DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Medicare Plan Payment Group
Enterprise Systems Solutions Group

DATE: **December 20, 2016**

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

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SUBJECT: **Announcement of the February 2017 Software Release**

The Centers for Medicare and Medicaid Services (CMS) continues to implement software
improvements to the enrollment and payment systems that support Medicare Advantage
Prescription Drug (MAPD) programs. This letter provides detailed information regarding the
planned release of systems changes scheduled for February 2017. This release focuses on
improving the efficiency of CMS systems as well as Plan processing. The updates described in
this communication will be included in the February 2017 Plan Communications User Guide
v11.0, scheduled for publication on February 28, 2017.

The February 2017 Release changes are as follows and may require Plan action:

1. **Seamless Conversion Enrollment Election Type**
2. **Medicare Secondary Payer (MSP) Notification Enhancements**
3. **Medicaid Reporting Enhancements**
4. **Employer Group Waiver Plan (EGWP) Edit Removal and Flag Changes**
5. **Supplemental Data on the MAO-004 Report Due to Quarterly HCPCS/CPT Update**
6. **Risk Adjustment Suite of Systems (RASS) MOR Maintenance for 2017**
7. **Update to the November 2016 Software Release Letter Regarding the New 2017
   Part C Risk Adjustment Model**

1. **Seamless Conversion Enrollment Election Type Code**

There is a provision of the law that permits a Medicare Advantage Organization (MAO) to "seamlessly" enroll a beneficiary enrolled in one of its non-MA health plans (e.g. a commercial policy or a Medicaid plan) into a Medicare Advantage (MA) plan as long as the MAO is able to identify individuals approaching Medicare eligibility at least 90 days prior to their Medicare eligibility. The seamless conversion enrollment mechanism is optional for MAOs but requires prior CMS approval of the MAO's process for identifying and notifying beneficiaries newly eligible for Medicare. The MAO must provide notification of the proposed enrollment at least 60 days prior to the enrollment effective date. The beneficiary is then able to decline ("opt-out") the enrollment up to and including the day prior to the enrollment effective date. MAOs without express CMS approval to conduct seamless conversion enrollment are not permitted to use this enrollment mechanism.

This change will establish a new election code type, 'J', for Seamless Conversion Election Mechanism (SCEM), to identify and track Plan submitted seamless conversion enrollment transactions. Seamless conversion enrollments may not be submitted with any other election type code. An individual's decision not to opt out of the enrollment, prior to the effective date, is considered to be an enrollment request. The SCEM election type code will use the same time periods and edits as the Initial Coverage Election Period (ICEP) or Initial Election Period (IEP) election type code. The enrollment source code used on the seamless conversion enrollment transactions will follow the same enrollment rules and edits as the enrollment source code 'B', for Beneficiary Election. If a seamless conversion enrollment is submitted with an election type code 'J' and an enrollment source code other than 'B', then the enrollment will be rejected with a new TRC 367 - Enrollment Rejected, incorrect Enrollment Source Code (ESC) or Enrollment Type Code (ETC).

An IEP/ICEP enrollment will take precedence over a seamless conversion enrollment. If an IEP/ICEP enrollment transaction is received with the same application date as a seamless conversion enrollment, the seamless conversion enrollment will be rejected with new TRC 369 - Enrollment Rejected, IEP/ICEP enroll available.

Seamless conversion enrollments can only be made into MA and MAPD Plans. They cannot be made into standalone Part D Plans or Cost Plans. If a seamless conversion enrollment is submitted for a Part D or Cost Plan, the enrollment will be rejected with new TRC 370 Enrollment Rejected, Invalid Plan for SCEM.

- *New Transaction Reply Codes*, *Attachment A, Figure 1*
- *Updated Transaction Reply Codes,* *Attachment B, Figure 1*

2. **Medicare Secondary Payer (MSP) Notification Enhancement**

The Medicare Advantage-Prescription Drug (MARx) system reports that a beneficiary has a Medicare Secondary Payer (MSP) period, and the information is reported to the Plan on the Daily Transaction Reply Report (DTRR) using a Transaction Reply Code (TRC) 245 (Member Has MSP Period) and 280 (Member MSP Period Ends). TRC 245 informs the Plan that an MSP period has started and TRC 280 informs the Plan when the MSP period has ended. MARx reports the dates properly when an MSP period contains only a start or only an end date; however, MARx does not accurately report dates for an MSP period when the period contains both a start and end date at the time the MSP period is processed.

With this release, MARx will add functionality to issue TRC 245 and 280, containing both an MSP start date and end date when MARx processes an MSP period that contains both a start and end date. This will provide a Plan with comprehensive MSP data in the DTRR. The TRCs affected include:

- TRC 245 and 280 will provide a start date, end date, or both (start and end dates) in the following manner when reported on the DTRR:
    - TRC 245 when MARx processes and reports an MSP period that consists of a start date only.
    - TRC 280 when MARx processes and reports an MSP period that consists of an update to the end date only.
    - Both TRC 245 and 280, when MARx processes and reports an MSP period that consists of both a start and end date.

In addition, a new TRC 368 (Member MSP Period Exists) is being added. When a new enrollment is processed, TRC 368 will be reported on the DTRR to inform the Plan that an MSP period exists for the newly enrolled beneficiary.

On the DTRR, the start and end date fields will display differently for TRC 245, 280, and 368. Prior to the February software release, the MSP period's start date is displayed in Field 18 (Effective Date), and the end date is displayed in Field 24 (bb) (currently defined as: MSP Period End Date). Following this software release, Field 18 (Effective Date) will be used for informational purposes only, and will contain the date that payments will begin to be impacted. The MSP period's start date will be newly defined and displayed in Field 24 (bb) (newly defined: MSP Period Start Date), and the end date will be displayed in Field 44 (End Date).

The fields associated to the TRCs are detailed below (per the February software release):

- ***Transaction Reply Code 245 – Member has MSP Period,*** *Attachment B, Figure 1*
  - Field 18 (Effective Date) - the date that payments will begin to be impacted due to the change of MSP period.
  - Field 24 (bb) (MSP Period Start Date) - the start date of the MSP period.
  - Field 44 (End Date) - the end date of the MSP period. (Note: When MARx processes and reports an MSP period that consist of both a start and end date.)

- ***Transaction Reply Code 280 – Member MSP Period Ended,*** *Attachment B, Figure 1*
  - Field 18 (Effective Date) - the date that payments will begin to be impacted due to the change of the MSP period
  - Field 24 (bb) (MSP Period Start Date) - the start date of the MSP period. (Note: When MARx processes and reports an MSP period that consists of both a start and end date.)
  - Field 44 (End Date) - the end date of the MSP period.

- ***Transaction Reply Code 368 – Member MSP Period Exists,*** *Attachment A, Figure 1*
  - Field 18 (Effective Date) - the date that payments will begin to be impacted due to the change of MSP period.
  - Field 24 (bb) (MSP Period Start Date) - the start date of the MSP period
  - Field 44 (End Date) - the end date of the MSP period.

- ***Updated Fields in the Daily Transaction Reply Report Layout,*** *Attachment B, Figure 2*

3. Medicaid Reporting Enhancements

To implement the 2017 CMS-HCC (Hierarchical Condition Category) risk adjustment model, CMS is making several changes to provide more information to MAOs, PACE organizations, and certain Demonstration Plans, about the dual status of their beneficiaries:

- CMS will be updating the MARx UI Status Detail: Medicaid Payment (M257) screen to allow Plans to identify the applicable dual status (full, partial, or non-dual) and dual status code of their beneficiaries for January 2017 onward. Audited information will be available when the user selects "View Audit".

  o *Medicaid Payment (M257) Screenshots*, *Attachment C, Figure 1*

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

  o *Medicare Advantage Medicaid Status Data File*, *Attachment C, Figure 2*

- The Medicaid Indicator Field (Field 21) on the Monthly Membership Report (MMR) will no longer be populated for MAOs when a Community Risk Adjustment Factor (RAF) has been used to calculate payments. Instead, in these instances, Field 21 will be filled with spaces. Field 21 indicates that Medicaid status was reflected in the beneficiary's risk score, which, for full risk beneficiaries, reflects dual status in the data collection period, and this indicator is no longer relevant for MAOs when using the 2017 model in payment. MAOs will be able to see which Community Risk Adjustment Factor (RAF) is used by referring the Current Medicaid Status (Field 39) and Medicaid Dual Status (Field 84).

  o *Monthly Membership Detail Report Layout*, *Attachment C, Figure 3*

4. Employer Group Waiver Plan (EGWP) Edit Removal and Flag Changes

This change will allow non-Employer Group Plans (EGP) Plan Benefit Packages (PBPs) that contain employer group beneficiaries to use the Disenrollment Reason Code (DRC) 65 (loss of Employer Group Plan eligibility). These non-EGP PBPs also have to use DRC 65 when the beneficiary's enrollment Employer Group Health Plan (EGHP) flag has been set to 'Yes'. When a non-EWP beneficiary is rolled into an EGWP, MARx will automatically add the EGHP flag to the beneficiary's record.

- *DRC 65 – Loss of Employer Group Plan Eligibility*, *Attachment D, Figure 1*

5. Supplemental Data on the MAO-004 Report Due to Quarterly HCPCS/CPT Update

CMS is planning quarterly updates to the list of Healthcare Common Procedure Coding System (HCPCS) and the Common Procedural Terminology (CPT) codes that are acceptable for encounter data risk adjustment filtering. Because the acceptable HCPCS & CPT code list might be updated after new codes are first used and reported on encounter data records, CMS will be retroactively reviewing encounter data records with diagnoses that did not initially pass the filtering logic. To accommodate the reporting of these diagnoses from prior months, CMS will be appending newly filtered diagnoses in the next available month's MAO-004 report. There will be no change to the MAO-004 file layout. Plans can use the Encounter ICN (Field 9) and the Plans Submission Date (Field 15) on the report to identify the corresponding submission month(s) for those retroactive data.

6. RASS MOR Maintenance 2017

As part of the efforts to implement the 2017 CMS-HCC (Hierarchical Condition Category) Risk Adjustment model, CMS is making changes to the 2017 Initial Model Run Model Output Report (MOR). These updated layouts will be published separately in a forthcoming HPMS memo. Please note that the MOR will be updated separately for both the 2016 Final Model Run and the 2017 Mid-year Model Run to reflect the inclusion of encounter data in these model runs. Information on these changes will also be published separately in a forthcoming HPMS memo.

7. Update to the November 2016 Software Release Letter Regarding the New 2017 Part C Risk Adjustment Model

Plans were informed in the September 9, 2016 letter titled, Announcement of the November 2016 Software Release about changes to the Daily Transaction Reply Report (DTRR) related to the 2017 Part C Risk Adjustment Model, beginning Payment Year 2017.

The following updates were made to the Daily Transaction Reply Report (DTRR) layout:

- Field 24, ee was added – Month used to determine Medicaid Status.

In the letter, Field 24, ee (Month used to determine Medicaid Status), was incorrectly labeled as a 6 character field in positions 85-90, YYYYMM. The correct format is YYYYMMDD and is an 8 character field in positions 85-92.

- ***Updated Fields on the Daily Transaction Reply Report Layout, Attachment B, Figure 2***

Plans are encouraged to contact the MAPD Help Desk for any issues encountered during the systems update process. Please direct any questions or concerns to the MAPD Help Desk at 1-800-927-8069 or e-mail at mapdhelp@cms.hhs.gov.

Figure 1: New Transaction Reply Codes

Code	Type	Title	Short Definition	Definition
367	R	Enrollment Rejected, incorrect ESC or ETC	BAD ESC OR ETC	This enrollment transaction was rejected because it contained an Enrollment Source Code or Election Type Code that indicated it was a seamless conversion enrollment transaction, but only one of these values was submitted. Plan-submitted seamless conversion enrollment transactions must have an Enrollment Source Code = 'B' (Beneficiary Election) and Election Type Code = 'J' (Seamless Conversion Election Mechanism). **Plan Action:** Correct the enrollment source code or election type code and resubmit the enrollment transaction.
368	I	Member MSP Period Exists	MEMBER HAS MSP	This TRC is returned with a transaction type 61. The beneficiary has an existing MSP (Medicare Secondary Payer) period. This TRC accompanies an enrollment acceptance TRC that is included in the same DTRR. It provides additional information related to the beneficiary's accepted enrollment. One TRC 368 for each MSP period is sent to the plan(s) that have enrollment(s) impacted by the MSP period(s). o Field 18 (Effective Date) - the date that payments will begin to be impacted due to the change of MSP period. o Field 24, bb (MSP Period Start Date) - the start date of the MSP period o Field 44 (End Date) - the end date of the MSP period. **Plan Action:** Update the Plan's records accordingly.
369	R	Enrollment Rejected, IEP/ICEP enroll available	IEP/ICEP AVAIL	This seamless conversion enrollment transaction (Transaction Type 61) was rejected because an IEP/ICEP enrollment transaction with the same effective date was already accepted. **Plan Action:** Update the Plan's records accordingly. Take the appropriate actions as per CMS enrollment guidance.

Code	Type	Title	Short Definition	Definition
370	R	Enrollment Rejected, Invalid Plan for SCEM	INVAL SCEM PLN	This seamless conversion enrollment transaction (Transaction Type 61) was rejected because it was submitted for an invalid Plan. Seamless conversion enrollments are only valid for MA and MAPD plans. **Plan Action:** Update the Plan's records accordingly. Take the appropriate actions as per CMS enrollment guidance.

Figure 1: Updated Transaction Reply Codes 103, 104, 108, 245, and 280

Code	Type	Title	Short Definition	Definition
103	R	Missing A/B Entitlement Date	NO A/B ENT	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary does not have entitlement for Part A and/or enrollment in Part B on record (required for enrollment transactions). This TRC will only be returned on enrollment transactions submitted with election type I (Initial Coverage Election Period), E (Initial Enrollment Period for Part D) or J (Seamless Conversion Election Mechanism). **Plan Action**: Verify the beneficiary's Part A / Part B entitlement / enrollment. Take the appropriate actions as per CMS enrollment guidance. If the election type is J (Seamless Conversion Election Mechanism), the plan is not allowed to resubmit the enrollment transaction.

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

Code	Type	Title	Short Definition	Definition
108	R	Rejected, Election Limits Exceeded	NO MORE ELECTS	A transaction for which an election type is required (Transaction Types 51, 61) was rejected because the transaction will exceed the beneficiary's election limits for the submitted election type. The valid Election Type values which have limits are: • A – Annual Election Period (AEP) o 1 per calendar year • E – Initial Enrollment Period for Part D (IEP) o 1 per lifetime • F – Initial Enrollment Period for Part D (IEP2) o 1 per lifetime • I – Initial Coverage Election Period (ICEP) o 1 per lifetime • J – Seamless Conversion Enrollment Mechanism (SCEM) o 1 per lifetime **Plan Action**: Review the discussion of election type requirements in Chapter 2 of the Medicare Managed Care Manual or the PDP Guidance on Eligibility, Enrollment and Disenrollment. Correct the election type and resubmit the transaction if appropriate.
245	M	Member has MSP period	MEMBER IS MSP	This TRC is returned with a transaction type 01. The beneficiary has a change to their MSP (Medicare Secondary Payer) period that impacts payments for one or more of the beneficiary's enrollments in your plan. TRC 245 is sent to the plan(s) that have enrollment(s) that are impacted by the new MSP period. o Field 18 (Effective Date) - the date that payments will begin to be impacted due to the change of MSP period. o Field 24, bb (MSP Period Start Date) - the start date of the MSP period. o Field 44 (End Date) - the end date of the MSP period. (Note: When MARx processes and reports an MSP period that consist of both a start and end date.) **Plan Action:** Update the Plan's records accordingly.

Code	Type	Title	Short Definition	Definition
280	M	Member MSP Period Ended	MEMBER NOT MSP	This TRC is returned with a transaction type 01. The beneficiary has an MSP (Medicare Secondary Payer) period that has been ended or updated. The MSP period change impacts payments for one or more of the beneficiary's enrollments in your plan. TRC 280 is sent to the plan(s) that have enrollment(s) that are impacted by the change in the MSP period. o Field 18 (Effective Date) - the date that payments will begin to be impacted due to the change of the MSP period o Field 24, bb (MSP Period Start Date) - the start date of the MSP period. (Note: When MARx processes and reports an MSP period that consist of both a start and end date.) o Field 44 (End Date) - the end date of the MSP period. Note: If the MSP period has both start and end dates, plans will receive both TRC 245 and 280. **Plan Action:** Update the Plan's records accordingly.

Figure 2: Updated Fields on the Daily Transaction Reply Report (DTRR)

Item	Field	Size	Position	Description
18	Effective Date	8	63 – 70	YYYYMMDD Format; Effective date is present for all TRCs unless listed below. Field content is TRC dependent for the following TRCs: 071 & 072 – Effective date of the hospice period 090 – Current Calendar Month 091 – Previously reported incorrect death date 121, 194, and 223 – PBP enrollment effective date 245 – the date that payments will begin to be impacted due to the addition of the MSP period 280 – the date that payments will begin to be impacted due to the addition of the MSP period 293 – Enrollment End Date; Last day of the month 305 – New ZIP Code Start Date 366 – The effective date of the change in Medicaid status 368 – the date that payments will begin to be impacted due to the addition of the MSP period 701 – New enrollment period start date 702 – Fill-in enrollment period start date 703 – Start date of cancelled enrollment period 704 – Start date of enrollment period cancelled for PBP correction 705 – Start date of enrollment period for corrected PBP 706 – Start date of enrollment period cancelled for segment correction 707 – Start date of enrollment period for corrected segment 708 – Enrollment period end date assigned to existing opened ended enrollment 709 & 710 – New start date resulting from update 711 & 712 – New end date resulting from update 713 – "00000000" – End date removed. Original end date is in field 24.X

Item	Field	Size	Position	Description
24	Positions 85 – 96 are dependent upon the value of the TRANSACTION REPLY CODE. There are spaces for all codes except where indicated below.	8	85 – 92	YYYYMMDD Format; Present only when the Transaction Reply Code is one of the following: 13, 14, 18
bb	MSP Period Start Date	8	85 – 92	YYYYMMDD Format: Will be present when Transaction Reply Code is 245, 280, or 368 and will contain the MSP Period Start Date.
ee	Month used to determine Medicaid Status	8	85 – 92	YYYYMMDD Format: The month is either the anchor month (before final reconciliation) or the actual month of the start of the period (post final reconciliation).
44	End Date	8	178 - 185	YYYYMMDD Format: End Date associated with the Transaction Reply Code when applicable: o TRCs that report a Premium Payment Option (PPO) value that is not open-ended o TRC 366 – last month that is calculated using the Medicaid status in Field 85 MSP TRCs 245, 280, and 368 - contains the MSP period end date, if available

Figure 1: MARx User Interface (UI) Updates – Status Detail: Medicaid (M257)

On the MARx UI, the user can find Medicaid status for beneficiaries on the Status Activity (M256) screen. Click on the "View" hyperlink next to Medicaid and the Status Detail: Medicaid (M257) screen will display. The default display on the screen is the Medicaid Status – Community information, shown below.

Select the "View Medicaid Status – All" hyperlink to view all Medicaid records.

Click on a Chevron next to a record under "Medicaid Status – All" to view all underlying records for that time period.

Claim #:11111111A **JANE DOE** **DOB: XX/XX/XXXX**

XXXX XXXXX XX ACTIVE Age: XX Sex: FEMALE

XXXXXX, XX XXXXX State: XX (XX) County: XXXXXXXXX (XXX)

Status Detail: Medicaid (M257) User: XXXX Role: PREMIUM OPERATIONS Date: X/XX/XXXX [Close] [Print] [Help...]

The Medicaid Status Community records were used for calculating payments (if applicable).

The Medicaid Status - All table displays all Medicaid records. To view table, select the View Medicaid Status - All link. To close the table, select the Hide Medicaid Status - All link.

Medicaid Status - Community View Audit

Status Period Start Date	Status Period End Date	Medicaid Source	State	Valid/ Audit	Medicaid Status	Dual Status Code	Record Add Timestamp	Record Update Timestamp	Record Audit Timestamp
02/01/2015	08/31/2016	STATES	VA (49)	V	F	08 - Eligible is entitled to Medicare-Other Dual Eligibles with Medicaid coverage including Rx	08/26/2016 09:10:09	07/01/2013 00:00:00	
07/01/2013	09/30/2013	STATES	VA (49)	V	F	08 - Eligible is entitled to Medicare-Other Dual Eligibles with Medicaid coverage including Rx	12/27/2013 01:32:23	01/01/2014 02:43:40	

Hide Medicaid Status - All

Medicaid Status - All

Status Period Start Date	Status Period End Date	Medicaid Source	State	Premiums Payer Code	Medicaid Status	Dual Status Code	Record Add Timestamp	Record Update Timestamp
» 02/01/2015	08/31/2016	STATES	VA (49)		F	08 - Eligible is entitled to Medicare-Other Dual Eligibles with Medicaid coverage including Rx	02/22/2015 09:11:09	07/01/2016 05:02:01
» 02/01/2015	02/28/2015	STATES	MD (21)		P	03 - Eligible - entitled to Medicare- SLMB only (Partial Dual)	01/03/2015 03:19:17	02/22/2015 04:23:52
⸕ 07/01/2013	09/30/2013	STATES	VA (49)		F	08 - Eligible is entitled to Medicare-Other Dual Eligibles with Medicaid coverage including Rx	06/05/2013 02:05:19	09/21/2013 10:11:50

Medicaid Eligibility Month/Year	Medicaid Status	Dual Status Code	Record Add Timestamp	Record Update Timestamp	Action
09/2013	F	08 - Eligible is entitled to Medicare-Other Dual Eligibles with Medicaid coverage including Rx	08/01/2013 10:40:13	08/31/2013 02:06:04	View Audit
08/2013	F	08 - Eligible is entitled to Medicare-Other Dual Eligibles with Medicaid coverage including Rx	07/01/2013 04:32:08	07/21/2013 05:30:23	View Audit
07/2013	F	08 - Eligible is entitled to Medicare-Other Dual Eligibles with Medicaid coverage including Rx	06/01/2013 11:20:24	06/02/2013 03:36:02	View Audit

Below, the two screen displays illustrate the "View Audit" capability.

Claim #:11111111A	JANE DOE	DOB: XX/XX/XXXX
XXXX XXXXX XX	ACTIVE	Age: XX Sex: FEMALE
XXXXXX, XX XXXXX		State: XX (XX) County: XXXXXXXXX (XXX)

Status Detail: Medicaid (M257)   User: XXXX Role: PREMIUM OPERATIONS Date: X/XX/XXXX   Close   Print   Help...

The Medicaid Status Community records were used for calculating payments (if applicable).

The Medicaid Status - All table displays all Medicaid records. To view table, select the View Medicaid Status - All link. To close the table, select the Hide Medicaid Status - All link.

Medicaid Status - Community   View Audit

Status Period Start Date	Status Period End Date	Medicaid Source	State	Valid/ Audit	Medicaid Status	Dual Status Code	Record Add Timestamp	Record Update Timestamp	Record Audit Timestamp
02/01/2017	08/31/2017	LOW INCOME TERR	PR (40)	V	F	10 - Eligible is entitled to Medicare-Other Full Dual	12/26/2016 09:11:09	07/01/2017 10:20:25	

View Medicaid Status - All

Click the "View Audit" hyperlink to see "Medicaid Status – Community" audited records.

Claim #:11111111A	JANE DOE	DOB: XX/XX/XXXX
XXXX XXXXX XX	ACTIVE	Age: XX Sex: FEMALE
XXXXXX, XX XXXXX		State: XX (XX) County: XXXXXXXXX (XXX)

Status Detail: Medicaid (M257)   User: XXXX Role: PREMIUM OPERATIONS Date: X/XX/XXXX   Close   Print   Help...

The Medicaid Status Community records were used for calculating payments (if applicable).

The Medicaid Status - All table displays all Medicaid records. To view table, select the View Medicaid Status - All link. To close the table, select the Hide Medicaid Status - All link.

Medicaid Status - Community   Hide Audit

Status Period Start Date	Status Period End Date	Medicaid Source	State	Valid/ Audit	Medicaid Status	Dual Status Code	Record Add Timestamp	Record Update Timestamp	Record Audit Timestamp
02/01/2017	08/31/2017	LOW INCOME TERR	PR (40)	V	F	10 - Eligible is entitled to Medicare-Other Full Dual	12/26/2016 09:11:09	07/01/2017 10:20:25	
02/01/2017	02/28/2017	STATES	VA (49)	A	F	08 - Eligible is entitled to Medicare-Other Dual Eligibles with Medicaid coverage including Rx	08/26/2016 01:32:23	02/26/2017 02:43:40	03/01/2017 12:26:21

View Medicaid Status - All

Figure 2: Medicare Advantage Medicaid Status Data File

The data file will be generated monthly. Each month, all Medicaid records that start on or after January 2017 up to the report generation date will be included.

Beneficiary records (Type 2 and Type 3) will be left justified.

File Header Record

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

Beneficiary Identification Record

Item	Field	Size	Position	Description
1	Record Type	1	1	2 – Beneficiary Identification Record
2	Contract Number	5	2-6	Contract Identification
3	Beneficiary ID	12	7-18	Beneficiary Identifier
4	Last Name	12	19-30	Beneficiary Surname
5	First Name	7	31-37	First Name
6	Middle Initial	1	38	Beneficiary Middle Initial
7	DOB	8	39-46	Beneficiary Birth Date YYYYMMDD Format
8	Gender	1	47	Beneficiary Gender Identification Code '0' = Unknown '1' = Male '2' = Female
9	Filler	28	48-75	Spaces

Beneficiary Detail Record

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

File Trailer Record

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

Figure 3: Updated Fields on the Monthly Membership Detail Data File

This data file provides monthly payment and adjustment details reported to the Plan.

With this release, Field 21 (Medicaid Indicator) will be updated to provide spaces when a Community RAF is used to calculate payments.

Table 1 Monthly Membership Detail Data File Layout

Item	Field	Size	Position	Description
21	Medicaid Indicator	1	68	Indicator that the Medicaid Add-on was used for this payment or adjustment When: o A RAS-supplied factor is used in the payment, and o The Part C Default Indicator in the Payment Profile is blank, and o The Medicaid Switch present in the RAS-supplied data that corresponds to the risk factor used in payment is not blank then value is Y = Medicaid Add-on (RAS beneficiaries). Space = No Medicaid Add-on was used This field will be spaces when a Community RAF is used.

Figure 1: DRC 65 - Loss of Employer Group Plan Eligibility

Disenrollment Reason Code	Disenrollment Reason Description	Short Description	MARx UI	AUTO-DIS	PLAN SUB'D
65	LOSS OF EMPLOYER GROUP PLAN ELIGIBILITY	LOSS OF EGP ELGBLTY	Y	N/A	Y