
cc	Maximum NUNCMO Calculated	3	85 – 87	Maximum incremental number of uncovered months that can be submitted for the effective date; otherwise, spaces. Present only when Transaction Reply Code is one of the following: 216, 300, 341
dd	IC Model End Date	8	85 – 92	YYYYMMDD Format; Will be present when Transaction Reply Code is 351 or 359 and the IC Model End Date is populated, or when Transaction Reply Code is 362.
25	District Office Code	3	97 – 99	Code of the originating district office; Present only when Transaction Type Code is 53; otherwise, spaces if not applicable.
26	Previous Part D Contract/PBP for TrOOP Transfer.	8	100 – 107	CCCCCPPP Format; Present only if previous enrollment exists within reporting year in Part D Contract. Otherwise, field will be spaces. CCCCC = Contract Number; PPP = Plan Benefit Package (PBP) Number.
27	Filler	8	108 – 115	Spaces
28	Source ID	5	116 – 120	Transaction Source Identifier

Item	Field	Size	Position	Description
29	Prior Plan Benefit Package ID	3	121 – 123	Prior PBP number for PBP change transaction; present only when transaction type code is 61; otherwise, spaces. For files created prior to R2016.02, this field could contain the submitted LI-NET Plan PBP when it was changed to the PBP corresponding to enrollment processing date
30	Application Date	8	124 – 131	The date the plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper). Format: YYYYMMDD; otherwise, spaces if not applicable.
31	UI User Organization Designation	2	132 – 133	'01' = Plan '02' = Regional Office; '03' = Central Office; Spaces = not a UI transaction
32	Out of Area Flag	1	134 – 134	'Y' = Out of area; 'N' = Not out of area; Space = not applicable
33	Segment Number	3	135 – 137	Further definition of PBP by geographic boundaries; otherwise, spaces when not applicable.
34	Part C Beneficiary Premium	8	138 – 145	Cost to beneficiary for Part C benefits; otherwise, spaces if not applicable.
35	Part D Beneficiary Premium	8	146 – 153	Cost to beneficiary for Part D benefits; otherwise, spaces if not applicable.

Item	Field	Size	Position	Description
36	Election Type Code	1	154 – 154	'A' = AEP; 'C' = Plan-submitted Rollover SEP; 'D' = MADP; 'E' = IEP; 'F' = IEP2; 'I' = ICEP; 'N' = OEPNEW; 'O' = OEP; 'R' = 5 Star SEP; 'S' = Other SEP; 'T' = OEPI; 'U' = Dual/LIS SEP; 'V' = Permanent Change in Residence SEP; 'W' = EGHP SEP; 'X' = Administrative Action SEP; 'Y' = CMS/Case Work SEP; Space = not applicable. (MAs use A, C, D, F, I, N, O, R, S, T, U, V, W, X, and Y. MAPDs use A, C, E, F, I, N, O, R, S, T, U, V, W, X, and Y. PDPs use A, C, E, F, R, S, U, V, W, X, and Y.)
37	Enrollment Source Code	1	155 – 155	'A' = Auto enrolled by CMS; 'B' = Beneficiary Election; 'C' = Facilitated enrollment by CMS; 'D' = CMS Annual Rollover; 'E' = Plan initiated auto-enrollment; 'F' = Plan initiated facilitated-enrollment; 'G' = Point-of-sale enrollment; 'H' = CMS or Plan reassignment; 'I' = Invalid submitted value (transaction is not rejected); 'J' = State-submitted passive enrollment 'K' = CMS-submitted passive enrollment 'L' = MMP beneficiary election 'N' = Rollover by Plan Transaction Space = not applicable.
38	Part D Opt-Out Flag	1	156 – 156	'Y' = Opted out of Part D AE/FE; 'N' = Not opted out of Part D AE/FE; Space = No change to opt-out status

Item	Field	Size	Position	Description
39	Premium Withhold Option/Parts C-D	1	157 – 157	'D' = Direct self-pay; 'N' = No premium applicable; 'R' = Deduct from RRB benefits; 'S' = Deduct from SSA benefits; Space = not applicable. Option applies to both Part C and D Premiums and is populated only for TRCs related to enrollment acceptance, premium or premium withholding. Rejection TRCs report the submitted PPO. TRCs 120, 185 & 186 report the PPO involved with the communication with the Withholding Agency. All others report the PPO in effect as of the Effective Date after the submitted transaction is processed.
40	Cumulative Number of Uncovered Months	3	158 – 160	Count of Total Months without drug coverage as of the effective date submitted; otherwise, spaces. Present with Enrollment Acceptance TRCs, or when Transaction Reply Code is the following: 141, 216, 300, 341
41	Creditable Coverage Flag	1	161 – 161	'Y' = Covered; 'N' = Not Covered; 'A' = Setting uncovered months reset to zero due to a new IEP; 'L' = Setting uncovered months reset to zero due to a beneficiary Low Income; 'R' = Setting uncovered months to zero (other); 'U' = Reset removed and uncovered month restored to previous value; Space = not applicable.
42	Employer Subsidy Override Flag	1	162 – 162	'Y' = Beneficiary is in a plan receiving an employer subsidy, flag allows enrollment in a Part D plan; Space = no flag submitted by plan.
43	Processing Timestamp	15	163 – 177	Transaction processing time, or, for TRCs 121, 194, and 223, the report generation time. Format: HH.MM.SS.SSSSSS

Item	Field	Size	Position	Description
44	End Date	8	178 - 185	YYYYMMDD format End Date associated with the Transaction Reply Code when applicable: • TRCs that report a Premium Payment Option (PPO) value that is not open-ended • MSP TRCs 245, 280, and 368 - contains the MSP period end date, if available
45	Submitted Number of Uncovered Months	3	186 – 188	Incremental Number of Uncovered Months submitted in the transaction; otherwise, spaces. Present with Enrollment Acceptance TRCs, or when Transaction Reply Code is the following: 141, 216, 300, 341
46	Filler	9	189 – 197	Spaces
47	Secondary Drug Insurance Flag	1	198-198	Type 61 MAPD and PDP transactions: 'Y' = Beneficiary has secondary drug insurance; 'N' = Beneficiary does not have secondary drug insurance available; Space = No flag submitted by Plan. Type 72 MAPD and PDP transactions: 'Y' = Secondary drug insurance available 'N' = No secondary drug insurance available Space = no change. Space returned with any other transaction type has no meaning.
48	Secondary Rx ID	20	199 – 218	Beneficiary's secondary insurance Plan's ID number taken from the input transaction (61 or 72); otherwise, spaces for any other transaction type.
49	Secondary Rx Group	15	219 – 233	Beneficiary's secondary insurance Plan's Group ID number taken from the input transaction (61 or 72); otherwise, spaces for any other transaction type.
50	EGHP	1	234 - 234	Type 61 transactions: 'Y' = EGHP; Space = not EGHP. Type 74 transactions: 'Y' = EGHP; 'N' = Not EGHP; Space = no change. Space reported with any other transaction type has no meaning.

Item	Field	Size	Position	Description
51	Part D Low-Income Premium Subsidy Level	3	235 – 237	Part D LIPS percentage category: '000' = No subsidy, '025' = 25% subsidy level; '050' = 50% subsidy level; '075' = 75% subsidy level; '100' = 100% subsidy level; Spaces = not applicable.
52	Low-Income Co-Pay Category	1	238 – 238	Definitions of the co-payment categories: '0' = none, not low-income '1' = (High); '2' = (Low); '3' = (0); '4' = 15%; '5' = Unknown; Space = not applicable.
53	Low-Income Period Effective Date	8	239 - 246	Date low income period starts. Format: YYYYMMDD Spaces if not applicable.
54	Part D Late Enrollment Penalty Amount	8	247 - 254	Calculated Part D late enrollment penalty, not including adjustments indicated by items (53) and (54). Format: -9999.99; otherwise, spaces if not applicable.
55	Part D Late Enrollment Penalty Waived Amount	8	255 - 262	Amount of Part D late enrollment penalty waived. Format: -9999.99; otherwise, spaces if not applicable.
56	Part D Late Enrollment Penalty Subsidy Amount	8	263 - 270	Amount of Part D late enrollment penalty low-income subsidy. Format: -9999.99; otherwise, spaces if not applicable.
57	Low-Income Part D Premium Subsidy Amount	8	271- 278	Amount of Part D low-income premium subsidy as of the enrollment period start date. Format: -9999.99; otherwise, spaces if not applicable.
58	Part D Rx BIN	6	279 - 284	Beneficiary's Part D Rx BIN taken from the input transaction (61 or 72); otherwise, spaces for any other transaction type.
59	Part D Rx PCN	10	285 - 294	Beneficiary's Part D Rx PCN taken from the input transaction (61 or 72); otherwise, spaces if not provided via a transaction.
60	Part D Rx Group	15	295 - 309	Beneficiary's Part D Rx Group taken from the input transaction (61 or 72); otherwise, spaces for any other transaction type.

Item	Field	Size	Position	Description
61	Part D Rx ID	20	310 - 329	Beneficiary's Part D Rx ID taken from the input transaction (61 or 72); otherwise, spaces for any other transaction type.
62	Secondary Rx BIN	6	330 - 335	Beneficiary's secondary insurance BIN taken from the input transaction (61 or 72); otherwise, spaces for any other transaction type.
63	Secondary Rx PCN	10	336 - 345	Beneficiary's secondary insurance PCN taken from the input transaction (61 or 72); otherwise, spaces for any other transaction type.
64	De Minimis Differential Amount	8	346 - 353	Amount by which a Part D de minimis Plan's beneficiary premium exceeds the applicable regional low-income premium subsidy benchmark. Format: -9999.99; otherwise, spaces if not applicable.
65	MSP Status Flag	1	354 - 354	'P' = Medicare primary payer; 'S' = Medicare secondary payer; 'N' = Non-respondent beneficiary; Space = not applicable.
66	Low Income Period End Date	8	355 - 362	Date low income period closes. The end date is either the last day of the PBP enrollment or the last day of the low income period itself, whichever is earlier. This field is blank for LIS applicants with an open ended award or when the TRC is not one of the LIS TRCs 121, 194, 223. FORMAT: YYYYMMDD; otherwise, spaces if not applicable.
67	Low Income Subsidy Source Code	1	363 - 363	'A' = Approved SSA applicant; 'D' = Deemed eligible by CMS; Space = not applicable.
68	Enrollee Type Flag, PBP Level	1	364 - 364	Designation relative to the report generation date (Transaction Date, field #22) 'C' = Current PBP enrollee; 'P' = Prospective PBP enrollee; 'Y' = Previous PBP enrollee; Spaces = not applicable.
69	Application Date Indicator	1	365 – 365	Identifies whether the application date associated with a UI submitted enrollment has a system generated default value: 'Y' = Default value for UI enrollment; Space = Not applicable
70	TRC Short Name	15	366 – 380	TRC's short-name identifier

Item	Field	Size	Position	Description
71	Disenrollment Reason Code	2	381 – 382	DRC, see DRC list for values
72	MMP Opt Out Flag	1	383	'Y' = Opted out of passive enrollment into MMP plan 'N' = Not opted out of passive enrollment into MMP plan Space = Not applicable
73	Cleanup ID	10	384 – 393	Populated if there is a Cleanup ID associated with the transaction. Used to identify transactions that were created to correct payment data. Spaces if no value exists.
74	POS Drug Edit Update/Delete Flag	1	394	'U' = Update (Add) 'D' = Delete Space = Not applicable
75	POS Drug Edit Status	1	395	'N' = Notification 'I' = Implementation 'T' = Termination Space = Not applicable
76	POS Drug Edit Class	3	396-398	Three character drug class identifier. Spaces = Not applicable Present only when Transaction Type Code is 90 and POS Drug Edit Class is provided, otherwise blank
77	POS Drug Edit Code	3	399-401	Three character POS Drug Edit Code Spaces = Not applicable Present only when Transaction Type Code is 90 and POS Drug Edit Code is provided, otherwise blank
78	Notification Date	8	402--409	YYYYMMDD format, Date beneficiary is notified of a POS Drug Edit Present only when Transaction Type Code is 90 and notification date is provided, otherwise blank
79	Implementation Date	8	410-417	YYYYMMDD format Date POS Drug Edit is implemented Present only when Transaction Type Code is 90 and implementation date is provided, otherwise blank
80	Termination Date	8	418-425	YYYYMMDD format Date POS Drug Edit is terminated Present only when Transaction Type Code is 90 and termination date is provided, otherwise blank
81	Hospice Provider Number	13	426 – 438	Hospice Medicare Provider Number

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

Total Length = 500

F.4.2 Verbatim Plan Submitted Transaction on DTRR

Item	Field	Size	Position	Description
1	Beneficiary ID	12	1-12	The same beneficiary ID submitted on the transaction
2	Surname	12	13-24	Beneficiary Surname

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

Total Length = 500

F.5 Batch Eligibility Query (BEQ) Request File

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

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

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

This file includes the following records:

- Header Record
- Detail Record
- Trailer Record

F.5.1 *Header Record*

Item	Field	Size	Position	Format	Valid Values	Description
1	File ID Name	8	1- 8	CHAR	"MMABEQRH"	Critical Field: This field is always set to the value "MMABEQRH." This code identifies the file as a BEQ Request File and this record as the Header Record of the file.
2	Sending Entity: CMS	8	9-16	CHAR	Sending Organization (left justified space filled) Acceptable Values: 5-position Contract. (3 Spaces are for Future use)	Critical Field: This field provides CMS with the identification of the entity that is sending the BEQ Request File. The value for this field is provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Trailer Record. The Sending Entity may participate in Part D.

Item	Field	Size	Position	Format	Valid Values	Description
3	File Creation Date	8	17-24	CHAR	YYYYMMDD	Critical Field: The date that the Sending Entity created the BEQ Request File. This value's format is YYYYMMDD. For example, January 3 2010 is the value 20100103. This value should agree with the corresponding value in the Trailer Record. CMS returns this information to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File.
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity	Critical Field The specific Control Number assigned by the Sending Entity to the BEQ Request File. CMS returns this information to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Trailer Record.
5	Filler	717	34-750	CHAR	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.

Total Length = 750

F.5.2 *Detail Record (Transaction)*

Item	Field	Size	Position	Format	Valid Values	Description
1	Record Type	5	1-5	CHAR	"DTL01" = BEQ Transaction Note: The value above is DTL-zero-one.	Critical Field This field is set to the value "DTL01," which indicates that this detail record is a BEQ Transaction. This code identifies the record as a detail record for processing specifically for BEQ Service.
2	Beneficiary ID	12	6-17	CHAR	Beneficiary ID, HICN, or RRB	Critical Field • Before the Medicare Beneficiary Identifier (MBI) Transition period, the acceptable values are the Health Insurance Claim Number (HICN) and the Railroad Retirement Board (RRB) Number. • During the MBI Transition period, the acceptable values are the HICN, RRB Number and MBI. • When the MBI Transition period ends, the acceptable value is the MBI. The last position may be a space.
3	Filler	9	18-26	CHAR	Spaces	

Item	Field	Size	Position	Format	Valid Values	Description
4	DOB	8	27-34	CHAR	YYYYMMDD	Critical Field The date of the individual's birth; value format is YYYYMMDD. The value should not include dashes, decimals, or commas. The value should include only numbers.
5	Gender Code	1	35	CHAR	0 (Zero) = Unknown; 1 = Male; 2 = Female	Not Critical Field The gender of the individual. The acceptable values include 0 (Zero) = Unknown, 1 = Male, 2 = Female.
6	Detail Record Sequence Number	7	36-42	NUM	Seven-byte number unique within the BEQ Request File	Critical Field A unique number assigned by the Sending Entity to the Transaction (Detail Record). This number should uniquely identify the Transactions (Detail Record) within the BEQ Request File.
7	Filler	708	43-750	CHAR	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for or used to store meaningful information, unless specifically documented otherwise.

Total Length = 750

F.5.3 *Trailer Record*

Item	Field	Size	Position	Format	Valid Values	Description
1	File ID Name	8	1-8	CHAR	"MMABEQRT"	Critical Field This field is always set to the value "MMABEQRT." This code identifies the record as the Trailer Record of a BEQ Request File.
2	Sending Entity (CMS)	8	9-16	CHAR	Sending Organization (left justified space filled) Acceptable Values: 5-position Contract Identifier + 3 Spaces (3 Spaces for Future use)	Critical Field This field provides CMS with the identification of the entity that is sending the BEQ Request File. The value for this field is provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Header Record. The Sending Entity may participate in Part D.
3	File Creation Date	8	17-24	CHAR	YYYYMMDD	Critical Field The date when the Sending Entity created the BEQ Request File. This value's format is YYYYMMDD. For example, January 3, 2010 is the value 20100103. This value should agree with the corresponding value in the Header Record. CMS will pass this information back to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File.
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity	Critical Field The specific Control Number assigned by the Sending Entity to the BEQ Request File. CMS will return this information to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Header Record.
5	Record Count	7	34-40	NUM	Numeric value greater than Zero.	Critical Field The total number of Transactions (Detail Records) supplied on the BEQ Request File. This value is right-justified in the field, with leading zeroes. This value should not include non-numeric characters, such as commas, spaces, dashes, decimals.
6	Filler	710	41-750	CHAR	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.

Total Length = 750

F.5.4 Sample BEQ Request File Pass and Fail Acknowledgments

Description

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

Example

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

Example of BEQ Request File "Pass" Acknowledgment

TO: Jim.Doe@xxs.net

TO: Chris.Doe@dxxx.org

TO: Falcon.Doe@xxxx.org

TO: eevs.helpdesk@ngc.com

FROM: MBD#BQ94.HCFJES@cms.hhs.gov

Subject: CMS MMA DATA EXCHANGE FOR MMABTCH

MMABTCH file has been received and passed surface edits by CMS.

QUESTIONS? Contact 1-800-927-8069 or E-mail mapdhelp@cms.hhs.gov

INPUT HEADER RECORD

MMABEQRHS0094 20070306F20070306

INPUT TRAILER RECORD

MMABEQRTS0094 20070306F200703060000074

Example of BEQ Request File "Fail" Acknowledgment

TO: Jim.Doe@xxs.net

TO: Chris.Doe@dxxx.org

TO: Falcon.Doe@xxxx.org

TO: eevs.helpdesk@ngc.com

FROM: MBD#BQ30.HCFJES@cms.hhs.gov

Subject: CMS MMA DATA EXCHANGE FOR MMABTCH

MMABTCH file has been received and failed surface edits by CMS.

QUESTIONS? Contact 1-800-927-8069 or E-mail mapdhelp@cms.hhs.gov

INPUT HEADER RECORD

MMABEQRHH0030 20070228 84433346

INPUT TRAILER RECORD

MMABEQRTH0030 20070221 844333460074065

THE TRAILER RECORD IS INVALID

F.6 BEQ Response File

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

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

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

The following records are included in this file:

- Header Record
- Detail Record
- Trailer Record

F.6.1 *Header Record*

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

Total Length = 2000

F.6.2 *Detail Record (Transaction)*

Item	Field	Size	Position	Format	Valid Values
1	Record Type	3	1 – 3	CHAR	'DTL'
	Start of Original Detail Record				
2	Record Type	5	4 – 8	CHAR	
3	Beneficiary ID	12	9 – 20	CHAR	This field will contain exactly what is received in the same field of the beneficiary's Detail record in the related BEQ Request file.
4	Filler	9	21 –29	CHAR	
5	Beneficiary's Date of Birth	8	30 – 37	CHAR	
6	Beneficiary's Gender Code	1	38	CHAR	
7	Detail Record Sequence Number	7	39 – 45	ZD	
	End of Original Detail Record				
8	Processed Flag	1	46	CHAR	'Y' or 'N'
9	Beneficiary Match Flag	1	47	CHAR	'Y' or 'N'
10	Medicare Part A Entitlement Start Date	8	48 – 55	CHAR	CCYYMMDD
11	Medicare Part A Entitlement End Date	8	56 – 63	CHAR	CCYYMMDD
12	Medicare Part B Entitlement Start Date	8	64 – 71	CHAR	CCYYMMDD
13	Medicare Part B Entitlement End Date	8	72 – 79	CHAR	CCYYMMDD
14	Medicaid Indicator	1	80	CHAR	'0' or '1'
15	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence one)	8	81 – 88	CHAR	CCYYMMDD
16	Part D Disenrollment Date or Employer Subsidy End Date (occurrence one)	8	89 – 96	CHAR	CCYYMMDD
17	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence two)	8	97 – 104	CHAR	CCYYMMDD
18	Part D Disenrollment Date or Employer Subsidy End Date (occurrence two)	8	105 – 112	CHAR	CCYYMMDD
19	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence three)	8	113 – 120	CHAR	CCYYMMDD
20	Part D Disenrollment Date or Employer Subsidy End Date (occurrence three)	8	121 – 128	CHAR	CCYYMMDD
21	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence four)	8	129 – 136	CHAR	CCYYMMDD
22	Part D Disenrollment Date or Employer Subsidy End Date (occurrence four)	8	137 – 144	CHAR	CCYYMMDD
23	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence five)	8	145 – 152	CHAR	CCYYMMDD
24	Part D Disenrollment Date or Employer Subsidy End Date (occurrence five)	8	153 – 160	CHAR	CCYYMMDD
25	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence six)	8	161 – 168	CHAR	CCYYMMDD
26	Part D Disenrollment Date or Employer Subsidy End Date (occurrence six)	8	169 – 176	CHAR	CCYYMMDD
27	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence seven)	8	177 – 184	CHAR	CCYYMMDD

Item	Field	Size	Position	Format	Valid Values
28	Part D Disenrollment Date or Employer Subsidy End Date (occurrence seven)	8	185 – 192	CHAR	CCYYMMDD
29	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence eight)	8	193 – 200	CHAR	CCYYMMDD
30	Part D Disenrollment Date or Employer Subsidy End Date (occurrence eight)	8	201 – 208	CHAR	CCYYMMDD
31	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence nine)	8	209 – 216	CHAR	CCYYMMDD
32	Part D Disenrollment Date or Employer Subsidy End Date (occurrence nine)	8	217 – 224	CHAR	CCYYMMDD
33	Part D Enrollment Effective Date or Employer Subsidy Start Date (occurrence 10)	8	225 – 232	CHAR	CCYYMMDD
34	Part D Disenrollment Date or Employer Subsidy End Date (occurrence 10)	8	233 – 240	CHAR	CCYYMMDD
35	Sending Entity	8	241 – 248	CHAR	
36	File Control Number	9	249 – 257	CHAR	
37	File Creation Date	8	258 – 265	CHAR	CCYYMMDD
38	Part D Eligibility Start Date	8	266 – 273	CHAR	
-39	Deemed / Low-Income Subsidy Effective Date (occurrence one)	8	274 – 281	CHAR	CCYYMMDD
40	Deemed / Low-Income Subsidy End Date (occurrence one)	8	282 – 289	CHAR	CCYYMMDD
41	Co-Payment Level Identifier (occurrence one)	1	290	CHAR	‘1’, ‘2’, ‘3’, ‘4’ or ‘5’
42	Part D Premium Subsidy Percent (occurrence one)	3	291 – 293	CHAR	‘100’, ‘075’, ‘050’, or ‘025’
43	Deemed / Low-Income Subsidy Effective Date (occurrence two)	8	294 – 301	CHAR	CCYYMMDD
44	Deemed / Low-Income Subsidy End Date (occurrence two)	8	302 – 309	CHAR	CCYYMMDD
45	Co-Payment Level Identifier (occurrence two)	1	310	CHAR	1’, ‘2’, ‘3’, ‘4’ or ‘5’
46	Part D Premium Subsidy Percent (occurrence two)	3	311 – 313	CHAR	‘100’, ‘075’, ‘050’, or ‘025’
	Part D/RDS Indicator (10 occurrences)				
47	RDS/Part D Indicator (occurrence one)	1	314	CHAR	‘D’ or ‘R’
48	RDS/Part D Indicator (occurrence two)	1	315	CHAR	‘D’ or ‘R’
49	RDS/Part D Indicator (occurrence three)	1	316	CHAR	‘D’ or ‘R’
50	RDS/Part D Indicator (occurrence four)	1	317	CHAR	‘D’ or ‘R’
51	RDS/Part D Indicator (occurrence five)	1	318	CHAR	‘D’ or ‘R’
52	RDS/Part D Indicator (occurrence six)	1	319	CHAR	‘D’ or ‘R’
53	RDS/Part D Indicator (occurrence seven)	1	320	CHAR	‘D’ or ‘R’
54	RDS/Part D Indicator (occurrence eight)	1	321	CHAR	‘D’ or ‘R’
55	RDS/Part D Indicator (occurrence nine)	1	322	CHAR	‘D’ or ‘R’
56	RDS/Part D Indicator (occurrence 10)	1	323	CHAR	‘D’ or ‘R’
	Uncovered Months Data (20 occurrences)				
57	Start Date (occurrence one)	8	324 – 331	CHAR	CCYYMMDD
58	Number of Uncovered Months (occurrence one)	3	332 – 334	ZD	

Item	Field	Size	Position	Format	Valid Values
59	Number of Uncovered Months Status Indicator (occurrence one)	1	335	CHAR	
60	Total Number of Uncovered Months (occurrence one)	3	336 – 338	ZD	
61	Uncovered Months (occurrence two)	15	339 – 353		
62	Uncovered Months (occurrence three)	15	354 – 368		
63	Uncovered Months (occurrence four)	15	369 – 383		
64	Uncovered Months (occurrence five)	15	384 – 398		
65	Uncovered Months (occurrence six)	15	399 – 413		
66	Uncovered Months (occurrence seven)	15	414 – 428		
67	Uncovered Months (occurrence eight)	15	429 – 443		
68	Uncovered Months (occurrence nine)	15	444 – 458		
69	Uncovered Months (occurrence 10)	15	459 – 473		
70	Uncovered Months (occurrence 11)	15	474 – 488		
71	Uncovered Months (occurrence 12)	15	489 – 503		
72	Uncovered Months (occurrence 13)	15	504 – 518		
73	Uncovered Months (occurrence 14)	15	519 – 533		
74	Uncovered Months (occurrence 15)	15	534 – 548		
75	Uncovered Months (occurrence 16)	15	549 – 563		
76	Uncovered Months (occurrence 17)	15	564 – 578		
77	Uncovered Months (occurrence 18)	15	579 – 593		
78	Uncovered Months (occurrence 19)	15	594 – 608		
79	Uncovered Months (occurrence 20)	15	609 – 623		
80	Beneficiary's Retrieved Date of Birth (as retrieved from CMS database for matching beneficiary)	8	624 – 631	CHAR	CCYYMMDD
81	Beneficiary's Retrieved Gender Code (as retrieved from CMS database for matching beneficiary)	1	632	CHAR	0 = Unknown 1 = Male 2 = Female
82	Last Name	40	633 – 672	CHAR	
83	First Name	30	673 – 702	CHAR	
84	Middle Initial	1	703	CHAR	
85	Current State Code	2	704 – 705	CHAR	
86	Current County Code	3	706 – 708	CHAR	
87	Date of Death	8	709 – 716	CHAR	CCYYMMDD
88	Part C/D Contract Number (if available)	5	717 – 721	CHAR	
89	Part C/D Enrollment Start Date (if available)	8	722 – 729	CHAR	CCYYMMDD
90	Part D Indicator (if available)	1	730	CHAR	Y = Yes, N = No Space
91	Part C Contract Number (if available)	5	731 – 735	CHAR	
92	Part C Enrollment Start Date (if available)	8	736 – 743	CHAR	
93	Part D Indicator (if available)	1	744	CHAR	N = No Space

Item	Field	Size	Position	Format	Valid Values
94	ESRD Indicator	1	745	CHAR	End Stage Renal Disease Indicator 0 = No ESRD 1 = ESRD
95	PBP Number (associated with contract number in positions 717 – 721)	3	746 – 748	CHAR	Plan Benefit Package number
96	Plan Type Code (associated with PBP number in positions 746 – 748)	2	749 – 750	CHAR	Type of plan 01 = HMO 02 = HMOPOS 04 = Local PPO 05 = PSO (State License) 07 = MSA 08 = RFB PFFS 09 = PFFS 18 = 1876 Cost 19 = HCPP 1833 Cost 20 = National PACE 28 = Chronic Care 29 = Medicare Prescription Drug Plan 30 = Employer/ Union Only Direct Contract PDP 31 = Regional PPO 32 = Fallback 40 = Employer/ Union Only Direct Contract PFFS 42 = RFB HMO 43 = RFB HMOPOS 44 = RFB Local PPO 45 = RFB PSO (State License) 46 = Point-of-Sale Contractor 47 = Employer/ Union Only Direct Contract PPO 48 = Medicare-Medicaid Plan HMO 49 = Medicare-Medicaid Plan HMOPOS 50 = Medicare-Medicaid Plan PPO 99 = Undefined Historical Data

Item	Field	Size	Position	Format	Valid Values
97	EGHP Indicator (associated with PBP number in positions 746 – 748)	1	751	CHAR	Employer Group Health Plan Switch Y = EGHP N = not EGHP
98	PBP Number (associated with contract number in positions 731 – 735)	3	752 – 754	CHAR	Plan Benefit Package number
99	Plan Type Code (associated with PBP number in positions 752 – 754)	2	755 – 756	CHAR	See values for positions 1167–1168.
100	EGHP Indicator (associated with PBP number in positions 752 – 754)	1	757	CHAR	Employer Group Health Plan Switch Y = EGHP N = not EGHP
101	Mailing Address Line 1	40	758 – 797	CHAR	
102	Mailing Address Line 2	40	798 – 837	CHAR	
103	Mailing Address Line 3	40	838 – 877	CHAR	
104	Mailing Address Line 4	40	878 – 917	CHAR	
105	Mailing Address Line 5	40	918 – 957	CHAR	
106	Mailing Address Line 6	40	958 – 997	CHAR	
107	Mailing Address City	40	998 – 1037	CHAR	
108	Mailing Address Postal State Code	2	1038 – 1039	CHAR	
109	Mailing Address ZIP Code	9	1040 – 1048	CHAR	
110	Mailing Address Start Date	8	1049 – 1056	CHAR	CCYYMMDD
111	Residence Address Line 1	60	1057 – 1116	CHAR	
112	Residence Address City	40	1117 – 1156	CHAR	
113	Residence Address Postal State Code	2	1157 – 1158	CHAR	
114	Residence Address ZIP Code	9	1159 – 1167	CHAR	
115	Residence Address Start Date	8	1168 – 1175	CHAR	CCYYMMDD
116	Medicare Plan Ineligibility Due to Incarceration Start Date(1)	8	1176 – 1183	CHAR	CCYYMMDD
117	Medicare Plan Ineligibility Due to Incarceration End Date(1)	8	1184 – 1191	CHAR	CCYYMMDD
118	Medicare Plan Ineligibility Due to Incarceration Start Date(2)	8	1192 – 1199	CHAR	CCYYMMDD
119	Medicare Plan Ineligibility Due to Incarceration End Date(2)	8	1200 – 1207	CHAR	CCYYMMDD
120	Medicare Plan Ineligibility Due to Incarceration Start Date(3)	8	1208 – 1215	CHAR	CCYYMMDD
121	Medicare Plan Ineligibility Due to Incarceration End Date(3)	8	1216 – 1223	CHAR	CCYYMMDD
122	Medicare Plan Ineligibility Due to Incarceration Start Date(4)	8	1224 – 1231	CHAR	CCYYMMDD

Item	Field	Size	Position	Format	Valid Values
123	Medicare Plan Ineligibility Due to Incarceration End Date(4)	8	1232 – 1239	CHAR	CCYYMMDD
124	Medicare Plan Ineligibility Due to Incarceration Start Date(5)	8	1240 – 1247	CHAR	CCYYMMDD
125	Medicare Plan Ineligibility Due to Incarceration End Date(5)	8	1248 – 1255	CHAR	CCYYMMDD
126	Medicare Plan Ineligibility Due to Incarceration Start Date(6)	8	1256 – 1263	CHAR	CCYYMMDD
127	Medicare Plan Ineligibility Due to Incarceration End Date(6)	8	1264 – 1271	CHAR	CCYYMMDD
128	Medicare Plan Ineligibility Due to Incarceration Start Date(7)	8	1272 – 1279	CHAR	CCYYMMDD
129	Medicare Plan Ineligibility Due to Incarceration End Date(7)	8	1280 – 1287	CHAR	CCYYMMDD
130	Medicare Plan Ineligibility Due to Incarceration Start Date(8)	8	1288 – 1295	CHAR	CCYYMMDD
131	Medicare Plan Ineligibility Due to Incarceration End Date(8)	8	1296 – 1303	CHAR	CCYYMMDD
132	Medicare Plan Ineligibility Due to Incarceration Start Date(9)	8	1304 – 1311	CHAR	CCYYMMDD
133	Medicare Plan Ineligibility Due to Incarceration End Date(9)	8	1312 – 1319	CHAR	CCYYMMDD
134	Medicare Plan Ineligibility Due to Incarceration Start Date(10)	8	1320 – 1327	CHAR	CCYYMMDD
135	Medicare Plan Ineligibility Due to Incarceration End Date(10)	8	1328 – 1335	CHAR	CCYYMMDD
136	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(1)	8	1336-1343	CHAR	CCYYMMDD
137	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (1)	8	1344-1351	CHAR	CCYYMMDD
138	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(2)	8	1352-1359	CHAR	CCYYMMDD
139	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (2)	8	1360-1367	CHAR	CCYYMMDD
140	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(3)	8	1368-1375	CHAR	CCYYMMDD
141	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (3)	8	1376-1383	CHAR	CCYYMMDD
142	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(4)	8	1384-1391	CHAR	CCYYMMDD
143	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (4)	8	1392-1399	CHAR	CCYYMMDD
144	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(5)	8	1400-1407	CHAR	CCYYMMDD
145	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (5)	8	1408-1415	CHAR	CCYYMMDD
146	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(6)	8	1416-1423	CHAR	CCYYMMDD
147	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (6)	8	1424-1431	CHAR	CCYYMMDD
148	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(7)	8	1432-1439	CHAR	CCYYMMDD

Item	Field	Size	Position	Format	Valid Values
149	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (7)	8	1440-1447	CHAR	CCYYMMDD
150	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(8)	8	1448-1455	CHAR	CCYYMMDD
151	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (8)	8	1456-1463	CHAR	CCYYMMDD
152	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(9)	8	1464-1471	CHAR	CCYYMMDD
153	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (9)	8	1472-1479	CHAR	CCYYMMDD
154	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date(10)	8	1480-1487	CHAR	CCYYMMDD
155	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (10)	8	1488-1495	CHAR	CCYYMMDD
156	Current Enrollment Source Type Code (associated with PBP number in positions 746 – 748)	1	1496	CHAR	A=Part D Auto-Enrolled by CMS B=Beneficiary Election C=Part D Facilitated enrollment by CMS D=System-Generated Enrollment(Rollover) E=Plan-submitted auto-enrollments F=Plan-submitted facilitated enrollments G=Point of Sale (POS) submitted enrollments H=CMS or Plan submitted re-assignment enrollments I=Assigned to Plan-submitted transactions with enrollment source other than any of the following: B,E,F,G,H and blank J=State-Submitted MMP Passive Enrollment K=CMS-Submitted MMP Passive Enrollment L=Beneficiary MMP Election
157	Current Enrollment Source Type Code (associated with PBP number in positions 752– 754)	1	1497	CHAR	See values for position 1496.
158	Prior Part C/D Contract Number	5	1498-1502	CHAR	

Item	Field	Size	Position	Format	Valid Values
159	Prior Part C/D Enrollment Start Date (associated with PBP Number in positions 1520-1522)	8	1503-1510	CHAR	
160	Prior Part C/D Disenrollment Date (associated with PBP Number in positions 1520-1522)	8	1511-1518	CHAR	
161	Prior Part D Indicator (associated with PBP Number in positions 1520-1522)	1	1519	CHAR	Y = Yes N = No Space
162	Prior PBP Number (associated with Contract Number in positions 1498-1502)	3	1520-1522	CHAR	Plan Benefit Package number
163	Prior Plan Type Code (associated with PBP Number in positions 1520-1522)	2	1523-1524	CHAR	See values for positions 749-750.
164	Prior EGHP Indicator (associated with PBP Number in positions 1520-1522)	1	1525	CHAR	Employer Group Health Plan Switch Y = EGHP N = not EGHP
165	Prior Enrollment Source Type Code (associated with PBP Number in positions 1520-1522)	1	1526	CHAR	See values for position 1496.
166	Prior Part C Contract Number	5	1527-1531	CHAR	
167	Prior Part C Enrollment Start Date (associated with PBP Number in positions 1549-1551)	8	1532-1539	CHAR	
168	Prior Part C Disenrollment Date (associated with PBP Number in positions 1549-1551)	8	1540-1547	CHAR	
169	Prior Part D Indicator (associated with PBP Number in positions 1549-1551)	1	1548	CHAR	N = No Space
170	Prior PBP Number (associated with Contract Number in positions 1527-1531)	3	1549-1551	CHAR	Plan Benefit Package number
171	Prior Plan Type Code (associated with PBP Number in positions 1549-1551)	2	1552-1553	CHAR	See values for positions 749-750.
172	Prior EGHP Indicator (associated with PBP Number in positions 1549-1551)	1	1554	CHAR	Employer Group Health Plan Switch Y = EGHP N = not EGHP
173	Prior Enrollment Source Type Code (associated with PBP Number in positions 1549-1551)	1	1555	CHAR	See values for position 1496.
174	Active MBI	11	1556-1566	CHAR	The MBI from the beneficiary's active Beneficiary MBI period. The value is a system-generated identifier used internally and externally to uniquely identify the beneficiary in the Medicare database.
175	Filler	434	1567 - 2000	CHAR	Spaces

Total Length = 2000

F.6.3 *Trailer Record*

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

Total Length = 2000

Weekly Record Layouts

F.7 LIS/Part D Premium Data File

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

Item	Field	Size	Position	Description
1	Beneficiary ID	12	1-12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then, • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
2	Contract Number	5	13-17	Contract Identification Number
3	PBP Number	3	18-20	Beneficiary's PBP ID, blank if none
4	Segment Number	3	21-23	Beneficiary's Segment Identification Number, blank if none
5	Run Date	8	24-31	Data File Generation Date YYYYMMDD – Format
6	Subsidy Start Date	8	32-39	Beneficiary's Subsidy Start Date YYYYMMDD – Format
7	Subsidy End Date	8	40-47	Beneficiary's Subsidy End Date YYYYMMDD – Format
8	Part D Premium Subsidy Percentage	3	48-50	Beneficiary's LIPS Percent '100' = 100% Premium Subsidy '075' = 75% Premium Subsidy '050' = 50% Premium Subsidy '025' = 25% Premium Subsidy
9	Low-Income Co-Payment Level ID	1	51	Co-Payment Category Definitions: '1'=High; '2'=Low; '3'=$0; '4'=15%
10	Beneficiary Enrollment Effective Date	8	52-59	Beneficiary's Enrollment effective date, YYYYMMDD – Format
11	Beneficiary Enrollment End Date	8	60-67	Beneficiary's Enrollment End Date YYYYMMDD – Format Space can remain blank
12	Part C Premium Amount	8	68-75	Beneficiary's Part C Premium Amount (----9.99)
13	Part D Premium Amount	8	76-83	Beneficiary's Part D Premium Amount Net of De Minimis if Applicable, (----9.99)

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

Total Length = 278

Monthly Record Layouts

F.8 820 Format Payment Advice Data File

The 820 Format Payment Advice data file is a Health Insurance Portability & Accountability Act (HIPAA)-compliant version of the Plan Payment Report, which is also known as the Automated Plan Payment System (APPS) Payment Letter. The data file itemizes the final monthly payment to the Plan. It is produced by APPS when final payments are calculated, and is available to Plans as part of the month-end processing. This file is not available through Medicare Advantage Prescription Drug System (MARx).

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

System	Type	Frequency	Dataset Naming Conventions
APPS	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PLAN820D.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PLAN820D.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PLAN820D.Dyymm01.Thhmmsst

The following records are included in this file:

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

The segments are listed in a required order:

1. ST, 820 Header
2. BPR, Financial Information
3. TRN, Re-association Key
4. DTM, Coverage Period
5. N1, Premium Receiver's Name
6. N1, Premium Payer's Name
7. RMR, Organization Summary Remittance Detail
8. IT1, Summary Line Item
9. SLN, Member Count
10. ADX, Organization Summary Remittance Level Adjustment
11. SE, 820 Trailer

The physical layout of a segment is:

- Segment Identifier, an alphanumeric code, followed by
- Each selected field (data element) preceded by a data element separator ("*")
- And terminated by a segment terminator ("~").

Fields are mostly variable in length and do not contain leading/trailing spaces. If fields are empty,

they are skipped by inserting contiguous data element separators ("*****") unless they are at the end of the segment. Fields that are not selected are represented in the same way as fields that are selected, but as this particular iteration of the transaction set contain no data, they are skipped.

For example, in fictitious segment XXX, fields 2, 3, and 5 (the last field) are skipped:

XXX*field 1 content*field 4 content~**

BALANCING REQUIREMENTS[1]

Following are two balancing rules:

1. BPR02 = total of all RMR04
2. RMR04 = RMR05 + ADX01

To comply with balancing rules, BPR02 and RMR04 are set equal to Net Payment (paid amount), RMR05 is set equal to Gross/Calculated Payment (billed amount), and ADX01 is set equal to Adjustment amount.

On Cost/Health Care Prepayment Plan (HCPP) contracts, Plans should enter the actual dollars billed, rather than the "risk equivalent" dollar amounts, into RMR05.

F.8.1 Header Record

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

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

Item	Segment	Data Element	Description	Size	Type	Contents
11	TRN	TRN01	Trace Type Code	1/2	ID	"3" (Financial Re-association Trace Number)
12	TRN	TRN02	Check or EFT Trace Number	1/30	AN	"USTREASURY"
13	**Coverage Period**			3	AN	"DTM"
14	DTM	DTM01	Date/Time Qualifier	3/3	ID	"582" (Report Period)
15	DTM	DTM05	Date/Time Period Format Qualifier	2/3	ID	"RD8"(Range of dates expressed in format YYYYMMDD – YYYYMMDD)
16	DTM	DTM06	Date/Time Period	1/35	AN	Range of Dates for Payment Month. See DTM05.
17	**Premium Receiver's Name**			2	AN	"N1"
18	1000A	N101	Entity Identifier Code	2/3	ID	"PE" (Payee)
19	1000A	N102	Name	1/60	AN	Contract Name
20	1000A	N103	Identification Code Qualifier	1/2	ID	"EQ" Insurance Company Assigned ID Number
21	1000A	N104	Identification Code	2/80	AN	Contract Number
22	**Premium Payer's Name**			2	AN	"N1"
23	1000B	N101	Entity Identifier Code	2/3	ID	"PR" (Payer)
24	1000B	N102	Name	1/60	AN	"CMS"
25	1000B	N103	Identification Code Qualifier	1/2	ID	"EQ" Insurance Company Assigned ID Number
26	1000B	N104	Identification Code	2/80	AN	"CMS"

F.8.2 Detail Record

Item	Segment	Data Element	Description	Size	Type	Contents
1	**Organization Summary Remittance Detail**			3	AN	"RMR"
2	2300A	RMR01	Reference Identification Qualifier	2/3	ID	"CT"
3	2300A	RMR02	Contract Number	1/30	AN	Payment Letter – Contract #
4	2300A	RMR04	Detail Premium Payment Amount	1/18	R	Payment Letter – Net Payment See discussion on Balancing.
5	2300A	RMR05	Billed Premium Amount	1/18	R	Payment Letter – Capitated Payment. See discussion on Balancing.
6	**Summary Line Item**			3	AN	"IT1"
7	2310A	IT101	Line Item Control Number	1/20	AN	"1" (Assigned for uniqueness)
8	**Member Count**			3	AN	"SLN"
9	2315A	SLN01	Line Item Control Number	1/20	AN	"1" (Assigned for uniqueness)

Item	Segment	Data Element	Description	Size	Type	Contents
10	2315A	SLN03	Information Only Indicator	1/1	ID	"O" (For Information only)
11	2315A	SLN04	Head Count	1/15	R	Payment Letter – Total Members
12	2315A	SLN05-1	Unit or Basis for Measurement Code	2/2	ID	"IE" - used to identify that the value of SLN04 represents the number of contract holders with individual coverage
13	**Organization Summary Remittance Level Adjustment**			3	AN	"ADX"
14	2320A	ADX01	Adjustment Amount	1/18	R	Payment Letter – Total Adjustments is the difference between Capitated Payment and Net Payment. See discussion on Balancing.
15	2320A	ADX02	Adjustment Reason Code	2/2	ID	"H1" - Information forthcoming – detailed information related to the adjustment is provided through a separate mechanism

F.8.3 Trailer Record

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

F.9 BIPA 606 Payment Reduction Data File

The BIPA 606 Payment Reduction Data File will no longer be generated beginning November 2017.

F.10 Monthly Membership Detail Data File

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

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

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

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

Item	Field	Size	Position	Description
8	Date of Birth	8	41 - 48	Beneficiary's date of birth (YYYYMMDD)
9	Age Group	4	49 - 52	Age group for the beneficiary for this payment month (BBEE) BB = Beginning Age of range EE = Ending Age of range
10	State & County Code	5	53 - 57	Beneficiary State and County Code
11	Out of Area Indicator	1	58	Indicator that the beneficiary is Out of Area for the Plan Y = Out of Contract-level service area Space = Not out of area Always Space on Adjustment rows
12	Part A Entitlement	1	59	Indicator that the beneficiary is entitled to Part A Y = Entitled to Part A Space = Not entitled to Part A
13	Part B Entitlement	1	60	Indicator that the beneficiary is entitled to Part B Y = Entitled to Part B Space = Not entitled to Part B
14	Hospice	1	61	Indicator that the beneficiary is in Hospice status Y = Hospice Space = Not in Hospice status
15	ESRD	1	62	Indicator that the beneficiary has ESRD Y = ESRD Space = Not ESRD
16	Aged/Disabled MSP	1	63	Indicator that Medicare is Secondary Payer Y = aged/disabled factor applicable to beneficiary; N = aged/disabled factor not applicable to beneficiary
17	Institutional	1	64	Indicator that the beneficiary is institutional Y = Institutional (monthly) Space = Not institutional
18	NHC	1	65	Indicator that the beneficiary is in Nursing Home Certifiable status Y = Nursing Home Certifiable Space = Beneficiary is not NHC

Item	Field	Size	Position	Description

19	New Medicare Beneficiary Medicaid Status Flag	1	66	Beneficiary's Medicaid Status used for the month being paid or adjusted.
				1. Calculated 2009 and later:
				• Prospective payments with effective date in 2008 or after:
				  • Y = Medicaid and a default risk factor was used,
				  • N = Not Medicaid and a default risk factor was used,
				  • Space = No default risk factor or beneficiary is Part D only.
				• Adjustments with effective date in 2007 or earlier:
				  • Y = Medicaid and adjustment was made to the demographic component of a blended payment.
				  • N = Not Medicaid and adjustment was made to the demographic component of a blended payment.
				  • Blank = Either the adjusted payment had no demographic component, or only the risk portion of a blended payment was adjusted.
				2. Calculated during 2008:
				• Y = Medicaid and a default risk factor was used
				• N = Not Medicaid and a default risk factor was used,
				• Space = No default risk factor used or beneficiary is Part D only.
				3. Calculated prior to calendar year 2008:
				• Y = Medicaid
				• Space = not Medicaid

20	LTI Flag	1	67	Indicator that beneficiary has Part C Long Term Institutional Status Y = Part C Long Term Institutional Space = Not LTI

Item	Field	Size	Position	Description
21	Medicaid Indicator	1	68	Indicator that the Medicaid Add-on was used for this payment or adjustment When: • A RAS-supplied factor is used instead of a Part C Default factor in the payment, and • The beneficiary is enrolled in a PACE plan or has ESRD or LTI status. Space = No Medicaid Add-on was used in payment for beneficiaries enrolled in a PACE plan or with ESRD or LTI status. Space = This field is not applicable for NON-ESRD, Full risk, NON-PACE beneficiaries assigned a Community factor.
22	PIP-DCG	2	69-70	PIP-DCG Category - Only on pre-2004 adjustments
23	Default Risk Factor Code	1	71	Indicator that a Default Risk Adjustment Factor (RAF) was used for calculating this payment or adjustment. **2009 and after**, for payments and payment adjustments and regardless of the effective date: '1' = Default Enrollee- Aged/Disabled '2' = Default Enrollee- ESRD dialysis '3' = Default Enrollee- ESRD Kidney Transplant- Month 1 '4' = Default Enrollee- ESRD Kidney Transplant - Months 2-3 '5' = Default Enrollee- ESRD Post Graft - Months 4-9 '6' = Default Enrollee- ESRD Post Graft - 10+ Months '7' = Default Enrollee Chronic Care SNP Space = The beneficiary is not a default enrollee. **For 2004 through 2008:** 'Y' Default factor was used due to lack of a RAF for the beneficiary **Prior to 2004:** 'Y' = new enrollee default RAF was used.
24	Risk Adjustment Factor A	7	72-78	Part A Risk Adjustment Factor used for the Payment Calculation (NN.DDDD)
25	Risk Adjustment Factor B	7	79-85	Part B Risk Factor used for the Payment Calculation (NN.DDDD)
26	Number of Paymt/Adjustmt Months Part A	2	86-87	Number of months included in this payment or adjustment for Part A
27	Number of Paymt/Adjustmt Months Part B	2	88-89	Number of months included in this payment or adjustment for Part B

Item	Field	Size	Position	Description
28	Adjustment Reason Code	2	90-91	Code that indicates the reason for this adjustment Always Spaces on Payments
29	Paymt/Adjustment/ Start Date	8	92-99	Earliest date covered by this payment or adjustment (YYYYMMDD)
30	Paymt/Adjustment/ End Date	8	100-107	Latest date covered by this payment or adjustment (YYYYMMDD)
31	Demographic Paymt/Adjustmt Rate A	9	108-116	Part A Demographic Rate used in this payment or adjustment calculation (-99999.99) **2008 and later** = Always 0.00 because Demographic component is no longer part of the payment calculation **Prior to 2008** = Demographic Paymt/Adjustmt Rate A
32	Demographic Paymt/Adjustmt Rate B	9	117-125	Part B Demographic Rate used in this payment or adjustment calculation (-99999.99) **2008 and later** = Always 0.00 because Demographic component is no longer part of the payment calculation **Prior to 2008** = Demographic Paymt/Adjustmt Rate B
33	Monthly Paymt/Adjustmt Amount Rate A	9	126-134	Part A portion of the payment or adjustment dollars (-99999.99). For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA
34	Monthly Paymt/Adjustmt Amount Rate B	9	135-143	Part B portion of the payment or adjustment dollars (-99999.99) For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term.
35	LIS Premium Subsidy	8	144-151	Low Income Premium Subsidy Amount for the beneficiary (-9999.99)
36	ESRD MSP Flag	1	152	Indicator that Medicare is a Secondary Payer due to ESRD. **As of January 2011:** 'T' = MSP due to Transplant/Dialysis 'P' = MSP due to Post Graft Space = ESRD MSP not applicable **Prior to 2011:** 'Y' = ESRD MSP 'N' = No ESRD MSP
37	Medication Therapy Management (MTM) Add On	10	153-162	The total Medication Therapy Management (MTM) Add-On for the member (999999.99)

Item	Field	Size	Position	Description
38	Filler	8	163-170	Spaces
39	Medicaid Status	1	171	The Medicaid status that is in effect for the month used to determine the appropriate community risk score for a NON-ESRD, Full-risk, NON-PACE beneficiary. For all other risk scores, this field is informational. It is the Medicaid status that would be in effect if the beneficiary met the criteria for an aged/disabled community risk score. '1' = Beneficiary is determined to be full or partial Medicaid '0' = Beneficiary is not Medicaid Blank = This is a retroactive adjustment for a month prior to January 2017.
40	Risk Adjustment Age Group (RAAG)	4	172-175	The Risk Adjustment Age Group for the beneficiary (BBEE) BB = Beginning Age EE = Ending Age Beginning in 2011, if the risk adjustment factor is from RAS, the Risk Adjuster Age Group reported will be the one used by RAS in calculating the RAF.
41	Previous Disable Ratio (PRDIB)	7	176-182	Percentage of Year (in months) for Previous Disable Add-On (NN.DDDD) Greater than 0.00 – Only on adjustments for pre-2004 periods. 0.00 – On adjustments beyond 2004 Spaces – On prospective payments
42	De Minimis	1	183	Indicates if de minimis applies for this row. Prior to 2008, flag is spaces. Beginning 2008: 'N' = "de minimis" does not apply, 'Y' = "de minimis" applies.
43	Beneficiary Dual and Part D Enrollment Status Flag	1	184	The beneficiary's dual enrollment status '0' = Plan without drug benefit, beneficiary not dual enrolled '1' = Plan with drug benefit, beneficiary not dual enrolled '2' = Plan without drug benefit, beneficiary dual enrolled '3' = Plan with drug benefit, beneficiary dual enrolled.
44	Plan Benefit Package ID	3	185-187	PBP Number

Item	Field	Size	Position	Description
45	Race Code	1	188	Beneficiary's Race 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
46	Risk Adjustment Factor Type Code	2	189-190	The type of Part C Risk Adjustment Factor used to calculate this payment or adjustment. C = Community (Adjustments before 2017; PACE only beginning 1/2017) C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) CF = Community Full Dual CP = Community Partial Dual CN = Community Non-Dual D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) E1 = New Enrollee Post-Graft I (ESRD) E2 = New Enrollee Post-Graft II (ESRD) G1 = Graft I (ESRD) G2 = Graft II (ESRD) I = Institutional I1 = Institutional Post-Graft I (ESRD) I2 = Institutional Post-Graft II (ESRD) SE = New Enrollee Chronic Care SNP PA = PACE Dialysis Factor PB = PACE New Enrollee Dialysis Factor PC = PACE Community Post Graft 4-9 PD = PACE Institutional Post Graft 4-9 PE = PACE New Enrollee Post Graft 4-9 PF = PACE Community Post Graft 10+ PG = PACE Institutional Post Graft PH = PACE New Enrollee Post Graft 10+ Note: The actual RAF values are in fields 24 – 25.
47	Frailty Indicator	1	191	Indicator that a Plan-level Frailty Factor was included in the calculation of the payment or adjustment Y = Frailty Factor Included N = No Frailty Factor

Item	Field	Size	Position	Description
48	Original Reason for Entitlement Code (OREC)	1	192	The original reason that the beneficiary was entitled to Medicare 0 = Beneficiary insured due to age 1 = Beneficiary insured due to disability 2 = Beneficiary insured due to ESRD 3 = Beneficiary insured due to disability and current ESRD 9 = None of the above
49	Lag Indicator	1	193	Indicator that there is a lag in the encounter data used to calculate RAF Y = Lags payment year by 6 months N = No lag
50	Segment Number	3	194-196	Segment number for the beneficiary's enrollment. 000 = Plan with no segments.
51	Enrollment Source	1	197	The source of the enrollment A = Auto-enrolled by CMS B = Beneficiary election C = Facilitated enrollment by CMS D = Systematic enrollment by CMS (rollover) N = Plan-submitted rollover
52	EGHP Flag	1	198	Indicator that the Plan is an Employer Group Health Plan Y = Employer Group Health Plan N = Not an Employer Group Health Plan
53	Part C Basic Premium – Part A Amount	8	199-206	The premium amount for determining the MA payment attributable to Part A. It is subtracted from the MA plan payment for plans that bid above the benchmark. (-9999.99)
54	Part C Basic Premium – Part B Amount	8	207-214	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA plan payment for plans that bid above the benchmark. (-9999.99)
55	Rebate for Part A Cost Sharing Reduction	8	215-222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. (-9999.99)
56	Rebate for Part B Cost Sharing Reduction	8	223-230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. . (-9999.99)

Item	Field	Size	Position	Description
57	Rebate for Other Part A Mandatory Supplemental Benefits	8	231-238	The amount of the rebate allocated to providing Part A supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. . (-9999.99)
58	Rebate for Other Part B Mandatory Supplemental Benefits	8	239-246	The amount of the rebate allocated to providing Part B supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. . (-9999.99)
59	Rebate for Part B Premium Reduction – Part A Amount	8	247-254	The Part A amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. . (-9999.99)
60	Rebate for Part B Premium Reduction – Part B Amount	8	255-262	The Part B amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. . (-9999.99)
61	Rebate for Part D Supplemental Benefits – Part A Amount	8	263–270	Part A Amount of the rebate allocated to providing Part D supplemental benefits. . (-9999.99)
62	Rebate for Part D Supplemental Benefits – Part B Amount	8	271–278	Part B Amount of the rebate allocated to providing Part D supplemental benefits. (-9999.99)
63	Total Part A MA Payment	10	279–288	The total Part A MA payment. . (-999999.99)
64	Total Part B MA Payment	10	289–298	The total Part B MA payment. (-999999.99)
65	Total MA Payment Amount	11	299-309	The total MA A/B payment including MMA adjustments. This also includes the Rebate Amount for Part D Supplemental Benefits (-9999999.99)
66	Part D RA Factor	7	310-316	Part D Risk Adjustment Factor used for the Payment Calculation (NN.DDDD)
67	Part D Low-Income Indicator	1	317	Indicator of beneficiary's Low Income status for the Part D payment or adjustment. Calculations for Low Income beneficiaries include a Part D Low-Income multiplier. **For 2011 and later:** 'Y' = beneficiary is Low Income 'N' = beneficiary is not Low Income **From 2006 through 2010:** 1 = Beneficiary is in subset 1 2 = Beneficiary is in subset 2 Spaces = Not applicable

Item	Field	Size	Position	Description
68	Part D Low-Income Multiplier	7	318-324	The Part D low-income multiplier used in the calculation of the payment or adjustment (NN.DDDD)
69	Part D Long Term Institutional Indicator	1	325	Indicator of beneficiary's Long Term Institutional (LTI) status for the Part D payment or adjustment. Calculations for Low Income beneficiaries include a Part D LTI multiplier. A = LTI (aged) D = LTI (disabled) Space = No LTI
70	Part D Long Term Institutional Multiplier	7	326-332	Part D LTI multiplier used in the calculation of the payment or adjustment (NN.DDDD) For payment months 2011 and beyond, this field will be zero.
71	Rebate for Part D Basic Premium Reduction	8	333-340	Amount of the rebate allocated to reducing the member's basic Part D premium. (-9999.99)
72	Part D Basic Premium Amount	8	341-348	Plan's Part D premium amount. (-9999.99)
73	Part D Direct Subsidy Monthly Payment Amount	10	349-358	Total Part D Direct subsidy payment for the member. For the LINET plan (X is first character of contract number) this is the total LINET Direct Subsidy for the beneficiary. (-999999.99)
74	Reinsurance Subsidy Amount	10	359-368	The amount of reinsurance subsidy included in the payment (-999999.99)
75	Low-Income Subsidy Cost-Sharing Amount	10	369-378	The amount low-income subsidy cost-sharing amount included in the payment. (-999999.99)
76	Total Part D Payment	11	379-389	The total Part D payment for the member (-9999999.99)
77	Number of Paymt/Adjustmt Months Part D	2	390-391	Number of months included in this payment or adjustment.
78	PACE Premium Add On	10	392-401	Total Part D Pace Premium Add-on amount (-999999.99)
79	PACE Cost Sharing Add-on	10	402-411	Total Part D Pace Cost Sharing Add-on amount (-999999.99)
80	Part C Frailty Score Factor	7	412-418	Part C frailty score factor used in this payment or adjustment calculation, (NN.DDDD) Spaces = Not applicable

Item	Field	Size	Position	Description
81	MSP Factor	7	419-425	MSP secondary payer reduction factor used in this payment or adjustment calculation(NN.DDDD) Spaces = Not applicable
82	MSP Reduction/Reduction Adjustment Amount – Part A	10	426-435	Net MSP reduction or reduction adjustment dollar amount– Part A (SSSSSS9.99)
83	MSP Reduction/Reduction Adjustment Amount – Part B	10	436-445	Net MSP reduction or reduction adjustment dollar amount – Part B (SSSSSS9.99)
84	Medicaid Dual Status Code	2	446-447	This field reports the Medicaid dual status code that is in effect for the month used to determine the appropriate community risk score for a NON-ESRD, Full-risk, NON-PACE beneficiary (Field 46 is CF, CP or CN). For all other risk scores, this field is informational. It is the dual status code that would be in effect if the beneficiary met the criteria for an aged/disabled community score. 00 = No Medicaid status 01 = Eligible - entitled to Medicare- QMB only (Partial Dual) 02 = Eligible - entitled to Medicare- QMB AND Medicaid coverage (Full Dual) 03 = Eligible - entitled to Medicare- SLMB only (Partial Dual) 04 = Eligible - entitled to Medicare- SLMB AND Medicaid coverage (Full Dual) 05 = Eligible - entitled to Medicare- QDWI (Partial Dual) 06 = Eligible - entitled to Medicare- Qualifying individuals (Partial Dual) 08 = Eligible - entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB, QDWI or QI) with Medicaid coverage (Full Dual) 09 = Eligible - entitled to Medicare – Other Dual Eligibles but without Medicaid coverage (Non-Dual) 10 = Other Full Dual 99 = Unknown
85	Part D Coverage Gap Discount Amount	8	448-455	Amount of the Coverage Gap Discount Amount included in the payment (-9999.99)

Item	Field	Size	Position	Description
86	Part D Risk Adjustment Factor Type	2	456-457	Beginning with January 2011 payments, the type of Part D Risk Adjustment Factor used to calculate this payment or adjustment. D1 = Community Non-Low Income Continuing Enrollee, D2 = Community Low Income Continuing Enrollee, D3 = Institutional Continuing Enrollee, D4 = New Enrollee Community Non-Low Income Non-ESRD, D5 = New Enrollee Community Non-Low Income ESRD, D6 = New Enrollee Community Low Income Non-ESRD, D7 = New Enrollee Community Low Income ESRD, D8 = New Enrollee Institutional Non-ESRD, D9 = New Enrollee Institutional ESRD, P1 = PACE New Enrollee Community Low Income Non- ESRD P2 = PACE New Enrollee Community Non- Low Income Non-ESRD P3 = PACE New Enrollee Institutional Non-ESRD P4 = PACE New Enrollee Institutional ESRD P5 = PACE New Enrollee Community Low Income ESRD P6 = PACE New Enrollee Community Non- Low Income ESRD P7 = PACE Community Non- Low Income CONTINUING Enrollee P8 = PACE Community Low Income Continuing Enrollee P9 = PACE Institutional Continuing Enrollee Spaces = Not applicable. Note: The value of the Part D RAF is found in field 66.

Item	Field	Size	Position	Description
87	Default Part D Risk Adjustment Factor Code	1	458	Beginning with January 2011 payment, the code that further breaks down the Part D RAF type. : 1 = Not ESRD, Not Low Income, Not Originally Disabled, 2 = Not ESRD, Not Low Income, Originally Disabled, 3 = Not ESRD, Low Income, Not Originally Disabled, 4 = Not ESRD, Low Income, Originally Disabled, 5 = ESRD, Not Low Income, Not Originally Disabled, 6 = ESRD, Low Income, Not Originally Disabled, 7 = ESRD, Not Low Income, Originally Disabled, 8 = ESRD, Low Income, Originally Disabled, Spaces = Not applicable
88	Part A Risk Adjusted Monthly Rate Amount for Pymt/Adj	9	459-467	Beginning August 2011, the Part A Risk Adjusted amount used in the payment or adjustment calculation (-99999.99) Payments = Rate amount in effect for payment period Adjustments = Rate amount in effect for adjustment period
89	Part B Risk Adjusted Monthly Rate Amount for Pymt/Adj	9	468-476	Beginning August 2011, the Part B Risk Adjusted amount used in the payment or adjustment calculation (-99999.99) Payments = Rate amount in effect for payment period Adjustments = Rate amount in effect for adjustment period
90	Part D Direct Subsidy Monthly Rate Amount for Pymt/Adj	9	477-485	Beginning August 2011, the Part D Direct Subsidy amount used in the payment or adjustment calculation (-99999.99) Payments = Rate amount in effect for payment period Adjustments = Rate amount in effect for adjustment period
91	Cleanup ID	10	486-495	The Cleanup ID field is used in the event of a cleanup or a RAS overpayment run. It is used to uniquely identify the cleanup with which the record is associated. It is usually the Remedy Ticket number for the cleanup or overpayment run. RAS overpayment runs are associated with an ARC 60 or ARC 61 in Field 28. ARC 94 in Field 28 is used to identify clean-ups when no other ARC codes apply. The field will be blank when the record reports: • A prospective payment • A non-cleanup adjustment • Any payment or adjustment prior to August 2011.

Total Length = 495

F.11 Monthly Membership Summary Data File

This is a data file version of the Monthly Membership Summary Report (MMSR) for both Part C and Part D members, summarizing payments made to a Plan for the month, in several categories; and the adjustments, by all adjustment categories.

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

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

Item	Field	Size	Position	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	Adjustment Reason Code	2	20-21	Adjustment Reason Code (ARC) This is populated with a valid ARC for adjustments. For prospective payment components, it is populated with 00.
5	Record Description	10	22-31	This field is populated with a short description of the type of data reported in the record. See Appendix A for the table of record types for all possible values.
6	Payment Adjustment Count	7	32-38	Beneficiary Count
7	Month count	7	39-45	Payment Record: 1 for each member on the record Adjustment record: spaces
8	Part A Member count	7	46-52	Payment Record: Beneficiary count for Part A; Adjustment record: spaces
9	Part A Month count	7	53-59	Payment Record: 1 for each member with Part A Adjustment record: The number of months adjusted for Part A
10	Part B Member count	7	60-66	Payment Record: Beneficiary count for Part B Adjustment record: Spaces
11	Part B Month count	7	67-73	Payment Record: 1 for each member with Part B Adjustment record: The number of months adjusted for Part B

Item	Field	Size	Position	Description
12	Part A Payment/Adjustment Amount	15	74-88	Part A Amount
13	Part B Payment/Adjustment Amount	15	89-103	Part B Amount
14	Total Amount	15	104-118	Total Payment/Adjustment Amount
15	Part A Average	9	119-127	Average Part A Amount per Part A Member
16	Part B Average	9	128-136	Average Part B Amount per Part B Member
17	Payment/Adjustment Indicator	1	137-137	'P' for Payments and 'A' for Adjustments
18	PBP Number	3	138-140	Plan Benefit Package Number On records in a Contract Level summarization, this will be set to "PBP".
19	Segment Number	3	141-143	Segment Number On records in a PBP Level summarization, this will be set to "000". On records in a Contract Level summarization, this will be set to "SEG".
20	Part D Member Count	7	144-150	Payment Record: Beneficiary count for Part D Adjustment records: Spaces
21	Part D Month Count	7	151-157	Payment Record: 1 for each member with Part D Adjustment record: The number of months adjusted for Part D
22	Part D Amount	15	158-172	Part D Amount
23	Part D Average	9	173-181	Average Part D Amount per Part D Member
24	LIS Band 25% member count	7	182-188	Count of Beneficiaries in the 25% LIS band
25	LIS Band 50% member count	7	189-195	Count of Beneficiaries in the 50% LIS band
26	LIS Band 75% member count	7	196-202	Count of Beneficiaries in the 75% LIS band
27	LIS Band 100% member count	7	203-209	Count of Beneficiaries in the 100% LIS band
28	Filler	11	210-220	Spaces

Total Length = 220

F.12 Monthly Premium Withholding Report (MPWR) Data File

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

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

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

The file includes the following records:

- Header Record
- Detail Record
- Trailer Record

F.12.1 *Header Record*

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

Total Length = 165

F.12.2 *Detail Record*

Item	Field	Size	Position	Description
1	Record Type	2	1-2	D = Detail Record PIC XX
2	MCO Contract Number	5	3-7	MCO Contract Number PIC X(5)
3	Plan Benefit Package Id	3	8-10	Plan Benefit Package ID PIC X(3)
4	Plan Segment Id	3	11-13	PIC X(3)
5	Beneficiary ID	12	14-25	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
6	Surname	7	26-32	PIC X(7)
7	First Initial	1	33	PIC X
8	Sex	1	34	M = Male, F = Female PIC X
9	Date of Birth	8	35-42	YYYYMMDD PIC 9(8)
10	PPO	3	43-45	PPO in effect for this Pay Month "SSA" = Withholding by SSA "RRB" = Withholding by RRB PIC X(3)
11	Filler	1	46	Space
12	Premium Period Start Date	8	47-54	Starting Date of Period Premium Payment Covers YYYYMMDD PIC 9(8)
13	Premium Period End Date	8	55-62	Ending Date of Period Premium Payment Covers YYYYMMDD PIC 9(8)
14	Number of Months in Premium Period	2	63-64	PIC 99
15	Part C Premiums Collected	8	65-72	Part C Premiums Collected for this Beneficiary, Plan, and premium period. A negative amount indicates a refund by withholding agency to Beneficiary of premiums paid in a prior premium period. PIC -9999.99
16	Part D Premiums Collected	8	73-80	Part D Premiums Collected (excluding LEP) for this Beneficiary, Plan, and premium period. A negative amount indicates a refund by withholding agency to Beneficiary of premiums paid in a prior premium period. PIC -9999.99
17	Part D Late Enrollment Penalties Collected	8	81-88	Part D Late Enrollment Penalties Collected for this Beneficiary, Plan, and premium period. A negative amount indicates a refund by withholding agency to Beneficiary of penalties paid in a prior premium period. PIC -9999.99
18	Cleanup ID	10	89-98	If collected premium is the result of a cleanup = XXXXXXXXXX All other records will = Blank.

Item	Field	Size	Position	Description
19	Filler	67	99-165	Spaces

Total Length = 165

F.12.3 *Trailer Record*

Item	Field	Size	Position	Description
1	Record Type	2	1-2	T1 = Trailer Record, withheld totals at segment level T2 = Trailer Record, withheld totals at PBP level T3 = Trailer record, withheld totals at contract level PIC XX
2	MCO Contract Number	5	3-7	MCO contract number PIC X(5)
3	Plan Benefit Package (PBP) ID	3	8-10	PBP ID, not populated on T3 records PIC X(3)
4	Plan Segment Id	3	11-13	Not populated on T2 or T3 records PIC X(3)
5	Total Part C Premiums Collected	14	14-27	Total withholding collections as specified by Trailer Record type, field (1) PIC -9(10).99
6	Total Part D Premiums Collected	14	28-41	Total withholding collections as specified by Trailer Record type, field (1) PIC -9(10).99
7	Total Part D LEPs Collected	14	42-55	Total withholding collections as specified by Trailer Record type, field (1) PIC -9(10).99
8	Total Premiums Collected	14	56-69	Total Premiums Collected = + Total Part C Premiums Collected + Total Part D Premiums Collected + Total Part D Penalties Collected PIC -9(10).99
9	Filler	96	70-165	Spaces

Total Length = 165

F.13 Part B Claims Data File

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

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

F.13.1 *Record Type 1*

Item	Field	Size	Position	Description
1	Contract Number	5	1-5	MCO contract number
2	Record Type	1	6	Record Type Number 6 – Physician/Supplier Record Type Number 7 – Durable Medical Equipment
3	Beneficiary ID	12	7-18	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
4	Period From	8	19-26	Start Date – YYYYMMDD
5	Period To	8	27-34	End Date – YYYYMMDD
6	Date of Birth	8	35-42	Beneficiary's Date of Birth – YYYYMMDD
7	Surname	6	43-48	First six positions of Beneficiary's surname.
8	First Name	1	49	First letter of Beneficiary's first name.
9	Middle Initial	1	50	First letter of Beneficiary's middle name.
10	Reimbursement Amount	11	51-61	Reimbursement amount for claim.
11	Total Allowed Charges	11	62-72	Total allowed charges for claim.
12	Report Date	6	73-78	Claims processed through date – YYYYMM. Assigned by the system as it produces this file. This is the cut-off date for including a claim in this file.
13	Contractor identification number	5	79-83	Identification number of the contractor that processed claim.

14	Provider identification number	10	84-93	Provider's identification number.
15	Internal Control Number	15	94-108	Internal control number assigned by the Medicare contractor to claim.
16	Provider Payment Amount	11	109-119	Total amount paid to provider for this claim.
17	Beneficiary Payment Amount	11	120-130	Total amount paid to Beneficiary for this claim.
18	Filler	57	131-187	Spaces

Total Length = 187

F.13.2 *Record Type 2*

Item	Field	Size	Position	Description
1	Contract Number	5	1-5	MCO contract number
2	Record Type	1	6	Record Type Number 5 – Home Health Agency
3	Beneficiary ID	12	7-18	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
4	Period From	8	19-26	Start Date – YYYYMMDD
5	Period To	8	27-34	End Date – YYYYMMDD
6	Date of Birth	8	35-42	Beneficiary's Date of Birth – YYYYMMDD
7	Surname	6	43-48	First six positions of Beneficiary's surname.
8	First Name	1	49	First letter of Beneficiary's first name.
9	Middle Name	1	50	First letter of Beneficiary's middle name.
10	Reimbursement Amount	11	51-61	Reimbursement amount for claim.
11	Total Charges	11	62-72	Total charges on the claim.
12	Report Date	6	73-78	Claims processed through date – YYYYMM. Assigned by the system when processing claims. This is the cut-off date for including a claim in this file.
13	Contractor identification number	5	79-83	Identification number of the contractor that processed the claim.
14	Provider identification number	6	84-89	Provider's identification number.
15	Filler	98	90-187	Spaces

Total Length = 187

F.14 Part C Risk Adjustment Model Output Data File

This is the data file version of the Part C Risk Adjustment Model Output Report, which shows the Hierarchical Condition Codes (HCCs) used by the RAS to calculate Part C risk adjustment factors for each Beneficiary. RAS produces the report, and MARx forwards it to Plans as part of the month-end processing.

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

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

The following records are included in this file:

- Header Record
- Detail Record
- Trailer Record

F.14.1 Header Record

Item	Field	Format	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "1"	1 = Header
2	Contract Number	Char(5)	5	2-6		Unique identification for a Medicare Advantage Contract
3	Run Date	Char(8)	8	7-14	Format as yyyymmdd	The run date when this file was created
4	Payment Year and Month	Char(6)	6	15-20	Format as yyyymm	This identifies the risk adjustment payment year and month for the model run.
5	Filler	Char(180)	180	21-200	Spaces	Filler

Total Length = 200

F.14.2 Detail Record Type B, E, and G (PY2012 through PY2018)

Item	Field	Format	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "B," "E," or "G"	"B" = Details for new V21 PTC MOR (PACE and PACE ESRD) (RAPS, FFS, and Encounter data) "E" = Details for new V21 PTC MOR (ESRD) (RAPS and FFS) "G" = Details for new V21 PTC MOR (ESRD) (Encounter and FFS)
2	Health Insurance Claim Account Number	Char(12)	12	2-13	Also known as HICAN	This is the Health Insurance Claim Account Number (known as HICAN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICAN, consisting of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD), uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.
3	Beneficiary Last Name	Char(12)	12	14-25	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	7	26-32	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	1	33	1-byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	8	34-41	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	1	42	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary. Examples include Male and Female.
8	Social Security Number	Char(9)	9	43-51	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration

Item	Field	Format	Size	Position	Comment	Description
9	RAS ESRD Indicator Switch	Char(1)	1	52	Y = ESRD N = not ESRD	The beneficiary's ESRD status as of the model run. Also indicates if the beneficiary was processed by the ESRD models in the model run.
10	Age Group Female0_34	Char(1)	1	53	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 0 and 34, inclusive
11	Age Group Female35_44	Char(1)	1	54	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 35 and 44, inclusive
12	Age Group Female45_54	Char(1)	1	55	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 45 and 54, inclusive
13	Age Group Female55_59	Char(1)	1	56	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 55 and 59, inclusive
14	Age Group Female60_64	Char(1)	1	57	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 60 and 64, inclusive
15	Age Group Female65_69	Char(1)	1	58	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 65 and 69, inclusive
16	Age Group Female70_74	Char(1)	1	59	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 70 and 74, inclusive
17	Age Group Female75_79	Char(1)	1	60	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages 75 and 79, inclusive
18	Age Group Female80_84	Char(1)	1	61	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages of 80 and 84, inclusive

Item	Field	Format	Size	Position	Comment	Description
19	Age Group Female85_89	Char(1)	1	62	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages of 85 and 89, inclusive
20	Age Group Female90_94	Char(1)	1	63	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female between ages of 90 and 94, inclusive
21	Age Group Female95_GT	Char(1)	1	64	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: female, age 95 or greater
22	Age Group Male0_34	Char(1)	1	65	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 0 and 34, inclusive
23	Age Group Male35_44	Char(1)	1	66	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 35 and 44, inclusive
24	Age Group Male45_54	Char(1)	1	67	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 45 and 54, inclusive
25	Age Group Male55_59	Char(1)	1	68	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 55 and 59, inclusive
26	Age Group Male60_64	Char(1)	1	69	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 60 and 64, inclusive
27	Age Group Male65_69	Char(1)	1	70	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 65 and 69, inclusive
28	Age Group Male70_74	Char(1)	1	71	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 70 and 74, inclusive
29	Age Group Male75_79	Char(1)	1	72	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 75 and 79, inclusive

Item	Field	Format	Size	Position	Comment	Description
30	Age Group Male80_84	Char(1)	1	73	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 80 and 84, inclusive
31	Age Group Male85_89	Char(1)	1	74	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 85 and 89, inclusive
32	Age Group Male90_94	Char(1)	1	75	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male between ages of 90 and 94, inclusive
33	Age Group Male95_GT	Char(1)	1	76	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date: male, age 95 or greater
34	Medicaid Female Disabled	Char(1)	1	77	Set to "1" if applicable, otherwise "0"	Beneficiary is a female disabled and also entitled to Medicaid.
35	Medicaid Female Aged	Char(1)	1	78	Set to "1" if applicable, otherwise "0"	Beneficiary is a female aged (> 64) and also entitled to Medicaid.
36	Medicaid Male Disabled	Char(1)	1	79	Set to "1" if applicable, otherwise "0"	Beneficiary is a male disabled and also entitled to Medicaid.
37	Medicaid Male Aged	Char(1)	1	80	Set to "1" if applicable, otherwise "0"	Beneficiary is a male aged (> 64) and also entitled to Medicaid.
38	Originally Disabled Female	Char(1)	1	81	Set to "1" if applicable, otherwise "0"	Beneficiary is a female and original Medicare entitlement was due to disability.
39	Originally Disabled Male	Char(1)	1	82	Set to "1" if applicable, otherwise "0"	Beneficiary is a male and original Medicare entitlement was due to disability.
40	HCC001	Char(1)	1	83	Set to "1" if applicable, otherwise "0"	HIV/AIDS
41	HCC002	Char(1)	1	84	Set to "1" if applicable, otherwise "0"	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
42	HCC006	Char(1)	1	85	Set to "1" if applicable, otherwise "0"	Opportunistic Infections
43	HCC008	Char(1)	1	86	Set to "1" if applicable, otherwise "0"	Metastatic Cancer and Acute Leukemia
44	HCC009	Char(1)	1	87	Set to "1" if applicable, otherwise "0"	Lung and Other Severe Cancers

Item	Field	Format	Size	Position	Comment	Description
45	HCC010	Char(1)	1	88	Set to "1" if applicable, otherwise "0"	Lymphoma and Other Cancers
46	HCC011	Char(1)	1	89	Set to "1" if applicable, otherwise "0"	Colorectal, Bladder, and Other Cancers
47	HCC012	Char(1)	1	90	Set to "1" if applicable, otherwise "0"	Breast, Prostate, and Other Cancers and Tumors
48	HCC017	Char(1)	1	91	Set to "1" if applicable, otherwise "0"	Diabetes with Acute Complications
49	HCC018	Char(1)	1	92	Set to "1" if applicable, otherwise "0"	Diabetes with Chronic Complications
50	HCC019	Char(1)	1	93	Set to "1" if applicable, otherwise "0"	Diabetes without Complication
51	HCC021	Char(1)	1	94	Set to "1" if applicable, otherwise "0"	Protein-Calorie Malnutrition
52	HCC022	Char(1)	1	95	Set to "1" if applicable, otherwise "0"	Morbid Obesity
53	HCC023	Char(1)	1	96	Set to "1" if applicable, otherwise "0"	Other Significant Endocrine and Metabolic Disorders
54	HCC027	Char(1)	1	97	Set to "1" if applicable, otherwise "0"	End-Stage Liver Disease
55	HCC028	Char(1)	1	98	Set to "1" if applicable, otherwise "0"	Cirrhosis of Liver
56	HCC029	Char(1)	1	99	Set to "1" if applicable, otherwise "0"	Chronic Hepatitis
57	HCC033	Char(1)	1	100	Set to "1" if applicable, otherwise "0"	Intestinal Obstruction/Perforation
58	HCC034	Char(1)	1	101	Set to "1" if applicable, otherwise "0"	Chronic Pancreatitis
59	HCC035	Char(1)	1	102	Set to "1" if applicable, otherwise "0"	Inflammatory Bowel Disease
60	HCC039	Char(1)	1	103	Set to "1" if applicable, otherwise "0"	Bone/Joint/Muscle Infections/Necrosis
61	HCC040	Char(1)	1	104	Set to "1" if applicable, otherwise "0"	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
62	HCC046	Char(1)	1	105	Set to "1" if applicable, otherwise "0"	Severe Hematological Disorders

Item	Field	Format	Size	Position	Comment	Description
63	HCC047	Char(1)	1	106	Set to "1" if applicable, otherwise "0"	Disorders of Immunity
64	HCC048	Char(1)	1	107	Set to "1" if applicable, otherwise "0"	Coagulation Defects and Other Specified Hematological Disorders
65	HCC051	Char(1)	1	108	Set to "1" if applicable, otherwise "0"	Dementia With Complications
66	HCC052	Char(1)	1	109	Set to "1" if applicable, otherwise "0"	Dementia Without Complication
67	HCC054	Char(1)	1	110	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Psychosis
68	HCC055	Char(1)	1	111	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Dependence
69	HCC057	Char(1)	1	112	Set to "1" if applicable, otherwise "0"	Schizophrenia
70	HCC058	Char(1)	1	113	Set to "1" if applicable, otherwise "0"	Major Depressive, Bipolar, and Paranoid Disorders
71	HCC070	Char(1)	1	114	Set to "1" if applicable, otherwise "0"	Quadriplegia
72	HCC071	Char(1)	1	115	Set to "1" if applicable, otherwise "0"	Paraplegia
73	HCC072	Char(1)	1	116	Set to "1" if applicable, otherwise "0"	Spinal Cord Disorders/Injuries
74	HCC073	Char(1)	1	117	Set to "1" if applicable, otherwise "0"	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
75	HCC074	Char(1)	1	118	Set to "1" if applicable, otherwise "0"	Cerebral Palsy
76	HCC075	Char(1)	1	119	Set to "1" if applicable, otherwise "0"	Polyneuropathy
77	HCC076	Char(1)	1	120	Set to "1" if applicable, otherwise "0"	Muscular Dystrophy
78	HCC077	Char(1)	1	121	Set to "1" if applicable, otherwise "0"	Multiple Sclerosis
79	HCC078	Char(1)	1	122	Set to "1" if applicable, otherwise "0"	Parkinsons and Huntingtons Diseases
80	HCC079	Char(1)	1	123	Set to "1" if applicable, otherwise "0"	Seizure Disorders and Convulsions

Item	Field	Format	Size	Position	Comment	Description
81	HCC080	Char(1)	1	124	Set to "1" if applicable, otherwise "0"	Coma, Brain Compression/Anoxic Damage
82	HCC082	Char(1)	1	125	Set to "1" if applicable, otherwise "0"	Respirator Dependence/Tracheostomy Status
83	HCC083	Char(1)	1	126	Set to "1" if applicable, otherwise "0"	Respiratory Arrest
84	HCC084	Char(1)	1	127	Set to "1" if applicable, otherwise "0"	Cardio-Respiratory Failure and Shock
85	HCC085	Char(1)	1	128	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure
86	HCC086	Char(1)	1	129	Set to "1" if applicable, otherwise "0"	Acute Myocardial Infarction
87	HCC087	Char(1)	1	130	Set to "1" if applicable, otherwise "0"	Unstable Angina and Other Acute Ischemic Heart Disease
88	HCC088	Char(1)	1	131	Set to "1" if applicable, otherwise "0"	Angina Pectoris
89	HCC096	Char(1)	1	132	Set to "1" if applicable, otherwise "0"	Specified Heart Arrhythmias
90	HCC099	Char(1)	1	133	Set to "1" if applicable, otherwise "0"	Cerebral Hemorrhage
91	HCC100	Char(1)	1	134	Set to "1" if applicable, otherwise "0"	Ischemic or Unspecified Stroke
92	HCC103	Char(1)	1	135	Set to "1" if applicable, otherwise "0"	Hemiplegia/Hemiparesis
93	HCC104	Char(1)	1	136	Set to "1" if applicable, otherwise "0"	Monoplegia, Other Paralytic Syndromes
94	HCC106	Char(1)	1	137	Set to "1" if applicable, otherwise "0"	Atherosclerosis of the Extremities with Ulceration or Gangrene
95	HCC107	Char(1)	1	138	Set to "1" if applicable, otherwise "0"	Vascular Disease with Complications
96	HCC108	Char(1)	1	139	Set to "1" if applicable, otherwise "0"	Vascular Disease
97	HCC110	Char(1)	1	140	Set to "1" if applicable, otherwise "0"	Cystic Fibrosis
98	HCC111	Char(1)	1	141	Set to "1" if applicable, otherwise "0"	Chronic Obstructive Pulmonary Disease

Item	Field	Format	Size	Position	Comment	Description
99	HCC112	Char(1)	1	142	Set to "1" if applicable, otherwise "0"	Fibrosis of Lung and Other Chronic Lung Disorders
100	HCC114	Char(1)	1	143	Set to "1" if applicable, otherwise "0"	Aspiration and Specified Bacterial Pneumonias
101	HCC115	Char(1)	1	144	Set to "1" if applicable, otherwise "0"	Pneumococcal Pneumonia, Emphysema, Lung Abscess
102	HCC122	Char(1)	1	145	Set to "1" if applicable, otherwise "0"	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
103	HCC124	Char(1)	1	146	Set to "1" if applicable, otherwise "0"	Exudative Macular Degeneration
104	HCC134	Char(1)	1	147	Set to "1" if applicable, otherwise "0"	Dialysis Status
105	HCC135	Char(1)	1	148	Set to "1" if applicable, otherwise "0"	Acute Renal Failure
106	HCC136	Char(1)	1	149	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Stage 5
107	HCC137	Char(1)	1	150	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Severe (Stage 4)
108	HCC138	Char(1)	1	151	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Moderate (Stage 3)
109	HCC139	Char(1)	1	152	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)
110	HCC140	Char(1)	1	153	Set to "1" if applicable, otherwise "0"	Unspecified Renal Failure
111	HCC141	Char(1)	1	154	Set to "1" if applicable, otherwise "0"	Nephritis
112	HCC157	Char(1)	1	155	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
113	HCC158	Char(1)	1	156	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Full Thickness Skin Loss
114	HCC159	Char(1)	1	157	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Partial Thickness Skin Loss
115	HCC160	Char(1)	1	158	Set to "1" if applicable, otherwise "0"	Pressure Pre-Ulcer Skin Changes or Unspecified Stage
116	HCC161	Char(1)	1	159	Set to "1" if applicable, otherwise "0"	Chronic Ulcer of Skin, Except Pressure

Item	Field	Format	Size	Position	Comment	Description
117	HCC162	Char(1)	1	160	Set to "1" if applicable, otherwise "0"	Severe Skin Burn or Condition
118	HCC166	Char(1)	1	161	Set to "1" if applicable, otherwise "0"	Severe Head Injury
119	HCC167	Char(1)	1	162	Set to "1" if applicable, otherwise "0"	Major Head Injury
120	HCC169	Char(1)	1	163	Set to "1" if applicable, otherwise "0"	Vertebral Fractures without Spinal Cord Injury
121	HCC170	Char(1)	1	164	Set to "1" if applicable, otherwise "0"	Hip Fracture/Dislocation
122	HCC173	Char(1)	1	165	Set to "1" if applicable, otherwise "0"	Traumatic Amputations and Complications
123	HCC176	Char(1)	1	166	Set to "1" if applicable, otherwise "0"	Complications of Specified Implanted Device or Graft
124	HCC186	Char(1)	1	167	Set to "1" if applicable, otherwise "0"	Major Organ Transplant or Replacement Status
125	HCC188	Char(1)	1	168	Set to "1" if applicable, otherwise "0"	Artificial Openings for Feeding or Elimination
126	HCC189	Char(1)	1	169	Set to "1" if applicable, otherwise "0"	Amputation Status, Lower Limb/Amputation Complications
127	Disabled Disease HCC006	Char(1)	1	170	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 006 Opportunistic Infections
128	Disabled Disease HCC034	Char(1)	1	171	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 034 Chronic Pancreatitis
129	Disabled Disease HCC046	Char(1)	1	172	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 046 Severe Hematological Disorders
130	Disabled Disease HCC054	Char(1)	1	173	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 054 Drug/Alcohol Psychosis
131	Disabled Disease HCC055	Char(1)	1	174	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 055 Drug/Alcohol Dependence
132	Disabled Disease HCC110	Char(1)	1	175	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 110 Cystic Fibrosis
133	Disabled Disease HCC176	Char(1)	1	176	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 176 Complications of Specified Implanted Device or Graft

Item	Field	Format	Size	Position	Comment	Description
134	CANCER_ IMMUNE	Char(1)	1	177	Set to "1" if applicable, otherwise "0"	CANCER_IMMUNE
135	CHF_COPD	Char(1)	1	178	Set to "1" if applicable, otherwise "0"	CHF_COPD
136	CHF_RENAL	Char(1)	1	179	Set to "1" if applicable, otherwise "0"	CHF_RENAL
137	COPD_CARD _RESP_FAIL	Char(1)	1	180	Set to "1" if applicable, otherwise "0"	COPD_CARD_RESP_FAIL
138	DIABETES_ CHF	Char(1)	1	181	Set to "1" if applicable, otherwise "0"	DIABETES_CHF
139	SEPSIS_ CARD_RESP_ FAIL	Char(1)	1	182	Set to "1" if applicable, otherwise "0"	SEPSIS_CARD_RESP_FAI L
140	Medicaid	Char(1)	1	183	Set to "1" if applicable, otherwise "0"	Beneficiary is entitled to Medicaid.
141	Originally Disabled	Char(1)	1	184	Set to "1" if applicable, otherwise "0"	Beneficiary original Medicare entitlement was due to disability.
142	Disabled Disease HCC039	Char(1)	1	185	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 039 Bone/Joint/Muscle Infections/Necrosis
143	Disabled Disease HCC077	Char(1)	1	186	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 077 Multiple Sclerosis
144	Disabled Disease HCC085	Char(1)	1	187	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 085 Congestive Heart Failure
145	Disabled Disease HCC161	Char(1)	1	188	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS V21 HCC 161 Chronic Ulcer of Skin, Except Pressure
146	ART_ OPENINGS_ PRESSURE_ ULCER	Char(1)	1	189	Set to "1" if applicable	ART_OPENINGS_PRESSU RE_ ULCER
147	ASP_SPEC_ BACT_ PNEUM_ PRES_ULC	Char(1)	1	190	Set to "1" if applicable	ASP_SPEC_BACT_PNEU M_ PRES_ULC
148	COPD_ASP_ SPEC_BACT_ PNEUM	Char(1)	1	191	Set to "1" if applicable	COPD_ASP_SPEC_BACT_ PNEUM
149	DISABLED_ PRESSURE_ ULCER	Char(1)	1	192	Set to "1" if applicable	DISABLED_PRESSURE_U LCER

Item	Field	Format	Size	Position	Comment	Description
150	SCHIZO-PHRENIA_CHF	Char(1)	1	193	Set to "1" if applicable	SCHIZO-PHRENIA_CHF
151	SCHIZO-PHRENIA_COPD	Char(1)	1	194	Set to "1" if applicable	SCHIZO-PHRENIA_COPD
152	SCHIZO-PHRENIA_SEIZURES	Char(1)	1	195	Set to "1" if applicable	SCHIZO-PHRENIA_SEIZURES
153	SEPSIS_ARTIF_OPENINGS	Char(1)	1	196	Set to "1" if applicable	SEPSIS_ARTIF_OPENINGS
154	SEPSIS_ASP_SPEC_BACT_PNEUM	Char(1)	1	197	Set to "1" if applicable	SEPSIS_ASP_SPEC_BACT_PNEUM
155	SEPSIS_PRESSURE_ULCER	Char(1)	1	198	Set to "1" if applicable	SEPSIS_PRESSURE_ULCER
156	Filler	Char(2)	2	199-200	Spaces	Filler

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

F.14.3 Detail Record Type C and F (PY2014 through PY2016)

Item	Field	Format	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "C" or "F"	"C" = Details for new V22 PTC MOR (RAPS and FFS) - non-PACE and non-ESRD "F" = Details for new V22 PTC MOR (Encounter Data and FFS) - non-PACE and non-ESRD
2	Health Insurance Claim Account Number	Char(12)	12	2-13	Also known as HICAN	This is the Health Insurance Claim Account Number (known as HICAN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICAN consist of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD) uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.
3	Beneficiary Last Name	Char(12)	12	14-25	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	7	26-32	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	1	33	1-byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	8	34-41	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	1	42	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary. Examples include Male and Female.
8	Social Security Number	Char(9)	9	43-51	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration.
Beneficiary Demographic Indicators:						
9	Age Group Female0_34	Char(1)	1	52	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 0 and 34, inclusive.

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

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

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

Item	Field	Format	Size	Position	Comment	Description
46	HCC012	Char(1)	1	89	Set to "1" if applicable, otherwise "0"	Breast, Prostate, and Other Cancers and Tumors
47	HCC017	Char(1)	1	90	Set to "1" if applicable, otherwise "0"	Diabetes with Acute Complications
48	HCC018	Char(1)	1	91	Set to "1" if applicable, otherwise "0"	Diabetes with Chronic Complications
49	HCC019	Char(1)	1	92	Set to "1" if applicable, otherwise "0"	Diabetes without Complication
50	HCC021	Char(1)	1	93	Set to "1" if applicable, otherwise "0"	Protein-Calorie Malnutrition
51	HCC022	Char(1)	1	94	Set to "1" if applicable, otherwise "0"	Morbid Obesity
52	HCC023	Char(1)	1	95	Set to "1" if applicable, otherwise "0"	Other Significant Endocrine and Metabolic Disorders
53	HCC027	Char(1)	1	96	Set to "1" if applicable, otherwise "0"	End-Stage Liver Disease
54	HCC028	Char(1)	1	97	Set to "1" if applicable, otherwise "0"	Cirrhosis of Liver
55	HCC029	Char(1)	1	98	Set to "1" if applicable, otherwise "0"	Chronic Hepatitis
56	HCC033	Char(1)	1	99	Set to "1" if applicable, otherwise "0"	Intestinal Obstruction/Perforation
57	HCC034	Char(1)	1	100	Set to "1" if applicable, otherwise "0"	Chronic Pancreatitis
58	HCC035	Char(1)	1	101	Set to "1" if applicable, otherwise "0"	Inflammatory Bowel Disease
59	HCC039	Char(1)	1	102	Set to "1" if applicable, otherwise "0"	Bone/Joint/Muscle Infections/Necrosis
60	HCC040	Char(1)	1	103	Set to "1" if applicable, otherwise "0"	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
61	HCC046	Char(1)	1	104	Set to "1" if applicable, otherwise "0"	Severe Hematological Disorders
62	HCC047	Char(1)	1	105	Set to "1" if applicable, otherwise "0"	Disorders of Immunity
63	HCC048	Char(1)	1	106	Set to "1" if applicable, otherwise "0"	Coagulation Defects and Other Specified Hematological Disorders

Item	Field	Format	Size	Position	Comment	Description
64	HCC054	Char(1)	1	107	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Psychosis
65	HCC055	Char(1)	1	108	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Dependence
66	HCC057	Char(1)	1	109	Set to "1" if applicable, otherwise "0"	Schizophrenia
67	HCC058	Char(1)	1	110	Set to "1" if applicable, otherwise "0"	Major Depressive, Bipolar, and Paranoid Disorders
68	HCC070	Char(1)	1	111	Set to "1" if applicable, otherwise "0"	Quadriplegia
69	HCC071	Char(1)	1	112	Set to "1" if applicable, otherwise "0"	Paraplegia
70	HCC072	Char(1)	1	113	Set to "1" if applicable, otherwise "0"	Spinal Cord Disorders/Injuries
71	HCC073	Char(1)	1	114	Set to "1" if applicable, otherwise "0"	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
72	HCC074	Char(1)	1	115	Set to "1" if applicable, otherwise "0"	Cerebral Palsy
73	HCC075	Char(1)	1	116	Set to "1" if applicable, otherwise "0"	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
74	HCC076	Char(1)	1	117	Set to "1" if applicable, otherwise "0"	Muscular Dystrophy
75	HCC077	Char(1)	1	118	Set to "1" if applicable, otherwise "0"	Multiple Sclerosis
76	HCC078	Char(1)	1	119	Set to "1" if applicable, otherwise "0"	Parkinsons and Huntingtons Diseases
77	HCC079	Char(1)	1	120	Set to "1" if applicable, otherwise "0"	Seizure Disorders and Convulsions
78	HCC080	Char(1)	1	121	Set to "1" if applicable, otherwise "0"	Coma, Brain Compression/Anoxic Damage
79	HCC082	Char(1)	1	122	Set to "1" if applicable, otherwise "0"	Respirator Dependence/Tracheostomy Status
80	HCC083	Char(1)	1	123	Set to "1" if applicable, otherwise "0"	Respiratory Arrest

Item	Field	Format	Size	Position	Comment	Description
81	HCC084	Char(1)	1	124	Set to "1" if applicable, otherwise "0"	Cardio-Respiratory Failure and Shock
82	HCC085	Char(1)	1	125	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure
83	HCC086	Char(1)	1	126	Set to "1" if applicable, otherwise "0"	Acute Myocardial Infarction
84	HCC087	Char(1)	1	127	Set to "1" if applicable, otherwise "0"	Unstable Angina and Other Acute Ischemic Heart Disease
85	HCC088	Char(1)	1	128	Set to "1" if applicable, otherwise "0"	Angina Pectoris
86	HCC096	Char(1)	1	129	Set to "1" if applicable, otherwise "0"	Specified Heart Arrhythmias
87	HCC099	Char(1)	1	130	Set to "1" if applicable, otherwise "0"	Cerebral Hemorrhage
88	HCC100	Char(1)	1	131	Set to "1" if applicable, otherwise "0"	Ischemic or Unspecified Stroke
89	HCC103	Char(1)	1	132	Set to "1" if applicable, otherwise "0"	Hemiplegia/Hemiparesis
90	HCC104	Char(1)	1	133	Set to "1" if applicable, otherwise "0"	Monoplegia, Other Paralytic Syndromes
91	HCC106	Char(1)	1	134	Set to "1" if applicable, otherwise "0"	Atherosclerosis of the Extremities with Ulceration or Gangrene
92	HCC107	Char(1)	1	135	Set to "1" if applicable, otherwise "0"	Vascular Disease with Complications
93	HCC108	Char(1)	1	136	Set to "1" if applicable, otherwise "0"	Vascular Disease
94	HCC110	Char(1)	1	137	Set to "1" if applicable, otherwise "0"	Cystic Fibrosis
95	HCC111	Char(1)	1	138	Set to "1" if applicable, otherwise "0"	Chronic Obstructive Pulmonary Disease
96	HCC112	Char(1)	1	139	Set to "1" if applicable, otherwise "0"	Fibrosis of Lung and Other Chronic Lung Disorders
97	HCC114	Char(1)	1	140	Set to "1" if applicable, otherwise "0"	Aspiration and Specified Bacterial Pneumonias
98	HCC115	Char(1)	1	141	Set to "1" if applicable, otherwise "0"	Pneumococcal Pneumonia, Emphysema, Lung Abscess

Item	Field	Format	Size	Position	Comment	Description
99	HCC122	Char(1)	1	142	Set to "1" if applicable, otherwise "0"	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
100	HCC124	Char(1)	1	143	Set to "1" if applicable, otherwise "0"	Exudative Macular Degeneration
101	HCC134	Char(1)	1	144	Set to "1" if applicable, otherwise "0"	Dialysis Status
102	HCC135	Char(1)	1	145	Set to "1" if applicable, otherwise "0"	Acute Renal Failure
103	HCC136	Char(1)	1	146	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Stage 5
104	HCC137	Char(1)	1	147	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Severe (Stage 4)
105	HCC157	Char(1)	1	148	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
106	HCC158	Char(1)	1	149	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Full Thickness Skin Loss
107	HCC161	Char(1)	1	150	Set to "1" if applicable, otherwise "0"	Chronic Ulcer of Skin, Except Pressure
108	HCC162	Char(1)	1	151	Set to "1" if applicable, otherwise "0"	Severe Skin Burn or Condition
109	HCC166	Char(1)	1	152	Set to "1" if applicable, otherwise "0"	Severe Head Injury
110	HCC167	Char(1)	1	153	Set to "1" if applicable, otherwise "0"	Major Head Injury
111	HCC169	Char(1)	1	154	Set to "1" if applicable, otherwise "0"	Vertebral Fractures without Spinal Cord Injury
112	HCC170	Char(1)	1	155	Set to "1" if applicable, otherwise "0"	Hip Fracture/Dislocation
113	HCC173	Char(1)	1	156	Set to "1" if applicable, otherwise "0"	Traumatic Amputations and Complications
114	HCC176	Char(1)	1	157	Set to "1" if applicable, otherwise "0"	Complications of Specified Implanted Device or Graft
115	HCC186	Char(1)	1	158	Set to "1" if applicable, otherwise "0"	Major Organ Transplant or Replacement Status
116	HCC188	Char(1)	1	159	Set to "1" if applicable, otherwise "0"	Artificial Openings for Feeding or Elimination

Item	Field	Format	Size	Position	Comment	Description
117	HCC189	Char(1)	1	160	Set to "1" if applicable, otherwise "0"	Amputation Status, Lower Limb/Amputation Complications
Disabled HCCs						
118	Disabled Disease HCC006	Char(1)	1	161	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 006 Opportunistic Infections
119	Disabled Disease HCC034	Char(1)	1	162	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 034 Chronic Pancreatitis
120	Disabled Disease HCC046	Char(1)	1	163	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 046 Severe Hematological Disorders
121	Disabled Disease HCC054	Char(1)	1	164	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 054 Drug/Alcohol Psychosis
122	Disabled Disease HCC055	Char(1)	1	165	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 055 Drug/Alcohol Dependence
123	Disabled Disease HCC110	Char(1)	1	166	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 110 Cystic Fibrosis
124	Disabled Disease HCC176	Char(1)	1	167	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 176 Complications of Specified Implanted Device or Graft
Disease Interactions:						
125	CANCER_ IMMUNE	Char(1)	1	168	Set to "1" if applicable, otherwise "0"	CANCER_IMMUNE
126	CHF_COPD	Char(1)	1	169	Set to "1" if applicable, otherwise "0"	CHF_COPD
127	CHF_RENAL	Char(1)	1	170	Set to "1" if applicable, otherwise "0"	CHF_RENAL
128	COPD_CARD _RESP_FAIL	Char(1)	1	171	Set to "1" if applicable, otherwise "0"	COPD_CARD_RESP_ FAIL
129	DIABETES_ CHF	Char(1)	1	172	Set to "1" if applicable, otherwise "0"	DIABETES_CHF
130	SEPSIS_CARD _RESP_FAIL	Char(1)	1	173	Set to "1" if applicable, otherwise "0"	SEPSIS_CARD_ RESP_FAIL
Additional Institutional Coefficients						
131	Medicaid	Char(1)	1	174	Set to "1" if applicable, otherwise "0"	Beneficiary is entitled to Medicaid.
132	Originally Disabled	Char(1)	1	175	Set to "1" if applicable, otherwise "0"	Beneficiary original Medicare entitlement was due to disability.

Item	Field	Format	Size	Position	Comment	Description
Disabled HCCs						
133	Disabled Disease HCC039	Char(1)	1	176	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 039 Bone/Joint/Muscle Infections/Necrosis
134	Disabled Disease HCC077	Char(1)	1	177	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 077 Multiple Sclerosis
135	Disabled Disease HCC085	Char(1)	1	178	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 085 Congestive Heart Failure
136	Disabled Disease HCC161	Char(1)	1	179	Set to "1" if applicable, otherwise "0"	Disabled (Age<65) and CMS Ver 021 HCC 161 Chronic Ulcer of Skin, Except Pressure
137	DISABLED_PRESSURE_ULCER	Char(1)	1	180	Set to "1" if applicable, otherwise "0"	DISABLED_PRESSURE_ULCER
Disease Interactions						
138	ART_OPENINGS_PRESSURE_ULCER	Char(1)	1	181	Set to "1" if applicable	ART_OPENINGS_PRESSURE_ULCER
139	ASP_SPEC_BACT_PNEUM_PRES_ULC	Char(1)	1	182	Set to "1" if applicable	ASP_SPEC_BACT_PNEUM_PRES_ULC
140	COPD_ASP_SPEC_BACT_PNEUM	Char(1)	1	183	Set to "1" if applicable	COPD_ASP_SPEC_BACT_PNEUM
141	SCHIZO-PHRENIA_CHF	Char(1)	1	184	Set to "1" if applicable	SCHIZO-PHRENIA_CHF
142	SCHIZO-PHRENIA_COPD	Char(1)	1	185	Set to "1" if applicable	SCHIZO-PHRENIA_COPD
143	SCHIZO-PHRENIA_SEIZURES	Char(1)	1	186	Set to "1" if applicable	SCHIZO-PHRENIA_SEIZURES
144	SEPSIS_ARTIF_OPENINGS	Char(1)	1	187	Set to "1" if applicable	SEPSIS_ARTIF_OPENINGS
145	SEPSIS_ASP_SPEC_BACT_PNEUM	Char(1)	1	188	Set to "1" if applicable	SEPSIS_ASP_SPEC_BACT_PNEUM
146	SEPSIS_PRESSURE_ULCER	Char(1)	1	189	Set to "1" if applicable	SEPSIS_PRESSURE_ULCER
147	Filler	Char(11)	11	190-200	Spaces	Filler

Total Length = 200.
NOTE: Fields 131-146 are associated with the CMS HCC V22 Institutional Score only.

F.14.4 Detail Record Type D (PY2017 and PY2018)

Item	Field	Format	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "D"	MOR .D = Details for new 2017 PTC model MOR - non-PACE and non-ESRD Beneficiaries
2	Health Insurance Claim Account Number	Char(12)	12	2-13	Also known as HICAN	This is the Health Insurance Claim Number (known as HICN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICN, consisting of Beneficiary Claim Number along with the Beneficiary Identification Code uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.
3	Beneficiary Last Name	Char(12)	12	14-25	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	7	26-32	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	1	33	1-byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	8	34-41	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	1	42	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary. Examples include Male and Female.
8	Social Security Number	Char(9)	9	43-51	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration.
Beneficiary Demographic Indicators:						
9	Age Group Female0_34	Char(1)	1	52	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 0 and 34, inclusive.
10	Age Group Female35_44	Char(1)	1	53	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 35 and 44, inclusive.

Item	Field	Format	Size	Position	Comment	Description
11	Age Group Female45_54	Char(1)	1	54	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 45 and 54, inclusive.
12	Age Group Female55_59	Char(1)	1	55	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 55 and 59, inclusive.
13	Age Group Female60_64	Char(1)	1	56	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 60 and 64, inclusive.
14	Age Group Female65_69	Char(1)	1	57	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 65 and 69, inclusive.
15	Age Group Female70_74	Char(1)	1	58	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 70 and 74, inclusive.
16	Age Group Female75_79	Char(1)	1	59	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages 75 and 79, inclusive.
17	Age Group Female80_84	Char(1)	1	60	Set to “1” if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 and 84, inclusive.
18	Age Group Female85_89	Char(1)	1	61	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 and 89, inclusive.
19	Age Group Female90_94	Char(1)	1	62	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 and 94, inclusive.
20	Age Group Female95_GT	Char(1)	1	63	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female, age 95 or greater.
21	Age Group Male0_34	Char(1)	1	64	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 and 34, inclusive.

Item	Field	Format	Size	Position	Comment	Description
22	Age Group Male35_44	Char(1)	1	65	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 and 44, inclusive.
23	Age Group Male45_54	Char(1)	1	66	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 and 54, inclusive.
24	Age Group Male55_59	Char(1)	1	67	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 and 59, inclusive.
25	Age Group Male60_64	Char(1)	1	68	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 and 64, inclusive.
26	Age Group Male65_69	Char(1)	1	69	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 and 69, inclusive.
27	Age Group Male70_74	Char(1)	1	70	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 and 74, inclusive.
28	Age Group Male75_79	Char(1)	1	71	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 and 79, inclusive.
29	Age Group Male80_84	Char(1)	1	72	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 and 84, inclusive.
30	Age Group Male85_89	Char(1)	1	73	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 and 89, inclusive.
31	Age Group Male90_94	Char(1)	1	74	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 and 94, inclusive.
32	Age Group Male95_GT	Char(1)	1	75	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male, age 95 or greater.

Item	Field	Format	Size	Position	Comment	Description
33	Originally Disabled Female	Char(1)	1	76	Set to "1" if applicable, otherwise "0"	Beneficiary is a female and original Medicare entitlement is due to disability.
34	Originally Disabled Male	Char(1)	1	77	Set to "1" if applicable, otherwise "0"	Beneficiary is a male and original Medicare entitlement is due to disability.
HCC Indicators:						
35	HCC001	Char(1)	1	78	Set to "1" if applicable, otherwise "0"	HIV/AIDS
36	HCC002	Char(1)	1	79	Set to "1" if applicable, otherwise "0"	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
37	HCC006	Char(1)	1	80	Set to "1" if applicable, otherwise "0"	Opportunistic Infections
38	HCC008	Char(1)	1	81	Set to "1" if applicable, otherwise "0"	Metastatic Cancer and Acute Leukemia
39	HCC009	Char(1)	1	82	Set to "1" if applicable, otherwise "0"	Lung and Other Severe Cancers
40	HCC010	Char(1)	1	83	Set to "1" if applicable, otherwise "0"	Lymphoma and Other Cancers
41	HCC011	Char(1)	1	84	Set to "1" if applicable, otherwise "0"	Colorectal, Bladder, and Other Cancers
42	HCC012	Char(1)	1	85	Set to "1" if applicable, otherwise "0"	Breast, Prostate, and Other Cancers and Tumors
43	HCC017	Char(1)	1	86	Set to "1" if applicable, otherwise "0"	Diabetes with Acute Complications
44	HCC018	Char(1)	1	87	Set to "1" if applicable, otherwise "0"	Diabetes with Chronic Complications
45	HCC019	Char(1)	1	88	Set to "1" if applicable, otherwise "0"	Diabetes without Complication
46	HCC021	Char(1)	1	89	Set to "1" if applicable, otherwise "0"	Protein-Calorie Malnutrition
47	HCC022	Char(1)	1	90	Set to "1" if applicable, otherwise "0"	Morbid Obesity
48	HCC023	Char(1)	1	91	Set to "1" if applicable, otherwise "0"	Other Significant Endocrine and Metabolic Disorders

Item	Field	Format	Size	Position	Comment	Description
49	HCC027	Char(1)	1	92	Set to "1" if applicable, otherwise "0"	End-Stage Liver Disease
50	HCC028	Char(1)	1	93	Set to "1" if applicable, otherwise "0"	Cirrhosis of Liver
51	HCC029	Char(1)	1	94	Set to "1" if applicable, otherwise "0"	Chronic Hepatitis
52	HCC033	Char(1)	1	95	Set to "1" if applicable, otherwise "0"	Intestinal Obstruction/Perforation
53	HCC034	Char(1)	1	96	Set to "1" if applicable, otherwise "0"	Chronic Pancreatitis
54	HCC035	Char(1)	1	97	Set to "1" if applicable, otherwise "0"	Inflammatory Bowel Disease
55	HCC039	Char(1)	1	98	Set to "1" if applicable, otherwise "0"	Bone/Joint/Muscle Infections/Necrosis
56	HCC040	Char(1)	1	99	Set to "1" if applicable, otherwise "0"	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
57	HCC046	Char(1)	1	100	Set to "1" if applicable, otherwise "0"	Severe Hematological Disorders
58	HCC047	Char(1)	1	101	Set to "1" if applicable, otherwise "0"	Disorders of Immunity
59	HCC048	Char(1)	1	102	Set to "1" if applicable, otherwise "0"	Coagulation Defects and Other Specified Hematological Disorders
60	HCC054	Char(1)	1	103	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Psychosis
61	HCC055	Char(1)	1	104	Set to "1" if applicable, otherwise "0"	Drug/Alcohol Dependence
62	HCC057	Char(1)	1	105	Set to "1" if applicable, otherwise "0"	Schizophrenia
63	HCC058	Char(1)	1	106	Set to "1" if applicable, otherwise "0"	Major Depressive, Bipolar, and Paranoid Disorders
64	HCC070	Char(1)	1	107	Set to "1" if applicable, otherwise "0"	Quadriplegia
65	HCC071	Char(1)	1	108	Set to "1" if applicable, otherwise "0"	Paraplegia
66	HCC072	Char(1)	1	109	Set to "1" if applicable, otherwise "0"	Spinal Cord Disorders/Injuries

Item	Field	Format	Size	Position	Comment	Description
67	HCC073	Char(1)	1	110	Set to "1" if applicable, otherwise "0"	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
68	HCC074	Char(1)	1	111	Set to "1" if applicable, otherwise "0"	Cerebral Palsy
69	HCC075	Char(1)	1	112	Set to "1" if applicable, otherwise "0"	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
70	HCC076	Char(1)	1	113	Set to "1" if applicable, otherwise "0"	Muscular Dystrophy
71	HCC077	Char(1)	1	114	Set to "1" if applicable, otherwise "0"	Multiple Sclerosis
72	HCC078	Char(1)	1	115	Set to "1" if applicable, otherwise "0"	Parkinsons and Huntingtons Diseases
73	HCC079	Char(1)	1	116	Set to "1" if applicable, otherwise "0"	Seizure Disorders and Convulsions
74	HCC080	Char(1)	1	117	Set to "1" if applicable, otherwise "0"	Coma, Brain Compression/Anoxic Damage
75	HCC082	Char(1)	1	118	Set to "1" if applicable, otherwise "0"	Respirator Dependence/Tracheostomy Status
76	HCC083	Char(1)	1	119	Set to "1" if applicable, otherwise "0"	Respiratory Arrest
77	HCC084	Char(1)	1	120	Set to "1" if applicable, otherwise "0"	Cardio-Respiratory Failure and Shock
78	HCC085	Char(1)	1	121	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure
79	HCC086	Char(1)	1	122	Set to "1" if applicable, otherwise "0"	Acute Myocardial Infarction
80	HCC087	Char(1)	1	123	Set to "1" if applicable, otherwise "0"	Unstable Angina and Other Acute Ischemic Heart Disease
81	HCC088	Char(1)	1	124	Set to "1" if applicable, otherwise "0"	Angina Pectoris
82	HCC096	Char(1)	1	125	Set to "1" if applicable, otherwise "0"	Specified Heart Arrhythmias
83	HCC099	Char(1)	1	126	Set to "1" if applicable, otherwise "0"	Cerebral Hemorrhage

Item	Field	Format	Size	Position	Comment	Description
84	HCC100	Char(1)	1	127	Set to "1" if applicable, otherwise "0"	Ischemic or Unspecified Stroke
85	HCC103	Char(1)	1	128	Set to "1" if applicable, otherwise "0"	Hemiplegia/Hemiparesis
86	HCC104	Char(1)	1	129	Set to "1" if applicable, otherwise "0"	Monoplegia, Other Paralytic Syndromes
87	HCC106	Char(1)	1	130	Set to "1" if applicable, otherwise "0"	Atherosclerosis of the Extremities with Ulceration or Gangrene
88	HCC107	Char(1)	1	131	Set to "1" if applicable, otherwise "0"	Vascular Disease with Complications
89	HCC108	Char(1)	1	132	Set to "1" if applicable, otherwise "0"	Vascular Disease
90	HCC110	Char(1)	1	133	Set to "1" if applicable, otherwise "0"	Cystic Fibrosis
91	HCC111	Char(1)	1	134	Set to "1" if applicable, otherwise "0"	Chronic Obstructive Pulmonary Disease
92	HCC112	Char(1)	1	135	Set to "1" if applicable, otherwise "0"	Fibrosis of Lung and Other Chronic Lung Disorders
93	HCC114	Char(1)	1	136	Set to "1" if applicable, otherwise "0"	Aspiration and Specified Bacterial Pneumonias
94	HCC115	Char(1)	1	137	Set to "1" if applicable, otherwise "0"	Pneumococcal Pneumonia, Emphysema, Lung Abscess
95	HCC122	Char(1)	1	138	Set to "1" if applicable, otherwise "0"	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
96	HCC124	Char(1)	1	139	Set to "1" if applicable, otherwise "0"	Exudative Macular Degeneration
97	HCC134	Char(1)	1	140	Set to "1" if applicable, otherwise "0"	Dialysis Status
98	HCC135	Char(1)	1	141	Set to "1" if applicable, otherwise "0"	Acute Renal Failure
99	HCC136	Char(1)	1	142	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Stage 5
100	HCC137	Char(1)	1	143	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease, Severe, Stage 4
101	HCC157	Char(1)	1	144	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone

Item	Field	Format	Size	Position	Comment	Description
102	HCC158	Char(1)	1	145	Set to "1" if applicable, otherwise "0"	Pressure Ulcer of Skin with Full Thickness Skin Loss
103	HCC161	Char(1)	1	146	Set to "1" if applicable, otherwise "0"	Chronic Ulcer of Skin, Except Pressure
104	HCC162	Char(1)	1	147	Set to "1" if applicable, otherwise "0"	Severe Skin Burn or Condition
105	HCC166	Char(1)	1	148	Set to "1" if applicable, otherwise "0"	Severe Head Injury
106	HCC167	Char(1)	1	149	Set to "1" if applicable, otherwise "0"	Major Head Injury
107	HCC169	Char(1)	1	150	Set to "1" if applicable, otherwise "0"	Vertebral Fractures without Spinal Cord Injury
108	HCC170	Char(1)	1	151	Set to "1" if applicable, otherwise "0"	Hip Fracture/Dislocation
109	HCC173	Char(1)	1	152	Set to "1" if applicable, otherwise "0"	Traumatic Amputations and Complications
110	HCC176	Char(1)	1	153	Set to "1" if applicable, otherwise "0"	Complications of Specified Implanted Device or Graft
111	HCC186	Char(1)	1	154	Set to "1" if applicable, otherwise "0"	Major Organ Transplant or Replacement Status
112	HCC188	Char(1)	1	155	Set to "1" if applicable, otherwise "0"	Artificial Openings for Feeding or Elimination
113	HCC189	Char(1)	1	156	Set to "1" if applicable, otherwise "0"	Amputation Status, Lower Limb/Amputation Complications
Disabled HCCs						
114	Disabled Disease HCC6	Char(1)	1	157	Set to "1" if applicable, otherwise "0"	Disabled, Opportunistic Infections
115	FILLER	Char(1)	1	158	Space	Not used
116	FILLER	Char(1)	1	159	Space	Not used
117	FILLER	Char(1)	1	160	Space	Not used
Disease Interactions						
118	Disease Interactions HCC47_gCancer	Char(1)	1	161	Set to "1" if applicable, otherwise "0"	Immune Disorders and Cancer Group
119	Disease Interactions HCC85_gDiabetesM ellit	Char(1)	1	162	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure and Diabetes Group

Item	Field	Format	Size	Position	Comment	Description
120	Disease Interactions HCC85_gCopdCF	Char(1)	1	163	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure and Chronic Obstructive Pulmonary Disease Group
121	Disease Interactions HCC85_gRenal	Char(1)	1	164	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure and Renal Group
122	Disease Interactions HCC85_HCC96	Char(1)	1	165	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure*Specified Heart Arrhythmias
123	Disease Interactions gRespDepandArre_g CopdCF	Char(1)	1	166	Set to "1" if applicable, otherwise "0"	Cardiorespiratory Failure Group and Chronic Obstructive Pulmonary Disease Group
124	Disease Interactions gSubstanceAbuse_g Psychiatric	Char(1)	1	167	Set to "1" if applicable, otherwise "0"	Substance Abuse Group and Psychiatric Group
Additional Institutional Coefficients						
125	Medicaid	Char(1)	1	168	Set to "1" if applicable, otherwise "0"	Beneficiary is entitled to Medicaid
126	Originally Disabled	Char(1)	1	169	Set to "1" if applicable, otherwise "0"	Beneficiary original Medicare entitlement is due to disability
Disabled HCCs						
127	Disabled Disease DISABLED_HCC39	Char(1)	1	170	Set to "1" if applicable, otherwise "0"	Disabled, Bone/Joint Muscle Infections/Necrosis
128	Disabled Disease DISABLED_HCC77	Char(1)	1	171	Set to "1" if applicable, otherwise "0"	Disabled, Multiple Sclerosis
129	Disabled Disease DISABLED_HCC85	Char(1)	1	172	Set to "1" if applicable, otherwise "0"	Disabled, Congestive Heart Failure
130	Disabled Disease HCC161	Char(1)	1	173	Set to "1" if applicable, otherwise "0"	Disabled, Chronic Ulcer of the Skin, Except Pressure Ulcer
131	Disabled Disease e-DISABLED_PRESSURE_ULCER	Char(1)	1	174	Set to "1" if applicable, otherwise "0"	Disabled and Pressure Ulcer
Disease Interactions						
132	Disease Interactions ART_OPENINGS_PRESSURE_ULCER	Char(1)	1	175	Set to "1" if applicable, otherwise "0"	Artificial Openings for Feeding or Eliminating and Pressure Ulcer

Item	Field	Format	Size	Position	Comment	Description
133	Disease Interactions ASP_SPEC_BACT PNEUM_PRES_ULC	Char(1)	1	176	Set to "1" if applicable, otherwise "0"	Aspiration and Specified Bacterial Pneumonias and Pressure Ulcer
134	Disease Interactions gCopdCF_ASP_SPEC_BACT_PNEUM	Char(1)	1	177	Set to "1" if applicable, otherwise "0"	Chronic Obstructive Pulmonary Disease and Aspiration and Specified Bacterial Pneumonias
135	Disease Interactions SCHIZOPHRENIA_ CHF	Char(1)	1	178	Set to "1" if applicable, otherwise "0"	Schizophrenia and Congestive Heart Failure
136	Disease Interactions SCHIZOPHRENIA_g CopdCF	Char(1)	1	179	Set to "1" if applicable, otherwise "0"	Schizophrenia and Chronic Obstructive Pulmonary Disease
137	Disease Interactions SCHIZOPHRENIA_S EIZURES	Char(1)	1	180	Set to "1" if applicable, otherwise "0"	Schizophrenia and Seizure Disorders and Convulsions
138	Disease Interactions SEPSIS_ARTIF_OP ENINGS	Char(1)	1	181	Set to "1" if applicable, otherwise "0"	Sepsis and Artificial Openings for Feeding or Elimination
139	Disease Interactions SEPSIS_ASP_SPEC BACT_PNEUM	Char(1)	1	182	Set to "1" if applicable, otherwise "0"	Sepsis and Aspiration and Specified Bacterial Pneumonias
140	Disease Interactions SEPSIS_PRESSUR E_ULCER	Char(1)	1	183	Set to "1" if applicable, otherwise "0"	Sepsis and Pressure Ulcers
141	FILLER	Char(1)	17	184 - 200	Space	FILLER

Total Length = 200.

NOTE: Fields 125-140 are associated with the CMS HCC 2017 model Institutional Score only.

F.14.5 Trailer Record

Item	Field	Data Type	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "3"	3 = Trailer
2	Contract Number	Char(5)	5	2-6	Also known as MCO plan number	Unique identification for a Managed Care Organization (MCO) enabling the MCO to provide coverage to eligible beneficiaries
3	Total Record Count	Char(9)	9	7-15	Includes all header and trailer records	Record count in display format
4	Filler	Char(185)	185	16-200	Spaces	Filler

Total Length = 200

F.15 Risk Adjustment System (RAS) Prescription Drug Hierarchical Condition Category (RxHCC) Model Output Data File (Payment Year 2016)

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

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

The following records are included in this file:

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

F.15.1 *Header Record (PY2016)*

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

Item	Field	Data Type	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "1"	1 = Header
2	Contract Number	Char(5)	5	2-6	Also known as MCO plan number	Unique identification for a Managed Care Organization (MCO) enabling the MCO to provide coverage to eligible beneficiaries.
3	Run Date	Char(8)	8	7-14	Format as yyyymmdd	The run date when this file was created.
4	Payment Year and Month	Char(6)	6	15-20	Format as yyyymm	This identifies the risk adjustment payment year and month for the model run.
5	Filler	Char (148)	148	21-168	Spaces	Filler

Total Length = 168

F.15.2 *Detail/Beneficiary Record Types 2, 4, and 5 (PY2016)*

Each Detail/Beneficiary Record contains information for an HCC beneficiary in a Medicare Prescription Drug Contract/Plan, as of the last RAS model run for PY2016.

Item	Field	Data Type	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "2," "4," or "5"	"2" = V05 PTD MOR (RAPS and FFS) "4" = V05 PTD MOR (Encounter and FFS) "5" = V05 PTD MOR (PACE) (RAPS, FFS, and Encounter)
2	Health Insurance Claim Account Number	Char(12)	12	2-13	Also known as HICAN	This is the Health Insurance Claim Account Number (known as HICAN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICAN, consisting of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD), uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.
3	Beneficiary Last Name	Char(12)	12	14-25	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	7	26-32	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	1	33	1 byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	8	34-41	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	1	42	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary.
8	Social Security Number	Char(9)	9	43-51	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female 0-34	Char(1)	1	52	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 0 and 34.

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

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

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

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

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

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

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

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

Item	Field	Data Type	Size	Position	Comment	Description
109	Disease Coefficients RXHCC396	Char(1)	1	152	Set to "1" if applicable, otherwise "0"	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas
110	Disease Coefficients RXHCC397	Char(1)	1	153	Set to "1" if applicable, otherwise "0"	Pancreas Transplant Status
111	Originally Disabled	Char(1)	1	154	Set to "1" if applicable, otherwise "0"	The original reason for Medicare entitlement was due to disability.
112	NONAGED RXHCC1	Char(1)	1	155	Set to "1" if applicable, otherwise "0"	Non-Aged and HIV/AIDS
113	NONAGED RXHCC130	Char(1)	1	156	Set to "1" if applicable, otherwise "0"	Non-Aged and Schizophrenia
114	NONAGED RXHCC131	Char(1)	1	157	Set to "1" if applicable, otherwise "0"	Non-Aged and Bipolar Disorders
115	NONAGED RXHCC132	Char(1)	1	158	Set to "1" if applicable, otherwise "0"	Non-Aged and Major Depression
116	NONAGED RXHCC133	Char(1)	1	159	Set to "1" if applicable, otherwise "0"	Non-Aged and Specified Anxiety, Personality, and Behavior Disorders
117	NONAGED RXHCC134	Char(1)	1	160	Set to "1" if applicable, otherwise "0"	Non-Aged and Depression
118	NONAGED RXHCC135	Char(1)	1	161	Set to "1" if applicable, otherwise "0"	Non-Aged and Anxiety Disorders
119	NONAGED RXHCC160	Char(1)	1	162	Set to "1" if applicable, otherwise "0"	Non-Aged and Multiple Sclerosis
120	NONAGED RXHCC163	Char(1)	1	163	Set to "1" if applicable, otherwise "0"	Non-Aged and Multiple Sclerosis
121	FILLER	Char (5)	164	168	Spaces	Filler

Total Length = 168

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

F.15.3 *Trailer Record (PY2016)*

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

Item	Field	Data Type	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "3"	3 = Trailer
2	Contract Number	Char(5)	5	2-6	Also known as MCO plan number	Unique identification for a Managed Care Organization (MCO) enabling the MCO to provide coverage to eligible beneficiaries.
3	Total Record Count	Char(9)	9	7-15	Includes all header and trailer records	Record count in display format 9(9).
4	Filler	Char(153)	153	16-168	Spaces	Filler

Total Length = 168

F.16 Risk Adjustment System (RAS) Prescription Drug Hierarchical Condition Category (RxHCC) Model Output Data File (Payment Year 2017 and 2018)

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

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

The following records are included in this file:

- Header Record
- Detail Record
- Trailer Record

F.16.1 *Header Record (PY2017 and PY2018)*

Item	Field	Data Type	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "1"	1 = Header
2	Contract Number	Char(5)	5	2-6	Also known as MCO plan number	Unique identification for a Managed Care Organization (MCO) enabling the MCO to provide coverage to eligible beneficiaries.
3	Run Date	Char(8)	8	7-14	Format as yyyymmdd	The run date when this file was created.
4	Payment Year and Month	Char(6)	6	15-20	Format as yyyymm	This identifies the risk adjustment payment year and month for the model run.
5	Filler	Char(143)	160	21-180	Spaces	Filler

Total Length = 180

F.16.2 *Detail Record (PY2017 and PY2018)*

Item	Field	Data Type	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "2," "4," or "5"	2 = Details
2	Health Insurance Claim Number	Char(12)	12	2-13	Also known as HICN	This is the Health Insurance Claim Number (known as HICN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICN, consisting of Beneficiary Claim Number along with the Beneficiary Identification Code uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.
3	Beneficiary Last Name	Char(12)	12	14-25	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	7	26-32	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	1	33	1 byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	8	34-41	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	1	42	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary.
8	Social Security Number	Char(9)	9	43-51	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female 0-34	Char(1)	1	52	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 0 and 34.
10	Age Group Female35_44	Char(1)	1	53	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 35 and 44, inclusive.
11	Age Group Female45_54	Char(1)	1	54	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 45 and 54, inclusive.

Item	Field	Data Type	Size	Position	Comment	Description
12	Age Group Female55_59	Char(1)	1	55	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 55 and 59, inclusive.
13	Age Group Female60_64	Char(1)	1	56	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 60 and 64, inclusive.
14	Age Group Female65_69	Char(1)	1	57	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 65 and 69, inclusive.
15	Age Group Female70_74	Char(1)	1	58	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 70 and 74, inclusive.
16	Age Group Female75_79	Char(1)	1	59	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 75 and 79, inclusive.
17	Age Group Female80_84	Char(1)	1	60	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 and 84, inclusive.
18	Age Group Female85_89	Char(1)	1	61	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 and 89, inclusive.
19	Age Group Female90_94	Char(1)	1	62	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 and 94, inclusive.
20	Age Group Female95_GT	Char(1)	1	63	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Female, age 95 and greater.
21	Age Group Male0_34	Char(1)	1	64	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 and 34, inclusive.
22	Age Group Male35_44	Char(1)	1	65	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 and 44, inclusive.

Item	Field	Data Type	Size	Position	Comment	Description
23	Age Group Male45_54	Char(1)	1	66	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 and 54, inclusive.
24	Age Group Male55_59	Char(1)	1	67	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 and 59, inclusive.
25	Age Group Male60_64	Char(1)	1	68	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 and 64, inclusive.
26	Age Group Male65_69	Char(1)	1	69	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 and 69, inclusive.
27	Age Group Male70_74	Char(1)	1	70	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 and 74, inclusive.
28	Age Group Male75_79	Char(1)	1	71	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 and 79, inclusive.
29	Age Group Male80_84	Char(1)	1	72	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 and 84, inclusive.
30	Age Group Male85_89	Char(1)	1	73	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 and 89, inclusive.
31	Age Group Male90_94	Char(1)	1	74	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 and 94, inclusive.
32	Age Group Male95_GT	Char(1)	1	75	Set to "1" if applicable, otherwise "0"	The sex and age group for the beneficiary based on a given as of date. Male, age 95 and greater.
33	Originally Disabled Female	Char(1)	1	76	Set to "1" if applicable, otherwise "0"	Beneficiary is a female and original Medicare entitlement was due to disability.

Item	Field	Data Type	Size	Position	Comment	Description
34	Originally Disabled Male	Char(1)	1	77	Set to "1" if applicable, otherwise "0"	Beneficiary is a male and original Medicare entitlement was due to disability.
35	Disease Coefficients RXHCC1	Char(1)	1	78	Set to "1" if applicable, otherwise "0"	HIV/AIDS
36	Disease Coefficients RXHCC5	Char(1)	1	79	Set to "1" if applicable, otherwise "0"	Opportunistic Infections
37	Disease Coefficients RXHCC15	Char(1)	1	80	Set to "1" if applicable, otherwise "0"	Chronic Myeloid Leukemia
38	Disease Coefficients RXHCC16	Char(1)	1	81	Set to "1" if applicable, otherwise "0"	Multiple Myeloma and Other Neoplastic Disorders
39	Disease Coefficients RXHCC17	Char(1)	1	82	Set to "1" if applicable, otherwise "0"	Secondary Cancers of Bone, Lung, Brain, and Other Specified Sites; Liver Cancer
40	Disease Coefficients RXHCC18	Char(1)	1	83	Set to "1" if applicable, otherwise "0"	Lung, Kidney, and Other Cancers
41	Disease Coefficients RXHCC19	Char(1)	1	84	Set to "1" if applicable, otherwise "0"	Breast and Other Cancers and Tumors
42	Disease Coefficients RXHCC30	Char(1)	1	85	Set to "1" if applicable, otherwise "0"	Diabetes with Complications
43	Disease Coefficients RXHCC31	Char(1)	1	86	Set to "1" if applicable, otherwise "0"	Diabetes without Complication
44	Disease Coefficients RXHCC40	Char(1)	1	87	Set to "1" if applicable, otherwise "0"	Specified Hereditary Metabolic/Immune Disorders
45	Disease Coefficients RXHCC41	Char(1)	1	88	Set to "1" if applicable, otherwise "0"	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders
46	Disease Coefficients RXHCC42	Char(1)	1	89	Set to "1" if applicable, otherwise "0"	Thyroid Disorders

Item	Field	Data Type	Size	Position	Comment	Description
47	Disease Coefficients RXHCC43	Char(1)	1	90	Set to "1" if applicable, otherwise "0"	Morbid Obesity
48	Disease Coefficients RXHCC45	Char(1)	1	91	Set to "1" if applicable, otherwise "0"	Disorders of Lipoid Metabolism
49	Disease Coefficients RXHCC54	Char(1)	1	92	Set to "1" if applicable, otherwise "0"	Chronic Viral Hepatitis C
50	Disease Coefficients RXHCC55	Char(1)	1	93	Set to "1" if applicable, otherwise "0"	Chronic Viral Hepatitis, Except Hepatitis C
51	Disease Coefficients RXHCC65	Char(1)	1	94	Set to "1" if applicable, otherwise "0"	Chronic Pancreatitis
52	Disease Coefficients RXHCC66	Char(1)	1	95	Set to "1" if applicable, otherwise "0"	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis
53	Disease Coefficients RXHCC67	Char(1)	1	96	Set to "1" if applicable, otherwise "0"	Inflammatory Bowel Disease
54	Disease Coefficients RXHCC68	Char(1)	1	97	Set to "1" if applicable, otherwise "0"	Esophageal Reflux and Other Disorders of Esophagus
55	Disease Coefficients RXHCC80	Char(1)	1	98	Set to "1" if applicable, otherwise "0"	Aseptic Necrosis of Bone
56	Disease Coefficients RXHCC82	Char(1)	1	99	Set to "1" if applicable, otherwise "0"	Psoriatic Arthropathy and Systemic Sclerosis
57	Disease Coefficients RXHCC83	Char(1)	1	100	Set to "1" if applicable, otherwise "0"	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy
58	Disease Coefficients RXHCC84	Char(1)	1	101	Set to "1" if applicable, otherwise "0"	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies
59	Disease Coefficients RXHCC87	Char(1)	1	102	Set to "1" if applicable, otherwise "0"	Osteoporosis, Vertebral and Pathological Fractures

Item	Field	Data Type	Size	Position	Comment	Description
60	Disease Coefficients RXHCC95	Char(1)	1	103	Set to "1" if applicable, otherwise "0"	Sickle Cell Anemia
61	Disease Coefficients RXHCC96	Char(1)	1	104	Set to "1" if applicable, otherwise "0"	Myelodysplastic Syndromes and Myelofibrosis
62	Disease Coefficients RXHCC97	Char(1)	1	105	Set to "1" if applicable, otherwise "0"	Immune Disorders
63	Disease Coefficients RXHCC98	Char(1)	1	106	Set to "1" if applicable, otherwise "0"	Aplastic Anemia and Other Significant Blood Disorders
64	Disease Coefficients RXHCC111	Char(1)	1	107	Set to "1" if applicable, otherwise "0"	Alzheimer's Disease
65	Disease Coefficients RXHCC112	Char(1)	1	108	Set to "1" if applicable, otherwise "0"	Dementia, Except Alzheimer's Disease
66	Disease Coefficients RXHCC130	Char(1)	1	109	Set to "1" if applicable, otherwise "0"	Schizophrenia
67	Disease Coefficients RXHCC131	Char(1)	1	110	Set to "1" if applicable, otherwise "0"	Bipolar Disorders
68	Disease Coefficients RXHCC132	Char(1)	1	111	Set to "1" if applicable, otherwise "0"	Major Depression
69	Disease Coefficients RXHCC133	Char(1)	1	112	Set to "1" if applicable, otherwise "0"	Specified Anxiety, Personality, and Behavior Disorders
70	Disease Coefficients RXHCC134	Char(1)	1	113	Set to "1" if applicable, otherwise "0"	Depression
71	Disease Coefficients RXHCC135	Char(1)	1	114	Set to "1" if applicable, otherwise "0"	Anxiety Disorders
72	Disease Coefficients RXHCC145	Char(1)	1	115	Set to "1" if applicable, otherwise "0"	Autism

Item	Field	Data Type	Size	Position	Comment	Description
73	Disease Coefficients RXHCC146	Char(1)	1	116	Set to "1" if applicable, otherwise "0"	Profound or Severe Intellectual Disability/Developmental Disorder
74	Disease Coefficients RXHCC147	Char(1)	1	117	Set to "1" if applicable, otherwise "0"	Moderate Intellectual Disability/Developmental Disorder
75	Disease Coefficients RXHCC148	Char(1)	1	118	Set to "1" if applicable, otherwise "0"	Mild or Unspecified Intellectual Disability/Developmental Disorder
76	Disease Coefficients RXHCC156	Char(1)	1	119	Set to "1" if applicable, otherwise "0"	Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
77	Disease Coefficients RXHCC157	Char(1)	1	120	Set to "1" if applicable, otherwise "0"	Spinal Cord Disorders
78	Disease Coefficients RXHCC159	Char(1)	1	121	Set to "1" if applicable, otherwise "0"	Inflammatory and Toxic Neuropathy
79	Disease Coefficients RXHCC160	Char(1)	1	122	Set to "1" if applicable, otherwise "0"	Multiple Sclerosis
80	Disease Coefficients RXHCC161	Char(1)	1	123	Set to "1" if applicable, otherwise "0"	Parkinson's and Huntington's Diseases
81	Disease Coefficients RXHCC163	Char(1)	1	124	Set to "1" if applicable, otherwise "0"	Intractable Epilepsy
82	Disease Coefficients RXHCC164	Char(1)	1	125	Set to "1" if applicable, otherwise "0"	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy
83	Disease Coefficients RXHCC165	Char(1)	1	126	Set to "1" if applicable, otherwise "0"	Convulsions
84	Disease Coefficients RXHCC166	Char(1)	1	127	Set to "1" if applicable, otherwise "0"	Migraine Headaches
85	Disease Coefficients RXHCC168	Char(1)	1	128	Set to "1" if applicable, otherwise "0"	Trigeminal and Postherpetic Neuralgia

Item	Field	Data Type	Size	Position	Comment	Description
86	Disease Coefficients RXHCC185	Char(1)	1	129	Set to "1" if applicable, otherwise "0"	Primary Pulmonary Hypertension
87	Disease Coefficients RXHCC186	Char(1)	1	130	Set to "1" if applicable, otherwise "0"	Congestive Heart Failure
88	Disease Coefficients RXHCC187	Char(1)	1	131	Set to "1" if applicable, otherwise "0"	Hypertension
89	Disease Coefficients RXHCC188	Char(1)	1	132	Set to "1" if applicable, otherwise "0"	Coronary Artery Disease
90	Disease Coefficients RXHCC193	Char(1)	1	133	Set to "1" if applicable, otherwise "0"	Atrial Arrhythmias
91	Disease Coefficients RXHCC206	Char(1)	1	134	Set to "1" if applicable, otherwise "0"	Cerebrovascular Disease, Except Hemorrhage or Aneurysm
92	Disease Coefficients RXHCC207	Char(1)	1	135	Set to "1" if applicable, otherwise "0"	Spastic Hemiplegia
93	Disease Coefficients RXHCC215	Char(1)	1	136	Set to "1" if applicable, otherwise "0"	Venous Thromboembolism
94	Disease Coefficients RXHCC216	Char(1)	1	137	Set to "1" if applicable, otherwise "0"	Peripheral Vascular Disease
95	Disease Coefficients RXHCC225	Char(1)	1	138	Set to "1" if applicable, otherwise "0"	Cystic Fibrosis
96	Disease Coefficients RXHCC226	Char(1)	1	139	Set to "1" if applicable, otherwise "0"	Chronic Obstructive Pulmonary Disease and Asthma
97	Disease Coefficients RXHCC227	Char(1)	1	140	Set to "1" if applicable, otherwise "0"	Pulmonary Fibrosis and Other Chronic Lung Disorders
98	Disease Coefficients RXHCC241	Char(1)	1	141	Set to "1" if applicable, otherwise "0"	Diabetic Retinopathy

Item	Field	Data Type	Size	Position	Comment	Description
99	Disease Coefficients RXHCC243	Char(1)	1	142	Set to "1" if applicable, otherwise "0"	Open-Angle Glaucoma
100	Disease Coefficients RXHCC260	Char(1)	1	143	Set to "1" if applicable, otherwise "0"	Kidney Transplant Status
101	Disease Coefficients RXHCC261	Char(1)	1	144	Set to "1" if applicable, otherwise "0"	Dialysis Status
102	Disease Coefficients RXHCC262	Char(1)	1	145	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease Stage 5
103	Disease Coefficients RXHCC263	Char(1)	1	146	Set to "1" if applicable, otherwise "0"	Chronic Kidney Disease Stage 4
104	Disease Coefficients RXHCC311	Char(1)	1	147	Set to "1" if applicable, otherwise "0"	Chronic Ulcer of Skin, Except Pressure
105	Disease Coefficients RXHCC314	Char(1)	1	148	Set to "1" if applicable, otherwise "0"	Pemphigus
106	Disease Coefficients RXHCC316	Char(1)	1	149	Set to "1" if applicable, otherwise "0"	Psoriasis, Except with Arthropathy
107	Disease Coefficients RXHCC355	Char(1)	1	150	Set to "1" if applicable, otherwise "0"	Narcolepsy and Cataplexy
108	Disease Coefficients RXHCC395	Char(1)	1	151	Set to "1" if applicable, otherwise "0"	Lung Transplant Status
109	Disease Coefficients RXHCC396	Char(1)	1	152	Set to "1" if applicable, otherwise "0"	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas
110	Disease Coefficients RXHCC397	Char(1)	1	153	Set to "1" if applicable, otherwise "0"	Pancreas Transplant Status
111	Originally Disabled	Char(1)	1	154	Set to "1" if applicable, otherwise "0"	The original reason for Medicare entitlement was due to disability.

Item	Field	Data Type	Size	Position	Comment	Description
112	NONAGED RXHCC1	Char(1)	1	155	Set to "1" if applicable, otherwise "0"	Non-Aged and HIV/AIDS
113	NONAGED RXHCC130	Char(1)	1	156	Set to "1" if applicable, otherwise "0"	Non-Aged and Schizophrenia
114	NONAGED RXHCC131	Char(1)	1	157	Set to "1" if applicable, otherwise "0"	Non-Aged and Bipolar Disorders
115	NONAGED RXHCC132	Char(1)	1	158	Set to "1" if applicable, otherwise "0"	Non-Aged and Major Depression
116	NONAGED RXHCC133	Char(1)	1	159	Set to "1" if applicable, otherwise "0"	Non-Aged and Specified Anxiety, Personality, and Behavior Disorders
117	NONAGED RXHCC134	Char(1)	1	160	Set to "1" if applicable, otherwise "0"	Non-Aged and Depression
118	NONAGED RXHCC135	Char(1)	1	161	Set to "1" if applicable, otherwise "0"	Non-Aged and Anxiety Disorders
119	NONAGED RXHCC160	Char(1)	1	162	Set to "1" if applicable, otherwise "0"	Non-Aged and Multiple Sclerosis
120	NONAGED RXHCC163	Char(1)	1	163	Set to "1" if applicable, otherwise "0"	Non-Aged and Intractable Epilepsy
121	NONAGED RXHCC145	Char(1)	1	164	Set to "1" if applicable, otherwise "0"	Non-Aged and Autism
122	NONAGED RXHCC164	Char(1)	1	165	Set to "1" if applicable, otherwise "0"	Non-Aged and Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy
123	NONAGED RXHCC165	Char(1)	1	166	Set to "1" if applicable, otherwise "0"	Non-Aged and Convulsions
124	FILLER	Char(14)	14	167-180	Spaces	FILLER

Total Length = 180

NOTE: Fields 111-123 are associated with the Rx HCC Continuing Enrollee Institutional Score only.

F.16.3 *Trailer Record (PY2017 and PY2018)*

Item	Field	Data Type	Size	Position	Comment	Description
1	Record Type Code	Char(1)	1	1	Set to "3"	3 = Trailer
2	Contract Number	Char(5)	5	2-6	Also known as MCO plan number	Unique identification for a Managed Care Organization (MCO) enabling the MCO to provide coverage to eligible beneficiaries.
3	Total Record Count	Char(9)	9	7-15	Includes all header and trailer records	Record count in display format 9(9).
4	Filler	Char(165)	165	16-180	Spaces	Filler

Total Length = 180

F.17 Medicare Advantage Organization (MAO) 004 Report – Encounter Data Diagnosis Eligible for Risk Adjustment Phase III MAO-004, Version 3

Beginning with Payment Year (PY) 2015, diagnoses from encounter data records with 2014 dates of service that are valid for risk adjustment were added as another source of data when calculating risk scores, in addition to diagnoses from the Risk Adjustment Processing System (RAPS) and from fee-for-service (FFS) claims. In December 2015, CMS created the MAO-004 report, a 500 byte flat file, to inform Medicare Advantage Organizations (MAOs) of the risk adjustment eligibility of diagnosis data submitted on accepted Encounter Data Records (EDRs). The MAO-004 reports are produced on a monthly basis from data submitted by contracts to CMS in the immediately preceding month. For example, the MAO-004 reports sent to MAOs in August 2017 were based on EDRs submitted to and accepted by the CMS' Encounter Data Processing System (EDPS) in July 2017.

The MAO-004 report is distributed to MAOs by Contract Identification Number via MARx.

If you have any questions about the report, please email RiskAdjustment@cms.hhs.gov with the subject line of "MAO-004 report, Contract XXXX.

System	Type	Frequency	Dataset Naming Conventions
RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MAO004PV.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MAO004PV.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MAO004PV.Dyymmdd.Thhmmsst

Where:

- zzzzzzzz is the plan sponsor-provided high level qualifier
- xxxxx is the contract number
- ppppp is the contract number, representing the contract that the MAO-004 report is for
- P = Phase: The Phase can be 1 to 9 or A to Z
- V= Version: The version can be 1 to 9 or A to Z
- yy is the two digit year when the file was sent
- mm is the two digit month when the file was sent
- dd is the two digit day when the file was sent
- tttttt is the timestamp, representing the time the file was sent

F.17.1 *Header Record*

Item	Field	Size	Position	Format and Comments
1	Record Type	1	1	• Numeric, no commas and/or decimals • 0=Header
2	Delimiter	1	2	• Alphanumeric • Uses the * character
3	Report ID	7	3-9	• Alphanumeric • Value is 'MAO-004'
4	Delimiter	1	10	• Alphanumeric • Uses the * character
5	Medicare Advantage Contract ID	5	11-15	• Alphanumeric • Medicare Contract ID assigned to the submitting contract
6	Delimiter	1	16	• Alphanumeric • Uses the * character
7	Report Date	8	17-24	• Numeric • Format CCYYMMDD • The last date of the submission month
8	Delimiter	1	25	• Alphanumeric • Uses the * character
9	Report Description	53	26-78	• Alphanumeric, • Left justify, blank fill • Value is "Encounter Data Diagnosis Eligible for Risk Adjustment"
10	Delimiter	1	79	• Alphanumeric • Uses the * character
11	Filler	30	80-109	• Spaces
12	Delimiter	1	110	• Alphanumeric • Uses the * character
13	Submission File Type	4	111-114	• Alphanumeric • Value of 'PROD,' for production and 'TEST' for test files
14	Delimiter	1	115	• Alphanumeric • Uses the * character
15	Phase	1	116	• Alphanumeric
16	Delimiter	1	117	• Alphanumeric • Uses the * character
17	Version	1	118	• Alphanumeric • This field will designate which version within the phase
18	Delimiter	1	119	• Alphanumeric • Uses the * character
19	Filler	381	120-500	• Spaces

Total Length = 500

F.17.2 *Detail Record*

Item	Field	Size	Position	Format and Comments
1	Record Type	1	1	• Numeric • 1=Detail
2	Delimiter	1	2	• Alphanumeric • Uses the * character
3	Report ID	7	3-9	• Alphanumeric • Value is 'MAO-004'
4	Delimiter	1	10	• Alphanumeric • Uses the * character
5	Medicare Advantage Contract ID	5	11-15	• Alphanumeric • Medicare Contract ID assigned to the submitting contract
6	Delimiter	1	16	• Alphanumeric • Uses the * character
7	Beneficiary Identifier	12	17-28	• Alphanumeric • Beneficiary Health Insurance Claim Number or Medicare Beneficiary Identifier (MBI)
8	Delimiter	1	29	• Alphanumeric • Uses the * character
9	Encounter ICN	20	30-49	• Numeric • Encounter Data System (EDS) Internal Control Number. In encounter data, only 13 spaces represent the ICN; however, there are 20 spaces on the records to allow enhancement of the ICN.
10	Delimiter	1	50	• Alphanumeric • Uses the * character
11	Encounter Type Switch	1	51	• Alpha Numeric • This field can take on 9 different values: “1” = Encounter, “2” = Void to an Encounter, “3”= Replacement to an Encounter, "4" = Chart Review Add, “5” = Void to a Chart Review, “6” = Replacement to a Chart Review “7” = Chart Review Delete, “8” = Void to a chart review delete, “9” = Replacement to a chart review delete
12	Delimiter	1	52	• Alphanumeric • Uses the * character
13	ICN of Encounter Linked To	20	53-72	• Alphanumeric • Encounter Data System (EDS) Internal Control Number. This field reports the ICN of the record an adjustment, void, linked chart review add, or linked chart review delete is linked to. It will be blank for original encounters and unlinked chart reviews.

Item	Field	Size	Position	Format and Comments
14	Delimiter	1	73	• Alphanumeric • Uses the * character
15	Allowed/ Disallowed Status of Encounter Linked To	1	74	• Alphanumeric • This field indicates if the diagnoses on the encounter data record or chart review record that is referenced in Field 13 were allowed or disallowed for risk adjustment. 'A' = Diagnoses on previous record were allowed. 'D' = Diagnoses on previous record were disallowed. Blank = (1) if the current record is an original encounter data record, or (2) if the current record is an unlinked chart review record and no record is referenced in Field #13, or (3) if the record is a linked chart review with an invalid ICN in Field #13, or (4) if the diagnoses on the record whose ICN is in Field 13 did not pass the filtering logic and were not previously reported on a MAO-004 report.
16	Delimiter	1	75	• Alphanumeric • Uses the * character
17	Encounter Submission Date	8	76-83	• Numeric, format CCYYMMDD • Identifies the date the MAO submitted the encounter.
18	Delimiter	1	84	• Alphanumeric • Uses the * character
19	"From" Date of Service	8	85-92	• Numeric • Format CCYYMMDD • The start date for a provided service
20	Delimiter	1	93	• Alphanumeric • Uses the * character
21	"Through" Date of Service	8	94-101	• Numeric, • Format CCYYMMDD • The end date for a provided service.
22	Delimiter	1	102	• Alphanumeric • Uses the * character
23	Service Type	1	103	• Alphanumeric • Type of Claim: 'P' = Professional; 'I' = Inpatient; 'O' = Outpatient; 'D' = DME; 'N' = (All Others) Not Applicable
24	Delimiter	1	104	• Alphanumeric • Uses the * character

Item	Field	Size	Position	Format and Comments
25	Allowed/ Disallowed flag	1	105	• Alphanumeric • This field indicates if diagnoses on the current encounter data record (Field #9) are allowed or disallowed for risk adjustment. 'A' = Diagnoses are allowed for risk adjustment. 'D' = Diagnoses are disallowed for risk adjustment. **Note**: Non voids and non-chart review deletes with Service Type (Field #23) designated with 'N' will be 'D'. Blank = All Voids and chart review deletes, regardless of the service type, since allowed and disallowed status do not apply.
26	Delimiter	1	106	• Alphanumeric • Uses the * character

Item	Field	Size	Position	Format and Comments
27	Allowed/ Disallowed Reason Code	1	107	• Alphanumeric • If applicable, this field will indicate why diagnoses on the current record are disallowed, or will indicate that diagnoses which previously did not pass the CMS filtering logic are now allowed based on an updated CPT/HCPCS list. 'H' = CPT/HCPCS code is not acceptable for risk adjustment. This value is applicable to only outpatient and professional encounters, not to inpatient encounters. 'T'= Type of Bill is not acceptable for risk adjustment. This value is applicable to only outpatient and inpatient encounters, not to professional encounters. 'Q' = the diagnoses on the current encounter are now allowed due to CPT/HCPCS quarterly update. This value is only applicable to reprocessed outpatient and professional encounters, not to inpatient encounters. Blank = the diagnoses on the current record have passed CMS filtering criteria and are allowed. • If the diagnoses on the record is disallowed for both type of bill and CPT/HCPCS code, reason code 'T' will be reported. This is only applicable to outpatient encounters. 'D' = for diagnoses on EDRs and CRRs that were submitted and accepted after the risk-adjustment deadline for the relevant payment year. 'N' = for all other EDRs and CRRs that are not Inpatient, Outpatient, Professional or DME **Note:** The risk adjustment deadline will take precedence over TOB and HCPCS disallowed reason codes. If the cutoff date is missed, it doesn't matter whether a record has CPT/HCPCS (Prof & Outpatient) or TOB (Inpatient or Outpatient) since it is disallowed due to the risk adjustment deadline. 'D' = (Deadline Date) > T (Type of Bill) > H (CPT/HCPCS)
28	Delimiter	1	108	• Alphanumeric • Uses the * character
29	Diagnoses ICD	1	109	• Alphanumeric • ICD code for All the diagnoses (9 or 0). 9=ICD-9 and 0=ICD-10
30	Delimiter	1	110	• Uses the * character

Item	Field	Size	Position	Format and Comments
31	Diagnosis Codes	7	111-117	• Alphanumeric • ICD-9 codes will be accepted prior to the ICD-10 implementation date. Only ICD-10 codes will be accepted starting with ICD-10 implementation date.
32	Delimiter	1	118	• Alphanumeric • Uses the * character
33	Add or Delete flag	1	119	• Alphanumeric • This field will indicate if a diagnosis is an Add or Delete. Diagnoses added on original and replacement encounters (including chart reviews) for the first time in that encounter family, will be marked as "A." Diagnoses deleted on replacements, voids, and chart review deletes will be marked as "D". Diagnoses reported before in the encounter family are reported with a blank. 'A' = Add, 'D' = Delete Blank = diagnosis has been reported before in the encounter family.
34	Delimiter	1	120	• Alphanumeric • Uses the * character
35	Diagnosis Codes & Delimiters & Add/Delete flags for 37 diagnoses	370	121-490	• Alphanumeric • This field includes up to 37 additional diagnoses, for a total of 38 diagnoses per transaction line. When there are more than 38 diagnoses on a record, the remaining diagnoses will wrap around in the next line of the report with all elements of the detail line repeated except the diagnoses.
36	Filler	10	491-500	• Spaces

Total Length = 500

[1] **Definition of an Encounter Family:** A group of encounter data records that are linked by an ICN(s) (can include original encounter data records, original chart review records, replacements, and voids) to an original encounter data record, either non-chart review or chart review.

F.17.3 *Trailer Record*

Item	Field	Size	Position	Format and Comments
1	Record Type	1	1	• Numeric • 9 = Trailer
2	Delimiter	1	2	• Alphanumeric • Uses the * character
3	Report ID	7	3-9	• Alphanumeric • Value is 'MAO-004'

Item	Field	Size	Position	Format and Comments
4	Delimiter	1	10	• Alphanumeric • Uses the * character
5	Medicare Advantage Contract ID	5	11-15	• Alphanumeric • Medicare Contract ID assigned to the submitting contract
6	Delimiter	1	16	• Alphanumeric • Uses the * character
7	Total Number of Records	18	17-34	• Numeric • Count of detail records on this report
8	Delimiter	1	35	• Alphanumeric • Uses the * character
9	Filler	465	36-500	• Alphanumeric • Spaces

Total Length = 500

F.18 Monthly Full Enrollment Data File

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

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

Item	Field	Size	Position	Description
1	Beneficiary ID	12	1 – 12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
2	Surname	12	13 – 24	Beneficiary Surname
3	First Name	7	25 – 31	Beneficiary Given Name
4	Middle Initial	1	32	Beneficiary Middle Initial
5	Gender Code	1	33	Beneficiary Gender Identification Code 0 = Unknown 1 = Male 2 = Female
6	Date of Birth	8	34 – 41	YYYYMMDD – Format
7	Medicaid Indicator	1	42	Spaces
8	Contract Number	5	43 – 47	Plan Contract Number
9	State Code	2	48 – 49	Beneficiary State Code
10	County Code	3	50 – 52	Beneficiary County Code
11	Disability Indicator	1	53	Spaces
12	Hospice Indicator	1	54	Spaces
13	Institutional/NHC/HCBS Indicator	1	55	Spaces
14	ESRD Indicator	1	56	Spaces
15	TRC	3	57 – 59	TRC; Defaulted to '999'
16	TC	2	60 – 61	TC; Defaulted to '01' for special reports
17	Entitlement Type Code	1	62	Spaces

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

Item	Field	Size	Position	Description
44	Rx Group	15	183 – 197	Spaces
45	Secondary Drug Insurance Flag	1	198-198	Spaces
46	Secondary Rx ID	20	199 – 218	Spaces
47	Secondary Rx Group	15	219 – 233	Spaces
48	EGHP	1	234 – 234	Spaces
49	Part D LIPS Level	3	235 – 237	Part D LIPS category: '000' = No subsidy (default for blank) '025' = 25% subsidy level, '050' = 50% subsidy level, '075' = 75% subsidy level, '100' = 100% subsidy level
50	Low-Income Co-Pay Category	1	238 – 238	Definitions of the co-payment categories: '0' = none, not low-income (default for blank) '1' = (High) '2' = (Low) '3' = $0 (0) '4' = 15% '5' = unknown
51	Low-Income Co-Pay Effective Date	8	239 – 246	YYYYMMDD – Format
52	Part D LEP Amount	8	247 – 254	Spaces
53	Part D LEP Waived Amount	8	255 – 262	Spaces
54	Part D LEP Subsidy Amount	8	263 – 270	Spaces
55	Low-Income Part D Premium Subsidy Amount	8	271- 278	Part D Low-Income Premium Subsidy Amount

Total Length = 278

F.19 LEP Data File

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

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

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

F.19.1 *Header Record*

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

Total Length = 165

F.19.2 *Detail Record*

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

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

Total Length = 165

F.19.3 *Trailer Record*

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

Total Length = 165

F.20 LIS History Data File (LISHIST)

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

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

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

Please note the following limitations:

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

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

F.20.2 *Header Record*

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

Total Length = 165

F.20.3 *Detail Record (Transaction)*

Item	Field	Size	Position	Format	Description
1	Record Type	1	1	CHAR	'D' = Detail Record
2	MCO Contract Number	5	2-6	CHAR	Contract ID: 9xxxx, Exxxx, Fxxxx, Hxxxx, Rxxxx, or Sxxxx, where "xxxx" is the contract's numeric designation.
3	PBP Number	3	7-9	CHAR	PBP Number, blank when Beneficiary premium profile is unavailable.
4	Beneficiary ID	12	10-21	CHAR	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. MBI is 11 characters, left-justified with one space at the end
5	Surname	12	22-33	CHAR	Beneficiary's Surname
6	First Name	7	34-40	CHAR	Beneficiary's First Initial
7	Middle Initial	1	41	CHAR	Beneficiary's Middle Initial
8	Sex	1	42	CHAR	M = Male, F = Female
9	Date of Birth	8	43-50	CHAR	Date of Birth YYYYMMDD – Format
10	Low Income Period Start Date	8	51-58	CHAR	Start date for beneficiary's Low Income Period Amount: YYYYMMDD – Format
11	Low Income Period End Date	8	59-66	CHAR	End date for beneficiary's Low Income Period Amount: YYYYMMDD – Format
12	LIPS Percentage	3	67-69	CHAR	Beneficiary's LIPS Percentage '100' = 100% Premium subsidy '075' = 75% Premium subsidy '050' = 50% Premium subsidy '025' = 25% Premium subsidy
13	Premium LIS Amount	8	70-77	CHAR	The portion of the Part D basic premium paid by the Government on behalf of a low-income individual. A zero dollar amount here represents several possibilities: 1. There is no Plan premium and therefore no premium subsidy. 2. Although the Beneficiary is enrolled and LIS eligible, a system error occurred making premium data unavailable. Premium LIS Amount is entered in spaces when data is unavailable. 99999.99 – Format

Item	Field	Size	Position	Format	Description
14	Low Income Co-pay Level ID	1	78	CHAR	Co-Payment Category Definitions: '1' = High '2' = Low '3' = $0 '4' = 15% Co-pay level IDs 1 and 2 change each year. In 2007, 1 = $2.15/$5.35 and 2 = $1/$3.10. In 2006 1 = $2/$5 and 2 = $1/$3.
15	Beneficiary Source of Subsidy Code	1	79	CHAR	Source of beneficiary subsidy. Valid values are: A = Determined Eligible for LIS by the Social Security Administration or a State Medicaid Agency D = Deemed Eligible for LIS
16	LIS Activity Flag	1	80	CHAR	'N' = No change in reported LIS data since last month's data file 'Y' = One of the following may have changed since the last month's data file: Co-payment level Low-income premium subsidy level Low-income period start or end date Changes occur to low-income information that do not impact the Plan. The changes are not yet separable from variations in which the Plan is interested. Although it is possible that data records are flagged as representing a change, the data of interest to the Plan is unaffected.
17	PBP Start Date	8	81-88	CHAR	PBP enrollment effective start date: YYYYMMDD – Format
18	Net Part D Premium Amount	8	89-96	CHAR	The total Part D premium net of any Part A/B rebates less the Beneficiary's premium subsidy amount. Spaces when the premium record is unavailable. 99999.99 – Format
19	Contract Year	4	97-100	CHAR	Calendar Year associated with the low income premium subsidy amount; YYYY – Format
20	Institutional Status Indicator	1	101	CHAR	'1' (Institutionalized) '2' (Non Institutionalized) '3' (Home and Community- Based Services [HCBS]) '9' (Not applicable)
21	PBP Enrollment Termination Date	8	102-109	CHAR	PBP enrollment termination date: YYYYMMDD – Format
22	Filler	56	110-165	CHAR	Spaces

Total Length = 165

F.20.4 *Trailer Record*

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

Total Length = 165

F.21 NoRx File

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

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

The following records are included in this file:

- Header Record
- Detail Record
- Trailer Record

F.21.1 *Header Record*

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

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

Total Length = 750

F.21.3 *Detail Record*

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

Item	Field	Size	Position	Format	Valid Values	Description
1	Record Type	3	1-3	CHAR	"NRX"	Critical Field This field is set to the value "NRX," indicating that this detail record is a NoRx record. This code allows recognition of the detail record as a No Rx record from CMS.
2	Record Type from Original Detail	5	4-8	CHAR	Filler	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
3	Beneficiary HICN or RRB Number	12	9-20	CHAR	HICN or RRB	• Before or during the Medicare Beneficiary Identifier (MBI) Transition period, the RRB Number is populated if present; else the active HICN is populated. • When the MBI Transition period ends, the field is filled with spaces.
4	SSN	9	21-29	CHAR	SSN from CMS	Not a Critical Field This field may contain the SSN of the Beneficiary that does not have 4Rx data.
5	MBI	11	30-40	CHAR		The MBI from the beneficiary's active Beneficiary MBI period. The value is a system-generated identifier used internally and externally to uniquely identify the beneficiary in the Medicare database.
6	Filler	49	41-89	CHAR	Spaces	
7	Contract Number	5	90-94	CHAR	Contract Number from CMS	The field contains the Contract Number of the beneficiary that does not have 4Rx data.
8	PBP Number	3	95- 97	CHAR	PBP Number from CMS	Critical Field This field contains the beneficiary PBP number but does not have 4Rx data.
9	PBP Enrollment Effective Date from Original Detail	8	98-105	CHAR	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.
10	Record Sequence Number from Original Detail	7	106-112	CHAR	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for meaningful information.

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

Total Length = 750

F.21.4 *Trailer Record*

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

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

Total Length = 750

F.22 MA Full Dual Auto Assignment Notification File

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

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

The following records are included in this file:

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

F.22.1 *Header Record*

Item	Field	Size	Position	Format	Valid Values	Description
1	File ID Name	8	1-8	CHAR	"MMAADUAH "	This field is always set to the value "MMAADUAH." This code identifies the record as the Header Record of an Auto Assignment Full Dual Notification File.
2	Sending Entity: MBD	8	9-16	CHAR	"MBD " (MBD + 5 Spaces)	This is always set to the value "MBD ." The value specifically is MBD + 5 following Spaces. This value agrees with the corresponding value in the Trailer Record.
3	File Creation Date	8	17-24	CHAR	YYYYMMDD	The date on which the Full Dual File was created by CMS. This value is in the format of YYYYMMDD. For example, January 3, 2010 is the value 20100103. This value agrees with the corresponding value in the Trailer Record.
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity (MBD)	The specific Control Number assigned by CMS to the Full Dual Notification File. CMS utilizes this value to track the Full Dual Notification File through CMS processing and archive. This value agrees with the corresponding value in the Trailer Record.

Item	Field	Size	Position	Format	Valid Values	Description
5	Filler	67	34-100	CHAR	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for or used to store meaningful information, unless specifically documented otherwise.

Total Length = 100

F.22.2 *Detail Record (Transaction)*

Item	Field	Size	Position	Description
1	Contract Number	5	1-5	This field provides the Contract assigned to the beneficiary; CNTRCT_NUM in CME_SRVC_DEL_ELCT.
2	Run Date	8	6-13	This field provides the creation date of the file in YYYYMMDD format.
3	Filler	6	14-19	This field is all spaces.
4	Beneficiary HICN or RRB Number	12	20-31	• Before and during the Medicare Beneficiary Identifier (MBI) Transition period, the RRB Number is written if a value is present in the beneficiary's record; else, the HICN is written. • After the MBI Transition period ends, the field is filled with spaces.
5	Beneficiary's Surname	12	32-43	This field provides the last name of the individual; BENE_LAST_NAME in CME_BENE_NAME.
6	Initial of Beneficiary's First Name	1	44	This field provides the initial of the first name of the individual; BENE_1ST_NAME in CME_BENE_NAME.
7	Beneficiary's Gender	1	45	This field provides the gender of the individual; BENE_SEX_CD in MBD_BENE; '0', '1', or '2'.
8	Beneficiary's Date of Birth	8	46-53	This field provides the date of birth of the individual in YYYYMMDD format; BENE_BIRTH_DT in CME_BENE.
9	Medicare Beneficiary ID	11	54-64	A system-generated identifier used by CMS to identify the beneficiary. The field will contain the active MBI from the beneficiary's Medicare record. Eventually, this identifier replaces the HICN and RRB Number.
10	Filler	36	65-100	Spaces

Total Length = 100

F.22.3 *Trailer Record*

Item	Field	Size	Position	Format	Valid Values	Definition
1	File ID Name	8	1- 8	CHAR	"MMAADUAT "	This field is always set to the value "MMAADUAT." This code identifies the record as the Trailer Record of an Auto Assignment Full Dual Notification File.
2	Sending Entity MBD	8	9-16	CHAR	"MBD " (MBD + 5 Spaces)	This field is always set to the value "MBD ." The value specifically is MBD + 5 following Spaces. This value agrees with the corresponding value in the Header Record.
3	File Creation Date	8	17-24	CHAR	YYYYMMDD	The date on which the Full Dual Notification File was created by CMS. This value is formatted as YYYYMMDD. For example, January 3, 2010 is the value 20100103. This value agrees with the corresponding value in the Header Record.
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity (MBD)	The specific Control Number assigned by CMS to the Full Dual Notification File. CMS utilizes this value to track the Full Dual Notification File through CMS processing and archive. This value agrees with the corresponding value in the Header Record.
5	Record Count	9	34-42	NUM	Numeric value greater than Zero.	The total number of Transactions or Detail Records on the Full Dual Notification File. This value is right justified in the field, with leading zeroes. This value does not include non-numeric characters, such as commas, spaces, dashes, decimals.
6	Filler	58	43-100	CHAR	Spaces	No meaningful values are supplied in this field. This field is set to SPACES and is not referenced for or used to store meaningful information, unless specifically documented otherwise.

Total Length = 100

F.23 Auto Assignment Address Notification File

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

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

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

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

- Beneficiary Address Lines 1-6 is limited to Representative Payee Name (if applicable), and street address, and these elements "wrap."
- When a Beneficiary has a Representative Payee, the Beneficiary Representative Payee Name prints on Address Line 1, and may use more Address Lines.
- The actual street address in such cases is printed on the line after the name concludes.
- Address Lines print on fewer than six lines with the remainder of the lines padded with space prior to printing.
- City/State/Zip Code data only appear in the fields labeled as City/State/Zip Code data fields.

F.23.1 *Header Record*

Item	Field	Size	Position	Description
1	Header Code	9	1-9	Used for file/record identification purposes, 'MMAAPDPGH'.
2	Sending Entity	8	10-17	Identifies the sending entity, 'MBD '(MBD + 5 spaces).
3	File Creation Date	8	18-25	The date the file was created in YYYYMMDD format.
4	File Control Number	9	26-34	Unique file identifier created by Sending Entity.

Item	Field	Size	Position	Description
5	Filler	592	35-626	This field is all spaces.

Total Length = 626

F.23.2 *Detail Record*

Item	Field	Size	Position	Description
1	Beneficiary HICN or RRB Number	12	1-12	The identifier issued under the SSA or RRB program that is used to uniquely identify the Medicare beneficiary. Based on the following phases of the MBI transition, the value will be populated accordingly. • Before or during the MBI Transition period, the field will contain the RRB if it exists in the beneficiary's Medicare record; else it will contain the active HICN. • When the MBI Transition period ends, the field will contain spaces.
2	Beneficiary's Last Name	12	13-24	This field provides the first twelve characters of the last name of the individual.
3	Beneficiary's First name	7	25-31	This field provides the first seven characters of the first name of the individual.
4	Beneficiary's Middle Initial	1	32	This field provides the middle initial of the individual.
5	Beneficiary's Gender	1	33	This field provides the gender of the individual; '0', '1', or '2'.
6	Beneficiary's DOB	8	34-41	This field provides the date of birth of the individual in YYYYMMDD format.
7	Medicaid Indicator	1	42	This field indicates the beneficiary's Medicaid eligibility; this field will always contain the value of '1' to indicate 'Yes'.
8	Contract Number	5	43-47	This field provides the Contract assigned to the beneficiary.
9	State Code	2	48-49	This field provides the beneficiary's state of residency.
10	County Code	3	50-52	This field provides the beneficiary's county of residency.
11	Filler	7	53-59	This field is all spaces.
12	TC	2	60-61	This field identifies the type of record; '61'.
13	Filler	1	62	This field is all spaces.
14	Effective Date	8	63-70	The effective date of the assignment in YYYYMMDD format.
15	Filler	1	71	This field is all spaces.

Item	Field	Size	Position	Description
16	PBP	3	72-74	This field notes the PBP of the auto-assigned contract.
17	Filler	49	75-123	This field is all spaces.
18	Application Date	8	124-131	The date of the application in YYYYMMDD format.
19	Filler	30	132-161	This field is all spaces.
20	Election Type	1	162	This field indicates the type of election; 'Z'.
21	Enrollment Source	1	163	This field indicates the source of the enrollment; 'A' or 'C'.
22	Filler	1	164	This field is all spaces.
23	Premium Withhold Option/Parts C-D	1	165	This field indicates the payment option for payment of Part C and D premiums; 'D'.
24	Filler	77	166-242	This field is all spaces.
25	Part D Subsidy Level	3	243-245	This field identifies the portion of the Part D Premium subsidized; For monthly, value is always '100'; For Facilitated, values are either '100', '075', '050', or '025'.
26	Co-Payment Category	1	246	This field indicates the Subsidy Co-Payment level for the beneficiary; '1' or '4'.
27	Co-Payment Effective Date	8	247-254	This field is filler and is filled with zeroes.
28	Beneficiary Address Line 1	40	255-294	First line in the mailing address.
29	Beneficiary Address Line 2	40	295-334	Second line in the mailing address.
30	Beneficiary Address Line 3	40	335-374	Third line in the mailing address.
31	Beneficiary Address Line 4	40	375-414	Fourth line in the mailing address.
32	Beneficiary Address Line 5	40	415-454	Fifth line in the mailing address.
33	Beneficiary Address Line 6	40	455-494	Sixth line in the mailing address.
34	Beneficiary Address City	40	495-534	The city in the mailing address.
35	Beneficiary Address State	2	535-536	The state in the mailing address.
36	Beneficiary Zip Code	9	537-545	The zip code in the mailing address.
37	Full Last Name	40	546-585	This field provides the last name of the individual.
38	Full First Name	30	586-615	This field provides the first name of the individual.
39	MBI	11	616-626	The MBI from the beneficiary's active Beneficiary MBI period. The value is a system-generated identifier used internally and the externally to uniquely identify the beneficiary in the Medicare database.

Total Length = 626

F.23.3 *Trailer Record*

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

Total Length = 626

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

Also known as the Plan Payment Letter, this data file itemizes the final monthly payment to the Plan. CMS makes this report available to the Plans as part of month-end processing.

The IPPR is provided when a Plan is approved for an interim payment outside of the normal monthly process. The data file/report contains the amount and reason for the interim payment to the Plan.

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

F.24.1 *Header Record*

Item	Field	Size	Position	Format	Definition
1	Contract Number	5	1-5	CHAR	Contract Number
2	Record Identification Code	1	6	CHAR	Record Type Identifier H = Header Record
3	Contract Name	50	7-56	CHAR	Name of the Contract
4	Payment Cycle Date	6	57-62	CHAR	Identified the month and year of payment. Format = YYYYMM
5	Run Date	8	63-70	CHAR	Identifies the date file was created. Format = YYYYMMDD
6	Filler	180	71-250	CHAR	Spaces

Total Length = 250

F.24.2 *Capitated Payment – Current Activity*

Item	Field	Size	Position	Format	Description
1	Contract Number	5	1-5	CHAR	Contract Number
2	Record Identification Code	1	6	CHAR	Record Type Identifier C = Capitated Payment
3	Table ID Number	1	7	CHAR	1
4	Adjustment Reason Code	2	8-9	CHAR	Blank = for prospective pay See Appendix D for the list of Adjustment Reason Codes.
5	Part A Total Members	9	10-18	NUM	Number of beneficiaries for whom Part A payments is being made prospectively. For adjustment records this will hold the total number of transactions. Format: ZZZZZZZZ9
6	Part B Total Members	9	19-27	NUM	Number of beneficiaries for whom Part B payments is being made prospectively. Blank for adjustment records. Format: ZZZZZZZZ9
7	Part D Total Members	9	28-36	NUM	Number of beneficiaries for whom Part D payments is being made prospectively. Blank for Adjustment records. Format: ZZZZZZZZ9
8	Part A Payment Amount	15	37-51	NUM	Total Part A Amount Format: SSSSSSSSSS9.99
9	Part B Payment Amount	15	52-66	NUM	Total Part B Amount Format: SSSSSSSSSS9.99
10	Part D Payment Amount	15	67-81	NUM	Total Part D Amount Format: SSSSSSSSSS9.99
11	Coverage Gap Discount Amount	15	82 – 96	NUM	The Coverage Gap Discount Amount included in Part D Payment. Format: SSSSSSSSSS9.99
12	Total Payment	15	97- 111	NUM	Total Payment Format: SSSSSSSSSS9.99
13	Filler	139	112 – 250	CHAR	Spaces

Total Length = 250

F.24.3 *Premium Settlement*

Item	Field	Size	Position	Format	Description
1	Contract Number	5	1 – 5	CHAR	Contract Number
2	Record Identification Code	1	6	CHAR	Record Type Identifier P = Premium Settlement
3	Table ID Number	1	7	CHAR	2
4	Part C Premium Withholding Amount	15	8 – 22	NUM	Total Part C Premium Amount Format: SSSSSSSSSS9.99
5	Part D Premium Withholding Amount	15	23 – 37	NUM	Total Part D Premium Amount Format: SSSSSSSSSS9.99
6	Part D Low Income Premium Subsidy	15	38 – 52	NUM	Total Low Income Premium Subsidy Format: SSSSSSSSSS9.99
7	Part D Late Enrollment Penalty	15	53 – 67	NUM	Total Late Enrollment Penalty Format: SSSSSSSSSS9.99
8	Total Premium Settlement Amount	15	68 – 82	NUM	Total Premium Settlement Format: SSSSSSSSSS9.99
9	Filler	168	83 – 250	CHAR	Spaces

Total Length = 250

F.24.4 *Fees*

Item	Field	Size	Position	Format	Description
1	Contract Number	5	1 – 5	CHAR	Contract Number
2	Record Identification Code	1	6	CHAR	Record Type Identifier F = FEES
3	Table ID Number	1	7	CHAR	3
4	NMEC Part A Subject to Fee	15	8 – 22	NUM	Part A amount subject to National Medicare Educational Campaign fees. Format:ZZZZZZZZZZZ9.99
5	NMEC Part A Rate	7	23 – 29	NUM	Rate used to calculate the fees for Part A. Format: 0.99999
6	Part A Fee Amount	15	30 – 44	NUM	Fee Assessed for Part A Format:SSSSSSSSSS9.99

Item	Field	Size	Position	Format	Description
7	NMEC Part B Subject to Fee	15	45 – 59	NUM	Part B amount subject to National Medicare Educational Campaign fees. Format: ZZZZZZZZZZZ9.99
8	NMEC Part B Rate	7	60 – 66	NUM	Rate used to calculate the fees for Part B. Format: 0.99999
9	Part B Fee Amount	15	67 – 81	NUM	Fee Assessed for Part B Format:SSSSSSSSSS9.99
10	NMEC Part D Subject to Fee	15	82 – 96	NUM	Part D amount subject to National Medicare Educational Campaign fees. Format: ZZZZZZZZZZ9.99
11	NMEC Part D Rate	7	97 – 103	NUM	Rate used to calculate the fees for Part D. Format: 0.99999
12	Part D Fee Amount	15	104 – 118	NUM	Fee Assessed for Part D Format:SSSSSSSSSS9.99
13	Total NMEC Fee Assessed	15	119 – 133	NUM	Total NMEC Fee Assessed for Part A, B and D Format:SSSSSSSSSS9.99
14	Total Prospective Part D Members	9	134 – 142	NUM	Total members for Part D Format: ZZZZZZZZ9
15	Rate for COB Fees	4	143 – 146	NUM	Rate used to calculate the COB fees. Format: 0.99
16	Amount of COB Fees	15	147 – 161	NUM	COB Fee Format:SSSSSSSSSS9.99
17	Total of Assessed Fees	15	162 – 176	NUM	Total of all Fees Assessments Format:SSSSSSSSSS9.99
18	Filler	74	177 – 250	CHAR	Spaces

Total Length = 250

F.24.5 *Special Adjustments*

Item	Field	Size	Position	Format	Description
1	Contract Number	5	1 – 5	CHAR	Contract Number
2	Record Identification Code	1	6	CHAR	Record Type Identifier S = Special Adjustments
3	Table ID Number	1	7	CHAR	4

Item	Field	Size	Position	Format	Description
4	Document ID	8	8 – 15	NUM	The document ID for identifying the adjustment.
5	Source	5	16 – 20	CHAR	The CMS division responsible for initiating the adjustments.
6	Description	50	21 – 70	CHAR	The reason the adjustment was made.
7	Adjustment Type	3	71 – 73	CHAR	The payment component the adjustment is for. CMP-Civil Monetary Penalty CST-Cost Plan Adjustment PRS-Annual Part D Reconciliation RSK-Risk Adjustment CGD-Coverage Gap Invoice OTH-Other – default non-specific group.
8	Adjustment to Part A	15	74 – 88	NUM	Adjustment amount for Part A Format:SSSSSSSSSS9.99
9	Adjustment to Part B	15	89 – 103	NUM	Adjustment amount for Part B Format:SSSSSSSSSS9.99
10	Adjustment to Part D	15	104 – 118	NUM	Adjustment amount for Part D. Format:SSSSSSSSSS9.99
11	Premium C Withholding Part A	15	119 – 133	NUM	Adjustment amount for Premium Withholding Part A. Format:SSSSSSSSSS9.99
12	Premium C Withholding Part B	15	134 – 148	NUM	Adjustment amount for Premium Withholding Part B. Format:SSSSSSSSSS9.99
13	Premium D Withholding	15	149 – 163	NUM	Adjustment amount for Premium D Withholding. Format:SSSSSSSSSS9.99
14	Part D Low Income Premium Subsidy	15	164 – 178	NUM	Adjustment amount for Low Income Subsidy. Format:SSSSSSSSSS9.99
15	Total Adjustment Amount	15	179 – 193	NUM	Total Adjustments Format:SSSSSSSSSS9.99
16	Filler	57	194 – 250	CHAR	Spaces

Total Length = 250

F.24.6 *Previous Cycle Balance Summary*

Item	Field	Size	Position	Format	Description
1	Contract Number	5	1 – 5	CHAR	Contract Number
2	Record Identification Code	1	6	CHAR	Record Type Identifier L = Last Period Carry Over Amounts carried over to this month from previous months
3	Table ID Number	1	7	CHAR	5
4	Part A Carry Over Amount	15	8 – 22	NUM	Part A Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99
5	Part B Carry Over Amount	15	23 – 37	NUM	Part B Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99
6	Part D Carry Over Amount	15	38 – 52	NUM	Part D Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99
7	Part C Premium Withholding Carry Over Amount	15	53 – 67	NUM	Part C Premium Withholding Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99
8	Part D Premium Withholding Carry Over Amount	15	68 – 82	NUM	Part D Premium Withholding Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99
9	Part D Low Income Premium Subsidy Carry Over Amount	15	83 – 97	NUM	Part D Low Income Premium Subsidy Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99
10	Part D Late Enrollment Penalty Carry Over Amount	15	98 – 112	NUM	Part D Late Enrollment Penalty Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99
11	Education User Fee Carry Over Amount	15	113 – 127	NUM	Education User Fee Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99
12	Part D COB User Fee Carry Over Amount	15	128 – 142	NUM	Part D COB User Fee Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99
13	CMS Special Adjustments Carry Over Amount	15	143 – 157	NUM	CMS Special Adjustments Carry Over Amount - Previous Balance Column. Format:SSSSSSSSSS9.99

Item	Field	Size	Position	Format	Description
14	Total Carry Over Amount	15	158 – 172	NUM	Sum of amounts in Previous Balance Column Format:SSSSSSSSSS9.99
15	Filler	78	173 – 250	CHAR	Spaces

Total Length = 250

F.24.7 Payment Balance Carried Forward

Item	Field	Size	Position	Format	Description
1	Contract Number	5	1 – 5	CHAR	Contract Number
2	Record Identification Code	1	6	CHAR	Record Type Identifier N = Balance Carried Forward to Next Cycle. Amounts carried forward (and not paid) to next month from this month
3	Table ID Number	1	7	CHAR	5
4	Part A Amount Carry Forward	15	8 – 22	NUM	Part A Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSS9.99
5	Part B Amount Carry Forward	15	23 – 37	NUM	Part B Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSS9.99
6	Part D Amount Carry Forward	15	38 – 52	NUM	Part D Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSS9.99
7	Part C Premium Withholding Amount Carry Forward	15	53 – 67	NUM	Part C Premium Withholding Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSS9.99
8	Part D Premium Withholding Amount Carry Forward	15	68 – 82	NUM	Part D Premium Withholding Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSS9.99
9	Part D Low Income Premium Subsidy Amount Carry Forward	15	83 – 97	NUM	Part D Low Income Subsidy Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSS9.99

Item	Field	Size	Position	Format	Description
10	Part D Late Enrollment Penalty Amount Carry Forward	15	98 – 112	NUM	Part D Late Enrollment Penalty Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSSS9.99
11	Education User Fee Amount Carry Forward	15	113 – 127	NUM	Education User Fee Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSSS9.99
12	Part D COB User Fee Amount Carry Forward	15	128 – 142	NUM	Part D COB User Fee Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSSS9.99
13	CMS Special Adjustments Amount Carry Forward	15	143 – 157	NUM	CMS Special Adjustments Amount Carry Forward - Balance Forward Column. Format:SSSSSSSSSSS9.99
14	Total Carry Forward Amount	15	158 – 172	NUM	Sum of amounts in Balance Forward Column Format:SSSSSSSSSSS9.99
15	Filler	78	173 – 250	CHAR	Spaces.

Total Length = 250

F.24.7 *Payment Summary*

Item	Field	Size	Position	Format	Description
1	Contract Number	5	1 – 5	CHAR	Contract Number
2	Record Identification Code	1	6	CHAR	Record Type Identifier A = Payment Summary Amounts included in this month's payment from Tables 1 through 4 plus Carry Over (from Previous Balance Column).
3	Table ID Number	1	7	CHAR	5
4	Part A Amount	15	8 – 22	NUM	Part A amount - Net Payment Column. Format:ZZZZZZZZZZZ9.99
5	Part B Amount	15	23 – 37	NUM	Part B amount - Net Payment Column. Format:ZZZZZZZZZZZ9.99
6	Part D Amount	15	38 – 52	NUM	Part D amount - Net Payment Column. Format:ZZZZZZZZZZZ9.99

Item	Field	Size	Position	Format	Description
7	Part C Premium Withholding Amount	15	53 – 67	NUM	Part C Premium Withholding Amount - Net Payment Column. Format:ZZZZZZZZZZZ9.99
8	Part D Premium Withholding Amount	15	68 – 82	NUM	Part D Premium Withholding Amount - Net Payment Column. Format:ZZZZZZZZZZZ9.99
9	Part D Low Income Premium Subsidy Amount	15	83 – 97	NUM	Part D Low Income Subsidy Amount - Net Payment Column. Format:ZZZZZZZZZZZ9.99
10	Part D Late Enrollment Penalty Amount	15	98 – 112	NUM	Part D Late Enrollment Penalty Amount - Net Payment Column. Format:SSSSSSSSSS9.99
11	Education User Fee Amount	15	113 – 127	NUM	Education User Fee Amount -Net Payment Column. Format:SSSSSSSSSS9.99
12	Part D COB User Fee Amount	15	128 – 142	NUM	Part D COB User Fee Amount - Net Payment Column. Format:SSSSSSSSSS9.99
13	CMS Special Adjustments Amount	15	143 – 157	NUM	CMS Special Adjustments Amount - Net Payment Column. Format:SSSSSSSSSS9.99
14	Total Net Payment	15	158 – 172	NUM	Sum of amounts in Net Payment Column. This is the plan's Net Payment Amount for this month. If the amount is negative, the payment will be carried forward. Format:SSSSSSSSSS9.99
15	Filler	78	173 – 250	CHAR	Spaces.

Total Length = 250

F.25 Agent Broker Compensation Report Data File

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

Based on the qualification rules, year 1 is the initial year and years 2 and on are the renewal years. Plans are responsible for using this information in conjunction with their internal payment and enrollment tracking systems to determine an agent's use and how much to pay the agent.

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

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

Item	Field	Size	Position	Description
1	Record Type	1	1	1 - Detail
2	Contract Number	5	2-6	Contract identification
3	PBP	3	7-9	Plan Benefit Package
4	Beneficiary ID	12	10-21	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
5	Last Name	12	22-33	Beneficiary Surname
6	First Name	7	34-40	Beneficiary Given Name
7	Middle Initial	1	41	Beneficiary Middle Initial
8	DOB	8	42-49	Beneficiary Birth Date YYYYMMDD Format
9	Gender	1	50	Beneficiary Gender Identification Code '0' = Unknown; '1' = Male; '2' = Female.

Item	Field	Size	Position	Description
10	Application Date	8	51-58	The date the Plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper). Format: YYYYMMDD; otherwise, spaces if not applicable.
11	Enrollment Effective Start Date	8	59-66	Date Beneficiary's Plan enrollment starts, YYYYMMDD – Format.
12	Compensation Type as of Enrollment Effective Date	1	67	Compensation type to be paid to the broker for the first year of enrollment 'I' – Initial 'R' – Renewal Blank -
13	Report Generation Date	8	68-75	Date data file created YYYYMMDD – Format
14	Cycle-Year as of Report Generation Date	3	76-78	Numeric value representing the broker compensation cycle-year as of the data file generation date: '-1' = no compensation cycle exists for this enrollment because the data file generation date is before the effective date of the enrollment '1' = first calendar year, '2' = second calendar year, '3' = third calendar year, '4' = fourth calendar year, '5' = fifth calendar year, '6' = sixth calendar year… The numeric value can go as high as 999 years. Right justified.
15	Compensation Payment Year	3	79-81	If the enrollment is prospective with a start date in the upcoming year, the numeric value representing the cycle year as of the enrollment effective date. Otherwise, the numeric value representing the broker compensation cycle-year as of the data file generation date. '1' = first calendar year, '2' = second calendar year, '3' = third calendar year, '4' = fourth calendar year, '5' = fifth calendar year, '6' = sixth calendar year… The numeric value can go as high as 999 years. Right justified.
16	Prior Plan Type	7	82-88	Broad classification of the Beneficiary's immediately prior Plan-type: "None" = no prior Plan "MA" = non-drug Medicare Advantage Plan "MAPD" = MA Plan offering prescription drugs "COST" = Non-drug Medicare COST Plan "COST/PD" = Medicare COST Plan providing prescription drugs "PDP" = Prescription Drug Plan

Item	Field	Size	Position	Description
17	Correction Indicator	2	89-90	'R' – Retroactive enrollment o Any enrollment processed by MARx after the effective date of the enrollment 'ER' – Enrollment reinstated o An disenrollment cancellation was processed by MARx o A cancelled enrollment reinstated a previous enrollment 'IR' – Change in Initial or Renewal o An enrollment was previously reported as Initial or Renewal however this information has been updated due to new information received by MARx 'O' – Change in the Compensation Year Blank – the enrollment does not have a corrected field
18	Filler	60	91-150	Spaces

Total Length = 150

Agent Broker Compensation Data File - Trailer Record

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

Total Length = 150

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

A Medicare Secondary Payment (MSP) data file is sent each month to the Plans. The data on this file reflects beneficiaries that have Medicare as their secondary payer sometime during their Medicare enrollment periods in Part A/B. It contains demographic information on the beneficiary as well as information on their primary insurance.

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

- A Header Record
- A Trailer Record
- A PRIMARY Record
- A DETAIL Record.

The PRIMARY ("PRM") record identifies and provides information about the beneficiary. The PRM record has a Detail Count field that identifies how many DETAIL records will follow the PRIMARY record. Each DETAIL ("DET##") record contains the details on a specific MSP period for the beneficiary identified in the PRM record.

The Trailer Record contains a total count of PRIMARY records and a total count of combined PRIMARY and DETAIL records.

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

F.26.1 *Header Record*

Item	Field	Size	Position	Description
1	Header Code	8	1-8	Value 'CMSMSPDH'.
2	Sending Entity	4	9-12	Value 'MARX'.
3	File Creation Date	8	13-20	CCYYMMDD
4	Filler	680	21-700	spaces

Total Length = 700

F.26.2 *Primary Record*

Item	Field	Size	Position	Description
1	Record Type	3	1-3	"PRM"
2	Beneficiary ID	12	4-15	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
3	Detail Count	2	16-17	This is the count of MSP DET records that exist for each beneficiary
4	Date of Birth	8	18-25	CCYYMMDD
5	Sex Code	1	26	0 = Unknown 1 = Male 2 = Female
6	Contract	5	27-31	Contract Number
7	PBP	3	32-34	Plan Benefit Package

This begins the MSP Factor fields for the Prospective Payment.

Item	Field	Size	Position	Description
8	MSP Factor	7	35-41	Layout (00.0000)
9	PTA RDAMT SIGN	1	42	"-" = Negative blank = Positive
10	PTA RDAMT	9	43-51	Layout (999999.99)
11	PTB RDAMT SIGN	1	52	"-" = Negative blank = Positive
12	PTB RDAMT	9	53-61	Layout (999999.99)
13	PAID FLAG	1	62	Y = Yes, it was paid N = No, it was not paid

This ends the MSP Factor fields for the Prospective Payment.

Item	Field	Size	Position	Description
14	MSP Factor ADJ1	7	63-69	Layout (00.0000)
15	PTA RDAMT SIGN ADJ1	1	70	"-" = Negative blank = Positive
16	PTA RDAMT ADJ1	9	71-79	Layout (999999.99)

Item	Field	Size	Position	Description
17	PTB RDAMT SIGN ADJ1	1	80	"-" = Negative blank = Positive
18	PTB RDAMT ADJ1	9	81-89	Layout (999999.99)
19	PAID FLAG ADJ1	1	90	Y = Yes, it was paid N = No, it was not paid
20	MSP Factor ADJ2	7	91-97	Layout (00.0000)
21	PTA RDAMT SIGN ADJ2	1	98	"-" = Negative blank = Positive
22	PTA RDAMT ADJ2	9	99-107	Layout (999999.99)
23	PTB RDAMT SIGN ADJ2	1	108	"-" = Negative blank = Positive
24	PTB RDAMT ADJ2	9	109-117	Layout (999999.99)
25	PAID FLAG ADJ2	1	118	Y = Yes, it was paid N = No, it was not paid
26	MSP Factor ADJ3	7	119-125	Layout (00.0000)
27	PTA RDAMT SIGN ADJ3	1	126	"-" = Negative blank = Positive
28	PTA RDAMT ADJ3	9	127-135	Layout (999999.99)
29	PTB RDAMT SIGN ADJ3	1	136	"-" = Negative blank = Positive
30	PTB RDAMT ADJ3	9	137-145	Layout (999999.99)
31	PAID FLAG ADJ3	1	146	Y = Yes, it was paid N = No, it was not paid
32	MSP Factor ADJ4	7	147-153	Layout (00.0000)
33	PTA RDAMT SIGN ADJ4	1	154	"-" = Negative blank = Positive
34	PTA RDAMT ADJ4	9	155-163	Layout (999999.99)
35	PTB RDAMT SIGN ADJ4	1	164	"-" = Negative blank = Positive
36	PTB RDAMT ADJ4	9	165-173	Layout (999999.99)

Item	Field	Size	Position	Description
37	PAID FLAG ADJ4	1	174	Y = Yes, it was paid N = No, it was not paid
38	Filler	526	175-700	Spaces

Total Length = 700

F.26.3 Detail Record

Item	Field	Size	Position	Description
1	Record Type	5	1-5	Value: DET## (## = number of the MSP occurrence. 01 through 17)
2	Beneficiary ID	12	6-17	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
3	Delete Ind	1	18	D = occurrence to be deleted or audited
4	Validity Ind	1	19	I = FI/Carrier added occurrence N = Beneficiary does not have MSP coverage Y = COBC added.
5	MSP Code	1	20	The field value is cross-walked. (All values: 12 = Working Aged (A) 13 = ESRD (B) 14 = No Fault (D) 15 = Worker Comp (E) 16 = Federal (Public Health) (F) 41 = Black Lung (H) 42 = Veterans (I) 43 = Disabled (G) 47 = Liability (L)
6	COB Contractor Number	5	21-25	N/A
7	Date Entry Added	8	26-33	CCYYMMDD
8	Update Contractor Number	5	34-38	N/A
9	Maintenance Date	8	39-46	CCYYMMDD; Date the data was updated by MSP updating contractor.
10	CWF Occurrence	2	47-48	2 digit numeric value Spaces if no value present on table
11	Filler	4	49-52	Spaces

Item	Field	Size	Position	Description
12	INSURER TYPE	1	53	A = Insurance or indemnity, B = HMP, C = Preferred provider organization, D = Third party administrator arrangement under an administrative service only contract without stop loss from any entity E = Third party administrator arrangement with stop loss insurance issued from any entity, F = Self-insured/self-administered, G = Collectively-bargained health and welfare, H = Multiple employer health plan with at least one employer who has more than 100 full and/or part-time employees, J = Hospitalization only plan which covers only Inpatient services, K = Medicare services only plan which covers only non-inpatient services, M = Medicare supplemental plan: Medigap, Medicare Wraparound Plan or Medicare Carve Out Plan , ' ' = spaces
13	Insurer Name	32	54-85	The name of the group coverage plan in which the beneficiary is enrolled.
14	Insurer Address 1	32	86-117	The first line of the insurer's mailing street address.
15	Insurer Address 2	32	118-149	The second line of the insurer's mailing street address.
16	Insurer City	15	150-164	The name of the city for the insurer's mailing address.
17	Insurer State Code	2	165-166	The postal state code for the insurer's mailing address.
18	Insurer Zip Code	9	167-175	The zip code associated with the address.
19	Policy Number	17	176-192	The identifier for the group coverage plan in which the beneficiary is enrolled.
20	MSP Effective Date	8	193-200	CCYYMMDD
21	MSP Termination Date	8	201-208	CCYYMMDD

Item	Field	Size	Position	Description
22	Patient Relationship Code	2	209-210	01 = Patient is Insured, 02 = Spouse, 03 = Natural Child, Insured has Financial Responsibility, 04 = Natural Child, Insured does not have Financial Responsibility, 05 = Step Child, 06 = Foster Child, 07 = Ward of the Court, 08 = Employee, 09 = Unknown, 10 = Handicapped Dependent, 11 = Organ Donor, 12 = Cadaver Donor, 13 = Grandchild, 14 = Niece/Nephew, 15 = Injured Plaintiff, 16 = Sponsored Dependent, 17 = Minor Dependent of a Minor Dependent, 18 = Parent, 19 = Grandparent dependent, 20 = Life Partner
23	Subscriber First Name	9	211-219	First name of policyholder
24	Subscriber Last Name	16	220-235	Last name of policyholder
25	Employee ID Number	12	236-247	Employee ID number assigned by employer

Item	Field	Size	Position	Description
26	Source Code	2	248-249	A = Claim Processing, B = IRS/SSA/CMS Data Match, C = First Claim Development, D = IRS/SSA/CMS Data Match II, E = Black Lung (DOL), F = Veterans (VA), G = Other Data Matches, H = Worker's Compensation, I = Notified by Beneficiary, J = Notified by Provider, K = Notified by Insurer, L = Notified by Employer, M = Notified by Attorney, N = Notified by Group Health Plan/Primary Payer, O = Initial Enrollment Questionnaire, P = HMP Rate Cell Adjustment, Q = Voluntary Insurer Reporting, S = Miscellaneous Reporting, T = IRS/SSA/CMS Data Match III, U = IRS/SSA/CMS Data Match IV, V = IRS/SSA/CMS Data Match V, W = IRS/SSA/CMS Data Match VI, X = Self reports, Y = 411.25, Spaces = Unknown, 0 = COB Contractor, 1 = Initial Enrollment questionnaire, 2 = IRS/SSA/CMS/data match, 3 = HMP Rate cell, 4 = Litigation Settlement, 5 = Employer Voluntary Reporting, 6 = Insurer Voluntary Reporting, 7 = First Claim Development, 8 = Trauma Code Development, 9 = Secondary Claims Investigation, 10 = Self Reports, 11 = 411.25, 12 = BC/BS Voluntary Agreements, 13 = Office of Personnel Management (OPM), 14 = Workmen's Compensation (WC) Data match, 25 = Recovery Audit Contractor (California), 26 = Recovery Audit Contractor (Florida)
27	Employee INFO Data	1	250	P = Patient, S = Spouse, M = Mother, F = Father
28	Employer Name	32	251-282	The name of the employer providing coverage
29	Employer Address 1	32	283-314	Employer's street address line 1
30	Employer Address 2	32	315-346	Employer's street address line 2

Item	Field	Size	Position	Description
31	Employer City	15	347-361	The name of employer's city
32	Employer State	2	362-363	Employer's state code
33	Employer Zip Cd	9	364-372	Employer's zip code
34	Insurer Group Number	20	373-392	Group number assigned by primary payer
35	Insurer Group Name	17	393-409	The name of the insurance group
36	Prepaid Health Plan Date	8	410-417	CCYYMMDD; Date beneficiary was notified that the Medicare is secondary payer for services performed outside the prepaid Health Plan when they could have been performed by a prepaid Health Plan provider
37	Remarks Code 1	2	418-419	Remarks Code 1
38	Remarks Code 2	2	420-421	Remarks Code 2
39	Remarks Code 3	2	422-423	Remarks Code 3
40	Payer ID	10	424-433	The identifier of the primary payer
41	Diagnosis Code Ind 1	1	434	0 = ICD 10, 9 = ICD 9
42	Diagnosis Code 1	7	435-441	Diagnosis Code 1
43	Diagnosis Code Ind 2	1	442	0 = ICD 10, 9 = ICD 9
44	Diagnosis Code 2	7	443-449	Diagnosis Code 2
45	Diagnosis Code Ind 3	1	450	0 = ICD 10, 9 = ICD 9
46	Diagnosis Code 3	7	451-457	Diagnosis Code 3
47	Diagnosis Code Ind 4	1	458	0 = ICD 10, 9 = ICD 9
48	Diagnosis Code 4	7	459-465	Diagnosis Code 4
49	Diagnosis Code Ind 5	1	466	0 = ICD 10, 9 = ICD 9
50.	Diagnosis Code 5	7	467-473	Diagnosis Code 5
51	Diagnosis Code Ind 6	1	474	0 = ICD 10, 9 = ICD 9
52	Diagnosis Code 6	7	475-481	Diagnosis Code 6
53	Diagnosis Code Ind 7	1	482	0 = ICD 10, 9 = ICD 9

Item	Field	Size	Position	Description
54	Diagnosis Code 7	7	483-489	Diagnosis Code 7
55	Diagnosis Code Ind 8	1	490	0 = ICD 10, 9 = ICD 9
56	Diagnosis Code 8	7	491-497	Diagnosis Code 8
57	Diagnosis Code Ind 9	1	498	0 = ICD 10, 9 = ICD 9
58	Diagnosis Code 9	7	499-505	Diagnosis Code 9
59	Diagnosis Code Ind 10	1	506	0 = ICD 10, 9 = ICD 9
60	Diagnosis Code 10	7	507-513	Diagnosis Code 10
61	Diagnosis Code Ind 11	1	514	0 = ICD 10, 9 = ICD 9
62	Diagnosis Code 11	7	515-521	Diagnosis Code 11
63	Diagnosis Code Ind 12	1	522	0 = ICD 10, 9 = ICD 9
64	Diagnosis Code 12	7	523-529	Diagnosis Code 12
65	Diagnosis Code Ind 13	1	530	0 = ICD 10, 9 = ICD 9
66	Diagnosis Code 13	7	531-537	Diagnosis Code 13
67	Diagnosis Code Ind 14	1	538	0 = ICD 10, 9 = ICD 9
6	Diagnosis Code 14	7	539-545	Diagnosis Code 14
69	Diagnosis Code Ind 15	1	546	0 = ICD 10, 9 = ICD 9
70	Diagnosis Code 15	7	547-553	Diagnosis Code 15
71	Diagnosis Code Ind 16	1	554	0=ICD 10, 9=ICD 9
72	Diagnosis Code 16	7	555-561	Diagnosis Code 16
73	Diagnosis Code Ind 17	1	562	0=ICD 10, 9=ICD 9
74	Diagnosis Code 17	7	563-569	Diagnosis Code 17
75	Diagnosis Code Ind 18	1	570	0=ICD 10, 9=ICD 9
76	Diagnosis Code 18	7	571-577	Diagnosis Code 18

Item	Field	Size	Position	Description
77	Diagnosis Code Ind 19	1	578	0=ICD 10, 9=ICD 9
78	Diagnosis Code 19	7	579-585	Diagnosis Code 19
79	Diagnosis Code Ind 20	1	586	0=ICD 10, 9=ICD 9
80	Diagnosis Code 20	7	587-593	Diagnosis Code 20
81	Diagnosis Code Ind 21	1	594	0=ICD 10, 9=ICD 9
82	Diagnosis Code 21	7	595-601	Diagnosis Code 21
83	Diagnosis Code Ind 22	1	602	0=ICD 10, 9=ICD 9
84	Diagnosis Code 22	7	603-609	Diagnosis Code 22
85	Diagnosis Code Ind 23	1	610	0=ICD 10, 9=ICD 9
86	Diagnosis Code 23	7	611-617	Diagnosis Code 23
87	Diagnosis Code Ind 24	1	618	0=ICD 10, 9=ICD 9
88	Diagnosis Code 24	7	619-625	Diagnosis Code 24
89	Diagnosis Code Ind 25	1	626	0=ICD 10, 9=ICD 9
90	Diagnosis Code 25	7	627-633	Diagnosis Code 25
91	Filler	67	634-700	Spaces

Total Length = 700

F.26.4 *Trailer Record*

Item	Field	Size	Position	Description
1	Trailer Code	8	1-8	Value ‘CMSMSPDT’.
2	Sending Entity	4	9-12	Value 'MARX'
3	File Creation Date	8	13-20	CCYYMMDD
4	TOTAL PRM Count	8	21-28	Total count of primary beneficiary records
5	TOTAL RECORDS Count	8	29-36	Total count of all records (minus the Header and Trailer)
6	Filler	664	37-700	spaces

Total Length = 700

F.27 Failed Payment Reply Report (FPRR) Data File

Along with the other monthly payment reports, MARx generates the FPRR. If payment calculation for a beneficiary cannot complete, MARx identifies the beneficiary and time period for which the payment calculation is not performed. The records in this file are the same length as those in the DTRR and contain their own unique Payment Reply Codes (PRCs) found in Table I-5.

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

Item	Field	Size	Position	Description
1	Beneficiary ID	12	1-12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
2	Surname	12	13-24	Beneficiary's last name, included with PRC 264
3	First Name	7	25-31	Beneficiary's given name, included with PRC 264
4	Middle Name	1	32	First initial of beneficiary's middle name, included with PRC 264
5	Gender Code	1	33	Beneficiary's gender identification code, included with PRC 264: '0' = Unknown, '1' = Male, '2' = Female
6	Date of Birth	8	34-41	Beneficiary's birth date, formatted YYYYMMDD, included with PRC 264
7	FILLER	1	42	Spaces
8	Contract Number	5	43-47	Plan Contract Number, included with PRC 000 and PRC 264
9	State Code	2	48-49	Beneficiary's residence SSA state code, included with PRC 264; otherwise, spaces if not available
10	County Code	3	50-52	Beneficiary's residence SSA county code, included with PRC 264; otherwise, spaces if not available
11	FILLER	4	53-56	Spaces
12	Payment Reply Code	3	57-59	"000" = no missing payments; "264" = payment not yet completed "299" = Correction to Previously Failed Payment
13	FILLER	3	60-62	Spaces
14	Effective Date	8	63-70	Enrollment effective date, formatted YYYYMMDD and included with PRC 264
15	FILLER	1	71	Spaces

Item	Field	Size	Position	Description
16	PBP ID	3	72-74	PBP number, included with both PRC 000 and PRC 264
17	FILLER	1	75	Spaces
18	Transaction Date	8	76-83	Report generation date, formatted YYYYMMDD and included with both PRC 000 and PRC 264
19	FILLER	1	84	Spaces
20	CPM	12	85- 96	CPM, formatted YYYYMM, left justified with six spaces completing the field, and included with both PRC 000 and PRC 264, and PRC 299
21	FILLER	38	97-134	Spaces
22	Segment Number	3	135-137	Segment in PBP, included with PRC 264
23	FILLER	25	138-162	Spaces
24	Processing Timestamp	15	163-177	Report generation time, formatted HH.MM.SS.SSSSSS and included with both PRC 000 and PRC 264
25	FILLER	188	178-365	Spaces
26	PRC Short Name	15	366-380	PRC short name associated with PRC 000 is “NO REPORT,” with PRC 264 is “NO PAYMENT,” and with PRC 299 is “RESTORED PYMT.” Text is left justified with following spaces completing the field.
27	FILLER	120	381-500	Spaces

Total Length = 500

F.28 MSA Deposit-Recovery Data File Layout

The MSA Deposit-Recovery Data File includes MSA lump sum deposit and recovery amounts for the Current Payment Month (CPM) at the beneficiary level. The file is used by MSA participating Plans to reconcile and identify MSA deposit amounts.

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

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

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

- Header Record –
  - Record ID = 'HDR', provides Contract number and pertinent dates for the file
- Detail Record –
  - Record ID = 'DPT', provides beneficiary level information on the Lump-Sum Deposits
  - Record ID = 'RCV', provides beneficiary level information on Lump-Sum Deposit amounts to be recovered from the plan
- Trailer Record –
  - Record ID= 'TR1', provides a total of Deposit amounts at the contract/plan benefit package (PBP) level
  - Record ID = 'TR2', provides a total of Deposit amounts at the contract level

All detail records for a single PBP are grouped together. Each group is followed by a TR1 Trailer that provides totals for the PBP. A TR2 Trailer is the last record in the file. It provides the totals at the Contract level (i.e. all PBPs).

F.28.1 *Header Record*

Item	Field	Size	Position	Description
1	Record ID	3	1-3	HDR = Header Record
2	MCO Contract Number	5	4-8	MCO Contract Number
3	Run Date of the file	8	9-16	Date this data file was created YYYYMMDD
4	Payment Date	6	17-22	YYYYMM
5	Filler	143	23-165	Spaces

Total Length = 165

F.28.2 *Detail Record*

Item	Field	Size	Position	Description
1	Record ID	3	1-3	DPT = MSA Deposit Record RCV = MSA Recovery Record
2	MCO Contract Number	5	4-8	MCO Contract Number
3	Plan Benefit Package ID	3	9-11	Plan Benefit Package ID Format: 999
4	Beneficiary ID	12	12-23	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
5	Surname	7	24-30	Surname
6	First Initial	1	31	First Initial
7	Sex	1	32	M = Male F = Female
8	Date of Birth	8	33-40	YYYYMMDD
9	Filler	1	41	Blank
10	Disenrollment Reason Code	2	42-43	Disenrollment Reason Code associated with the Recovery Blank for a Deposit record
11	MSA Deposit or Recovery Start Date	8	44-51	Start Date for Deposit or Recovery entry YYYYMMDD

Item	Field	Size	Position	Description
12	MSA Deposit or Recovery End Date	8	52-59	End Date for Deposit or Recovery entry YYYYMMDD
13	Number of Months in MSA Lump-sum Deposit or Recovery	2	60-61	Indicates Number of Months used to compute Lump-Sum or Recovery Payments. Format: 99
14	Part A Monthly Deposit Rate	7	62-68	The Medicare Part A dollar amount that is deposited monthly into the beneficiaries MSA Account. Format: 9999.99
15	Part B Monthly Deposit Rate	7	69-75	The Medicare Part B dollar amount that is deposited monthly into the beneficiaries MSA Account. Format: 9999.99
16	Lump-Sum MSA Deposit or Recovery Part A amount	9	76-84	Part A Lump Sum Amount provided to plan for bene's MSA enrollment. For disenrollment, Part A Lump Sum amount to be recovered from Plan Format: -99999.99 **NOTE**: A Recovery will be reported as a negative amount. A Deposit will be reported as a positive amount
17	Lump-Sum MSA Deposit or Recovery Part B amount	9	85-93	Part B Lump Sum Amount provided to plan for bene's MSA enrollment. For disenrollment, Part A Lump Sum amount to be recovered from Plan. Format: -99999.99 **NOTE**: A Recovery will be reported as a negative amount. A Deposit will be reported as a positive amount
18	Filler	72	94-165	Blanks

Total Length = 165

F.28.3 *Trailer Record*

Item	Field	Size	Position	Description
1	Record ID	3	1-3	Trailer Record TR1 – Trailer for Contract/PBP level TR2 – Trailer for Contract level
2	Contract Number	5	4-8	Contract Number
3	PBP Number	3	9-11	PBP Number on TR1 Blank on TR2
4	Beneficiary Count	7	12-18	TR1 - Distinct count of beneficiaries based on beneficiary IDs reported this month for the PBP TR2 – Sum of beneficiaries reported TR1 records Format: 9999999
5	Detail Record Count	7	19-25	Count of Deposit and Recovery records for the PBP (TR1) or all PBPs (TR2) Format: 9999999
6	PBP Count	4	26-29	Blank on TR1 Count of TR1 records for the contract Format: 9999
7	Filler	2	30-31	Spaces
8	Part A Total Deposit Amount	13	32-44	Total Part A Lump-Sum MSA Deposit amount Format: 9999999999.99
9	Part B Total Deposit Amount	13	45-57	Total Part B Lump-Sum MSA Deposit amount Format: 9999999999.99
10	Part A Total Recovery Amount	14	59-71	Total Part A Lump-Sum MSA Recovery amount Format: -9999999999.99
11	Part B Total Recovery Amount	14	72-85	Total Part B Lump-Sum MSA Recovery amount Format: -9999999999.99
12	Total Amount	15	86-100	Sum of all amounts on record Format: -99999999999.99
13	Filler	69	101-165	Spaces

Total Length = 165

F.29 Medicare Advantage Medicaid Status Data File

CMS will send a monthly report to Plans that provides the monthly dual statuses and corresponding dual status codes for their beneficiaries who are full or partial duals. Plans will receive a Medicare Advantage Medicaid Status data file to assist in predicting future revenue impacts under the new CMS-HCC risk adjustment model, and to assist in benefit coordination. Each report will provide the most recent Medicaid information on plan enrollees, back to the beginning of the payment.

The data file will be generated monthly. The data file is comprehensive beginning with January 2017. Each month, all overlapping enrollment and Medicaid records that start on or after January 2017 up to the data file generation date will be included.

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

F.29.1 *Header Record*

Item	Field	Size	Position	Description
1	Record Type	1	1	1 – File Header
2	Contract Number	5	2-6	Contract identification
3	Start Year	4	7-10	Earliest year associated with the data
4	End Year	4	11-14	Latest year associated with the data
5	File Generation Date	8	15-22	Date the file was generated YYYYMMDD Format
6	Filler	53	23-75	Spaces

Total Length = 75

F.29.2 *Beneficiary Identification Record*

Item	Field	Size	Position	Description
1	Record Type	1	1	2 – Beneficiary Identification Record
2	Contract Number	5	2-6	Contract Identification
3	Beneficiary ID	12	7-18	Beneficiary Identifier
4	Last Name	12	19-30	Beneficiary Surname
5	First Name	7	31-37	First Name

Item	Field	Size	Position	Description
6	Middle Initial	1	38	Beneficiary Middle Initial
7	DOB	8	39-46	Beneficiary Birth Date YYYYMMDD Format
8	Gender	1	47	Beneficiary Gender Identification Code '0' = Unknown '1' = Male '2' = Female
9	Filler	28	48-75	Spaces

Total Length = 75

F.29.3 *Beneficiary Detail Record*

Item	Field	Size	Position	Description
1	Record Type	1	1	3 - Beneficiary Detail Record(s)
2	Contract Number	5	2-6	Contract Identification
3	Medicaid Status Start Date	8	7-14	Medicaid Status Start Date YYYYMMDD Format
4	Medicaid Status End Date	8	15-22	Medicaid Status End Date YYYYMMDD Format Spaces if there is no end date
5	Medicaid Status	1	23	F – Full P – Partial
6	Dual Status Code Start Date	8	24-31	Dual Status Code Start Date YYYYMMDD Format
7	Dual Status Code End Date	8	32-39	Dual Status Code End Date YYYYMMDD Format
8	Dual Status Code	2	40-41	Dual Status Code
9	Record Add Timestamp	12	42-53	Record Add Timestamp for Dual Status Code YYYYMMDDHHMM format
10	Record Update Timestamp	12	54-65	Record Update Timestamp for Dual Status Code YYYYMMDDHHMM Format
11	Filler	18	66-75	Spaces

Total Length = 75

F.29.4 *File Trailer Record*

Item	Field	Size	Position	Description
1	Record Type	1	1	4 – File Trailer
2	Contract Number	5	2-6	Contract Identification
3	Record Count	7	7-13	Number of records on the data file (count of Type1,Type 2, Type 3 and Type 4 records) Left padded with zeroes
4	Beneficiary Record Count	7	14-20	Number of beneficiary records (Type 2) on the data file. Left padded with zeroes
5	Filler	55	21-75	Spaces

Total Length = 75

Yearly Record Layouts

F.30 Loss of Subsidy Data File

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

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

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

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

F.30.1 *LIS Data File Detail Record*

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

Item	Field	Size	Position	Description
9	State Code	2	48-49	Beneficiary State Code
10	County Code	3	50-52	Beneficiary County Code
11	Filler	4	53-56	Spaces
12	TRC	3	57-59	TRC '996'
13	Transaction Type Code	2	60-61	Transaction Type Code '01'
14	Filler	1	62	Spaces
15	Effective Date	8	63-70	YYYYMMDD – Format is 01/01 of the next year. Start of Beneficiary's Loss of LIS status.
16	Filler	1	71	Spaces
17	Plan Benefit Package ID	3	72-74	PBP number
18	Filler	1	75	Spaces
19	Transaction Date	8	76-83	Set to Current Date (YYYYMMDD), is the run date.
20	Filler	1	84	Spaces
21	Low-Income Subsidy End Date	8	85-92	End Date of Beneficiary's LIS Period (YYYYMMDD), is 12/31 of the current year.
22	Filler	42	93-134	Spaces
23	Segment Number	3	135-137	'000' if no segment in PBP
24	Filler	97	138-234	Spaces
25	Part D Low-Income Premium Subsidy Level	3	235-237	Part D low-income premium subsidy category: '000' = No subsidy
26	Low-Income Co-Pay Category	1	238	Co-payment category: '0' = none, not low-income
27	Filler	124	239-362	Spaces
28	LIS Source Code	1	363	'A' = Approved SSA Applicant; 'D' = Deemed eligible by CMS
29	Filler	137	364-500	Spaces

Total Length = 500

F.31 Long-Term Institutionalized (LTI) Resident Report Data File

The LTI Resident Report provides Part D sponsors with a list of their enrolled beneficiaries who are LTI residents for longer than 90 days.

CMS will release the LTI report twice yearly. This report provides information to Part D Sponsors on institutionalized enrollees, as well as the names and addresses of the particular long-term care (LTC) facilities in which those beneficiaries reside. This information is obtained by linking Medicare enrollment information with data from the Minimum Data Set (MDS) of nursing home assessments.

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

System	Type	Frequency	Dataset Naming Conventions
MDS	Report	Twice Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst

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

Item	Field	Size	Position	Format	Description
10	Nursing Home Admission Date	8	125-132	DATE	Admission date associated with the last assessment for the resident. YYYYMMDD – Format
11	Last Nursing Home Assessment Date	8	133-140	DATE	Target date of the last assessment for the resident. YYYYMMDD – Format
12	Prospective Payment System (PPS) Indicator	1	141	CHAR	Identifies those long-term nursing home residents whose last reported resident assessment was a Medicare-PPS type assessment. (Data source: Minimum Data Set (MDS) system, field A0310B). This field was formerly known as the Part A Indicator.
13	Nursing Home Name	50	142-191	CHAR	Name of Nursing Home associated with the last assessment for the resident.
14	Medicare Provider ID	12	192-203	CHAR	Medicare Provider ID of Nursing Home associated with the last assessment for the resident.
15	Provider Telephone Number	13	204-216	CHAR	Telephone Number of Nursing Home associated with the last assessment for the resident.
16	Provider Address	50	217-266	CHAR	Address of Nursing Home associated with the last assessment for the resident.
17	Provider City	20	267-286	CHAR	City of Nursing Home associated with the last assessment for the resident.
18	Provider State Code	2	287-288	CHAR	State Code of Nursing Home associated with the last assessment for the resident.
19	Provider Zip Code	11	289-299	CHAR	Zip Code of Nursing Home associated with the last assessment for the resident.

Total Length = 299

F.32 No Premium Due Data File Layout

MA enrollees who elect optional supplemental benefits may also elect SSA premium withholding. In mid-November, MARx begins preparing the premium records for the next year. Since MARx cannot anticipate which optional premiums an enrollee may elect for next year, an enrollee only paying optional premiums may convert from "SSA Premium Withholding" status in one year to "No Premium Due" status for the next year. Plans should use the No Premium Due Data File to identify enrollees in a "No Premium Due" status for the next year. Plans should review the report and submit both a Part C Premium Update (TC 78) to update the Part C premium Amount, and a PPO Update (TC 75) to request SSA Withholding Status, for enrollees who are renewing both elections for the next year.

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

Item	Field	Size	Position	Description
1	Beneficiary ID	12	1-12	• Health Insurance Claim Number (HICN) until the start of Medicare Beneficiary Identifier (MBI) transition then • MBI during and after MBI transition. ○ MBI is 11 characters, left-justified with one space at the end.
2	Surname	12	13-24	Beneficiary Surname
3	First Name	7	25-31	Beneficiary Given Name
4	Middle Initial	1	32	Beneficiary Middle Initial
5	Gender Code	1	33	Beneficiary Gender Identification Code '0' = Unknown; '1' = Male; '2' = Female.
6	Date of Birth	8	34-41	YYYYMMDD – Format
7	Filler	1	42	Space
8	Contract Number	5	43-47	Plan Contract Number
9	State Code	2	48-49	Spaces
10	County Code	3	50-52	Spaces
11	Disability Indicator	1	53	Space
12	Hospice Indicator	1	54	Space
13	Institutional/NHC Indicator	1	55	Space
14	ESRD Indicator	1	56	Space
15	TRC	3	57-59	TRC Defaulted to '267'

Item	Field	Size	Position	Description
16	Transaction Code	2	60-61	TC Defaulted to '01' for special reports
17	Entitlement Type Code	1	62	Space
18	Effective Date	8	63-70	YYYYMMDD – Format; Example: 20110101 (set to first of January of the upcoming year)
19	WA Indicator	1	71	Space
20	PBP ID	3	72-74	PBP number
21	Filler	1	75	Space
22	Transaction Date	8	76-83	YYYYMMDD – Format; Set to the report generation date.
23	UI Initiated Change Flag	1	84	Space
24	FILLER	12	85-96	Spaces
25	District Office Code	3	97-99	Spaces
26	Previous Part D Contract/PBP for TrOOP Transfer.	8	100-107	Spaces
27	End Date	8	108-115	Spaces
28	Source ID	5	116-120	Spaces
29	Prior PBP ID	3	121-123	Spaces
30	Application Date	8	124-131	Spaces
31	UI User Organization Designation	2	132-133	Spaces
32	Out of Area Flag	1	134	Space
33	Segment Number	3	135-137	Further definition of PBP by geographic boundaries; Default to '000' when blank.
34	Part C Beneficiary Premium	8	138-145	Part C Premium Amount: Since this report is only reporting on Beneficiaries that have No Premium Due, by definition, this amount is zero
35	Part D Beneficiary Premium	8	146-153	Part D Premium Amount: Since this report is only reporting on Beneficiaries that have No Premium Due, by definition, this amount is zero
36	Election Type	1	154	Space
37	Enrollment Source	1	155	Space
38	Part D Opt-Out Flag	1	156	Space
39	Premium Withhold Option/Parts C-D	1	157	'N' = No premium applicable;
40	Number of Uncovered Months	3	158-160	Spaces
41	Creditable Coverage Flag	1	161	Space
42	Employer Subsidy Override Flag	1	162	Space
43	Processing Timestamp	15	163-177	The report generation time. Format: HH.MM.SS.SSSSSS
44	Filler	20	178-197	Spaces
45	Secondary Drug Insurance Flag	1	198	Space
46	Secondary Rx ID	20	199-218	Spaces
47	Secondary Rx Group	15	219-233	Spaces
48	EGHP	1	234	Space

Item	Field	Size	Position	Description
49	Part D LIPS Level	3	235-237	Spaces
50	Low-Income Co-Pay Category	1	238	Space
51	Low-Income Period Effective Date	8	239-246	Spaces
52	Part D LEP Amount	8	247-254	Spaces
53	Part D LEP Waived Amount	8	255-262	Spaces
54	Part D LEP Subsidy Amount	8	263-270	Spaces
55	Low-Income Part D Premium Subsidy Amount	8	271- 278	Spaces
56	Part D Rx BIN	6	279-284	Spaces
57	Part D Rx PCN	10	285-294	Spaces
58	Part D Rx Group	15	295-309	Spaces
59	Part D Rx ID	20	310-329	Spaces
60	Secondary Rx BIN	6	330-335	Spaces
61	Secondary Rx PCN	10	336-345	Spaces
62	De Minimis Differential Amount	8	346-353	Spaces
63	MSP Status Flag	1	354	Space
64	Low Income Period End Date	8	355-362	Spaces
65	LIS Source Code	1	363	Space
66	Enrollee Type Flag, PBP Level	1	364	Space
67	Application Date Indicator	1	365	Space
68	Filler	135	366-500	Spaces

Total Length = 500

Special Record Layouts

F.33 HICN to MBI Crosswalk File Layout

To assist MAOs and Part D sponsors with the ability to determine or match their beneficiary population between HICN and MBI, MARx will generate and distribute a monthly crosswalk data file. Each crosswalk data file will be created at the MAO/PDP Contract level. The crosswalk files will be sent monthly during the transition period.

- In March 2018 plans will receive an "initial" (one-time only) HICN to MBI Crosswalk file for past and present membership back to 2006.
- After the initial Crosswalk file, a monthly file will be sent to Plans to include any new enrollment changes.

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

Item	Field	Size	Position	Description
1	Contract	5	1 – 5	Plan Contract Number
2	PBP	3	6 – 8	Plan Benefit Package ID
3	HICN	12	9 – 20	Health Insurance Claim Number
4	MBI	11	21 – 31	Medicare Beneficiary Identifier
5	Surname	30	32 – 61	Beneficiary's last name
6	First Name	12	62 – 73	Beneficiary's first name
7	Date of Birth	8	74 – 81	YYYYMMDD Format
8	Date of Death	8	82 – 89	YYYYMMDD Format
9	Gender	1	90	Beneficiary Gender Identification Code '0' = Unknown '1' = Male '2' = Female
10	Recent Enrollment Date	8	91 – 98	YYYYMMDD Format; The effective date of the beneficiary's most recent enrollment in the contract.

11	Recent Disenrollment Date	8	99 – 106	YYYYMMDD Format; The disenrollment date (if present) for the beneficiary's most recent enrollment in the contract.

G: *Screen Hierarchy*

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

Table G-1: Screen Lookup Table

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

Screen Name	Screen Number
Status Activity	M256
Status Activity Detail	M257
Transactions Screens	
Transactions: Batch Status	M307
Batch File Details	M314
Special Batch Approval Request	M316
View Special Batch File Request	M317
Payments Screens	
Payments: MCO	M401
Payments: MCO Payments	M402
Payments: Beneficiary	M403
Payments: Beneficiary Search Results	M404
Beneficiary Payment History	M406
Adjustment Detail	M408
Payments: Premiums and Rebates	M409
Reports Screens	
Reports: Find	M601
Reports: Search Results	M602

H: *Validation Messages*

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

Figure H-1: Validation Message Placement on Screen

These are common validation messages, not specific to a single screen but related to the fields that appear on many screens. Note that screen/function-specific messages appear in the section related to the specific function and are associated with the specific screen.

Table H-1: Validation Messages

Error Messages	Suggested Action
User must enter a contract number	Enter the field specified by the message.
A contract number must start with an 'E', 'H', 'R', 'S', 'X,' or '9', followed by four characters	Re-enter the field and follow the format indicated in the message.
User must enter a sex	Enter the field specified by the message.
User must select a state	Enter the field specified by the message.
Invalid Contract/PBP combination	Check the combination and re-enter.
Invalid Contract/PBP/segment combination	Check the combination and re-enter.
<kind-of-date> is invalid. Must have format (M)M/(D)D/YYYY	Re-enter the field and follow the format indicated in the message.
User must enter <kind of date>	Enter the field specified by the message.
PBP number must have three alphanumeric characters	Re-enter the field and follow the format indicated in the message.
Please enter at least one of the required fields	Make sure to enter all the required fields.
Please enter user ID or password	Make sure to enter one of the fields specified by the message.
Segment number must have three digits	Re-enter the field and follow the format indicated in the message.
The claim number is not a valid SSA or RRB number, or CMS Internal number	Re-enter the field in SSA, RRB, or CMS Internal format.
The last name contains invalid characters	Re-enter the field using only letters, apostrophes, hyphens, or blanks.
The user ID contains invalid characters	Re-enter the field and follow the format indicated in the message.
You do not have access rights to this contract	First, make sure that the Contract # correctly is entered correctly. If not, re-enter it. If the user did, he/she should have rights to this contract; see the Security Administrator who can update the user profile for these rights.

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I: *Codes*

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

I.1 Transaction Codes

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

Table I-1: Transaction Codes

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

I.2 Transaction Reply Codes (TRCs)

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

TRC Types:

A - Accepted - A transaction is accepted and the requested action is applied (Example: enrollment or disenrollment)

R - Rejected - A transaction is rejected due to an error or other condition. The requested action is not applied to the CMS System. The TRC indicates the reason for the transaction rejection. The Plan should analyze the rejection to validate the submitted transaction and to determine whether to resubmit the transaction with corrections.

I - Informational - These replies accompany Accepted TRC replies and provide additional information about the transaction or Beneficiary. For example: If an enrollment transaction for a Beneficiary who is "out of area" is accepted, the Plan receives an accepted TRC (TRC 011) and an additional reply is included in the Transaction Reply Report (TRR) that gives the Plan the additional information that the Beneficiary is "Out of Area" (TRC 016).

M - Maintenance - These replies provide information to Plans about the beneficiaries enrolled in their Plans. They are sent in response to information received by CMS. For example: If CMS is informed of a change in a beneficiary's identifier, a reply is included in the Plan's TRR with TRC 086, giving the Plan the new beneficiary identifier.

F - Failed - A transaction failed due to an error or other condition and the requested action did not occur. The TRC indicates the reason for the transaction's failure. The Plan should analyze the failed transaction and determine whether to resubmit with corrections. Replies with the Failed TRCs are not included in the DTRR. These are provided on the Failed Records reported in the BCSS that goes back to the submitter.

Legend for Type: A = Accepted R = Rejected I = Informational

M = Maintenance F = Failed

Table I-2: Transaction Reply Codes

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

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

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

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

Code	Type	Title	Short Definition	Definition

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

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

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

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

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

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

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

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

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

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

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

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

Code	Type	Title	Short Definition	Definition
077	M	Medicaid Status Set	MEDICAID ON	This TRC is returned on a reply with Transaction Type 01. This beneficiary has been identified as having Medicaid. The effective date of the Medicaid Status is reported in field 18 (Effective Date) and field 24. The beneficiary's Medicaid status identification may be the result of any of the following: • The Medicaid status was updated for a beneficiary whose payments are calculated using a default factor. • The beneficiary's Medicaid status was updated through the UI by CMS. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
078	M	Medicaid Status Terminated	MEDICAID OFF	This TRC is returned on a reply with Transaction Type 01. A period of Medicaid status for this beneficiary has ended. The end date of the Medicaid Status is reported in field 18 (Effective Date) and field 24. The beneficiary's Medicaid status change may be the result of any of the following: • The Medicaid status was updated for a beneficiary whose payments are calculated using a default factor. • The beneficiary's Medicaid status was updated through the UI by CMS. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
079	M	Part A Termination	MEDICARE A OFF	This TRC is returned on a reply with Transaction Type 01 and occasionally with Transaction Type 61. When returned with Transaction Type 01, the TRC is in response to a change in beneficiary Part A Entitlement. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. In the case of Transaction Type 01, this beneficiary's Part A Entitlement has been terminated. The effective date of the termination is reported in DTRR fields 18 and 24. When this TRC is returned with Transaction Type 61, the TRC is in response to a retroactive enrollment and is identifying the fact that an enrollment end date has been established due to the beneficiary's termination of Part A. The enrollment start date is in DTRR field 18 and the enrollment end date is in field 24. In this circumstance it is also accompanied by TRC 018, Automatic Disenrollment. **Note:** A DTRR record with this reply code is only reported to the Plan in which the beneficiary is currently enrolled, even if it affects periods of enrollment in other Plans. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.

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

Code	Type	Title	Short Definition	Definition
082	M	Part B Reinstatement	MEDICARE B ON	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. This beneficiary's Part B Entitlement has been reinstated. The effective date of the start of Part B entitlement is reported in DTRR fields 18 and 24. Note: A DTRR record with this reply code is only reported to the Plan in which the beneficiary is currently enrolled, even if it affects periods of enrollment in other Plans. If, as a result of a loss of Part B entitlement, the beneficiary has been disenrolled, but not re-enrolled, the reply code is not issued. **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
085	M	State and County Code Change	NEW SCC	This TRC is returned on a reply with Transaction Type 01. It supplies the Plan with additional beneficiary information. This beneficiary's State and County Code (SCC) information has changed. The new SCC information is reported in DTRR fields 9 (state code), 10 (county code), and together in field 24. **Plan Action:** Update the Plan's records.
086	M	Beneficiary Identifier Change	NEW MBI	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. This beneficiary's MBI has changed. The new beneficiary identifier is reported in DTRR field 1 and the old beneficiary identifier is in Field 24. **Plan Action:** Update the Plan's records. The new beneficiary identifier is used on all future transactions for this beneficiary.
087	M	Name Change	NEW NAME	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. This beneficiary's name has changed. The new name is reported in the DTRR name fields (2, 3 and 4), SURNAME, FIRST NAME and MI. The effective date field (field 18) reports the date the name change was processed by CMS. **Plan Action:** Update the Plan's records. To ensure accurate identification of the beneficiary, future submitted transactions for this beneficiary should use the new name.

Code	Type	Title	Short Definition	Definition
088	M	Sex Code Change	NEW SEX CODE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional beneficiary information. This beneficiary's sex code has changed. The new sex code is reported in DTRR field 5. The effective date field (field 18) reports the date CMS processed the sex code change. **Plan Action:** Update the Plan's records. To ensure accurate identification of the beneficiary, future submitted transactions for this beneficiary should use the new sex code.
089	M	Date of Birth Change	NEW BIRTH DATE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary's date of birth has changed. The new date of birth is reported in DTRR field 6 (DOB) and field 24. Field 18 (Effective Date) reports the date the DOB change was processed by CMS. **Plan Action:** Update the Plan's records. To ensure accurate beneficiary identification, future submitted transactions for this beneficiary should use the new date of birth.

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

Code	Type	Title	Short Definition	Definition
091	M	Date Of Death Removed	DEATH DATE OFF	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. Although the Plan has previously received a transaction reply reporting a date of death for this beneficiary, the date of death has been removed. The beneficiary is still alive. DTRR fields 18 and 24 contain the date of death that was previously reported to the Plan. If the date of death is removed after the auto disenrollment has taken effect, the Plan will not receive this transaction reply. *The removal of the Date of Death may initiate the reinstatement of an enrollment. (See TRC 287)* **Plan Action:** Update the Plan's records and restore the beneficiary's enrollment with the original enrollment start and end dates. Take the appropriate actions as per CMS enrollment guidance.
092	M	Date of Death Corrected	NEW DEATH DATE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. The date of death for this beneficiary has been corrected. The corrected date of death is reported in DTRR field 24. *The correction of the DOD may initiate the reinstatement of an enrollment. (See TRC 287)* **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
099	M	Medicaid Period Change/Cancellation	MCAID CHANGE	A change has been made to a period of Medicaid status information for the beneficiary. **Plan Action**: Plan should update beneficiary record.
100	A	PBP Change Accepted as Submitted	PBP CHANGE OK	A submitted PBP Change transaction (Transaction Type 61) has been successfully processed. The beneficiary has been moved from the original PBP to the new PBP. The effective date of enrollment in the new PBP is reported in fields 18 and 24 of the DTRR. The effective date is always the first day of the month. This is the definitive PBP Change acceptance record. Other accompanying replies with different TRCs may give additional information about this accepted PBP Change. Field 20 (Plan Benefit Package ID) contains the new PBP identifier. The old PBP is reported in field 29 (Prior Plan Benefit Package ID). **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.

Code	Type	Title	Short Definition	Definition
102	R	Rejected; Incorrect or Missing Application Date	BAD APP DATE	If the Application Date on an enrollment transaction (Transaction Type 61) is blank or contains a valid date that is not appropriate for the submitted transaction, TRC 102 is returned in the DTRR record. Examples of inappropriate application dates: • Date is blank • Date is later than the submitted Effective Date. • Date does not lie within the election period specified on the submitted transaction ***Note:*** *Plans should see Chapter 2 of the MMCM or the PDP Guidance on Eligibility, Enrollment and Disenrollment for detailed descriptions of the Election Periods.* **Plan Action:** Correct the Application Date and resubmit if appropriate.
103	R	Missing A/B Entitlement Date	NO A/B ENT	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary does not have entitlement for Part A and/or enrollment in Part B on record (required for enrollment transactions). This TRC will only be returned on enrollment transactions submitted with election type I (Initial Coverage Election Period), E (Initial Enrollment Period for Part D) or J (Seamless Conversion Enrollment Mechanism). **Plan Action**: Verify the beneficiary's Part A / Part B entitlement / enrollment. Take the appropriate actions as per CMS enrollment guidance. If the election type is J (Seamless Conversion Enrollment Mechanism), the plan is not allowed to resubmit the enrollment transaction.

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

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

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

Code	Type	Title	Short Definition	Definition

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Code	Type	Title	Short Definition	Definition
172	R	Change Rejected; Creditable Coverage/2 Drug Info NA	CRED COV/RX NA	A 4RX or NUNCMO transaction (Transaction Type 72 or 73) was rejected because the information was not applicable to the selected Plan type (MAs and other Plans without drug coverage). Non-drug Plans should not submit drug Plan information. The inappropriate information included on the transaction could be any or all of the following: • Creditable Coverage Information (Creditable Coverage Flag and NUNCMO) • Primary Drug Insurance Information (Rx ID, Rx GRP, Rx PCN and Rx BIN) • Secondary Drug Insurance Information (Secondary Insurance Flag, Rx ID, Rx GRP, Rx PCN and Rx BIN) **Plan Action**: Verify that the above fields are not populated and resubmit the transaction if appropriate.
173	R	Change Rejected; Premium Not Previously Set	NO PREMIUM INFO	An Uncovered Months, PPO, or Part C premium amount change transaction (Transaction Types 73, 75, 78) was rejected because the beneficiary's premium was not established as of the transaction effective date. **Plan Action**: Review the beneficiary's premium data and resubmit if appropriate.
176	R	Transaction Rejected, Another Transaction Accepted	TRANS REJ	An enrollment transaction (Transaction Type 61) was rejected. A transaction enrolling the beneficiary into another contract was previously accepted. That transaction and this submitted one had the same effective and application dates. The beneficiary is not enrolled in the Plan in this newly submitted transaction. **Plan Action**: Take the appropriate actions as per CMS enrollment guidance.
177	M	Change in Late Enrollment Penalty	NEW PENALTY AMT	This TRC is intended to supply the Plan with additional information about the beneficiary. The beneficiary's total late enrollment penalty has changed. This may be the result of: • A change to the beneficiary's NUNCMO (but there are still uncovered months); • A change to the beneficiary's LIS status; • A new Initial Election Period (IEP); or • The addition, withdrawal, or change in the CMS-granted waiver of penalty. **Plan Action**: Adjust the beneficiary's payment amount. The new total penalty amount can be determined by subtracting amounts in DTRR fields 55 (waived amount) and 56 (subsidized amount) from field 54 (base penalty). Take the appropriate actions as per CMS enrollment guidance.

Code	Type	Title	Short Definition	Definition
178	M	Late Enrollment Penalty Rescinded	PNLTY RESCINDED	This TRC is intended to supply the Plan with additional information about the beneficiary. The LEP, reported in field 52 of the DTRR, associated with the specified effective date has been rescinded (set to zero). **Plan Action**: Adjust the beneficiary's payment amount. Take the appropriate actions as per CMS enrollment guidance.
179	A	Transaction Accepted, No Change to Premium Record	NO CHNG TO PREM	A Record Update transaction (Transaction Type 73, 75, 78) was submitted, however, no data change was made to the beneficiary's premium. The submitted transaction contained premium data values that matched those already on record with CMS for the specified period. This transaction had no effect on the beneficiary's records. **Plan Action**: Ensure that the Plan's system reflects the amounts in the DTRR record.
182	I	Invalid PTC Premium Submitted Corrected, Accepted	PTC PRM OVERIDE	An Enrollment, Residence Address Change, Segment ID Change, PBP change, Enrollment Cancellation, Disenrollment Cancellation or Part C Premium Record Update transaction (Transaction Types 61, 76, 77, 78, 80, 81, 82) was accepted but the Part C premium did not agree with the Plan's HPMS contracted Part C premium rate. The premium has been adjusted to reflect the contracted rate. • If the submitted Part C premium amount has pennies, the Part C premium amount was rounded to the nearest dime. • If the rounded Part C premium amount was less than the HPMS contracted Part C premium minimum amount or greater than the HPMS contracted Part C premium maximum amount for the Plan, MARx has reset the premium to the HPMS contracted Part C premium minimum amount. ***Note:*** *If any of the HPMS contracted Part C premium amounts contained pennies, the amounts were rounded for these comparisons.* The updated Part C premium rate is reported in Daily Transaction Reply Report (DTRR) data record fields 24 and 34. TRC 182 is the acceptance TRC for Transaction Type 78. For the other transaction types, normal acceptance TRCs will be returned along with TRC 182. **Plan Action**: Update the Plan's beneficiary records with the premium information in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.

Code	Type	Title	Short Definition	Definition
184	R	Enrollment Rejected, Beneficiary is in Medicaid	MBR IN MEDICAID	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary was in Medicaid status and the Plan is not eligible to enroll Medicaid beneficiaries. This TRC is Plan specific. It only applies to MSA/MA and MSA/Demo Plans. **Plan Action**: Update the Plan's beneficiary records to reflect the fact that the beneficiary is not enrolled in the Plan. Take the appropriate actions as per CMS enrollment guidance.
185	M	Withholding Agency Accepted Transaction	ACCEPTED	CMS submitted information on a beneficiary to SSA/RRB (See TRC 120). TRC 185 is sent to the Plan when SSA/RRB acknowledges that they have accepted and processed the beneficiary data. If the submittal to SSA/RRB was the result of a requested premium withholding change, TRC 185 informs the Plan that SSA/RRB has accepted and processed the change. The beneficiary's PPO is reported in DTRR field 39. The effective date of the PPO change is reported in field 18. Note: The reported new PPO may be the same as the existing PPO. Plans will not see the results of any requested premium withholding changes until TRC 185 is received. **Plan Action**: Ensure the Plan's system matches the information, primarily the PPO, included in the DTRR.
186	I	Withholding Agency Rejected Transaction	REJECTED	CMS submitted information on a beneficiary to SSA/RRB (See TRC 120). This data transmittal was rejected by SSA/RRB. This is exclusive to the communication between CMS and SSA/RRB. CMS will continue to interface with SSA/RRB to resolve the rejection. If CMS is unable to resolve this rejection and the Beneficiary-requested PPO is changed, the Plan may receive a TRC 144. **Plan Action**: No action required.
187	R	No Change in Number of Uncovered Mths Information	DUP NO UNCV MTH	A NUNCMO Record Change transaction (Transaction Type 73) was rejected. No data change was made to the beneficiary's record. The submitted transaction contained NUNCMO Information that matched those already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action**: None required.

Code	Type	Title	Short Definition	Definition
188	A	No Change in Segment ID	DUP SEGMENT ID	A Segment ID Update transaction (Transaction Type 77) was accepted, however, no data change was made to the beneficiary's record. The submitted transaction contained a Segment ID value that matched the Segment ID already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action**: None required.
189	A	No Change in EGHP Flag	DUP EGHP FLAG	An EGHP Record Update transaction (Transaction Type 74) was submitted, however, no data change was made to the beneficiary's record. The submitted transaction contained an EGHP Flag value that matched the EGHP Flag already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action**: None required.
190	A	No Change in Secondary Drug Information	DUP SECNDARY RX	A 4Rx Record Update transaction (Transaction Type 72) was submitted, however, no data change was made to the beneficiary's record. The submitted transaction contained Secondary Drug Insurance Information (Secondary Drug Insurance flag, Secondary Rx ID, Secondary Rx Group, Secondary Rx BIN, Secondary Rx PCN) that matched the Secondary Drug Insurance values already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action**: None required.

Code	Type	Title	Short Definition	Definition
191	R	No Change in Premium Withhold Option	DUP PRM WH OPTN	A Premium Payment Option Change transaction (Transaction Type 75) was rejected and no data change was made to the beneficiary's record for one of the following reasons: 1. The submitted transaction contained a Premium Payment Option value that matched the Premium Payment Option already on record with CMS. 2. Beneficiary has a premium. Setting the Premium Payment Option to "no premium", "N", is not acceptable. Beneficiary premium may be due wholly or in part to a late enrollment penalty. 3. Beneficiary premiums are zero. Withholding cannot be established. 4. A Premium Payment Option request of 'Deduct from SSA (S)' or 'Deduct from RRB (R)' was submitted on a Premium Payment Option Change transaction (Transaction Type 75) when the beneficiary has 'No Premiums'. The Premium Payment Option was set to 'N', which matches the Premium Payment Option already on record with CMS. 5. SSA or RRB Withholding was requested for a LINET, MMP or PACE Plan. This transaction had no effect on the beneficiary's records. **Plan Action:** None required.
195	M	SSA Unsolicited Response	SSA WHOLD UPDT	An unsolicited response has been received from SSA. The PPO for this beneficiary is set to Direct Bill. This action is not in response to a Plan-initiated transaction. The effective change date change is reported in DTRR field 18. **Plan Action**: Change the beneficiary to direct bill as of the effective date in field 18. Take the appropriate actions as per CMS enrollment guidance.
196	R	Transaction Rejected, Bene not Eligible for Part D	NO PART D	An enrollment transaction or PBP change transaction (Transaction Type 61) or disenrollment cancellation transaction (Transaction Type 81) [enrollment reinstatement] was rejected. Part D eligibility is required for Part D Plan enrollment. • TC61 – transaction was rejected because the submitted enrollment date is outside the beneficiary's Part D eligibility period • TC81 – transaction was rejected because the enrollment reinstatement period is outside the beneficiary's Part D eligibility period **Plan Action**: Take the appropriate actions as per CMS enrollment guidance.

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

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

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

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

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

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

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

Code	Type	Title	Short Definition	Definition
225	I	Exceeds SSA Benefit & Safety Net Amount	INSUF FUND&SNET	CMS has changed the PPO specified on the transaction to "D – Direct Bill" because the transaction would result in the SSA benefit being insufficient to cover the withholding and the withholding would exceed the Safety Net amount. This TRC may be generated in response to an accepted enrollment or PBP change (Transaction Type 61), NUNCMO Record Update (Transaction Type 73), Part C Premium Update (Transaction Type 78), PPO Change (Transaction Type 75), or may be initiated by CMS. **Plan Action:** Change the beneficiary to direct bill and contact them to explain the consequences of the PPO change. Take the appropriate actions as per CMS enrollment guidance.
235	I	SSA Accepted Part B Reduction Transaction	SSA PT B ACCEPT	CMS submitted Part B Reduction information on a beneficiary to SSA (See TRC 237). TRC 235 is sent to the Plan when SSA acknowledges that they have accepted and processed the beneficiary data. If the submittal to SSA was the result of a requested Part B Reduction change, TRC 235 informs the Plan that SSA has accepted and processed the change. Plans will not see the results of any requested Part B Reduction change until TRC 235 is received and SSA has processed the request. This may take as long as 60 days. **Plan Action:** No action required.
236	I	SSA Rejected Part B Reduction Transaction	SSA PT B REJECT	CMS submitted Part B Reduction information on a beneficiary to SSA (See TRC 237). This data transmittal was rejected by SSA. This is exclusive to the communication between CMS and SSA. CMS will continue to interface with SSA to resolve the rejection. **Plan Action**: No action required**.**
237	I	Part B Premium Reduction Sent to SSA	PT B RED UPDATE	As a result of an accepted Plan-submitted transaction (Transaction Types 51, 61, 72, 73, 75, 78) or UI update to a beneficiary's records, information has been forwarded to SSA/RRB to update SSA/RRB records and implement any requested Part B premium reduction changes. Any requested change will not take effect until an SSA/RRB acceptance is received. Plans are notified of the SSA/RRB acceptance with a TRC 235 on a future DTRR. **Plan Action:** None required. Take the appropriate actions as per CMS enrollment guidance. ***Note:*** *The Plan will not see the result of any Part B Reduction change until they have received a TRC 235 or 236 on a future DTRR.*

Code	Type	Title	Short Definition	Definition
238	I	RRB Rejected Part B Reduction, Delayed Processing	DELAY RRB PROC	CMS submitted Part B Reduction information for a beneficiary to RRB (See TRC 237). This data transmittal was rejected by RRB because they are unable to process the data at this time. CMS continues to interface with RRB to resolve the rejection. **Plan Action**: No action required.
239	I	RRB Rejected Part B Reduction, Jurisdiction	NOT RRB JRSDCTN	CMS submitted Part B Reduction information for a beneficiary to the RRB (See TRC 237). This data transmittal was rejected by the RRB. The beneficiary no longer falls under the RRB jurisdiction. **Plan Action**: The beneficiary jurisdiction must be assessed and aligned between agencies to successfully process the data.
240	A	Transaction Received, Withholding Pending	WHOLD UPDATE	As a result of an accepted Plan-submitted transaction to update a beneficiary's PPO (Transaction Type 75) or a UI update of same, a request will soon be forwarded to SSA. Plans will receive TRC 120 when this request is forwarded to SSA. Plans are notified of the subsequent SSA acceptance or rejection of the PPO change with a TRC 185 or 186, respectively, on a future DTRR. All data provided for change other than the PPO field was ignored. **Plan Action:** Take the appropriate actions as per CMS enrollment guidance. **Note:** The Plan will not see the result of any PPO change until they have received a TRC 185 on a future DTRR.
241	I	No Change in Part D Opt Out Flag	DUP PTD OPT OUT	A Part D Opt-Out Record Update transaction (Transaction Type 79) was submitted, however, no data change was made to the beneficiary's record. The submitted transaction contained a Part D Opt Out Flag value that matched the Part D Opt Out Flag already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action**: None required.
242	I	No Change in Primary Drug Information	DUP PRIMARY RX	A 4Rx Record Update transaction (72) was submitted, however, no data change was made to the beneficiary's record. The submitted transaction contained Primary Drug Insurance Information (Primary Rx ID, Primary Rx Group, Primary Rx BIN, Primary Rx PCN) that matched the Primary Drug Insurance values already on record with CMS. This transaction had no effect on the beneficiary's records. **Plan Action**: None required.

Code	Type	Title	Short Definition	Definition
243	R	Change to SSA Withholding rejected due to no SSN	NO SSN AT CMS	A PPO Change transaction (Transaction Type 75) was submitted to change the beneficiary's PPO to SSA withholding, however, there is no Social Security Number (SSN) on file at CMS. The beneficiary's PPO is not changed to SSA withholding. The beneficiary's records were unchanged. **Plan Action**: Update the Plan's beneficiary record accordingly. Take the appropriate action with member as per CMS enrollment guidance.
245	M	Member has MSP period	MEMBER IS MSP	This TRC is returned with a transaction type 01. The beneficiary has a change to their MSP (Medicare Secondary Payer) period that impacts payments for one or more of the beneficiary's enrollments in your plan. TRC 245 is sent to the plan(s) that have enrollment(s) that are impacted by the new/changed MSP period. • Field 18 will contain the Start Date of the payments impacted by the MSP period • Field 24 will contain the actual start date of the MSP period • Field 44 will contain the actual end date of the MSP period if available **Plan Action:** Update the Plan's records accordingly.
252	I	Prem Payment Option Changed to Direct Bill; No SSN	W/O CHG;NO SSN	CMS has changed the PPO specified on the transaction to "D – Direct Bill" because the beneficiary does not have a Social Security number on file at CMS. This TRC may be generated in response to an accepted Enrollment, PBP change or PPO Change transaction (Transaction Types 61 or, 75) or may be initiated by CMS. **Plan Action:** Update the Plan's beneficiary records to reflect the direct bill payment method. Take the appropriate actions with member as per CMS enrollment guidance.
253	M	Changed to Direct Bill; no Funds Withheld	W/O CHG;NO W/H	CMS has changed the PPO to "D-Direct Bill" because no funds have been withheld by the withholding agency in the two months since withholding was accepted. **Plan Action:** Update the Plan's beneficiary records to reflect the direct bill payment method. Take the appropriate actions with member as per CMS enrollment guidance.

Code	Type	Title	Short Definition	Definition
254	I	Beneficiary set to Direct Bill, spans jurisdiction	DIR BIL JRSDCTN	CMS has changed the PPO to "D-Direct Bill" because the withholding request spans two different withholding agency jurisdictional periods. This could occur for one of the following reasons: • SSA is the beneficiary's current withholding agency but the withholding request contains one or more periods from when RRB was the beneficiary's withholding agency. • RRB is the beneficiary's current withholding agency but the withholding request contains one or more periods from when SSA was the beneficiary's withholding agency. **Plan Action:** Update the Plan's beneficiary records to reflect the Direct Bill payment method. Take the appropriate actions with member as per CMS enrollment guidance.
255	I	Plan Submitted RRB W/H for SSA Beneficiary	RRB WHOLD 4 SSA	CMS has changed the PPO to "S-SSA Withhold" because SSA is the correct withholding agency for this beneficiary. **Plan Action:** None required.
256	I	Plan Submitted SSA W/H for RRB Beneficiary	SSA WHOLD 4 RRB	CMS has changed the PPO to "R-RRB Withhold" because RRB is the correct withholding agency for this beneficiary. **Plan Action:** None required.
257	F	Failed; Birth Date Invalid for Database Insertion	INVALID DOB	An Enrollment transaction (Transaction Type 61), change transaction (Transaction Types 72, 73, 74, 75, 77, 78, 79, 83), residence address transaction (Transaction Type 76), cancellation transaction (Transaction Types 80, 81, 82), or POS drug edit (Transaction Type 90), or IC Model Participation transaction (Transaction Type code 91) failed because the submitted birth date was either • Not formatted as YYYYMMDD (e.g., "Aug 1940"), or • Formatted correctly but contained a nonexistent month or day (e.g., "19400199"). As a result, the beneficiary could not be identified. The transaction record will not appear on the Daily Transaction Reply Report (DTRR) data file but will be returned on the Batch Completion Status Summary (BCSS) data file along with the failed record. **Plan Action:** Correct the date format and resubmit transaction.

Code	Type	Title	Short Definition	Definition
258	F	Failed; Efctv Date Invalid for Database Insertion	INVALID EFF DT	A disenrollment transaction (Transaction Types 51, 54), enrollment transaction (Transaction Type 61), change transaction (Transaction Types 72, 73, 74, 75, 77, 78, 79, 83), residence address transaction (Transaction Type 76) or cancellation transaction (Transaction Types 80, 81, 82) or IC Model Participation transaction (Transaction Type 91) failed because the submitted effective date was either, • Blank, • Not formatted as YYYYMMDD (e.g., "Aug 1940"), or • Formatted correctly but contained a nonexistent month or day (e.g., "19400199"). The transaction record will not appear on the Daily Transaction Reply Report (DTRR) data file but will be returned on the Batch Completion Status Summary (BCSS) data file along with the failed record. **Plan Action:** Correct the date format and resubmit transaction.
259	F	Failed; End Date Invalid for Database Insertion	INVALID END DT	A residence address transaction (Transaction Type 76) failed because the submitted end date was either not formatted as YYYYMMDD (e.g., "Aug 1940") or was formatted correctly but contained a nonexistent month or day (e.g., "19400199"). The transaction record does not appear on the DTRR data file is returned on the BCSS data file along with the failed record. **Plan Action:** Correct the date format and resubmit transaction.
260	R	Rejected; Bad End Date on Residence Address Change	BAD RES END DT	A residence address transaction (Transaction Type 76) was rejected because the End Date is not appropriate for one or more of the following reasons: • It is earlier than address change start date, • It is not the last day of the month, or • It is not within the contract enrollment period. **Plan Action:** Correct the End Date and resubmit.
261	R	Rejected; Incomplete Residence Address Information	BAD RES ADDR	A residence address transaction (Transaction Type 76) was rejected for one of the following reasons: The residence address information was incomplete – • Residence Address Line 1 was empty, • Residence City was empty, • USPS state code was missing, • Residence zip code was missing or non-numeric, • The value specified for the Address Update/Delete Flag was blank or not valid, • The supplied residence address information could not be resolved in terms of identifiable address components, or • The address was not a U.S. address. **Plan Action:** Correct address information and resubmit.

Code	Type	Title	Short Definition	Definition
262	R	Bad RRB Premium Withhold Effective Date	INVALID EFF DTE	A PPO Change Transaction (Transaction Type 75) was rejected because request for RRB withholding is NOT allowed for effective date prior to 6/1/2011. **Plan Action:** Correct the Effective date and resubmit.
263	F	Failed; Aplctn Date Invalid for Database Insertion	INVALID APP DT	An enrollment transaction (Transaction Type 61) failed and did not process because the submitted application date was either not formatted as YYYYMMDD (e.g., "Aug 1940") or was formatted correctly but contained a nonexistent month or day (e.g., "19400199"). The transaction record does not appear on the DTRR data file is returned on the BCSS data file along with the failed record. **Plan Action:** Correct the date format and resubmit transaction.
265	A	Residence Address Change Accepted, New SCC	RES ADR SCC	A residence address change transaction (Transaction Type 76) was accepted. The submitted residence address overrides the beneficiary's default address for the submitted effective period. The state and county code (SCC) and/or zip code used for enrollment changes and payments may have changed. The SCC and/or zip code in this residence address will be used for the effective period to determine if the beneficiary is out of area for the Plan. SCC values are returned in DTRR fields 9 (state code) and 10 (county code). The residence address period start date is in field 18 and any provided end date is in field 24. This TRC may be accompanied by TRC 154 if the submitted residence address has placed the beneficiary outside the Plan's service area. **Plan Action**: Update the Plan's records.
266	R	Unable to Resolve SSA State County Codes	SCC UNRESOLVED	A residence address transaction (Transaction Type 76) was rejected because SSA state and county codes (SCC) could not be resolved. The beneficiary's residence address was not changed. **Plan Action:** Confirm the address specified in the transaction. Update and resubmit the transaction if necessary; otherwise, contact your district office for assistance.
267	M	PPO set to N due to No Premium	PPO SET TO N	The beneficiary's PPO was set to N because their premium is $0. This occurs as part of an end-of-year process based on the Plan's basic Part C premium for the upcoming year. **Plan Action:** Submit a transaction to reset the Part C premium and to renew a request for withholding status if appropriate.

Code	Type	Title	Short Definition	Definition
268	I	Beneficiary Has Dialysis Period	DIALYSIS EXISTS	This TRC is returned on an enrollment. It is intended to supply the Plan with additional information about the beneficiary. Each TRC 268 returns start and end dates for each dialysis period that overlaps the enrollment period. There may be more than one TRC 268 returned. The effective date for the dialysis period is shown in the Effective Date field (field 18). The end date, if one exists, is in the Open Data field (field 24). **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
269	I	Beneficiary Has Transplant	TRNSPLNT EXISTS	This TRC is returned on an enrollment. It is intended to supply the Plan with additional information about the beneficiary. Each TRC 269 returns transplant and failure dates for each kidney transplant that overlaps the enrollment period. There may be more than one TRC 269 returned. The transplant date is shown in the Effective Date field (field 18). The end date, if one exists, is shown in Transplant End Date (field 24). **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.
270	M	Beneficiary Transplant Has Ended	TRANSPLANT END	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. CMS was notified that the beneficiary's transplant s failed or was an error. The effective date of the failure or removal is reported in field 18 of the DTRR record and in the EFF DATE column on the printed report. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Take the appropriate actions as per CMS enrollment guidance.

Code	Type	Title	Short Definition	Definition
280	M	Member MSP Period Ended	MEMBER NOT MSP	This TRC is returned with a transaction type 01. The beneficiary has an MSP (Medicare Secondary Payer) period that has been ended or updated. The MSP period change impacts payments for one or more of the beneficiary's enrollments in your plan. TRC 280 is sent to the plan(s) that have enrollment(s) that are impacted by the change in the MSP period. • Field 18 will contain the earliest date that the payments are impacted by the MSP period change, based on the MSP new/changed end date • Field 24 will contain the actual start date of the MSP period • Field 44 will contain the end date of the MSP period Note: If the MSP period has both start and end dates, plans will receive both TRC 245 and 280. **Plan Action:** Update the Plan's records accordingly.
282	A	Residence Address Deleted	RES ADR DELTD	The residence address associated with the DTRR effective date (in field 18) has been deleted and is no longer valid. The address was removed either through "delete" action via the 76 transaction or because an overlapping residence address change was submitted with the same or earlier effective date. **Plan Action:** None required.
283	R	Residence Address Delete Rejected	RJCTD ADR DELT	The residence address delete attempted was rejected. No residence address exists for the effective date provided. See DTRR field 18. **Plan Action:** Correct effective date and resubmit.
284	R	Cancellation Rjctd, Prior Enroll/Disenroll Changed	NO REINSTATE	A Disenrollment Cancellation (Transaction Type 81) was rejected. The cancellation action attempted the reinstatement of the enrollment and this reinstatement could not be accomplished. The reinstatement could not be accomplished because some aspect of the enrollment, or the beneficiary's status during that enrollment, has been changed by the Plan (examples include: 4Rx, Residence Address or Segment ID) prior to their issuance of this current cancellation transaction. **Plan Action:** Enroll the beneficiary using a Transaction Type 61, Enrollment.
285	I	Enrollment Cancellation Accepted	ACPT ENROLL CAN	An Enrollment Cancellation (Transaction Type 80) transaction was accepted. The identified enrollment is cancelled. The start date of the cancelled enrollment period is reported in the DTRR Effective Date field 18. **Plan Action:** Update the Plan's records accordingly.

Code	Type	Title	Short Definition	Definition
286	R	Enrollment Cancellation Rejected	RJCT ENROLL CAN	An Enrollment Cancellation (Transaction Type 80) or an MMP Enrollment Cancellation (Transaction Type 81) transaction was rejected. Rejection occurred for one of the following reasons: The cancellation was submitted more than one month after the enrollment became active, the transaction attempts to cancel a Rollover, Auto or Facilitated Enrollment, or when the transaction attempts to cancel a closed enrollment period. **Plan Action:** Submit a Disenrollment transaction.
287	A	Enrollment Reinstated	ENROLL REINSTAT	The identified enrollment period was reinstated. The start date of the reinstated period is reported in the DTRR Effective Date field 18. The reinstatement occurred for one of the following reasons: • For Transaction Type 80, cancellation of another Plan's enrollment; • For Transaction Type 81, cancellation of Plan's disenrollment; • For Transaction Type 82, cancellation of another Plan's enrollment; • For Transaction Type 01, change or removal of a date of death. If the reinstated enrollment has an end date, it is reported in the DTRR field 24. The end date may or may not have existed with the enrollment originally. **Plan Action:** Update the Plan's records accordingly following CMS guidance for enrollment reinstatement.
288	A	Disenrollment Cancellation Accepted	ACPT DISNRL CAN	A Disenrollment Cancellation (Transaction Type 81) transaction was accepted. The identified disenrollment was cancelled. The start date of the cancelled disenrollment period is reported in the DTRR Effective Date field 18. The Disenrollment Cancellation (Transaction Type 81) may have been submitted by a Plan or the result of a Date of Death Change or Date of Death Rescinded notification that cancels an auto-disenrollment that was created by a Date of Death notification. **Plan Action:** Update the Plan's records accordingly.

Code	Type	Title	Short Definition	Definition
289	R	Disenrollment Cancellation Rejected	RJCT DISNRL CAN	A Disenrollment Cancellation (Transaction Type 81) transaction was rejected. Rejection occurred for one of the following reasons: • Beneficiary was still enrolled in plan, never disenrolled; • Beneficiary was not enrolled in the plan; • Disenrollment being cancelled was not submitted by the Plan. • Cannot restore prior enrollment due to associated disenrollment reason codes 5, 6, 8, 9, 10, 13, 15, 18, 19, 54, 56, 57, 61. • Reinstated enrollment would conflict with another existing enrollment. • The beneficiary's benefits have been suspended due to confirmed incarceration or a Not Lawfully Present period. **Plan Action:** Submit Enrollment transaction.
290	I	IEP NUNCMO Reset	NUNCMO RSET IEP	This TRC was the result of an automatic system reset, or zeroing, of the cumulative uncovered months for the identified beneficiary. This reset occurred for one of the following reasons: • Disabled beneficiary became age-qualified for Medicare, • An aged beneficiary had a retroactive NUNCMO transaction with an effective date prior to aged qualification at the beginning of the IEP period. Reset effective date is in DTRR field 18. **Plan Action:** Update Plan records accordingly.
291	I	Enrollment Reinstated, Disenrollment Cancellation	ENROLL REINSTAT	A Disenrollment Cancellation (Transaction Type 81) transaction cancelled a disenrollment and the enrollment was reinstated. The start date of the reinstated period is reported in the DTRR Effective Date field 18. If the reinstated enrollment has an end date, it is reported in the DTRR field 24. The end date may or may not have existed with the enrollment originally. **Plan Action:** Update the Plan's records accordingly following CMS guidance for enrollment reinstatement.
292	R	Disenrollment Rejected, Was Cancellation Attempt	NOT CANCELLATN	A Disenrollment transaction (Transaction Type 51) was rejected. The submitted disenrollment effective date is the same as the enrollment start date. Only Auto or Facilitated enrollments may be cancelled using the Transaction Type 51. **Plan Action:** Submit an Enrollment Cancellation transaction (Transaction Type 80) if it is desired to cancel the enrollment; otherwise, correct the disenrollment effective date and resubmit.

Code	Type	Title	Short Definition	Definition
293	A	Disenroll, Failure to Pay Part D IRMAA	FAIL PAY PTD IRMAA	A disenrollment transaction (Transaction Type 51) has been successfully processed due to failure to pay Part D IRMAA. The last day of the enrollment is reported in DTRR fields 18 and 24. The disenrollment date is always the last day of the month. **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record and that the beneficiary's disenrollment date matches the date in field 24. Take the appropriate actions as per CMS enrollment guidance.
294	I	No 4Rx Insurance Changed	NO INSUR CHANGE	A 4Rx Change (Transaction Type 72) transaction was received with no primary or secondary insurance information provided on the transaction. No insurance data changes took place for this beneficiary. **Plan Action:** Resubmit with new 4Rx data as needed.
295	M	Low Income NUNCMO RESET	NUNCMO RSET LIS	This TRC was the result of an automatic system reset, or zeroing, of the cumulative uncovered months for the identified beneficiary. This reset occurred because the beneficiary has been identified as having the Part D low-income subsidy. Reset effective date is in DTRR field 18. **Plan Action:** Update Plan records accordingly.
300	R	NUNCMO Change Rejected, Exceeds Max Possible Value	NM CHG EXDS MAX	A NUNCMO Record Update transaction (73) was rejected because the submitted incremental NUNCMO exceeds the maximum possible value. The original (existing) incremental NUNCMO associated with this effective date has been retained. Field 24 (Maximum Number of Uncovered Months) reports the maximum incremental NUNCMO value that could be associated with the enrollment effective date submitted. Field 40 (Cumulative Number of Uncovered Months) reports the total uncovered months as of the effective date. Field 45 (Submitted Number of Uncovered Months) reports the incremental NUNCMO value submitted by the Plan. **Plan Action**: Review the incremental NUNCMO submitted, the maximum incremental NUNCMO calculated by the system, and/or the effective date submitted. If the NUNCMO and/or the effective date should be another value, review CMS enrollment guidance, and correct the NUNCMO value using a new NUNCMO Record Update (73) transaction.

Code	Type	Title	Short Definition	Definition
301	M	Merged Beneficiary, beneficiary identifier Change	BENE MBI MERGE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary had multiple conflicting beneficiary identifier (MBIs) which were merged under a single MBI. This DTRR reports the **VALID** MBI in field 1 and the **INVALID** MBI in field 24. **Plan Action:** Update the Plan's records to use the **VALID MBI** from field 1 for this beneficiary. The **valid** beneficiary identifier must be used on all future transactions for this beneficiary.
302	M	Enrollment Cancelled, beneficiary identifier Change	ENRL CNCL MERGE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary had multiple conflicting MBIs, which were merged into one. Plan enrollments for the conflicting MBIs have been combined under a valid MBI. This enrollment conflicted with another existing enrollment. As a result, the conflicting enrollment period was cancelled. The effective date of the enrollment which has been cancelled is reported in the Effective Date field (18). The termination date of the enrollment (if present) is reported in field 24. **Plan Action**: Because the enrollment period is now cancelled, the enrollment period should be adjusted in the Plan's enrollment records. **This change may impact premiums that you collected directly from the beneficiary.** Take the appropriate actions as per CMS enrollment guidance.
303	M	Termination Date Change due to Beneficiary Merge	TRM DT CHG MERGE	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. This beneficiary had multiple conflicting beneficiary identifier (MBIs) which were merged into one. Plan enrollments for the conflicting MBIs have been combined under a valid MBI. This enrollment conflicted with another existing enrollment. Current enrollment rules regarding the application signature date were applied and this enrollment's termination date was changed from the original date. The effective date of the enrollment with the changed termination date is reported in the Effective Date field (18). The new termination date of this enrollment is reported in Field 24. **Plan Action:** Because the termination date has changed, the enrollment period should be adjusted in the Plan's enrollment records. **This change may impact premiums that you collected directly from the beneficiary.** Take the appropriate actions as per CMS enrollment guidance.

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

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

Code	Type	Title	Short Definition	Definition
316	I	Default Segment ID Assignment	DEFAULT SEG ID	A default Segment ID is assigned because the beneficiary is Out-of-Area for the Contract/PBP. For enrollments with effective dates prior to 2014, the default Segment is the Segment with the lowest valid Segment ID for the Contract/PBP. For years 2014 and later, the default Segment is the Segment with the lowest premiums. **Plan Action:** Verify the beneficiary's address is correct. Submit a Residence Address Change if appropriate.

317	I	Segment ID Reassigned after Address Update	SEG ID REASSIGN	A Segment ID reassigns because updated address information is received. The updated address information either results from a Plan-submitted Residence Address Change (Transaction Type 76) or an SCC change notification.
				
				This TRC is returned when a Segment ID reassigns for one of the following reasons:
				• Updated address information is received. The updated address information is either a result of a Plan-submitted Residence Address Change (Transaction Type 76) or a State and County Code change notification.
				• An Enrollment Transaction (Transaction Type 61) or Segment ID Change (Transaction Type 77) is received for a segmented Plan where part of the enrollment has a terminated Segment ID. Examples include:
				  ○ A retroactive enrollment that spans more than one year and the Segment ID is not valid for both years
				  ○ An enrollment that is effective at the end of one year and the Segment ID is not valid for the upcoming year
				• An Enrollment Transaction (Transaction Type 61) is received with an invalid Segment ID.
				The effective date of the reassignment is reported in field 18.
				
				Plan Action: Verify the Segment ID is correct. Submit a Residence Address Change or a Segment ID change if appropriate.

318	R	Invalid or Missing MMP Demo Enrlmt Source Code	INVALID MMP SRC	A Medicare and Medicaid Plan (MMP) enrollment transaction was rejected because the enrollment source code was missing or invalid. Valid values are J, K, and L **Plan Action**: Correct the enrollment source code and resubmit.
319	M	RRB to SSA Beneficiary Jurisdiction Change	RRB - SSA Jur	A beneficiary undergoes a jurisdiction change from RRB to SSA. CMS attempts to establish premium withholding with SSA, which may take up to two months. If the transfer is successful, a TRC 185 is issued. If it is unsuccessful, TRCs 186 and 144 are issued. This action is not in response to a Plan-initiated transaction. **Plan Action:** None required at this time.

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

Code	Type	Title	Short Definition	Definition

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

326	R	POS Drug Edit Implementation Date Incorrect	PSDE IMP DT INC	A POS drug edit transaction (Transaction Type code 90) with a status of I was rejected because the implementation date is before the notification date. **Plan Action:** Correct the dates and resubmit the POS Drug Edit Transaction, if appropriate.
327	R	POS Drug Edit Termination Date Incorrect	PSDE TERM DT INC	A POS drug edit transaction (Transaction Type Code 90) with a status of T was rejected because: • the termination date is before the implementation date if the latest status is I, or • the termination date is before the notification date if the latest status is N. **Plan Action:** Correct the dates and resubmit the POS Drug Edit Transaction, if appropriate.
328	R	POS Drug Edit Duplicate Transaction	PSDE DUP	A POS Drug Edit transaction (Transaction Type code 90) was rejected because it is a duplicate. The submitted transaction matched the following values on an existing POS Drug Edit record: • Status • POS Drug Edit Class • POS Drug Edit Code • POS Drug Edit dates (notification, implementation and/or termination) This TRC will only be issued for update transactions not delete. **Plan Action:** None required.
329	R	POS Drug Edit Delete Error	PSDE DEL ERR	A POS Drug Edit transaction (Transaction Type 90) was rejected because the transaction attempted to delete an existing POS Drug Edit but there was no corresponding existing record. **Plan Action:** Correct the information provided and resubmit the transaction, if appropriate.

Code	Type	Title	Short Definition	Definition
330	R	POS Drug Edit Without Associated Records	PSDE WO ASSOC	A POS Drug Edit transaction (Transaction Type Code 90) was rejected because it was submitted for a beneficiary without a corresponding POS Drug Edit record. • When Status = I - Submitted notification date must match an existing record • When Status = T - Both the submitted notification date and implementation date (if exists) must match an existing record(s) • When Status = I or T - POS Drug Edit Class must match an existing notification record with the same notification date • When Status = I or T - POS Drug Edit Code must be the same or less restrictive as the notification record with the same notification date • When Status = T – POS Drug Edit Code must be the same as the implementation record with the same implementation date provided. • A notification record can only be associated with one implementation and termination record (same POS Drug Edit Class and POS Drug Edit Code) **Plan Action**: Verify the dates associated with the POS Drug Edit to be updated. Verify that the correct POS Drug Edit Code and Class were submitted. Correct and resubmit the transaction, if appropriate.
331	R	Future POS Drug Edit Date Exceeds CCM Plus One	PSDE DT FUT	A POS Drug Edit transaction (Transaction Type 90) was rejected because a submitted notification, implementation or termination date is later than the end of the month that follows the current calendar month. **Plan Action:** Correct the date(s) and resubmit the transaction, as appropriate.
332	F	Failed, PSDE Dates Invalid for Database Insertion	F PSDE DT INVAL	A POS Drug Edit transaction (Transaction Type 90) failed because one of the following dates was either not formatted as YYYYMMDD (e.g., "Aug 1940") or was formatted correctly but contained a nonexistent month or day (e.g., "19400199"): • Notification Date • Implementation Date • Termination Date The failed transaction record is not returned in the DTRR data file. It is returned on the Batch Completion Status Summary (BCSS) data file. **Plan Action**: Correct the date(s) and resubmit the transaction, as appropriate.

Code	Type	Title	Short Definition	Definition
333	R	Reject, Invalid POS Drug Edit Status	PSDE INV STATUS	A POS Drug Edit transaction (Transaction Type 90) was rejected because the submitted POS Drug Edit Status field was blank or contained an invalid value. Valid values are N (Notification), I (Implementation), T (Termination). **Plan Action:** Correct the POS Drug Edit Status and resubmit the transaction, if appropriate.
334	R	Reject, Invalid POS Drug Edit Class	PSDE INV CLASS	A POS Drug Edit transaction (Transaction Type 90) was rejected because the submitted Drug Class field was blank or contained an invalid value. **Plan Action:** Correct the Drug Class and resubmit the transaction, if appropriate.
335	R	Reject, Invalid POS Drug Edit Code	PSDE INV CODE	A POS Drug Edit transaction (Transaction Type 90) was rejected because the submitted Drug Edit Code field was blank or contained an invalid value. **Plan Action:** Correct the Drug Edit Code and resubmit the transaction, if appropriate.
336	R	Reject, Invalid POS Drug Edit U/D	PSDE INV U/D	A POS Drug Edit transaction (Transaction Type 90) was rejected because the submitted POS Drug Edit Update/Delete flag was blank or contained an invalid value. Valid values are U (Update) or D (Delete). **Plan Action:** Correct the POS Drug Edit Update/Delete flag and resubmit the transaction, if appropriate.
337	A	POS Drug Edit Event Deleted - Plan	PSDE EVT DEL P	A Plan User with POS Drug Edit update Authority deleted a POS Drug Edit event via the MARx UI for this beneficiary. • If the latest status was T (Termination), the associated Notification, Implementation (if exists) and Termination POS Drug Edit records were deleted. • If the latest status was I (Implementation), the associated Notification and Implementation POS Drug Edit records were deleted. • If the latest status was N, the Notification POS Drug Edit record was deleted. If the Notification record is associated with a different valid Implementation record the Notification record will not be deleted; it will remain associated with that event. **Plan Action:** None.

Code	Type	Title	Short Definition	Definition
338	I	Enrollment Accepted, PPO Changed	PPO CHG	CMS has changed the Premium Payment Option specified on the enrollment transaction because the beneficiary is enrolled in a LINET, MMP, or PACE plan. If the beneficiary premiums are zero, the PPO is changed to 'N – No Premium'. If the beneficiary premiums are greater than zero, the PPO is changed to 'D – direct bill'. This TRC may be generated in response to an accepted Enrollment or PBP change (Transaction Type 61). **Plan Action:** Update the Plan's beneficiary records to reflect the updated premium payment method.
339	I	Enrollment Accepted, PBP Changed	PBP CHANGE OK	A submitted Enrollment transaction (Transaction Type 61) for the Limited Income Newly Eligible Transition (LINET) Plan has been successfully processed. The beneficiary has been moved from the submitted PBP to the PBP that is active for the transaction processing date. Field 20 (Plan Benefit Package ID) contains the new PBP identifier. The submitted PBP is reported in field 29 (Prior Plan Benefit Package ID). **Plan Action:** Ensure the Plan's system matches the information included in the DTRR record. Take the appropriate actions as per CMS enrollment guidance.
340	A	DISENROLLMENT DUE TO MMP PASSIVE ENROLLMENT	DISNROL-NEW MMP	The beneficiary has been automatically disenrolled from the Plan. The last day of enrollment is reported in DTRR fields 18 and 24. This date is always the last day of the month. This disenrollment results from an action by CMS or a state to passively enroll a full benefit dual eligible beneficiary into a Medicare-Medicaid Plan (MMP). **Plan Action**: Update the Plan's records to reflect the disenrollment using the date in field 24. Take the appropriate actions as per CMS enrollment guidance.

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

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

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

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

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

Code	Type	Title	Short Definition	Definition
360	R	Reject, Invalid IC Model U/D	IC MDL INV U/D	An IC Model Participation transaction (Transaction Type code 91) was rejected because the submitted Update/Delete flag was blank or contained an invalid value. Valid values are U (Update) or D (Delete). **Plan Action**: Correct the Update/Delete flag and resubmit the transaction, if appropriate.
361	R	Reject, Invalid IC Model End Date Reason Code	IC END RSN ERR	An IC Model Participation transaction (Transaction Type code 91) was rejected because the submitted End Date Reason Code field was blank when an End Date is present in the transaction or contained an invalid value. Valid values are: • '01' No Longer Eligible • '02' Opted out of program • '03' Benefit Status Change **Plan Action**: Correct the End Date Reason Code and resubmit the transaction, if appropriate.
362	R	IC Model End Date Incorrect	IC END DT ERROR	An IC Model Participation transaction (Transaction Type code 91) was rejected because the IC Model End Date: • is earlier than the IC Model Start Date, or • is after the Enrollment End Date **Plan Action**: Correct the IC Model End Date and resubmit the transaction, if appropriate.
363	R	ICM Trans Dates Overlap an Existing ICM Prd	OVERLAP DATES	An IC Model Participation update transaction (Transaction Type code 91) was rejected because the IC Model Start or End Date overlaps an existing IC Model period for a beneficiary that has the same contract number, PBP, and transaction type indicator. **Plan Action:** Submit a Transaction Type code 91 with Delete for the stored IC Model Participation record. Submit a second Transaction Type code 91 with Update and the new dates.
365	R	Reject, Invalid IC Model Benefit Status Code	BNFT STUS ERR	An IC Model Participation transaction (Transaction Type code 91) was rejected because the submitted Benefit Status Code field was blank or contained an invalid value when the IC Model Type Indicator is '01' (VBID). Valid values are: • '01' Full Status • '02' Unearned Status **Plan Action**: Correct the Benefit Status Code and resubmit the transaction, if appropriate.

Code	Type	Title	Short Definition	Definition
366	M	Community Medicaid Status	MEDICAID UPDATE	This TRC is returned on a reply with Transaction Type 01. An update has been made to the Medicaid status used to determine the Community Risk Adjustment Factor that will impact future payments. The effective date of the change of Medicaid status is reported in field 18. The new Medicaid status is reported in field 85: • 'F' – Full Dual • 'P' – Partial Dual • 'N' – Non-dual **Plan Action:** Update the Plan's records. Take the appropriate actions as per CMS guidance.
367	R	Enrollment Rejected, incorrect ESC or ETC	BAD ESC OR ETC	This enrollment transaction was rejected because it contained an Enrollment Source Code or Election Type Code that indicated it was a seamless conversion enrollment transaction, but only one of these values was submitted. Plan-submitted seamless conversion enrollment transactions must have an Enrollment Source Code = 'B' (Beneficiary Election) and Election Type Code = 'J' (Seamless Conversion Enrollment Mechanism). **Plan Action:** Correct the enrollment source code or election type code and resubmit the enrollment transaction.
368	I	Member MSP Period Exists	MEMBER HAS MSP	This TRC is returned with transaction types 61, 76, 77, 80, 81, or 82. The beneficiary has an existing MSP (Medicare Secondary Payer) period. This TRC accompanies an enrollment acceptance TRC that is included in the same DTRR. It provides additional information related to the beneficiary's accepted enrollment. One TRC 368 for each MSP period is sent to the plan(s) that have enrollment(s) impacted by the MSP period. o Field 18 contains the Start Date of the payments impacted by the MSP period change o Field 24 contains the actual start date of the MSP period o Field 44 contains the end date of the MSP period **Plan Action:** Update the Plan's records accordingly.
369	R	Enrollment Rejected, IEP/ICEP enroll available	IEP/ICEP AVAIL	This seamless conversion enrollment transaction (Transaction Type 61) was rejected because an IEP/ICEP enrollment transaction with the same application date was already accepted. **Plan Action:** Update the Plan's records accordingly. Take the appropriate actions as per CMS enrollment guidance.

Code	Type	Title	Short Definition	Definition
370	R	Enrollment Rejected, Invalid Plan for SCEM	INVAL SCEM PLN	This seamless conversion enrollment transaction (Transaction Type 61) was rejected because it was submitted for an invalid Plan. Seamless conversion enrollments are only valid for MA and MAPD plans. **Plan Action:** Update the Plan's records accordingly. Take the appropriate actions as per CMS enrollment guidance.
371	I	LEP Exceeds SSA Harm Limit	LEP HARM	A NUNCMO Change transaction (Transaction Type 73) was processed for a period of SSA withholding. The sum of the current premium amount and additional retroactive LEP amounts to be collected exceeds the SSA Harm Limit of $300.00 per month. The additional LEP amount for retroactive months will be directly collected from the beneficiary by the plan. The amount to be directly collected will be reported as a Harm Detail Record on the LEP Data File. **Note:** See Appendices section ***I.2.1*** for calculation examples. Pl**an Action:** Update the Plan's records accordingly and collect amounts reported as Harm Detail Records from the beneficiary. LEP amounts previously collected by the withholding agency will remain with CMS.
372	I	SSA Harm LEP Refund	HRM LEP RFND	There is a subsequent change to retroactive LEP, and the beneficiary is due a partial or full refund of the amount that was previously collected based on the TRC 371. Harm Detail Records on the LEP Data File will report the negative LEP amounts to be refunded to the beneficiary. **Note:** See Appendices section ***I.2.1*** for calculation examples. **Plan Action:** Update the Plan's records accordingly and refund amounts reported as Harm Detail Records to the beneficiary.
701	A	New UI Enrollment (Open Ended)	UI ENROLLMENT	A CMS User enrolled this beneficiary in this contract under the indicated PBP (if applicable) and segment (if applicable). DTRR data record, field 18 contains the enrollment effective date. This is an open-ended enrollment, which does not have a disenrollment date. The Part C Premium amount may have been populated automatically with the base Part C premium amount. **Plan Action:** Update the Plan's beneficiary records with the information in the DTRR. Verify the Part C premium amount and submit a Record Update transaction if necessary. Take the appropriate actions as per CMS enrollment guidance.

Code	Type	Title	Short Definition	Definition
702	A	UI Fill-In Enrollment	UI FILL-IN ENRT	A CMS User enrolled this beneficiary in this contract under the indicated PBP (if applicable) and segment (if applicable). This enrollment is a Fill-In Enrollment and represents a complete enrollment period that begins on the date in DTRR data record field 18 and ends on the date in field 24. This is a distinct enrollment period and does not affect any existing enrollments. The Part C Premium amount may have been populated automatically with the base Part C premium amount. **Plan Action:** Update the Plan's records to reflect the beneficiary's enrollment as of the effective date in Daily Transaction Reply Report data record field 18 and ending on the date in field 24. This end date should not affect the beginning of any existent enrollment periods. Verify the Part C premium amount and submit a Record Update transaction if necessary. Take the appropriate actions as per CMS enrollment guidance.
703	A	UI Enrollment Cancel (Delete)	UI ENROLL CANCL	A CMS User cancelled the beneficiary's existing enrollment and the beneficiary is disenrolled. When an enrollment is cancelled, it means that the enrollment never occurred. DTRR field 18 contains the effective date (start date) of the cancelled enrollment period. **Plan Action:** Remove the indicated enrollment from the Plan's records. Take the appropriate actions as per CMS enrollment guidance.
704	A	UI Enrollment Cancel PBP Correction	UI CNCL PBP COR	A CMS User updated the PBP on an existing enrollment. This generates two transaction replies, a Transaction Type 51 with TRC 704 and a Transaction Type 61 with TRC 705. This reply with TRC 704 (Transaction Type 51) represents the cancellation of the enrollment in the original PBP. The effective (start) and disenrollment (end) dates of the enrollment being cancelled are found in DTRR fields 18 & 24, respectively. When an enrollment is cancelled it means that the enrollment never occurred. **Plan Action:** Remove the indicated enrollment in the original PBP from the Plan's records. Look for the accompanying reply with TRC 705 to determine the replacement enrollment period. Take the appropriate actions as per CMS enrollment guidance.

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

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

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

Code	Type	Title	Short Definition	Definition
716	I	UI changed the Number of Uncovered Months	UI CHGD NUNCMO	A CMS User updated the beneficiary's Number of Uncovered Months. **Plan Action:** Update the Plan's records accordingly. Ensure that the Plan is billing the correct amount for the LEP. Take the appropriate actions as per CMS enrollment guidance.
717	I	UI changed only the Application Date	UI CHGD APP DT	A CMS User updated only the Application Date of a beneficiary's enrollment, which results in a blank TC on the DTRR, Field 16. **Plan Action**: Update the Plan's records accordingly.
718	I	UI MMP Opt-Out Change Accepted	UI MMP OPTOUT OK	A CMS User added or changed the value of the MMP Opt-Out Flag for this beneficiary. The new MMP Opt-Out Flag is reported in DTRR data record field 70. **Plan Action:** Update the Plan's records accordingly.
719	I	UI Enrollment Source Code Accepted	UI ENRL SRC OK	A CMS User updates the Enrollment Source Code on this beneficiary's enrollment record. **Plan Action**: Update the Plan's records accordingly.
720	I	CMS Audit Review POS Drug Edit	PSDE REVIEW	A CMS User flagged this beneficiary's POS Drug Edit for review. **Plan Action**: Review the POS Drug Edit transactions for this beneficiary and submit corrections if appropriate. Contact CMS via e-mail at PartDPolicy@cms.hhs.gov with subject "POS Edit Reporting" to discuss the flagged POS Drug Edit information.
721	A	POS Drug Edit Accepted as submitted –UI	PSDE ACC UI	A CMS User added (updated) or deleted a POS Drug Edit record via the MARx UI for this beneficiary. **Plan Action:** None.
722	A	POS Drug Edit Event Deleted - CMS	PSDE EVT DEL C	A CMS User deleted a POS Drug Edit event via the MARx UI for this beneficiary. If the latest status was T (Termination), the associated Notification, Implementation (if exists) and Termination POS Drug Edit records were deleted. If the latest status was I (Implementation), the associated Notification and Implementation POS Drug Edit records were deleted. If the latest status was N, the Notification POS Drug Edit record was deleted. **Plan Action:** None.
990 – 995				These codes appear only on special DTRRs that are generated for specific purposes; for example, those generated to communicate Full Enrollment or to report beneficiaries losing low-income deeming. When a special DTRR produces one of these TRCs, CMS will provide the Plans with communications which define the TRC descriptions and Plan actions (if applicable).

Code	Type	Title	Short Definition	Definition
996	I	EOY Loss of Low Income Subsidy Status	EOY LOSS SBSDY	Identifies those beneficiaries who are losing their deemed or LIS Applicant status as of December 31st of the current year with no low income status determined for January of the following year. **Plan Action**: Update Plan records accordingly.
997 – 999				These codes appear only on special DTRRs that are generated for specific purposes; for example, those generated to communicate Full Enrollment or to report beneficiaries losing low-income deeming. When a special DTRR produces one of these TRCs, CMS will provide the Plans with communications which define the TRC descriptions and Plan actions (if applicable).

I.2.1 Example Calculations for TRCs 371 and 372

PROSPECTIVE PREMIUM STAYS **BELOW** SSA HARM LIMIT (TRC 371)

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

PROSPECTIVE PREMIUM **EXCEEDS** SSA HARM LIMIT (TRC 371)

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

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

#	Condition	Value
Premium		
a)	Beneficiary's PPO is currently set to SSA Withhold	TRUE
b)	Current monthly premium amount	$245.00
	Current monthly LEP amount	$5.00
	Current monthly premium amount	**$250.00**
c)	Increase of monthly LEP amount (per month)	$15.00
	New prospective monthly premium amount total:	**$265.00**
d)	LEP increase is due for 10 retroactive months ($15.00 * 10 months)	**$150.00**
	Total premium amount owed (for 1 month)	**$415.00**
	(New monthly premium amount + 10 mo. LEP increase due)	
MARx Action		
a)	Beneficiary's PPO *remains set to SSA Withhold*	TRUE
b)	DTRR will display TRC 371 (SSA LEP Exceeds Harm Limit)	TRUE
	LEP increase for 10 retroactive months is Direct Billed by Plan	
	Direct Billed by Plan:	**$150.00**
c)	New prospective monthly premium amount	
	Withheld by SSA:	**$265.00**
d)	Total premium amount owed (for 1 month)	**$415.00**
Subsequent Premium Conditions		
a)	Beneficiary's PPO is currently set to SSA Withhold	TRUE
b)	Current monthly premium amount	$245.00
	Current monthly LEP amount	$20.00
	Current monthly premium amount	**$265.00**
c)	Decrease of monthly LEP amount (per month)	($15.00)
	New prospective monthly premium amount total:	**$250.00**
d)	LEP decrease should be refunded for 10 retroactive months ($15.00 * 10 months)	**($150.00)**
MARx Action		
a)	Beneficiary's PPO *remains set to SSA Withhold*	TRUE
b)	DTRR will display TRC 372 (SSA Harm Limit Refund)	TRUE
	LEP decrease for 10 retroactive months is refunded by Plan	
	Refunded by Plan	**($150.00)**
c)	New monthly premium amount	
	Withheld by SSA:	**$250.00**

I.3 Transaction Reply Code (TRC) Groupings

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

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

Transaction Rely Code	TRC Title
050R	DISENROLLMENT REJECTED, NOT ENROLLED
051R	DISENROLLMENT REJECTED, INCORRECT EFFECTIVE DATE
052R	DISENROLLMENT REJECTED, DUPLICATE TRANSACTION
054R	DISENROLLMENT REJECTED, RETROACTIVE EFFECTIVE DATE
090M	DATE OF DEATH ESTABLISHED
104R	REJECTED; INVALID OR MISSING ELECTION TYPE
105R	REJECTED; INVALID EFFECTIVE DATE FOR ELECTION TYPE
108R	REJECTED; ELECTION LIMITS EXCEEDED
114R	DRUG COVERAGE CHANGE REJECTED; NOT AEP
120A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
151I	DISENROLLMENT ACCEPTED, INVALID DISENR REASON CODE
205I	INVALID DISENROLLMENT REASON CODE
293A	DISENROLL, FAILURE TO PAY PART D IRMAA
340A	DISENROLLMENT DUE TO MMP PASSIVE ENROLLMENT
346M	PRISONER SUSPENSION PERIOD CANCEL/DISENROLL
349I	DISENROLLMENT DUE TO NOT LAWFULLY PRESEMT PERIOD
DISENROLLMENT CANCELLATION TRC GROUPING	
036R	TRANSACTION REJECTED BENEFICIARY IS DECEASED
042R	TRANSACTION REJECTED, BLOCKED
044R	TRANSACTION REJECTED, OUTSIDE CONTRACT PERIOD
116R	ENROLLMENT OR CHANGE REJECTED; INVALID SEGMT NUM
284R	CANCELLATION REJECTED, ENROLL/DISENROLL CANCELLATION
288A	DISENROLLMENT CANCELLATION ACCEPTED
289R	DISENROLLMENT CANCELLATION REJECTED
291I	ENROLLMENT REINSTATED, DISENROLLMENT CANCELLATION
296R	DISENROLL CANCEL REJECTED, REINSTATEMENT CONFLICT (CONFLICTS WITH AN EXISTING ENROLLMENT)
DISENROLLMENT TRANSACTION (TC 51) ***Rejected when used to attempt an enrollment Cancellation***	
292R	DISENROLLMENT REJECTED, WAS CANCELLATION ATTEMPT
EGHP TRC GROUPING	
110R	REJECTED; NO PART A AND NO EGHP ENROLLMENT WAIVER
127R	PART D ENROLLMENT REJECTED, EMPLOYER SUBSIDY
128R	PART D ENROLL REJECT, EMPLYR SBSDY SET: NO PRIOR TRN
129I	PART D ENROLL ACCEPT, EMP SBSDY SET: PRIOR TURN REJECT
139A	EGHP FLAG CHANGE ACCEPTED
162R	INVALID EGHP FLAG VALUE
164R	EGHP FLAG VALUE NOT 'Y'
189A	NO CHANGE IN EGHP FLAG

Transaction Rely Code	TRC Title
ENROLLMENT TRC GROUPING	
011A	ENROLLMENT ACCEPTED AS SUBMITTED
015A	ENROLLMENT CANCELED
016I	ENROLLMENT ACCEPTED, OUT OF AREA
017I	ENROLLMENT ACCEPTED, PAYMENT DEFAULT RATE
019R	ENROLLMENT REJECTED- NO PART- A & PART-B ENTITLEMENT
020R	ENROLLMENT REJECTED-PACE UNDER 55
032R	ENROLLMENT REJECTED, BENEFICIARY NOT ENTIT PART B
033R	ENROLLMENT REJECTED, BENEFICIARY NOT ENTIT PART A
034R	ENROLLMENT REJECTED, BENEFICIARY IS NOT AGE 65
035R	ENROLLMENT REJECTED, BENEFICIARY IS IN HOSPICE
036R	TRANSACTION REJECTED, BENEFICIARY IS DECEASED
038R	ENROLLMENT REJECTED, DUPLICATE TRANSACTION
039R	ENROLLMENT REJECTED, CURRENTLY ENOLL IN SAME PLAN
042R	TRANSACTION REJECTED, BLOCKED
044R	TRANSACTION REJECTED, OUTSIDE CONTRACT PERIOD
045R	ENROLLMENT REJECTED, BENEFICIARY IS IN ESRD
056R	DEMONSTRATION ENROLLMENT REJECTED
100A	PBP CHANGE ACCEPTED AS SUBMITTED
102R	REJECTED; INCORRECT OR MISSING APPLICATION DATE
103R	ICEP/IEP ELECTION, MISSING A/B ENTITLEMENT DATE
104R	REJECTED; INVALID OR MISSING ELECTION TYPE
105R	REJECTED; INVAILD EFFECTIVE DATE FOR ELECTION TYPE
106R	REJECTED; ANOTHER TRANSACTION RECEIVED WITH LATER APPLICATION DATE
108R	REJECTED; ELECTION LIMITS EXCEEDED
114R	DRUG COVERAGE CHANGE REJECTED; NOT AEP
116R	ENROLLMENT OR CHANGE REJECTED; INVALID SEGMT NUM
120A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
124R	ENROLLMENT/CHANGE REJECTED; INVALID UNCOVERED MONTHS
126R	ENROLLMENT/CHANGE REJECTED; INVALID CRED CVRG FLAG
127R	PART D ENROLLMENT REJECTED; EMPLOYER SUBSIDY STATUS
128R	PART D ENROLLMENT REJECT, EMPLYR SBSDY SET; NO PRIOR TRN
129I	PART D ENROLL ACCEPT; EMP SBSDY SET; PRIOR TRN REJECT
133R	PART D ENROLL REJECTED; INVALID SECNDRY INSUR FLAG
134I	MISSING SECONDARY INSURANCE INFORMATION
150I	ENROLLMENT ACCEPTED, EXCEEDS CAPACITY LIMIT
176R	TRANSACTION REJECTED, ANOTHER TRANSACTION ACCEPTED
184R	ENROLLMENT REJECTED, BENEFICIARY IS Medicaid
196R	TRANSACTION REJECTED, BENE NOT ELIGIBLE FOR PART D
211R	RE-ASSIGNMENT ENROLLMENT REJECTED
212A	RE-ASSIGNMENT ENROLLMENT ACCEPTED
246A	GAP ENROLLMENT ACCEPTED; NO CHANGE TO DATES

Transaction Rely Code	TRC Title
247A	GAP ENROLLMENT ACCEPTED; NEW END DATE
248R	GAP ENROLLMENT REJECTED; INVALID END DATE
249R	GAP ENROLLMENT OVERLAP AE, FE OR POS/LI NET PERIOD
250R	GAP ENROLLMENT DATES FALL WITHIN ANOTHER ENROLLMENT
251R	GAP ENROLLMENT NOT IN RETRO FILE
268I	BENEFICIARY HAS DIALYSIS PERIOD
269I	BENEFICIARY HAS TRANSPLANT
307A	MMP PASSIVE ENROLLMENT ACCEPTED
308R	MMP PASSIVE ENROLLMENT REJECTED
312A	MMP ENROLLMENT CANCELLATION ACCEPTED
313R	MMP ENROLLMENT CANCELLATION REJECTED
367R	ENROLLMENT REJECTED, INCORRECT ESC OR ETC
369R	ENROLLMENT REJECTED, IEP/ICEP ENROLL AVAILABLE
370R	ENROLLMENT REJECTED, INVALID PLAN FOR SCEM
338I	ENROLLMENT ACCEPTED, PPO CHANGED
339	ENROLLMENT ACCEPTED, PBP CHANGED
345R	ENROLLMENT REJECTED – CONFIRMED INCARCERATION
347I	REENROLLMENT DUE TO CLOSED INCARCERATION PERIOD
348R	ENROLLMENT REJECTED – NOT LAWFULLY PRESENT PERIOD
355R	ENROLLMENT REJECTED, PLN RO NOT IN POVER FILE
356R	ENROLLMENT REJECTED, PLN RO WITHOUT ESC OR ETC
357R	ENROLLMENT REJECTED, PLN RO IMPACTS DUAL ENROLL
719I	UI ENROLLMENT SOURCE CODE ACCEPTED
ENROLLMENT CANCELLATION TRC GROUPING	
060R	TRANSACTION REJECTED, NOT ENROLLED
285A	ENROLLMENT CANCELLATION ACCEPTED
286R	ENROLLMENT CANCELLATION REJECTED
287A	ENROLLMENT REINSTATED
292R	DISENROLLMENT REJECTED, WAS CANCELLATION ATTEMPT
312A	MMP ENROLLMENT CANCELLATION ACCEPTED
313R	MMP ENROLLMENT CANCELLATION REJECTED
314R	INVALID CANCELLATION TRANSACTION
ESRD TRC GROUPING	
055M	ESRD CANCELLATION
073M	ESRD STATUS SET
074M	ESRD STATUS TERMINIATED
135M	BENEFICIARY HAS STARTED DIALYSIS TREATMENTS
136M	BENEFICIARY HAS ENDED DIALYSIS TREATMENTS
137M	BENEFICIARY HAS RECEIVED A KIDNEY TRANSPLANT
268I	BENEFICIARY HAS DIALYSIS PERIOD
269I	BENEFICIARY HAS TRANSPLANT

Transaction Rely Code	TRC Title
FAILED PAYMENT	
000I	NO DATA TO REPORT
264I	PAYMENT NOT YET COMPLETED
299I	CORRECTION TO PREVIOUSLY FAILED PAYMENT
FAILED TRCs GROUPING	
257F	FAILED; BIRTH DATE INVALID FOR DATABASE INSERTION
258F	FAILED; EFFECTIVE DATE INVALID FOR DATABASE INSERTION
259F	FAILED; END DATE INVALID FOR DATABASE INSERTION
263F	APPLICATION DATE INVALID FOR DATABASE INSERTION
332F	FAILED, PSDE DATES INVALID FOR DATABASE INSERTION
HOSPICE TRC GROUPING	
071M	HOSPICE STATUS SET
072M	HOSPICE STATUS TERMINATED
IC MODEL TRC GROUPING	
351A	IC MODEL PARTICIPATION ACCEPTED
352R	IC MODEL PARTICIPATION DUPLICATE TRANSACTION
353R	IC MODEL PARTICIPATION DELETE ERROR
354R	REJECT, INVALID IC MODEL TYPE INDICATOR
358F	FAIL, IC MODEL END DATE HAD AN INVALID FORMAT
359R	ICM TRANS START DATE IS INCORRECT
360R	REJECT, INVALID IC MODEL U/D
361R	REJECT, INVALID IC MODEL END DATE REASON CODE
362R	IC MODEL END DATE INCORRECT
363R	ICM TRANS DATES OVERLAP AN EXISTING ICM PRD
365R	REJECT, INVALID IC MODEL BENEFIT STATUS CODE

LATE ENROLLMENT PENALTY/LEP TRC GROUPING	
177M	CHANGE IN LATE ENROLLMENT PENALTY
178M	LATE ENROLLMENT PENALTY RESCINDED
218M	LEP RESET UNDONE
219M	LEP RESET ACCEPTED
LIS/AUTO/FACI TRC GROUPING	
117A	FBD AUTO ENROLLMENT ACCEPTED
118A	LIS FACILITATED ENROLLMENT ACCEPTED
121M	LOW INCOME PERIOD STATUS
166R	PART D FBD AUTO ENROLLMENT OR FACILITATED ENROLLMENT REJECTED
194M	DEEMED CORRECTION
223I	LOW INCOME PERIOD CLOSED
MEDICAID TRC GROUPING	
077M	MEDICAID STATUS SET
078M	MEDICAID STATUS TERMINATED
097R	MEDICAID PREVIOUSLY TURNED ON
098R	MEDICAID PREVIOUSLY TURNED OFF
099M	MEDICAID PERIOD CHANGE/CANCELLATION
184R	ENROLLMENT REJECTED, BENEFICIARY IS IN MEDICAID
366M	COMMUNITY MEDICAID STATUS
MEDICARE SECONDARY PAYER/MSP TRC GROUPING	
227R	AGED/DISABLED TRANSACTION REJECTED-INVALID TRANSACTION TYPE
245M	MEMBER HAS MSP PERIOD
280I	MEMBER MSP PERIOD HAS ENDED
368I	MEMBER MSP PERIOD EXISTS
NUMBER OF UNCOVERED MONTHS/NUNCMO TRC GROUPING	
120A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
124R	ENROLLMENT/CHANGE REJECTED, INVALID UNCOV MONTHS
126R	ENROLLMENT/CHANGE REJECTED, INVALID CRED CVRG FLAG
141A	UNCOVERED MONTHS CHANGE ACCEPTED
187A	NO CHANGE IN NUMBER OF UNCOVERED MONTHS INFORMATION
215R	UNCOVERED MONTHS CHANGE REJECTED, INCORRECT EFF DATE
216I	UNCOVERED MONTHS EXCEEDS MAX POSSIBLE VALUE
217R	CAN'T CHANGE NUMBER OF UNCOVERED MONTHS
290I	IEP NUNCMO RESET
295M	LOW INCOME NUNCMO RESET
300R	NUNCMO CHANGE REJECTED, EXCEEDS MAX POSSIBLE VALUE
306R	NUNCMO CHANGE REJECTED, NO PART D ELIGIBILITY
341I	MAXIMUM NUNCMO CALCULATION

PLAN CHANGES TRC GROUPING	
060R	TRANSACTION REJECTED, NOT ENROLLED IN PLAN
116R	ENROLLMENT OR CHANGE REJECTED; INVALID SEGMT NUM
134I	MISSING SECONDARY INSURANCE INFORMATION
140A	SEGMENT ID CHANGE ACCEPTED
171R	RECORD UPDATE REJECTED, INVALID CHG EFFECTIVE DATE
172R	CHANGE REJECTED; CREDITABLE COVERAGE//2 DRUG INFO NOT APPLICABLE
188A	NO CHANGE IN SEGMENT ID
316I	DEFAULT SEGMENT ID ASSIGNMENT
317I	SEGMENT ID REASSIGNED AFTER ADDRESS UPDATE
PART D OPT OUT TRC GROUPING	
130R	PART D OPT-OUT REJECTED, OPT-OUT FLAG NOT VALID
131A	PART D OPT-OUT ACCEPTED
241I	NO CHANGE IN PART D OPT OUT FLAG
POINT OF SALE (POS) TRC GROUPING	
210A	POS ENROLLMENT ACCEPTED
220R	TRANSACTION REJECTED; INVALID POS ENROLL SOURCE CODE
321A	POS DRUG EDIT ACCEPTED AS SUBMITTED
322I	NEW ENROLLEE POS DRUG EDIT NOTIFICATION
323R	POS DRUG EDIT INVALID EROLLMENT
324R	POS DRUG EDIT INVALID CONTRACT
325R	POS DRUG EDIT STATUS/DATE ERROR
326R	POS DRUG EDIT IMPLEMENTATION DATE INCORRECT
327R	POS DRUG EDIT TERMINATION DATE INCORRECT
328R	POS DRUG EDIT DUPLICATE TRANSACTION
329R	POS DRUG EDIT DELETE ERROR
330R	POS DRUG EDIT WITHOUT ASSOCIATED RECORDS
331R	FUTURE POS DRUG EDIT DATE EXCEEDS CCM PLUS ONE
333R	REJECT, INVALID POS DRUG EDIT STATUS
334R	REJECT, INVALID POS DRUG EDIT CLASS
335R	REJECT, INVALID POS DRUG EDIT CODE
336R	REJECT, INVALID POS DRUG EDIT U/D
337A	POS DRUG EDIT EVENT DELETED - PLAN
343I	POS DRUG EDIT CLASS INACTIVE
342R	REJECT, MULTIPLE NOTIFICATION
344R	REJECT, MORE RESTRICTIVE IMPLEMENTATION
720I	CMS AUDIT REVIEW POS DRUG EDIT
721A	POS DRUG EDIT ACCEPTED AS SUBMITTED –UI
722A	POS DRUG EDIT EVENT DELETED - CMS

PREMIUM PAYMENT TRC GROUPING	
119A	PREMIUM AMOUNT CHANGE ACCEPTED
120A	PREMIUM PAYMENT OPTION CHANGE SENT TO W/H AGENCY
122R	ENROLLMENT/CHANGE REJECTED, INVALID PREM AMT
123R	ENROLLMENT/CHANGE REJECTED, INVALID PREM PAY OPT CD
144M	PREMIUM PAYMENT OPTION CHANGED TO DIRECT BILL
170I	PREMIUM WITHHOLD OPTION CHANGE TO DIRECT BILL
173R	CHANGE REJECTED; PREMIUM NOT PREVIOUSLY SET
179A	TRANSACTION ACCEPTED- NO CHANGE TO PREMIUM RECORD
182I	INVALID PTC PREMIUM SUBMITTED, CORRECTED
191A	NO CHANGE IN PREMIUM WITHHOLD OPTION
206I	PART C PREMIUM HAS BEEN CORRECTED TO ZERO
213I	PREMIUM WITHHOLD OPTION CHANGE TO DIRECT BILL
222I	BENE EXCLUDED FROM TRANSMISSION TO SSA/RRB
237I	PART B PREMIUM REDUCTION SENT TO SSA
240A	TRANSACTION RECEIVED, WITHHOLDING PENDING
243R	CHANGE TO SSA WITHHOLDING REJECTED DUE TO NO SSN
252I	PREM PAYMENT OPTION CHANGED TO DIRECT BILL, NO SSN
253M	CHANGED TO DIRECT BILL; NO FUNDS WITHHELD
267M	PREMIUM PAYMENT OPTION SET TO "**N**" DUE TO NO PREMIUM
371I	LEP EXCEEDS SSA HARM LIMIT
372I	SSA HARM LEP REFUND
RESIDENCE ADDRESS CHANGE TRC GROUPING	
154M	OUT OF AREA STATUS
260R	REJECTED; BAD END DATE, REJECT RESIDENCE ADDRESS CHANGE
261R	REJECTED; INCOMPLETE RESIDENCE ADDRESS INFORMATION
265A	RESIDENCE ADDRESS CHANGE ACCEPTED, NEW SCC
266R	UNABLE TO RESOLVE SSA STATE COUNTY CODES
282A	RESIDENCE ADDRESS DELETED
283R	RESIDENCE ADDRESS DELETE REJECTED
RRB TRC GROUPING	
120A	PPO CHANGE SENT TO W/H AGENCY
123R	ENROLLMENT/CHANGE REJECTED, INVALID PRE PAY OPT CD
144M	PREMIUM PAYMENT OPTION CHANGED TO DIRECT BILL
185M	WITHHOLDING AGENCY ACCEPTED TRANSACTION
186I	WITHHOLDING AGENCY REJECTED TRANSACTION
191A	NO CHANGE IN PREMIUM WITHHOLD OPTION
222I	BENE EXCLUDED FROM TRANSMISSION TO SSA/RRB
238I	RRB REJECTED PART B REDUCTION, DELAYED PROCESSING
252I	PRE PAYMENT OPTION CHANGED TO DIRECT BILL; NO SSN
254I	BENE SET TO DIRECT BILL, SPANS JURISDICTION
255I	PLAN SUBMITTED RRB W/H FOR SSA BENE

256I	PLAN SUBMITTED SSA W/H FOR RRB BENE
262R	BAD RRB PREMIUM WITHHOLD EFFECTIVE DATE
319M	RRB TO SSA BENEFICIARY JURISDICTION CHANGE
SCC ADDRESS TRC GROUPING	
085M	STATE AND COUNTY CODE CHANGE
138M	BENEFICIARY ADDRESS CHANGE TO OUTSIDE THE U.S.
154M	OUT OF AREA STATUS
305M	ZIP CODE CHANGE
SPECIAL REPLY TRC GROUPING	
990-995	APPEAR ON SPECIAL TRR GENERATED FOR SPECIFIC PURPOSE. WHEN A SPECIAL TRR PRODUCES ONE OF THESE CODES, CMS WILL PROVIDE COMMUNICATIONS TO EXPLAIN THE TRC
996	EOY LOSS OR LOW INCOME SUBSIDY STATUS
997-999	APPEAR ON SPECIAL TRR GENERATED FOR SPECIFIC PURPOSE. WHEN A SPECIAL TRR PRODUCES ONE OF THESE CODES, CMS WILL PROVIDE COMMUNICATIONS TO EXPLAIN THE TRC
SSA TRC GROUPING	
185M	WITHHOLDING AGENCY ACCEPTED TRANSACTION
186I	WITHHOLDING AGENCY REJECTED TRANSACTION
195M	SSA UNSOLICITED RESPONSE (SSA WITHHOLD UPDATE)
225I	EXCEEDS SSA BENEFIT & SAFETY NET AMOUNT
235I	SSA ACCEPTED PART B REDUCTION TRANSACTION
236I	SSA REJECTED PART B REDUCTION TRANSACTION
243R	CHANGE TO SSA WITHHOLDING REJECTED DUE TO NO SSN
320M	SSA TO RRB BENEFICIARY JURISDICTION CHANGE
371I	LEP EXCEEDS SSA HARM LIMIT
372I	SSA HARM LEP REFUND
SYSTEM NOTIFICATION TRC GROUPING	
048 R	NURSEING HOME CERTIFIABLE STATUS SET
062 R	CORRECTION REJECTED, OVERLAPS OTHER PERIOD
075 A	INSTITUTIONAL STATUS SET
079 M	PART A TERMINATION
080 M	PART A REINSTATEMENT
081 M	PART B TERMINIATION
082 M	PART B REINSTATEMENT
086 M	BENFICIARY IDENTIFIER CHANGE
087 M	NAME CHANGE
088 M	SEX CODE CHANGE
089 M	DATE OF BIRTH CHANGE
090 M	DATE OF DEATH ESTABLISHED
091 M	DATE OF DEATH REMOVED
092 M	DATE OF DEATH CORRECTED
121M	LOW INCOME PERIOD STATUS

152 M	RACE CODE CHANGE
154M	OUT OF AREA STATUS
155 M	INCARCERATION NOTIFICATION RECEIVED
158 M	INSTITUTIONAL PERIOD CHANGE/CANCELLATION
159 M	NURSING HOME CERT PERIOD CHANGE/CANCELLATION
161 M	BENEFICIARY RECORD ALERT FROM MBD
165 R	PROCESSING DELAYED DUE TO MARX SYSTEM PROBLEMS
194M	DEEMED CORRECTION
197M	PART D ELIGIBILITY TERMINATION
198M	PART D ELIGIBILITY REINSTATEMENT
267M	PREMIUM PAYMENT OPTION SET TO **"N"** DUE TO NO PREMIUM
270M	BENEFICIARY TRANSPLANT HAS ENDED
303M	TERMINATION DATE CHANGE DUE TO BENEFICIARY MERGE
350I	MBI IS AVAILABLE FOR BENEFICIARY

I.4 Payment Reply Codes (PRCs)

PRCs are codes similar to the DTRR's TRCs. PRCs, however, are not reported on the DTRR. They are included on records in the Failed Payment Reply Report (FPRR) data file. PRCs are used to communicate to the Plan when a payment calculation is delayed and also when the delayed payment has been processed.

Table I-3: Payment Reply Codes

Code/Type*	Title	Short Definition	Definition
000 I	No Data to Report	NO REPORT	This TRC can appear on both the DTRR and the Failed Payment Reply Report (FPRR) data files. On the DTRR it indicates that none of the following occurred during the reporting period for the given contract/PBP, a beneficiary status change, user interface (UI) activity, or CMS or Plan transaction processing. The reporting period is the span between the previous DTRR and the current DTRR. On the FPRR it indicates the presence of all prospective payments for the Plan (contract/PBP), none are missing. **Plan Action**: None
264 I	Payment Not Yet Completed	NO PAYMENT	A transaction was accepted requiring a payment calculation. The calculation has not been completed. **Plan Action:** None
299 I	Correction to Previously Failed Payment	RESTORED PYMT	A previously incomplete payment calculation is now completed. **Plan Action**: None required.

I.5 MMR Adjustment Reason Codes

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

Table I-4: Adjustment Reason Codes

Code	Description
01	Notification of Death of Beneficiary
02	Retroactive Enrollment
03	Retroactive Disenrollment
04	Correction to Enrollment Date
05	Correction to Disenrollment Date
06	Correction to Part A Entitlement
07	Retroactive Hospice Status
08	Retroactive ESRD Status
09	Retroactive Institutional Status
10	Retroactive Medicaid Status
11	Retroactive Change to State County Code
12	Date of Death Correction
13	Date of Birth Correction
14	Correction to Sex Code
15	Obsolete
16	Obsolete
17	For APPS use only
18	Part C Rate Change
19	Correction to Part B Entitlement
20	Retroactive Working Aged Status
21	Retroactive NHC Status
22	Disenrolled Due to Prior ESRD
23	Demo Factor Adjustment
24	Obsolete
25	Part C Risk Adj Factor Change/Recon
26	Mid-year Part C Risk Adj Factor Change
27	Retroactive Change to Congestive Heart Failure (CHF) Payment
28	Retroactive Change to BIPA Part B Premium Reduction Amount
29	Retroactive Change to Hospice Rate
30	Retroactive Change to Basic Part D Premium
31	Retroactive Change to Part D Low Income Status
32	Retroactive Change to Estimated Cost-Sharing Amount
33	Retroactive Change to Estimated Reinsurance Amount
34	Retroactive Change Basic Part C Premium

Code	Description
35	Retroactive Change to Rebate Amount
36	Part D Rate Change
37	Part D Risk Adjustment Factor Change
38	Part C Segment ID Change
41	Part D Risk Adjustment Factor Change (ongoing)
42	Retroactive MSP Status
44	Retroactive correction of previously failed Payment (affects Part C and D)
45	Disenroll for Failure to Pay Part D IRMAA Premium – Reported for Pt C and Pt D
46	Correction of Part D Eligibility – Reported for Pt D
50	Payment adjustment due to Beneficiary Merge
60	Part C Payment Adjustments created as a result of the RAS overpayment file processing
61	Part D Payment Adjustments created as a result of the RAS overpayment file processing
65	Confirmed Incarceration – Reported for Pt C and Pt D
66	Not Lawfully Present
90	System of Record History Alignment
94	Special Payment Adjustment Due to Clean-Up

I.6 State Codes

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

Table I-5: State Code Table

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

State / Territory	Numeric Code	Character Code
Oregon	38	OR
Pennsylvania	39	PA
Puerto Rico	40	PR
Rhode Island	41	RI
South Carolina	42	SC
South Dakota	43	SD
Tennessee	44	TN
Texas	45	TX
Utah	46	UT
Vermont	47	VT
Virgin Islands	48	VI
Virginia	49	VA
Washington	50	WA
West Virginia	51	WV
Wisconsin	52	WI
Wyoming	53	WY
Africa	54	
Asia	55	
Canada	56	
Ctrl America/West Indies/Alvarado (Honduras)	57	
Himariotis (Greece) (Europe)	58	
Ibarra (Mexico)	59	
Oceania (Australia & Islands in the Pacific)	60	
Bush (Philippine Islands)	61	
South America	62	
U.S. Possessions	63	
American Samoa	64	
Gogue (Guam)	65	
Dirksz (Aruba)	78	
Lynch (APO NE)	94	
Correa (APO)	95	
St. Peter (Plaisted)	99	

I.7 Entitlement Status and Enrollment Reason Codes

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

1.8.1 Entitlement Status Code Tables

Part A – Entitlement Status Codes

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

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

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

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

Part A – Non Entitlement Status Codes

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

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

Part A - Enrollment Reason Codes

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

Part B - Entitlement Status Codes

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

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

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

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

Part B – Non Entitlement Reason Codes

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

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

Part B - Enrollment Reason Codes

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

I.8 Disenrollment Reason Codes

Table I-7 lists the reason codes for Disenrollment.

Table I-6: Disenrollment Reason Code Table

Disenrollment Reason Code	Disenrollment Reason Description	Short Description	MARx UI	AUTO-DIS	PLAN SUB'D
01	FAILURE TO PAY PREMIUMS	PREMIUMS NOT PAID	N/A	N/A	N/A
02	RELOCATION OUT OF PLAN SERVICE AREA (NO SPECIAL PROVISIONS)	RELO OUT OF AREA	N/A	N/A	N/A
03	FAILURE TO CONVERT TO RISK PROVISIONS	NOT CONVERT TO RISK	N/A	N/A	N/A
04	FRAUD	FRAUD	N/A	N/A	N/A
05	LOSS OF PART B ENTITLEMENT	LOSS OF PART B	N/A	Y	N/A
06	LOSS OF PART A ENTITLEMENT (PLAN-SPECIFIC)	LOSS OF PART A	N/A	Y	N/A
07	FOR CAUSE	FOR CAUSE	Y	N/A	N/A
08	REPORT OF DEATH	REPORT OF DEATH	N/A	Y	N/A
09	TERMINATION OF CONTRACT (CMS-INITIATED)	CONTR TERMD-CMS	N/A	Y	N/A
10	TERMINATION OF CONTRACT/Plan Benefit Package (PBP)/SEGMENT (PLAN WITHDRAWAL)	CONTR TERMD-PLAN	N/A	Y	N/A
11	VOLUNTARY DISENROLLMENT THROUGH PLAN	VLNTRY DSNR THRU PLN	Y	N/A	Y
12	VOLUNTARY DISENROLLMENT THROUGH DISTRICT OFFICE	VLNTRY DSNR THRU DOF	N/A	N/A	N/A
13	DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	ENR IN OTHER PLAN	N/A	Y	N/A
14	RETROACTIVE	RETROACTIVE	N/A	N/A	N/A
15	TERMINATED IN ERROR BY CMS SYSTEM	TERM IN ERR-CMS	N/A	N/A	N/A
16	END OF State and County Code (SCC) CONDITIONAL ENROLLMENT PERIOD	END OF SCC COND ENRL	N/A	N/A	N/A
17	BENE DOES NOT MEET AGE CRITERION (PLAN-SPECIFIC)	AGE CRIT NOT MET	N/A	N/A	N/A
18	ROLLOVER	ROLLOVER	N/A	Y	N/A

Disenrollment Reason Code	Disenrollment Reason Description	Short Description	MARx UI	AUTO-DIS	PLAN SUB'D
19	TERMINATED BY Social Security Administration (SSA) DISTRICT OFFICE	TERM BY SSA DO	N/A	N/A	N/A
20	INVALID ENROLLMENT WITH End Stage Renal Disease (ESRD)	ESRD AUTO DISENROL	N/A	Y	N/A
21	CANNOT TRAVEL/POOR HEALTH/TO Health Maintenance Organization (HMO)/PLAN DOCTORS	BAD HEALTH/CANT TRVL	N/A	N/A	N/A
22	SPOUSE IS NO LONGER MEMBER OF HMO/PLAN	SPOUSE PLN TERMINATD	N/A	N/A	N/A
23	COULDN'T USE MEDICARE CARD TO SEE OTHER PLAN	CANT USE MEDICARE	N/A	N/A	N/A
24	DID NOT KNOW I JOINED THIS HMO	NO KNOWLEDGE OF ENRL	N/A	N/A	N/A
25	DIFFICULTY REACHING HMO/PLAN DOCTOR BY PHONE PROBLEM	CANT REACH DR BY PHN	N/A	N/A	N/A
26	CALLED HMO/PLAN COULD NOT GET HELP WITH PROBLEM	GOT NO HLP W/PROBLEM	N/A	N/A	N/A
27	DISSATISFIED WITH MEDICAL CARE/DOCS OR HOSPITAL	DISSATISFIED W/CARE	N/A	N/A	N/A
28	TOLD BY PLAN DOCTORS OR STAFF I SHOULD DISENROLL	TLD BY PRVDR TO DSNR	N/A	N/A	N/A
29	PREFER TRADITIONAL MEDICARE	PREFER REG MEDICARE	N/A	N/A	N/A
30	HAVE OTHER HEALTH INSURANCE BENEFITS AVAILABLE	NOT USING MEDICARE	N/A	N/A	N/A
31	FOUND HMO/PLAN TO BE TOO CONFUSING	PLAN TOO CONFUSING	N/A	N/A	N/A
32	MY CLAIMS/BILLS WERE NOT PAID	CLAIMS/BILS NOT PAID	N/A	N/A	N/A
33	HAD LITTLE OR NO CHOICE OF SPECIALIST	COUDNT PIK SPECIALST	N/A	N/A	N/A
34	TREATED DISCOURTEOUSLY BY DOCTOR/NURSE/STAFF	BAD TRTMNT BY PRVDR	N/A	N/A	N/A
35	DOCTOR COULDN'T IMPROVE MY CONDITION	NO CHG IN CONDITION	N/A	N/A	N/A

Disenrollment Reason Code	Disenrollment Reason Description	Short Description	MARx UI	AUTO-DIS	PLAN SUB'D
36	HMO/PLAN MEDICAL GROUP WAS LOCATED TOO FAR AWAY	PLN LOC TOO FAR AWAY	N/A	N/A	N/A
37	HAD LIMITED OR NO CHOICE OF MY PRIMARY DOCTOR	COULDNT PIK PRM PHYS	N/A	N/A	N/A
41	YOU MOVED PERMANENTLY OUT OF AREA WHERE PLAN PROVIDES SERVIC	LIVE OUTSDE SVC AREA	N/A	N/A	N/A
42	YOUR DOCTOR OR THE PLAN TOLD YOU TO DISENROLL	TOLD BY DR TO DSNR	N/A	N/A	N/A
43	YOUR DOCTOR DIDN'T GIVE YOU GOOD QUALITY CARE	POOR QUALITY OF CARE	N/A	N/A	N/A
44	YOU USED UP THE PRESCRIPTION ALLOWANCE	RX ALLOWANCE USED UP	N/A	N/A	N/A
45	THE PLAN COST YOU TOO MUCH	PLAN COST TOO MUCH	N/A	N/A	N/A
46	YOU COULDN'T GET CARE WHEN YOU NEEDED IT	LACK OF TIMELY CARE	N/A	N/A	N/A
47	YOUR DOCTOR ISN'T IN THE PLAN	DOCTOR NOT IN PLAN	N/A	N/A	N/A
48	YOU DIDN'T KNOW YOU SIGNED UP FOR THIS PLAN	DIDNT SIGN UP 4 PLAN	N/A	N/A	N/A
49	YOU DIDN'T LIKE HOW THE PLAN WORKED	DIDNT LIKE PLAN	N/A	N/A	N/A
50	ROLLED OVER ENROLLMENT REMOVED/AUDITED	RLVR ENRT RMVD/AUDT	N/A	Y	N/A
54	PART A OR B START DATE CHANGE	LIVE OUTSDE SVC AREA	N/A	Y	N/A
56	BENEFICIARY MEDICAID PERIOD RECEIVED	TOLD BY DR TO DSNR	N/A	N/A	N/A
57	BENEFICIARY HOSPICE PERIOD RECEIVED	POOR QUALITY OF CARE	N/A	Y	N/A
59	INVALID ENROLLMENT WITH HOSPICE	RX ALLOWANCE USED UP	N/A	Y	N/A
60	BENEFICIARY LIVES IN USA LESS THAN 183 DAYS A YEAR	IN US LT 183 DAYS	N/A	N/A	N/A

Disenrollment Reason Code	Disenrollment Reason Description	Short Description	MARx UI	AUTO-DIS	PLAN SUB'D
61	LOSS OF PART D ELIGIBILITY	INVALID ENROLLMENT	N/A	Y	N/A
62	PART D DISENROLLMENT DUE TO FAILURE TO PAY IRMAA	FAILURE TO PAY IRMAA	N/A	Y	N/A
63**	MMP (Medicare and Medicaid Plan) OPT-OUT AFTER ENROLLED	ENRL, OPTOUT MMP	Y	N/A	Y
64**	LOSS OF DEMONSTRATION ELIGIBILITY	LOSS OF FA DEMO ELIG	Y	N/A	Y
65	LOSS OF EMPLOYER GROUP PLAN ELIGIBILITY	LOSS OF EGP ELGBLTY	Y	N/A	Y
70	CONFIRMED INCARCERATION	CONFIRMED INCARC	N/A	Y	N/A
71	NOT LAWFULLY PRESENT	NOTLAW PRESENT	N/A	Y	N/A
72	DISENROLLMENT DUE TO PLAN-SUBMITTED ROLLOVER	PLAN ROLL	N/A	N/A	Y
88	CONVERSION	CONVERSION	N/A	N/A	N/A
90	ENROLLMENT CANCELLED DUE TO BENEFICIARY MERGE	ENRL CNCL BENE MRG	N/A	Y	N/A
91	FAILURE TO PAY PREMIUMS	PREMIUMS NOT PAID	Y	N/A	Y
92	RELOCATION OUT OF PLAN SERVICE AREA	RELO OUT OF AREA	Y	N/A	Y
93	LOST SPECIFIC PLAN ELIGIBILITY (Special Needs Plan (SNP) ONLY)	LOST SNP	Y	N/A	Y
99*	OTHER (NOT SUPPLIED BY BENE)	OTHER	N/A	N/A	Y
Y8	REPORT OF DEATH DATE CHANGE	REPORT OF DEATH	N/A	Y	N/A

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

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

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

I.9 BEQ Response File Error Condition Table

I.9.1 *Request File Error Conditions*

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

Table I-7: File Level Error information

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

I.9.2 *Request Transaction Detail Record Error Conditions*

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

Table I-8: Error Conditions

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

I.10 IC Model Beneficiary Participation End Date Reason Codes

Table I-10: IC Model Beneficiary Participation End Date Reason Codes

IC Model End Date Reason Code	End Date Reason Code Description	MARx UI	AUTO-DIS	PLAN SUB'D (TC91)
01	No Longer Eligible	N/A	N/A	Y
02	Opted out of program	N/A	N/A	Y
03	Benefit status change	N/A	N/A	Y
04	Automatic CMS Disenrollment	N/A	Y	N/A

J: *Report Files*

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

Table J-1: Reports Lookup Table

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

J.1 HMO Bill Itemization Report

Description

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

Part A Bills Posted (BILLITEM)

12345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012
1PART A BILLS POSTED IN MMM YYYY PAGE1
* * * * * HMO Hnnn * * * * *

BILL TYPE: INPATIENT

Bene ID	Name	PROV	INTER	HMO PD	ADM DATE	TOTAL CHARGES	NON-COV CHARGES	INP DED	NC BLD DEDUCT	CO INS DAYS	CO INSC HGS	CO INS AMOUNT	TOTAL DEDUCT	FROM DATE	THRU DATE	COV DAYS	REIM AMT	NP CD	CR
1AA0AA0AA00	SMITH	010139	52280	1	20180308	181547	0	0	0	0	0	0	0	20180308	20180326	18	0	n/a	CR
1AA0AA0AA00	SMITH	010113	10101	n/a	20180109	17527	0	0	0	0	0	0	0	20180109	20180113	4	14	n/a	n/a
1AA0AA0AA00	SMITH	010103	10101	n/a	20180213	594311	0	0	0	0	0	0	0	20180213	20180324	39	6464	n/a	n/a
1AA0AA0AA00	SMITH	010113	10101	n/a	20180322	30454	0	0	0	0	0	0	0	20180322	20180326	4	27	n/a	n/a
1AA0AA0AA00	SMITH	010113	10101	n/a	20180310	56084	0	0	0	0	0	0	0	20180310	20180316	6	85	n/a	CR
1AA0AA0AA00	SMITH	010104	10101	n/a	20180307	48325	0	0	0	0	0	0	0	20180307	20180316	9	396	n/a	n/a
1AA0AA0AA00	SMITH	010113	10101	n/a	20181117	22712	0	0	0	0	0	0	0	20181117	20181121	4	27	n/a	n/a
1AA0AA0AA00	SMITH	010113	10101	n/a	20181117	23389	0	0	0	0	0	0	0	20181117	20181121	4	27	n/a	n/a
1AA0AA0AA00	SMITH	01T113	10101	n/a	20180322	22095	22095	0	0	0	0	0	0	20180322	20180331	0	0	N	n/a
1AA0AA0AA00	SMITH	010023	52280	1	20180227	97203	0	0	0	0	0	0	0	20180227	20180316	17	0	n/a	n/a

J.2 Monthly Membership Summary Report (MMSR)

Description

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

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

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

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

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

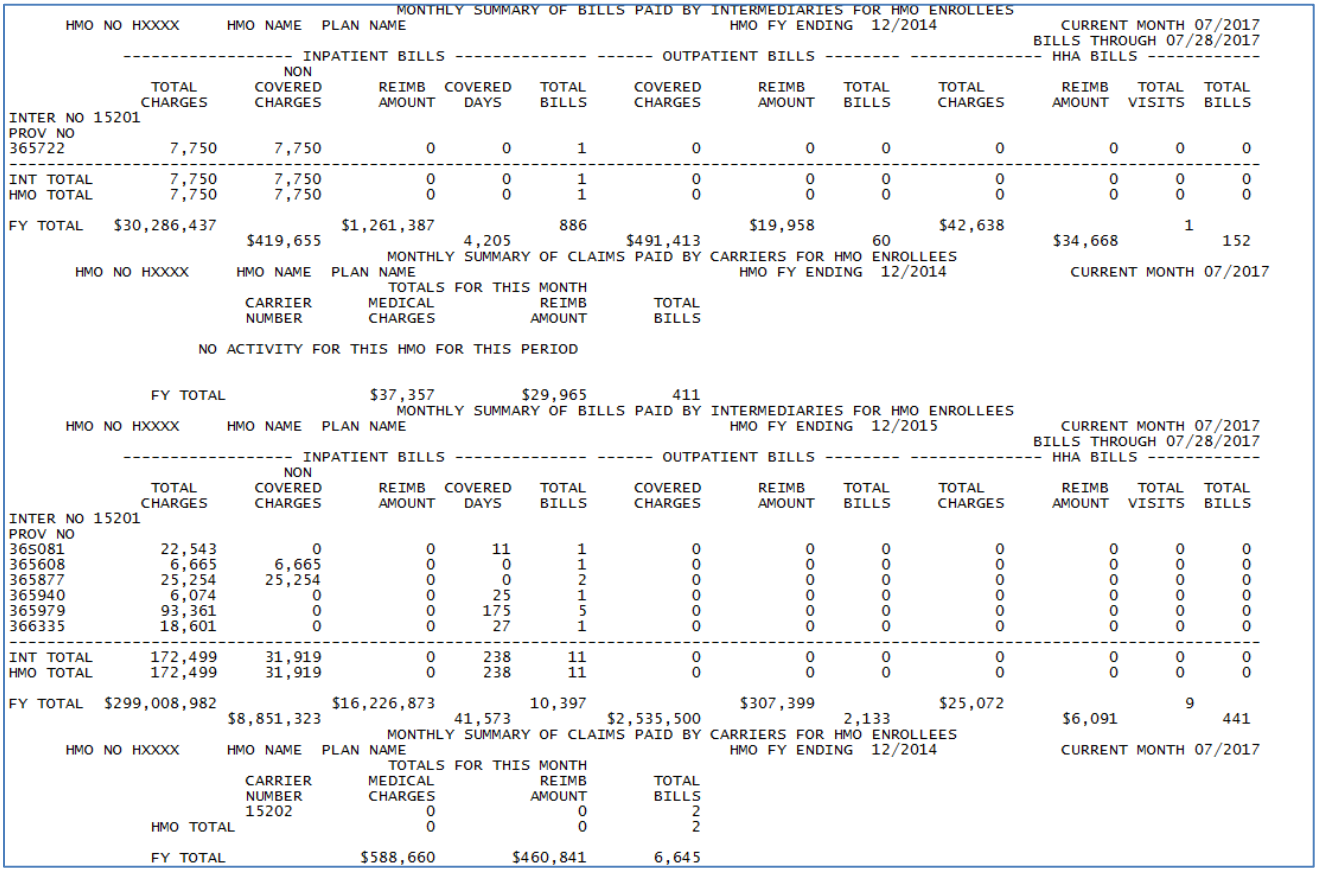
MONTHS A :	12	PART A AMOUNT :	$760.44
MONTHS B :	12	PART B AMOUNT :	$728.40
MONTHS D :	0	PART D AMOUNT :	$0.00
NUMBER OF ADJUSTMENTS :	1	TOTAL AMOUNT :	$1,488.84

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

J.3 Monthly Summary of Bills Report

Description

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



MONTHLY SUMMARY OF BILLS PAID BY INTERMEDIARIES FOR HMO ENROLLEES

HMO NO HXXXX HMO NAME PLAN NAME HMO FY ENDING 12/2014 CURRENT MONTH 07/2017
BILLS THROUGH 07/28/2017

	INPATIENT BILLS				OUTPATIENT BILLS				HHA BILLS		
	TOTAL CHARGES	NON COVERED CHARGES	REIMB AMOUNT	COVERED DAYS	TOTAL BILLS	COVERED CHARGES	REIMB AMOUNT	TOTAL BILLS	TOTAL CHARGES	REIMB AMOUNT	TOTAL VISITS	TOTAL BILLS
INTER NO 15201												
PROV NO												
365722	7,750	7,750	0	0	1	0	0	0	0	0	0	0
INT TOTAL	7,750	7,750	0	0	1	0	0	0	0	0	0	0
HMO TOTAL	7,750	7,750	0	0	1	0	0	0	0	0	0	0
FY TOTAL	$30,286,437		$1,261,387		886		$19,958		$42,638		1	
		$419,655		4,205		$491,413		60		$34,668		152

MONTHLY SUMMARY OF CLAIMS PAID BY CARRIERS FOR HMO ENROLLEES

HMO NO HXXXX HMO NAME PLAN NAME HMO FY ENDING 12/2014 CURRENT MONTH 07/2017

TOTALS FOR THIS MONTH

CARRIER NUMBER	MEDICAL CHARGES	REIMB AMOUNT	TOTAL BILLS

NO ACTIVITY FOR THIS HMO FOR THIS PERIOD

FY TOTAL	$37,357	$29,965	411

MONTHLY SUMMARY OF BILLS PAID BY INTERMEDIARIES FOR HMO ENROLLEES

HMO NO HXXXX HMO NAME PLAN NAME HMO FY ENDING 12/2015 CURRENT MONTH 07/2017
BILLS THROUGH 07/28/2017

	INPATIENT BILLS				OUTPATIENT BILLS				HHA BILLS		
	TOTAL CHARGES	NON COVERED CHARGES	REIMB AMOUNT	COVERED DAYS	TOTAL BILLS	COVERED CHARGES	REIMB AMOUNT	TOTAL BILLS	TOTAL CHARGES	REIMB AMOUNT	TOTAL VISITS	TOTAL BILLS
INTER NO 15201												
PROV NO												
365081	22,543	0	0	11	1	0	0	0	0	0	0	0
365608	6,665	6,665	0	0	1	0	0	0	0	0	0	0
365877	25,254	25,254	0	0	2	0	0	0	0	0	0	0
365940	6,074	0	0	25	1	0	0	0	0	0	0	0
365979	93,361	0	0	175	5	0	0	0	0	0	0	0
366335	18,601	0	0	27	1	0	0	0	0	0	0	0
INT TOTAL	172,499	31,919	0	238	11	0	0	0	0	0	0	0
HMO TOTAL	172,499	31,919	0	238	11	0	0	0	0	0	0	0
FY TOTAL	$299,008,982		$16,226,873		10,397		$307,399		$25,072		9	
		$8,851,323		41,573		$2,535,500		2,133		$6,091		441

MONTHLY SUMMARY OF CLAIMS PAID BY CARRIERS FOR HMO ENROLLEES

HMO NO HXXXX HMO NAME PLAN NAME HMO FY ENDING 12/2014 CURRENT MONTH 07/2017

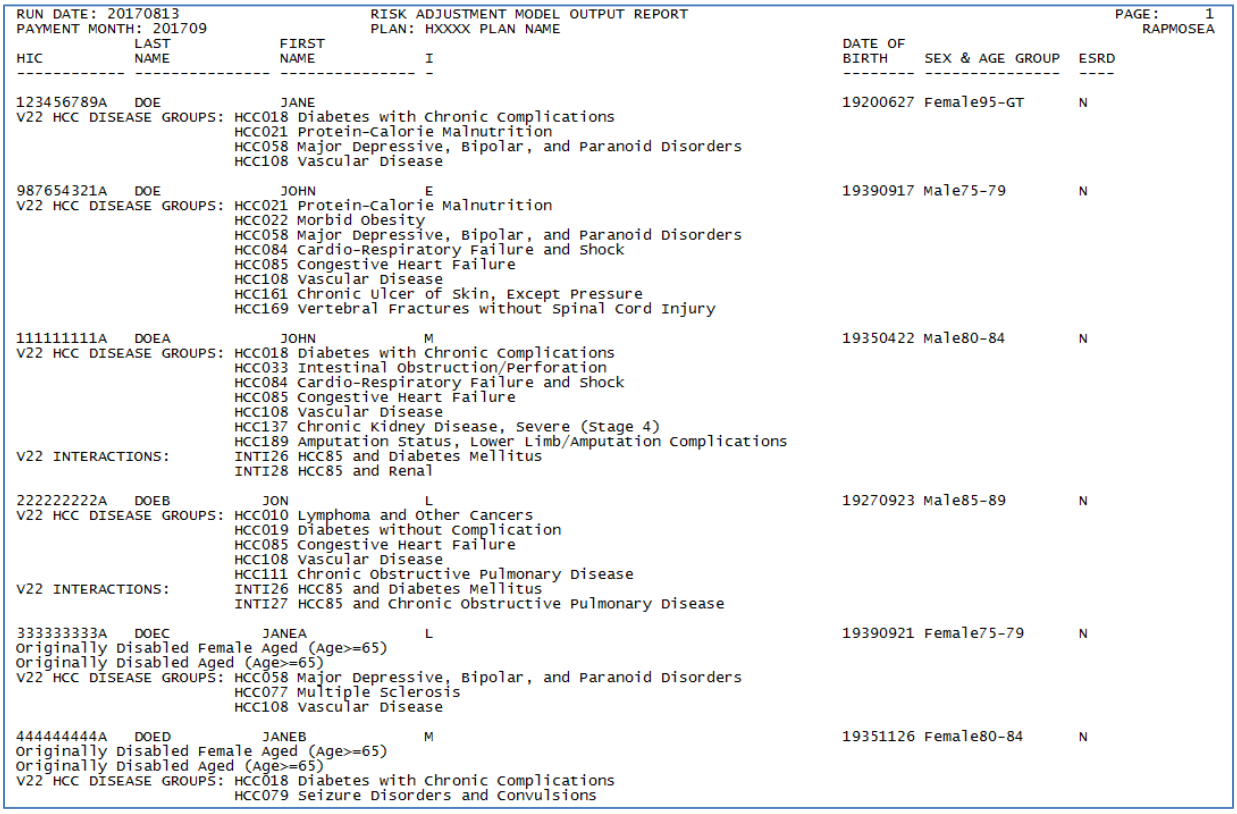
TOTALS FOR THIS MONTH

CARRIER NUMBER	MEDICAL CHARGES	REIMB AMOUNT	TOTAL BILLS
15202	0	0	2
HMO TOTAL	0	0	2
FY TOTAL	$588,660	$460,841	6,645

J.4 Part C Risk Adjustment Model Output Report

Description

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



```
RUN DATE: 20170813                    RISK ADJUSTMENT MODEL OUTPUT REPORT                                          PAGE:     1
PAYMENT MONTH: 201709                 PLAN: HXXXX PLAN NAME                                                          RAPMOSEA
            LAST            FIRST                                                  DATE OF
HIC         NAME            NAME           I                                       BIRTH    SEX & AGE GROUP  ESRD
----------- --------------- -------------- -                                       -------- ---------------  ----

123456789A   DOE             JANE                                                  19200627 Female95-GT      N
V22 HCC DISEASE GROUPS: HCC018 Diabetes with Chronic Complications
                        HCC021 Protein-Calorie Malnutrition
                        HCC058 Major Depressive, Bipolar, and Paranoid Disorders
                        HCC108 Vascular Disease

987654321A   DOE             JOHN           E                                      19390917 Male75-79        N
V22 HCC DISEASE GROUPS: HCC021 Protein-Calorie Malnutrition
                        HCC022 Morbid Obesity
                        HCC058 Major Depressive, Bipolar, and Paranoid Disorders
                        HCC084 Cardio-Respiratory Failure and Shock
                        HCC085 Congestive Heart Failure
                        HCC108 Vascular Disease
                        HCC161 Chronic Ulcer of Skin, Except Pressure
                        HCC169 Vertebral Fractures without Spinal Cord Injury

111111111A   DOEA            JOHN           M                                      19350422 Male80-84        N
V22 HCC DISEASE GROUPS: HCC018 Diabetes with Chronic Complications
                        HCC033 Intestinal Obstruction/Perforation
                        HCC084 Cardio-Respiratory Failure and Shock
                        HCC085 Congestive Heart Failure
                        HCC108 Vascular Disease
                        HCC137 Chronic Kidney Disease, Severe (Stage 4)
                        HCC189 Amputation Status, Lower Limb/Amputation Complications
V22 INTERACTIONS:       INTI26 HCC85 and Diabetes Mellitus
                        INTI28 HCC85 and Renal

222222222A   DOEB          JON             L                                      19270923 Male85-89        N
V22 HCC DISEASE GROUPS: HCC010 Lymphoma and Other Cancers
                        HCC019 Diabetes without Complication
                        HCC085 Congestive Heart Failure
                        HCC108 Vascular Disease
                        HCC111 Chronic Obstructive Pulmonary Disease
V22 INTERACTIONS:       INTI26 HCC85 and Diabetes Mellitus
                        INTI27 HCC85 and Chronic Obstructive Pulmonary Disease

333333333A   DOEC          JANEA           L                                      19390921 Female75-79      N
Originally Disabled Female Aged (Age>=65)
Originally Disabled Aged (Age>=65)
V22 HCC DISEASE GROUPS: HCC058 Major Depressive, Bipolar, and Paranoid Disorders
                        HCC077 Multiple Sclerosis
                        HCC108 Vascular Disease

444444444A   DOED          JANEB           M                                      19351126 Female80-84      N
Originally Disabled Female Aged (Age>=65)
Originally Disabled Aged (Age>=65)
V22 HCC DISEASE GROUPS: HCC018 Diabetes with Chronic Complications
                        HCC079 Seizure Disorders and Convulsions
```

J.5 RAS RxHCC Model Output Report - aka - Part D RA Model Output Report

Description

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

```
RUN DATE: 20170813                    RISK ADJUSTMENT MODEL OUTPUT REPORT                                          PAGE:     1
PAYMENT MONTH: 201709                 PLAN: HXXXX PLAN NAME                                                      RAPMODEA
            LAST                              FIRST                                 DATE OF
HIC         NAME                              NAME                              I  BIRTH   SEX & AGE GROUP
----------- ----------------------------------- --------------------------------- - -------- ---------------

123456789A   DOE                                JANE                              J 19300920 Female85-89
RXHCC DISEASE GROUPS:   RXHCC216 Peripheral Vascular Disease

123456789B   DOE                                JANEA                               19380227 Female75-79
RXHCC DISEASE GROUPS:   RXHCC042 Thyroid Disorders
                        RXHCC045 Disorders of Lipoid Metabolism
                        RXHCC087 Osteoporosis, Vertebral and Pathological Fractures

987654321A   DOE                                JANEB                             E 19421014 Female70-74
Originally Disabled Female Aged (Age>=65)
Originally Disabled Aged (Age>=65)
RXHCC DISEASE GROUPS:   RXHCC068 Esophageal Reflux and Other Disorders of Esophagus
                        RXHCC132 Major Depression
                        RXHCC187 Hypertension

987654321C   DOE                                JOHN                                19440925 Male70-74
Originally Disabled Male Aged (Age>=65)
Originally Disabled Aged (Age>=65)
RXHCC DISEASE GROUPS:   RXHCC042 Thyroid Disorders
                        RXHCC045 Disorders of Lipoid Metabolism
                        RXHCC068 Esophageal Reflux and Other Disorders of Esophagus
                        RXHCC186 Congestive Heart Failure
                        RXHCC188 Coronary Artery Disease
                        RXHCC216 Peripheral Vascular Disease

123456789C   DOE                                JON                               E 19410429 Male75-79
RXHCC DISEASE GROUPS:   RXHCC042 Thyroid Disorders
                        RXHCC045 Disorders of Lipoid Metabolism
                        RXHCC068 Esophageal Reflux and Other Disorders of Esophagus
                        RXHCC187 Hypertension
```

J.6 Payment Records Report

Description

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

Part B Claim Records Posted (PAYRECDS)

PART B CLAIMS RECORDS POSTED IN MMM YYYY PAGE 1
0* * * * *HMO Hnnnn * * * * *

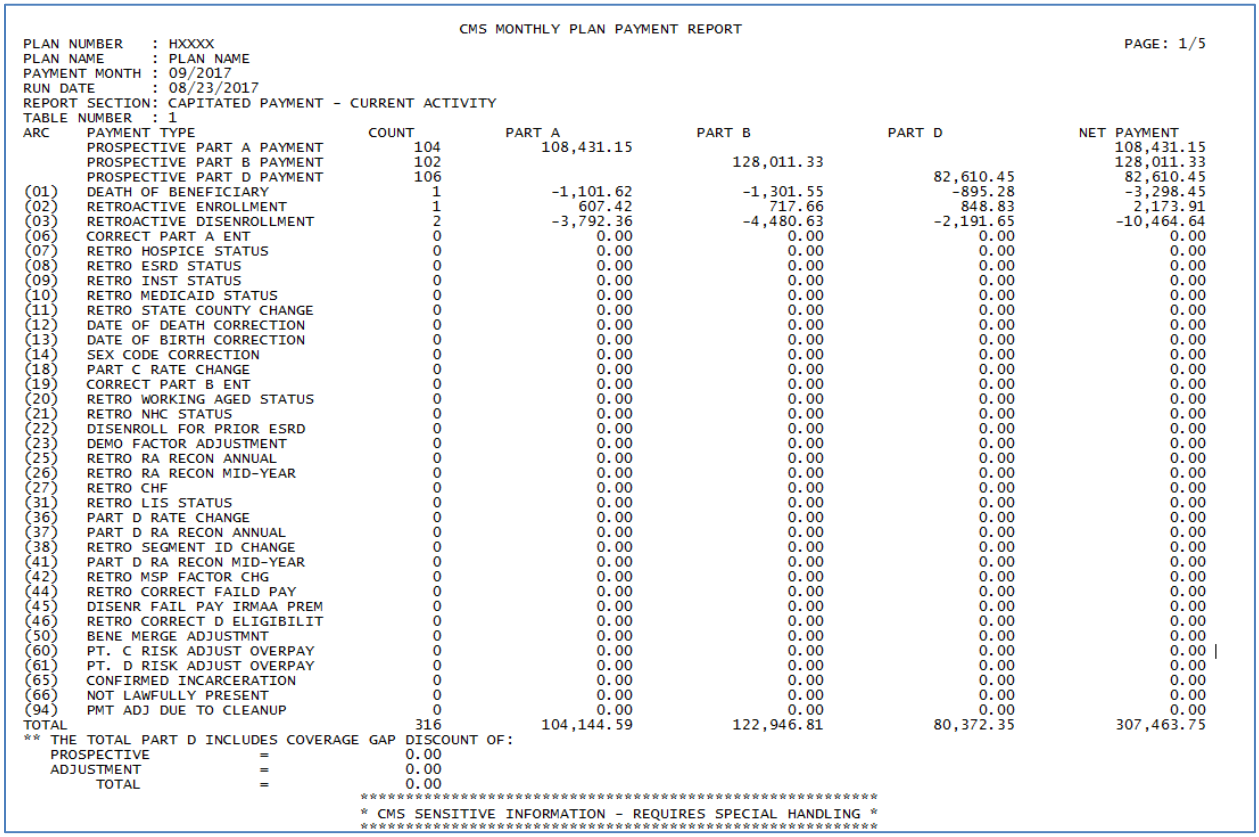
BENE ID	NAME	EXPENSE FIRST	DATES LAST	ALLOWED TOTAL CHARGES	REIMB AMT	CO INS AMT	DED APP	PHYS SUPP ID	PAY IND	CARRIER NUMBER	CARRIER PAID	INFORMATION CONTROL NUMBER
1AA0AA0AA00	SMITH	20100219	20100219	86.25	69.00	17.25	.00	AP233Z	1	01192	20100508	551210095332060
1AA0AA0AA00	SMITH	20100219	20100219	190.04	152.03	38.01	.00	AP233Z	1	01192	20100408	551120095332070
1AA0AA0AA00	SMITH	20091014	20091014	183.68	146.94	36.74	.00	F36241067	1	00953	20100523	682110111795270
1AA0AA0AA00	SMITH	20091014	20091014	95.31	76.25	19.06	.00	F37698329	1	00953	20100423	681130111796030
1AA0AA0AA00	SMITH	20091015	20091021	584.68	467.73	116.95	.00	F37698372	1	00953	20100523	685110111801720
1AA0AA0AA00	SMITH	20091016	20091016	33.54	26.83	6.71	.00	N33470209	1	00953	20100423	681116111802170
1AA0AA0AA00	SMITH	20091021	20091021	122.39	97.91	24.48	.00	P48970001	1	00953	20100505	681818092314320
1AA0AA0AA00	SMITH	20090215	20090215	31.58	22.73	8.85	.00	U7741Z	1	09102	20100501	591019085112690
1AA0AA0AA00	SMITH	20100225	20100225	35.09	28.07	7.02	.00	000000820	1	10102	20100410	492710091059500
1AA0AA0AA00	SMITH	20100301	20100301	35.09	28.07	7.02	.00	000000820	1	10102	20100510	499210091059710

J.7 Plan Payment Report (APPS Payment Letter)

Description

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

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



CMS MONTHLY PLAN PAYMENT REPORT

PLAN NUMBER : HXXXX — PAGE: 1/5
PLAN NAME : PLAN NAME
PAYMENT MONTH : 09/2017
RUN DATE : 08/23/2017
REPORT SECTION: CAPITATED PAYMENT - CURRENT ACTIVITY
TABLE NUMBER : 1

ARC	PAYMENT TYPE	COUNT	PART A	PART B	PART D	NET PAYMENT
	PROSPECTIVE PART A PAYMENT	104	108,431.15			108,431.15
	PROSPECTIVE PART B PAYMENT	102		128,011.33		128,011.33
	PROSPECTIVE PART D PAYMENT	106			82,610.45	82,610.45
(01)	DEATH OF BENEFICIARY	1	-1,101.62	-1,301.55	-895.28	-3,298.45
(02)	RETROACTIVE ENROLLMENT	1	607.42	717.66	848.83	2,173.91
(03)	RETROACTIVE DISENROLLMENT	2	-3,792.36	-4,480.63	-2,191.65	-10,464.64
(06)	CORRECT PART A ENT	0	0.00	0.00	0.00	0.00
(07)	RETRO HOSPICE STATUS	0	0.00	0.00	0.00	0.00
(08)	RETRO ESRD STATUS	0	0.00	0.00	0.00	0.00
(09)	RETRO INST STATUS	0	0.00	0.00	0.00	0.00
(10)	RETRO MEDICAID STATUS	0	0.00	0.00	0.00	0.00
(11)	RETRO STATE COUNTY CHANGE	0	0.00	0.00	0.00	0.00
(12)	DATE OF DEATH CORRECTION	0	0.00	0.00	0.00	0.00
(13)	DATE OF BIRTH CORRECTION	0	0.00	0.00	0.00	0.00
(14)	SEX CODE CORRECTION	0	0.00	0.00	0.00	0.00
(18)	PART C RATE CHANGE	0	0.00	0.00	0.00	0.00
(19)	CORRECT PART B ENT	0	0.00	0.00	0.00	0.00
(20)	RETRO WORKING AGED STATUS	0	0.00	0.00	0.00	0.00
(21)	RETRO NHC STATUS	0	0.00	0.00	0.00	0.00
(22)	DISENROLL FOR PRIOR ESRD	0	0.00	0.00	0.00	0.00
(23)	DEMO FACTOR ADJUSTMENT	0	0.00	0.00	0.00	0.00
(25)	RETRO RA RECON ANNUAL	0	0.00	0.00	0.00	0.00
(26)	RETRO RA RECON MID-YEAR	0	0.00	0.00	0.00	0.00
(27)	RETRO CHF	0	0.00	0.00	0.00	0.00
(31)	RETRO LIS STATUS	0	0.00	0.00	0.00	0.00
(36)	PART D RATE CHANGE	0	0.00	0.00	0.00	0.00
(37)	PART D RA RECON ANNUAL	0	0.00	0.00	0.00	0.00
(38)	RETRO SEGMENT ID CHANGE	0	0.00	0.00	0.00	0.00
(41)	PART D RA RECON MID-YEAR	0	0.00	0.00	0.00	0.00
(42)	RETRO MSP FACTOR CHG	0	0.00	0.00	0.00	0.00
(44)	RETRO CORRECT FAILD PAY	0	0.00	0.00	0.00	0.00
(45)	DISENR FAIL PAY IRMAA PREM	0	0.00	0.00	0.00	0.00
(46)	RETRO CORRECT D ELIGIBILIT	0	0.00	0.00	0.00	0.00
(50)	BENE MERGE ADJUSTMNT	0	0.00	0.00	0.00	0.00
(60)	PT. C RISK ADJUST OVERPAY	0	0.00	0.00	0.00	0.00
(61)	PT. D RISK ADJUST OVERPAY	0	0.00	0.00	0.00	0.00
(65)	CONFIRMED INCARCERATION	0	0.00	0.00	0.00	0.00
(66)	NOT LAWFULLY PRESENT	0	0.00	0.00	0.00	0.00
(94)	PMT ADJ DUE TO CLEANUP	0	0.00	0.00	0.00	0.00
TOTAL		316	104,144.59	122,946.81	80,372.35	307,463.75

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

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

J.8 Interim Plan Payment Report (IPPR)

Description

Also known as the Interim Payment Letter, this report itemizes interim payments to the MCO. It is produced by APPS when interim payments are calculated. CMS computes interim payments on an as-needed basis. When this occurs, the interim payment letter is pushed to the involved Plan(s).

The APPS IPPR is provided when a Plan is approved for an interim payment outside of the normal monthly process. The report contains the amount and reason for the interim payment to the Plan. Plans may request the IPPR via the MARx User Interface under the weekly reports section of the menu.

CMS INTERIM PLAN PAYMENT REPORT

PLAN NUMBER : HXXXX PAGE: 1/5
PLAN NAME : PLAN NAME
PAYMENT MONTH : 04/2016
RUN DATE : 04/27/2016
REPORT SECTION: CAPITATED PAYMENT - CURRENT ACTIVITY
TABLE NUMBER : 1

ARC	PAYMENT TYPE	COUNT	PART A	PART B	PART D	NET PAYMENT
	PROSPECTIVE PART A PAYMENT	0	0.00			0.00
	PROSPECTIVE PART B PAYMENT	0		0.00		0.00
	PROSPECTIVE PART D PAYMENT	0			0.00	0.00
(01)	DEATH OF BENEFICIARY	0	0.00	0.00	0.00	0.00
(02)	RETROACTIVE ENROLLMENT	0	0.00	0.00	0.00	0.00
(03)	RETROACTIVE DISENROLLMENT	0	0.00	0.00	0.00	0.00
(06)	CORRECT PART A ENT	0	0.00	0.00	0.00	0.00
(07)	RETRO HOSPICE STATUS	0	0.00	0.00	0.00	0.00
(08)	RETRO ESRD STATUS	0	0.00	0.00	0.00	0.00
(09)	RETRO INST STATUS	0	0.00	0.00	0.00	0.00
(10)	RETRO MEDICAID STATUS	0	0.00	0.00	0.00	0.00
(11)	RETRO STATE COUNTY CHANGE	0	0.00	0.00	0.00	0.00
(12)	DATE OF DEATH CORRECTION	0	0.00	0.00	0.00	0.00
(13)	DATE OF BIRTH CORRECTION	0	0.00	0.00	0.00	0.00
(14)	SEX CODE CORRECTION	0	0.00	0.00	0.00	0.00
(18)	PART C RATE CHANGE	0	0.00	0.00	0.00	0.00
(19)	CORRECT PART B ENT	0	0.00	0.00	0.00	0.00
(20)	RETRO WORKING AGED STATUS	0	0.00	0.00	0.00	0.00
(21)	RETRO NHC STATUS	0	0.00	0.00	0.00	0.00
(22)	DISENROLL FOR PRIOR ESRD	0	0.00	0.00	0.00	0.00
(23)	DEMO FACTOR ADJUSTMENT	0	0.00	0.00	0.00	0.00
(25)	RETRO RA RECON ANNUAL	0	0.00	0.00	0.00	0.00
(26)	RETRO RA RECON MID-YEAR	0	0.00	0.00	0.00	0.00
(27)	RETRO CHF	0	0.00	0.00	0.00	0.00
(31)	RETRO LIS STATUS	0	0.00	0.00	0.00	0.00
(36)	PART D RATE CHANGE	0	0.00	0.00	0.00	0.00
(37)	PART D RA RECON ANNUAL	0	0.00	0.00	0.00	0.00
(38)	RETRO SEGMENT ID CHANGE	0	0.00	0.00	0.00	0.00
(41)	PART D RA RECON MID-YEAR	0	0.00	0.00	0.00	0.00
(42)	RETRO MSP FACTOR CHG	0	0.00	0.00	0.00	0.00
(44)	RETRO CORRECT FAILD PAY	0	0.00	0.00	0.00	0.00
(45)	DISENR FAIL PAY IRMAA PREM	0	0.00	0.00	0.00	0.00
(46)	RETRO CORRECT D ELIGIBILIT	0	0.00	0.00	0.00	0.00
(50)	BENE MERGE ADJUSTMNT	0	0.00	0.00	0.00	0.00
(60)	PT. C RISK ADJUST OVERPAY	0	0.00	0.00	0.00	0.00
(61)	PT. D RISK ADJUST OVERPAY	0	0.00	0.00	0.00	0.00
(65)	CONFIRMED INCARCERATION	0	0.00	0.00	0.00	0.00
(66)	NOT LAWFULLY PRESENT	0	0.00	0.00	0.00	0.00
(94)	PMT ADJ DUE TO CLEANUP	0	0.00	0.00	0.00	0.00
TOTAL		0	0.00	0.00	0.00	0.00

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

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

K: *All Transmissions Overview*

Table K-1: All Transmissions Overview

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Dataset naming conventions key: [GUID] = 7 character EIDM User ID P = Production Data [.ZIP] = Appended if the file is compressed [directory] = optional directory specification from non-mainframe C:D clients (if present, may consist of up to 60 characters). If none exists, directory defaults to the constant "EFTO." for Production files and "EFTT." for Test files.		pn = Processing number of varying length assigned to the file by Gentran ccccc = Contract number Pccccc = Plan Contract Number for C:D Uuuu-uuuuuuu = 4-7 character transmitter RACF ID xxxxx = 5 character Contract ID yyyymmdd = Calendar year, month & day yymmdd = two digit year, month, day zzzzzzzz = Plan-provided high level qualifier eeee = Year for which final yearly RAS file was produced vvvvv = Sequence counter for final yearly RAS files			Annnnn & Bnnnnn = MARx batch transaction ID, nnnnnnnnnn split into two nodes A…and B …with leading zeroes as necessary to complete ten-character batch ID hhmm = hour and minute ssssss= Sequentially assigned number mmyyyy = Calendar month & year hlq = High Level Qualifier or Directory per VSAM File freq = Frequency code of file	
Plan Submittals to CMS						
1	**MARx Batch Input Transaction Data File** Header Record Disenrollment (51/54) Detail Record Enrollment (61) Detail Record Miscellaneous Change Detail Records: Correction (01) Record 4Rx Data Change (72) Number of Uncovered Months (NUNCMO) Change (73) Employer Group Health Plan (EGHP) Change (74) Premium Payment Option (PPO) Change (75) Residence Address Change (76) Segment ID Change (77) Part C Premium Change (78) Part D Opt-Out (79) MMP Opt-Out Update (TC83) Cancellation of Enrollment (80) and Cancellation of Disenrollment (81) Detail Records MMP Enrollment Cancellation (TC82) POS Drug Edit (TC90) **PCUG Record Layout – F.3**	Enrollment Transaction file to CMS MARx system requesting new enrollment, disenrollment, changes, etc. Only the 1-800-Medicare group submits a Part D Opt-Out (41) transaction.	MARx	Data File	Batch - Daily PRN	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].MARX.D.xxxxx.FUTURE.[P/T][.ZIP] Note: FUTURE is part of the filename and does not change. **Connect:Direct (Mainframe):** P#EFT.IN.uuuuuuu.MARXTR.DYYMMDD.THHMMSST Note: DYYMMDD.THHMMSST must be coded as shown, as it is a literal
2	**Batch Eligibility Query (BEQ) Request File** Header Record Detail Record Trailer Record **PCUG Record Layout – F.5**	File of transactions submitted by Plans to request eligibility information for prospective Plan enrollees. Used to do initial eligibility checks against CMS MBD system to verify member is Part A/B eligible.	MBD	Data File	PRN (Plans can send multiple files in a day)	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].MBD.D.xxxxx.BEQ.[P/T][.ZIP] **Connect:Direct (Mainframe):** P#EFT.IN.PLxxxxx.BEQ4RX.DYYMMDD.THHMMSST Note: DYYMMDD.THHMMSST must be coded as shown, as it is a literal

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Plan Submittals to CMS						
3	**Electronic Correspondence Referral System (ECRS) Batch Submittal File**	File used by Plans to submit other healthcare information (OHI) to CMS (*rather than submittal through the ECRS online system)*	ECRS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].ECRS.D.ccccc.FUTURE.[P/T] [.ZIP] **Connect:Direct:** TRANSMITTED TO GHI
4	**Prescription Drug Event (PDE) Submittal File**	File of transactions submitted by the Plans with Prescription Drug Events.	PDE	Data File	Can be Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].PDE.D.ccccc.FUTURE.[P/T] [.ZIP] **Connect:Direct:** TRANSMITTED TO PALMETTO
5	**RAPS Submittal File**	File of transactions submitted by the Plans with diagnoses for FFS Beneficiaries.	RAPS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACFID].RAPS.D.ccccc.FUTURE.[P/T] [.ZIP] **Connect:Direct:** TRANSMITTED TO PALMETTO
6	**Encounter Data Services (EDS) Submittal File**	File of transactions submitted by the Plans with EDS.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** [GUID].[RACF].EDS.D.xxxxx.FUTURE.[P/T][.ZIP] **Connect:Direct:** TRANSMITTED TO PALMETTO

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Plans						
7	**Failed Transaction Data File** Header Record Failed Record	This report is no longer generated as a result of the November 2009 software release. Failed Records are now reported on the BCSS data file.	MARx	Data File	Response to transaction batch file	Obsolete
8	**Batch Completion Status Summary Data File** Summary Record Failed Records **PCUG Record Layout – F.1**	Data file sent to the submitter once a batch of submitted transactions has been processed. Provides a count of all transactions within the batch and details the number of rejected and accepted transactions. It provides an image of the rejected and accepted transactions.	MARx	Data File	Once batch is processed	**Gentran Mailbox/TIBCO MFT Internet Server:** P.uuuuuuu.BCSSD.Annnnn.Bnnnnn.Thhmmss **Connect:Direct (Mainframe)**: zzzzzzzz.uuuuuuu.BCSSD.Annnnn.Bnnnnn.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]uuuuuuu.BCSSD.Annnnn.Bnnnnn.Thhmmss
9	**Enrollment Transmission Message File (STATUS)**	This message is no longer generated as a result of the April 2011 software release. This information is now incorporated into the Batch Completion Status Summary (BCSS) data file.	MARx	Report	Response to transaction batch file	Obsolete
10	**Coordination of Benefits (Validated Other Insurer Information) Data File for Part D** Detail Record Primary Record Supplemental Record **PCUG Record Layout – F.2**	File containing members' primary and secondary drug coverage that has been validated through COB processing. MARx forwards this report whenever a Plan's enrollees are affected. It may be as often as daily.The enrollees included on the report are those newly enrolled who have known Other Health Insurance (OHI) for drugs and those Plan enrollees with changes to their OHI.	MBD (MARx)	Data File	As Needed (can be daily)	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MARXCOB.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MARXCOB.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MARXCOB.Dyymmdd.Thhmmsst
11	**MA Full Dual Auto Assignment Notification File** Header Record Detail Record (Transaction) Trailer Record **PCUG Record Layout – F.22**	Monthly file of Full Dual Beneficiaries in an existing Plan.	MBD	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#ADUA4.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#ADUA4.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#ADUA4.Dyymmdd.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Plans						
12	**Auto Assignment (PDP) Address Notification File** Header Record Detail Record(s) Trailer Record **PCUG Record Layout – F.23**	Monthly file of addresses of Beneficiaries who have been either Auto Assigned or Facilitated Assigned to PDPs.	MBD	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#APDP4.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#APDP4.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#APDP4.Dyymmdd.Thhmmsst
13	**NoRx File** Header Record Detail Record Trailer Record **PCUG Record Layout – F.21**	File containing records identifying those enrollees that do not currently have 4Rx information stored in CMS files. A Detail Record Type containing a value of "NRX" in positions 1 – 3 of the file layout will indicate that this record is a request for your organization to send CMS 4Rx information for the beneficiary.	MBD	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#NORX.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#NORX.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#NORX.Dyymmdd.Thhmmsst
14	**Batch Eligibility Query (BEQ) Request File Acknowledgment (Accept/Reject)** **PCUG Sample Report – F.5.4**	MBD will determine if a BEQ Request File is Accepted or Rejected. MBD will issue an e-mail acknowledgment of receipt and status to the Sending Entity. If Accepted the file will be processed. If Rejected, the e-mail shall inform the Sending Entity of the first File Error Condition that caused the BEQ Request File to be Rejected. A rejected file will not be returned.	MBD	E-mail	Response to BEQ	N/A
15	**Batch Eligibility Query (BEQ) Response File** Header Record Detail Record (Transaction) Trailer Record **PCUG Record Layout – F.6**	File containing records produced as a result of processing the transactions of accepted BEQ Request files. Detail records for all submitted records that were successfully processed will contain Processed Flag = Y. Detail records for all submitted records that were not successfully processed contain Processed Flag = N.	MBD	Data File	Response to BEQ	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.#BQN4.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.#BQN4.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.#BQN4.Dyymmdd.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Plans						
16	**ECRS Data File**	File containing errors and statuses of ECRS submissions.	ECRS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** PCOB.BA.ECRS.ccccc.RESPONSE.ssssss **Connect:Direct:** TRANSMITTED FROM GHI
17	**Prescription Drug Event (PDE) PDFS Response Data File**	File containing responses if files are accepted or rejected.	PDE	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RSP.PDFS_RESP_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
18	**Prescription Drug Event (PDE) Drug Data Processing System (DDPS Return Data File**	File provides feedback on every record processed in a batch. Up to 10 specific errors are reported for each PDE in the file.	PDE	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS_TRANS_VALIDATION_ssssss **Connect:Direct (Mainframe):** TRANSMITTED FROM PALMETTO
19	**Prescription Drug Event (PDE) DDPS Transaction Error Summary Data File**	File provides frequency of occurrence for each error code encountered during the processing of a PDE file. The percentage to the total errors is also computed and displayed for each error code.	PDE	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS_ERROR_SUMMARY_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
20	**Front-End Risk Adjustment System (FERAS) Response Reports**	Report indicates that the file was accepted or rejected by the Front-End Risk Adjustment System.	FERAS	Report	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RSP.FERAS_RESP_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
21	**Front-End Risk Adjustment System (FERAS) Response Data Files**	File contains all of the submitted transactions whether or not the file contains errors.	FERAS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_RETURN_FLAT_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
22	**Front-End Risk Adjustment System (FERAS) Response Reports Transaction Error Report**	Report lists the transactions that contained errors and identifies the errors found.	FERAS	Report	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_ERRORRPT_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Plans						
23	**Front-End Risk Adjustment System (FERAS) Response Reports Transaction Summary Report**	**Report contains all of the transactions submitted, whether accepted or rejected.**	FERAS	Report	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_SUMMARY_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
24	**Front-End Risk Adjustment System (FERAS) Response Reports Duplicate Diagnosis Cluster Report**	Report identifies diagnosis clusters with 502 error message, clusters accepted, but not stored.	FERAS	Report	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_DUPDX_RPT_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
25	**Transaction Reply Daily Activity Data File** **PCUG Record Layout – F.4**	Data file version of the Transaction Reply Daily Activity Report.	MARx	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.DTRRD.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.DTRRD.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.DTRRD.Dyymmdd.Thhmmsst
26	**Encounter Data Services (EDS) Response Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_RESPONSE **Connect:Direct:** TRANSMITTED FROM PALMETTO
27	**Encounter Data Services (EDS) Reject IC ISAIEA Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_REJT_IC_ISAIEA.pn **Connect:Direct:** TRANSMITTED FROM PALMETTO
28	**Encounter Data Services (EDS) Reject Function Transaction Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_REJT_FUNCT_TRANS **Connect:Direct:** TRANSMITTED FROM PALMETTO
29	**Encounter Data Services (EDS) Accept Function Transaction Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_ACCPT_FUNCT_TRANS **Connect:Direct:** TRANSMITTED FROM PALMETTO

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
CMS Transmittals to the Plans						
30	**Encounter Data Services (EDS) Response Claim Number Data File**	File containing responses if files are accepted or rejected.	EDS	Data File	Daily	**Gentran Mailbox/TIBCO MFT Internet Server:** P.xxxxx.EDS_RESP_CLAIM_NUM **Connect:Direct:** TRANSMITTED FROM PALMETTO
Weekly Transmittals (Data & Reports)						
31	**LIS/Part D Premium Data File** **PCUG Record Layout – F.7**	The data in the report reflects LIS info, premium subsidy levels, Low-income co-pay levels, etc. for all Beneficiaries who have a low-income designation enrolled in a Plan. This data file is produced bi-weekly. It is not automatically transmitted to the Plans. Through the MARx UI Plans can request or reorder this data file.	MARx	Data File	Biweekly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LISPRMD.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LISPRMD.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LISPRMD.Dyymmdd.Thhmmsst
Monthly Transmittals (Data & Reports)						
32	**Part C Monthly Membership Detail Report (Non Drug Report)** aka: Monthly Membership Report (MMR) **PCUG Sample Report – J.5**	Report listing every Part C Medicare member of the contract and providing details about the payments and adjustments made for each. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMR.Dyymm01.Thhmmsst P.Rxxxxx.MONMEMR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMR.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEMR.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMR.Dyymm01.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
33	**Part D Monthly Membership Detail Report (Drug Report)** aka: Monthly Membership Report (MMR) **PCUG Sample Report – J.3**	Report listing every Part D Medicare member of the contract and provides details about the payments and adjustments made for each. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMDR.Dyymm01.Thhmmsst P.Rxxxxx.MONMEMDR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMDR.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMDR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEDR.Dyymm01.Thhmmsst [directory]Rxxxxx.MONMEDR.Dyymm01.Thhmmsst
34	**Monthly Membership Detail Data File** **PCUG Record Layout – F.11**	Data file version of the Monthly Membership Detail Reports. This file contains the data for both Part C and Part D members. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMD.Dyymm01.Thhmmsst P.Rxxxxx.MONMEMD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMD.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEMD.Dyymm01.Thhmmsst [directory]Rxxxxx.MONMEMD.Dyymm01.Thhmmsst
35	**Monthly Membership Summary Report** **PCUG Sample Report – J.5**	Report summarizing payments to a Plan for the month, in several categories, and adjustments, by all adjustment categories. This report contains data for both Part C and Part D members. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.MONMEMSR.Dyymm01.Thhmmsst P.Rxxxxx.MONMEMSR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.MONMEMSR.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.MONMEMSR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.MONMEMSR.Dyymm01.Thhmmsst [directory]Rxxxxx.MONMEMSR.Dyymm01.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
36	**RAS RxHCC Model Output Report** ***AKA: Part D Risk Adjustment Model Output Report*** **PCUG Sample Report – J.8**	Report showing the Part D risk adjustment factors for each beneficiary. MARx forwards this report that is produced by RAS to Plans as part of the month-end processing. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	RAS (MARx)	Report (.pdf)	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMODR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMODR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMODR.Dyymm01.Thhmmsst
37	**RAS RxHCC Model Output Data File *(Payment Year 2016)*** Header Record Detail / Beneficiary Record Format Trailer Record **PCUG Record Layout – F.15**	Data file version of the RAS RxHCC Model Output Report. MARx forwards this report that is produced by RAS to Plans as part of the month-end processing. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMODD.Dyymm01.Thhmmsst
38	**Part C Risk Adjustment Model Output Report** **PCUG Sample Report – J.7**	Report showing the Hierarchical Condition Codes (HCCs) used by the Risk Adjustment System (RAS) to calculate Part C risk adjustment factors for each beneficiary. MARx forwards this report that is produced by RAS to Plans as part of the month-end processing. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	RAS (MARx)	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.HCCMODR.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.HCCMODR.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.HCCMODR.Dyymm01.Thhmmsst
39	**Part C Risk Adjustment Model Output Data File** Header Record Detail Record Trailer Record **PCUG Record Layout – F.14**	Data file version of the Risk Adjustment Model Output Report. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.HCCMODD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.HCCMODD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.HCCMODD.Dyymm01.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
40	**RAS RxHCC Model Output Data File Type 2 (Payment Year 2017 through 2018)** Header Record Detail Record Trailer Record **PCUG Record Layout – F.16**	Data file version of the RAS RxHCC Model Output Report. MARx forwards this report that is produced by RAS to Plans as part of the month-end processing. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** **P.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst** **Connect:Direct (Mainframe):** **zzzzzzzz.Rxxxxx.PTDMODD.Dyymm01.Thhmmsst** **Connect:Direct (Non-Mainframe):** **[directory]Rxxxxx.PTDMODD.Dyymm01.Thhmmsst**
41	**BIPA 606 Payment Reduction Report** **PCUG Sample Report – J.1**	Report listing members for whom the Plan is paying a portion of the Part B premium. Generated only if there are pre-2006 adjustments that involve BIPA 606 premium reductions. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly, if applicable	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.BIPA606R.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.BIPA606R.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.BIPA606R.Dyymm01.Thhmmsst
42	**BIPA 606 Payment Reduction Data File** **PCUG Record Layout – F.9**	Data file version of the BIPA 606 Reduction Report. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Data File	Monthly, if applicable	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.BIPA606D.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.BIPA606D.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.BIPA606D.Dyymm01.Thhmmsst
43	**Monthly Summary of Bills Report** **PCUG Sample Report – J.6**	Report summarizing all Medicare fee-for-service activity, both Part A and Part B, for Beneficiaries enrolled in the contract Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.SUMBILLS.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.SUMBILLS.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.SUMBILLS.Dyymm01.Thhmmsst
44	**HMO Bill Itemization Report** **PCUG Sample Report – J.2**	Report listing the Part A bills that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.BILLITEM.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.BILLITEM.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.BILLITEM.Dyymm01.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
45	**Part B Claims Data File** **Record Type 1** **Record Type 2** **PCUG Record Layout – F.13**	Data file listing the Part B physician and supplier claims and Part B home health claims that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.CLAIMDAT.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.CLAIMDAT.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.CLAIMDAT.Dyymm01.Thhmmsst
46	**Payment Records Report** **PCUG Sample Report – J.9**	Report listing the Part B physician and supplier claims that were processed under Medicare fee-for-service for Beneficiaries enrolled in the contract. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PAYRECDS.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PAYRECDS.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PAYRECDS.Dyymm01.Thhmmsst
47	**Monthly Premium Withholding Report Data File (MPWR)** **Header Record** **Detail Record** **Trailer - T1 - Total at segment level** **Trailer - T2 - Total at PBP level** **Trailer - T3 - Total at contract level** **PCUG Record Layout – F.12**	Monthly reconciliation file of premiums withheld from SSA or RRB checks. Includes Part C and Part D premiums and any Part D Late Enrollment Penalties. This file is produced by the Premium Withhold System (PWS). MARx makes this report available to Plans as part of the month-end processing. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	PWS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MPWRD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MPWRD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MPWRD.Dyymm01.Thhmmsst
48	**Failed Payment Reply Report** **Detail Record** **PCUG Record Layout – F.27**	Data file reporting payment actions which failed to complete.	MARx	Data File	Monthly Payment Cycle	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.FPRRD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx FPRRD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx. FPRRD.Dyymm01.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
49	**Plan Payment Report (APPS Payment Letter)** **PCUG Sample Report – J.10**	Report itemizing the final monthly payment to the Plan. This report is produced by the APPS when final payments are calculated. MARx makes this report available to Plans as part of the month-end processing. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	APPS	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.PLANPAY.Dyymm01.Thhmmsst P.Rxxxxx.PLANPAY.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.PLANPAY.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.PLANPAY.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.PLANPAY.Dyymm01.Thhmmsst [directory]Rxxxxx.PLANPAY.Dyymm01.Thhmmsst
50	**Plan Payment Report (APPS Payment Letter) Data File** **PCUG Record Layout – F.24**	This data file itemizes the final monthly payment to the MCO. This data file and subsequent report are produced by the APPS when final payments are calculated. CMS makes this report available to MCO's as part of month-end processing. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	APPS	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PPRD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PPRD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory].Rxxxxx.PPRD.Dyymm01.Thhmmsst
51	**Interim APPS Plan Payment Report** **PCUG Sample Report – J.11**	When a Plan is approved for an interim payment outside of the normal monthly process, an interim Plan Payment Report is distributed to that Plan. The report contains the amount and reason for the interim payment. Plans can also request these reports via the MARx user interface under the weekly report section of the menu.	APPS	Report	As needed	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PLNPAYI.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PLNPAYI.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PLNPAYI.Dyymm01.Thhmmsst
52	**Interim APPS Plan Payment Report Data File** **PCUG Sample Layout – F.24**	The Interim APPS Plan Payment Data File and Report is provided when a Plan is approved for an interim payment outside of the normal monthly process. The data file / report contains the amount and reason for the interim payment to the Plan.	APPS	Data File	As needed	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PPRID.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PPRID.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory].Rxxxxx.PPRID.Dyymmdd.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
53	**820 Format Payment Advice Data File** **PCUG Record Layout – F.8**	HIPAA-Compliant version of the Plan Payment Report. This data file itemizes the final monthly payment to the Plan. This data file is not available through MARx. Note: The date in the file name defaults to "01" denoting the first day of the CCM.	APPS	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PLAN820D.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PLAN820D.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PLAN820D.Dyymm01.Thhmmsst
54	**Monthly Full Enrollment Data File** **PCUG Record Layout – F.18**	File includes all active Plan membership on the date the file is run. This file is considered a definitive statement of current Plan enrollment. The file is distributed on or about the first of the month.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.FEFD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.FEFD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.FEFD.Dyymm01.Thhmmsst
55	**Prescription Drug Event (PDE) DBC Cumulative Beneficiary Summary Report**	File includes summary for the beneficiary of accumulated overall totals in PDE amount fields with accumulated totals for covered drugs.	PDE	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS.CUM_BENE_ACT_COV_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
56	**Prescription Drug Event (PDE) DBC Cumulative Beneficiary Summary Report**	File includes summary for the beneficiary of accumulated overall totals in PDE amount fields with accumulated totals for enhanced drugs.	PDE	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS_CUM_BENE_ACT_ENH_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
57	**Prescription Drug Event (PDE) DBC Cumulative Beneficiary Summary Report**	File includes summary for the beneficiary of accumulated overall totals in PDE amount fields with accumulated totals for over-the-counter drugs.	PDE	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.DDPS_CUM_BENE_ACT_OTC_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
58	**Front-End Risk Adjustment System (FERAS) Response Reports** **Monthly Plan Activity Report**	Report provides monthly summary of the status of submissions by submitter and Plan number.	FERAS	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_MONTHLY_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
59	**Front-End Risk Adjustment System (FERAS) Response Reports** **Cumulative Plan Activity Report**	Report provides cumulative summary of the status of submissions by Submitter ID and Plan number.	FERAS	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RPT.RAPS_CUMULATIVE_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
60	**Front-End Risk Adjustment System (FERAS) Response Reports** **Frequency Report Monthly Report**	Report provides monthly summary of all errors on all file submissions within the month.	FERAS	Report	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** RAPS_ERRORFREQ_MNTH_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
61	**LEP Data File** Header Record Detail Record Trailer Record **PCUG Record Layout – F.19**	This report provides information on low-income subsidized Beneficiaries and on direct-billed Beneficiaries with late enrollment penalties. Note: The date in the file name defaults to "01" denoting the first day of the current payment month.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Fxxxxx.LEPD.Dyymm01.Thhmmsst P.Rxxxxx.LEPD.Dyymm01.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Fxxxxx.LEPD.Dyymm01.Thhmmsst zzzzzzzz.Rxxxxx.LEPD.Dyymm01.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Fxxxxx.LEPD.Dyymm01.Thhmmsst [directory]Rxxxxx.LEPD.Dyymm01.Thhmmsst
62	**LIS History Data File (LISHIST)** **PCUG Record Layout – F.20**	This file supplements existing files that provide LIS notifications. It provides a complete picture of a beneficiary's LIS eligibility over a period of time not to exceed 36 months. Note: The date in the file name defaults to "dd" denoting the day of the calendar month.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LISHIST.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LISHIST.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LISHIST.Dyymmdd.Thhmmsst
63	**Agent Broker Compensation Data File** **PCUG Record Layout – F.25**	This data file provides the broker compensation cycle-year counts. Data is sent to Plans 1) when a beneficiary enrolls, 2) each January when the cycle-year count increments and 3) as necessary when retroactive change affects the compensation cycle. Plans may re-order the Broker Compensation Report Data File" via the UI.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rnnnnn.COMPRPT.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rnnnnn.COMPRPT.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rnnnnn.COMPRPT.Dyymmdd.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Monthly Transmittals (Data & Reports)						
64	**Monthly MSP Information Data File** **PCUG Record Layout – F.26**	This data file is sent directly to Part C Plans on the first Monday after the MARx month-end processing completes. This file contains MSP details for all Part beneficiaries in the Part C Plan. It covers MSP periods for the previous 48 months.	MARx	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory].Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst
65	**Medicare Advantage Organization (MAO) 004 Report**	This report contains the diagnoses that meet the risk adjustment rules and are, therefore, eligible for risk adjustment.	RAS (MARx)	Data File	Monthly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.MAO004.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.MAO004.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.MAO004.Dyymmdd.Thhmmsst
Quarterly Report						
66	**Front-End Risk Adjustment System (FERAS) Response Reports** **Frequency Report Quarterly Report**	Report provides quarterly summary of all errors on all file submissions within the three-month quarter.	FERAS	Report	Quarterly	**Gentran Mailbox/TIBCO MFT Internet Server:** RAPS_ERRORFREQ_QTR_ssssss **Connect:Direct:** TRANSMITTED FROM PALMETTO
Yearly Report						
67	**RAS Final Yearly Model Output Report, Part D**	Report indicates the year-end Part D risk adjustment factors for each beneficiary. MARx forwards this report, produced by RAS, to Plans as part of the month-end processing.	RAS (MARx)	Report (.pdf)	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMOFR.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMOFR.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMOFR.Yeeee.Cvvvvv.Thhmmss
68	**RAS Final Yearly Model Output Data File, Part D**	Data file version of the year end Part D RAS Model Output Report. MARx forwards this report, produced by RAS, to Plans as part of the month-end processing.	RAS (MARx)	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.PTDMOFD.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.PTDMOFD.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.PTDMOFD.Yeeee.Cvvvvv.Thhmmss

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Yearly Report						
69	**RAS Final Yearly Model Output Report, Part C**	Report indicates the year end Part C risk adjustment factors for each beneficiary. MARx forwards this report, produced by RAS, to Plans as part of the month-end processing.	RAS (MARx)	Report (.pdf)	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.HCCMOFR.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.HCCMOFR.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.HCCMOFR.Yeeee.Cvvvvv.Thhmmss
70	**RAS Final Yearly Model Output Data File, Part C**	Data file version of the year end Part C RAS Model Output Report. MARx forwards this report, produced by RAS, to Plans as part of the month-end processing.	RAS (MARx)	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.HCCMOFD.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.HCCMOFD.Yeeee.Cvvvvv.Thhmmss **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.HCCMOFD.Yeeee.Cvvvvv.Thhmmss
71	**Loss of Subsidy Data File** **PCUG Record Layout – F.30**	The first file is sent in September and identifies members receiving a joint CMS and SSA letter informing them they will not have Deemed status for the following year. The second file is sent in December and is an updated version of the September file, indicating those Beneficiaries who still do not have Deemed status for the following year. The data file has a record length of 500 bytes. The TRC used for this special file type is 996. TRC 996 indicates the loss of Deeming which means the Beneficiary will not be redeemed for the upcoming period.	MARx	Data File	Twice Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst
72	**PDP Loss Data File**	Once a year notification file sent by CMS providing a preliminary listing of LIS-eligible Beneficiaries whom CMS reassigns to a new PDP or to a new PBP within the same Plan sponsor effective January 1, 2008. The LOSS file notifies PDPs of the members they will lose as a result of reassignment to other Plans. These members are classified as losing members.	MBD	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.APDP5.LOSS.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.APDP5.LOSS.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.APDP5.LOSS.Dyymmdd.Thhmmsst

ID#	Transmittal	Description	Responsible System	Type	Freq.	Dataset Naming Conventions
Yearly Report						
73	**PDP Gain Data File**	Once a year notification file, sent by CMS, provides a preliminary listing of LIS-eligible Beneficiaries whom CMS reassigns to a new PDP or to a new PBP within the same Plan sponsor effective January 1, 2008. The GAIN file notifies PDPs of members they will gain as a result of the yearly reassignment. These members are classified as gaining members.	MBD	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.APDP5.GAIN.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.APDP5.GAIN.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.APDP5.GAIN.Dymmdd.Thhmmsst
74	**Long-Term Institutionalized Resident Report** **PCUG Record Layout – F.31**	The Long-Term Institutionalized (LTI) Resident Report provides Part D sponsors a list of their Beneficiaries who are LTI residents during July and January of each year. This report contains basic information on the Beneficiaries and their institutions (Skilled Nursing Home or Nursing Home).	MDS	Report	Twice Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.LTCRPT.Dyymmdd.Thhmmsst
75	**No Premium Due Data File** **PCUG Record Layout – F.32**	The no premium due data file reports members that had a Part C premium, but will no longer have the Part C premium in the upcoming year. This data file is produced during MARx end of year processing.	MARx	Data File	Yearly	**Gentran Mailbox/TIBCO MFT Internet Server:** P.Rxxxxx.SPCLPEX.Dyymmdd.Thhmmsst **Connect:Direct (Mainframe):** zzzzzzzz.Rxxxxx.SPCLPEX.Dyymmdd.Thhmmsst **Connect:Direct (Non-Mainframe):** [directory]Rxxxxx.SPCLPEX.Dyymmdd.Thhmmsst

L: *MA Plan Connectivity Checklist*

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

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

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

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

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

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

Table M-1: Valid Election Types for Plans

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

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

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

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

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

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

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

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

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