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	Centers for Medicare & Medicaid Services (CMS)
	Date: August 31, 2007
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PROGRAM AREA: OIS, ISDDG (MA & Part D Systems)

SUBJECT: Announcement of Fall Software Changes

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

I. SUMMARY OF DOCUMENT:
CMS will be implementing software improvements to the enrollment and payment suite of systems this Fall to support the Medicare Modernization Act. As part of this effort, system changes have been scheduled to move into production as of November 8, 2007 affecting Plan exchanges with CMS for the January 2008 payment month, unless otherwise noted. This letter provides information regarding these changes so Plans may assess the impact on their organization and make any necessary changes to accommodate the changes described below. In general, Plans will see resultant changes in the Medicare Advantage & Part D Inquiry System (Common UI), as well as the enrollment and payment reports and data files.

The changes for the Fall release are categorized as follows and described in the memo in greater detail:

1. **Enrollment Processing Changes**
   - Annual Auto-Enrollment and Facilitated Enrollment Opt-Out
   - Change to Data for Uncovered Months
   - Disenrollment Reason Codes
   - New Retroactive Enrollment (62) Transaction
   - Additional Special Election Period (SEP) Election Type Distinctions
   - Enrollment Source Code for Enrollment Transactions
   - Disenrollment Reason Code 10

2. **Report and Data File Changes**
   - Medical Savings Account (MSA) & MSA Demonstration Data
   - Interim Plan Payment Reports
   - Data Source for Medicaid Status Part C Risk Adjustment
   - De Minimis Data

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)
STATUS: R=REVISED, N=NEW, D=DELETED.

Status	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	N/A

III. CLEARANCES:

Clearance & Point of Contact (POC)	Name/Telephone/Component
Senior Official Clearance	Alan Constantian/410-786-2773/OIS/ISDDG Henry Chao/410-786-7811/OIS/ISDDG
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IV. TYPE (Check appropriate boxes for type of guidance)

	Audit Guide
	Change Request
X	**HPMS**
	Joint Signature Memorandum/Technical Director Letter
	Manual Transmittal/Non-Change Request
	State Medicaid Director Letters
X	**Other**

V. STATUTORY OR REGULATORY AUTHORITY: [include the citation of what statute or regulation is being interpreted. If not applicable, indicate N/A]

N/A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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OFFICE OF INFORMATION SERVICES

DATE: September 13, 2007

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

FROM: Henry Chao /s/
Deputy Director, Information Services Design and Development Group

SUBJECT: Announcement of Fall Software Changes

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1. Enrollment Processing Changes

Annual Auto-Enrollment and Facilitated Enrollment Opt Out

Current CMS policy as stated in Chapter 2 of the *Medicare Managed Care Manual and the PDP Guidance – Eligibility, Enrollment, and Disenrollment* allows a beneficiary to opt out of auto-enrollment (AE) or facilitated enrollment (FE). When a beneficiary requests to opt-out of AE or FE, the Part D Opt-Out Flag (field 24) is set to 'Y' using a PBP change (71) transaction (MA organizations only) or a disenrollment (51) transaction (all Part D Plans). This prevents the beneficiary from being auto-enrolled or facilitated-enrolled into a Part D Plan. The opt-out flag does not prevent a voluntary enrollment by the beneficiary.

Effective with the Fall software release, CMS will modify the PBP change (71) transaction to also include 'N' as a valid value for the Part D Opt-Out Flag (field 24). The Plan change (72) transaction will also be modified to allow all Part D Plans to use the Part D Opt-Out Flag (field 24) to change a beneficiary's election from 'Y' to 'N' and vice versa. The weekly/monthly Transaction Reply Report (TRR) will also be updated to reflect this change. Refer to *Attachment G* (data file) and *Attachment H* (report file) for details.

CMS has also created a new Opt-Out (41) transaction for use by CMS and authorized staff such as 1-800-MEDICARE, CMS Regional Office, and other CMS staff solely for the purpose of setting the Part D Opt-Out Flag to 'Y' or 'N'. Any changes made using this new transaction type will be reported to Plans via the weekly/monthly TRR, with a value of '41' in the Transaction Type Code (field 16) on the TRR record.

Two transaction reply codes (TRCs) are being updated and one new TRC is being added as a result of this change. Refer to *Attachment B: New/Updated Transaction Reply Codes (TRCs)* for details.

TRC 130 – Part D Opt-Out Rejected, Opt-Out Indicator Not Valid
A submitted transaction 41/51/54/71/72 was rejected because the Part D Opt-Out Flag contained an invalid value. Valid values of Part D Opt-Out flag are as follows:

- For transaction type 41, valid values are Y and N
- For transaction types 51/54/71/72, valid values are Y or N or blank

TRC 131 – Part D Opt-Out Accepted
A transaction 41/51/54/71/72 was received that specified a Part D Opt-Out Flag value or a change to a Part D Opt-Out Flag value. The Part D Opt-Out Flag value on the transaction was accepted. The new value for the Part D Opt-Out Flag is reported in field 38 on the TRR record.

TRC 714 – UI Part D Opt-Out Change Accepted
A CMS user updated the beneficiary's Part D Opt-Out Flag value. The new value for the Part D Opt-Out Flag is reported in field 38 on the TRR record.

Change to Data for Uncovered Months

Effective with the Fall release, the way in which CMS processes the number of uncovered months (NUNCMO) for Part D Plans will be modified, as will the way in which Plans populate the field. The following summarizes the changes Plans will see on the Common UI and BEQ Response file, as well as the change in the process of submitting uncovered months data.

Changes will be made to the Common UI to include the beneficiary's number of uncovered months (NUNCMO) data. A new section entitled "Number of Uncovered Months" will be added to the center of the Beneficiary: Eligibility (M232) screen to provide the following functionality:

- Complete history of Plan submitted NUNCMO data
- Beneficiary information for each Part D enrollment *processed* on or after November 15, 2007 will be automatically assigned an incremental NUNCMO indicator
- Beneficiary information for each Part D enrollment *processed* prior to November 15, 2007 will be automatically assigned a cumulative NUNCMO indicator
- Part D enrollment and employer subsidy periods will continue to display separately

A sample of this updated screen is provided in *Attachment A: New/Updated UI Screens.*

It is important to note that any change in the number of uncovered months, as validated and submitted by Plans following the CMS LEP/CC guidance, impacts the late enrollment penalty and subsequently the total premium amount. The CMS LEP/CC guidance is presented in the August 13, 2007 memo from Anthony Culotta entitled "Technical Errors in Enrollment Transactions for Creditable Coverage Period Determinations."

Plans may view the data used to calculate the late enrollment penalty and total premium amounts on the new Beneficiary: Eligibility (M232) screen, which will include the following fields:

- Start Date: Part D Plan Effective Date
- Indicator: Defines the number of uncovered months as incremental, cumulative, or reset; valid values are:
  I – Incremental: For enrollments processed on or after 11/15/2007
  C – Cumulative: For enrollments processed prior to 11/15/2007
  R – Reset to 0 (cumulative): This value sets the late enrollment penalty (LEP) to zero for the remainder of the beneficiary's enrollment
- Incremental Number of Uncovered Months: This field will display '0' for enrollments processed before 11/15/2007
- Cumulative Number of Uncovered Months: Displays the cumulative number of uncovered months; this value is used in LEP calculations
- Record Add-TimeStamp

CMS authorized staff will also have the ability to update NUNCMO data. Changes will be reported to Plans via the weekly/monthly Transaction Reply Report (TRR) with Transaction Reply Code (TRC) 716 – UI Changed the Number of Uncovered Months.

The BEQ Response File will be modified to include the NUNCMO data submitted by Plans. An updated layout is provided as *Attachment F: Updated Batch Eligibility Query (BEQ) Response File*.

Enrollment (60/61/62) and PBP Change (71) Transactions

Effective with the Fall release, Part D Plans will submit an incremental, rather than a cumulative, NUNCMO for a beneficiary in a Part D enrollment transaction (60/61/62) and PBP (71) change transaction. A Plan may also submit a 60/61/62/71 transaction with Creditable Coverage Flag = 'R' which will reset the cumulative NUNCMO to zero as of the enrollment effective date. Details on these transaction types may be found in *Attachment C: Consolidated Layouts for Enrollment/Disenrollment/Retroactive/PBP Change Transaction Data File (60/61/62/51/54/71).*

Note: The NUNCMO field applies to Part D Plans only. If a non-drug Plan submits a transaction with a non-blank value in the NUNCMO field, the transaction will be rejected with TRC 172 - Change Rejected; Creditable Coverage and/or Primary/Secondary Drug Information Not Applicable.

Plan change (72) Transactions

Currently, Plan change (72) transactions for non-4Rx are prospective and apply only to Current Payment Month minus one month (CPM-1) through Current Payment Month plus two months (CPM+2). Plan change (72) transactions for 4Rx may be prospective as well as retroactive. In situations where the Plan is unable to submit a Plan change (72) transactions within the range of CPM-1 to CPM+2, the Plan needs to contact its Division of Payment Operations (DPO) representative to receive approval to submit the Plan change (72) transactions in a "retro" file.

Effective with the Fall release, Plans will be able to submit a NUNCMO change via a separate 72 transaction. Plan change (72) transactions for NUNCMO may be retroactive but not prior to August 1, 2006, or prospective but not beyond CPM+2.

Plans may submit multiple change transactions for the same beneficiary in the same transmission file. Details on these transaction types may be found in *Attachment D: Consolidated Layouts for Plan Change (72) and Part D Opt-Out (41) Transaction Data File.*

In a Plan change (72) NUNCMO transaction, Plans will be required to provide the effective date, new NUNCMO, and the current contract/PBP information. In addition, the following requirements must be met:

- The Creditable Coverage flag must be 'N' or 'Y', the NUNCMO value must be non-blank, and the effective date of the change transaction must match the effective start date of the Part D enrollment or the effective date of a previously submitted (and accepted) Plan change (72) NUNCMO transaction.

- If the Creditable Coverage flag reported on the Plan change (72) NUNCMO transaction is 'R' (Reset LEP to 0) and the NUNCMO value is zero or blank, the effective date of the change transaction is not required to match the effective start date of the current Part D enrollment period. However, the effective date must be within the Part D enrollment period or match the effective start date of the Part D enrollment, and may not be beyond CPM+2 or retroactive prior to August 1, 2006.
- Plans will be able to undo or reset the Late Enrollment Penalty (LEP) by submitting a 'U' in the Creditable Coverage flag in a Plan change (72) transaction. The effective date must match the effective date of the reset NUNCMO transaction. This will cause the LEP to be recalculated for the beneficiary.
- To rescind LEP for a beneficiary with multiple active NUNCMO periods, a separate 72 transaction must be submitted for each NUNCMO period.
- A beneficiary's current Plan will have the ability to correct a previous Plan's NUNCMO.
- When the Creditable Coverage flag is submitted with a value of 'R' or 'U', the NUNCMO value will always be assumed to be zero.
- Only NUNCMO-related data elements shall be accepted for processing.

Refer to *Attachment D: Consolidated Layouts for Plan Change (72) and Part D Opt-Out (41) Transaction Data Files* for details.

Important: Plans must submit changes to NUNCMO data as a separate transaction. NUNCMO 72 transactions submitted with data in non-NUNCMO fields will be rejected.

If multiple transactions (60/61/62/71/72) containing NUNCMO data for the same beneficiary are processed during the same week, all of the transactions will be reported on the same weekly TRR. The most recent NUNCMO status can be determined by checking the processing timestamp in field 43 of each TRR record for the beneficiary. Details on the TRR layout may be found in *Attachment G: Updated Transaction Reply Report (TRR) Data File.*

To more clearly communicate the status of the NUNCMO data processing, CMS has added seven new Transaction Reply Codes (TRCs) and modified four existing TRCs to accommodate validation edits of Plan change (72) transactions for the submitted NUNCMO. Details on these TRCs may be found in *Attachment B: New/Updated Transaction Reply Codes (TRCs)*.

TRC 124 – Enrollment or Change Rejected; Invalid Uncovered Months Field
The transaction (60/61/62/71/72) was rejected because the "Number of Uncovered Months" field contained a non-numeric value; OR, the "Uncovered Months" field was zero when the Creditable Coverage Switch was set to "N"; OR, the "Uncovered Months" field was greater than zero when the Creditable Coverage Switch was set to "Y" or blank; OR, a code 72 correction transaction was rejected because a non-blank "Number of Uncovered Months" field contained a non-numeric value. Transactions should be resubmitted with corrected fields.

TRC 126 – Enrollment or Change Rejected; Invalid Creditable Coverage Flag
The transaction (60/61/62/71/72) was rejected because the "Creditable Coverage Flag" field contained an invalid value. A code 72 correction transaction was rejected because a non-blank "Creditable Coverage Flag" field contained an invalid value. Transactions should be resubmitted with corrected fields.

TRC 141 – Creditable Coverage Change Accepted
The beneficiary's creditable coverage information has been changed successfully (Creditable Coverage Flag, Number of Uncovered Months). This change was the result of a plan-submitted change (72) transaction.

TRC 178 – Late Enrollment Penalty Rescinded
The beneficiary's base late enrollment penalty has been rescinded to $0 as a result of the beneficiary's number of uncovered months having been rescinded to zero. The $0 penalty amount will be in field 52 (base penalty).

TRC 214 – Plan Change Rejected, Both Uncovered Months and Other non-4Rx Changes
Plan change (type 72) transaction attempted to process. The transaction was rejected because the submitted transaction included number of uncovered months as well as for other non-4Rx information plan changes. The effective date edits for uncovered months change are different than the effective date edits for other non-4Rx information.

TRC 215 – Uncovered Months Change Rejected, Invalid Effective Date
Plan change (type 72) transaction attempted to process. The transaction was rejected because the effective date on the number of uncovered month change transaction is before August 1, 2006; OR the effective date on the number of uncovered month change transaction is after the prospective Current Payment Month plus two months (CPM+2); OR the effective date on the change transaction does not match with any row in the Creditable Coverage common table.

TRC 216 – Number of Uncovered Months exceeds the maximum possible value
Enrollment (type 60/61/62), PBP change (type 71), or Plan change (type 72) transaction attempted to process. Number of uncovered months is not consistent with the number of months for Part D enrollment. The number of months is defaulted to zero and the transaction is processed. Plan should resubmit correct number of uncovered months via a Plan change (type 72) transaction.

TRC 217 – Can't Change LEP Reset Uncovered Months
Plan change (type 72) transaction attempted to process. The transaction was rejected because the submitted transaction attempted to change the number of uncovered months for an effective date corresponding to an "LEP Reset" transaction in the CMS database.

TRC 218 – LEP Reset Undone
Plan change (type 72) transaction to undo an "LEP Reset" transaction was successfully processed.

TRC 219 – LEP Reset Accepted
The beneficiary's Number of Uncovered Months has been reset to zero due to either a new IEP or a Late Enrollment Penalty reconsideration decision. The beneficiary's Late Enrollment Penalty is set to zero for the remainder of the enrollment.

TRC 716 – UI Changed the Number of Uncovered Months
A CMS user changed the Number of uncovered months of the beneficiary.

Disenrollment Reason Codes

To identify voluntary versus involuntary disenrollment actions submitted by Plans, the CMS enrollment system will accept one of four possible values in the existing Disenrollment Reason Code field on the disenrollment (51) transaction. Refer to *Attachment C: Consolidated Layouts for Enrollment/Disenrollment/Retroactive/PBP Change Transaction Data File (60/61/62/51/54/71)* for details. The following table defines the appropriate codes and when they should be used.

Please note: Plans are not required to have the change for disenrollment reason codes described below implemented for the Fall release. In order to provide time for Plans to make system changes to accommodate the CMS system change, these disenrollment reason codes are not mandatory for use with disenrollment transactions until the CMS Spring release in April 2008.

Plan Action	When to Use	Code Value
Voluntary Disenrollment	Beneficiary requested disenrollment during a valid enrollment period	11
Involuntary Disenrollment for Failure to Pay Plan Premiums	Beneficiary has failed to pay Plan premiums and Plan has completed all the necessary steps in CMS disenrollment guidance to effectuate an involuntary disenrollment	91
Involuntary Disenrollment for a Move Out of Plan Service Area	Beneficiary has been determined to be out of the Plan service area according to the procedures in CMS disenrollment guidance, and all requirements necessary to effectuate an involuntary disenrollment have been met	92
Involuntary Disenrollment for Loss of SNP Eligibility	Beneficiary has been determined to no longer meet the eligibility requirements for enrollment in an exclusive SNP, and all requirements to effectuate an involuntary disenrollment, as defined in CMS disenrollment guidance (including the deemed continuous eligibility provisions) have been met	93

Because Plans may take until April 2008 to implement this enhancement, if a Plan submits a disenrollment (51) transaction after November 8, 2007 with a blank value in the Disenrollment Reason Code field, the CMS system will default to disenrollment reason code 99. When this occurs, the disenrollment will be accepted and processed, assuming all other existing disenrollment processing edits are successful, and the Plan will receive the appropriate Transaction Reply Code (TRC). In addition to the applicable TRC normally provided, Plans will also receive TRC 205. Refer to *Attachment B: New/Updated Transaction Reply Codes (TRCs)* for details.

TRC 205 – Invalid Disenrollment Reason Code
Invalid disenrollment reason code was submitted in the transaction. MARx substituted a default value of '99' for the disenrollment reason code.

Additionally, since involuntary disenrollment actions are not "beneficiary elections," Plans will now use the election period identifier value 'X' on the disenrollment (51) transaction submitted to report involuntary disenrollment (disenrollment reason codes 91, 92 and 93). (For more details, refer to the section in this memo titled *Additional Special Election Period (SEP) Election Type Distinction*s.) Voluntary disenrollment is a beneficiary election, and thus must be reported with a valid election period identifier correctly identifying the election period the Plan has determined is applicable to the disenrollment request. Procedures to determine election periods are defined in the CMS enrollment and disenrollment guidance applicable to your Plan type.

New Retroactive Enrollment (62) Transaction

Please note: Plans are not required to have the change for the new retroactive enrollment transaction type 62 described below implemented for the Fall release. In order to provide time for Plans to make system changes to accommodate the CMS system change, the new retroactive enrollment transaction types are not mandatory for use until the CMS Spring release in April 2008.

CMS enrollment and disenrollment policy guidance provides flexibility for Plans to complete beneficiary enrollment requests for up to 21 calendar days following the receipt of the request to enroll. In some limited cases, this process results in transactions that are considered "retroactive" to the Current Payment Month (CPM). Thus, Plans are unable to submit these valid enrollments directly to the CMS system.

To facilitate this process, the CMS system will provide a new enrollment (62) transaction for these specific retroactive enrollments. The effective date of enrollment on the submitted 62 enrollment transaction is limited to enrollment effective dates equal to the CPM minus 2 (CPM-2). The example below illustrates the acceptable enrollment effective dates for use of a 62 enrollment transaction during the CPM for November 2007.

- Plan submission timeframe for the November payment month is September 14, 2007 through October 17, 2007
- Current calendar date is September 17, 2007
- CPM-2 = September 1, 2007

A 62 enrollment transaction submitted with effective dates of any value other than CPM-2 will be rejected. The effective date parameters remain unchanged for the existing 60 and 61enrollment transactions and the PBP change (71) transaction with the addition of the new 62 enrollment transaction. The format of the 62 enrollment transaction is also the same as the existing 60 and 61 enrollment transaction. Refer to *Attachment C: Consolidated Layouts for Enrollment/Disenrollment/Retroactive/PBP Change Transaction Data File (60/61/62/51/54/71)* for details.

The valid uses of the 62 enrollment transaction are as follows:

1. Enrollment requests received at the end of a month, made complete within the 21 calendar days provided in CMS enrollment guidance, but after the CMS Plan Data Due (cut-off) date.
2. Point-of-Sale (POS) related activity, available only to the POS contractor.

Enrollment requests with valid retroactive effective dates, other than the two scenarios described above, will continue to be processed by Integriguard and/or CMS under existing processes. The new 62 enrollment transaction is not available for use by Plans for any reason other than the two described.

Additionally, multiple Transaction Reply Codes (TRCs) will be updated as a result of this new transaction type. For most, the change is minor to adjust the description to note the TRC will be a valid response for the retroactive transaction. The one TRC of note is summarized below with the specific change. A list of the other affected TRCs can be found in *Attachment B: New/Updated Transaction Reply Codes (TRCs).*

TRC 037 – Enrollment Rejected, Invalid Date
An enrollment request (transaction type 60/61/62), or PBP change request (transaction type 71) attempted to process. The transaction is rejected as follows:

1. For type 60 transaction, the effective date may be any of the following:
   - Outside the timeframe of CPM-3 and CPM-1 (where CPM = Current Payment Month) or
   - Invalid numeric value or
   - Date not first of the month.

2. For type 61 and 71 transaction, the effective date may be any of the following:
   - Outside the timeframe of CPM-1 and CPM+2 or
   - Invalid numeric value or
   - Date not first of the month.

3. For type 62 transaction, the effective date may be any of the following:
   - Outside the timeframe of CPM-2 or
   - Invalid numeric value or
   - Date not first of the month.

Additional Special Election Period (SEP) Election Type Distinctions

Please note: Plans are not required to have the change for the multiple Special Election Period (SEP) election type distinctions described below implemented for the Fall release. In order to provide time for Plans to make system changes to accommodate the CMS system change, the multiple SEP election types are not mandatory for use until the CMS spring release in April 2008.

CMS is defining major groups of Special Enrollment Periods (SEPs) to assist in determining when SEPs are used for specific circumstances. Plans are responsible for selecting the appropriate election period identifier based on CMS enrollment guidance, as summarized below. In addition to those election period identifiers already in use for submission of enrollment (60/61/62), disenrollment (51), PBP change (71) and Plan change (72) transaction types, the following new election period identifiers will be shown on multiple screens on the Common UI:

Special Enrollment Period (SEP)	CMS Enrollment Guidance Reference	Correct Election Period Identifier
• SEP for Dual-eligible Individuals or Individuals Who Lose Their Dual-Eligibility; **AND** • SEP for Non-Dual Eligible Individuals with LIS and Individuals who Lose LIS	**MA Guidance**: Section 30.4.4, items # 5 and # 12 **PDP Guidance**: Section 20.3.2 and Section 20.3.8, item # 7	**U** Note: Auto and Facilitated enrollment transactions will use the "U" election period identifier.
SEP For Changes in Residence (permanent moves)	**MA Guidance**: Section 30.4.1 **PDP Guidance**: Section 20.3.1	**V**
SEP EGHP (Employer/Union Group Health Plan)	**MA Guidance**: Section 30.4.4, item # 1 **PDP Guidance**: Section 20.3.8, item # 1	**W**
CMS Casework Exceptional Condition SEP(s)	**MA Guidance**: Section 30.4.4, **PDP Guidance**: Section 20.3.8	**Y** **Note: Typically, this election period identifier will be used by CMS caseworks and/or contractors. Plans would only use this specific identifier when specifically instructed to do so on a case by case basis by CMS.
All other SEPs not identified in this table	**MA Guidance**: Section 30.4 **PDP Guidance**: Section 20.3	**S**

In addition to these additional election period identifiers, CMS will also provide a valid value of 'X' for use in the election period identifier field. This value is an Administrative Action and may be used when a transaction being submitted 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 being submitted for this purpose.

- Involuntary Disenrollment. In limited circumstances, Plans may involuntarily disenroll individuals for specific reasons and 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 being submitted for this purpose.

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

A valid election period identifier is required to be submitted on all enrollment (60/61/62), disenrollment (51), PBP change (71) and Plan change (72) transactions. As stated previously, Plans are responsible for selecting the appropriate election period identifier based on CMS enrollment guidance.

As a minor note, TRC 104 – Rejected; Invalid or Missing Election Type will also be updated to account for these new SEP election types. Refer to *Attachment B: New/Updated Transaction Reply Codes (TRCs)* for details.

Enrollment Source Code for Enrollment Transactions

Please note: Plans are not required to have the change for the new enrollment source codes for auto-enrollment and facilitated enrollment PBP change transactions described below implemented for the Fall release. In order to provide time for Plans to make system changes to accommodate the CMS system change, the new enrollment source codes are not mandatory for use until the CMS Spring release in April 2008.

Currently, field 30, position 171 of the enrollment (60/61/62), disenrollment (51), PBP change (71) and Plan change (72) transactions is named the Enrollment Source field, identified as filler, and is not in use for submitted transactions. With the Fall release, CMS is defining the data that Plans, as well as the Point of Sale (POS) contractor, must provide in the Enrollment Source field

when submitting these various transaction types. CMS systems currently use four types of enrollment source codes as described for field 37, position 155, of the weekly/monthly Transaction Reply Report (TRR). These existing enrollment source codes are as follows and will not be affected or adjusted by the addition of the new enrollment source codes:

- A = Auto-enrolled by CMS
- B = Beneficiary election
- C = Facilitated enrollment by CMS
- D = CMS annual rollover

As part of the Fall release, CMS will add the following enrollment source codes for Plans to use with the submission of a PBP change (71) transaction, unless otherwise noted:

- 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-submitted reassignment enrollment
- I = Assigned to Plan-submitted enrollment with enrollment source other than any of the following: B, E, F, G, H and blank

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. This code is not for use by stand-alone PDPs, as CMS generates all auto/facilitated enrollments into PDPs. Upon receipt of a transaction using any of the enrollment source codes for a Plan submitted auto-enrollment or facilitated enrollment, the system will also complete the customary enrollment edits and check for Part D Opt-Out indicators prior to enrollment processing. After the system processes the enrollment including these new enrollment source codes, a Transaction Reply Code (TRC) will be provided to the Plan. Plans should expect to see the usual TRC 011 – Enrollment Accepted as Submitted along with other existing TRCs such as TRC 117 – FBD Auto Enrollment Accepted or TRC 118 – LIS Facilitated Enrollment Accepted, or one of the following three new TRCs being added as part of this change. Refer to *Attachment B: New/Updated Transaction Reply Codes (TRCs)* for details.

TRC 210 – POS Enrollment Accepted
Enrollment request for a beneficiary into a Part D Plan submitted by Point Of Sale (POS) contractor is accepted.

TRC 211 – Re-Assignment Enrollment Rejected
Re-assignment enrollment request for a beneficiary into a Part D Plan submitted by CMS attempted to process. The request is rejected because beneficiary's Part D Opt-Out Flag is already set to Yes in MARx common table.

TRC 212 – Re-Assignment Enrollment Accepted
Re-assignment enrollment request for a beneficiary into a Part D Plan submitted by CMS is accepted.

The weekly/monthly Transaction Reply Report (TRR) will also be updated to reflect this change. Refer to *Attachment G* (data file) and *Attachment H* (report file) for details.

Disenrollment Reason Code 10

When a contract, PBP, or segment is terminated, beneficiaries may be rolled over into a new Plan based on information provided through HPMS. If no rollover information is provided, beneficiaries are automatically disenrolled from the terminating plan. Currently, these disenrollments are assigned disenrollment reason code 15 - TERMINATED IN ERROR BY CMS. This has been confusing to some Plans. In an effort to provide Plans with more insight as to why the disenrollment occurred, the system will now use new reason code 10 - TERMINATION OF CONTRACT (PLAN WITHDRAWAL). Reason code 15 will continue to be used in other instances where CMS terminated beneficiary coverage in error.

2. Report and Data File Changes

Medical Savings Account (MSA) & MSA Demonstration Data

Legislative authority documented in the Social Security Act authorizes CMS to establish Medical Savings Accounts (MSAs) and MSA Demonstrations as options for beneficiaries. Under this authority, CMS systems are being modified to account for needed changes to accommodate the administration of enrollment and payment operations. Effective January 2008, upon beneficiary enrollment to a MSA or MSA Demonstration Plan and for every year enrolled thereafter, CMS will generate a lump sum deposit to the beneficiary's MSA. Additionally, effective January 2008, for beneficiaries enrolled in a MSA or MSA Demonstration Plan, when a disenrollment occurs before the end of the year, CMS will generate a lump sum amount to be recovered from the beneficiary's MSA. Authorized users (CMS users and the MSA Plan that enrolled the beneficiary) will be able to view the deposit amounts and any recoveries at the beneficiary level in the Common UI screen MSA Lump Sum (M235). A sample of the screen is available in *Attachment A: New/Updated UI Screens*.

Additionally, there are updates to the Monthly Membership Detail Data File for positions 153-171, previously identified as filler. An updated format is provided as *Attachment I*, with new/updated fields denoted in **blue bolded** text for your convenience.

- Field 37 (Position 153-160) – MSA Part A Deposit/Recovery Amount: MSA lump sum Part A dollars to be deposited/recovered; deposits are positive values and recoveries are negative
- Field 38 (Position 161-168) – MSA Part B Deposit/Recovery Amount: MSA lump sum Part B dollars to be deposited/recovered; deposits are positive values and recoveries are negative
- Field 39 (Position 169-170) – MSA Deposit/Recovery Months: Number of months associated with MSA deposit or recovery dollars
- Field 40 (Position 171) – FILLER

Interim Plan Payment Reports

Beginning in November 2007, Plans that have been pre-approved by CMS will have the ability to receive an interim Plan payment report. Plans can expect to receive the report between month-end payment cycles, based on business need. The format for the file is the same as the monthly Plan payment reports. The report will also be available to Plans through the Common UI as a listed weekly report, as approved by CMS.

The standard naming conventions for the new data file will be:

Gentran mailbox
P.Rxxxxx.PLNPAYI.Dyymmdd.Thhmmsst.pn

Connect:Direct (Mainframe)
zzzzzzzz.Rxxxxx.PLNPAYI.Dyymmdd.Thhmmsst

Connect:Direct (Non-Mainframe)
[directory].Rxxxxx.PLNPAYI.Dyymmdd.Thhmmsst

Data Source for Medicaid Status Part C Risk Adjustment

The Fall software changes are a subset of the risk adjustment and payment systems' changes needed to implement the new data sources for Medicaid status, as discussed in the February 16, 2007 "Advance Notice of Methodological Changes for Calendar Year 2008 for Medicare Advantage (MA) Capitation Rates" and in the April 2, 2007 "Announcement of Calendar Year (CY) 2008 Medicare Advantage Capitation Rates and Payment Policies." Plans should refer to these documents for official CMS guidance regarding these changes. The systems changes are described as follows.

Currently, Plans may submit Medicaid status changes using an MCO correction (01) transaction. Starting January 1, 2008, CMS will no longer accept batch 01 transactions from Plans to change a beneficiary's Medicaid status with an effective date after December 31, 2007. Batch 01 transactions for effective dates prior to January 1, 2008 will continue to be accepted. Medicaid periods with effective dates prior to 2008, whether submitted by a Plan via a 01 transaction or via updates made through the Common UI, will be assigned an end date of '12/31/07' in the CMS system. This means CMS will no longer use Medicaid status changes, submitted via batch 01 transactions, with effective dates after December 31, 2007 to determine Medicaid status for purposes of calculating Part C risk scores. Medicaid status information will be communicated to Plans in the Monthly Membership Detail Data File and Monthly Membership Detail Report. Refer to *Attachment I: Monthly Membership Detail Data File* for details.

CMS has updated the MMR detail data file and report as part of the system change for Medicaid status. Currently, field 19 is defined as a Medicaid flag that represents the beneficiary's Medicaid status used by CMS systems to assign the default risk factors. As of January 1, 2008, this field will be renamed as the New Medicare Beneficiary Medicaid Status Flag and field data will correspond to the CMS data for Medicaid status using the following indicators:

- Medicaid default risk factors = 'Y' (currently in use); CMS is using a default risk factor with Medicaid add-on
- Non-Medicaid default risk factor = 'N'; CMS is using a non-Medicaid default risk factor
- No default risk factor = blank; CMS is not using a default risk factor

The weekly/monthly Transaction Reply Report (TRR) format is also being modified to remove the Medicaid Indicator from field 7. An updated format is provided as *Attachment G* with new/updated fields denoted in **blue bolded** text for your convenience.

Three Transaction Reply Codes (TRCs) are also affected as a result of this change. Refer to *Attachment B: New/Updated Transaction Reply Codes (TRCs)* for details.

TRC 097 – Medicaid Previously Turned On
This TRC will be used only in reply to updates to Medicaid status, submitted via batch 01 transactions, with effective dates prior to January 1, 2008.
A transaction attempted to process the start of a Medicaid period and was rejected because the Medicaid status for the beneficiary was already on for the month in question. No action required by the Plan.

TRC 098 – Medicaid Status Previously Turned Off
This TRC will be used in reply to updates to Medicaid status, submitted via batch 01 transactions, with end dates prior to December 31, 2007.
A transaction attempted to process the end of a Medicaid period and was rejected because the Medicaid status was already off for the month in question. No action required by the Plan.

TRC 715 – Medicaid Change Accepted
This TRC will be used in reply to updates to Medicaid status with effective and end dates after December 31, 2007.
A CMS user updated the beneficiary's Medicaid status. This transaction may or may not change the beneficiary's status, since multiple source of Medicaid information are used to determine the beneficiary's Medicaid status. Information from the accepted transaction will be included in the next scheduled update of Medicaid status information.

To assist in tracking beneficiary Medicaid status, CMS is adding a new screen to the Common UI and modifying two existing screens. Samples of these changes are included in *Attachment A: New/Updated UI Screens.*

- A new Beneficiary Detail Medicaid (M236) screen will be added to show the beneficiary's Medicaid status. This screen will also show the source of Medicaid eligibility if the beneficiary was determined to be Medicaid. The following data will be provided on this new screen:
  - Medicaid status
  - Medicaid eligibility start and end dates
  - Source from which Medicaid eligibility is determined

- The dual-eligible Medicaid information currently displayed on the Beneficiary Detail: Utilization (M233) screen will be moved to the new Beneficiary Detail Medicaid (M236) screen.
- The Medicaid information (Plan Medicaid and third-party Medicaid) currently displayed on the Beneficiary Detail: Status (M205) screen will be moved to the new Beneficiary Detail Medicaid (M236) screen.
- The Medicaid Status Flag currently displayed on the Beneficiary: Snapshot (M203) screen will be removed, as this information will be available on the new Beneficiary Detail Medicaid (M236) screen.

De Minimis Data

As noted in CMS published guidance from the May 24, 2007 HPMS memo from Abby Block entitled "Part D premium billing for 'de minimis' Plans," CMS will ensure applicable system reports account for the de minimis adjustment for eligible beneficiaries. In keeping with this goal, CMS is adjusting various reports to reflect the CMS processing of beneficiary premium data affected by the de minimis adjustment. This applies only to Part D premiums for CY 2008 and beyond.

The Monthly Membership Detail Data File and Monthly Membership Detail Report – Drug Report File (Part D) will include a De Minimis flag in field 43. The De Minimis flag will be set to 'Y' when HPMS has flagged the contract/PBP as a de minimis Plan and the beneficiary is 100% Low Income Subsidy (LIS). Otherwise, the value of the flag will be set to 'N' for contracts/PBPs not flagged as a de minimis Plan and the beneficiary has less than 100% LIS. An updated format is provided as *Attachment I* (data file) and *Attachment J* (report file), with new/updated fields denoted in **blue bolded** text for your convenience.

The Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File will also be updated. If a beneficiary is 100% LIS and the contract/PBP is de minimis, the Net Monthly Part D Basic Premium, field 14, is equal to the Part D Premium Basic Rate minus the de minimis differential. An updated format is provided as *Attachment K*, with new/updated fields denoted in **blue bolded** text for your convenience.

In addition, the Bi-Weekly Deemed/LIS Premium Report Data File will also reflect premium data as adjusted for the de minimis differential.. An updated format is provided as *Attachment L* with new/updated fields denoted in **blue bolded** text for your convenience.

Additionally, the Common UI Beneficiary Snapshot (M203) and Beneficiary: Detail Premiums (M231) screens will be updated to include de minimis data relating to the de minimis differential and the Part D premium net of de minimis differential. Samples of these screens are available in *Attachment A: New/Updated UI Screens*.

Please note that all new/updated Transaction Reply Codes (TRCs), Common UI screens, and file layouts presented in this memo will be reflected in the next release of the Plan Communications User Guide (PCUG), scheduled for publication in mid-November.

For additional information, please reference the Q&A database found on the CMS website, www.cms.hhs.gov. The MMA Help questions can be found by entering "MMAHelp" in the keyword search, or by using the drop down menu choices for Research, Statistics, Data & Systems, then CMS Information Technology, then MMA Systems Help.

Plans are encouraged to contact the MMA Help Desk for any issues encountered during the system update process. Please direct any questions or concerns to the MMA Help Desk at 1-800-927-8069 or email at mmahelp@cms.hhs.gov.

New/Updated Common UI Screens

New Screens:

Beneficiary Detail: MSA Lump Sum (M235)

Claim #:997199598A
1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803

LISA D. JOHANNSON

DOB: 04/16/1911
Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | History | Transactions | Factors | Utilization | MSA Lump Sum

Beneficiary Detail: MSA Lump Sum (M235) User: XXXX Role: REGIONAL OFFICE USER Date: 10/15/2008 Close Change... Print Help...

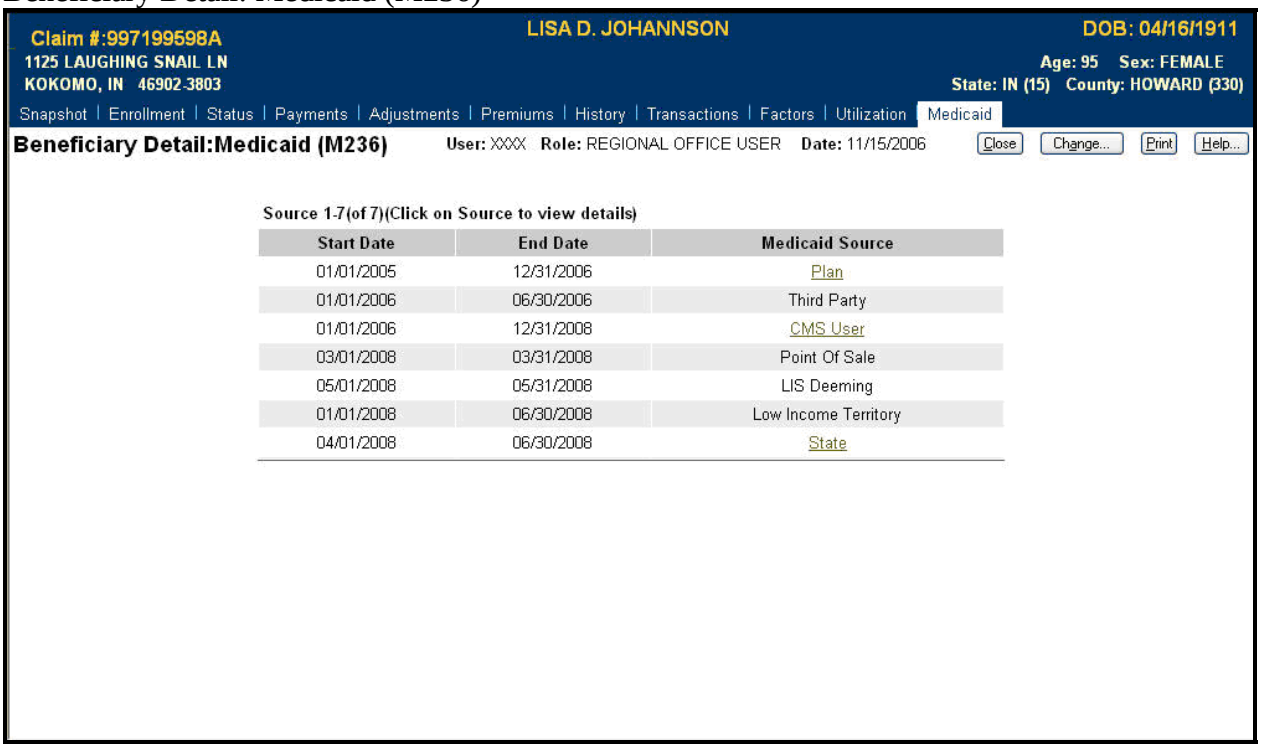
Change year to re-display MSA Lump Sum Deposit/Recovery Details and click "Find."

Year: 2008 Find

MSA Lump Sum Deposit/Recovery 1-3(of 3)

	Enrollment					Lump Sum			
	Contract	PBP #	Seg #	Disenroll Reason	Payment Month	Start Date	End Date	Deposit	Recovery
1	H6666	A01	123		01/2008	01/01/2008	12/31/2008	1200.00	0.00
2	H6666	A01	123	DISENROLLMENT BECAUSE OF ENROLLMENT IN ANOTHER PLAN	08/2008	08/01/2008	12/31/2008	0.00	500.00
3	H5555	002	000		08/2008	08/01/2008	12/31/2008	500.00	0.00

Beneficiary Detail: Medicaid (M236)



Claim #:997199598A
1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803

LISA D. JOHANNSON

DOB: 04/16/1911
Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | History | Transactions | Factors | Utilization | Medicaid

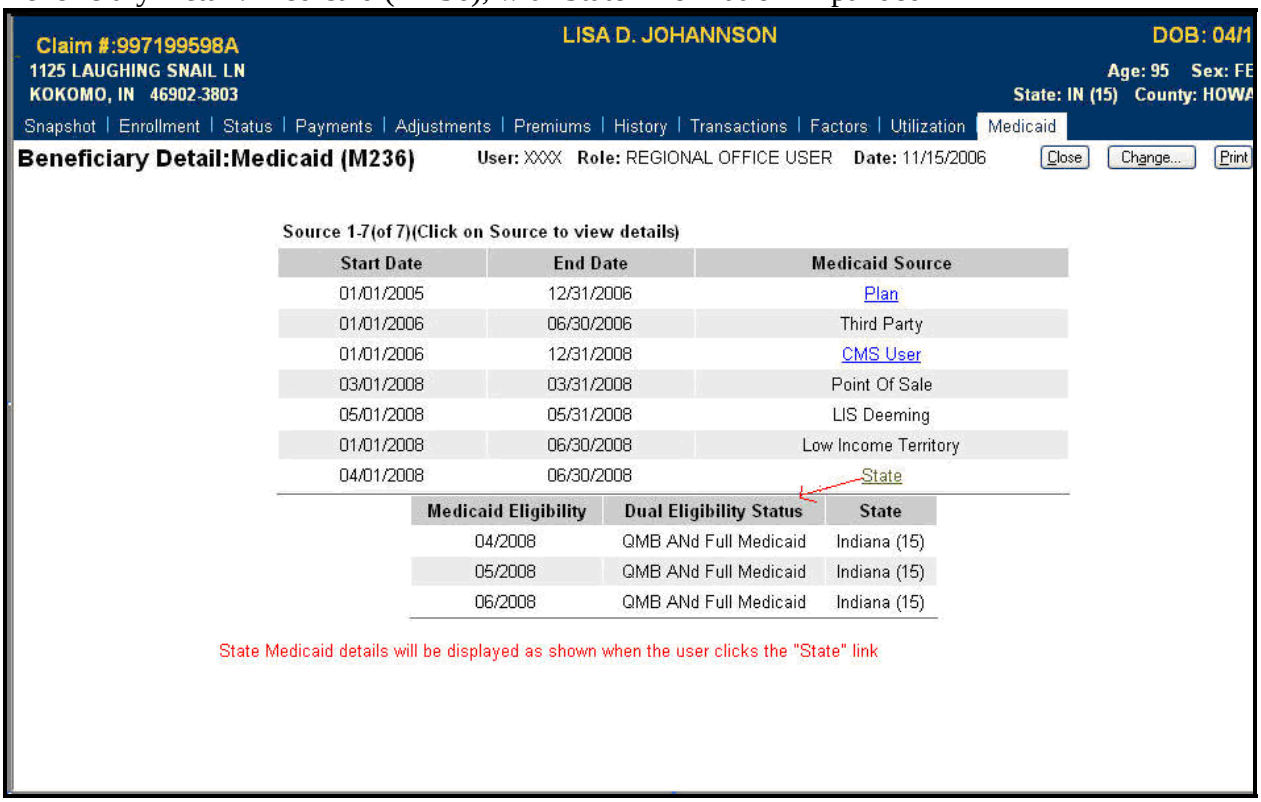
Beneficiary Detail:Medicaid (M236) User: XXXX Role: REGIONAL OFFICE USER Date: 11/15/2006 Close Change... Print Help...

Source 1-7(of 7)(Click on Source to view details)

Start Date	End Date	Medicaid Source
01/01/2005	12/31/2006	Plan
01/01/2006	06/30/2006	Third Party
01/01/2006	12/31/2008	CMS User
03/01/2008	03/31/2008	Point Of Sale
05/01/2008	05/31/2008	LIS Deeming
01/01/2008	06/30/2008	Low Income Territory
04/01/2008	06/30/2008	State

New/Updated Common UI Screens

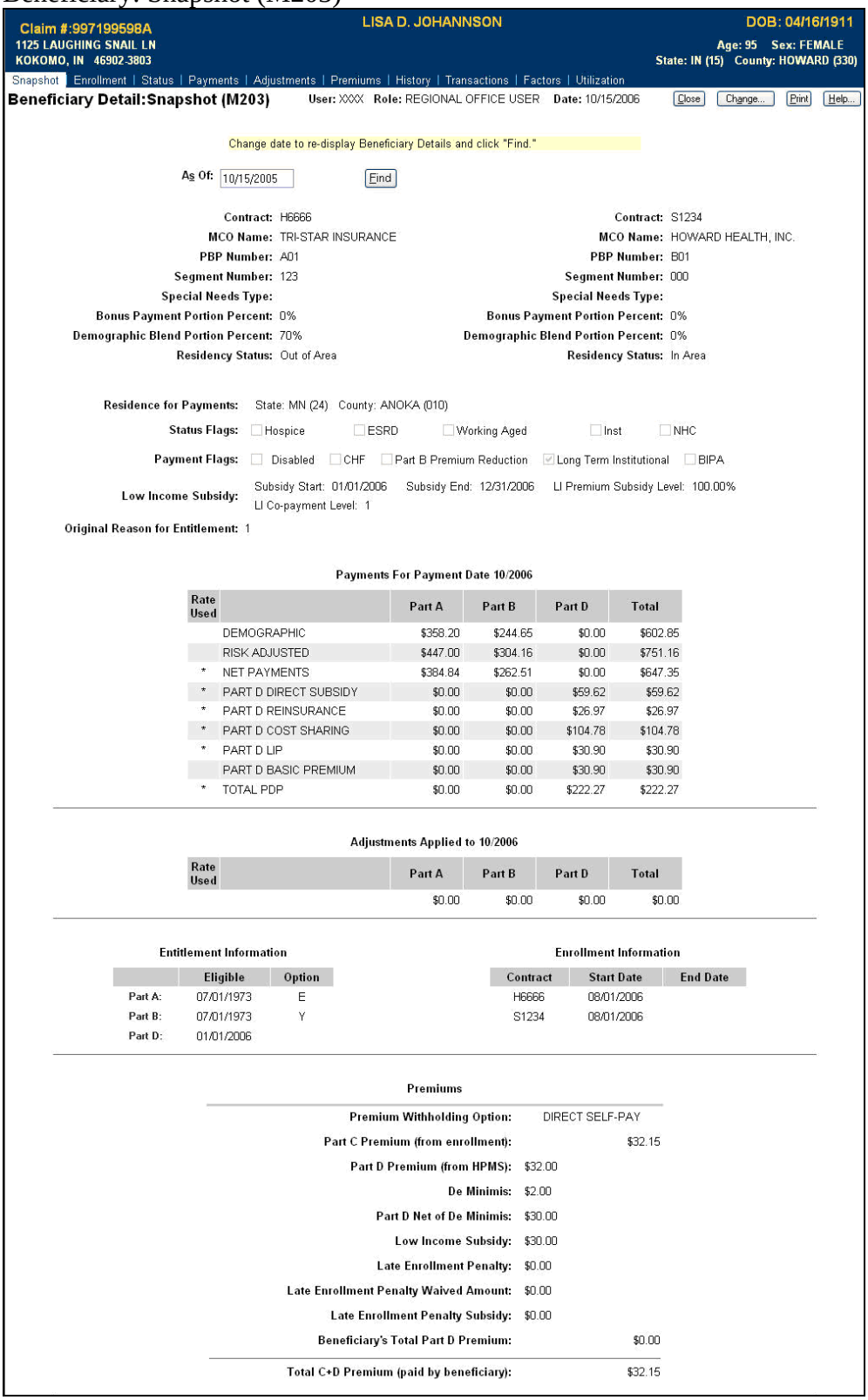
Beneficiary Detail: Medicaid (M236), with State Information Expanded



New/Updated Common UI Screens

Updated Screens:

Beneficiary: Snapshot (M203)



Claim #:997199598A
1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803

LISA D. JOHANNSON

DOB: 04/16/1911
Age: 95 Sex: FEMALE
State: IN (15) County: HOWARD (330)

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | History | Transactions | Factors | Utilization

Beneficiary Detail:Snapshot (M203) User: XXXX Role: REGIONAL OFFICE USER Date: 10/15/2006 [Close] [Change...] [Print] [Help...]

Change date to re-display Beneficiary Details and click "Find."

As Of: 10/15/2005 [Find]

Contract:	H6666	Contract:	S1234
MCO Name:	TRI-STAR INSURANCE	MCO Name:	HOWARD HEALTH, INC.
PBP Number:	A01	PBP Number:	B01
Segment Number:	123	Segment Number:	000
Special Needs Type:		Special Needs Type:	
Bonus Payment Portion Percent:	0%	Bonus Payment Portion Percent:	0%
Demographic Blend Portion Percent:	70%	Demographic Blend Portion Percent:	0%
Residency Status:	Out of Area	Residency Status:	In Area

Residence for Payments: State: MN (24) County: ANOKA (010)

Status Flags: ☐ Hospice ☐ ESRD ☐ Working Aged ☐ Inst ☐ NHC

Payment Flags: ☐ Disabled ☐ CHF ☐ Part B Premium Reduction ☑ Long Term Institutional ☐ BIPA

Low Income Subsidy: Subsidy Start: 01/01/2006 Subsidy End: 12/31/2006 LI Premium Subsidy Level: 100.00%
LI Co-payment Level: 1

Original Reason for Entitlement: 1

Payments For Payment Date 10/2006

Rate Used		Part A	Part B	Part D	Total
	DEMOGRAPHIC	$358.20	$244.65	$0.00	$602.85
	RISK ADJUSTED	$447.00	$304.16	$0.00	$751.16
*	NET PAYMENTS	$384.84	$262.51	$0.00	$647.35
*	PART D DIRECT SUBSIDY	$0.00	$0.00	$59.62	$59.62
*	PART D REINSURANCE	$0.00	$0.00	$26.97	$26.97
*	PART D COST SHARING	$0.00	$0.00	$104.78	$104.78
*	PART D LIP	$0.00	$0.00	$30.90	$30.90
	PART D BASIC PREMIUM	$0.00	$0.00	$30.90	$30.90
*	TOTAL PDP	$0.00	$0.00	$222.27	$222.27

Adjustments Applied to 10/2006

Rate Used		Part A	Part B	Part D	Total
		$0.00	$0.00	$0.00	$0.00

Entitlement Information

	Eligible	Option
Part A:	07/01/1973	E
Part B:	07/01/1973	Y
Part D:	01/01/2006	

Enrollment Information

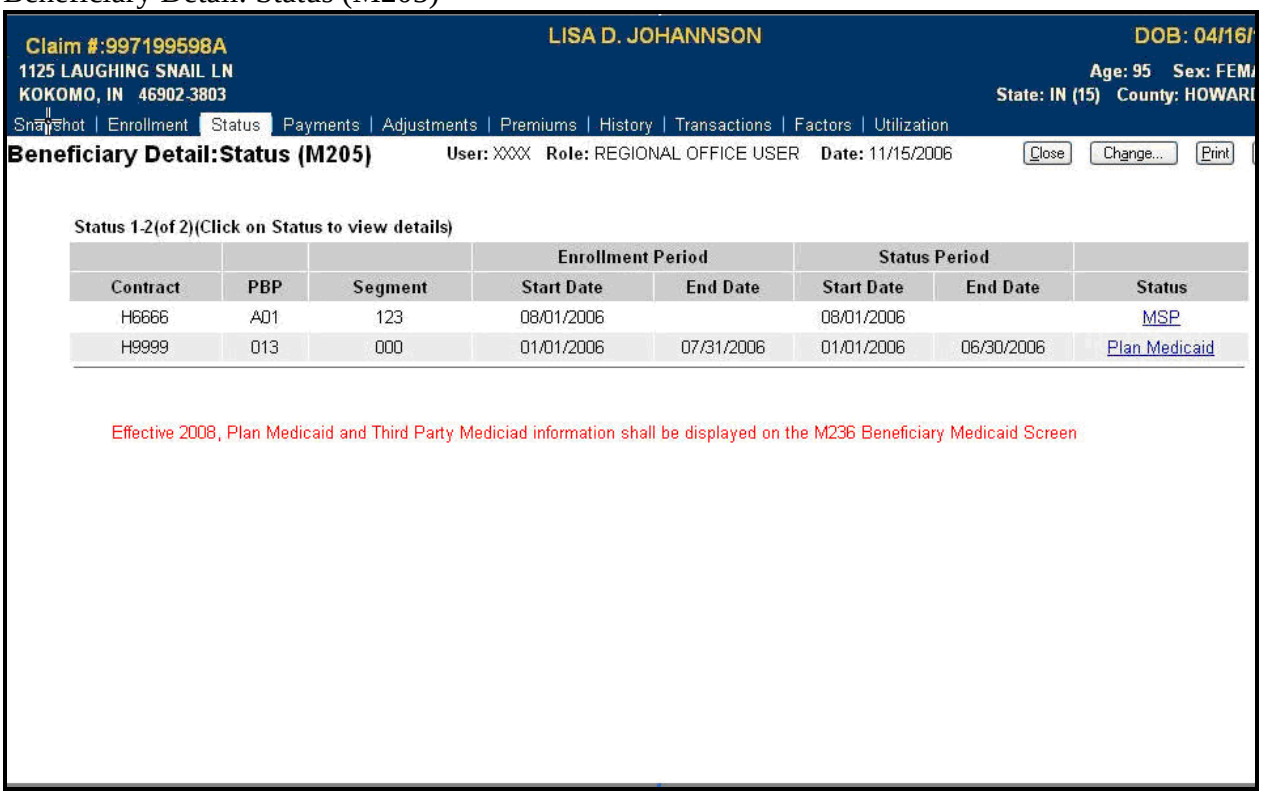
Contract	Start Date	End Date
H6666	08/01/2006	
S1234	08/01/2006	

Premiums

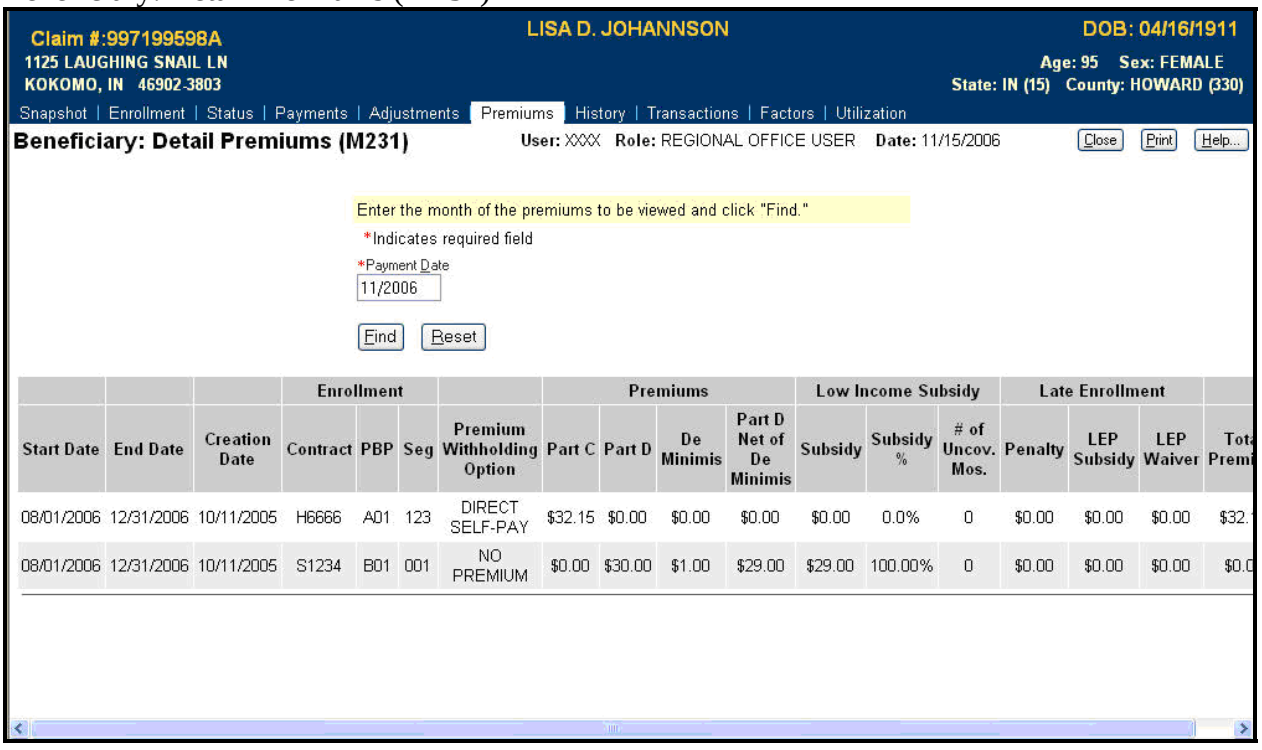
Premium Withholding Option:	DIRECT SELF-PAY	
Part C Premium (from enrollment):		$32.15
Part D Premium (from HPMS):	$32.00	
De Minimis:	$2.00	
Part D Net of De Minimis:	$30.00	
Low Income Subsidy:	$30.00	
Late Enrollment Penalty:	$0.00	
Late Enrollment Penalty Waived Amount:	$0.00	
Late Enrollment Penalty Subsidy:	$0.00	
Beneficiary's Total Part D Premium:		$0.00
Total C+D Premium (paid by beneficiary):		$32.15

New/Updated Common UI Screens

Beneficiary Detail: Status (M205)

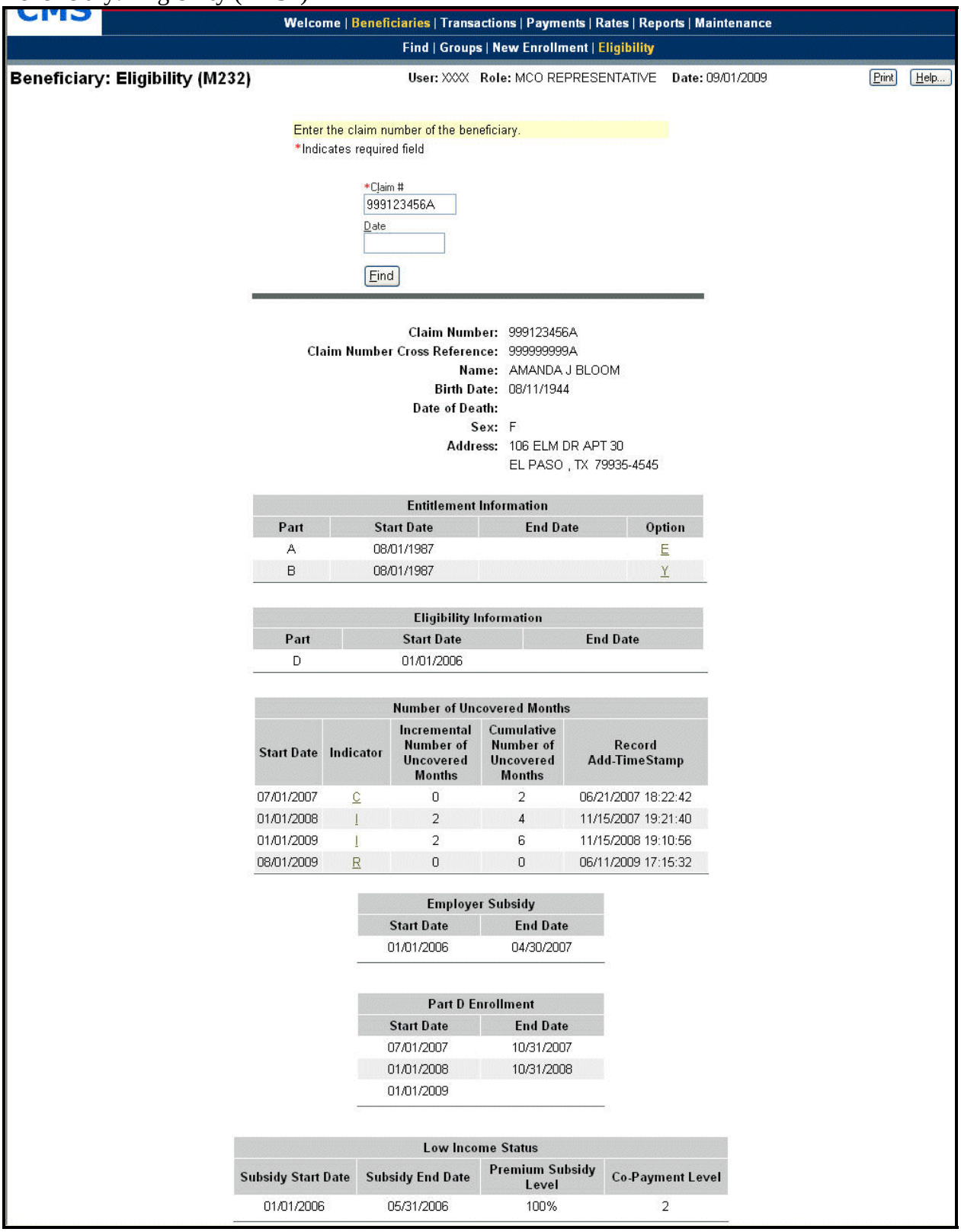


Beneficiary: Detail Premiums (M231)



New/Updated Common UI Screens

Beneficiary: Eligibility (M232)



Welcome | Beneficiaries | Transactions | Payments | Rates | Reports | Maintenance

Find | Groups | New Enrollment | Eligibility

Beneficiary: Eligibility (M232) **User:** XXXX **Role:** MCO REPRESENTATIVE **Date:** 09/01/2009 Print Help...

Enter the claim number of the beneficiary.

*Indicates required field

*Claim # 999123456A

Date

Find

Claim Number: 999123456A
Claim Number Cross Reference: 999999999A
Name: AMANDA J BLOOM
Birth Date: 08/11/1944
Date of Death:
Sex: F
Address: 106 ELM DR APT 30
EL PASO , TX 79935-4545

Entitlement Information			
Part	Start Date	End Date	Option
A	08/01/1987		E
B	08/01/1987		Y

Eligibility Information		
Part	Start Date	End Date
D	01/01/2006	

Number of Uncovered Months				
Start Date	Indicator	Incremental Number of Uncovered Months	Cumulative Number of Uncovered Months	Record Add-TimeStamp
07/01/2007	C	0	2	06/21/2007 18:22:42
01/01/2008	I	2	4	11/15/2007 19:21:40
01/01/2009	I	2	6	11/15/2008 19:10:56
08/01/2009	R	0	0	06/11/2009 17:15:32

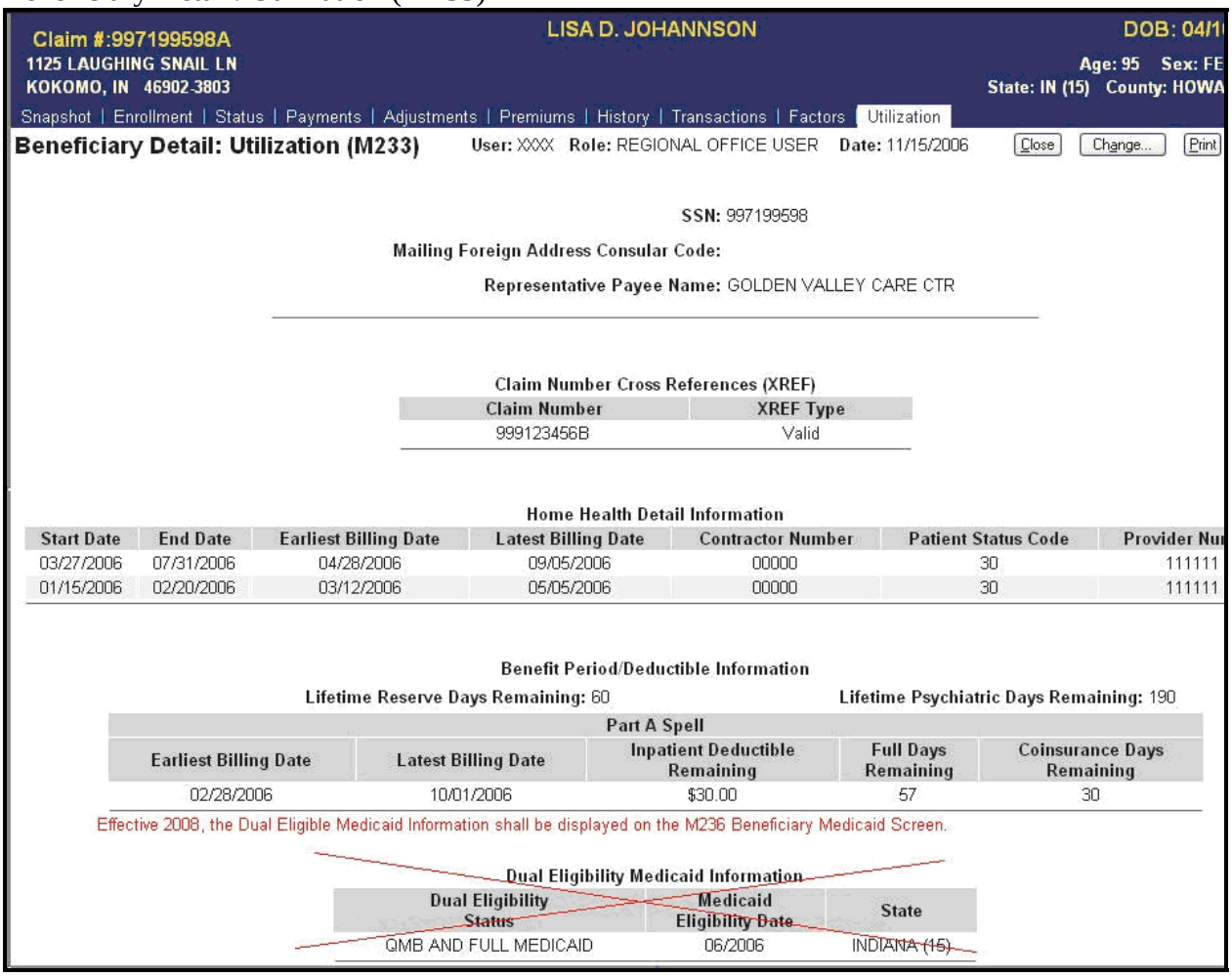
Employer Subsidy	
Start Date	End Date
01/01/2006	04/30/2007

Part D Enrollment	
Start Date	End Date
07/01/2007	10/31/2007
01/01/2008	10/31/2008
01/01/2009	

Low Income Status			
Subsidy Start Date	Subsidy End Date	Premium Subsidy Level	Co-Payment Level
01/01/2006	05/31/2006	100%	2

New/Updated Common UI Screens

Beneficiary Detail: Utilization (M233)



Claim #:997199598A
1125 LAUGHING SNAIL LN
KOKOMO, IN 46902-3803

LISA D. JOHANNSON

DOB: 04/1(
Age: 95 Sex: FE
State: IN (15) County: HOWA

Snapshot | Enrollment | Status | Payments | Adjustments | Premiums | History | Transactions | Factors | Utilization

Beneficiary Detail: Utilization (M233) User: XXXX Role: REGIONAL OFFICE USER Date: 11/15/2006 Close Change... Print

SSN: 997199598

Mailing Foreign Address Consular Code:

Representative Payee Name: GOLDEN VALLEY CARE CTR

Claim Number Cross References (XREF)

Claim Number	XREF Type
999123456B	Valid

Home Health Detail Information

Start Date	End Date	Earliest Billing Date	Latest Billing Date	Contractor Number	Patient Status Code	Provider Nu
03/27/2006	07/31/2006	04/28/2006	09/05/2006	00000	30	111111
01/15/2006	02/20/2006	03/12/2006	05/05/2006	00000	30	111111

Benefit Period/Deductible Information

Lifetime Reserve Days Remaining: 60 Lifetime Psychiatric Days Remaining: 190

Part A Spell				
Earliest Billing Date	Latest Billing Date	Inpatient Deductible Remaining	Full Days Remaining	Coinsurance Days Remaining
02/28/2006	10/01/2006	$30.00	57	30

Effective 2008, the Dual Eligible Medicaid Information shall be displayed on the M236 Beneficiary Medicaid Screen.

Dual Eligibility Medicaid Information

Dual Eligibility Status	Medicaid Eligibility Date	State
QMB AND FULL MEDICAID	06/2006	INDIANA (15)

New/Updated Transaction Reply Codes (TRCs)

New TRCs

Code/ Type*	Title	Short Definition	Definition
205 A	Invalid Disenrollment Reason Code	INVLD DISENROLL RSN	Invalid disenrollment reason code was submitted in the transaction. MARx substituted a default value of '99' for the disenrollment reason code.
210 A	POS Enrollment Accepted	POS ENROLLMENT	Enrollment request for a beneficiary into a Part D plan submitted by Point Of Sale (POS) contractor is accepted.
211 R	Re-Assignment Enrollment Rejected	RE-ASSMNT ENROLLMENT REJECTED	Re-assignment enrollment request for a beneficiary into a Part D plan submitted by CMS attempted to process. The request is rejected because beneficiary's Part D Opt Out Flag is already set to Yes in MARx common table.
212 A	Re-Assignment Enrollment Accepted	RE-ASSMNT ENROLLMENT ACCEPTED	Re-assignment enrollment request for a beneficiary into a Part D plan submitted by CMS is accepted.
213 A	Premium Withhold Option Change to Direct Bill	PRM WH OPT CHG	A transaction was processed by MARx which would result in SSA withholding more than $200 from the beneficiary's check in one month. CMS has changed the premium withhold option for the beneficiary to Direct Bill.
214 R	Plan Change Rejected, Both Uncovered Months and Other non-4Rx Changes	BOTH PLN CHG RQST	Plan change (type 72) transaction attempted to process. The transaction was rejected because the submitted transaction included number of uncovered months as well as for other non-4Rx information plan changes. The effective date edits for uncovered months change are different than the effective date edits for other non-4Rx information.
215 R	Uncovered Months Change Rejected, Invalid Effective Date	BAD CRDT CVG CHG EFF DT	Plan change (type 72) transaction attempted to process. The transaction was rejected because the effective date on the number of uncovered month change transaction is before August 1, 2006; OR the effective date on the number of uncovered month change transaction is after the prospective Current Payment Month plus two months (CPM+2); OR the effective date on the change transaction does not match with any row in the Creditable Coverage common table.
216 M	Number of Uncovered Months exceeds the maximum possible value	NUNCMO SUBMTD EXCEEDS MAX VALUE	Enrollment (type 60/61/62), PBP change (type 71), or Plan change (type 72) transaction attempted to process. Number of uncovered months is not consistent with the number of months for Part D enrollment. The number of months is defaulted to zero and the transaction is processed. Plan should resubmit correct number of uncovered months via a Plan change (type 72) transaction.
217 R	Can't Change LEP Reset Uncovered Months	CAN'T CHG LEP RESET	Plan change (type 72) transaction attempted to process. The transaction was rejected because the submitted transaction attempted to change the number of uncovered months for an effective date corresponding to an "LEP Reset" transaction in the CMS database.

New/Updated Transaction Reply Codes (TRCs)

Code/ Type*	Title	Short Definition	Definition
218 A	LEP Reset Undone	LEP RESET UNDONE	Plan change (type 72) transaction to undo an "LEP Reset" transaction was successfully processed.
219 A	LEP Reset Accepted	LEP RESET	The beneficiary's Number of Uncovered Months has been reset to zero due to a new IEP. The beneficiary's Late Enrollment Penalty is set to zero for the remainder of the enrollment.
714 A	UI Part D Opt-Out Change Accepted	UI OPT OUT OK	A CMS user updated the beneficiary's Part D Opt-Out Flag value. The new value for the Part D Opt-Out Flag is reported in field 38 on the TRR record. **Action:** None
715 M	Medicaid Change Accepted	MCAID CHG ACCEPTED	A CMS user updated the beneficiary's Medicaid status. This transaction may or may not change the beneficiary's status, since multiple sources of Medicaid information are used to determine the beneficiary's Medicaid status. Information from the accepted transaction will be included in the next scheduled update of Medicaid status information. **Note:** This TRC will be used in reply to updates to Medicaid status with effective and end dates after December 31, 2007.
716 A	UI changed the Number of Uncovered months	UI CHGD NUNCMO	A CMS user changed the Number of uncovered months of the beneficiary.

New/Updated Transaction Reply Codes (TRCs)

Updated TRCs

Code/ Type*	Title	Short Definition	Definition
001 R	Invalid Transaction Code	BAD TRANS CODE	A transaction attempted to process. The transaction was rejected, because the input transaction code was an invalid value. Valid transaction code values are 01, 51, 60, 61, **62**, 71 and 72. The transaction should be resubmitted with a valid transaction code. *NOTE: Tran Codes 30 & 31 are valid for pre-2004 adjustments*
037 R	Enrollment Rejected, Invalid Date	BAD ENROLL DATE	An enrollment request (transaction type 60/61/62), or PBP change request (transaction type 71) attempted to process. The transaction is rejected as follows: 1. For type 60 transaction, the effective date can be any of the following: • Outside the timeframe of CPM-3 and CPM-1 (where CPM=Current Payment Month) or • Invalid numeric value or • Date not first of the month. 2. For type 61 and 71 transaction, the effective date can be any of the following: • Outside the timeframe of CPM-1 and CPM+2 or • Invalid numeric value or • Date not first of the month. **3. For type 62 transaction, the effective date can be any of the following:** • **Outside the timeframe of CPM- 2 or** • **Invalid numeric value or** • **Date not first of the month.** The transaction request should be resubmitted with a valid date.
097 R	Medicaid Previously Turned On	MCAID PREV ON	A transaction attempted to process the start of a Medicaid period and was rejected because the Medicaid status for the beneficiary was already on for the month in question. No action required by the plan. **Note:** This TRC will be used only in reply to updates to Medicaid status, submitted via batch 01 transactions, with effective dates prior to January 1, 2008.
098 R	Medicaid Status Previously Turned Off	MCAID PREV OFF	A transaction attempted to process the end of a Medicaid period and was rejected because the Medicaid status was already off for the month in question. No action required by the plan. **Note:** This TRC will be used only in reply to updates to Medicaid status, submitted via batch 01 transactions, with end dates prior to December 31, 2007.

New/Updated Transaction Reply Codes (TRCs)

Code/ Type*	Title	Short Definition	Definition
102 R	Rejected; Invalid or Missing Application Date	BAD APP DATE	A transaction was rejected (60/61/**62**/71) because it was submitted with an invalid or missing application date. The application date must be present, represent a valid date and precede the effective date on the transaction (effective date of the enrollment or PBP change). Note that the application date is not a required field on transaction type 51 or 72, nor is it required for any enrollment submitted online by CMS. The transaction should be resubmitted with a valid date.
103 R	ICEP/IEP Election with Missing A/B Entitlement Date	ICEP/IEP NO ENT	The transaction is rejected because the beneficiary does not have entitlement for Part A and/or Part B on record—required for enrollment transactions (Code 61/**62**). Code is for transaction type 61/**62** and election types I and E only.
104 R	Rejected; Invalid or Missing Election Type	BAD ELECT TYPE	Election type is either missing, not valid for plan or transaction type. , Election types A, N, S, **U, V, W, X, Y,** O and T are valid for transaction types 51/60/61/**62**/71. Election types I and E are valid for transaction type 60/61/**62**.
105 R	Rejected; Invalid Effective Date for Election Type	BAD ELECT DATE	Effective date specified is not valid for the election type. Code is for transaction types 71/**62**/61/60/51; applies only to election types A, I, E, N, O, and T.
106 R	Rejected; Another Transaction Received with a Later Application Date	LATER APPLIC	The transaction was rejected (60/61/**62**/71) because a transaction with a more recent application date was received for the same effective date. When multiple transactions are received for the same beneficiary with the same effective date but with different contract/PBP #s, the application date will be used to determine which election to accept. Note that this code does not apply to transaction type 51, nor does it apply to an enrollment submitted online by CMS. If the application dates are different, the system will accept the election containing the most recent date. If the application dates are the same, they will all be rejected with a code of 176.
107 R	Rejected; Invalid or Missing PBP Number	BAD PBP NUMBER	The transaction was rejected (60/61/**62**/71/72) because the PBP # was missing or invalid. Note that the PBP # is not required on transaction type 51. The PBP # submitted on the 60/61/71/72 must be valid for the contract number on the transaction. The transaction should be resubmitted with a valid PBP #.
108 R	Rejected; Election Limits Exceeded	NO MORE ELECTS	Election limit exceeded for this election type. Code is for transaction types 71/**62**/61/60/51 and election types A, I, E, N, and O.
110 R	Rejected; No Part A and No EGHP Enrollment Waiver	NO PART A/EGHP	The transaction was rejected (60/61/**62**/71) because the beneficiary lacks Part A and there was no EGHP Part B-only waiver in place. MCOs can offer PBP for EGHP members only, and, if the MCO chooses, it can define such PBPs for individuals who do not have Part A.
114 R	Drug Coverage Change Rejected; Election Type must be AEP or OEPI	RX NOT AEP/OEPI	Existing plan members and previously enrolled individuals cannot add or drop drug coverage except during an AEP or OEPI. This TR Code will appear for transaction types 71/**62**/61/60 when election type is N or O for the described individual.

New/Updated Transaction Reply Codes (TRCs)

Code/ Type*	Title	Short Definition	Definition
116 R	Enrollment or Change Rejected; Invalid or Missing Segment number	BAD SEGMENT NUM	The transaction (60/61/**62**/71) was rejected because the enrollment is for a PBP that has been segmented, and segment number on the transaction was missing or invalid. The Segment number submitted on transaction type 60/61/62/71 must be valid for the PBP and contract number. Or, a code 72 transaction was rejected because the (non-blank) segment number provided was invalid for that contract/PBP combination. The transaction should be resubmitted with a valid Segment number. *NOTE: Segment number is not required for transaction type 51.*
117 A	FBD Auto Enrollment Accepted	FBD AUTO ENROLL	Auto-enrollment request of a full-benefit dual eligible beneficiary into a Part D plan submitted by CMS or Plan is accepted.
118 A	LIS Facilitated Enrollment Accepted	LIS FAC ENROLL	Facilitated enrollment of a low-income subsidy beneficiary into a Part D plan submitted by CMS or Plan is accepted.
122 R	Enrollment or Change Rejected, Invalid Premium Amount	BAD PREMIUM AMT	The transaction (60/61/62/71/72) was rejected because the Part C or Part D premium amount was not numeric. A code 72 correction transaction was rejected because a non-blank Part C or Part D premium amount was not numeric. Transaction should be resubmitted with corrected premium amount.
123 R	Enrollment or Change Rejected, Invalid Premium Withholding Option Code	BAD W/HOLD OPT	The transaction (60/61/62/71) was rejected because the Premium Withholding Option code contained an invalid value (valid values are D, S, R, O and N). A code 72 correction transaction was rejected because a non-blank Premium Withholding Option code contained an invalid value. Transactions should be resubmitted with corrected option codes.
124 R	Enrollment or Change Rejected; Invalid Uncovered Months Field	BAD UNCOV MNTHS	The transaction (60/61/62/71/72) was rejected because the "Number of Uncovered Months" field contained a non-numeric value; OR, the "Uncovered Months" field was zero when the Creditable Coverage Switch was set to "N"; OR, the "Uncovered Months" field was greater than zero when the Creditable Coverage Switch was set to "Y" or blank; OR, a code 72 correction transaction was rejected because a non-blank "Number of Uncovered Months" field contained a non-numeric value. Transactions should be resubmitted with corrected fields.
125 R	MSA Enrollment or Change Rejected, Invalid MSA Fields	BAD MSA DATA	The transaction (60/61/62/71) for Medical Savings Account (MSA) was rejected because one or more of these required fields was missing: beneficiary's social security number, bank account number, bank routing number, or bank account type code.
126 R	Enrollment or Change Rejected; Invalid Creditable Coverage Flag	BAD CRED COV FL	The transaction (60/61/62/71/72) was rejected because the "Creditable Coverage Flag" field contained an invalid value. A code 72 correction transaction was rejected because a non-blank "Creditable Coverage Flag" field contained an invalid value. Transactions should be resubmitted with corrected fields.

New/Updated Transaction Reply Codes (TRCs)

Code/ Type*	Title	Short Definition	Definition
130 R	Part D Opt-Out Rejected, Opt-Out Indicator Not Valid	BAD OPT OUT CD	A submitted transaction (41/51/54/71/72) was rejected because the Part D Opt-Out Flag contained an invalid value. Valid values of Part D Opt Out flag are as follows: • For transaction type 41, valid values are Y and N • For transaction types 51/54/71/72, valid values are Y or N or blank **Action:** If the transaction was submitted by the Plan (51/71/72), correct the Part D Opt-Out Flag value and resubmit the transaction. If the transaction was submitted by CMS (41/54), no Plan action is required.
131 A	Part D Opt-Out Accepted	OPT OUT OK	A transaction 41/51/54/71/72 was received that specified a Part D Opt-Out Flag value or a change to a Part D Opt-Out Flag value. The Part D Opt-Out Flag value on the transaction is accepted. The new Part D Opt-Out Flag value is reported in field 38 on the TRR record. **Action:** No Plan Action
133 R	Part D Enrollment Rejected; Invalid Secondary Insurance Flag	BAD 2 INS FLAG	Plans submitting Part D transactions (60/61/62/71) must provide a valid value for the secondary drug coverage flag.
134 A	Part D Enrollment Accepted; Invalid Secondary Insurance	NO 2 INS INFO	Plans submitting Part D transactions (60/61/62/71) must indicate when a beneficiary has secondary drug coverage. This transaction reply indicates that the secondary insurance flag was set, but the secondary insurance Rx ID and Rx Group were not supplied. Plan should follow up with secondary insurance Rx ID and Rx Group information on a change transaction (72).
141 A	Creditable Coverage Change Accepted	CRED COV CHG	The beneficiary's creditable coverage information has been changed successfully (Creditable Coverage Flag, Number of Uncovered Months). This change was the result of a plan-submitted change (72) transaction.

New/Updated Transaction Reply Codes (TRCs)

Code/ Type*	Title	Short Definition	Definition
144 M	Premium withhold option change to direct bill	PREM WH OPT CHG	An enrollment request (transaction types 60/61/**62**/71) or plan change request (transaction type 72) was processed. MARx changed the premium withhold option specified on the transaction to "Direct Bill" for one of the following reasons: 1. More than 3 months of retroactive premium withholding was requested. 2. The beneficiary's retirement system (SSA, RRB or OPM) was unable to withhold the entire premium amount from the beneficiary's monthly check. 3. The beneficiary has a BIC of M or T and chose "SSA" as the withhold option. SSA cannot withhold premiums for these beneficiaries (there is no benefit check to withhold from). 4. The beneficiary chose "RRB" or "OPM" as the withhold option. RRB and OPM are not withholding premiums at this time. 5. The beneficiary is an RRB beneficiary and chose "SSA" as the withhold option. "SSA" is not a valid option for RRB beneficiaries. 6. The Plan has submitted a Part C premium amount that exceeds the maximum Part C premium value provided by HPMS. MARx has changed the Plan submitted premium withhold option to direct bill. The transaction has not been rejected as a result of this condition. The Plan should contact the beneficiary to explain the consequences of this premium withhold option change.
170 A	Enrollment or Change Accepted; Premium Withhold Option Changed to Direct Billing	PREM WH OPT CHG	Premium withholding option has been changed to "Direct Billing" for enrollees who are retirees (transaction type 60, 61, **62**, 71 or 72). The plan should contact the beneficiary to explain the consequences of this change.
176 R	Transaction Rejected: Another Transaction Accepted	TRANSACTION REJECTED	A transaction (60/61/**62**/71) attempted to process. The beneficiary request for enrollment into a different contract was rejected by membership because the beneficiary enrollment request into another contract for the same effective and application dates was successfully processed.
178 M	Late Enrollment Penalty Rescinded	PENALTY RESCINDED	The beneficiary's base late enrollment penalty has been rescinded to $0 as a result of the beneficiary's number of uncovered months having been rescinded to zero. The $0 penalty amount will be in field 52 (base penalty).
182 M	Part C Premium Change	PTC PRM OVERIDE	1. The part C premium submitted with the input transaction does not agree with plan's defined premium rate. The premium has been adjusted to reflect the defined rate. 2. The part C premium submitted with the input transaction has exceeded the maximum Part C amount defined on the HPMS file. This value has been changed to equal to the Part C Basic plus Mandatory Supplemental Premium Rate, Net of Rebate from the HPMS file.

New/Updated Transaction Reply Codes (TRCs)

Code/ Type*	Title	Short Definition	Definition
199 R	Transaction Rejected – Pending	RTRN FOR RESRCH	Transaction (51/54/60/61/**62**/71/72/Notification) is rejected due to pending status of the request. This transaction was placed into a pending status due to multiple transactions were concurrently processed for the same beneficiary. Subsequent transactions may have been processed while this transaction was still pending. Therefore, the Plan must review the beneficiary current status and resubmit transaction(s) accordingly.
200 R	Rx BIN Blank or Not Valid	BIN BLANK/INVLID	Enrollment transaction (60, 61, **62** and 71) or plan change (72) transaction by a Part D plan attempted to process. The enrollment transaction request was rejected because the primary drug insurance Rx BIN field is either blank or does not have a valid value. The plan change transaction request was rejected because the primary drug insurance Rx BIN field does not have a valid value. **Exception:** Rx BIN for primary drug insurance is not a mandatory field for enrollment transaction for PACE National Part D plans and Plan Change transaction (type 72). If Rx BIN is provided for the transaction (60/61/62/71/72), it must be a valid value for the transaction to process; otherwise transaction will be rejected.
201 R	Rx ID Blank or Not Valid	ID BLANK/INVLID	Enrollment transaction (60, 61, **62** and 71) or plan change (72) transaction by a Part D plan attempted to process. The enrollment transaction request was rejected because the primary drug insurance Rx ID field is either blank or does not have a valid value. The plan change transaction request was rejected because the primary drug insurance Rx ID field does not have a valid value. **Exception:** Rx ID for primary drug insurance is not a mandatory field for enrollment transaction for PACE National Part D plans and Plan Change transaction (type 72). If Rx ID is provided for the transaction (60/61/**62**/71/72), it must be a valid value for the transaction to process; otherwise transaction will be rejected.
202 R	Rx GRP Not Valid	RX GRP INVALID	Enrollment transaction (60, 61, **62** and 71) or plan change (72) transaction by a Part D plan attempted to process. The transaction request was rejected because the primary drug insurance Rx GRP field does not have a valid value.
203 R	Rx PCN Not Valid	RX PCN INVALID	Enrollment transaction (60, 61, **62** and 71) or plan change (72) transaction by a Part D plan attempted to process. The transaction request was rejected because the primary drug insurance Rx PCN field does not have a valid value.

*** Types of Transaction Reply Codes:**

A – Accepted
D – Duplicate
M – Maintenance
P – Pending
R - Rejected

Consolidated Layouts for Enrollment/Disenrollment/Retroactive/PBP Change Transaction Data File (60/61/62/51/54/71)

Header Record

ITEM	FIELDS	SIZE	POSITION	HEADER	DESCRIPTION
1	Header Message	12	1 – 12	R	'AAAAAAHEADER'
2	Filler	21	13 – 33	N/A	Spaces
3	Payment Month	6	34 – 39	R	MMYYYY (Note that the date should be one month after the processing date, e.g. input 022002 for data submitted before the January 2002 cutoff.)
4	Filler	261	40 – 300	N/A	Spaces

Detail Record

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (60/61/62) [Note 1]	DISENROLLMENT (51/54)	PBP CHANGE (71) [Note 1& Note 2]
1	HIC#	12	1 – 12	R	R	R
2	Surname	12	13 – 24	R	R	R
3	First Name	7	25 – 31	R	R	R
4	M. Initial	1	32			
5	Sex	1	33	R	R	R
6	Birth Date (YYYYMMDD)	8	34 – 41	R	R	R
7	EGHP Flag	1	42	blank field has a meaning	N/A	blank field has a meaning
8	PBP #	3	43 – 45	R	N/A	R (Change-to value)
9	Election Type	1	46	R (for all plan types when [Note 1] is true; otherwise not required for HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MDHO demo, MSHO demo, and PACE National plans)	R (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)	R (for all plan types when [Note 1] is true; otherwise not required for HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MDHO demo, MSHO demo, and PACE National plans)
10	Contract #	5	47 – 51	R	R	R
11	Application Date	8	52 – 59	R	N/A	R

Consolidated Layouts for Enrollment/Disenrollment/Retroactive/PBP Change Transaction Data File (60/61/62/51/54/71)

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (60/61/62) [Note 1]	DISENROLLMENT (51/54)	PBP CHANGE (71) [Note 1& Note 2]
12	Transaction Code	2	60 – 61	R	R	R
13	Disenrollment Reason **(Required for Involuntary Disenrollments)**	2	62 – 63	N/A	**Required for Involuntary Disenrollments. Optional for Voluntary Disenrollments**.	N/A
14	Effective Date (YYYYMMDD)	8	64 – 71	R	R	R
15	Segment ID	3	72-74	R, blank for non-segmented organizations; otherwise, 3-digits	N/A	R, blank for non-segmented organizations; otherwise, 3-digits
16	Filler	5	75-79	N/A	N/A	N/A
17	Prior Commercial Override	1	80	If applies; otherwise, zero or blank	N/A	If applies; otherwise, zero or blank
18	Premium Withhold Option/ Parts C-D	1	81	R (required for all plan types except HCPP, COST 1 without drug, COST 2 without drug, CCIP/FFS demo, MSA/MA and MSA/demo plans)	N/A	R (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	R (required for all plan types except HCPP, COST 1, COST 2, CCIP/FFS demo, MSA/MA and MSA/demo plans)	N/A	R (required for all plan types except HCPP, COST 1, COST 2, CCIP/FFS demo, MSA/MA and MSA/demo plans)
20	Part D Premium Amount (XXXXvXX)	6	88 – 93	R (for all Part D plans); otherwise blank	N/A	R (for all Part D plans); otherwise blank
21	Creditable Coverage Flag	1	94	R (for all Part D plans); otherwise blank	N/A	R (for all Part D plans); otherwise blank
22	Number of Uncovered Months	3	95-97	R (for all Part D plans); otherwise blank. Blank = zero, meaning no uncovered months	N/A	R (for all Part D plans); otherwise blank. Blank = zero, meaning no uncovered months

Consolidated Layouts for Enrollment/Disenrollment/Retroactive/PBP Change Transaction Data File (60/61/62/51/54/71)

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (60/61/62) [Note 1]	DISENROLLMENT (51/54)	PBP CHANGE (71) [Note 1& Note 2]
23	Employer Subsidy Enrollment Override Flag	1	98	R if beneficiary has Employer Subsidy status for Part D; otherwise blank	N/A	R if beneficiary has Employer Subsidy status for Part D; otherwise blank
24	Part D Opt-Out Flag	1	99	N/A	Optional (for all Part D plans); otherwise blank	R (Y when Opting Out for Part D; **N when Opting in for Part D**); otherwise blank)
25	Filler	20	100-119	N/A	N/A	N/A
26	Filler	15	120-134	N/A	N/A	N/A
27	Secondary Drug Insurance Flag	1	135	R (for all Part D plans, value is Y or N or Blank; for auto/facilitated enrollments and rollovers value should be blank); for non Part D plans, value should be blank.	N/A	R (for all Part D plans, value is Y or N or Blank; for auto/facilitated enrollments and rollovers value should be blank); for non Part D plans, value should be blank
28	Secondary Rx ID	20	136-155	R if secondary insurance; otherwise blank	N/A	R if secondary insurance; otherwise blank
29	Secondary Rx Group	15	156-170	R if secondary insurance; otherwise blank	N/A	R if secondary insurance; otherwise blank
30	Enrollment Source	1	171	R (for POS submitted enrollment transactions); otherwise optional.	FILLER	R (for plan submitted auto-enrollments and facilitated enrollment transactions includes [Note 2]); otherwise optional.
31	SSN	9	172-180	FILLER	FILLER	FILLER
32	Trustee Routing Number	9	181-189	FILLER	FILLER	FILLER
33	Bank Account Number	17	190-206	FILLER	FILLER	FILLER
34	Bank Account Type	1	207	FILLER	FILLER	FILLER
35	Filler	17	208-224	N/A	N/A	N/A
36	Part D Rx BIN	6	225-230	R (for all Part D plan except PACE National); otherwise blank	N/A	R (for all Part D plan except PACE National); otherwise blank

Consolidated Layouts for Enrollment/Disenrollment/Retroactive/PBP Change Transaction Data File (60/61/62/51/54/71)

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (60/61/62) [Note 1]	DISENROLLMENT (51/54)	PBP CHANGE (71) [Note 1& Note 2]
37	Part D Rx PCN	10	231-240	Change-to value (for all Part D plans except PACE National); otherwise blank	N/A	Change-to value (for all Part D plans except PACE National); otherwise blank
38	Part D Rx Group	15	241-255	Change-to value (for all Part D plans except PACE National); otherwise blank	N/A	Change-to value (for all Part D plans except PACE National); otherwise blank
39	Part D Rx ID	20	256-275	R (for all Part D plan except PACE National); otherwise blank	N/A	R (for all Part D plan except PACE National); otherwise blank
40	Secondary Drug BIN	6	276-281	R if secondary insurance; otherwise blank	N/A	R if secondary insurance; otherwise blank
41	Secondary Drug PCN	10	282-291	R if secondary insurance; otherwise blank	N/A	R if secondary insurance; otherwise blank
42	Filler	9	292-300	FILLER	FILLER	FILLER

Note 1: 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 case where such enrollment would cause in an automatic disenrollment from a plan requiring election type edits. The election type for the plan on the enrollment request should be consistent with the election type for the plan resulting in automatic disenrollment.

Note 2: 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

Consolidated Layouts for Plan Change (72) and Part D Opt-Out (41) Transaction Data File

Header Record

ITEM	FIELDS	SIZE	POSITION	HEADER	DESCRIPTION
1	Header Message	12	1 – 12	R	'AAAAAAHEADER'
2	Filler	21	13 – 33	N/A	Spaces
3	Payment Month	6	34 – 39	R	MMYYYY (Note that the date should be one month after the processing date, e.g. input 022002 for data submitted before the January 2002 cutoff.)
4	Filler	261	40 – 300	N/A	Spaces

Detail Record

ITEM	FIELDS	SIZE	POSITION	4RX PLAN CHANGE (72) [Note 1]	NON-4RX PLAN CHANGE (72) [Note 2]	NUNCMO PLAN CHANGE (72) [Note 3]	PART D OPT OUT (41)
1	HIC#	12	1 – 12	R	R	**R**	**R**
2	Surname	12	13 – 24	R	R	**R**	**R**
3	First Name	7	25 – 31	R	R	**R**	**R**
4	M. Initial	1	32	Optional	Optional	**Optional**	**Optional**
5	Sex	1	33	R	R	**R**	**R**
6	Birth Date (YYYYMMDD)	8	34 – 41	R	R	**R**	**R**
7	EGHP Flag	1	42	N/A	Blank or change to value	**N/A**	**N/A**
8	PBP #	3	43 – 45	R	R	**R**	**N/A**
9	Election Type	1	46	N/A	R for premium withhold option changes; otherwise, N/A	**N/A**	**N/A**
10	Contract #	5	47 – 51	R	R	**R**	**R (transaction for type 41 when beneficiary is enrolled in Medicare); otherwise, N/A.**
11	Application Date	8	52 – 59	N/A	N/A	**N/A**	**N/A**
12	Transaction Code	2	60 – 61	R	R	**R**	**R**

Consolidated Layouts for Plan Change (72) and Part D Opt-Out (41) Transaction Data File

ITEM	FIELDS	SIZE	POSITION	4RX PLAN CHANGE (72) [Note 1]	NON-4RX PLAN CHANGE (72) [Note 2]	NUNCMO PLAN CHANGE (72) [Note 3]	PART D OPT OUT (41)
13	Disenrollment Reason **(Required for Involuntary Disenrollments)**	2	62 – 63	N/A	N/A	**N/A**	**N/A**
14	Effective Date (YYYYMMDD)	8	64 – 71	R	R	**R**	**N/A**
15	Segment ID	3	72-74	N/A	Blank or change-to value for local plans; otherwise, N/A	**N/A**	**N/A**
16	Filler	5	75-79	N/A	N/A	**N/A**	**N/A**
17	Prior Commercial Override	1	80	N/A	N/A	**N/A**	**N/A**
18	Premium Withhold Option/ Parts C-D	1	81	N/A	Blank or change-to value	**N/A**	**N/A**
19	Part C Premium Amount (XXXXvXX)	6	82 – 87	N/A	Blank or change-to value	**N/A**	**N/A**
20	Part D Premium Amount (XXXXvXX)	6	88 – 93	N/A	Blank or change-to value	**N/A**	**N/A**
21	Creditable Coverage Flag	1	94	N/A	**N/A**	**R**	**N/A**
22	Number of Uncovered Months	3	95-97	N/A	**N/A**	**Blank or change-to value**	**N/A**
23	Employer Subsidy Enrollment Override Flag	1	98	N/A	N/A	**N/A**	**N/A**
24	Part D Opt-Out	1	99	N/A	**Blank or change-to value**	**N/A**	**R**

Consolidated Layouts for Plan Change (72) and Part D Opt-Out (41) Transaction Data File

ITEM	FIELDS	SIZE	POSITION	4RX PLAN CHANGE (72) [Note 1]	NON-4RX PLAN CHANGE (72) [Note 2]	NUNCMO PLAN CHANGE (72) [Note 3]	PART D OPT OUT (41)
	Flag						
25	Filler	20	100-119	N/A	N/A	**N/A**	**N/A**
26	Filler	15	120-134	N/A	N/A	**N/A**	**N/A**
27	Secondary Drug Insurance Flag	1	135	Blank or new value. Blank does not remove or replace existing data.	**N/A**	**N/A**	**N/A**
28	Secondary Rx ID	20	136-155	Blank or new additional value. Blank does not remove or replace existing data.	**N/A**	**N/A**	**N/A**
29	Secondary Rx Group	15	156-170	Blank or new additional value. Blank does not remove or replace existing data.	**N/A**	**N/A**	**N/A**
30	Enrollment Source	1	171	**N/A**	**N/A**	**N/A**	**N/A**
31	SSN	9	172-180	**N/A**	**N/A**	**N/A**	**N/A**
32	Trustee Routing Number	9	181-189	**N/A**	**N/A**	**N/A**	**N/A**
33	Bank Account Number	17	190-206	**N/A**	**N/A**	**N/A**	**N/A**
34	Bank Account Type	1	207	**N/A**	**N/A**	**N/A**	**N/A**
35	Filler	17	208-224	N/A	N/A	**N/A**	**N/A**
36	Part D Rx BIN	6	225-230	Required together with Part D Rx ID when changing 4Rx primary insurance information. Must either be the beneficiary's current field value or the change-to value. Can only be blank when not changing a beneficiary's 4Rx primary insurance	**N/A**	**N/A**	**N/A**

Consolidated Layouts for Plan Change (72) and Part D Opt-Out (41) Transaction Data File

ITEM	FIELDS	SIZE	POSITION	4RX PLAN CHANGE (72) [Note 1]	NON-4RX PLAN CHANGE (72) [Note 2]	NUNCMO PLAN CHANGE (72) [Note 3]	PART D OPT OUT (41)
				information.			
37	Part D Rx PCN	10	231-240	Change-to value, either a new value or a blank. Blank will remove the beneficiary's existing value.	**N/A**	**N/A**	**N/A**
38	Part D Rx Group	15	241-255	Change-to value, either a new value or a blank. Blank will remove the beneficiary's existing value.	**N/A**	**N/A**	**N/A**
39	Part D Rx ID	20	256-275	Required together with Part D Rx BIN when changing 4Rx primary insurance information. Must either be the beneficiary's current field value or the change-to value. Can only be blank when not changing a beneficiary's 4Rx primary insurance information.	**N/A**	**N/A**	**N/A**
40	Secondary Drug BIN	6	276-281	Blank or new additional value. Blank does not remove or replace existing data.	**N/A**	**N/A**	**N/A**
41	Secondary Drug PCN	10	282-291	Blank or new additional value. Blank does not remove or replace existing data.	**N/A**	**N/A**	**N/A**
42	Filler	9	292-300	FILLER	FILLER	**FILLER**	**FILLER**

Note 1: 4Rx (Type 72) Plan Change transactions can be retroactive as well as prospective. Any effective date will be accepted as long as it matches a Part D enrollment effective date. When Primary 4Rx values are specified on a 72 transaction, MARx replaces the current Primary 4Rx values for the enrollment (if any) with the Primary 4Rx values from the 72 transaction. When Secondary 4Rx values are specified on a 72 transaction, MARx adds the Secondary 4Rx values from the 72 transaction as a new instance of Secondary 4Rx coverage. There is no mechanism for plans to delete or replace an instance of Secondary 4Rx coverage via MARx transactions.

Consolidated Layouts for Plan Change (72) and Part D Opt-Out (41) Transaction Data File

ITEM	FIELDS	SIZE	POSITION	4RX PLAN CHANGE (72) [Note 1]	NON-4RX PLAN CHANGE (72) [Note 2]	NUNCMO PLAN CHANGE (72) [Note 3]	PART D OPT OUT (41)
Note 2: Non-4Rx (Type 72) Plan Change transactions excluding Creditable Coverage information are prospective, meaning the current processing month plus three months. Said another way, plan change effective date between current payment month minus one month and current payment month plus two months.							
Note 3: Creditable Coverage Plan change transaction (Type 72) information can be retroactive (not prior to August 2006) as well as prospective (not past CPM plus 2 months). Effective date on the transaction should match Part D enrollment dates if the creditable coverage flag is Y, N and blank. Effective date on the transaction can be within a Part D enrollment period if the creditable coverage flag is R and U.							

Field Values for Enrollment/Disenrollment/Retroactive/PBP Change/Plan Change Transaction Data File (60/61/62/51/54/71/72/41)

ITEM	FIELDS	DESCRIPTION
1	HIC#	Claim Account Number (CAN) plus Beneficiary Identification Code (BIC)
2	Surname	No comment.
3	First Name	No comment.
4	M. Initial	No comment.
5	Sex	1 = male, 2 = female, 0 = unknown
6	Birth Date (YYYYMMDD)	YYYYMMDD
7	EGHP Flag	Y if EGHP; otherwise, blank = not EGHP for type 60, 61, **62** and 71 transactions. For type 72 transactions, Y if EGHP, N if not EGHP, and blank indicates no change.
8	PBP #	3-blanks = non-PBP organizations (HCPP, CCIP/FFS Demos); 3-character numeric = PBP number, zero-padded, 001-999 valid for all organizations except HCPP and CCIP/FFS demos.
9	Election Type	A=AEP; E=IEP; I=ICEP; S=SEP; O=OEP; N=OEPNEW; T=OEPI; U=Dual/LIS SEP; V=Permanent Change in Residence SEP; W=EGHP SEP; X=Administrative SEP; Y=CMS/Case Worker SEP; MAs have I, A, O, S, N, U, V, W, X, Y and T. MA-PDs have I, A, O, S, U, V, W, X, Y, T, E and N. PDPs have A, S, U, V, W, X, Y and E.
10	Contract #	Hxxxx = identifies local plans. Rxxxx = identifies regional plans. Sxxxx = identifies PDPs. Fxxxx = identifies fallback plans, Exxxx=identifies employer sponsored MA/MA-PD and PDP plans.
11	Application Date	YYYYMMDD -- Either the date the plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper).
12	Transaction Code	51/54 = disenrollment; 60/61 = enrollment**; 62=retroactive batch enrollments for CPM-2;** 71 =plan election (PBP change); 72 = plan change; **41=1-800-MEDICARE submitted or CMS contractors submitted.**
13	Disenrollment Reason	**Required for Involuntary Disenrollments.**
14	Effective Date (YYYYMMDD)	YYYYMMDD
15	Segment ID	3-blanks = non-segmented organization transaction; for segmented organization transactions, 3-character numeric = segment number, zero padded, 001-999 valid plan Segment ID range. Only local MA/MA-PD plans (Hxxxx) may have segments.
16	Filler	N/A
17	Prior Commercial Override	Required if beneficiary is ESRD and wants to enroll in a non PDP plans. Not required if plan is special-needs-plan (SNP). Alpha-numeric, 0-9 and A-F. Zero (0) and blank = no override.
18	Premium Withhold Option/Parts C-D	D = direct self-pay; S = deduct from SSA benefits; R = deduct from RRB benefits; O = deduct from OPM benefits; N=No Premium. The option applies to both Part C and D premiums.

Field Values for Enrollment/Disenrollment/Retroactive/PBP Change/Plan Change Transaction Data File (60/61/62/51/54/71/72/41)

ITEM	FIELDS	DESCRIPTION
19	Part C Premium Amount (XXXXvXX)	6-digits with leading zeroes, or blank if premium does not apply. Decimal point assumed 2-digits from right, XXXXvXX. Any value other than a blank on a type 72 transaction indicates a change-to value. That is, 000000 is an acceptable change-to value meaning $0.00.
20	Part D Premium Amount (XXXXvXX)	6-digits with leading zeroes, or blank if premium does not apply. Decimal point assumed 2-digits from right, XXXXvXX. Any value other than a blank on a type 72 transaction indicates a change-to value. That is, 000000 is an acceptable change-to value meaning $0.00.
21	Creditable Coverage Flag	Valid for durg plans. For enrollment (type 60/61/62/71) transactions, valid values are Y, N, R and blank. For plan change (type 72) transactions, valid values are Y, N, R, U and blank. Y if covered, N if not covered, R is resetting uncovered months to zero due to a new IEP and U for resetting uncovered months to the value prior to using R.
22	Number of Uncovered Months	Count of total months without drug coverage. When creditable coverage flag is blank, value should be zero. When creditable coverage flag is Y, value should be zero. When creditable coverage flag is N, value should be greater than zero. When creditable coverage flag is R, value should be zero. When creditable cover flag is U, value should be zero.
23	Employer Subsidy Override Flag	If the beneficiary is in a plan receiving an employer subsidy, but still wants to enroll in a Part D plan, submit the enrollment with the override = Y; otherwise blank.
24	Part D Opt-Out Flag	Applies to full benefit dual eligible and facilitated enrolled beneficiaries. Y= opt-out of Part D; blank=no change to opt-out status. For 71 type of transaction, applies when a beneficiary wants to opt out from MA-PD plan and desire to enroll in MA only PBP of the same contract. **For 71 type of transaction, also applies when a beneficiary wants to change from from MA plan and desire to enroll in MA-PD only PBP of the same contract. For 41 type of transactions, Y= Opt-out of Part D; N=Not to Opt-out of Part D. Part D Opt-Out Flag will be used to allow (when value is N) or reject (when value is Y) auto-enrollment (full benefit dual eligible) or facilitated enrollment (partial benefit dual eligible) beneficiaries.**
25	Filler	N/A
26	Filler	N/A
27	Secondary Drug Insurance Flag	For types 60, 61, **62**, 71 and 72 transactions, Y = beneficiary has secondary drug insurance; N = beneficiary does not have secondary drug insurance available; blank = do not know whether beneficiary has secondary drug insurance.
29	Secondary Rx ID	Secondary insurance plan's ID number for a beneficiary. Alphanumeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces. Applicable for transaction types 60, 61, 62, 71 and 72.
	Secondary RX Group	Secondary insurance plan's group ID number for a beneficiary. Alphanumeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces. Applicable for transaction types 60, 61, 62, 71 and 72.
30	Enrollment Source	A = auto-enrolled by CMS; B = beneficiary election; C = facilitated enrollment by CMS; D=System generated rollovers; E = Plan submitted auto-enrollments; F = Plan submitted facilitated enrollments; G = Point of Sale (POS) submitted enrollments and H = Reassignments submitted by CMS or Plans. Plan submitted enrollments are defaulted to enrollment source of B when submitted with blank enrollment source.
31	SSN	N/A

Field Values for Enrollment/Disenrollment/Retroactive/PBP Change/Plan Change Transaction Data File (60/61/62/51/54/71/72/41)

ITEM	FIELDS	DESCRIPTION
32	Trustee Routing Number	N/A
33	Bank Account Number	N/A
34	Bank Account Type	N/A
35	Filler	N/A
36	Part D Rx BIN	Part D insurance plan's BIN number for a beneficiary. Numeric; right justified (for example, if BIN is five position numeric (12345), plan should set BIN to six position numeric with zero added in the first position (012345)). Applicable for transaction types 60, 61, **62**, 71 and 72.
37	Part D Rx PCN	Part D insurance plan's PCN number for a beneficiary. Alphanumeric, upper case when alpha; left justified. Limited to upper case characters (A-Z) and/or numeric (0-9) and default value of spaces. Applicable for transaction types 60, 61, **62**, 71 and 72.
38	Part D Rx Group	Part D insurance plan's group ID number for a beneficiary. Alphanumeric, upper case when alpha; left justified. Limited to upper case characters (A-Z) and/or numeric (0-9) and default value of spaces. Applicable for transaction types 60, 61, **62**, 71 and 72.
39	Part D Rx ID	Part D insurance plan's ID number for a beneficiary. Alphanumeric, upper case when alpha; left justified. Limited to upper case characters (A-Z) and/or numeric (0-9) and default value of spaces. Applicable for transaction types 60, 61, **62**, 71 and 72.
40	Secondary Rx BIN	Secondary insurance plan's BIN number for a beneficiary. Numeric. Applicable for transaction types 60, 61, **62**, 71 and 72.
41	Secondary Rx PCN	Secondary insurance plan's PCN number for a beneficiary. Alphanumeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces. Applicable for transaction types 60, 61, **62**, 71 and 72.
42	Filler	N/A

Updated Batch Eligibility Query (BEQ) Response File

BEQ Response File Header Record

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	“CMSBEQRH”	This field will always be set to the value "CMSBEQRH." This code identifies the record as the Header Record of a BEQ Response File.
Sending Entity (MBD)	8	9 … 16	X(8)	“MBD „ (MBD + 5 Spaces)	This field will always be set to the value "MBD „ The value specifically is MBD + 5 following Spaces. This value will agree with the corresponding value in the Trailer Record.
File Creation Date	8	17 … 24	X(8)	CCYYMMDD	The date on which the BEQ Response File was created by CMS. This value will be in the format of CCYYMMDD. For example, January 3, 2010 would be the value 20100103. This value will agree with the corresponding value in the Trailer Record.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity (MBD)	The specific Control Number assigned by CMS to the BEQ Response File. CMS will utilize this value to track the BEQ Response File through CMS processing and archive. This value will agree with the corresponding value in the Trailer Record.
FILLER	717	34 … 750	X(717)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

BEQ Response Detail Record (Transaction)

Data Field	Length	Position	Format	Valid Values	Field Definition
Record Type	3	1 ... 3	X(3)	"DTL"	This field will be set to the value "DTL," which indicates that this is a detail record.
Original Detail Record	42	4 ... 45	X(42)	The first 42 positions of the original Transaction (Detail Record) supplied by the Sending Entity.	This field provides the meaningfully-populated area of the BEQ Request File Transaction (Detail Record) provided by the Sending Entity.
Processed Flag	1	46 ... 46	X(1)	"Y" = The detail record was accepted for processing. "N" = The detail record was not accepted for processing.	A flag that indicates if the Transaction (Detail Record) was accepted for processing. A Transaction will be accepted for processing if all critical fields contain valid values.

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
Beneficiary Match Flag	1	47 ... 47	X(1)	"Y" = The beneficiary was matched (located) successfully. "N" = The beneficiary was not matched (located) successfully. " " (SPACE) = Beneficiary Match was not attempted due to an Invalid condition in the Transaction (Detail Record).	A flag that indicates whether or not the beneficiary in the Transaction (Detail Record) was successfully matched (located) to a beneficiary on the CMS Medicare Beneficiary Database (MBD).
Medicare Part A Entitlement Start Date	8	48 ... 55	X(8)	CCYYMMDD Spaces = Not currently enrolled or Data Not Found.	The Entitlement Start Date of the beneficiary's most recent or active Medicare Part A entitlement period.
Medicare Part A Entitlement End Date	8	56 ... 63	X(8)	CCYYMMDD Spaces = Not currently enrolled or Data Not Found.	The Entitlement End Date of the beneficiary's most recent or active Medicare Part A entitlement period.
Medicare Part B Entitlement Start Date	8	64 ... 71	X(8)	CCYYMMDD Spaces = Not currently enrolled or Data Not Found.	The Entitlement Start Date of the beneficiary's most recent or active Medicare Part B entitlement period.
Medicare Part B Entitlement End Date	8	72 ... 79	X(8)	CCYYMMDD Spaces = Not currently enrolled or Data Not Found.	The Entitlement End Date of the beneficiary's most recent or active Medicare Part B entitlement period.
Medicaid Indicator	1	80 ...80	X(1)	"0" = The beneficiary has no current or active Medicaid coverage; "1" = The beneficiary has current or active Medicaid coverage.	An indicator of the presence of current Medicaid coverage for the beneficiary. The value for this field is based upon the presence of Medicaid reported for the beneficiary by states in the previous calendar month via the MMA State Files.
Part D Enrollment Effective Date/Employer Subsidy Start Date (Occurrence 1)	8	81... 88	X(8)	CCYYMMDD Spaces = No Drug coverage period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (most recent or presently active).

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
Part D Disenrollment Date/ Employer Subsidy End Date (Occurrence 1)	8	89 ... 96	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (most recent or presently active).
Part D Enrollment Effective Date/ Employer Subsidy Start Date (Occurrence 2)	8	97 ... 104	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (second most recent).
Part D Disenrollment Date/ Employer Subsidy End Date (Occurrence 2)	8	105 ... 112	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (second most recent).
Part D Enrollment Effective Date/ Employer Subsidy Start Date (Occurrence 3)	8	113 ... 120	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (third most recent).
Part D Disenrollment Date/ Employer Subsidy End Date (Occurrence 3)	8	121 ... 128	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (third most recent).
Part D Enrollment Effective Date/ Employer Subsidy Start Date (Occurrence 4)	8	129 ...136	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (fourth most recent).
Part D Disenrollment Date / Employer Subsidy End Date (Occurrence 4)	8	137 ... 144	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (fourth most recent).

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
Part D Enrollment Effective Date/ Employer Subsidy Start Date (Occurrence 5)	8	145 ... 152	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (fifth most recent).
Part D Disenrollment Date / Employer Subsidy End Date (Occurrence 5)	8	153 ... 160	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (fifth most recent).
Part D Enrollment Effective Date / Employer Subsidy Start Date (Occurrence 6)	8	161 ... 168	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (sixth most recent).
Part D Disenrollment Date / Employer Subsidy End Date (Occurrence 6)	8	169 ... 176	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (sixth most recent).
Part D Enrollment Effective Date/ Employer Subsidy Start Date (Occurrence 7)	8	177 ... 184	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (seventh most recent)
Part D Disenrollment Date / Employer Subsidy End Date (Occurrence 7)	8	185 ... 192	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (seventh most recent)
Part D Enrollment Effective Date/ Employer Subsidy Start Date (Occurrence 8)	8	193 ... 200	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (eighth most recent).

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
Part D Disenrollment Date / Employer Subsidy End Date (Occurrence 8)	8	201 ... 208	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (eighth most recent).
Part D Enrollment Effective Date/ Employer Subsidy Start Date (Occurrence 9)	8	209 ... 216	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (ninth most recent).
Part D Disenrollment Date / Employer Subsidy End Date (Occurrence 9)	8	217 ... 224	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (ninth most recent).
Part D Enrollment Effective Date / Employer Subsidy Start Date (Occurrence 10)	8	225 ... 232	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective start date of the Part D plan or the Start Date of the Employer Subsidy coverage for the beneficiary (tenth most recent).
Part D Disenrollment Date / Employer Subsidy End Date (Occurrence 10)	8	233 ... 240	X(8)	CCYYMMDD Spaces = No Drug Coverage Period for this occurrence or Data Not Found.	Effective disenrollment date of the Part D plan or the End Date of the Employer Subsidy coverage for the beneficiary (tenth most recent).
Sending Entity	8	241 ... 248	X(8)	Sending Part D Organization (left justified space filled) Acceptable Values: 5-position Contract Identifier + 3 Spaces (3 Spaces are for Future Use)	The Sending Entity provided on the Header Record of the BEQ Request File in which the Transaction (Detail Record) was found. The Sending Entity may be a Part D Organization.

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
File Control Number	9	249 ... 257	X(9)	Assigned by Sending Entity	The File Control Number provided by the Sending Entity on the Header record of the BEQ Request File in which the Transaction (Detail Record) was found.
File Creation Date	8	258 ... 265	X(8)	CCYYMMDD	The File Creation Date provided on the Header Record of the BEQ Request File in which the Transaction (Detail Record) was found.
Part D Eligibility Start Date	8	266…273	X(8)	CCYYMMDD	This field identifies the date the beneficiary became eligible for Part D Benefits.
Deemed / Low Income Subsidy Effective Date (occurrence 1)	8	274…281	X(8)	CCYYMMDD	Effective start date of the deeming period or Low Income Subsidy. This will be the first day of the month in which the deeming was made or the start date of the Low Income Subsidy (most recent or presently active).
Deemed / Low Income Subsidy End Date (Occurrence 1)	8	282…289	X(8)	CCYYMMDD	The end date of the Deemed period or Low Income Subsidy (most recent or presently active).
Co-payment Level Identifier (Occurrence 1)	1	290…290	X(1)	Deemed: 2006 Values: 1 - High ($2/$5) 2 - Low ($1/$3) 3 - zero (no co-pay) 5 - unknown LIS: 2006 Values: 1 - High ($2/$5) 4 - 15%	This field indicates the Co-Payment level for the beneficiary.
Part D Premium Subsidy Percent (Occurrence 1)	3	291…293	X(3)	‘100’, ‘075’, ‘050’, ‘025’ or ‘000’	If beneficiary is Deemed, subsidy is 100 percent. If beneficiary is LIS, this field identifies the portion of Part D Premium subsidized.
Deemed/Low Income Subsidy Effective Date (Occurrence 2)	8	294…301	X(8)	CCYYMMDD	Effective start date of the deeming period or Low Income Subsidy. This will be the first day of the month in which the deeming was made or the start date of the Low Income Subsidy (second most recent).

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
Deemed/ Low Income Subsidy End Date (Occurrence2)	8	302…309	X(8)	CCYYMMDD	The end date of the Deemed period or Low Income Subsidy (second most recent).
Co-payment Level Identifier (Occurrence 2)	1	310…310	X(1)	Deemed: 2006 Values: 1 - High ($2/$5) 2 - Low ($1/$3) 3 - zero (no co-pay) 5 - unknown LIS: 2006 Values: 1 - High ($2/$5) 4 - 15%	This field indicates the Co-Payment level for the beneficiary.
Part D Premium Subsidy Percent (Occurrence 2)	3	311…313	X(3)	'100', '075', '050', '025' or '000'	If beneficiary is Deemed, subsidy is 100 percent. If beneficiary is LIS, this field identifies the portion of Part D Premium subsidized.
RDS/Part D Indicator (Occurrence 1 for date fields beginning in position 81)	1	314…314	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 2 for date fields beginning in position 97)	1	315…315	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 3 for date fields beginning in position 113)	1	316…316	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 4 for date fields beginning in position 129)	1	317…317	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 5 for date fields beginning in position 145)	1	318…318	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 6 for date fields beginning in position 161)	1	319…319	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 7 for date fields beginning in position 177)	1	320…320	X(1)	R = RDS D = Part D	

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
RDS/Part D Indicator (Occurrence 8 for date fields beginning in position 193)	1	321…321	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 9 for date fields beginning in position 209)	1	322…322	X(1)	R = RDS D = Part D	
RDS/Part D Indicator (Occurrence 10 for date fields beginning in position 225)	1	323…323	X(1)	R = RDS D = Part D	
Effective Date (Occurrence 1)	8	324…331	X(8)		
Number of Uncovered Months (Occurrence 1)	3	332…334	9(3)		
Number of Uncovered Months Status (Occurrence 1)	1	335…335	X(1)		
Effective Date (Occurrence 2)	8	336…343	X(8)		
Number of Uncovered Months (Occurrence 2)	3	344…346	9(3)		
Number of Uncovered Months Status (Occurrence 2)	1	347…347	X(1)		
Effective Date (Occurrence 3)	8	334…355	X(8)		
Number of Uncovered Months (Occurrence 3)	3	356…358	9(3)		
Number of Uncovered Months Status (Occurrence 3)	1	359…359	X(1)		
Effective Date (Occurrence 4)	8	360…367	X(8)		
Number of Uncovered Months (Occurrence 4)	3	368…370	9(3)		
Number of Uncovered Months Status (Occurrence 4)	1	371…371	X(1)		
Effective Date (Occurrence 5)	8	372…379	X(8)		
Number of Uncovered Months (Occurrence 5)	3	380…382	9(3)		
Number of Uncovered Months Status (Occurrence 5)	1	383…383	X(1)		
Effective Date (Occurrence 6)	8	384…391	X(8)		
Number of Uncovered Months (Occurrence 6)	3	392…394	9(3)		
Number of Uncovered Months	1	395…395	X(1)		

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
Status (Occurrence 6)					
Effective Date (Occurrence 7)	8	396…403	X(8)		
Number of Uncovered Months (Occurrence 7)	3	404…406	9(3)		
Number of Uncovered Months Status (Occurrence 7)	1	407…407	X(1)		
Effective Date (Occurrence 8)	8	408…415	X(8)		
Number of Uncovered Months (Occurrence 8)	3	416…418	9(3)		
Number of Uncovered Months Status (Occurrence 8)	1	419…419	X(1)		
Effective Date (Occurrence 9)	8	420…427	X(8)		
Number of Uncovered Months (Occurrence 9)	3	428…430	9(3)		
Number of Uncovered Months Status (Occurrence 9)	1	431…431	X(1)		
Effective Date (Occurrence 10)	8	432…439	X(8)		
Number of Uncovered Months (Occurrence 10)	3	440…442	9(3)		
Number of Uncovered Months Status (Occurrence 10)	1	443…443	X(1)		
Effective Date (Occurrence 11)	8	444…451	X(8)		
Number of Uncovered Months (Occurrence 11)	3	452…454	9(3)		
Number of Uncovered Months Status (Occurrence 11)	1	455…455	X(1)		
Effective Date (Occurrence 12)	8	456…463	X(8)		
Number of Uncovered Months (Occurrence 12)	3	464…466	9(3)		
Number of Uncovered Months Status (Occurrence 12)	1	467…467	X(1)		
Effective Date (Occurrence 13)	8	468…475	X(8)		
Number of Uncovered Months (Occurrence 13)	3	476…478	9(3)		
Number of Uncovered Months Status (Occurrence 13)	1	479…479	X(1)		
Effective Date (Occurrence 14)	8	480…487	X(8)		
Number of Uncovered Months	3	488…490	9(3)		

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
(Occurrence 14)					
Number of Uncovered Months Status (Occurrence 14)	1	491…491	X(1)		
Effective Date (Occurrence 15)	8	492…499	X(8)		
Number of Uncovered Months (Occurrence 15)	3	500…502	9(3)		
Number of Uncovered Months Status (Occurrence 15)	1	503…503	X(1)		
Effective Date (Occurrence 16)	8	504…511	X(8)		
Number of Uncovered Months (Occurrence 16)	3	512…514	9(3)		
Number of Uncovered Months Status (Occurrence 16)	1	515…515	X(1)		
Effective Date (Occurrence 17)	8	516…523	X(8)		
Number of Uncovered Months (Occurrence 17)	3	524…526	9(3)		
Number of Uncovered Months Status (Occurrence 17)	1	527…527	X(1)		
Effective Date (Occurrence 18)	8	528…535	X(8)		
Number of Uncovered Months (Occurrence 18)	3	536…538	9(3))		
Number of Uncovered Months Status (Occurrence 18)	1	539…539	X(1)		
Effective Date (Occurrence 19)	8	540…547	X(8)		
Number of Uncovered Months (Occurrence 19)	3	548…550	9(3)		
Number of Uncovered Months Status (Occurrence 19)	1	551…551	X(1)		
Effective Date (Occurrence 20)	8	552…559	X(8)		
Number of Uncovered Months (Occurrence 20)	3	560…562	9(3)		
Number of Uncovered Months Status (Occurrence 20)	1	563…563	X(1)		
Number of Uncovered Months Total	4	564…567	9(4)		

Updated Batch Eligibility Query (BEQ) Response File

Data Field	Length	Position	Format	Valid Values	Field Definition
FILLER	183	568…750	X(183)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

BEQ Response Trailer Record

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"**CMSBEQRT**"	This field will always be set to the value "**CMSBEQRT.**" This code identifies the record as the Trailer Record of a Batch Eligibility Query (BEQ) Response File.
Sending Entity (MBD)	8	9 … 16	X(8)	"MBD " (MBD + 5 Spaces)	This field will always be set to the value "MBD „ The value specifically is MBD + 5 following Spaces. This value will agree with the corresponding value in the Header Record.
File Creation Date	8	17 … 24	X(8)	CCYYMMDD	The date on which the BEQ Response File was created by CMS. This value will be formatted as CCYYMMDD. For example, January 3, 2010 would be the value 20100103. This value will agree with the corresponding value in the Header Record.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity (MBD)	The specific Control Number assigned by CMS to the BEQ Response File. CMS will utilize this value to track the BEQ Response File through CMS processing and archive. This value will agree with the corresponding value in the Header Record.
Record Count	7	34 … 40	9(7)	Numeric value greater than Zero.	The total number of Transactions (Detail Records) on the BEQ Response File. This value will be right-justified in the field, with leading zeros. This value will not include non-numeric characters, such as commas, spaces, dashes, decimals.
FILLER	710	41 … 750	X(710)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

Updated Transaction Reply Report (TRR) Data File

Field	Size	Position	Description
1. Claim Number	12	1 – 12	Claim Account Number
2. Surname	12	13 – 24	Beneficiary Surname
3. First Name	7	25 – 31	Beneficiary Given Name
4. Middle Name	1	32	Beneficiary Middle Initial
5. Sex Code	1	33	Beneficiary Sex Identification Code '0' = Unknown '1' = Male '2' = Female
6. Date of Birth	8	34 – 41	YYYYMMDD Format
7. Filler	**1**	**42**	**Space**
8. Contract Number	5	43 – 47	Plan Contract Number
9. State Code	2	48 – 49	Beneficiary Residence State Code
10. County Code	3	50 – 52	Beneficiary Residence County Code
11. Disability Indicator	1	53	'1' = Disabled '0' = No Disability
12. Hospice Indicator	1	54	'1' = Hospice '0' = No Hospice
13. Institutional/NHC Indicator	1	55	'1' = Institutional '2' = NHC '0' = No Institutional
14. ESRD Indicator	1	56	'1' = End-Stage Renal Disease '0' = No End-Stage Renal Disease
15. Transaction Reply Code	3	57 – 59	Transaction Reply Code
16. Transaction Type Code	2	60 – 61	Transaction Type Code
17. Entitlement Type Code	1	62	Beneficiary Entitlement Type Code: 'Y' = Entitled to Part A and B Blank = Entitled to Part A or B

Updated Transaction Reply Report (TRR) Data File

Field	Size	Position	Description
18. Effective Date	8	63 – 70	YYYYMMDD Format; Effective date is present for all Transaction Reply Codes. However, for UI Transaction Reply Codes (TRC), field content is TRC dependent: 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 can be found in field 24.X.
19. WA Indicator	1	71	'1' = Working Aged '0' = No Working Aged
20. Plan Benefit Package ID	3	72 – 74	PBP number
21. Filler	1	75	Spaces
22. Transaction Date	8	76 – 83	YYYYMMDD Format; Present for all transaction reply codes
23 UI Initiated Change Flag	1	84	'1' = transaction created through user interface '0' = transaction from source other than user interface
24. Positions 85 – 96 are dependent upon the value of the TRANSACTION REPLY CODE. There are spaces for all codes except where indicated below.			
a. Effective Date of the Disenrollment	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 13, 14, 18, 84
b. New Enrollment Effective Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 17, 83
c. Claim Number (new)	12	85 – 96	Present only when Transaction Reply Code is one of the following: 22, 25, 86

Updated Transaction Reply Report (TRR) Data File

Field	Size	Position	Description
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 Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 71
f. Hospice End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 72
g. ESRD Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 73
h. ESRD End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 74
i. Institutional/ NHC Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is one of the following: 48, 75, 158, 159
j. Medicaid Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 77
k. Medicaid End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 78
l. Part A End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 79
m. WA Start Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 66
n. WA End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 67
o. Part A Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 80
p. Part B End Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 81
q. Part B Reinstate Date	8	85 – 92	YYYYMMDD Format; Present only when Transaction Reply Code is 82
r. New SCC	5	85 – 89	Beneficiary Residence State and County Code; Present only when Transaction Reply Code is 85
s. 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
t. New Low-Income Premium Subsidy	12	85 – 96	ZZZZZZZZ9.99 Format; Part D low-income premium subsidy amount. Present only when Transaction Reply Code is 167.

Updated Transaction Reply Report (TRR) Data File

Field	Size	Position	Description
u. New Low-income Cost Sharing Subsidy	1	85 – 85	The beneficiary's Part D low-income subsidy status has changed, resulting in a co-pay level change. The new co-pay level is: '1' = (High) '2' = (Low) '3' = (0) '4' = 15% Present only when Transaction Reply Code is 168.
v. PBP Effective Date	8	85 – 92	YYYYMMDD Format. Effective date of a beneficiary's PBP change. Present only when Transaction Reply Code is 100.
w. 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.
x. 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.
y. 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.**
25. District Office Code	3	97 – 99	Code of the originating district office; Present only when Transaction Type Code is 53
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 blank. CCCCC = Contract Number PPP = Plan Benefit Package (PBP) Number
27. Filler	8	108 – 115	Spaces
28. Source ID	5	116 – 120	Transaction Source Identifier
29. Prior Plan Benefit Package ID	3	121 – 123	Prior PBP number; present only when transaction type code is 71
30. Application Date	8	124 – 131	The date the plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper). Format: YYYYMMDD

Updated Transaction Reply Report (TRR) Data File

Field	Size	Position	Description
31. UI User Organization Designation	2	132 – 133	'02' = Regional Office, '03' = Central Office, Blank if not UI transaction
32. Out of Area Flag	1	134 – 134	Out of Area Indicator
33. Segment Number	3	135 – 137	Further definition of PBP by geographic boundaries
34. Part C Beneficiary Premium	8	138 – 145	Cost to beneficiary for Part C benefits
35. Part D Beneficiary Premium	8	146 – 153	Cost to beneficiary for Part D benefits
36. Election Type	1	154 – 154	'A' = AEP; 'E' = IEP;'I' = ICEP; 'O' = OEP; 'N' = OEPNEW; 'T' = OEPI 'S'= **Other** SEP; **'U'=Dual/LIS SEP;** **'V'=Permanent Change in Residence SEP;** **'W'=EGHP SEP;** **'X'=Administrative Action SEP;** **'Y'=CMS/Case Work SEP.** **MAs use I, A, N, O, S, T, U, V, W, X, and Y.** MAPDs use I, A, E, N, O, S, T, **U, V, W, X, Y.** PDPs use A, E, S, **U, V, W, X, and Y.**
37. Enrollment Source	1	155 – 155	'A' = Auto enrolled by CMS; 'B' = Beneficiary Election; 'C' = Facilitated enrollment by CMS; 'D' = CMS Annual Rollover; **'E' = Plan initiated auto-enrollment;** **'F' = Plan initiated facilitated-enrollment;** **'G' = Point-of-sale enrollment;** **'H' = CMS or Plan reassignment** **'I' = Invalid submitted value (transaction is not rejected)**
38. Part D Opt-Out Flag	1	156 – 156	'Y' = Opt-out of auto-enrollment; **'N' = Opted out of auto-enrollment;** Blank = No change to opt-out status
39. Premium Withhold Option/Parts C-D	1	157 – 157	'D' = Direct self-pay 'S' = Deduct from SSA benefits 'R' = Deduct from RRB benefits 'O' = Deduct from OPM benefits 'N' = No premium applicable Option applies to both Part C and D Premiums
40. Number of Uncovered Months	3	158 – 160	Count of Total Months without drug coverage
41. Creditable Coverage Flag	1	161 – 161	'Y' = Covered 'N' = Not Covered **'R' = Setting uncovered months to zero due to a new IEP** **'U' = Setting uncovered months to the value prior to using R**

Updated Transaction Reply Report (TRR) Data File

Field	Size	Position	Description
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.
43. Processing Timestamp	15	163 – 177	Transaction processing time, Format: HH.MM.SS.SSSSSS
44. Filler	20	178 – 197	Spaces
45. Secondary Drug Insurance Flag	1	198-198	Type 61 & 71 MA-PD and PDP transactions: 'Y' = Beneficiary has secondary drug insurance 'N' = Beneficiary does not have secondary drug insurance available Blank – Do not know whether beneficiary has secondary drug insurance Type 72 MA-PD and PDP transactions: 'Y' = Secondary drug insurance available 'N' = No secondary drug insurance available Blank = no change
46. Secondary Rx ID	20	199 – 218	Secondary insurance Plan's ID number for beneficiary
47. Secondary Rx Group	15	219 – 233	Secondary insurance Plan's Group ID number for beneficiary
48. EGHP	1	234 - 234	Type 60, 61, 71 transactions: 'Y' = EGHP Blank = not EGHP Type 72 transactions: 'Y' = EGHP 'N' = Not EGHP Blank = no change
49. Part D Low-Income Premium Subsidy Level	3	235 – 237	Part D low-income premium subsidy category: '000' = No subsidy, '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 '1' = (High) '2' = (Low) '3' = (0) '4' = 15% '5' = Unknown
51. Low-Income Co-Pay Effective Date	8	239 - 246	Date co-pay category became effective, YYYYMMDD.
52. 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

Updated Transaction Reply Report (TRR) Data File

Field	Size	Position	Description
53. Part D Late Enrollment Penalty Waived Amount	8	255 - 262	Amount of Part D late enrollment penalty waived. Format: -9999.99
54. Part D Late Enrollment Penalty Subsidy Amount	8	263 - 270	Amount of Part D late enrollment penalty low-income subsidy. Format: -9999.99
55. Low-Income Part D Premium Subsidy Amount	8	271- 278	Amount of Part D low-income premium subsidy. Format: -9999.99
56. Part D Rx BIN	6	279 - 284	Beneficiary's Part D Rx BIN taken from the input transaction (60/61, 71, or 72); otherwise, blank if not provided
57. Part D Rx PCN	10	285 - 294	Beneficiary's Part D Rx PCN taken from the input transaction (60/61, 71, or 72); otherwise, blank if not provided
58. Part D Rx Group	15	295 - 309	Beneficiary's Part D Rx Group taken from the input transaction (60/61, 71, or 72); otherwise, blank if not provided
59. Part D Rx ID	20	310 - 329	Beneficiary's Part D Rx ID taken from the input transaction (60/61, 71, or 72); otherwise, blank if not provided
60. Secondary Rx BIN	6	330 - 335	Beneficiary's secondary insurance BIN taken from the input transaction (60/61, 71, or 72); otherwise, blank if not provided
61. Secondary Rx PCN	10	336 - 345	Beneficiary's secondary insurance PCN taken from the input transaction (60/61, 71, or 72); otherwise, blank if not provided
62. 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**
62. Filler	147	354 - 500	Spaces

Updated Transaction Reply Report (TRR)

1RUN DATE: 08/02/2007 TRANSACTION REPLIES/WEEKLY ACTIVITY REPORT ID: 10

REPORTING MONTH: 09/2007 PLAN(S5967) PBP(056) SGMT(000) WELLCARE PRESCRIPTION INSURANCE, INC. PAGE: 4

* * * TRANSACTION REPLY SUMMARY * * *

0	TC 72	TC 71	TC 60	TC 61	**TC 62**	TC 51	TC 53	TC 54	TC 30	TC 31	**TC OTH**	ALL
+												
ACCEPTED ACTN	0	0	0	5	0	0	0	0	0	0	0	5
0REJECTED ACTN	0	0	0	0	0	0	0	0	0	0	0	0
0REGION ACTNS	0	0	0	0	0	0	0	0	0	0	0	0
0CNTRL OFFICE ACT	0	0	0	0	0	0	0	0	0	0	0	0
0DISTR OFFICE ACT	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0
0MCARE CUST SRVC	0	0	0	0	0	0	0	0	0	0	0	0
ACCEPTED:	0	0	0	0	0	0	0	0	0	0	0	0
REJECTED:	0	0	0	0	0	0	0	0	0	0	0	0
0BENE FACT ACTN	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0
ACCEPTED:	0	0	0	0	0	0	0	0	0	0	0	0
REJECTED:	0	0	0	0	0	0	0	0	0	0	0	0
0AUTO DISENROLL	0	0	0	0	0	0	0	0	0	0	0	0
0MAINTENANCE	0	0	0	0	0	0	0	0	0	0	0	0
ACCEPTED:	0	0	0	5	0	0	0	0	0	0	0	5
0** TOTAL ACTNS*	0	0	0	5	0	0	0	0	0	0	0	5
REJECTED:	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0
0* ORBIT/PENDING *	0	0	0	0	0	0	0	0	0	0	0	0
ACCEPTED:												
REJECTED:												

Monthly Membership Detail Data File

#	Field Name	Len	Pos	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	HIC Number	12	20-31	Member's HIC #
5	Surname	7	32-38	
6	First Initial	1	39-39	
7	Sex	1	40-40	M = Male, F = Female
8	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10	State & County Code	5	53-57	
11	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12	Part A Entitlement	1	59-59	Y = Entitled to Part A
13	Part B Entitlement	1	60-60	Y = Entitled to Part B
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD
16	Aged/Disabled MSP	1	63-63	Y = Aged/Disabled MSP
17	Institutional	1	64-64	Y = Institutional (monthly)
18	NHC	1	65-65	Y = Nursing Home Certifiable
19	Medicaid	1	66-66	Y = Medicaid Status
20	LTI Flag	1	67-67	Y = Part C Long Term Institutional
21	Medicaid Indicator	1	68-68	Y = Medicaid Addon
22	PIP-DCG	2	69-70	PIP-DCG Category - Only on pre-2004 adjustments
23	Default Indicator	1	71-71	Y = default RA factor in use • For pre-2004 adjustments, a "Y" indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a "Y" indicates that a default factor was generated by the system due to lack of a RA factor.
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28	Adjustment Reason Code	2	90-91	FORMAT: 99 Always Spaces on Payment and MSA Deposit or Recovery Records
29	Paymt/Adjustment/MSA Start Date	8	92-99	FORMAT: YYYYMMDD
30	Paymt/Adjustment/MSA End Date	8	100-107	FORMAT: YYYYMMDD
31	Demographic Paymt/Adjustmt Rate A	9	108-116	FORMAT: -99999.99
32	Demographic Paymt/Adjustmt Rate B	9	117-125	FORMAT: -99999.99

Monthly Membership Detail Data File

#	Field Name	Len	Pos	Description
33	Risk Adjuster Paymt/Adjustmt Rate A	9	126-134	Part A portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
34	Risk Adjuster Paymt/Adjustmt Rate B	9	135-143	Part B portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
35	LIS Premium Subsidy	8	144-151	FORMAT: -9999.99
36	ESRD MSP Flag	1	152-152	Format X. Values = 'Y' or 'N'(default) Indicates if Medicare is the Secondary Payer
37	**MSA Part A Deposit/Recovery Amount**	**8**	**153-160**	**Medicare Savings Account (MSA) lump sum Part A dollars to be deposited/recovered. Deposits are positive values and recoveries are negative. FORMAT: -9999.99**
38	**MSA Part B Deposit/Recovery Amount**	**8**	**161-168**	**Medicare Savings Account (MSA) lump sum Part B dollars to be deposited/recovered. Deposits are positive values and recoveries are negative. FORMAT: -9999.99**
39	**MSA Deposit/Recovery Months**	**2**	**169-170**	**Number of months associated with MSA deposit or recovery dollars**
40	**FILLER**	**1**	**171-171**	**SPACES**
41	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
42	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – Only on pre-2004 adjustments
43	**De Minimis**	**1**	**183-183**	**'N' = "de minimis" does not apply 'Y' = "de minimis" applies**
44	**Filler**	**1**	**184-184**	**Spaces**
45	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999
46	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native

Monthly Membership Detail Data File

#	Field Name	Len	Pos	Description
47	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) E1 = New Enrollee Post-Graft I (ESRD) E2 = New Enrollee Post-Graft II (ESRD) G1 = Graft I (ESRD) G2 = Graft II (ESRD) I = Institutional I1 = Institutional Post-Graft I (ESRD) I2 = Institutional Post-Graft II (ESRD)
48	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
49	Original Reason for Entitlement Code (OREC)	1	192-192	0 = Beneficiary insured due to age 1 = Beneficiary insured due to disability 2 = Beneficiary insured due to ESRD 3 = Beneficiary insured due to disability and current ESRD
50	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months
51	Segment ID	3	194-196	Identification number of the segment of the PBP. Blank if there are no segments.
52	Enrollment Source	1	197	The source of the enrollment. Values are A = Auto-enrolled by CMS, B = Beneficiary election, C = Facilitated enrollment by CMS, D = Systematic enrollment by CMS (rollover), E = Auto-enrolled by Plans, F = Facilitated enrollment by Plans, G = POS submitted enrollment, H= Re-assignment enrollment by CMS or Plans and I=Enrollments submitted by plans with enrollment source other than B, E, F, G, H and blank.
53	EGHP Flag	1	198	Employer Group flag; Y = member of employer group, N = member is not in an employer group
54	Part C Basic Premium – Part A Amount	8	199-206	The premium amount for determining the MA payment attributable to Part A. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
55	Part C Basic Premium – Part B Amount	8	207-214	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
56	Rebate for Part A Cost Sharing Reduction	8	215-222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99

Monthly Membership Detail Data File

#	Field Name	Len	Pos	Description
57	Rebate for Part B Cost Sharing Reduction	8	223-230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
58	Rebate for Other Part A Mandatory Supplemental Benefits	8	231-238	The amount of the rebate allocated to providing Part A supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
59	Rebate for Other Part B Mandatory Supplemental Benefits	8	239-246	The amount of the rebate allocated to providing Part B supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
60	Rebate for Part B Premium Reduction – Part A Amount	8	247-254	The Part A amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -9999.99
61	Rebate for Part B Premium Reduction – Part B Amount	8	255-262	The Part B amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non ESRD members and it is subtracted from ESRD member's payments. -9999.99
62	Rebate for Part D Supplemental Benefits – Part A Amount	8	263–270	Part A Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
63	Rebate for Part D Supplemental Benefits – Part B Amount	8	271–278	Part B Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
64	Total Part A MA Payment	10	279–288	The total Part A MA payment. -999999.99
65	Total Part B MA Payment	10	289–298	The total Part B MA payment. -999999.99
66	Total MA Payment Amount	11	299-309	The total MA A/B payment including MMA adjustments. This also includes the Rebate Amount for Part D Supplemental Benefits -9999999.99
67	Part D RA Factor	7	310-316	The member's Part D risk adjustment factor. NN.DDDD
68	Part D Low-Income Indicator	1	317	An indicator to identify if the Part D Low-Income multiplier is included in the Part D payment. Values are 1 (subset 1), 2 (subset 2) or blank.
69	Part D Low-Income Multiplier	7	318-324	The member's Part D low-income multiplier. NN.DDDD
70	Part D Long Term Institutional Indicator	1	325	An indicator to identify if the Part D Long-Term Institutional multiplier is included in the Part D payment. Values are A (aged), D (disabled) or blank.
71	Part D Long Term Institutional Multiplier	7	326-332	The member's Part D institutional multiplier. NN.DDDD

Monthly Membership Detail Data File

#	Field Name	Len	Pos	Description
72	Rebate for Part D Basic Premium Reduction	8	333-340	Amount of the rebate allocated to reducing the member's basic Part D premium. -9999.99
73	Part D Basic Premium Amount	8	341-348	The plan's Part D premium amount. -9999.99
74	Part D Direct Subsidy Payment Amount	10	349-358	The total Part D Direct subsidy payment for the member. -999999.99
75	Reinsurance Subsidy Amount	10	359-368	The amount of the reinsurance subsidy included in the payment. -999999.99
76	Low-Income Subsidy Cost-Sharing Amount	10	369-378	The amount of the low-income subsidy cost-sharing amount included in the payment. -999999.99
77	Total Part D Payment	11	379-389	The total Part D payment for the member -9999999.99.
78	Number of Paymt/Adjustmt Months Part D	2	390-391	99
79	PACE Premium Add On	10	392-401	Total Part D Pace Premium Addon amount -999999.99
80	PACE Cost Sharing Addon	10	402-411	Total Part D Pace Cost Sharing Addon amount -999999.99

Updated Monthly Membership Detail Report – Drug Report File (Part D)

1RUN DATE:20061027 MONTHLY MEMBERSHIP REPORT - DRUG PAGE:1

PAYMENT MONTH:200601 PLAN(H9999) PBP(999) SEGMENT(000) ACME HEALTH SERVICES

0 BASIC PREMIUM | ESTIMATED REINSURANCE

$10.60 | $0.00

0					FLAGS							PAYMENTS/ADJUSTMENTS						
CLAIM NUMBER	S E X	AGE GRP	STATE CNTY		P A A	P R R	E G U	0 O I	L I N	O N S	D E M	ADJ REA	RA FCTR START	DATES END	LOW-INCOME COST SHARING PERCENTAGE	LOW-INCOME COST SHARING SUBSIDY		
		DMG RA	BIRTH DATE	O A	T A	T B	H P	R C	C C	T T	N N	MTHS D	DIRECT SUBSIDY PAYMENT AMT		PACE PREMIUM ADD-0N	PACE COST SHARING ADD-ON		TOTAL PAYMENT
SURNAME F																		
123456789A	F	5559	33700										1.9770	200601	200601	000		$0.00
	S	5559	19491130			B			N		1		$129.17		$0.00	$0.00		$129.17
987654321A	F	8084	10050										1.0300	200601	200601	000		$0.00
FIRST	M	8084	19240306			B			Y		1		$62.22		$0.00	$0.00		$62.22
I																		
SECOND																		

PART D

Updated Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File

Header Record

Item	Field Name	Len	Pos	Description
1	Record Type	3	1-3	H = Header Record PIC XXX
2	MCO Contract Number	5	4-8	MCO Contract Number PIC X(5)
3	Payment/Payment Adjustment Date	6	9-14	YYYYMM First 6 digits contain Current Payment Month PIC 9(6)
4	Data file Date	8	15-22	YYYYMMDD Date this datafile created PIC 9(8)
5	FILLER	143	23-165	Spaces

Detail Record

Item	Field Name	Len	Pos	Description
1	Record Type	3	1-3	PD = Prospective Detail Record "Prospective" means Premium Period equals Payment Month reflected in Header Record AD = Adjustment Detail Record "Adjustment" means all premium periods other than Prospective PIC XXX
	***** PLAN IDENTIFICATION**			
2	MCO Contract Number	5	4-8	MCO Contract Number PIC X(5)
3	Plan Benefit Package Number	3	9-11	Plan Benefit Package Number PIC X(3)

Updated Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File

Item	Field Name	Len	Pos	Description
4	Plan Segment Number	3	12-14	Plan Segment Number PIC X(3)
	***** BENEFICIARY IDENTIFICATION & PREMIUM SETTINGS**			
5	HIC Number	12	15-26	Member's HIC # PIC X(12)
6	Surname	7	27-33	PIC X(7)
7	First Initial	1	34	PIC X
8	Sex	1	35	M = Male, F = Female PIC X
9	Date of Birth	8	36-43	YYYYMMDD PIC 9(8)
10	FILLER	1	44	Space
	***** PREMIUM PERIOD**			
11	Premium/Adjustment Period Start Date	6	45-50	PD: current processing month. AD: adjustment period. YYYYMM PIC 9(6)
12	Premium/Adjustment Period End Date	6	51-56	PD: current processing month. AD: adjustment period. YYYYMM PIC 9(6)
13	Number of Months in Premium/Adjustment Period	2	57-58	PIC 99

Updated Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File

Item	Field Name	Len	Pos	Description
14	PD: Net Monthly Part D Basic Premium AD: Net Monthly Part D Basic Premium Amount	8	59-66	Plan's Part D Basic Rate in effect for this premium period Net is Monthly Part D Basic Premium (minus) **DE MINIMIS DIFFERENTIAL.** NOTE: PD always equals AD for this field PIC -9999.99
15	Low Income Premium Subsidy Percentage	3	67-69	Low Income Premium Subsidy Percentage Subsidy percentage in effect for this premium period Valid values: 100, 075, 050, 025, Blank PIC 999
16	Premium Payment Option	1	70	Current view of Premium payment option. **Valid values:** D (direct bill) S (SSA withhold) R (RRB withhold) O (OPM withhold) N (no premium applicable) PIC X
	***** ACTIVITY FOR PREMIUM PERIOD**			

Updated Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File

Item	Field Name	Len	Pos	Description
17	Premium Low Income Subsidy Amount	8	71-78	PD: Premium Low Income Subsidy Amount – the portion of the Part D basic premium paid by the Government on behalf of a low income individual AD: For adjustments, compute the adjustment for each month in the (affected) payment period if the payment has already been made. PIC -9999.99
18	Net Late Enrollment Penalty Amount for Direct Billed Members	8	79-86	PD: Late Enrollment Penalty Amount for Direct Billed Members owed by beneficiary for premium period. This amount is net of any subsidized amounts for eligible LIS members. Net Late Enrollment Penalty Amount for Direct Billed Members = Late Enrollment Penalty Amount (minus) LEP Subsidy Amount (minus) Part D Penalty Waived Amount AD: For adjustments, compute the adjustment for each month in the (affected) payment period if the payment has already been made. PIC -9999.99

Updated Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File

Item	Field Name	Len	Pos	Description
19	Net Amount Payable to Plan	8	87-94	PD: Net Amount Payable to Plan = Premium Low Income Subsidy Amount (field 16) (minus) Net Late Enrollment Penalty Amount for Direct Billed Members (field 17) AD: For adjustments, compute the adjustment for each month in the (affected) payment period if the payment has already been made. PIC -9999.99
20	FILLER	71	95-165	Spaces

Updated Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File

Trailer Record

Totals by Contract, Plan and Segment for this Premium LIS/LEP data file

Item	Field Name	Len	Pos	Description
1	Record Type	3	1-3	PT1 = Trailer Record, Prospective Totals at Segment Level PT2 = Trailer Record, Prospective Totals at PBP Level PT3 = Trailer Record, Prospective Totals at Contract Level AT1 = Trailer Record, Adjustment Totals at Segment Level AT2 = Trailer Record, Adjustment Totals at PBP Level AT3 = Trailer Record, Adjustment Totals at Contract Level CT1 = Trailer Record, Combined Totals at Segment Level CT2 = Trailer Record, Combined Totals at PBP Level CT3 = Trailer Record, Combined Totals at Contract Level PIC XXX
	***** PLAN IDENTIFICATION**			
2	MCO Contract Number	5	4-8	MCO Contract Number PIC X(5)
3	Plan Benefit Package Number	3	9-11	Plan Benefit Package Number Not populated on T3 records PIC X(3)
4	Plan Segment Number	3	12-14	Plan Segment Number Not populated on T2 or T3 records PIC X(3)

Updated Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File

Item	Field Name	Len	Pos	Description
5	Total Premium Low Income Subsidy Amount	14	15-28	Total of All Beneficiary Premium Low Income Subsidy Amounts At Level Indicated By Record Type PIC -9(10).99
6	Total Late Enrollment Penalty Amount (net of subsidized amounts for eligible LIS members.)	14	29-42	Total of All Beneficiary Late Enrollment Penalty Amounts At Level Indicated By Record Type PIC -9(10).99
7	Total Net Amount Payable to Plan for Direct Billed Beneficiaries	14	43 - 56	Total Net Amount Payable to Contract for Direct Billed Beneficiaries = Total Premium Low Income Subsidy Amount (field 5) (minus) Total Late Enrollment Penalty Amount Net of any Subsidy (field 6) PIC -9(10).99
8	FILLER	109	57-165	Spaces

Updated Bi-Weekly Deemed LIS/Premium Report Data File

Field	Size	Position	Description
1. Claim Number	12	1 – 12	Beneficiary's Claim Account Number
2. Contract Number	5	13 – 17	Contract Identification Number
3. PBP Number	3	18 – 20	Beneficiary's Plan Benefit Package Identification Number, 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
6. Subsidy Start Date	8	32 - 39	Beneficiary's Subsidy Start Date, YYYYMMDD
7. Subsidy End Date	8	40 – 47	Beneficiary's Subsidy End Date, YYYYMMDD
8. Part D Premium Subsidy Percentage	3	48 – 50	Beneficiary's Low-Income Premium Subsidy 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 – 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, Format: YYYYMMDD
11. Beneficiary Enrollment End Date	8	60 - 67	Beneficiary's Enrollment End Date, Format: YYYYMMDD Can be blank
12. Part C Premium Amount	8	68 – 75	**Beneficiary's Part C Premium Amount, (----9.99)**
13. Part D Premium Amount	8	76 – 83	**Beneficiary's Part D Premium Amount Net of De Minimis if Applicable, (----9.99)**
14. Part D Late Enrollment Penalty Amount	8	84 - 91	Beneficiary's Part D Late Enrollment Penalty 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**