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

DATE: August 25, 2008

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

FROM: Alan Constantian /s/
Director, Information Services Design and Development Group

SUBJECT: **Updated - Announcement of Fall Software Release**

This memo, originally published on August 11, 2008 has been updated with additional information.

CMS will be implementing software improvements to the eligibility, enrollment and payment suite of systems supporting the Medicare Modernization Act (MMA) as of November 9, 2008 that affects Plan exchanges with CMS starting that same calendar month. This memo provides information regarding these changes so that Plans may assess the impact on their organization and accommodate the changes described below.

Plans should be aware that all information is approximate and subject to change. The MMA Help Desk will communicate any changes that occur after this memo is published.

The changes for the fall 2008 software release are categorized as follows:

1. Loss of Subsidy (Deemed Status) Data File
2. Monthly Membership Report (MMR)
3. Cost Plans and the Part C Premium
4. Updates to Beneficiary Data via the Common UI
5. New and Revised Transaction Reply Codes (TRCs) for Premium Withhold Option
6. Part C Risk Adjustment Model Output Data File

1. Loss of Subsidy (Deemed Status) Data File

Pursuant to the Low Income Subsidy (LIS) deeming process, in which LIS beneficiaries automatically qualify for the LIS, CMS sends two Loss of Subsidy files to Part D Plans each fall.

The first file is sent in September and identifies members who will receive a joint CMS and SSA letter informing them they will no longer be deemed for the following year. The second file is sent in December and is an updated version of the September file, indicating those beneficiaries who still do not have deemed status for the following year.

The September 2008 Loss of Subsidy file format will be based on an older version of the Transaction Reply Report (TRR) that had a total of 278 bytes. Some fields, however, will contain spaces rather than be populated with values and the Transaction Reply Code populating field 15 will be '996'. A copy of this file layout, which was documented in the December 2007 version of the *Plan Communications User Guide (PCUG)* as Appendix E.18, is provided as *Attachment A: Loss of Subsidy (Deemed Status) Data File (Current Version).*

The December 2008 Loss of Subsidy file format will be different than the format of the September 2008 file. It will be expanded to 500 bytes in length. A copy of this layout is provided as *Attachment B: Loss of Subsidy (Deemed Status) Data File (Expanded Version).*

Both files will follow the standard naming conventions outlined below:

Gentran Mailbox
P.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst.pn

Connect:Direct [Mainframe]
zzzzzzzz.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst

Connect:Direct [Non-mainframe]
[directory]Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst

The current version of the PCUG may be referenced at
http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp.

2. Monthly Membership Report (MMR)

CMS is updating the MMR data file and report to provide information at a more detailed level in several existing fields. Some fields will be modified to help Plans better identify whether a beneficiary's Medicaid status was used in the calculation of the Plan's payment Also, the De Minimis field will be populated differently in 2009 to address upcoming changes to the De Minimis policy. The detailed file layout for the MMR is located in *Attachment C: Monthly Membership Detail Data File*.

A. Medicaid Beneficiary Status / Medicaid Indicator

Currently, field 19 (New Medicare Beneficiary Medicaid Status Flag) is populated only for beneficiaries who are too new to Medicare to have been included in the periodic calculation of risk adjustment factors based on their diagnostic data. For these beneficiaries, CMS uses default risk factors which are adjusted by an add-on if the beneficiary is in Medicaid status. The value in

field 19 communicates whether the Medicaid add-on was included in the beneficiary's default factor.

Prior to 2008, the demographic portion of a Plan's Part C payment could also have been adjusted. Effective with the MMR data file and report transmitted in December 2008 for the January 2009 payment month, when the record represents a payment or adjustment for a month prior to 2008, field 19 will not only communicate whether the beneficiary's Medicaid status for that payment month affected the Part C payment or adjustment, but also whether the demographic portion of that payment was adjusted.

Field 19 values, starting with January 2009:

For pre-2008 payments and adjustments:
Y = Medicaid and demographic portion adjustment
N = Not Medicaid and demographic portion adjusted
Blank = No demographic adjustment

For payments and adjustments effective on/after January 1, 2008:
Y = Default factor used with Medicaid
N = Default factor used without Medicaid
Blank = Part D MMR record or the Part C factor was calculated by RAS (no default was used)

Also, since the November 2007 release, when the change to MMR detail field 19 was implemented, the Medicaid counts and dollars on the Monthly Membership Summary Report (MMSR) have been understated. As of the November 2008 release, the Medicaid counts and dollars will reflect all payments for which the beneficiary's Medicaid status was included in the payment calculation. This includes payments for which the default or RAS-calculated risk adjustment factor was affected by the beneficiary's Medicaid status at the time the factor was determined. There has been no change to the medical status hierarchy so Medicaid beneficiaries who have Hospice or ESRD will not be reported in the Medicaid counts but in the counts for Hospice or ESRD.

B. Default Risk Factor Code

MMR field 23 (Default Indicator) is currently populated with Y when a beneficiary is too new to Medicare to have a risk adjustment factor that has been calculated based on their diagnostic data. In this case, CMS uses a default risk adjustment factor that is selected based on the beneficiary's demographic characteristics, including age, disability and ESRD status. Effective with the November 2008 release, the name and values of field 23 are being modified to provide Plans with information on the selected payment model(s) being used for a new enrollee. MMR field 23 will now be defined as the 'Default Risk Factor Code'.

The new values are:

1 – Default Enrollee – Aged/Disabled
2 – Default Enrollee – ESRD Dialysis

3 – Default Enrollee – ESRD with Kidney Transplant, Month 1
4 – Default Enrollee – ESRD with Kidney Transplant, Months 2 – 3
5 – Default Enrollee – ESRD Post Graft, Months 4 – 9
6 – Default Enrollee – ESRD Post Graft, Months 10 +
Blank – Not a default enrollee - Risk Adjustment Factor calculated by CMS

C. De Minimis Policy Ending

Effective December 31, 2008, the De Minimis policy will end. Plans can expect to see a value of 'N' in field 43 (De Minimis Flag) for 2009 and beyond.

Field 43 values:

2009 and later:
N = 'De Minimis' does not apply

2008 and earlier
N = 'De Minimis' does not apply
Y = 'De Minimis' applies

D. Risk Adjustment Factor Type Code

Effective with the MMR data file and report transmitted in December 2008 for the January 2009 payment, field 47 (RA Factor Type Code) values will be modified. The RA Factor Type Code indicates the type of beneficiary-specific risk factor used in the calculation of the payments and adjustments.

Valid values include the following:

C – Community
C1 – Community Post-Graft I
C2 – Community Post-Graft II
D – Dialysis (ESRD)
E – New Enrollee
ED – New Enrollee Dialysis
E1 – New Enrollee Post-Graft I
E2 – New Enrollee Post-Graft II
G1 – Transplant (Graft) Month 1
G2 – Transplant (Graft) Months 2-3
I – Institutional
I1 – Institutional Post-Graft I
I2 – Institutional Post-Graft II
Blank – Part C Default C risk factor used in the calculation

3. Cost Plans and the Part C Premium

Effective January 2009, Cost Plans will have the ability to have beneficiaries' Part C premiums withheld from their Social Security checks. Currently, only the Part D premiums may be withheld. In order to take advantage of this new functionality, Cost Plans must have submitted bids for their 2009 non-drug PBPs so that the associated Part C premium amounts are recorded in the HPMS system. MARx will only allow Part C premium amounts that correspond to the amounts in HPMS. If a Cost Plan submits a Part C premium amount for Social Security withhold that does not match what is in HPMS for a particular PBP, the premium will be set to what is in HPMS and the premium payment option changed to 'D' - Direct Bill.

4. Updates to Beneficiary Data via the Common UI

Currently, the Beneficiary Detail: Medicaid (M236) screen reflects a Medicaid Source of 'Plan' or 'CMS User', depending on how a plan-reported Medicaid update was made in the CMS systems. Starting in December, all plan-reported Medicaid status, regardless of how the data was entered, will be shown as 'Plan reported'.

In addition, all Medicaid adjustments made via the Common UI are reflected on the Monthly Membership Detail Report (MMDR) – Drug Report (Part D). This existing functionality is not impacted by the changes described above.

5. New and Revised Transaction Reply Codes (TRCs) for Premium Withhold Option

To more clearly communicate the rules for submitting an enrollment transaction that will either establish or change the effective date and premium withhold option, CMS has revised one existing Transaction Reply Code (TRC) and created one new TRC.

Revised Transaction Reply Code (TRC)
TRC 144 - Premium withhold option change to direct bill

CMS has changed the premium withhold option specified on the transaction to 'D' - Direct Bill for one of the following reasons:

- Retroactive premium withholding was requested.
- The beneficiary's retirement system (SSA, RRB or OPM) was unable to withhold the entire premium amount from the beneficiary's monthly check.
- The beneficiary has a BIC of 'M' or 'T' and chose 'SSA' as the withhold option. SSA cannot withhold premiums for these beneficiaries (there is no benefit check to withhold from).
- The beneficiary chose 'RRB' or 'OPM' as the withhold option. RRB and OPM are not withholding premiums at this time.

- The beneficiary is an RRB beneficiary and chose 'SSA' as the withhold option. 'SSA' is not a valid option for RRB beneficiaries.
- The Plan has submitted a Part C premium amount that exceeds the maximum Part C premium value provided by HPMS.

This TRC may be generated in response to an accepted enrollment, PBP change or Plan Change transaction (60 61, 62, 71, 72) or may be initiated by CMS.

Plan Action: Update the Plan's beneficiary records to reflect the direct bill payment method. Take the appropriate actions as per CMS enrollment guidance.

New Transaction Reply Code (TRC)
TRC 221 - Premium withhold option change rejected, Retroactive effective date

A Plan Change (type 72) transaction for premium withhold option was rejected because the value of effective date was retroactive to establish or terminate SSA withhold.

Plan Change (type 72) transaction for premium withhold option that establish or terminate SSA withhold should have prospective (equal to or greater than the current payment month) effective date. Any other effective date will be rejected.

Plan Action: Correct effective date for premium withhold option change and resubmit.

6. Part C Risk Adjustment Model Output Data File

Effective with the November release, the Monthly and Yearly Part C Risk Adjustment Model Output Data File will be updated to reflect a 'Record Type' indicator in the first field of each record. Plans are advised to redefine their Information System processing to accept the record layout with the 'Record Type' indicator for both the Monthly Part C Risk Adjustment Model Output Data File (HCCMODD) and the Final Yearly Part C Risk Adjustment Model Output Data File (HCCMOFD).

Please note that the data file layout presented in the August 18, 2008, *Plan Communications User Guide (PCUG)* is correct. This update was made to align the file transmission with the actual layout and documentation.

A copy of this file layout can be found in the *Plan Communications User Guide (PCUG)* as Appendix E.13. The detailed layout is also located in *Attachment D: Part C Risk Adjustment Model Output Data File.*

Plans are encouraged to contact the MMA Help Desk for any issues encountered during the systems 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.

Attachment A: Loss of Subsidy (Deemed Status) Data File (Older Version)

Field	Size	Position	Format	Description
1. Claim Number	12	1 – 12	PIC X(12)	Claim Account Number
2. Surname	12	13 – 24	PIC X(12)	Beneficiary Surname
3. First Name	7	25 – 31	PIC X(7)	Beneficiary Given Name
4. Middle Name	1	32	PIC X(1)	Beneficiary Middle Initial
5. Sex Code	1	33	PIC X(1)	Beneficiary Sex Identification Code 0 = Unknown 1 = Male 2 = Female
6. Date of Birth	8	34 – 41	PIC 9(8)	YYYYMMDD Format
7. Medicaid Indicator	1	42		Spaces
8. Contract Number	5	43 – 47	PIC X(5)	Plan Contract Number
9. State Code	2	48 – 49	PIC X(2)	Beneficiary State Code
10. County Code	3	50 – 52	PIC X(3)	Beneficiary County Code
11. Disability Indicator	1	53		Spaces
12. Hospice Indicator	1	54		Spaces
13. Institutional/NHC Indicator	1	55		Spaces
14. ESRD Indicator	1	56		Spaces
15. Transaction Reply Code	3	57 – 59	PIC X(3)	Transaction Reply Code Defaulted to '996' for loss of Deemed Status report
16. Transaction Type Code	2	60 – 61	PIC X(2)	Transaction Type Code Defaulted to '01' for special reports
17. Entitlement Type Code	1	62		Spaces
18. Effective Date	8	63 – 70	PIC X(8)	YYYYMMDD Format
19. WA Indicator	1	71		Spaces
20. Plan Benefit Package ID	3	72 – 74	PIC X(3)	PBP number
21. Filler	1	75		Spaces
22. Transaction Date	8	76 – 83	PIC X(8)	Set to Current Date (YYYYMMDD)
23. Filler	1	84		Spaces
24. Normally Dependent on TR Code (With TRC-996, Low-Income Subsidy End Date)	12	85 – 96	PIC X(12)	End date of Beneficiary's Low-Income Subsidy Period (YYYYMMDD)
25. District Office Code	3	97 – 99		Spaces
26. Filler	8	100 – 107		Spaces
27. Filler	8	108 – 115		Spaces
28. Source ID	5	116 – 120		Spaces
29. Prior Plan Benefit Package ID	3	121 – 123		Spaces
30. Application Date	8	124 – 131		Spaces
31. Filler	2	132 – 133		Spaces

Loss of Subsidy (Deemed Status) Data File (Older Version)

Field	Size	Position	Format	Description
MMA Fields: (MMCS Data file ends with position 133)				
32. Out of Area Flag	1	134 – 134		Spaces
33. Segment Number	3	135 – 137	PIC X(3)	Default to '000' if blank
34. Part C Beneficiary Premium	8	138 – 145		Spaces
35. Part D Beneficiary Premium	8	146 – 153		Spaces
36. Election Type	1	154 – 154		Spaces
37. Enrollment Source	1	155 – 155	PIC X(1)	A = Auto Enrolled by CMS B = Beneficiary Election C = Facilitated Enrollment by CMS D = CMS Annual Rollover Space = not supplied
38. Part D Opt-Out Flag	1	156 – 156		Spaces
39. Premium Withhold Option/Parts C-D	1	157 – 157		Spaces
40. Number of Uncovered Months	3	158 – 160		Spaces
41. Creditable Coverage Flag	1	161 – 161		Spaces
42. Employer Subsidy Override Flag	1	162 – 162		Spaces
43. Rx ID	20	163 – 182		Spaces
44. Rx Group	15	183 – 197		Spaces
45. Secondary Drug Insurance Flag	1	198-198		Spaces
46. Secondary Rx ID	20	199 – 218		Spaces
47. Secondary Rx Group	15	219 – 233		Spaces
48. EGHP	1	234 - 234		Spaces
49. Part D Low-Income Premium Subsidy Level	3	235 – 237	PIC X(3)	Part D low-income premium subsidy category: Default to '000' = No subsidy
50. Low-Income Co-Pay Category	1	238 – 238	PIC X(1)	Definitions of the co-payment categories Default o '0' = none, not low-income
51. Low-Income Co-Pay Effective Date	8	239 – 246		Spaces
52. Part D Late Enrollment Penalty Amount	8	247 - 254		Spaces
53. Part D Late Enrollment Penalty Waived Amount	8	255 - 262		Spaces
54. Part D Late Enrollment Penalty Subsidy Amount	8	263 - 270		Spaces

Loss of Subsidy (Deemed Status) Data File (Older Version)

Field	Size	Position	Format	Description
55. Low-Income Part D Premium Subsidy Amount	8	271- 278		

Attachment B: Loss of Subsidy (Deemed Status) Data File (Expanded Version)

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	Spaces
8. Contract Number	5	43 – 47	Plan Contract Number
9. State Code	2	48 – 49	Beneficiary State Code
10. County Code	3	50 – 52	Beneficiary County Code
11 Filler	4	53 – 56	Spaces
12. Transaction Reply Code	3	57 – 59	Transaction Reply Code '996'
13. Transaction Type Code	2	60 – 61	Transaction Type Code '01'
14. Filler	1	62	Spaces
15. Effective Date	8	63 – 70	YYYYMMDD Format
16. Filler	1	71	Spaces
17. Plan Benefit Package ID	3	72 – 74	PBP number
18. Filler	1	75	Spaces
19. Transaction Date	8	76 – 83	Set to Current Date (YYYYMMDD)
20 Filler	1	84	Spaces
21. Low-Income Subsidy End Date	12	85 – 96	End Date of Beneficiary's Low-Income Subsidy Period (YYYYMMDD)
22. Filler	38	97 – 134	Spaces
23. Segment Number	3	135 – 137	'000' if no segment in PBP
24. Filler	17	138 – 154	Spaces
25. Enrollment Source	1	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); Space = not supplied

Loss of Subsidy (Deemed Status) Data File (Expanded Version)

Field	Size	Position	Description
26. Filler	79	156 - 234	Spaces
27. Part D Low-Income Premium Subsidy Level	3	235 – 237	Part D low-income premium subsidy category: '000' = No subsidy
28. Low-Income Co-Pay Category	1	238	Co-payment category: '0' = none, not low-income
29. Filler	262	239 – 500	Spaces

Attachment C: Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	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

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
19	New Medicare Beneficiary Medicaid Status Flag	1	66-66	1. Prior to calendar 2008, payments and payment adjustments report as follows: • Y = Medicaid status, • Blank = not Medicaid. 2. In calendar 2008, payments and payment adjustments were reported as follows: • Y = Beneficiary is Medicaid and a default risk factor was used, • N = Beneficiary is not Medicaid and a default risk factor was used, • Blank = CMS is not using a default risk factor or the beneficiary is Part D only. 3. Beginning in calendar 2009: • Payment adjustments with effective dates in 2008 and after, and all prospective payments report as follows: o Y = Beneficiary is Medicaid and a default risk factor was used, o N = Beneficiary is not Medicaid and a default risk factor was used, o Blank = CMS is not using a default risk factor or the beneficiary is Part D only. • Payment adjustments with effective dates in 2007 and earlier report as follows: o Y = A payment adjustment was made at a “Medicaid” rate to the demographic component of a blended payment. o N = A payment adjustment was made to the demographic payment component of a blended payment. The adjustment was not at a “Medicaid” rate. o Blank = Either the adjusted payment had no demographic component, or only the risk portion of a blended payment was adjusted.

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
20	LTI Flag	1	67-67	Y = Part C Long Term Institutional
21	Medicaid Indicator	1	68-68	Y = For pre-2008 demographic Medicaid retroactive payment adjustments Blank = No Medicaid Add-on
22	PIP-DCG	2	69-70	PIP-DCG Category - Only on pre-2004 adjustments
23	Default Risk Factor Code	1	71-71	1= Default Enrollee- Aged/Disabled 2= Default Enrollee- ESRD Dialysis 3= Default Enrollee- ESRD Transplant Kidney Month 1 4= Default Enrollee- ESRD Transplant Kidney Months 2-3 5= Default Enrollee- ESRD Post Graft 4-9 months 6= Default Enrollee- ESRD Post Graft 10+ months Blank= Not a default enrollee - Risk Adjustment Factor calculated by CMS
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

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
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
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

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
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	Beneficiary Current Medicaid Status	1	171-171	Beneficiary's current Medicaid status. '1' = Beneficiary was determined to be Medicaid as of current payment month minus two (CPM –2) or minus one (CPM – 1), '0' = Beneficiary was not determined to be Medicaid as of current payment month minus two (CPM – 2) or minus one (CPM – 1), Blank = This is a retroactive transaction and Medicaid status is not reported.
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	2009 and later: N = "De Minimis" does not apply 2008 and earlier N = "De Minimis" does not apply Y = "De Minimis" applies
44	Filler	1	184-184	Spaces

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
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

Item	Field Name	Size	Position	Description
47	RA Factor Type Code	2	189-190	Type of risk adjustment factor used to calculate the payment or adjustment amount. (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) Blank – Part C Default C risk factor used in the calculation
48	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
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. 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 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

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
54	Part C Basic Premium – Part A Amount	8	199-206	The premium amount for determining the MA payment attributable to Part A. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
55	Part C Basic Premium – Part B Amount	8	207-214	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
56	Rebate for Part A Cost Sharing Reduction	8	215-222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
57	Rebate for Part B Cost Sharing Reduction	8	223-230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
58	Rebate for Other Part A Mandatory Supplemental Benefits	8	231-238	The amount of the rebate allocated to providing Part A supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
59	Rebate for Other Part B Mandatory Supplemental Benefits	8	239-246	The amount of the rebate allocated to providing Part B supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
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

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
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
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

Monthly Membership Detail Data File

Item	Field Name	Size	Position	Description
79	PACE Premium Add On	10	392-401	Total Part D Pace Premium Add-on amount -999999.99
80	PACE Cost Sharing Add-on	10	402-411	Total Part D Pace Cost Sharing Add-on amount -999999.99

Attachment D: Part C Risk Adjustment Model Output Data File

Header Record

Item	Field	Size	Position	Description
1	Record Type	1	1	Set to “1”
2	Contract Number	5	2 – 6	Managed Care Organization (MCO) identification number
3	Run Date	8	7 – 14	Date when file was created, YYYYMMDD
4	Payment Year and Month	6	15 – 20	Identifies the risk adjustment payment year and month for the model run
5	Filler	142	21 – 162	Spaces

Detail Record

Item	Field	Size	Position	Description
1	Record Type	1	1	Set to “2”
2	Health Insurance Claim Number	12	2 - 13	This is the Health Insurance Claim Number (known as HICN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICN consist of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD) uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12 bytes account number.
3	Beneficiary Last Name	12	14 - 25	First 12 bytes of the Beneficiary Last Name
4	Beneficiary First Name	7	26 – 32	First 7 bytes of the Beneficiary First Name
5	Beneficiary Initial	1	33	Beneficiary Initial
6	Date of Birth	8	34 – 41	The date of birth of the Medicare Beneficiary. Format as YYYYMMDD.
7	Sex	1	42	Represents the sex of the Medicare Beneficiary. Examples include Male and Female. 0=unknown, 1=male, 2=female
8	Social Security Number	9	43 – 51	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female0_34	1	52	The sex and age group for the beneficiary base on a given as of date. Female between ages of 0 through 34. Set to "1" if existed, otherwise "'0."

Part C Risk Adjustment Model Output Data File

Item	Field	Size	Position	Description
10	Age Group Female35_44	1	53	The sex and age group for the beneficiary base on a given as of date. Female between ages of 35 through 44. Set to "1" if existed, otherwise "'0."
11	Age Group Female45_54	1	54	The sex and age group for the beneficiary base on a given as of date. Female between ages of 45 through 54. Set to "1" if existed, otherwise "'0."
12	Age Group Female55_59	1	55	The sex and age group for the beneficiary base on a given as of date. Female between ages of 55 through 59. Set to "1" if existed, otherwise "'0."
13	Age Group Female60_64	1	56	The sex and age group for the beneficiary base on a given as of date. Female between ages of 60 through 64. Set to "1" if existed, otherwise "'0."
14	Age Group Female65_69	1	57	The sex and age group for the beneficiary base on a given as of date. Female between ages of 65 through 69. Set to "1" if existed, otherwise "'0."
15	Age Group Female70_74	1	58	The sex and age group for the beneficiary base on a given as of date. Female between ages of 70 through 74. Set to "1" if existed, otherwise "'0."
16	Age Group Female75_79	1	59	The sex and age group for the beneficiary base on a given as of date. Female between ages of 75 through 79. Set to "1" if existed, otherwise "'0."
17	Age Group Female80_84	1	60	The sex and age group for the beneficiary base on a given as of date. Female between ages of 80 through 84. Set to "1" if existed, otherwise "'0."
18	Age Group Female85_89	1	61	The sex and age group for the beneficiary base on a given as of date. Female between ages of 85 through 89. Set to "1" if existed, otherwise "'0."
19	Age Group Female90_94	1	62	The sex and age group for the beneficiary base on a given as of date. Female between ages of 90 through 94. Set to "1" if existed, otherwise "'0."
20	Age Group Female95_GT	1	63	The sex and age group for the beneficiary base on a given as of date. Female between age of 95 and greater. Set to "1" if existed, otherwise "'0."
21	Age Group Male0_34	1	64	The sex and age group for the beneficiary base on a given as of date. Male between ages of 0 through 34. Set to "1" if existed, otherwise "'0."

Part C Risk Adjustment Model Output Data File

Item	Field	Size	Position	Description
22	Age Group Male35_44	1	65	The sex and age group for the beneficiary base on a given as of date. Male between ages of 35 through 44. Set to "1" if existed, otherwise "'0."
23	Age Group Male45_54	1	66	The sex and age group for the beneficiary base on a given as of date. Male between ages of 45 through 54. Set to "1" if existed, otherwise "'0."
24	Age Group Male55_59	1	67	The sex and age group for the beneficiary base on a given as of date. Male between ages of 55 through 59. Set to "1" if existed, otherwise "'0."
25	Age Group Male60_64	1	68	The sex and age group for the beneficiary base on a given as of date. Male between ages of 60 through 64. Set to "1" if existed, otherwise "'0."
26	Age Group Male65_69	1	69	The sex and age group for the beneficiary base on a given as of date. Male between ages of 65 through 69. Set to "1" if existed, otherwise "'0."
27	Age Group Male70_74	1	70	The sex and age group for the beneficiary base on a given as of date. Male between ages of 70 through 74. Set to "1" if existed, otherwise "'0."
28	Age Group Male75_79	1	71	The sex and age group for the beneficiary base on a given as of date. Male between ages of 75 through 79. Set to "1" if existed, otherwise "'0."
29	Age Group Male80_84	1	72	The sex and age group for the beneficiary base on a given as of date. Male between ages of 80 through 84. Set to "1" if existed, otherwise "'0."
30	Age Group Male85_89	1	73	The sex and age group for the beneficiary base on a given as of date. Male between ages of 85 through 89. Set to "1" if existed, otherwise "'0."
31	Age Group Male90_94	1	74	The sex and age group for the beneficiary base on a given as of date. Male between ages of 90 through 94. Set to "1" if existed, otherwise "'0."
32	Age Group Male95_GT	1	75	The sex and age group for the beneficiary base on a given as of date. Male between age of 95 and greater. Set to "1" if existed, otherwise "'0."
33	Medicaid Female Disabled	1	76	Beneficiary is a female disabled and also entitled to Medicaid. Set to "1" if existed, otherwise "'0."
34	Medicaid Female Aged	1	77	Beneficiary is a female aged (> 64) and also entitled to Medicaid. Set to "1" if existed, otherwise "'0."

Part C Risk Adjustment Model Output Data File

Item	Field	Size	Position	Description
35	Medicaid Male Disabled	1	78	Beneficiary is a male disabled and also entitled to Medicaid. Set to "1" if existed, otherwise "'0."
36	Medicaid Male Aged	1	79	Beneficiary is a male aged (> 64) and also entitled to Medicaid. Set to "1" if existed, otherwise "'0."
37	Originally Disabled Female	1	80	Beneficiary is a female and original Medicare entitlement was due to disability. Set to "1" if existed, otherwise "'0."
38	Originally Disabled Male	1	81	Beneficiary is a male and original Medicare entitlement was due to disability. Set to "1" if existed, otherwise "'0."
39	Disease Coefficients HCC1	1	82	HIV/AIDS. Set to "1" if existed, otherwise "'0."
40	Disease Coefficients HCC2	1	83	Septicemia/Shock. Set to "1" if existed, otherwise "'0."
41	Disease Coefficients HCC5	1	84	Opportunistic Infections. Set to "1" if existed, otherwise "'0."
42	Disease Coefficients HCC7	1	85	Metastatic Cancer and Acute Leukemia. Set to "1" if existed, otherwise "'0."
43	Disease Coefficients HCC8	1	86	Lung, Upper Digestive Tract, and Other Severe Cancers. Set to "1" if existed, otherwise "'0."
44	Disease Coefficients HCC9	1	87	Lymphatic, Head and Neck, Brain, and Other Major Cancers. Set to "1" if existed, otherwise "'0."
45	Disease Coefficients HCC10	1	88	Breast, Prostate, Colorectal and Other Cancers and Tumors. Set to "1" if existed, otherwise "'0."
46	Disease Coefficients HCC15	1	89	Diabetes with Renal or Peripheral Circulatory Manifestation. Set to "1" if existed, otherwise "'0."
47	Disease Coefficients HCC16	1	90	Diabetes with Neurologic or Other Specified Manifestation. Set to "1" if existed, otherwise "'0."
48	Disease Coefficients HCC17	1	91	Diabetes with Acute Complications. Set to "1" if existed, otherwise "'0."
49	Disease Coefficients HCC18	1	92	Diabetes with Ophthalmologic or Unspecified Manifestation. Set to "1" if existed, otherwise "'0."
50	Disease Coefficients HCC19	1	93	Diabetes without Complication. Set to "1" if existed, otherwise "'0."

Part C Risk Adjustment Model Output Data File

Item	Field	Size	Position	Description
51	Disease Coefficients HCC21	1	94	Protein-Calorie Malnutrition. Set to "1" if existed, otherwise "'0."
52	Disease Coefficients HCC25	1	95	End-Stage Liver Disease. Set to "1" if existed, otherwise "'0."
53	Disease Coefficients HCC26	1	96	Cirrhosis of Liver Set to "1" if existed, otherwise "'0."
54	Disease Coefficients HCC27	1	97	Chronic Hepatitis. Set to "1" if existed, otherwise "'0."
55	Disease Coefficients HCC31	1	98	Intestinal Obstruction/Perforation. Set to "1" if existed, otherwise "'0."
56	Disease Coefficients HCC32	1	99	Pancreatic Disease. Set to "1" if existed, otherwise "'0."
57	Disease Coefficients HCC33	1	100	Inflammatory Bowel Disease. Set to "1" if existed, otherwise "'0."
58	Disease Coefficients HCC37	1	101	Bone/Joint/Muscle Infections/Necrosis. Set to "1" if existed, otherwise "'0."
59	Disease Coefficients HCC38	1	102	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease. Set to "1" if existed, otherwise "'0."
60	Disease Coefficients HCC44	1	103	Severe Hematological Disorders. Set to "1" if existed, otherwise "'0."
61	Disease Coefficients HCC45	1	104	Disorders of Immunity. Set to "1" if existed, otherwise "'0."
62	Disease Coefficients HCC51	1	105	Drug/Alcohol Psychosis. Set to "1" if existed, otherwise "'0."
63	Disease Coefficients HCC52	1	106	Drug/Alcohol Dependence. Set to "1" if existed, otherwise "'0."
64	Disease Coefficients HCC54	1	107	Schizophrenia. Set to "1" if existed, otherwise "'0."
65	Disease Coefficients HCC55	1	108	Major Depressive, Bipolar, and Paranoid Disorders. Set to "1" if existed, otherwise "'0."
66	Disease Coefficients HCC67	1	109	Quadriplegia, Other Extensive Paralysis. Set to "1" if existed, otherwise "'0."

Part C Risk Adjustment Model Output Data File

Item	Field	Size	Position	Description
67	Disease Coefficients HCC68	1	110	Paraplegia. Set to "1" if existed, otherwise ""0."
68	Disease Coefficients HCC69	1	111	Spinal Cord Disorders/Injuries. Set to "1" if existed, otherwise ""0."
69	Disease Coefficients HCC70	1	112	Muscular Dystrophy. Set to "1" if existed, otherwise ""0."
70	Disease Coefficients HCC71	1	113	Polyneuropathy. Set to "1" if existed, otherwise ""0."
71	Disease Coefficients HCC72	1	114	Multiple Sclerosis. Set to "1" if existed, otherwise ""0."
72	Disease Coefficients HCC73	1	115	Parkinson's and Huntington's Diseases. Set to "1" if existed, otherwise ""0."
73	Disease Coefficients HCC74	1	116	Seizure Disorders and Convulsions. Set to "1" if existed, otherwise ""0."
74	Disease Coefficients HCC75	1	117	Coma, Brain Compression/Anoxic Damage. Set to "1" if existed, otherwise ""0."
75	Disease Coefficients HCC77	1	118	Respirator Dependence/Tracheostomy Status. Set to "1" if existed, otherwise ""0."
76	Disease Coefficients HCC78	1	119	Respiratory Arrest. Set to "1" if existed, otherwise ""0."
77	Disease Coefficients HCC79	1	120	Cardio-Respiratory Failure and Shock. Set to "1" if existed, otherwise ""0."
78	Disease Coefficients HCC80	1	121	Congestive Heart Failure. Set to "1" if existed, otherwise ""0."
79	Disease Coefficients HCC81	1	122	Acute Myocardial Infarction. Set to "1" if existed, otherwise ""0."
80	Disease Coefficients HCC82	1	123	Unstable Angina and Other Acute Ischemic Heart Disease. Set to "1" if existed, otherwise ""0."
81	Disease Coefficients HCC83	1	124	Angina Pectoris/Old Myocardial Infarction. Set to "1" if existed, otherwise ""0."
82	Disease Coefficients HCC92	1	125	Specified Heart Arrhythmias. Set to "1" if existed, otherwise ""0."

Part C Risk Adjustment Model Output Data File

Item	Field	Size	Position	Description
83	Disease Coefficients HCC95	1	126	Cerebral Hemorrhage. Set to "1" if existed, otherwise "'0."
84	Disease Coefficients HCC96	1	127	Ischemic or Unspecified Stroke. Set to "1" if existed, otherwise "'0."
85	Disease Coefficients HCC100	1	128	Hemiplegia/Hemiparesis. Set to "1" if existed, otherwise "'0."
86	Disease Coefficients HCC101	1	129	Cerebral Palsy and Other Paralytic Syndromes. Set to "1" if existed, otherwise "'0."
87	Disease Coefficients HCC104	1	130	Vascular Disease with Complications. Set to "1" if existed, otherwise "'0."
88	Disease Coefficients HCC105	1	131	Vascular Disease. Set to "1" if existed, otherwise "'0."
89	Disease Coefficients HCC107	1	132	Cystic Fibrosis. Set to "1" if existed, otherwise "'0."
90	Disease Coefficients HCC108	1	133	Chronic Obstructive Pulmonary Disease. Set to "1" if existed, otherwise "'0."
91	Disease Coefficients HCC111	1	134	Aspiration and Specified Bacterial Pneumonias. Set to "1" if existed, otherwise "'0."
92	Disease Coefficients HCC112	1	135	Pneumococcal Pneumonia, Empyema, Lung Abscess. Set to "1" if existed, otherwise "'0."
93	Disease Coefficients HCC119	1	136	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage. Set to "1" if existed, otherwise "'0."
94	Disease Coefficients HCC130	1	137	Dialysis Status. Set to "1" if existed, otherwise "'0."
95	Disease Coefficients HCC131	1	138	Renal Failure. Set to "1" if existed, otherwise "'0."
96	Disease Coefficients HCC132	1	139	Nephritis. Set to "1" if existed, otherwise "'0."
97	Disease Coefficients HCC148	1	140	Decubitus Ulcer of Skin. Set to "1" if existed, otherwise "'0."
98	Disease Coefficients HCC149	1	141	Chronic Ulcer of Skin, Except Decubitus. Set to "1" if existed, otherwise "'0."

Part C Risk Adjustment Model Output Data File

Item	Field	Size	Position	Description
99	Disease Coefficients HCC150	1	142	Extensive Third-Degree Burns. Set to "1" if existed, otherwise "'0."
100	Disease Coefficients HCC154	1	143	Severe Head Injury. Set to "1" if existed, otherwise "'0."
101	Disease Coefficients HCC155	1	144	Major Head Injury Set to "1" if existed, otherwise "'0."
102	Disease Coefficients HCC157	1	145	Vertebral Fractures without Spinal Cord Injury. Set to "1" if existed, otherwise "'0."
103	Disease Coefficients HCC158	1	146	Hip Fracture/Dislocation. Set to "1" if existed, otherwise "'0."
104	Disease Coefficients HCC161	1	147	Traumatic Amputation. Set to "1" if existed, otherwise "'0."
105	Disease Coefficients HCC164	1	148	Major Complications of Medical Care and Trauma. Set to "1" if existed, otherwise "'0."
106	Disease Coefficients HCC174	1	149	Major Organ Transplant Status. Set to "1" if existed, otherwise "'0."
107	Disease Coefficients HCC176	1	150	Artificial Openings for Feeding or Elimination. Set to "1" if existed, otherwise "'0."
108	Disease Coefficients HCC177	1	151	Amputation Status, Lower Limb/Amputation Complications. Set to "1" if existed, otherwise "'0."
109	Disabled Disease HCC5	1	152	Disabled*Opportunistic Infections. Set to "1" if existed, otherwise "'0."
110	Disabled Disease HCC44	1	153	Disabled*Severe Hematological Disorders. Set to "1" if existed, otherwise "'0."
111	Disabled Disease HCC51	1	154	Disabled*Drug/Alcohol Psychosis. Set to "1" if existed, otherwise "'0."
112	Disabled Disease HCC52	1	155	Disabled*Drug/Alcohol Dependence. Set to "1" if existed, otherwise "'0."
113	Disabled Disease HCC107	1	156	Disabled*Cystic Fibrosis. Set to "1" if existed, otherwise "'0."
114	Disease Interactions INT1	1	157	DM_CHF. Set to "1" if existed, otherwise "'0."

Part C Risk Adjustment Model Output Data File

Item	Field	Size	Position	Description
115	Disease Interactions INT2	1	158	DM_CVD. Set to "1" if existed, otherwise "'0."
116	Disease Interactions INT3	1	159	CHF_COPD. Set to "1" if existed, otherwise "'0."
117	Disease Interactions INT4	1	160	COPD_CVD_CAD. Set to "1" if existed, otherwise "'0."
118	Disease Interactions INT5	1	161	RF_CHF. Set to "1" if existed, otherwise "'0."
119	Disease Interactions INT6	1	162	RF_CHF_DM. Set to "1" if existed, otherwise "'0."

Trailer Record

Item	Field	Size	Position	Description
1	Record Type	1	1	Set to “3”
2	Contract Number	5	2 – 6	Managed Care Organization (MCO) identification number
3	Total Record Count	9	7 – 15	Record count in display format 9(9). Includes header and trailer records.
4	Filler	147	16 – 162	Spaces