Centers for Medicare & Medicaid Services

CMS-EDGE Server / CMS-ES

Risk Adjustment and Reinsurance (RARI) Interface Control Document –Reinsurance Addendum

February 11, 2019

Document Version History – Recent changes

The table below reflects the summary of changes incorporated in the most recent maintenance release of this ICD addendum.

Version Number	Date	Author/Owner	Description of Change
05.00.22	10/18/18	Accenture / CCIIO	Create separate ICD Addendum for Resinurance **For changes prior to version 05.00.22, refer to the RARI ICD Consolidated Version History

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1 Purpose of Interface Control Document

This Interface Control Document (ICD) Addendum was created from the consolidated Risk Adustment (RA) and Reinsurance (RI) ICD Addendum that was separated into the following five documents:

- RARI ICD- RA Addendum,
- RARI ICD- Risk Adjustment Data Validation (RADV) Addendum,
- RARI ICD- RI Addendum,
- RARI ICD- High Cost Risk Pool (HCRP) Addendum, and
- RARI ICD- Issuer Frequency Report Addendum.

This RARI ICD Addendum is for the Reinsurance outbound reports, and does not contain information regarding the remaining four (4) ICDs listed above. Following is the link to the Registration For Technical Assistance Portal (REGTAP) library for the five (5) ICD Addendums listed above: https://www.regtap.info/reg_library.php.

The RARI ICD (and its accompanying addenda) documents and tracks the necessary information required to effectively define the Centers for Medicare & Medicaid Services (CMS) External Data Gathering Environment (EDGE) server system interface, as well as any rules for communicating with the EDGE servers, to give the development team guidance on the architecture of the system to be developed. In addition, the purpose of the ICD is to clearly communicate all possible inputs for all potential actions. The RARI ICD helps ensure

compatibility between system segments and components.

The RARI ICD does not include information about specific business rules or how the verification edits included within this document affect the file processing logic. Additional information can be found in the EDGE Server Business Rules (ESBR) document available at :
https://www.regtap.info/reg_librarye.php?i=2673

2 Introduction

This is one for five addenda to the existing RARI ICD, which describes the relationship between CMS and the issuer's EDGE server. This document serves to define additional reports that will be produced by the issuer's EDGE servers as a supplement to the ICD, currently published in the Registration for Technical Assistance Portal (REGTAP) Library. These reports include the risk adjustment and reinsurance calculation reports that are used for payment processing, as well as additional analytic reports.

The CMS-EDGE server interface is only necessary when CMS is operating the Risk Adjustment and/or Reinsurance programs on behalf of a state.

The following information, with respect to the interface, is described further in this document:

- Additional EDGE server outbound report formats.

3 Overview

As part of the Affordable Care Act (ACA), two (2) programs were identified to mitigate the impact of adverse selection of plans and provide stability for issuers. States have the option to operate the following programs themselves or have the Department of Health and Human Services (HHS) operate the programs on their behalf.

- Section 1343 of the ACA created the Risk Adjustment (RA) program to better spread the financial risk borne by health insurance issuers in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. Under the RA program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Non-grandfathered, Individual and Small Group Market plans, irrespective of whether they are a part of the Marketplace, will submit RA data (claims and enrollee data) that will be used to determine individual-level risk scores, plan average actuarial risk and associated payments and charges.
- Section 1341 of the ACA establishes the Reinsurance (RI) program as a temporary three-year program that commences in 2014. RI provides funds to issuers that incur high costs for claims in the Individual Market. In accordance with the final rule, RI payments are based on a coinsurance rate or proportion of an issuer's claims costs that are above an attachment point and below a RI cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for RI payments, while the RI cap is the dollar limit at which point an issuer is no longer eligible for RI payments. The attachment point, coinsurance rate and RI cap are calculated based on an issuer's total incurred costs for an individual enrollee in a given calendar year. Non-grandfathered, Individual Market plans, both on and off the Marketplace, will submit RI

data (claims and enrollee data) that will be used to determine if an individual market plan issuer is eligible for RI.

CMS' Center for Consumer Information and Insurance Oversight (CCIIO) on behalf of HHS will develop the software to evaluate and perform the RA and RI calculations.

When evaluating the model for collecting and processing the data received from issuers, it was determined that a distributed data collection model would prove the most effective. Specifically, this model would ensure:

- Issuer proprietary data would not be transmitted to HHS;
- Minimal transfer of protected health information (PHI) to lower privacy and data security risks;
- Standardization of business processes, timing and rules.

These factors resulted in the concept of the EDGE server. Issuers, in states where HHS is operating an RA and/or RI program, will submit enrollee, pharmacy claim, medical claim and supplemental diagnosis information from their proprietary systems to an issuer-owned or Third Party Administrator (TPA)-hosted EDGE server. The EDGE server will run HHS-developed software designed to verify submitted data and execute the RA and RI processes. Issuers will have the option to own and operate the server themselves, or to have a third-party entity operate the server. Detailed data, file processing metrics and outbound data files will be provided to insurance companies/issuers. Only plan summarized data and file processing metrics will be provided to HHS.

4 General Interface Requirements

Interface Overview

This section describes updates to the EDGE server interface as a result of the additional reports defined in this document. For a complete description of the general interface requirements, refer to the existing EDGE server ICD, published in the REGTAP Library (Interface Control Document, document number: *0.0.4-CMSES-ICD-4763*).

Functional Allocation

The primary responsibility of the EDGE server is to provide distributed data processing capabilities to support RA and RI. The results of the data processing are available to CMS, insurance companies and their associated issuers through reports in the form of data files. Output reports can be generated in the Production, Test or Validation zones.

The reports defined in this document can be initiated by one (1) or more of the following methods:

- CMS Initiated Remote Command
- Issuer Executed EDGE Server Command

Transactions

The following reports are defined in this document. Once executed, all files are provided to the issuer/submitter and files with summary data only are provided to CMS for review.

- RI – Summary
- RI Enrollee – Detail

There are several types of outbound data files that will be sent to the issuer/submitter and to CMS as part of this process, including the following:

- Process Oriented Reports
- Operations Analytics Reports
- Management Reports
- Payment Processing Reports

The recipient of these outbound files is restricted by the content level of the files as specified by the table below.

Table 1: Report Type and Recipient

Report Type	Report Recipient
File Level Reports	Issuer/Submitter and CMS
Detail Reports	Issuer/Submitter
Summary Reports	Issuer/Submitter and CMS
Activity To Date Reports	Issuer/Submitter and CMS

Process Oriented Reports are data files generated for the issuer/submitter based on the results of the data processing of the submitted data file. This category includes the following report types:

Operations Analytics Reports are data files that help the user in understanding various operational metrics identified, thereby allowing process improvements. This also helps CMS/CCIIO in reaching out to the issuer/submitter to address any aberrant patterns.

Management Reports are outbound files of summary data used by management to gauge the execution of the overall process.

Payment Process Outputs are outbound files used to calculate the RA and RI payment amounts that will be applied for each issuer.

5 Detailed Interface Requirements

This section specifies the requirements for the interface between the insurance company/ submitting organization and the EDGE server. This includes explicit definitions of the content and format of every message or file that is expected to be transmitted between the insurance company/submitting organizations and the EDGE server and the conditions under which each file is to be sent.

Requirements for Additional EDGE Server Outbound Reports

This section describes the additional outbound report formats that will be made available to the issuer and CMS to review and analyze the processing results of the enrollment, claims and supplemental diagnosis information submitted for RI and RA processing. The files will be eXtensible Markup Language (XML) based and as per the XML Schema Definition (XSD) defined in this document.

This document describes the following reports:

- Reports sent to the insurance company/issuer administrator only:
  - RI Detail Enrollee Report
- Reports sent to both the insurance company/issuer administrator and CMS:
  - RI Summary Report
  - System Error Report

As the design of the remaining reports is completed, this document will be updated.

Assumptions

The assumptions for the delivery of the EDGE server outbound files are as follows:

- Outbound reports are posted to the issuer's Amazon Web Services (AWS) S3 file repository or On-Premise server output directory designated for the remote command execution zone, as described for each report in the below sections.
- Issuers will have a separate Amazon Web Services (AWS) S3 file repository or On-Premise server output directory for the validation zone, independent of the file repositories or output directories for the production and test zone.
- The data files defined to date are XML documents. As the requirements are refined, this section will be updated to reflect the final file layout and data characteristics.

General Processing Steps

After the enrollee and claim files have been validated, designated entities, as determined by the insurance company/issuer administrator, will receive information about the status of their submission through a series of file processing reports. Similarly, CMS/CCIIO will be issued summary reports which provide the status and metrics of the data being processed. All insurance company/issuer reports will be delivered to the AWS S3 bucket configured for the issuer for AWS servers or the server's output directory for On-Premise servers. Summary reports will be delivered to the CMS/CCIIO AWS S3 bucket.

File Naming Convention

All files produced will follow the standard naming convention outlined below.

File Format Mask:

<Submitting Entity ID>.<File Type>.D<YYYYMMDD>T<hhmmss>.<Execution Zone>.xml

Example File Name:

12345. RISR.D20140402T091533.P.xml

Table 2: File Name Parameters

Parameter	Description	Enumeration Values
Submitting Entity ID	Must be the 5 digit HIOS assigned Issuer ID.	**Example:** 12345
Date Timestamp	The date timestamp of when the file was generated.	**Example:** For April 2, 2014 at 9:15:33 AM Date Timestamp: D20140402T091533
Execution Zone	One (1) letter code indicating the execution zone where the file is to be processed.	Production:' P' Test: 'T' Local: 'L' Validation: 'V'

Outbound Report Data Components Message Format (or Record Layout) and Required Protocols

The structure of the EDGE server output reports has two (2) components:

Common Header category that is reused across the defined output reports; and

- Data elements/structures that are specific to a given report

5.1.1.1 Record Layout and Required Protocols for Common Outbound File Header Record

The data contents of the common outbound file header record data structure include report file identifier, report execution date, file identifier included in the submitted file, date of submission file generated by issuer/submitter, date of submission file received by the EDGE server, report type, sender identifier (EDGE server identifier) and submitter identifier associated with the submission.

5.1.1.2 Business Data Element Descriptions and Technical Characteristics

The data characteristics for the Common Outbound File Header Data Structure are as shown in Table 3. These elements are defined in the *RARICommonOutboundFileHeader.xsd*.

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
File ID	The CMS system generated unique identifier of a report file.	File Header	1	outboundFileIdentifier	String	minLength = 1 maxLength = 80
CMS Batch ID	CMS generated identifier to uniquely identify a batch job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsBatchIdentifier	String	minLength = 1 maxLength = 50
CMS Job ID	CMS generated identifier to uniquely identify the job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsJobIdentifier	String	minLength = 1 maxLength = 50

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Snap Shot File Name	File name of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileName	String	none
Snap Shot File Hash	Hash value of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileHash	String	none
Run Date	The date and time when the CMS processed file is generated.	File Header	1	outboundFileGenerationDateTime	String	Strict: YYYY-MM-DDTHH:mm:SS
Interface Control Release Number	Denotes the version number of the ICD that the file corresponds to as identified on page one (1) of this document.	File Header	1	interfaceControlReleaseNumber	String	Length = 8
EDGE Server Version	Version number that corresponds to the Application, Database, Operating System, and reference table versions that were used to process the inbound file and produce the report. The application version in the execution zone for which the report is generated, will be displayed in this field.	File Header	1	edgeServerVersion	String	minLength = 0; maxLength = 75

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Job ID	System generated unique identifier for job executed on the EDGE server.	File Header	0… 1	edgeServerProcessIdentifier	String	minLength = 0; maxLength= 12
Report Type	Defines values of outbound validation report.	File Header	1	outboundFileTypeCode	String	minLength = 1 maxLength = 30
Server ID	The unique identifier of an EDGE server.	File Header	1	edgeServerIdentifier	String	minLength = 1 maxLength = 12
Issuer ID	The unique identifier for an issuer.	File Header	1	issuerIdentifier	String	Length = 5

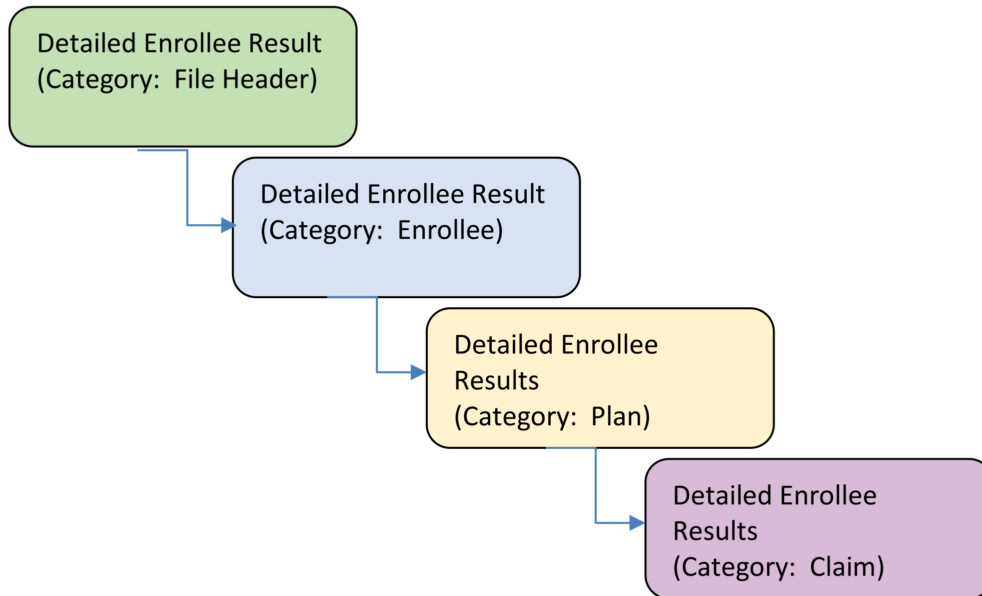
RI Detail Enrollee Report (RIDE) Message Format (or Record Layout) and Required Protocols

The outbound RIDE Report is available only to the issuer/submitting organization. It is not available to CMS. This report contains enrollee level details used for the RI calculation. The RIDE Report will be generated with the RI batch job.

5.1.1.3 File Layout

This section specifies the file layout for the RIDE Report. At a high level, it consists of four (4) record types or categories, as shown in Figure 1.

Figure 1 EDGE Server RI Enrollee Detail Report Data Categories



The RIDE Report XSD consists of report File Header, Enrollee, Plan and Claim categories.

The RIDE XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.4 Field/Data Elements and Descriptions

The data characteristics for the RIDE RI Detail Enrollee File Header category are as shown in Table 4. The root element of the RIDE in the XSD is RiDetailEnrolleeReport (*RiDetailEnrolleeReport.xsd*). This element is required and all the other elements defined in this section for the RIDE are embedded within this element start and end tags.

Table 4: RIDE RI Detail Enrollee File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader.xsd	none
Calendar Year	The calendar year for which RI was executed.	File Header	1	calendarYear	String	Strict: YYYY
Execution Type	Designate preliminary or final run.	File Header	1	executionType	String	minLength = 1; maxLength = 30 Enumeration Values: “P”: Preliminary “F”: Final
Enrollee Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report. The XML elements defined in the Supplemental Diagnosis Plan Processing result category are within this element as defined in the XSD.	Enrollee	1 or more per Enrollee	includedInsuredMemberIdentifier	RiDetailEnrolleeReportEnrolleeCategory	none

The data characteristics for the RIDE RI Detail Enrollee category are as shown Table 5. These elements are defined in the *RiDetailEnrolleeReportEnrolleeCategory.xsd*.

Table 5: RIDE RI Enrollee Detail Enrollee

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique Enrollee ID	Unique identifier for the enrollee.	Enrollee	1	insuredMemberIdentifier	String	minLength = 0; maxLength = 80
Member Months	The count of months for RI eligible enrollees within the payment year (Jan-Dec) for Individual Market plans.	Enrollee	1	memberMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total allowed claims	Total allowed amount of claims across all Individual Market plans.	Enrollee	1	totalAllowedClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Paid Claims	Total claim paid amount for claims across all Individual Market plans.	Enrollee	1	totalPaidClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99
MOOP Adjusted Paid Claims	Sum of paid claims minus the CSR MOOP Adjustment for the enrollee.	Enrollee	1	moopAdjustedPaidClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99
CSR MOOP Adjustment	Amount applied to the claims for RI payment calculation.	Enrollee	1	cSRMOOPAdjustment	Decimal	minInclusive = 0; maxInclusive = 999999999.99
RI Eligible Payments	The MOOP adjusted paid claims between the attachment point and the cap.	Enrollee	1	estimatedRIPayment	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 5: RIDE RI Enrollee Detail Enrollee (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Coinsurance Adjusted total RI Payment	Coinsurance adjusted total RI payment using the CMS published coinsurance rate for the payment year.	Enrollee	1	coinsurancePercentPayments	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report. The XML elements defined in the supplemental diagnosis plan processing Result category are within this element as defined in the XSD.	Plan	1 or more per plan in the reported submission file	includedPlanIdentifier	RiDetailEnrolleeReportPlanCategory	none

The data characteristics for the RIDE RI Enrollee Detail Plan category are as shown in Table 5. These elements are defined in the *RiDetailEnrolleeReportPlanCategory.xsd*.

Table 6: RIDE RI Enrollee Detail Report Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique identifier for insurance plan offered by issuer that the enrollee is covered under. The Plan ID includes the CSR variant.	Plan	1	planIdentifier	String	minLength = 0 maxLength = 16

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Claim Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report. The XML elements defined in the Supplemental Diagnosis Plan Processing result category are within this element as defined in the XSD.	Claim	0 or more per claim in the reported submission file	includedClaimIdentifier	RiDetailEnrolleeReport ClaimCategory	none

The data characteristics for the RIDE RI Enrollee Detail Claim category are as shown in Table 6. These elements are defined in the *RiDetailEnrolleeReportClaimCategory.xsd*.

Table 7: RIDE RI Detail Enrollee Report Claim

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Claim ID	Unique number generated by the issuer adjudication system to uniquely identify the transaction. The issuer adjudicated Claim ID may be de-identified by the issuer.	Claim	1	claimIdentifier	String	minLength = 0; maxLength = 50 **Note**: If issuer has multiple platforms that use identical Claim ID numbers, then the issuer must make Claim IDs unique or rejects for duplicate claims will result.
Claim Paid Amount	Total amount paid by enrollee's plan.	Claim	1	claimPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Cross Year Claim Indicator	Identifies if the claim is a cross year claim.	Claim	1	crossYearClaimIndicator	String	Length = 1 Enumeration Values: “Y”, “N”

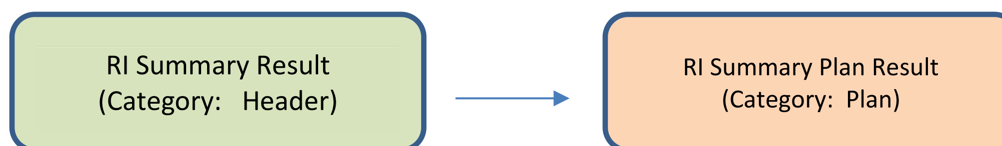
RI Summary Report (RISR) Message Format (or Record Layout) and Required Protocols

The outbound RISR Report is available to CMS and the issuer/submitting organization. This report contains the issuer level calculated RI outputs that will be used for payment processing. The RISR Report will be generated after the RI plan batch job.

5.1.1.5 File Layout

This section specifies the file layout for the RISR Report. At a high level, it consists of two (2) record types or categories as shown in Figure 2.

Figure 2: EDGE Server RI Summary Report Data Categories



The RISR XSD Report consists of report Header and Plan categories. The RISR XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.6 Field/Data Elements and Descriptions

The data characteristics for the RISR Plan Summary File Header Result category are as shown in Table 8. The root element of the RISR in the XSD is RISummaryReport (*RISummaryReport.xsd*). This element is required and all the other elements defined in this section for the RISR are embedded within this element start and end tags.

Table 8: RISR Summary File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader.xsd	none
Calendar Year	The calendar year for which RI was executed.	File Header	1	calendarYear	String	Strict: YYYY
Execution Type	Designate preliminary or final run.	File Header	1	executionType	String	minLength = 1; maxLength = 30 Enumeration Values: "P": Preliminary "F": Final
Issuer Legal Name	The issuer's legal name.	File Header	1	issuerLegalName	String	minLength = 0, maxLength = 80
State	State.	File Header	1	enrolleeState	String	minLength = 0 maxLength = 2
Member Months for RI Eligible Enrollees	The count of months for RI eligible enrollees within the payment year (Jan-Dec) for individual market plans.	File Header	1	memberMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Number of Unique RI Eligible Enrollee IDs	States the number of unique RI eligible Enrollee IDs for individual market plans.	File Header	1	numberOfUniqueEnrolleeIDs	Integer	minInclusive = 0; maxInclusive = 999999999

Table 8: RISR Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollees receiving RI payments	Total number of enrollees receiving RI Payments across all Individual Market plans.	File Header	1	totalIncurredClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Paid Amount for RI eligible Enrollees	The sum of the Paid Amount across all RI eligible enrollees, including enrollees with $0 RI payments.	File Header	1	paidAmountForAllEnrollees	Decimal	minInclusive = 0; maxInclusive = 9999999999999.99
Paid Amount for RI eligible Enrollees With Payments	The sum of the Paid Amount for enrollees with non-zero RI payments across all Individual Market plans.	File Header	1	paidAmountForRiEnrollees	Decimal	minInclusive = 0; maxInclusive = 9999999999999.99
MOOP Adjusted Paid Claims for RI Enrollees With Payments	Sum of paid claims minus the CSR MOOP Adjustment for RI enrollees with payments.	File Header	1	moopAdjustedPaidClaims	Decimal	minInclusive = 0; maxInclusive = 9999999999999.99
Total Allowed Amount for RI Eligible Enrollees	The sum of the allowed amount across all enrollees, including enrollees with $0 RI payments across all Individual Market plans.	File Header	1	rIEligibleClaimsAmountForAll	Decimal	minInclusive = 0; maxInclusive = 9999999999999.99
Total Allowed Amount for RI Enrollees With Payments	The sum of the allowed Paid Amount for enrollees with non-zero (0) RI payments across all Individual Market plans.	File Header	1	rIEligibleClaimsAmountRI	Decimal	minInclusive = 0; maxInclusive = 9999999999999.99
CSR MOOP Adjustment for RI Enrollees with Payments	Amount applied to the claims for RI payment calculation.	File Header	1	cSRMOOPAdjustment	Decimal	minInclusive = 0; maxInclusive = 999999999.99
RI Eligible Payments	The MOOP adjusted paid claims between the attachment point and the cap.	File Header	1	estimatedRIPayment	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 8: RISR Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Coinsurance Adjusted RI Payment	Total RI payment multiplied with the coinsurance rate.	File Header	1	coinsuranceAdjustedRiPayment	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Member Months for Enrollees With Payments	The count of months for RI enrollees with payments within the payment year (Jan-Dec) for Individual Market plans.	File Header	1	memberMonthsWithPayment	Decimal	minInclusive = 0; maxInclusive = 999999999.99
CSR MOOP Adjustment for RI Eligible Enrollees	CSR MOOP Amount for RI eligible enrollees.	File Header	1	rIEligibleCSRMOOPAdjustment	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Number of Enrollees Above the Cap	Total number of RI eligible enrollees with MOOP adjusted paid claims above the cap.	File Header	1	totalEnrolleesAboveCap	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RI Eligible Claims with Payment	Total number of claims for enrollees with payment across all Individual Market plans.	File Header	1	numberOfClaimsWithPayment	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RI Eligible Claims	Total number of claims eligible for Reinsurance across all Individual Market plans.	File Header	1	numberOfClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Plan Category	This XML element describes the RI plan-related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the RI Plan section of the report.	Plan	1 or more in the reported submission file	includedPlanIdentifier	riSummaryPlanCategory	none

The data characteristics for the RI Summary Plan Result category are as shown in Table 9. These elements are defined in the *RISummaryPlanCategory.xsd*.

Table 9: RISR Summary Plan Result

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	14-digit plan identifier.	Plan	1	planIdentifier	String	minLength = 0; maxLength = 14
Unique RI eligible enrollees	Number of unique RI eligible Enrollee IDs for Individual Market plans. Note: If an enrollee is in multiple plans, the enrollee will only appear in the first plan when sorted alphanumerically.	Plan	1	uniqueRIEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollees receiving RI payments	Total number of enrollees receiving RI payments in the plan. Note: If an enrollee is in multiple plans, the enrollee will only appear in the first plan when sorted alphanumerically.	Plan	1	enrolleesWithPayment	Integer	minInclusive = 0; maxInclusive = 999999999
Member Months for Enrollees With Payments	The count of months for RI enrollees with payments within the payment year (Jan-Dec) for the plan. Note: If an enrollee is in multiple plans, the member months will only be included for the first plan when sorted alphanumerically.	Plan	1	memberMonthsWithPayment	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Paid Amount for RI Eligible Enrollees With Payments	The sum of the paid amount for enrollees with non-zero (0) RI payments for the plan. Note: If an enrollee is in multiple plans, the Paid Amount from all plans will only be included for the first plan when sorted alphanumerically.	Plan	1	paidAmountForRiEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
MOOP Adjusted Paid Claims for RI Enrollees With Payments	Sum of paid claims minus the CSR MOOP Adjustment for RI enrollees with payments. Note: If an enrollee is in multiple plans, the MOOP adjusted paid claims amount from all plans will only be included for the first plan when sorted alphanumerically.	Plan	1	moopAdjustedPaidClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 9: RISR Summary Plan Result (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
CSR MOOP Adjustment for RI Enrollees with Payments	The sum of the amount applied to the claims for RI payment calculation across all enrollees in the plan. Note: If an enrollee is in multiple plans, the CSR MOOP adjustment from all plans will only be included for the first plan when sorted alphanumerically.	Plan	1	cSRMOOPAdjustment	Decimal	minInclusive = 0; maxInclusive = 999999999.99
RI Eligible Payments	The MOOP adjusted paid claims between the attachment point and the cap. Note: If an enrollee is in multiple plans, the RI eligible paid claims amount between the attachment point and the cap from all plans will only be included for the first plan when sorted alphanumerically.	Plan	1	estimatedRIPayment	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Coinsurance Adjusted RI Payment	Total RI payment multiplied with the coinsurance rate. Note: If an enrollee is in multiple plans, coinsurance adjusted payment from all plans will only be included for the first plan when sorted alphanumerically.	Plan	1	coinsuranceAdjustedRiPayment	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Communication Methods

This section describes the communication methods for the EDGE server. All communication between the EDGE server and CMS Management Console will use Secure Sockets Layer (SSL), namely Secure Shell (SSH)/Secure File Transfer Protocol (SFTP) and Hyper Text Transfer Protocol Secure (HTTPS). Further, all Web browser communication with the EDGE server will also be done using HTTPS. Internet Protocol (IP) Tables will be configured for the EDGE server to restrict incoming and outgoing network traffic across the server only for specific ports.

- Interface Initiation

The system operates on a SFTP interface along with user interface for lightweight submission and report access with 24/7 availability.

- Flow Control

Prior to start of the submission file structure and data validations, the system will create a backup of the inbound file and the data repository. After the data processing logic is executed, the system will create another backup of the outbound files and the data processing. This allows the system to recover from any failures and minimize reprocessing of data.

Notification of failures will be communicated to the EDGE server user through email. Detailed processing reports will sent to the issuer/submitter to correct the erroneous data and allow for resubmittal of the corrected information. The detailed error report will identify the records that are in error including the data element, submitted value and the detailed error message flagging the error. This allows the user to quickly identify their errors and apply the appropriate data corrections. The issuer/submitter can view the reports or data files using their Web browser user interface. Alternatively, they can download the files using SFTP either manually or as part of an automated process. The error reports will be placed in the output folder of the EDGE server application.

Security Requirements

The security requirements for accessing the outbound files are described in the existing EDGE server RARI ICD published on REGTAP, document number: *0.0.4-CMSES-ICD-4763*.

Acronyms

Table 13: Acronyms

Acronym	Literal Translation
ACA	Affordable Care Act of 2010
APTC	Advanced Premium Tax Credit
CCIIO	Center for Consumer Information and Insurance Oversight
CEFR	EDGE Server Claim and Enrollee Frequency Report
CMS	Centers for Medicare & Medicaid Services
CMS-ES	CMS-EDGE Server
CPT/HCPCS	Current Procedural Terminology/ Healthcare Common Procedure Coding System
CSR	Cost Sharing Reduction
DOB	Date Of Birth
Dx	Diagnosis
ECD	Enrollee Claims Detail
ECS	Enrollee Claims Summary
EDI	Electronic Data Interchange
ES	EDGE Server
ESES	EDGE Server Enrollment Submission
ESMCS	EDGE Server Medical Claims Submission
ESPCS	EDGE Server Pharmacy Claims Submission
ESSFS	EDGE Server Supplemental File Submission
FDEEAF	Frequency by Data Element for Enrollment Accepted Files Report
FDEPAF	Frequency by Data Element for Pharmacy Accepted Files Report
FDEMAF	Frequency by Data Element for Medical Accepted Files Report
FDESAF	Frequency by Data Element for Supplemental Accepted Files Report
HCC	Hierarchical Condition Category
HHS	Health & Human Services
HIPAA	Health Insurance Portability and Accountability Act
HTTPS	Hypertext Transfer Protocol Secure
ICD	Interface Control Document
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
IP	Internet Protocol
IVA	Initial Validation Audit
IVAS	Initial Validation Audit Statistics
MC	Medical Claim
MOOP	Maximum Out Of Pocket
MR	Medical Record
NDC	National Drug Code

Acronym	Literal Translation
NPI	National Provider Identifier
PHI	Protected Health Information
RA	Risk Adjustment
RI	Reinsurance
RIDE	Reinsurance Detail Enrollee Report
RISR	Reinsurance Summary Report
RxC	Pharmacy Claim
SE	EDGE Server System Error Report
SFTP	Secure File Transfer
SSH	Secure Shell
SSL	Secure Sockets Layer
XML	Extensible Markup Language
XSD	XML Schema Definition

Appendix A EDGE Server Outbound Reports XSDs

This section presents the XSD schema for the outbound reports generated by the EDGE server. The issuer/submitter will utilize these files to process the XML instance of these reports. These files are located in the REGTAP Library at https://www.REGTAP.info/.

- RI Summary
- RI Enrollee Detail
- System Error Report

Appendix B Referenced Documents

Table 14: Referenced Documents

Document Name	Document Number / URL	Issuance Date
Interface Control Document (ICD) Version 02.01.07	URL: https://www.REGTAP.info Document Number: 0.0.4-CMSES-ICD-4763	8/11/2015

Appendix C System Error Codes

This section defines the Error Codes that will be used for the EDGE Server System Error outbound Report. The table below specifies the Error Codes:

Table 15: System Error Codes

Unique Error Code	Error Code Description
100	Java.lang.OutOfMemoryError: Java heap space

Appendix D Document Control History

The table below records information regarding changes made to this document prior to the most recent maintenance release of this ICD Addendum.

Version Number	Date	Author/Owner	Description of Change
01.00.00	10/18/18	Accenture / CCIIO	Initial Version

Centers for Medicare & Medicaid Services

CMS-EDGE Server / CMS-ES

Risk Adjustment and Reinsurance (RARI) Interface Control Document – Addenda Zip File Table of Contents

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Version 05.00.23

February 11, 2019

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Addenda and reports with an asterisk (*) have been updated as of 2/11/2019

- **RARI ICD RA Addendum**
    - RA Claim Selection - Detail Report (RACSD)
    - RA Risk Score – Detail Report (RARSD)
    - RA Claim Selection – Summary Report (RACSS)
    - RA Risk Score – Summary Report (RARSS)
    - RA Transfer Element Extract Report (RATEE)
    - RA User Fee Report (RAUF)
    - RA Payment HCC Enrollee Report (RAPHCCER)
    - RADV Population Statistics Summary Report (RADVPS)
- **RARI ICD RADV Addendum***
    - RADV Population Summary Statistics Final Report (RADVPSF) *
    - RADV IVA Statistics Report (RADVIVAS) *
    - RADV Detailed Enrollee Report (RADVDE) *
    - RADV Enrollment Extract Report (RADVEE) *
    - RADV Medical Claim Extract Report (RADVMCE) *
    - RADV Pharmacy Claim Extract Report (RADVPCE)*
    - RADV Supplemental Extract Report (RADVSE)
- **RARI ICD RI Addendum**
    - Reinsurance – Summary Report (RISR)
    - Rinsurance Enrollee – Detail Report (RIDE)
- **RARI ICD HCRP Addendum**
    - High Cost Risk Pool Detail Enrollee Report (HCRPDE)
    - High Cost Risk Pool Summary Report (HCRPSR)
- **RARI ICD Enrollee Claims and Frequency Addendum**
    - Enrollee Claims – Summary Report (ECS)
    - Enrollee Claims – Detail Report (ECD)
    - Frequency by Data Element for Enrollment Accepted Files Report (FDEEAF)
    - Frequency by Data Element for Pharmacy Accepted Files Report (FDEPAF)
    - Frequency by Data Element for Medical Accepted Files Report (FDEMAF)
    - Frequency by Data Element for Supplemental Accepted Files Report (FDESAF)

    - System Error Report (SE)
    - Claim and Enrollee Frequency Report (CEFR)
    - Claim Resubmission Frequency Report (CRFR)
- **RARI ICD Addendum Version History**

Centers for Medicare & Medicaid Services

CMS-EDGE Server / CMS-ES

Risk Adjustment and Reinsurance (RARI) Interface Control Document – Risk Adjustment Addendum

February 11, 2019

Document Version History – Recent changes

The table below reflects the summary of changes incorporated in the most recent maintenance release of this ICD addendum.

Version Number	Date	Author/Owner	Description of Change
05.00.22	11/9/18	Accenture / CCIIO	Create separate ICD Addendum for Risk Adjustment **For changes prior to version 05.00.22, refer to the RARI ICD Consolidated Version History

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1 Purpose of Interface Control Document

This Interface Control Document (ICD) Addendum was created from the consolidated Risk Adustment (RA) and Reinsurance (RI) ICD Addendum that was separated into the following five documents:

- RARI ICD- RA Addendum,
- RARI ICD- Risk Adjustment Data Validation (RADV) Addendum,
- RARI ICD- RI Addendum,
- RARI ICD- High Cost Risk Pool (HCRP) Addendum, and
- RARI ICD- Issuer Frequency Report Addendum.

This RARI ICD Addendum is for the Risk Adjustment outbound reports, and does not contain information regarding the remaining four (4) ICDs listed above. Following is the link to the Registration For Technical Assistance Portal (REGTAP) library for the five (5) ICD Addendums listed above: https://www.regtap.info/reg_library.php.

The RARI ICD (and its accompanying addenda) documents and tracks the necessary information required to effectively define the Centers for Medicare & Medicaid Services (CMS) External Data Gathering Environment (EDGE) server system interface, as well as any rules for communicating with the EDGE servers, to give the development team guidance on the architecture of the system to be developed. In addition, the purpose of the ICD is to clearly communicate all possible inputs for all potential actions. The RARI ICD helps ensure compatibility between system segments and components.

The RARI ICD does not include information about specific business rules or how the verification edits included within this document affect the file processing logic. Additional information can be found in the EDGE Server Business Rules (ESBR) document available at : *https://www.regtap.info/reg_librarye.php?i=2673.*

2 Introduction

This is one for five addenda to the existing RARI ICD, which describes the relationship between CMS and the issuer's EDGE server. This document serves to define additional reports that will be produced by the issuer's EDGE servers as a supplement to the ICD, currently published in the Registration for Technical Assistance Portal (REGTAP) Library. These reports include the risk adjustment and reinsurance calculation reports that are used for payment processing, as well as additional analytic reports.

The CMS-EDGE server interface is only necessary when CMS is operating the Risk Adjustment and/or Reinsurance programs on behalf of a state.

The following information, with respect to the interface, is described further in this document:

- Additional EDGE server outbound report formats.

3 Overview

As part of the Affordable Care Act (ACA), two (2) programs were identified to mitigate the impact of adverse selection of plans and provide stability for issuers. States have the option to operate the following programs themselves or have the Department of Health and Human Services (HHS) operate the programs on their behalf.

- Section 1343 of the ACA created the Risk Adjustment (RA) program to better spread the financial risk borne by health insurance issuers in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. Under the RA program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Non-grandfathered, Individual and Small Group Market plans, irrespective of whether they are a part of the Marketplace, will submit RA data (claims and enrollee data) that will be used to determine individual-level risk scores, plan average actuarial risk and associated payments and charges.
- Section 1341 of the ACA establishes the Reinsurance (RI) program as a temporary three-year program that commences in 2014. RI provides funds to issuers that incur high costs for claims in the Individual Market. In accordance with the final rule, RI payments are based on a coinsurance rate or proportion of an issuer’s claims costs that are above an attachment point and below a RI cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for RI payments, while the RI cap is the dollar limit at which point an issuer is no longer eligible for RI payments. The attachment point, coinsurance rate and RI cap are calculated based on an issuer’s total incurred costs for an individual enrollee in a given calendar year. Non-grandfathered, Individual Market plans, both on and off the Marketplace, will submit RI data (claims and enrollee data) that will be used to determine if an individual market plan issuer is eligible for RI.

CMS’ Center for Consumer Information and Insurance Oversight (CCIIO) on behalf of HHS will develop the software to evaluate and perform the RA and RI calculations.

When evaluating the model for collecting and processing the data received from issuers, it was determined that a distributed data collection model would prove the most effective. Specifically, this model would ensure:

- Issuer proprietary data would not be transmitted to HHS;
- Minimal transfer of protected health information (PHI) to lower privacy and data security risks;
- Standardization of business processes, timing and rules.

These factors resulted in the concept of the EDGE server. Issuers, in states where HHS is operating an RA and/or RI program, will submit enrollee, pharmacy claim, medical claim and supplemental diagnosis information from their proprietary systems to an issuer-owned or Third Party Administrator (TPA)-hosted EDGE server. The EDGE server will run HHS-developed software designed to verify submitted data and execute the RA and RI processes. Issuers will have the option to own and operate the server themselves, or to have a third-party entity operate the server. Detailed data, file processing metrics and outbound data files will be provided to insurance companies/issuers. Only plan summarized data and file processing metrics will be provided to HHS.

4 General Interface Requirements

Interface Overview

This section describes updates to the EDGE server interface as a result of the additional reports defined in this document. For a complete description of the general interface requirements, refer to the existing EDGE server ICD, published in the REGTAP Library (Interface Control Document, document number: *0.0.4-CMSES-ICD-4763*).

Functional Allocation

The primary responsibility of the EDGE server is to provide distributed data processing capabilities to support RA and RI. The results of the data processing are available to CMS, insurance companies and their associated issuers through reports in the form of data files. Output reports can be generated in the Production, Test or Validation zones.

The reports defined in this document can be initiated by one (1) or more of the following methods:

- CMS Initiated Remote Command
- Issuer Executed EDGE Server Command

Transactions

The following reports are defined in this document. Once executed, all files are provided to the issuer/submitter and files with summary data only are provided to CMS for review.

- RA Claim Selection – Summary
- RA Risk Score – Summary
- RA User Fee
- RA Transfer Elements Extract
- RADV Population Statistics Summary Report
- RA Claim Selection – Detail
- RA Risk Score – Detail
- RA Payment HCC Enrollee Report

There are several types of outbound data files that will be sent to the issuer/submitter and to CMS as part of this process, including the following:

- Process Oriented Reports
- Operations Analytics Reports
- Management Reports
- Payment Processing Reports

The recipient of these outbound files is restricted by the content level of the files as specified by the table below.

Table 1: Report Type and Recipient

Report Type	Report Recipient
File Level Reports	Issuer/Submitter and CMS
Detail Reports	Issuer/Submitter
Summary Reports	Issuer/Submitter and CMS
Activity To Date Reports	Issuer/Submitter and CMS

Process Oriented Reports are data files generated for the issuer/submitter based on the results of the data processing of the submitted data file. This category includes the following report types:

Operations Analytics Reports are data files that help the user in understanding various operational metrics identified, thereby allowing process improvements. This also helps CMS/CCIIO in reaching out to the issuer/submitter to address any aberrant patterns.

Management Reports are outbound files of summary data used by management to gauge the execution of the overall process.

Payment Process Outputs are outbound files used to calculate the RA and RI payment amounts that will be applied for each issuer.

5 Detailed Interface Requirements

This section specifies the requirements for the interface between the insurance company/ submitting organization and the EDGE server. This includes explicit definitions of the content and format of every message or file that is expected to be transmitted between the insurance company/submitting organizations and the EDGE server and the conditions under which each file is to be sent.

Requirements for Additional EDGE Server Outbound Reports

This section describes the additional outbound report formats that will be made available to the issuer and CMS to review and analyze the processing results of the enrollment, claims and supplemental diagnosis information submitted for RI and RA processing. The files will be eXtensible Markup Language (XML) based and as per the XML Schema Definition (XSD) defined in this document.

This document describes the following reports:

- Reports sent to the insurance company/issuer administrator only:
  - RA Claim Selection - Detail
  - RA Risk Score – Detail
- Reports sent to both the insurance company/issuer administrator and CMS:
  - RA Claim Selection - Summary
  - RA Risk Score – Summary
  - RA Transfer Element Extract
  - RA User Fee
  - RA Payment HCC Enrollee Report
  - RADV Population Statistics Summary Report

As the design of the remaining reports is completed, this document will be updated.

Assumptions

The assumptions for the delivery of the EDGE server outbound files are as follows:

- Outbound reports are posted to the issuer's Amazon Web Services (AWS) S3 file repository or On-Premise server output directory designated for the remote command execution zone, as described for each report in the below sections.
- Issuers will have a separate Amazon Web Services (AWS) S3 file repository or On-Premise server output directory for the validation zone, independent of the file repositories or output directories for the production and test zone.
- The data files defined to date are XML documents. As the requirements are refined, this section will be updated to reflect the final file layout and data characteristics.

General Processing Steps

After the enrollee and claim files have been validated, designated entities, as determined by the insurance company/issuer administrator, will receive information about the status of their submission through a series of file processing reports. Similarly, CMS/CCIIO will be issued summary reports which provide the status and metrics of the data being processed. All insurance company/issuer reports will be delivered to the AWS S3 bucket configured for the issuer for AWS servers or the server's output directory for On-Premise servers. Summary reports will be delivered to the CMS/CCIIO AWS S3 bucket.

File Naming Convention

All files produced will follow the standard naming convention outlined below.

File Format Mask:

<Submitting Entity ID>.<File Type>.D<YYYYMMDD>T<hhmmss>.<Execution Zone>.xml

Example File Name:

12345. RACSD.D20140402T091533.P.xml

Table 2: File Name Parameters

Parameter	Description	Enumeration Values
Submitting Entity ID	Must be the 5 digit HIOS assigned Issuer ID.	**Example:** 12345
Date Timestamp	The date timestamp of when the file was generated.	**Example:** For April 2, 2014 at 9:15:33 AM Date Timestamp: D20140402T091533
Execution Zone	One (1) letter code indicating the execution zone where the file is to be processed.	Production:' P' Test: 'T' Local: 'L' Validation: 'V'

Shared Outbound Report Data Components Message Format (or Record Layout) and Required Protocols

The structure of the EDGE server output reports has two (2) components:

Common Header category that is reused across the defined output reports; and

- Data elements/structures that are specific to a given report

5.1.1.1 Record Layout and Required Protocols for Common Outbound File Header Record

The data contents of the common outbound file header record data structure include report file identifier, report execution date, file identifier included in the submitted file, date of submission file generated by issuer/submitter, date of submission file received by the EDGE server, report type, sender identifier (EDGE server identifier) and submitter identifier associated with the submission.

5.1.1.1.1 Business Data Element Descriptions and Technical Characteristics

The data characteristics for the Common Outbound File Header Data Structure are as shown in Table 3. These elements are defined in the *RARICommonOutboundFileHeader.xsd*.

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
File ID	The CMS system generated unique identifier of a report file.	File Header	1	outboundFileIdentifier	String	minLength = 1 maxLength = 80
CMS Batch ID	CMS generated identifier to uniquely identify a batch job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsBatchIdentifier	String	minLength = 1 maxLength = 50
CMS Job ID	CMS generated identifier to uniquely identify the job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsJobIdentifier	String	minLength = 1 maxLength = 50

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Snap Shot File Name	File name of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileName	String	none
Snap Shot File Hash	Hash value of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileHash	String	none
Run Date	The date and time when the CMS processed file is generated.	File Header	1	outboundFileGenerationDateTime	String	Strict: YYYY-MM-DDTHH:mm:SS
Interface Control Release Number	Denotes the version number of the ICD that the file corresponds to as identified on page one (1) of this document.	File Header	1	interfaceControlReleaseNumber	String	Length = 8
EDGE Server Version	Version number that corresponds to the Application, Database, Operating System, and reference table versions that were used to process the inbound file and produce the report. The application version in the execution zone for which the report is generated, will be displayed in this field.	File Header	1	edgeServerVersion	String	minLength = 0; maxLength = 75

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Job ID	System generated unique identifier for job executed on the EDGE server.	File Header	0… 1	edgeServerProcessIdentifier	String	minLength = 0; maxLength= 12
Report Type	Defines values of outbound validation report.	File Header	1	outboundFileTypeCode	String	minLength = 1 maxLength = 30
Server ID	The unique identifier of an EDGE server.	File Header	1	edgeServerIdentifier	String	minLength = 1 maxLength = 12
Issuer ID	The unique identifier for an issuer.	File Header	1	issuerIdentifier	String	Length = 5

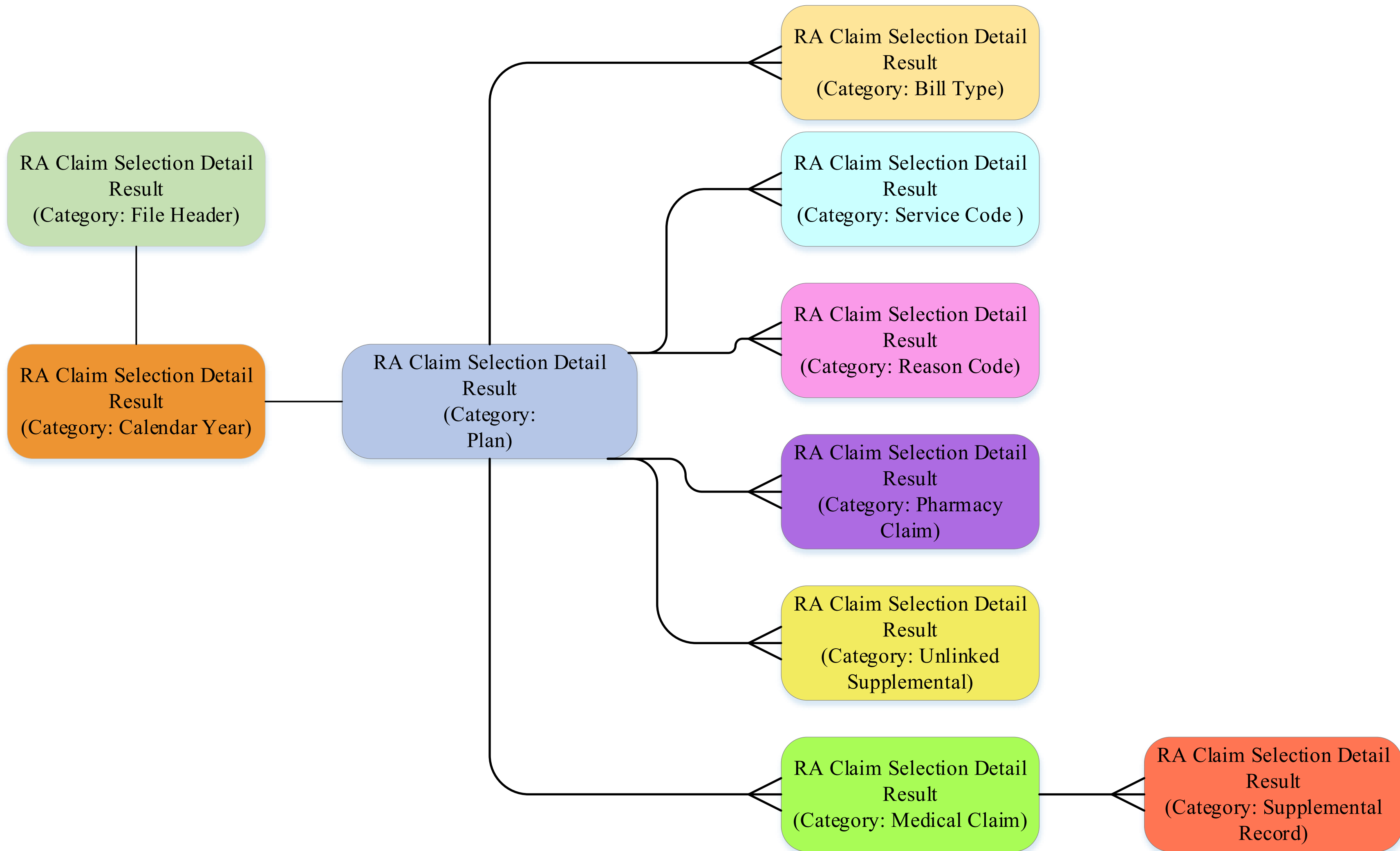
RA Claim Selection Detail Report (RACSD) Message Format (or Record Layout) and Required Protocols

The outbound RACSD Report is available to the issuer/submitting organization. This report contains the included and excluded medical claims for RA pharmacy claims, RA Medical, and supplemental records for RA, with details for each excluded claim. The RACSD Report will be generated with the risk score and transfer extract batch job.

5.1.1.2 File Layout

This section specifies the file layout for the RACSD Report. At a high level, it consists of ten (10) record types or categories, as shown in Figure 1.

Figure 1: EDGE Server RA Claim Selection Detail Report Data Categories



The RACSD Report consists of report File Header, Calendar Year, Plan, Bill Type, Service Code, Reason Code, Pharmacy Claim,

Unlinked Supplemental, Medical Claim and Supplemental Record categories.

The RACSD XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.3 Field/Data Elements and Descriptions

The data characteristics for the RACSD RA Claim Selection Detail File Header category are as shown in Table 4. The root element of the RACSD in the XSD is ClaimSelectionDetailReport (*ClaimSelectionDetailReport.xsd*). This element is required and all the other elements defined in this section for the RACSD are embedded within this element start and end tags.

Table 4: RACSD Claim Selection Detail File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader.xsd	none
Calendar Year Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Year	1 or more in the reported submission file	includedCalendarYearCategory	ClaimSelectionDetailCalendarYearCategory	none

The data characteristics for the RACSD RA Claim Selection Detail Calendar Year category are as shown in Table 5. These elements are defined in the *ClaimSelectionDetailCalendarYearCategory.xsd*.

Table 5: RACSD Claim Selection Detail Calendar Year

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Calendar Year	The calendar year associated with the claims as determined by the Statement Covers Through date/Prescription fill date.	File Header	1	calendarYear	String	Strict: YYYY Length = 4
Total Unique Enrollees	Total unique enrollees for all plans for the issuer.	File Header	1	totalEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Medical Claims Included	Total count of medical claims included for RA across all plans belonging to the issuer.	File Header	1	medicalClaimsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Medical Claims Excluded	Total count of medical claims excluded from RA for all plans belonging to the issuer.	File Header	1	medicalClaimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Supplemental Records Included	Total count of Supplemental Record ID's included for RA claim selection across all plans belonging to the issuer.	File Header	1	supplementalRecordsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Supplemental Records Excluded	Total count of Supplemental Records ID's excluded for RA claim selection across all plans belonging to the issuer.	File Header	1	supplementalRecordsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees with RA Eligible Claims	Total count of enrollees with RA claims included across all plans belonging to the issuer.	File Header	1	totalEnrolleesWRaEligibleclaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Pharmacy Claims Included	Total count of pharmacy claims included for RA claim selection across all plans belonging to the issuer.	File Header	1	pharmacyClaimsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Pharmacy Claims Excluded	Total count of pharmacy claims excluded for RA across all plans belonging to the issuer.	File Header	1	pharmacyClaimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999

Table 5: RACSD Claim Selection Detail Calendar Year (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Count of NDCs for Active Claims	Total unique count of NDCs (first 8 digits) for active claims belonging to the issuer included for RA.	File Header	1	totalUniqueNDC	Integer	minInclusive = 0; maxInclusive = 999999999
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report.	Plan	1 or more per calendar year in the reported submission file	includedPlanCategory	ClaimSelectionDetailPlanCategory	none

The data characteristics for the RACSD RA Claim Selection Detail Plan category are as shown in Table 6. These elements are defined in the *ClaimSelectionDetailPlanCategory.xsd*.

Table 6: RACSD Claim Selection Detail Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique identifier for the plan at the 16-digit.	Plan	1	planIdentifier	String	minLength = 0 maxLength = 16
Total Enrollees	Total unique enrollees for the plan.	Plan	1	totalEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Medical Claims Included	Total count of medical claims for the plan included for RA claim selection.	Plan	1	medicalClaimsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999

Table 6: RACSD Claim Selection Detail Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Count of Medical Claims Excluded	Total count of medical claims for the plan that were excluded from RA claim selection.	Plan	1	medicalClaimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Supplemental Records Included	Total count of supplemental records for the plan that were included for RA claim selection.	Plan	1	supplementalRecordsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Supplemental Records Excluded	Total count of supplemental records for the plan that were excluded for RA claim selection.	Plan	1	supplementalRecordsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees with RA Eligible Claims	Total count of enrollees for the plan with RA claims included in claim selection.	Plan	1	totalEnrolleesWRaEligibleclaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Pharmacy Claims Included	Total count of pharmacy claims for the plan included for RA claim selection.	Plan	1	pharmacyClaimsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Pharmacy Claims Excluded	Total count of pharmacy claims for the plan excluded for RA claim selection.	Plan	1	pharmacyClaimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Count of NDCs for Active Claims	Total Unique count of NDCs (first 8 digits) for active claims for the plan included for RA.	Plan	1	totalUniqueNDC	Integer	minInclusive = 0; maxInclusive = 999999999
Bill Type Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Bill Type	1 or more per bill type per insurance plan in the reported submission file	includedBilltypeCategory	ClaimSelectionDetailBillTypeCategory	none

Table 6: RACSD Claim Selection Detail Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Service Code Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Service Code	1 or more per service code per insurance plan in the reported submission file	includedServiceCodeCategory	ClaimSelectionDetailServiceCodeCategory	none
Reason Code Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Reason Code	1 or more per reason code per insurance plan in the reported submission file	includedReasonCodeCategory	ClaimSelectionDetailReasonCodeCategory	none
Pharmacy Claim Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Pharmacy	1 or more per claim per insurance plan in the reported submission file	includedPharmacyClaimCategory	ClaimSelectionDetailPharmacyClaimCategory	none
Unlinked Supplemental Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Unlinked Supplemental	1 or more per records per insurance plan in the reported submission file	includedUnlinkedSupplementalCategory	ClaimSelectionDetailUnlinkedSupplementalCategory	none

Table 6: RACSD Claim Selection Detail Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Medical Claim Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Medical	1 or more per claim per insurance plan in the reported submission file	includedMedicalClaimCategory	ClaimSelectionDetailMedicalClaimCategory	none

The data characteristics for the RACSD RA Claim Selection Detail Bill Type category are as shown in Table 7. These elements are defined in the *ClaimSelectionDetailBillTypeCategory.xsd*.

Table 7: RACSD Claim Selection Detail Bill Type

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Bill Type Code	Bill Type Code for the medical claim (only include the bill types for RA claim selection).	Bill Type	0..1	billTypeCode	String	minLength = 0 maxLength = 3
Total Count of Claims Included	Total count of medical claims included for RA claim selection with the bill code.	Bill Type	0..1	claimsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Claims Excluded	Total count of medical claims excluded for RA claim selection.	Bill Type	0..1	claimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RACSD RA Claim Selection Detail Service Code category are as shown in Table 8. These elements are defined in the *ClaimSelectionDetailServiceCodeCategory.xsd*.

Table 8: RACSD Claim Selection Detail Service Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Service Code	Service Code for the medical claim (only include Service Codes flagged for RA claim selection).	Service Code	0..1	serviceCode	String	minLength = 0 maxLength = 5
Total Count of Claims Included	Total count of medical claims included for RA claim selection with the Service Code.	Service Code	0..1	claimsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Claims Excluded	Total count of medical claims excluded for RA claim selection with the Service Code.	Service Code	0..1	claimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RACSD RA Claim Selection Detail Reason Code category are as shown in Table 9. These elements are defined in the *ClaimSelectionDetailReasonCodeCategory.xsd*.

Table 9 : RACSD Claim Selection Detail Reason Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Medical Reason Code	Reason Code why the medical claim was excluded from RA claim selection.	Reason Code	0..1	medicalReasonCode	String	minLength = 0 maxLength = 10
Total Count of Medical Claims Excluded	Total count of medical claims excluded for RA claim selection with the Reason Code.	Reason Code	0..1	medicalClaimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999
Pharmacy Reason Code	Reason Code why the pharmacy claim was excluded from RA claim selection.	Reason Code	0..1	pharmacyReasonCode	String	minLength = 0 maxLength = 10
Total Count of Pharmacy Claims Excluded	Total count of pharmacy claims excluded for RA claim selection with the Reason Code.	Reason Code	0..1	pharmacyClaimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999
Supplemental Reason Code	Reason Code why the supplemental record was excluded from RA claim selection.	Reason Code	0..1	supplementalReasonCode	String	minLength = 0 maxLength = 10
Total Count of Supplemental Records Excluded	Total count of supplemental records excluded for claim selection with the Reason Code.	Reason Code	0..1	supplementalRecordsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RACSD RA Claim Selection Detail Pharmacy Claim category are as shown in Table 10. These elements are defined in the *ClaimSelectionDetailPharmacyClaimCategory.xsd*.

Table 10: RACSD Claim Selection Detail Pharmacy Claim

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollee ID	Enrollee Identifier.	Pharmacy	1	enrolleeIdentifier	String	minLength = 0; maxLength = 80
Pharmacy Claim ID	Pharmacy Claim Identifier.	Pharmacy	1	pharmacyClaimIdentifier	String	minLength = 0; maxLength = 50
Product/Service ID	Unique ID of the product or service dispensed.	Pharmacy	1	nationalDrugCode	String	minLength=1; maxLength=12
RA Eligible Indicator	Indicates if the claim is eligible for RA or not.	Pharmacy	1	raEligibleIndicator	String	minLength = 0 maxLength = 1 Enumeration Values: “0”: RA Ineligible “1”: RA Eligible
Policy Paid Amount		Pharmacy	1	policyPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

	The policy paid amount for the claim under the plan.					
Reason Code	Reason Code why the pharmacy claim was excluded from RA if not included.	Pharmacy	0..1	reasonCode	String	minLength = 0; maxLength = 3

The data characteristics for the RACSD RA Claim Selection Detail Unlinked Supplemental category are as shown in **Table 11**. These elements are defined in the *ClaimSelectionDetailUnlinkedSupplementalCategory.xsd*.

Table 11: RACSD Claim Selection Detail Unlinked Supplemental

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollee ID	Enrollee Identifier (Enrollee level for the plan).	Unlinked Supplemental	1	enrolleeIdentifier	String	minLength = 0; maxLength = 80
Original Medical Claim Identifier	The medical Claim ID to which the supplemental record corresponds that was submitted on a previous claim and was accepted by the EDGE server.	Unlinked Supplemental	1	originalMedicalClaimId	String	minLength = 0; maxLength = 50
Supplemental Diagnosis Detail Record Identifier	Unique number generated by the issuer to uniquely identify the supplemental diagnosis transaction.	Unlinked Supplemental	1	supplementalDiagnosisDetailRecordId	String	minLength = 0; maxLength = 50
Add/Delete/Void Indicator	Identifies if a supplemental diagnosis is added, deleted, or if a previously	Unlinked Supplemental	1	addDeleteVoidCode	String	Length = 1 Enumeration Values: 'A', 'D', 'V'

Table 11: RACSD Claim Selection Detail Unlinked Supplemental						
Business Data Element	**Description**	**Data Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
	accepted supplemental diagnosis record is to be voided.					Enumeration Values description: 'A' = Add, 'D' = Delete, 'V' = Void

The data characteristics for the RACSD RA Claim Selection Detail Medical Claim category are as shown in Table 12. These elements are defined in the *ClaimSelectionDetailMedicalClaimCategory.xsd*.

Table 12: RACSD Claim Selection Detail Medical Claim

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollee ID	Enrollee Identifier.	Medical	1	enrolleeIdentifier	String	minLength = 0; maxLength = 80
Medical Claim Identifier	Medical Claim Identifier.	Medical	1	medicalClaimIdentifier	String	minLength = 0; maxLength = 50
RA Eligible Indicator	Indicates if the claim is eligible for RA.	Medical	1	raEligibleIndicator	String	minLength = 0 maxLength = 1 Enumeration Values: “0”: RA Ineligible “1”: RA Eligible

Table 12: RACSD Claim Selection Detail Medical Claim (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Bill Type Code	Bill Type Code for the medical claim.	Medical	0..1	billTypeCode	String	minLength = 0 maxLength = 3
Service Code	Service Code for the medical claim.	Medical	0..1	serviceCode	String	minLength = 0; maxLength = 5
Reason Code	Reason Code why the medical claim was excluded from RA.	Medical	0..1	reasonCode	String	minLength = 0; maxLength = 3
RXC Eligible Indicator	Identifies if the medical claim satisfied all criteria for at least one HCPCS code from the medical claim to create an RXC	Medical	0..1	rxcEligibleIndicator	String	minLength = 0 maxLength = 1 Enumeration Values: “1”: RXC eligible “0”: RXC Ineligible
Supplemental Category	The XML element exists to connect this level of the XXML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Detail Supplemental record section of the report.	Supplemental	1 or more per supplemental record per insurance plan in the reported submission file	includedSupplementalRecordCategory	ClaimSelectionDetailSupplementalRecordCategory	none

The data characteristics for the RACSD RA Claim Selection Detail Supplemental Record category are as shown in Table 13. These elements are defined in the *ClaimSelectionDetailSupplementalRecordCategory.xsd*.

Table 13: RACSD Claim Selection Detail Supplemental Claim

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollee ID	Enrollee Identifier.	Supplemental	1	enrolleeIdentifier	String	minLength = 0; maxLength = 80
Original Medical Claim Identifier	The medical Claim ID to which the supplemental record corresponds that was submitted on a previous claim and was accepted by the EDGE server.	Supplemental	1	originalMedicalClaimId	String	minLength = 0; maxLength = 50
Supplemental Diagnosis Detail Record Identifier	Unique number generated by the issuer to uniquely identify the supplemental diagnosis transaction.	Supplemental	1	supplementalDetailRecordId	String	minLength = 0; maxLength = 50
Add/Delete/Void Indicator	Identifies if a supplemental diagnosis is added, deleted, or if a previously accepted supplemental diagnosis record is to be voided.	Supplemental	1	addDeleteVoidCode	String	Length = 1 Enumeration Values: 'A', 'D', 'V' Enumeration Values description: 'A' = Add, 'D' = Delete, 'V' = Void
Reason Code	Reason Code why the supplemental record was excluded from RA claim selection.	Supplemental	0..1	reasonCode	String	minLength = 0; maxLength = 3

RA Risk Score Detail Report (RARSD) Message Format (or Record Layout) and Required Protocols

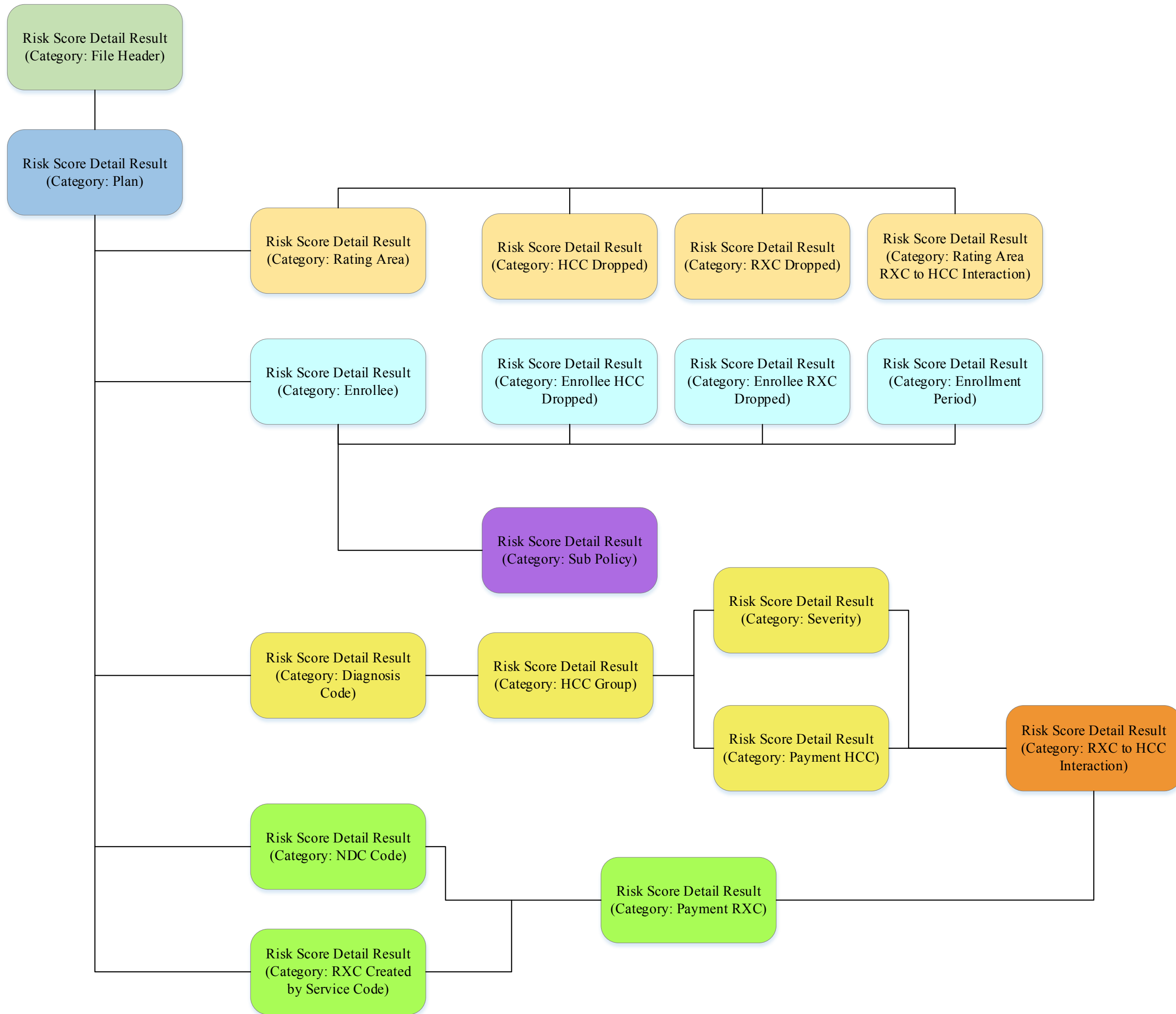
The outbound RARSD Report is available only to the issuer/submitting organization. It is not available to CMS. This report notifies the issuer about the average and individual risk score for the issuer, plan and enrollee. The RARSD Report will be generated when the risk score and transfer extract batch job is executed.

Note – System generated cross year enrollment periods, created during the RA calculation in order to include qualifying cross year claims, are included by the system when calculating the values in this report.

5.1.1.4 File Layout

This section specifies the file layout for the RARSD Report. At a high level, it consists of nineteen (19) record types or categories, as shown in Figure 2: EDGE Server RA Risk Score Detail Report Data Categories.

Figure 2: EDGE Server RA Risk Score Detail Report Data Categories



The RARSD Report consists of report File Header, Plan, Rating Area, Diagnosis Code, HCC Group, Severity, Payment HCC, RXC to HCC Interaction, NDC Code, RXC Created by Service Code, Payment RXC, Enrollee, Enrollment Period and Sub Policy categories.

The RARSD XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.5 Field/Data Elements and Descriptions

The data characteristics for the RARSD Risk Score Detail File Header category are as shown in **Table 14**. The root element of the RARSD in the XSD is RiskScoreDetailReport

(*RiskScoreDetailReport.xsd*). This element is required and all the other elements defined in this section for the RARSD are embedded within this element start and end tags.

Table 14: RARSD Risk Score Detail File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader.xsd	none
Plan Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Plan	1 or more per insurance plan	includedPlanIdentifier	RiskScoreDetailPlanCategory	none
Calendar Year	The calendar year for which risk score was executed.	File Header	1	calendarYear	String	Length = 4 Strict: YYYY
Execution Type	Designate preliminary or final run.	File Header	1	executionType	String	minLength = 1 maxLength = 30 Enumeration Values: "P": Preliminary "F": Final
Total Enrollees	Total number of unique enrollees across all plans.	File Header	1	totalEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Diagnoses Accepted	Total Count of Diagnosis Codes accepted for all plans for the issuer	File Header	1	totalDiagnosesAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total NDCs Accepted	Total Count of NDCs accepted for all adult model enrollees for all plans for the issuer	File Header	1	totalNdcsAccepted	Integer	minInclusive = 0; maxInclusive = 999999999

Table 14: RARSD Risk Score Detail File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Risk Adjustment Diagnoses Accepted	Total count of risk adjustment diagnoses accepted for all plans for a distinct issuer.	File Header	1	totalRADiagnosesAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total RA NDCs Accepted	Total count of risk adjustment NDCs accepted for all adult model enrollees for all plans for a distinct issuer	File Header	1	totalRANdcsAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total HCCs	Total count of Hierarchical Condition Categories (HCCs) (without hierarchies imposed) for all enrollees for all plans for a distinct issuer.	File Header	1	totalConditionCategories	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXCs	Total unique count of RXCs without hierarchies imposed for all adult model enrollees for all plans for a distinct issuer	File Header	1	totalRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Payment HCCs	Total count of payment HCCs (with hierarchies imposed) for all enrollees for all plans for a distinct issuer.	File Header	1	totalPaymentConditionCategories	Integer	minInclusive = 0; maxInclusive = 999999999
Total Payment RXCs	Total unique count of payment RXCs (with hierarchies imposed) for all adult model enrollees for all plans for a distinct issuer.	File Header	1	totalPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees with Payment HCCs	Total count of unique enrollees with payment HCCs for all plans for a distinct issuer.	File Header	1	totalEnrolleesWPaymentHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees with Payment RXCs	Total count of unique adult model enrollees with payment RXCs for all plans for a distinct issuer.	File Header	1	totalEnrolleesWPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees without Payment HCCs	Total count of unique enrollees that have no payment HCCs for all plans for a distinct issuer.	File Header	1	totalEnrolleesWOutPaymentHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees without Payment RXCs	Total count of unique adult model enrollees that have no payment RXCs for all plans for a distinct issuer.	File Header	1	totalEnrolleesWOutPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Enrollee Payment HCCs	Total count of unique enrollee payment HCCs across all plans for a distinct issuer.	File Header	1	totalUniqueEnrolleePaymentHCCs	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Average Number of Payment HCCs per Enrollee by all Enrollees (Child Model)	This field is calculated by summing the count of payment HCCs of each unique enrollee in the child model and then dividing by the unique number of enrollees in the child model.	File Header	1	averageNumberPaymentHccsEnrolleeByEnrolleeChild	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of Payment HCCs per Enrollee by all Enrollees (Adult Model)	This field is calculated by summing the count of payment HCCs of each unique enrollee in the adult model and then dividing by the unique number of enrollees in the adult model.	File Header	1	averageNumberPaymentHccsEnrolleeByEnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of Payment RXCs per Enrollee by all Enrollees (Adult Model)	This field is calculated by summing the count of unique payment RXCs of each unique enrollee in the adult model and then dividing by the unique number of enrollees in the adult model.	File Header	1	averageNumberPaymentRxcsEnrolleeByEnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of Payment HCCs per Enrollee by all Enrollees (Infant Model)	This field is calculated by summing the count of payment HCCs of each unique enrollee in the infant model and then dividing by the unique number of enrollees in the infant model.	File Header	1	averageNumberPaymentHccsEnrolleeByEnrolleeInfant	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 14: RARSD Risk Score Detail File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Average Number of HCCs per Enrollee by HCC Enrollees (Child Model)	This field is calculated by summing the count of HCCs for each unique enrollee with an HCC in the child model and then dividing by the unique number of enrollees with an HCC in the child model.	File Header	1	averageNumberHccsPerEnrolleeByEnrolleeChild	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of HCCs per Enrollee by HCC Enrollees (Adult Model)	This field is calculated by summing the count of HCCs for each unique enrollee with an HCC in the adult model and then dividing by the unique number of enrollees with an HCC in the adult model.	File Header	1	averageNumberHccsPerEnrolleeByEnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of RXCs per Enrollee By Enrollee (Adult Model)	This field is calculated by summing the count of unique RXCs for each unique enrollee with a RXC in the adult model and then dividing by the unique number of enrollees with a RXC in the adult model.	File Header	1	averageNumberRxcsPerEnrolleeByEnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Male	Total count of unique male enrollees for a distinct issuer.	File Header	1	totalMaleCount	Integer	minInclusive = 0; maxInclusive = 999999999
Males with Payment HCCs	Total count of unique male enrollees with payment HCCs for a distinct issuer.	File Header	1	totalMaleCountWithHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Males with RXCs	Total count of unique adult model male enrollees with RXCs for a distinct issuer.	File Header	1	totalMaleCountWithRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Infant Model	Total count of unique males in the infant model for a distinct issuer.	File Header	1	malesCountInfantModel	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Child Model	Total count of unique males in the child model for a distinct issuer.	File Header	1	malesCountChildModel	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Adult Model	Total count of unique males in the adult model for a distinct issuer.	File Header	1	malesCountAdultModel	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Female	Total count of unique female enrollees for a distinct issuer.	File Header	1	totalCountFemale	Integer	minInclusive = 0; maxInclusive = 999999999
Females with Payment HCCs	Total count of unique female enrollees with payment HCCs for a distinct issuer.	File Header	1	femaleCountWithHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Females with RXCs	Total count of unique adult model female enrollees with RXCs for a distinct issuer.	File Header	1	femaleCountWithRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Females in Infant Model	Total count of unique females in the infant model for a distinct issuer.	File Header	1	femaleCountInfantModel	Integer	minInclusive = 0; maxInclusive = 999999999

Table 14: RARSD Risk Score Detail File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Females in Child Model	Total count of unique females in the child model for a distinct issuer.	File Header	1	femaleCountChildModel	Integer	minInclusive = 0; maxInclusive = 999999999
Females in Adult Model	Total count of unique females in the adult model for a distinct issuer.	File Header	1	femaleCountAdultModel	Integer	minInclusive = 0; maxInclusive = 999999999
Infant Count	Total count of unique infant enrollees for a distinct issuer.	File Header	1	infantCount	Integer	minInclusive = 0; maxInclusive = 999999999
Child Count	Total count of unique child enrollees for a distinct issuer.	File Header	1	childCount	Integer	minInclusive = 0; maxInclusive = 999999999
Adult Count	Total count of unique adult enrollees for a distinct issuer.	File Header	1	adultCount	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Enrollee Count	Total count of unique enrollees that have at least one (1) system generated cross year enrollment period for a distinct issuer.	File Header	1	crossYearEnrolleeCount	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Enrollment Period Count	Total count of unique system generated cross year enrollment periods for a distinct issuer.	File Header	1	crossYearEnrollmentPeriodCount	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Member Month Count	Total sum of member months for all system generated cross year enrollment periods for a distinct issuer.	File Header	1	crossYearMemberMonthCount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

The data characteristics for the RARSD Risk Score Detail Plan category are as shown in Table 15. These elements are defined in the *RiskScoreDetailPlanCategory.xsd*.

Table 15: RARSD Risk Score Detail Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Rating Area Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Plan	1 or more per insurance plan in the Rating Area	includedRatingArea	RiskScoreDetailRatingAreaCategory	none
Plan ID	Unique 16-digit identifier for the plan.	Plan	1	planIdentifier	String	minLength = 0 maxLength = 16
Metal Level Indicator	Metal level indicator used to determine the metal level of the 16-digit Plan ID.	Plan	1	metalLevel	String	minLength = 0; maxLength = 15 Enumeration Values: "01-Platinum" "02-Gold" "03-Silver" "04-Bronze" "05-Catastrophic"
State	State where the plan is offered.	Plan	1	state	String	minLength = 0 maxLength = 2
Market	Market in the State where the plan is offered; Individual or Small Group.	Plan	1	market	String	minLength = 0; maxLength = 30 Enumeration Values: "1": Individual "2": Small Group

The data characteristics for the RARSD Risk Score Detail Rating Area category are as shown in Table 16. These elements are defined in the *RiskScoreDetailRatingAreaCategory.xsd*.

Table 16: RARSD Risk Score Detail Rating Area

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollee Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Enrollee	1 or more per enrollee per insurance plan in the Rating Area	includedEnrolleeCategory	RiskScoreDetailEnrolleeCategory	none
Rating Area	Plan Rating Area	Rating Area	1	ratingArea	String	maxLength = 3
Total Enrollees	Total count of unique enrollees for the Plan ID and Rating Area.	Rating Area	1	totalEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Diagnoses Accepted	Total count of Diagnosis Codes accepted for all enrollees for the Plan ID and Rating Area.	Rating Area	1	totalDiagnosesAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total NDCs Accepted	Total count of NDC Codes accepted for all adult model enrollees for the Plan ID and Rating Area.	Rating Area	1	totalNdcsAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total Risk Adjustment Diagnoses Accepted	Total count of risk adjustment diagnoses accepted for all enrollees for the Plan ID and Rating Area.	Rating Area	1	raDiagnosesAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total RANDCsRA NDCs Accepted	Total count of RA NDCs accepted for all adult model enrollees for the Plan ID and Rating Area.	Rating Area	1	totalRANdcsAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total HCCs	Total count of HCCs (without hierarchies imposed) for all enrollees for the Plan ID and Rating Area.	Rating Area	1	totalConditionCategories	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXCs	Total count of unique RXCs (without hierarchies imposed) for all adult model enrollees for the Plan ID and Rating Area.	Rating Area	1	totalRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Payment HCCs	Total count of payment HCCs (with hierarchies imposed) for all enrollees for the Plan ID and Rating Area.	Rating Area	1	totalPaymentConditionCategories	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Payment RXCs	Total count of unique Payment RXCs for the Plan ID and Rating Area.for adult model enrollees	Rating Area	1	totalPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total enrollee with Payment HCCs	Total count of unique enrollees with payment HCCs for the Plan ID and Rating Area.	Rating Area	1	totalEnrolleesPaymentConditionCategories	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees with Payment RXCs	Total count of unique adult model Enrollees with Payment RXCs for all enrollees for the Plan ID and Rating Area.	Rating Area	1	totalEnrolleesWPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees without Payment HCCs	Total count of unique enrollees that have no payment HCCs for the Plan ID and Rating Area.	Rating Area	1	totalEnrolleesWithoutPaymentConditionCategories	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees without Payment RXCs	Total count of unique adult model Enrollees without Payment RXCs for all enrollees for the Plan ID and Rating Area.	Rating Area	1	totalEnrolleesWOutPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXC to HCC interactions	Total unique count of RXC to HCC interactions for all plans for the issuer for all adult model enrollees	Rating Area	1	totalRxcToHccInteractions	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXCs Created From Service Codes	Total unique count of RXCs created from Service codes for all plans for the issuer for all adult model enrollees	Rating Area	1	totalRxcsCreatedFromSrvcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees With RXC to HCC Interactions	Total count of unique adult model Enrollees with RXC to HCC Interactions for all plans for the issuer.	Rating Area	1	totalEnrolleesWithRxcToHccInteractions	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees With RXCs Created From Service Codes	Total count of unique adult model Enrollees with RXCs Created from Service Codes for all plans for the issuer.	Rating Area	1	totalEnrollees WithRxcsCreatedFromSrvcCodes	Integer	minInclusive = 0; maxInclusive = 999999999

Table 16: RARSD Risk Score Detail Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Enrollee Payment HCCs	Total count of unique enrollee payment HCCs for the Plan ID and Rating Area.	Rating Area	1	uniqueEnrolleePaymentConditionCategories	Integer	minInclusive = 0; maxInclusive = 999999999
Average Number of Payment HCCs per Enrollee (all Enrollees) Child Model	Average number of payment HCCs per enrollee for enrollees that have enrollment in the plan and Rating Area. This field is calculated by summing the count of payment HCCs of each unique enrollee in the child model and then dividing by the unique number of enrollees in the child model.	Rating Area	1	averageNumberPaymentHccsEnrolleeByEnrolleeChild	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of Payment HCCs per Enrollee (all Enrollees): Adult Model	Average number of payment HCCs per enrollee for enrollees that have enrollment in the plan and Rating Area. This field is calculated by summing the count of payment HCCs of each unique enrollee in the adult model and then dividing by the unique number of enrollees in the adult model.	Rating Area	1	averageNumberPaymentHccsEnrolleeByEnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of Payment RXCs per Enrollee (all Enrollees): Adult Model	Average number of unique payment RXCs per enrollee for enrollees that have enrollment in the plan and Rating Area. This field is calculated by summing the count of unique payment RXCs of each unique enrollee in the adult model and then dividing by the unique number of enrollees in the adult model.	Rating Area	1	averageNumberPaymentRxcsEnrolleeByEnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Member Months	Total sum of member months for all enrollees in the Plan ID and Rating Area within the year.	Rating Area	1	totalMemberMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Male	Total count of unique male enrollees for the Plan ID and Rating Area.	Rating Area	1	totalMaleCount	Integer	minInclusive = 0; maxInclusive = 999999999

Males with Payment HCCs	Total count of unique male enrollees with payment HCCs for the Plan ID and Rating Area.	Rating Area	1	totalMaleCountWithHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Males Male Adults with Payment RXCs	Total count of unique adult model male enrollees with payment RXCs for the Plan ID and Rating Area.	Rating Area	1	totalMaleCountWithRxcs	Integer	minInclusive = 0; maxInclusive = 999999999

Table 16: RARSD Risk Score Detail Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Males in Infant Model	Total count of unique males in the infant model for the Plan ID and Rating Area.	Rating Area	1	malesCountInfantModel	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Child Model	Total count of unique males in the child model for the Plan ID and Rating Area.	Rating Area	1	malesCountChildModel	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Adult Model	Total count of unique males in the adult model for the Plan ID and Rating Area.	Rating Area	1	malesCountAdultModel	Integer	minInclusive = 0; maxInclusive = 999999999
Female	Total count of unique female enrollees for the Plan ID and Rating Area.	Rating Area	1	totalCountFemale	Integer	minInclusive = 0; maxInclusive = 999999999
Females with Payment HCCs	Total count of unique female enrollees with payment HCCs for the Plan ID and Rating Area.	Rating Area	1	femaleCountWithHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
FemalesFemale Adults with Payment RXCs	Total count of unique adult model female enrollees with payment RXCs for the Plan ID and Rating Area.	Rating Area	1	femaleCountWithRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Females in Infant Model	Total count of unique females in the infant model for the Plan ID and Rating Area.	Rating Area	1	femaleCountInfantModel	Integer	minInclusive = 0; maxInclusive = 999999999
Females in Child Model	Total count of unique females in the child model for the Plan ID and Rating Area.	Rating Area	1	femaleCountChildModel	Integer	minInclusive = 0; maxInclusive = 999999999
Females in Adult Model	Total count of unique females in the adult model for the Plan ID and Rating Area.	Rating Area	1	femaleCountAdultModel	Integer	minInclusive = 0; maxInclusive = 999999999
Infant Count	Total count of unique infant enrollees for a distinct issuer.	Rating Area	1	infantCount	Integer	minInclusive = 0; maxInclusive = 999999999

Table 16: RARSD Risk Score Detail Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Child Count	Total count of unique child enrollees for a distinct issuer.	Rating Area	1	childCount	Integer	minInclusive = 0; maxInclusive = 999999999
Adult Count	Total count of unique adult enrollees for a distinct issuer.	Rating Area	1	adultCount	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Enrollee Count	Total count of unique enrollees that have at least one (1) system generated cross year enrollment period for the Plan ID and Rating Area.	Rating Area	1	crossYearEnrolleeCount	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Enrollment Period Count	Total count of unique system generated cross year enrollment periods for the Plan ID and Rating Area.	Rating Area	1	crossYearEnrollmentPeriodCount	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Member Month Count	Total sum of member months for all system generated cross year enrollment periods for the Plan ID and Rating Area.	Rating Area	1	crossYearMemberMonthCount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Rating Area Dropped HCC Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	HCC Dropped	1 or more per enrollee per insurance plan in the Rating Area	includedRatingAreaHccDroppedCategory	RiskScoreDetailRatingAreaHccDroppedCategory	none
Severity Level (Infant model includes maturity level)	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Severity Level	1 or more per insurance plan per issuer in the reported submission file	includedRatingAreaSeverityLevelCategory	RiskScoreDetailRatingAreaSeverityLevelCategory	none

RXC to HCC Interaction Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	RXC to HCC Interaction	1 or more in the reported submission file	includedRxcToHccInteractionGroupCategory	RiskScoreDetailRxcToHccInteractionGroupCategory	None

The data characteristics for the RARSD Risk Score Detail Rating Area HCC Dropped category are as shown in Table 17. These elements are defined in the *RiskScoreDetailRatingAreaHccDroppedCategory.xsd*.

Table 17: RARSD Risk Score Detail Rating Area HCC Dropped

Table 17: RARSD Risk Score Detail Rating Area HCC Dropped

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Dropped HCC	HCCx dropped, across all RA Payment HCC Rating Area, due to HCC hierarchy, HCC Group. (*repeat for each HCC).	HCC Dropped	1	droppedHCCs	String	minLength = 0; maxLength = 10
Frequency of HCC	Frequency of HCCx dropped, across all RA Payment HCC Enrollees, due to HCC hierarchy, HCC Group. (*repeat for each HCC).	HCC Dropped	1	frequencyDroppedHCCs	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSD Risk Score Detail Rating Area Severity Level category are as shown in Table 18.. These elements are defined in the *RiskScoreDetailRatingAreaSeverityLevelCategory.xsd*.

Table 18: RARSD Risk Score Detail Rating Area Severity Level

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
IHCC Severity Level	Severity and maturity level assigned for the infant age model.	Severity Level	0..1	hccSeverity	String	minLength = 0 Enumeration Values: “1”: Extremely Immature & Severity 1 “2”: Extremely Immature & Severity 2 “3”: Extremely Immature & Severity 3 “4”: Extremely Immature & Severity 4 “5”: Extremely Immature & Severity 5 “6”: Immature & Severity 1 “7”: Immature & Severity 2 “8”: Immature & Severity 3 “9”: Immature & Severity 4 “10”: Immature & Severity 5 “11”: Premature Multiples & Severity 1 “12”: Premature Multiples & Severity 2 “13”: Premature Multiples & Severity 3 “14”: Premature Multiples & Severity 4 “15”: Premature Multiples & Severity 5 “16”: Term & Severity 1 “17”: Term & Severity 2 “18”: Term & Severity 3 “19”: Term & Severity 4 “20”: Term & Severity 5 “21”: One Year Old & Severity 1 “22”: One Year Old & Severity 2 “23”: One Year Old & Severity 3 “24”: One Year Old & Severity 4 “25”: One Year Old & Severity 5 NULL: No enrollees in the infant model to report
Enrollee Severity Count	Count of infant model enrollees with the defined severity level.	Severity Level	1	enrolleeSeverityCount	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RA Risk Score Detail (RARSD) Risk Score Detail Rating Area RXC to HCC interaction Group category are as shown in Table 19. These elements are defined in the *RiskScoreDetailRxcToHccInteractionGroupCategory.xsd*.

Table 19: RARSD Risk Score Detail Rating Area RXC to HCC Interaction

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
RXC to HCC Interaction	RXC to HCC Interaction from Adult Model Enrollees	RXC to HCC Interaction	1	rxcToHccInteraction	String	minLength = 0 maxLength = 30
RXC to HCC Interaction Count	Total count of unique adult model enrollees with at least one instance of the RXC to HCC interaction	RXC to HCC Interaction	1	rxcToHccInteractionCount	Integer	minInclusive= 0; maxInclusive = 9999999

The data characteristics for the RA Risk Score Detail (RARSD) Risk Score Detail Enrollee category are as shown in Table 20. These elements are defined in the *RiskScoreDetailEnrolleeCategory.xsd*.

Table 20: RARSD Risk Score Detail Enrollee

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique Enrollee ID	Issuer provided masked Enrollee ID.	Enrollee	1	insuredMemberIdentifier	String	minLength = 0; maxLength = 80
Enrollment Age	Enrolle age as of the first day of enrollment for the 16 digit plan and rating area combinationEach enrollee can have multiple ages, however only one for each 16 digit plan and rating area combination.Enrollment Age does not consider EPAI (For example from the system perspective an enrollee can have a mod to change plan ID or rating area that would trigger a new age for this field, but not a new ARF age or RA model age) This age is not used for RA	Enrollee	1	enrolleeAge	Integer	minInclusive = 0; maxInclusive = 999999999

Table 20: RARSD Risk Score Detail Enrollee (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Risk Adjustment Age	Age as of the last day of enrollment for the enrollee across all plans within the payment year Each enrollee can only have one RA model age for all plans. Assign RA age model of ‘1’ if cross-year infant enrollment age >= 1, but < 2 and does not have a Maturity HCC assigned. Assign RA age model of ‘1’ if the infants enrollment age >=0 but < 1 and does not have a Maturity HCC assigned. Enrollees in the infant model with a cross year birth will be assigned an RA age model of ‘0’.	Enrollee	1	riskAdjustmentAge	Integer	minInclusive = 0; maxInclusive = 999999999
Applicable RA Model	Infant, child or adult.	Enrollee	1	applicableRAModel	String	minLength = 0; maxLength = 10
Gender	Enrollee gender	Enrollee	1	Gender	String	minLength = 0 maxLength = 1 Enumeration Values: “M”,“F”,“U”

Table 20: RARSD Risk Score Detail Enrollee (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Diagnosis Code Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Diagnosis Code	1 or more per enrollee	includedDiagnosisCode Category	RiskScoreDetailDiag nosisCodeCategory	None
NDC Code Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	NDC Code	1 or more per enrollee	includedNdcCodeCateg ory	RiskScoreDetailNDC CodeCategory	None
Payment HCC Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Payment HCC	1 or more per enrollee	includedPaymentHccCa tegory	RiskScoreDetailPaym entHccCategory	none
Payment RXC Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Payment RXC	1 or more per enrollee	includedPaymentRxcCa tegory	RiskScoreDetailPaym entRxcCategory	none
Severity Level (Infant model includes maturity level)	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It	Severity Level	1 or more per enrollee	includedSeverityLevelC ategory	RiskScoreDetailSeve rityLevelCategory	none

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	should be processed to identify the risk score section of the report.					
HCC Group Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	HCC Group	1 or more per enrollee	includedHccGroupCategory	RiskScoreDetailHccGroupCategory	none
RXC to HCC Interaction Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	RXC to HCC interaction	1 or more per enrollee	includedRxcToHccInteractionCategory	RiskScoreDetailRxcToHccInteractionGroupCategory	none
RXC Created by Service Code Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	RXC Created by Service Code	1 or more per enrollee	includedRxcCreatedByServiceCodeCategory	RiskScoreDetailRxcCreatedByServiceCodeCategory	none
Dropped RXC Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	RXC Dropped	1 or more per enrollee	includedEnrolleeRxcDroppedCategory	RiskScoreDetailEnrolleeRxcDroppedCategory	none

Table 20: RARSD Risk Score Detail Enrollee (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollee Dropped HCC Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	HCC Dropped	1 or more per enrollee	includedEnrolleeHccDroppedCategory	RiskScoreDetailEnrolleeHccDroppedCategory	None
Enrollment Period Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Enrollment Period	1 or more per enrollee	includedEnrolleePeriodCategory	RiskScoreDetailEnrolleePeriodCategory	none

The data characteristics for the RARSD Risk Score Detail Diagnosis Code category are as shown in Table 21. These elements are defined in the *RiskScoreDetailDiagnosisCodeCategory.xsd*.

Table 21: RARSD Risk Score Detail Diagnosis Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Diagnosis Code	De-duped when Diagnosis Codes occurs multiple times for a benefit year; attributed to the risk score for the enrollment period; includes unique diagnoses from other Plan IDs within the same Issuer ID.	Diagnosis Code	1	diagnosisCode	String	minLength = 0; maxLength = 30

The data characteristics for the RARSD Risk Score Detail NDC Code category are as shown in Table 22. These elements are defined in the *RiskScoreDetailNDCCodeCategory.xsd*.

Table 22: RARSD Risk Score Detail NDC Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
NDC Code	De-duped when NDC Codes occurs multiple times for a benefit year; attributed to the risk score for the adult enrollee's enrollment period; includes unique NDCs from other Plan IDs within the same Issuer ID.	NDC Code	1	ndcCode	String	minLength = 0; maxLength = 30

The data characteristics for the RARSD Risk Score Detail Payment HCC category are as shown in Table 23. These elements are defined in the *RiskScoreDetailPaymentHccCategory.xsd*.

Table 23: RARSD Risk Score Detail Payment HCC

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Payment HCC	HCC Hierarchy Imposed.	Payment HCC	1	paymentHcc	String	minLength = 0; maxLength = 10

The data characteristics for the RARSD Risk Score Detail Payment RXC category are as shown in Table 24. These elements are defined in the *RiskScoreDetailPaymentRxcCategory.xsd*.

Table 24: RARSD Risk Score Detail Payment RXC

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Payment RXC	RXC with Hierarchy Imposed.	Payment RXC	1	paymentRxc	String	minLength = 0; maxLength = 10

The data characteristics for the RARSD Risk Score Detail Severity category are as shown in Table 25. These elements are defined in the *RiskScoreDetailSeverityLevelCategory.xsd*.

Table 25: RARSD Risk Score Detail Severity

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
IHCC Severity Level	Severity and maturity level assigned for the infant age model.	Severity Level	0..1	hccSeverity	String	minLength = 0 Enumeration Values “1”: Extremely Immature & Severity 1 “2”: Extremely Immature & Severity 2 “3”: Extremely Immature & Severity 3 “4”: Extremely Immature & Severity 4 “5”: Extremely Immature & Severity 5 “6”: Immature & Severity 1 “7”: Immature & Severity 2 “8”: Immature & Severity 3 “9”: Immature & Severity 4 “10”: Immature & Severity 5 “11”: Premature Multiples & Severity 1 “12”: Premature Multiples & Severity 2 “13”: Premature Multiples & Severity 3 “14”: Premature Multiples & Severity 4 “15”: Premature Multiples & Severity 5 “16”: Term & Severity 1 “17”: Term & Severity 2 “18”: Term & Severity 3 “19”: Term & Severity 4 “20”: Term & Severity 5 “21”: One Year Old & Severity 1 “22”: One Year Old & Severity 2 “23”: One Year Old & Severity 3 “24”: One Year Old & Severity 4 “25”: One Year Old & Severity 5 NULL: No enrollees in the infant model to report
Enrollee V3 Indicator (adult model only)	V3 indicator assigned for the enrollee.	Severity Level	1	enrolleeV3Indicator	String	minLength = 0 maxLength = 1 Enumeration Values: “Y”,“N”, NULL
Interaction Group	Interaction group assigned for the enrollee.	Severity Level	1	interactionGroup	String	minLength = 0 maxLength = 1 Enumeration Values: “M”, “H”, NULL

The data characteristics for the RARSD Risk Score Detail HCC Group category are as shown in Table 26. These elements are defined in the *RiskScoreDetailHccGroupCategory.xsd*.

Table 26: RARSD Risk Score Detail HCC Group

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
HCC Group	Lists the groups which have been assigned for the enrollment period.	HCC Group	1	hccGroup	String	minLength = 0 maxLength = 10

The data characteristics for the RARSD Risk Score Detail RXC to HCC Interaction category are as shown in Table 27. These elements are defined in the *RiskScoreDetailRxcToHccInteractionCategory.xsd*.

Table 27: RARSD Risk Score Detail RXC to HCC Interaction

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
RXC to HCC Interaction	Lists unique payment RXC to HCC interactions for the adult enrollee	RXC to HCC Interaction	1	rxcToHccInteraction	String	minLength = 0 maxLength = 30

The data characteristics for the RARSD Risk Score Detail RXC Created by Service Code Category are as shown in Table 28. These elements are defined in the *RiskScoreDetailRxcCreatedByServiceCodeCategory.xsd*.

Table 28: RARSD Risk Score Detail RXC Created by Service Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
RXC Created by Service Code	Lists unique payment RXC to HCC interactions for the adult enrollee	RXC Created by Service Code	1	rxcCreatedByServiceCode	String	minLength = 0 maxLength = 30

The data characteristics for the RARSD Risk Score Detail Enrollee RXC Dropped category are as shown in Table 29. These elements are defined in the *RiskScoreDetailEnrolleeRxcDroppedCategory.xsd*.

Table 29: RARSD Risk Score Detail Enrollee RXC Dropped

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Dropped RXC	RXC dropped across all RA Payment RXC adult Enrollees due to RXC hierarchy for a distinct user (*repeat for each RXC).	RXC Dropped	1	droppedRxcs	String	minLength = 0 maxLength = 10

The data characteristics for the RARSD Risk Score Detail Enrollee HCC Dropped category are as shown in Table 30. These elements are defined in the *RiskScoreDetailEnrolleeHccDroppedCategory.xsd*.

Table 30: RARSD Risk Score Detail Enrollee HCC Dropped

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Dropped HCC	HCC dropped across all RA Payment HCC Enrollees due to HCC hierarchy and HCC Group for a distinct user (*repeat for each HCC).	HCC Dropped	1	droppedHCCs	String	minLength = 0 maxLength = 10

The data characteristics for the RARSD Risk Score Detail Enrollee Period category are as shown in Table 31. These elements are defined in the *RiskScoreDetailEnrolleePeriodCategory.xsd*.

Table 31: RARSD Risk Score Detail Enrollee Period Category

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Subscriber Indicator	Subscriber indicator used to determine whether the enrollment period is a subscriber.	Enrollment Period	1	subscriberIndicator	String	Length = 1 Enumeration Values: “Y”, “N”
Enrollment Start Date	The date when the enrollment coverage for the enrollee became effective for the associated plan.	Enrollment Period	1	coverageStartDate	Date	Length = 10 Strict: YYYY-MM-DD
Enrollment End Date	The date when the enrollment coverage for the enrollee is no longer effective for the associated plan.	Enrollment Period	1	coverageEndDate	Date	Length = 10 Strict: YYYY-MM-DD
Enrollee Risk Score	Enrollee's risk score for the distinct enrollment period; includes: HCC factors derived from Diagnosis Codes, HCC Groups when applicable, HCC interaction groups when applicable, RXC factors, RXC to HCC interaction when applicable, enrollment duraction when applicable, demographic factor and CSR factor if applicable.	Enrollment Period	1	enrolleeRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
CSR Factor	CSR Factor for the enrollment period.	Enrollment Period	1	CSRFactor	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Member Months	Total count of Member Months for the enrollment period.	Enrollment Period	1	memberMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999 99
System Generated Cross Year Enrollment Period Indicator	Indicates if the enrollment period was created by the system due to a qualifying cross year claim.	Enrollment Period	1	crossYearEnrollmentIndicator	String	Length = 1 Enumeration Values: “Y”, “N”
Cross Year Claim ID	Claim ID of the claim that required the system generated cross year enrollment period to be created.	Enrollment Period	1	crossYearClaimIdentifier	String	minLength = 0; maxLength = 50

Table 31: RARSD Risk Score Detail Enrollee Period Category (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Sub-policy Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Sub-policy	1 or more per enrollment period	includedSubPolicy Category	RiskScoreDetailEnrolleePeriodCategory	None

The data characteristics for the RARSD Risk Score Detail Sub Policy category are as shown in Table 32. These elements are defined in the *RiskScoreDetailSubPolicyCategory.xsd*.

Table 32: RARSD Risk Score Detail Sub Policy

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Sub-policy Billable Indicator	Billable indicator used to determine whether enrollee in the sub-policy is billable in the sub-policy.	Sub Policy	1	billableIndicator	String	Length = 1 Enumeration Values: “Y”, “N”
Total Member Months	Total count of member months for the sub policy.	Sub Policy	1	totalMemberMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Sub-policy Start Date	The date when the enrollment coverage for the enrollee became effective for the sub policy.	Sub Policy	1	policyStartDate	Date	Length = 10 Strict: YYYY-MM-DD

Table 32: RARSD Risk Score Detail Sub Policy (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Sub-policy End Date	The last date of enrollment coverage for the enrollee in the sub policy.	Sub Policy	1	policyEndDate	Date	Length = 10 Strict: YYYY-MM-DD
Allowable Rating Factor (ARF) Age	Age based on the first day of the initial issuance enrollment period or first day of the renewal in a subsequent payment year. If an enrollment period is a modification (001), the first day of the previous enrollment period (021028, 021EC, or 021041) is used. ARF Age is calculated at enrollment period level for each initial issuance, renewal, or addition of a member EPAI (Mods do not trigger a new ARF age) The rating area is not considered, only the EPAI Each enrollee can have multiple ARF ages, even for the same 16 digit plan and rating area combination (For example due to a gap in coverage)	Sub Policy	1	allowableRatingFactorAge	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Allowable Rating Factor (ARF) Value	For Family Tier rating method: Allowable Rating Factor value determined by family structure as defined in the "State Specific Family Tier Ratios" reference table. Billable members are determined by state according to the "Max Billable Member Children" column of the reference table. For ACA rating method: Allowable Rating Factor is determined from the “ACA Age Rating Curve” reference tabled, based on the ARF age, state and market.	Sub Policy	1	allowableRatingFactorValue	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999

RA Risk Score Summary Report (RARSS) Message Format (or Record Layout) and Required Protocols

The outbound RARSS Report is available to CMS and the issuer/submitting organization. This report notifies CMS about average/individual risk score for the plan and will not include orphan claims. The RARSS Report will be generated with the risk score and transfer extract batch job.

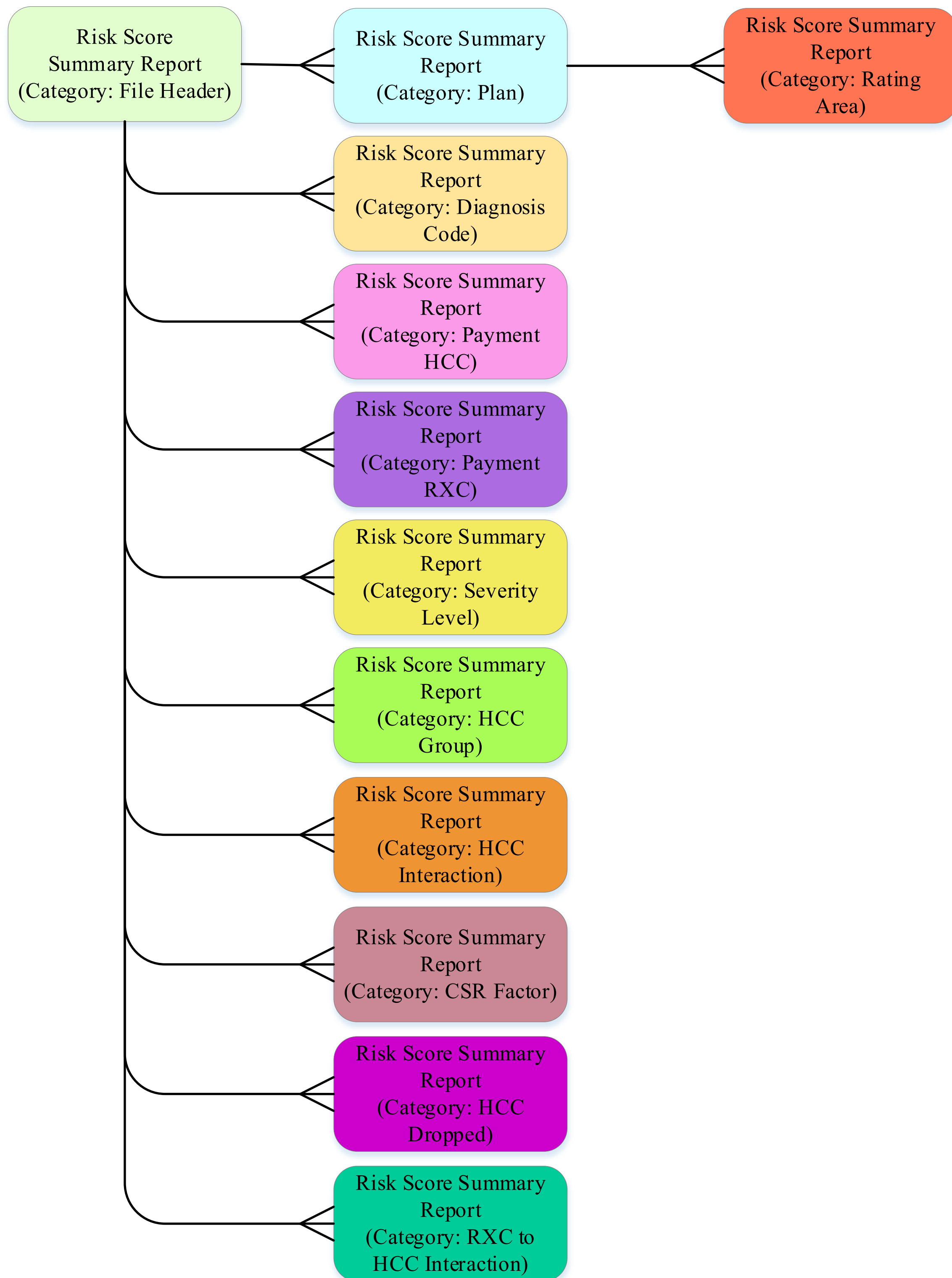
Note – System generated cross year enrollment periods, created during the RA calculation in order to include qualifying cross year claims, are included by the system when calculating the values in this report.

An RA utilizer is an enrollee that has an RA eligible claim

5.1.1.6File Layout

This section specifies the file layout for the RARSS Report. At a high level, it consists of twelve (12) record types or categories, as shown in Figure 3 : EDGE Server RA Risk Score Summary Report Data Categories.

Figure 3 : EDGE Server RA Risk Score Summary Report Data Categories



The RARSS Report consists of report File Header, Plan, Rating Area, Diagnosis Code, Payment HCC, Payment RXC, Severity Level, HCC Group, HCC Interaction, CSR Factor, HCC Dropped and RXC to HCC Interaction.

The RARSS XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.7 Field/Data Elements and Descriptions

The data characteristics for the RARSS Risk Score Summary File Header category are as shown in Table 33 : RARSS Risk Score Summary File Header. The root element of the RARSS in the XSD is RiskScoreSummaryReport (*RiskScoreSummaryReport.xsd*). This element is required and all the other elements defined in this section for the RARSS are embedded within this element start and end tags.

Table 33 : RARSS Risk Score Summary File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RA RICommonOutboundFileHeader.xsd	none
Plan Category	This XML element describes the risk score plan-related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Plan	1 or more in the reported submission file	includedPlanIdentifier	RiskScoreSummary PlanCategory	none
Calendar Year	The calendar year for which RA was executed.	File Header	1	calendarYear	String	Strict: YYYY
Execution Type	Designate preliminary or final run.	File Header	1	executionType	String	minLength = 1 maxLength = 30 Enumeration Values: “P”: Preliminary “F”: Final
Total Enrollees	Total number of unique enrollees.	File Header	1	totalEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Enrollee Utilizers	Total count of unique utilizers for a distinct issuer. A utilizer is an enrollee that has at least one (1) active medical claim for the payment year that is not orphaned.	File Header	1	totalEnrolleeUtilizer	Integer	minInclusive = 0; maxInclusive = 999999999
Total RA Utilizers	Total count of unique RA utilizers for all models. An RA utilizer is an enrollee that has at least one (1) RA eligible claim.	File Header	1	totalRaUtilizer	Integer	minInclusive = 0; maxInclusive = 999999999
Mean Risk Score for RA Utilizers	Mean risk score for all enrollees with an RA eligible claim (i.e., RA Utilizer). This field is calculated by summing the risk scores of each enrollment period of each enrollee that has at least one (1) RA eligible claim and then dividing by the total number of enrollment periods included.	File Header	1	meanUtilizerRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total RA Payment HCC Enrollees	Total count of unique enrollees with payment HCCs for all RA models.	File Header	1	totalRaPaymentHccEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total RA Payment RXC Enrollees	Total count of unique enrollees with payment RXCs for adult RA model.	File Header	1	totalRaPaymentRxcEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Mean Risk Score for RA Payment HCC Enrollees	Mean risk score for RA payment HCC Enrollees. This field is calculated by summing the risk scores of each enrollment period of each enrollee that has at least one (1) payment HCC and then dividing by the total number of enrollment periods included.	File Header	1	meanRiskScoreForRaPaymentHccEnrollees	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for RA Payment RXC Enrollees	Mean risk score for RA payment RXC Enrollees. This field is calculated by summing the risk scores of each enrollment period of each adult model enrollee that has at least one (1) payment RXC and then dividing by the total number of enrollment periods included.	File Header	1	meanRiskScoreForRaPaymentRxcEnrollees	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Enrollees without RA Payment HCCs	Total count of unique enrollees without RA payment HCCs.	File Header	1	totalEnrolleesWithoutRaPaymentHccs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees without RA Payment RXCs	Total count of unique adult model enrollees without RA payment RXCs.	File Header	1	totalEnrolleesWithoutRaPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Mean Risk Score for Enrollees Without RA Payments HCCs	Mean risk score for enrollees without RA payments HCCs. This field is calculated by summing the risk scores of each enrollment period of each enrollee that has no payment HCCs and then dividing by the total number of enrollment periods included.	File Header	1	meanRsEnrollees WithoutRaPayment Hccs	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for Enrollees Without RA Payments RXCs	Mean risk score for adult model enrollees without RA payments RXCs. This field is calculated by summing the risk scores of each enrollment period of each adult model enrollee that has no payment RXCs and then dividing by the total number of enrollment periods included.	File Header	1	meanRsEnrollees WithoutRaPayment Rxcs	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Percent of total RA Payment HCC Enrollees Who Have CSR	Percent of total RA Payment HCC Enrollees who have CSR. This field is calculated by dividing the unique count of enrollees with an HCC and a CSR factor other than 1.00 by the total unique count of enrollees who have an HCC.	File Header	1	percentTotalRaPay mentHccEnrolleeW hoCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Percent of total RA Payment RXC Enrollees Who Have CSR	Percent of total RA Payment RXC adult model Enrollees who have CSR. This field is calculated by dividing the unique count of adult model enrollees with an RXC and a CSR factor other than 1.00 by the total unique count of enrollees who have an RXC.	File Header	1	percentTotalRaPay mentRxcEnrolleeW hoCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for Total RA Payment HCC Enrollees Who Have CSR	Mean risk score for total RA Payment HCC Enrollees who has CSR. This field is calculated by summing the risk scores of each enrollment period of each enrollee that has a payment HCC and a CSR factor (A CSR factor other than 1.00) and then dividing by the total number of enrollment periods included.	File Header	1	meanRiskScoreTot alRaPaymentHccW ithCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Mean Risk Score for Total RA Payment RXC Enrollees Who Have CSR	Mean risk score for total RA Payment RXC adult model Enrollees who have CSR. This field is calculated by summing the risk scores of each enrollment period of each adult model enrollee that has a payment RXC and a CSR factor (A CSR factor other than 1.00) and then dividing by the total number of enrollment periods included.	File Header	1	meanRiskScoreTotalRaPaymentRxcWithCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for RA Payment HCC Enrollees Who Do Not Have CSR	Mean risk score for RA Payment HCC Enrollees who do not have CSR. This field is calculated by summing the risk scores of each enrollment period of each enrollee that has at least one (1) payment HCC and no CSR factor (A CSR factor of exactly 1.00) and then dividing by the total number of enrollment periods included.	File Header	1	meanRiskScoreRaPaymentHccEnrolleesNoCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for RA Payment RXC Enrollees Who Do Not Have CSR	Mean risk score for RA Payment RXC Enrollees belonging to the adult model who do not have CSR. This field is calculated by summing the risk scores of each enrollment period of each adult model enrollee that has at least one (1) payment RXC and no CSR factor (A CSR factor of exactly 1.00) and then dividing by the total number of enrollment periods included.	File Header	1	meanRiskScoreRaPaymentRxcEnrolleesNoCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Mean Unique Diagnoses Per Utilizers	Mean unique Diagnoses Codes per utilizer enrollees. This field is calculated by first summing the unique count of Diagnosis Codes for each utilizer and then dividing by the unique number of utilizers.	File Header	1	meanUniqueDiagnosisPerUtilizers	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Unique NDC Per Utilizers	Mean unique NDC Codes per utilizer adult model enrollees. This field is calculated by first summing the unique count of NDC Codes for each adult model utilizer and then dividing by the unique number of adult model utilizers.	File Header	1	meanUniqueNdcPerUtilizers	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Unique Diagnoses Per RA Utilizer	Mean unique Diagnoses Codes per RA utilizer enrollees. This field is calculated by first summing the unique count of Diagnosis Codes for each RA utilizer and then dividing by the unique number of RA utilizers.	File Header	1	meanUniqueDiagnosisPerRAUtilizers	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Unique NDC Per RA Utilizer	Mean unique NDC Codes per RA utilizer enrollees belonging to the adult model This field is calculated by first summing the unique count of NDC Codes for each RA utilizer belonging to the adult model and then dividing by the unique number of RA utilizers belonging to the adult model.	File Header	1	meanUniqueNdcPerRAUtilizers	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Unique Diagnoses Per RA Payment HCC Enrollee	Mean unique Diagnoses Codes per RA payment HCC enrollee. This field is calculated by first summing the unique count of Diagnosis Codes for each RA payment HCC enrollee and then dividing by the unique number of RA payment HCC enrollees.	File Header	1	meanUniqueDiagnosisPerRAPaymentHccEnrollee	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Mean Unique NDC Per RA Payment RXC Enrollee	Mean unique NDC Codes per RA payment RXC enrollee belonging to the adult model This field is calculated by first summing the unique count of NDC Codes for each RA payment RXC enrollee belonging to the adult model and then dividing by the unique number of RA payment RXC enrollees.belonging to the adult model	File Header	1	meanUniqueNdcPerRAPaymentRxcEnrollee	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Diagnoses Accepted	Total count of Diagnosis Codes accepted for all plans for a distinct issuer.	File Header	1	totalDiagnosesAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total NDC Accepted	Total count of NDC Codes accepted for all plans for a distinct issuer, belonging to adult model enrollees	File Header	1	totalNdcAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total Risk Adjustment Diagnoses Accepted	Total count of Risk Adjustment diagnoses accepted for a distinct issuer.	File Header	1	totalRADiagnosesAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total RA NDC Accepted	Total count of RA NDC Codes accepted for all plans for a distinct issuer, belonging to adult model enrollees	File Header	1	totalRANdcAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total HCCs	Total count of HCCs (without hierarchies imposed) for all enrollees for a distinct issuer.	File Header	1	totalConditionCategory	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXCs	Total count of RXCs (without hierarchies imposed) for all adult model enrollees for a distinct issuer.	File Header	1	totalRxcs	Integer	minInclusive = 0; maxInclusive = 999999999

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Payment HCCs	Total count of payment HCCs (with hierarchies imposed) for all enrollees for a distinct issuer.	File Header	1	totalPaymentsConditionCategories	Integer	minInclusive = 0; maxInclusive = 999999999
Total Payment RXCs	Total count of unique payment RXCs (with hierarchies imposed) for all adult model enrollees for a distinct issuer.	File Header	1	totalPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Payment HCCs	Total count of unique enrollee payment HCCs for a distinct issuer.	File Header	1	totalUniqueEnrolleePaymentHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXC to HCC interactions	Total unique count of RXC to HCC interactions for all plans for the issuer for enrollees belonging to adult model	File Header	1	totalRxcToHccInteractions	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXCs Created From Service Codes	Total unique count of RXCs created from Service codes for all plans for the issuer, for enrollees belonging to adult model	File Header	1	totalRxcsCreatedFromSrvcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees With RXC to HCC Interactions	Total unique count of adult model Enrollees with RXC to HCC Interactions for all plans for the issuer.	File Header	1	totalEnrolleesWithRxcToHccInteractions	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees With RXCs Created From Service Codes	Total unique count of adult model Enrollees with RXCs Created from Service Codes for all plans for the issuer.	File Header	1	totalEnrollees WithRxcsCreatedFromSrvcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Average Number of HCCs per Enrollee (all Enrollees): Infant Model	This field is calculated by summing the count of HCCs of each unique enrollee in the infant model and then dividing by the unique number of enrollees in the infant model.	File Header	1	avgHccConditionCategoriesPerEnbyEnInfant	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of HCCs per Enrollee (all Enrollees): Child Model	This field is calculated by summing the count of HCCs of each unique enrollee in the child model and then dividing by the unique number of enrollees in the child model.	File Header	1	avgHccConditionCategoriesPerEnbyEnChild	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Average Number of HCCs per Enrollee (all Enrollees): Adult Model	This field is calculated by summing the count of HCCs of each unique enrollee in the adult model and then dividing by the unique number of enrollees in the adult model.	File Header	1	avgHccsperEnrolleebyHccEnrolleesAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of RXCs per Enrollee (all Enrollees): Adult Model	This field is calculated by summing the count of unique RXCs of each unique enrollee in the adult model and then dividing by the unique number of enrollees in the adult model.	File Header	1	avgRxcsPerEnrolleebyRxcEnrolleesAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of Payment HCCs per Enrollee: Child Model	This field is calculated by summing the count of payment HCCs for each unique enrollee with a payment HCC in the child model and then dividing by the unique number of enrollees with a payment HCC in the child model.	File Header	1	avgNumberPaymentHccsEnrolleeChild	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Average Number of Payment HCCs per Enrollee: Adult Model	This field is calculated by summing the count of payment HCCs for each unique enrollee with a payment HCC in the adult model and then dividing by the unique number of enrollees with a payment HCC in the adult model.	File Header	1	avgNumberPaymentHccsEnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of Payment RXCs per Enrollee: Adult Model	This field is calculated by summing the count of unique payment RXCs for each unique enrollee with a payment RXC in the adult model and then dividing by the unique number of enrollees with a payment RXC in the adult model.	File Header	1	avgNumberPaymentRxcsEnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Number of RA Utilizers With Count of 1 Unique Dx Code	Number of unique RA utilizers with count of one (1) unique Diagnosis (Dx) code.	File Header	1	numberRaUtiWCt1Uniquedx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With Count of 1 Unique NDC Code	Number of unique adult model RA utilizers with count of one (1) unique NDC code.	File Header	1	numberRaUtiWCt1UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With Count of 2 Unique Dx Codes	Number of unique RA utilizers with count of two (2) unique Dx codes.	File Header	1	numberRaUtiWCt2UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With Count of 2 Unique NDC Codes	Number of unique adult model RA utilizers with count of two (2) unique NDC codes.	File Header	1	numberRaUtiWCt2UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with 3–4 Unique Dx Codes	Number of unique RA utilizers with three (3) to four (4) unique Dx codes.	File Header	1	numberRaUtiW3To4UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Number of RA Utilizers with 3–4 Unique NDC Codes	Number of unique adult model RA utilizers with three (3) to four (4) unique NDC codes.	File Header	1	numberRaUtiW3To4UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with 5–6 Unique Dx Codes	Number of unique RA utilizers with five (5) to six (6) unique Dx codes.	File Header	1	numberRaUtiW5To6UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with 5–6 Unique NDC Codes	Number of unique adult model RA utilizers with five (5) to six (6) unique NDC codes.	File Header	1	numberRaUtiW5To6UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With 7–9 Unique Dx Codes	Number of unique RA utilizers with seven (7) to nine (9) unique Dx codes.	File Header	1	numberRaUtiW7To9UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With 7–9 Unique NDC Codes	Number of unique adult model RA utilizers with seven (7) to nine (9) unique NDC codes.	File Header	1	numberRaUtiW7To9UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Number of RA Utilizers with >= 10 Unique Dx Codes	Number of unique RA utilizers with >= 10 unique Dx codes.	File Header	1	numberRaUtiWGreaterOrEquals10UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with >= 10 Unique NDC Codes	Number of unique adult model RA utilizers with >= 10 unique NDC codes.	File Header	1	numberRaUtiWGreaterOrEquals10UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With Count of 1 HCC	Number of unique RA utilizers with count of one (1) HCC.	File Header	1	numberRAUtiWCount1ConditionCategory	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With Count of 1 RXC	Number of unique adult model RA utilizers with count of one (1) RXC.	File Header	1	numberRAUtiWCount1Rxc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With Count of 2 HCCs	Number of unique RA utilizers with count of two (2) HCCs.	File Header	1	numberRaUtilizerWCount2	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With Count of 2 RXCs	Number of unique adult model RA utilizers with count of two (2) RXCs.	File Header	1	numberRaUtilizerWCount2Rxc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With 3–4 HCCs	Number of unique RA utilizers with three (3) to four (4) HCCs.	File Header	1	numberRaUtilizer3To4ConditionCategory	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With 3–4 RXCs	Number of unique adult model RA utilizers with three (3) to four (4) RXCs.	File Header	1	numberRaUtilizer3To4Rxc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With >=5 HCCs	Number of unique RA utilizers with >= five (5) HCCs.	File Header	1	numberRaUtiWgreaterorequals5UniqueHcc	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Number of RA Utilizers With >=5 RXCs	Number of unique adult model RA utilizers with >= five (5) RXCs.	File Header	1	numberRaUtiWgreaterorEquals5UniqueRxc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment HCC Enrollees With Count of 1 HCC	Number of unique RA payment HCC enrollees with count of one (1) HCC.	File Header	1	numberRaPaymentHccEnrollesWithCount1	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment RXC Enrollees With Count of 1 RXC	Number of unique RA payment RXC enrollees belonging to the adult model with count of one (1) RXC.	File Header	1	numberRaPaymentRxcEnrolleesWithCount1	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment HCC Enrollees With Count of 2 HCCs	Number of unique RA payment HCC enrollees with count of two (2) HCCs.	File Header	1	numberRaPaymentHccEnrollesWithCount2	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment RXC Enrollees With Count of 2 RXCs	Number of unique RA payment RXC enrollees belonging to the adult model with count of two (2) RXCs.	File Header	1	numberRaPaymentRxcEnrolleesWithCount2	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment HCC Enrollees With 3–4 HCCs	Number of unique RA payment HCC enrollees with three (3) to four (4) HCCs.	File Header	1	numberRaPaymentHccEnrollesWithCount3To4	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment RXC Enrollees With 3–4 RXCs	Number of unique RA payment RXC enrollees belonging to the adult model with three (3) to four (4) RXCs.	File Header	1	numberRaPaymentRxcEnrolleesWithCount3To4	Integer	minInclusive = 0; maxInclusive = 999999999

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Number of RA Payment HCC Enrollees With >=5 HCCs	Number of unique RA payment HCC enrollees with >= five (5) HCCs.	File Header	1	numberRaPaymentHccGreaterOrEquals5UniqueHcc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment RXC Enrollees With >=5 RXCs	Number of unique RA payment RXC enrollees belonging to the adult model with >= five (5) RXCs.	File Header	1	numberRaPaymentRxcGreaterOrEquals5UniqueRxc	Integer	minInclusive = 0; maxInclusive = 999999999
Male	Total count of unique male enrollees for a distinct issuer.	File Header	1	totalMaleCount	Integer	minInclusive = 0; maxInclusive = 999999999
Males with Payment HCCs	Total count of unique male enrollees with payment HCCs for a distinct issuer.	File Header	1	totalMaleCountWithHcc	Integer	minInclusive = 0; maxInclusive = 999999999
MalesMale Adults with Payment RXCs	Total count of unique male adult model enrollees with payment RXCs for a distinct issuer.	File Header	1	totalMaleCountWithRxc	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Infant Model	Total count of unique males in the infant model for a distinct issuer.	File Header	1	maleCountInfantModel	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Child Model	Total count of unique males in the child model for a distinct issuer.	File Header	1	malesCountChildModel	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Adult Model	Total count of unique males in the adult model for a distinct issuer.	File Header	1	malesCountAdultModel	Integer	minInclusive = 0; maxInclusive = 999999999
Female	Total count of unique female enrollees for a distinct issuer.	File Header	1	totalCountFemale	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Females with Payment HCCs	Total count of unique female enrollees with HCCs payment for a distinct issuer.	File Header	1	femaleCountWithConditionCategory	Integer	minInclusive = 0; maxInclusive = 999999999
FemalesFemale Adults with Payment RXCs	Total count of unique female adult model enrollees with RXCs payment for a distinct issuer.	File Header	1	femaleCountWithRxc	Integer	minInclusive = 0; maxInclusive = 999999999
Females in Infant Model	Total count of unique females in the infant model for a distinct issuer.	File Header	1	femaleCountInfantModel	Integer	minInclusive = 0; maxInclusive = 999999999

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Females in Child Model	Total count of unique females in the child model for a distinct issuer.	File Header	1	femaleCountChildModel	Integer	minInclusive = 0; maxInclusive = 999999999
Females in Adult Model	Total count of unique females in the adult model for a distinct issuer.	File Header	1	femaleCountAdultModel	Integer	minInclusive = 0; maxInclusive = 999999999
Infant Count	Total count of unique infant enrollees for a distinct issuer <2 – Infant.	File Header	1	infantCount	Integer	minInclusive = 0; maxInclusive = 999999999
Child Count	Total count of unique child enrollees for a distinct issuer >=2 & <=20 – Child.	File Header	1	childCount	Integer	minInclusive = 0; maxInclusive = 999999999
Adult Count	Total count of unique adult enrollees for a distinct issuer >=21 – Adult.	File Header	1	adultCount	Integer	minInclusive = 0; maxInclusive = 999999999
Total V3 Indicator (adult model only)	Total unique count of adult members with severity indicator V3.	File Header	1	totalV3Indicator	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Enrollee Count	Total count of unique enrollees that have at least one (1) system generated cross year enrollment period for a distinct issuer.	File Header	1	crossYearEnrolleeCount	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Enrollment Period Count	Total count of unique system generated cross year enrollment periods for a distinct issuer.	File Header	1	crossYearEnrollmentPeriodCount	Integer	minInclusive = 0; maxInclusive = 999999999

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
System Generated Cross Year Member Month Count	Total sum of member months for all system generated cross year enrollment periods for a distinct issuer.	File Header	1	crossYearMemberMonthCount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Diagnosis Code Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Diagnosis Code	1 or more per enrollment period per enrollee per insurance plan in the reported submission file	includedDiagnosisCodeCategory	RiskScoreSummaryDiagnosisCodeCategory	none
Payment HCC	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Payment HCC	1 or more in the reported submission file	includedPaymentHccCategory	RiskScoreSummaryPaymentHccCategory	none
Payment RXC	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Payment RXC	1 or more in the reported submission file	includedPaymentRxcCategory	RiskScoreSummaryPaymentRXCCategory	none
Severity Level (infant model includes maturity level)	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Severity Level	1 or more in the reported submission file	includedSeverityLevelCategory	RiskScoreSummarySeverityLevelCategory	none

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
HCC Group Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	HCC Group	1 or more in the reported submission file	includedHccGroup Category	RiskScoreSummary HccGroupCategory	None
HCC Interaction Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	HCC Interaction	1 or more in the reported submission file	includedHccInterac tionCategory	RiskScoreSummary HccInteractionCateg ory	none
CSR Factor Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	CSR Factor	1 or more in the reported submission file	includedCsrFactor Category	RiskScoreSummary CsrFactorCategory	none
HCC Dropped Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	HCC Dropped	1 or more in the reported submission file	includedHccDropC ategory	RiskScoreSummary HccDropCategory	none

Table 33: RARSS Risk Score Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
RXC to HCC Interaction Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	RXC to HCC Interaction	1 or more in the reported submission file	includedRxcToHcclnteractionCategory	RiskScoreSummaryRxcToHccInteractionCategory	None
Transfer Plan Category	This XML element describes the risk score plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the claim selection plan section of the report.	Transfer Plan	1 or more per insurance plan in the reported submission file	includedPaymentTransferPlanIdentifier	RATransferPlanCategory	None

The data characteristics for the RARSS Risk Score Summary Diagnosis Code category are as shown in Table 34. These elements are defined in the *RiskScoreSummaryDiagnosisCodeCategory.xsd*.

Table 34: RARSS Risk Score Summary Diagnosis Code

Table 38: RARSS Risk Score Summary Diagnosis Code						
Business Data Element	**Description**	**Data Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Diagnosis Code	De-duped when Diagnosis Codes occurs multiple times for a benefit year; attributed to the risk score for the enrollment period; includes unique diagnoses from other Plan IDs within the same Issuer ID.	Diagnosis Code	1	diagnosisCode	String	minLength = 0, maxLength = 30
Diagnosis Code Count	Number of unique enrollees with RA payment HCCs with the Diagnosis Code. Total RA Dx Counts for unique enrollees with Payment HCCs.	Diagnosis Code	1	diagnosisCodeCount	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary Payment HCC category are as shown in Table 35. These elements are defined in the *RiskScoreSummaryPaymentHccCategory.xsd*.

Table 35: RARSS Risk Score Summary Payment HCC

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Payment HCC	HCC Hierarchy imposed.	Payment HCC	1	paymentHcc	String	minLength = 0; maxLength = 10
Number of unique RA users with the HCC	Number of unique enrollees with at least one (1) payment HCC.	Payment HCC	1	numberOfUniqueRaUsersWHcc	Integer	minInclusive = 0; maxInclusive = 999999999
Mean number of co-occurring HCCs with the HCC	Mean number of co-occurring HCCs with the HCC defined.	Payment HCC	1	meanNumberOfCooccuringHccsWHcc	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Three (3) most frequent co-occurring HCCs with the HCC defined	Three (3) most frequently co-occurring HCCs with the HCC defined.	Payment HCC	1	threeMostFrequentCooccuringHccsWHcc	String	minLength = 0; maxLength = 30 Format: Comma separated values

The data characteristics for the RARSS Risk Score Summary Payment RXC category are as shown in Table 36. These elements are defined in the *RiskScoreSummaryPaymentRxcCategory.xsd*.

Table 36: RARSS Risk Score Summary Payment RXC

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Payment RXC	RXC Hierarchy imposed.	Payment RXC	1	paymentRxc	String	minLength = 0; maxLength = 10
Number of unique RA users with the RXC	Number of unique adult model enrollees with at least one (1) instance of the payment RXC.	Payment RXC	1	numberOfUniqueRaUsersWRxc	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary Severity category are as shown in Table 37. These elements are defined in the *RiskScoreSummarySeverityLevelCategory.xsd*.

Table 37: RARSS Risk Score Summary Severity

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
IHCC Severity Level	Severity and maturity level assigned for the infant age model.	Severity Level	0..1	hccSeverity	String	minLength = 0 Enumeration Values: “1”: Extremely Immature & Severity 1 “2”: Extremely Immature & Severity 2 “3”: Extremely Immature & Severity 3 “4”: Extremely Immature & Severity 4 “5”: Extremely Immature & Severity 5 “6”: Immature & Severity 1 “7”: Immature & Severity 2 “8”: Immature & Severity 3 “9”: Immature & Severity 4 “10”: Immature & Severity 5 “11”: Premature Multiples & Severity 1 “12”: Premature Multiples & Severity 2 “13”: Premature Multiples & Severity 3 “14”: Premature Multiples & Severity 4 “15”: Premature Multiples & Severity 5 “16”: Term & Severity 1 “17”: Term & Severity 2 “18”: Term & Severity 3 “19”: Term & Severity 4 “20”: Term & Severity 5 “21”: One Year Old & Severity 1 “22”: One Year Old & Severity 2 “23”: One Year Old & Severity 3 “24”: One Year Old & Severity 4 “25”: One Year Old & Severity 5 NULL: No enrollees in the infant model to report
Enrollee Severity Count	Count of infant model enrollees with the defined severity level.	Severity Level	1	enrolleeSeverityCount	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary HCC Group category are as shown in Table 38. These elements are defined in the *RiskScoreSummaryHccGroupCategory.xsd*.

Table 38: RARSS Risk Score Summary HCC Group

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
HCC Group	Lists the groups which have been assigned for the enrollment period.	HCC Group	1	hccGroup	String	minLength = 0; maxLength = 10
HCC Group Count	Total number of members in each HCC Group for a distinct issuer.	HCC Group	1	hccGroupCount	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary Interaction Group category are as shown in Table 39. These elements are defined in the *RiskScoreSummaryHccInteractionCategory.xsd*.

Table 39: RARSS Risk Score Summary HCC Interaction Group

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Interaction Group	Interaction group H or M.	HCC Interaction	1	interactionGroup	String	minLength = 0 maxLength = 1 Enumeration Values: "H","M"
Interaction Group Count	Total count of members interaction group H or M.	HCC Interaction	1	interactionGroupCount	Integer	minInclusive= 0; maxInclusive = 9999999

The data characteristics for the RARSS Risk Score Summary CSR Factor category are as shown in Table 40. These elements are defined in the *RiskScoreSummaryCsrFactorCategory.xsd*.

Table 40: RARSS Risk Score Summary CSR Factor

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
CSR Factor	CSR factor for a distinct issuer.	CSR Factor	1	membersbyCsrFactor	Decimal	minInclusive = 0; maxInclusive = 99.99
Members by CSR Factor Count	Total Count of members with the defined CSR factor.	CSR Factor	1	membersbyCsrFactorCount	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary CSR Factor category are as shown in Table 41. These elements are defined in the *RiskScoreSummaryHccDropCategory.xsd*.

Table 41: RARSS Risk Score Summary HCC Dropped

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Dropped HCC	HCCx dropped across all RA Payment HCC Enrollees due to HCC hierarchy, HCC Group, and/or HCC interaction for a distinct user (*repeat for each HCC).	HCC Dropped	1	droppedHCCs	String	minLength = 0; maxLength = 10
Frequency of HCC	Frequency of HCCx dropped across all RA Payment HCC Enrollees due to HCC hierarchy, HCC Group, and/or HCC interaction for a distinct user (*repeat for each HCC).	HCC Dropped	1	frequencyDroppedHCCs	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary RXC to HCC interaction category are as shown in Table 42. These elements are defined in the *RiskScoreSummaryRxcToHccInteractionCategory.xsd*.

Table 42: RARSS Risk Score Summary RXC to HCC Interaction

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
RXC to HCC Interaction	Unique RXC to HCC Interaction from Adult Model Enrollees	RXC to HCC Interaction	1	rxcToHccInteraction	String	minLength = 0 maxLength = 30
RXC to HCC Interaction Count	Total count of unique adult model enrollees with at least one instance of the RXC to HCC interaction	RXC to HCC Interaction	1	rxcToHccInteractionCount	Integer	minInclusive= 0; maxInclusive = 9999999

The data characteristics for the RARSS Risk Score Summary Plan category are as shown in Table 43. These elements are defined in the *RiskScoreSummaryPlanCategory.xsd*.

Table 43: RARSS Risk Score Summary Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Rating Area Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Rating Area	1 or more per insurance plan in the reported submission file	includedRatingArea	RiskScoreSummaryRatingAreaCategory	none
Plan ID	Unique 16-digit identifier for the plan.	Plan	1	planIdentifier	String	minLength = 0 maxLength = 16
Metal Level Indicator	Metal level indicator used to determine the metal level of the 16-digit Plan ID.	Plan	1	metalLevel	String	minLength = 0; maxLength = 15 Enumeration Values: "01-Platinum" "02-Gold" "03-Silver" "04-Bronze" "05-Catastrophic"
State	State where the plan is offered.	Plan	1	state	String	minLength = 0 maxLength = 2
Market	Market in the State where the plan is offered; Individual or Small Group.	Plan	1	market	String	minLength = 0; maxLength = 30 Enumeration Values: “1”: Individual “2”: Small Group

The data characteristics for the RARSS Risk Score Summary Rating Area category are as shown in Table 44. These elements are defined in the *RiskScoreSummaryRatingAreaCategory.xsd*.

Table 44: RARSS Risk Score Summary Rating Area

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Rating Area	Plan Rating Area.	Rating Area	1	ratingArea	String	maxLength = 3
Member Months	Total count of member months for all enrollees in a distinct plan and Rating Area for the year.	Rating Area	1	memberMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Enrollees	Total number of unique enrollees.	Rating Area	1	totalEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollee Utilizers	Total count of unique utilizers for the plan and Rating Area. A utilizer is an enrollee that has at least one (1) active medical claim for the payment year that is not orphaned.	Rating Area	1	totalEnrolleeUtilizer	Integer	minInclusive = 0; maxInclusive = 999999999
Total RA Utilizer	Total count of unique RA utilizers under the plan and Rating Area. An enrollee is considered an RA utilizer if they have an RA eligible medical claim for any plan and Rating Area.	Rating Area	1	totalRaUtilizer	Integer	minInclusive = 0; maxInclusive = 999999999
Mean Risk Score for RA Utilizers	Mean risk score for all enrollees with enrollment coverage in the plan and Rating Area and an RA eligible claim (i.e., RA Utilizer). This field is calculated by summing the risk scores of each enrollment period of each enrollee that has at least one (1) RA eligible claim and then dividing by the total number of enrollment periods included.	Rating Area	1	meanUtilizerRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total RA Payment HCC Enrollees	Total unique count of enrollees with payment HCCs for all RA models; see definition above.	Rating Area	1	totalRaPaymentHccEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total RA Payment RXC Enrollees	Total unique count of adult model enrollees with payment RXCs for all RA models; see definition above.	Rating Area	1	totalRaPaymentRxcEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Mean Risk Score for RA Payment HCC Enrollees	Mean risk score for all RA payment HCC enrollees with enrollment coverage in the plan and Rating Area. This field is calculated by summing the risk scores of each enrollment period of each enrollee that has at least one (1) payment HCC and then dividing by the total number of enrollment periods included.	Rating Area	1	meanRiskScoreForRaPaymentHccEnrollees	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for RA Payment RXC Enrollees	Mean risk score for all RA payment RXC adult model enrollees with enrollment coverage in the plan and Rating Area. This field is calculated by summing the risk scores of each enrollment period of each adult model enrollee that has at least one (1) payment RXC and then dividing by the total number of enrollment periods included.	Rating Area	1	meanRiskScoreForRaPaymentRxcEnrollees	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Enrollees Without RA Payment HCCs	Total unique count of enrollees that have no payment HCCs for a distinct plan and Rating Area for all RA models.	Rating Area	1	totalEnrolleesWithoutRaPaymentHccs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees Without RA Payment RXCs	Total unique count of adult model enrollees that have no payment RXCs for a distinct plan and Rating Area for all RA models.	Rating Area	1	totalEnrolleesWithoutRaPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Mean Risk Score for Enrollees Without RA Payments HCCs	Mean risk score for all enrollees without a payment HCC that have enrollment coverage in the plan and Rating Area. This field is calculated by summing the risk scores of each enrollment period of each enrollee that has no payment HCCs and then dividing by the total number of enrollment periods included.	Rating Area	1	totalMeanRsEnrolleeWRaPaymentHcc	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for Enrollees Without RA Payment RXCs	Mean risk score for all adult model enrollees without a payment RXC that have enrollment coverage in the plan and Rating Area.	Rating Area	1	totalMeanRsEnrolleeWRaPaymentRxc	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	This field is calculated by summing the risk scores of each enrollment period of each adult model enrollee that has no payment RXCs and then dividing by the total number of enrollment periods included.					
Percent of total RA Utilizers Who Have CSR	Percent of total RA Payment HCC Enrollees who have CSR and enrollment coverage in the plan and Rating Area. This field is calculated by dividing the unique count of enrollees with an HCC and a CSR factor other than 1.00 by the total unique count of enrollees who have an HCC.	Rating Area	1	percentTotalRAUtilizerCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Percent of total RA Payment RXCs Who Have CSR	Percent of total RA Payment RXC adult model Enrollees who have CSR and enrollment coverage in the plan and Rating Area. This field is calculated by dividing the unique count of adult model enrollees with a RXC and a CSR factor other than 1.00 by the total unique count of enrollees who have a RXC.	Rating Area	1	percentTotalRaPaymentRxcEnrolleeWhoCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Mean Risk Score for Total RA Payment HCC Enrollees Who Have CSR	Mean risk score for total RA Payment who have CSR and enrollment coverage in the plan and Rating Area. This field is calculated by summing the risk scores of each enrollment period of each enrollee that has a payment HCC and a CSR factor (A CSR factor other than 1.00) and then dividing by the total number of enrollment periods included.	Rating Area	1	meanRiskScoreTotalRaPaymentHccWithCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for Total RA Payment RXC Enrollees Who Have CSR	Mean risk score for total RA Payment RXC adult model enrollees who have CSR and enrollment coverage in the plan and Rating Area. This field is calculated by summing the risk scores of each enrollment period of each adult model enrollee that has a payment RXC and a CSR factor (A CSR factor other than 1.00) and then dividing by the total number of enrollment periods included.	Rating Area	1	meanRiskScoreTotalRaPaymentRxcWithCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for RA Utilizers Who Do Not Have CSR	Mean risk score for RA Payment HCC Enrollees who do not have CSR and have enrollment coverage in the plan and Rating Area. This field is calculated by summing the risk scores of each enrollment period of each enrollee that has at least one (1) payment HCC and no CSR factor (A CSR factor of exactly 1.00) and then dividing by the total number of enrollment periods included.	Rating Area	1	meanRiskScoreTotalRaPaymentHccNoCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Risk Score for Total RA Payment RXC Enrollees Who Do Not Have CSR	Mean risk score for RA Payment RXC adult model Enrollees who do not have CSR and have enrollment coverage in the plan and Rating Area. This field is calculated by summing the risk scores of each enrollment period of each adult model enrollee that has at least one (1) payment RXC and no CSR factor	Rating Area	1	meanRiskScoreRaPaymentRxcEnrolleesNoCSR	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	(A CSR factor of exactly 1.00) and then dividing by the total number of enrollment periods included.					
Mean Unique Diagnoses per Utilizers	Mean unique Diagnoses Codes per utilizer enrollees for enrollees who have enrollment coverage in the plan and Rating Area. This field is calculated by first summing the unique count of Diagnosis Codes for each utilizer and then dividing by the unique number of utilizers.	Rating Area	1	meanUniqueDiagnosisPerUtilizers	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Unique NDC per Utilizers	Mean unique NDC codes per utilizer enrollees for adult model enrollees who have enrollment coverage in the plan and Rating Area. This field is calculated by first summing the unique count of Diagnosis Codes for each adult model utilizer and then dividing by the unique number of utilizers.	Rating Area	1	meanUniqueNdcPerUtilizers	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Mean Unique Diagnoses per RA Utilizer	Mean unique Diagnoses Codes per RA utilizer enrollees for enrollees who have enrollment coverage in the plan and Rating Area. This field is calculated by first summing the unique count of Diagnosis Codes for each RA utilizer and then dividing by the unique number of RA utilizers.	Rating Area	1	meanUniqueDiagnosisPerRAUtilizers	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Unique NDC per RA Utilizer	Mean unique NDC codes per RA utilizer adult model enrollees for enrollees who have enrollment coverage in the plan and Rating Area. This field is calculated by first summing the unique count of NDC Codes for each adult model RA utilizer and then dividing by the unique number of adult model RA utilizers.	Rating Area	1	meanUniqueNdcPerRAUtilizers	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Unique diagnoses per RA Payment HCC Enrollee	Mean unique Diagnoses Codes per RA payment HCC enrollee This field is calculated by first summing the unique count of Diagnosis Codes for each RA payment HCC enrollee and then dividing by the unique number of RA payment HCC enrollees.	Rating Area	1	meanUniqueDiagnosisPerRAPaymentHccEnrollee	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Mean Unique NDC per RA Payment RXC Enrollee	Mean unique NDC Codes per RA payment RXC enrollee belonging to the adult model This field is calculated by first summing the unique count of NDC Codes for each RA payment RXC enrollee belonging to the adult model and then dividing by the unique number of RA payment RXC enrollees belonging to the adult model	Rating Area	1	meanUniqueNdcPerRAPaymentRxcEnrollee	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Diagnoses Accepted	Total count of Dx Codes accepted for a distinct plan and Rating Area.	Rating Area	1	totalDiagnosesAccepted	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total NDC Accepted	Total count of NDC Codes accepted for a distinct plan and Rating Area, belonging to adult model enrollees	Rating Area	1	totalNdcAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total Risk Adjustment Diagnoses Accepted	Total count of Risk Adjustment diagnoses accepted for a distinct plan and Rating Area.	Rating Area	1	totalRADiagnosesAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total Risk Adjustment NDC Accepted	Total count of Risk Adjustment NDC codes accepted for a distinct plan and Rating Area, belonging to adult model enrollees	Rating Area	1	totalRANdcAccepted	Integer	minInclusive = 0; maxInclusive = 999999999
Total HCCs	Total count of HCCs (without hierarchies imposed) for all enrollees for a distinct plan and Rating Area.	Rating Area	1	totalConditionCategory	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXCs	Total unique count of RXCs (without hierarchies imposed) for all adult model enrollees for a distinct plan and Rating Area.	Rating Area	1	totalRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Payment HCCs	Total count of payment HCCs (with hierarchies imposed) for all enrollees for a distinct plan and Rating Area.	Rating Area	1	totalPaymentsConditionCategories	Integer	minInclusive = 0; maxInclusive = 999999999
Total Payment RXCs	Total unique count of payment RXCs (with hierarchies imposed) for all adult model enrollees for a distinct plan and Rating Area.	Rating Area	1	totalPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Enrollee Payment HCCs	Total count of unique enrollee payment HCCs for a distinct plan and Rating Area.	Rating Area	1	totalUniqueEnrolleePaymentHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXC to HCC interactions	Total count of unique RXC to HCC interactions for all plans for the issuer, for adult model enrollees	Rating Area	1	totalRxcToHCCInteractions	Integer	minInclusive = 0; maxInclusive = 999999999
Total RXCs Created From Service Codes	Total count of unique RXCs created from Service codes for all plans for the issuer for adult model	Rating Area	1	totalRxcsCreatedFromSrvcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees With RXC to HCC Interactions	Total count of unique adult model Enrollees with RXC to HCC Interactions for all plans for the issuer.	Rating Area	1	totalEnrolleesWithRxcToHccInteractions	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Enrollees With RXCs Created From Service Codes	Total count of unique adult model Enrollees with RXCs Created from Service Codes for all plans for the issuer.	Rating Area	1	totalEnrollees WithRxcsCreatedFromSrvcCodes	Integer	minInclusive = 0; maxInclusive = 999999999

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Average Number of HCCs per Enrollee (all Enrollees): Infant Model	Average number of HCCs per enrollee for enrollees in the infant model that have enrollment in the plan and Rating Area. This field is calculated by summing the count of HCCs of each unique enrollee in the infant model and then dividing by the unique number of enrollees in the infant model.	Rating Area	1	avgHccConditionCategoriesPerEnbyEnInfant	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of HCCs per Enrollee (all Enrollees): Child Model	Average number of HCCs per enrollee for enrollees in the child model that have enrollment in the plan and Rating Area. This field is calculated by summing the count of HCCs of each unique enrollee in the child model and then dividing by the unique number of enrollees in the child model.	Rating Area	1	avgHccConditionCategoriesPerEnbyEnChild	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of HCCs per Enrollee (all Enrollees): Adult Model	Average number of HCCs per enrollee for enrollees in the adult model that have enrollment in the plan and Rating Area. This field is calculated by summing the count of HCCs of each unique enrollee in the adult model and then dividing by the unique number of enrollees in the adult model.	Rating Area	1	avgHccsperEnrolleebyHccEnrolleesAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of RXCs per Enrollee (all Enrollees): Adult Model	Average number of unique RXCs per enrollee for enrollees in the adult model that have enrollment in the plan and Rating Area. This field is calculated by summing the count of RXCs of each unique enrollee in the adult model and then dividing by the unique number of enrollees in the adult model.	Rating Area	1	avgRxcsPerEnrolleebyRxcEnrolleesAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Average Number of Payment HCCs per Enrollee: Child Model	Average number of payment HCCs per enrollee for enrollees in the child model that have enrollment in the plan and Rating Area. This field is calculated by summing the count of payment HCCs for each unique enrollee with a payment HCC in the child model and then dividing by the unique number of enrollees with a payment HCC in the child model.	Rating Area	1	avgNumberPaymentHccs EnrolleeChild	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of Payment HCCs per Enrollee: Adult Model	Average number of payment HCCs per enrollee for enrollees in the adult model that have enrollment in the plan and Rating Area. This field is calculated by summing the count of payment HCCs for each unique enrollee with a payment HCC in the adult model and then dividing by the unique number of enrollees with a payment HCC in the adult model.	Rating Area	1	avgNumberPaymentHccs EnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Number of Payment RXCs per Enrollee: Adult Model	Average number of unique payment RXCs per enrollee for enrollees in the adult model that have enrollment in the plan and Rating Area. This field is calculated by summing the count of payment RXCs for each unique enrollee with a payment RXC in the adult model and then dividing by the unique number of enrollees with a payment RXC in the adult model.	Rating Area	1	avgNumberPaymentRxcs EnrolleeAdult	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Number of RA Utilizers with Count of 1 Unique Dx Code	Number of unique RA utilizers with count of one (1) unique Dx Code.	Rating Area	1	numberRaUtiWCt1Unique Dx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with Count of 1	Number of unique adult model RA utilizers with count of one (1) unique NDC Code.	Rating Area	1	numberRaUtiWCt1Unique Ndc	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique NDC Code						
Number of RA Utilizers with Count of 2 Unique Dx Codes	Number of unique RA utilizers with count of two (2) unique Dx Codes.	Rating Area	1	numberRaUtiWCt2UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with Count of 2 Unique NDC Codes	Number of unique adult model RA utilizers with count of two (2) unique NDC Codes.	Rating Area	1	numberRaUtiWCt2UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with 3-4 Unique Dx Codes	Number of unique RA utilizers with three (3) to four (4) unique Dx Codes.	Rating Area	1	numberRaUtiW3To4UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with 3-4 Unique NDC Codes	Number of unique adult model RA utilizers with three (3) to four (4) unique NDC Codes.	Rating Area	1	numberRaUtiW3To4UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Number of RA Utilizers with 5-6 Unique Dx Codes	Number of unique RA utilizers with five (5) to six (6) unique Dx Codes.	Rating Area	1	numberRaUtiW5To6UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with 5-6 Unique NDC Codes	Number of unique adult model RA utilizers with five (5) to six (6) unique NDC Codes.	Rating Area	1	numberRaUtiW5To6UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with 7-9 Unique Dx Codes	Number of unique RA utilizers with seven (7) to nine (9) unique Dx Codes.	Rating Area	1	numberRaUtiW7To9UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with 7-9 Unique NDC Codes	Number of unique adult model RA utilizers with seven (7) to nine (9) unique NDC Codes.	Rating Area	1	numberRaUtiW7To9UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with >= 10 unique Dx Codes	Number of unique RA utilizers with >= 10 unique Dx Codes.	Rating Area	1	numberRaUtiWGreaterOrEquals10UniqueDx	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with >= 10 unique NDC Codes	Number of unique adult model RA utilizers with >= 10 unique NDC Codes.	Rating Area	1	numberRaUtiWGreaterOrEquals10UniqueNdc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with Count of 1 HCC	Number of unique RA utilizers with count of one (1) HCC.	Rating Area	1	numberRAUtiWCount1ConditionCategory	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with Count of 1 RXC	Number of unique adult model RA utilizers with count of one (1) RXC.	Rating Area	1	numberRAUtiWCount1Rxc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With Count of 2 HCCs	Number of unique RA utilizers with count of two (2) HCCs.	Rating Area	1	numberRaUtilizerWCount2	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers With Count of 2 RXCs	Number of unique adult model RA utilizers with count of two (2) RXCs.	Rating Area	1	numberRaUtilizerWCount2Rxcs	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Number of RA Utilizers with 3-4 HCCs	Number of unique RA utilizers with three (3) to four (4) HCCs.	Rating Area	1	numberRaUtilizer3To4ConditionCategory	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with 3-4 RXCs	Number of unique adult model RA utilizers with three (3) to four (4) Rxcs.	Rating Area	1	numberRaUtilizer3To4Rxc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with >=5 HCCs	Number of unique RA utilizers with >= five (5) HCCs.	Rating Area	1	numberRaUtiWgreaterorequals5UniqueHcc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Utilizers with >=5 RXCs	Number of unique adult model RA utilizers with >= five (5) RXCs.	Rating Area	1	numberRaUtiWgreaterorEquals5UniqueRxc	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment HCC Enrollees with Count of 1 HCC	Number of unique RA utilizers with count of one (1) HCC.	Rating Area	1	numberRaPaymentHccEnrollesWithCount1	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment RXC Enrollees with Count of 1 RXC	Number of unique adult model RA utilizers with count of one (1) RXC.	Rating Area	1	numberRaPaymentRxcEnrolleesWithCount1	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment HCC Enrollees with Count of 2 HCCs	Number of unique RA utilizers with count of two (2) HCCs.	Rating Area	1	numberRaPaymentHccEnrollesWithCount2	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment RXC Enrollees with Count of 2 RXCs	Number of unique adult model RA utilizers with count of two (2) RXCs.	Rating Area	1	numberRaPaymentRxcEnrolleesWithCount2	Integer	minInclusive = 0; maxInclusive = 999999999

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Number of RA Payment HCC Enrollees with 3–4 HCCs	Number of unique RA utilizers with three (3) to four (4) HCCs.	Rating Area	1	numberRaPaymentHccEnrollesWithCount3To4	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment RXC Enrollees with 3–4 RXCs	Number of unique adult model RA utilizers with three (3) to four (4) RXCs.	Rating Area	1	numberRaPaymentRxcEnrolleesWithCount3To4	Integer	minInclusive = 0; maxInclusive = 999999999
Number of RA Payment HCC Enrollees with >=5 HCCs	Number of unique RA utilizers with >= five (5) HCCs.	Rating Area	1	numberRaPaymentHccGreaterOrEquals5UniqueHcc	Integer	minInclusive =01; maxInclusive = 999999999
Number of RA Payment RXC Enrollees with >=5 RXCs	Number of unique adult model RA utilizers with >= five (5) RXCs.	Rating Area	1	numberRaPaymentRxcGreaterOrEquals5UniqueRxc	Integer	minInclusive =01; maxInclusive = 999999999
Total V3 Indicator (adult model only)	Total count of unique adult members with severity indicator V3 for a distinct plan.	Rating Area	1	totalV3Indicator	Integer	minInclusive = 0; maxInclusive = 999999999
Male	Total count of unique male enrollees for a distinct plan.	Rating Area	1	totalMaleCount	Integer	minInclusive = 0; maxInclusive = 999999999
Males with Payment HCCs	Total count of unique male enrollees with HCCs for a distinct plan.	Rating Area	1	totalMaleCountWithHCC	Integer	minInclusive = 0; maxInclusive = 999999999
MalesMale Adults with Payment RXCs	Total count of unique adult model male enrollees with RXCs for a distinct plan.	Rating Area	1	totalMaleCountWithRxc	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Infant Model	Total count of unique males in the infant model for a distinct plan.	Rating Area	1	maleCountInfantModel	Integer	minInclusive = 0; maxInclusive = 999999999
Males in Child Model	Total count of unique males in the child model for a distinct plan.	Rating Area	1	malesCountChildModel	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Males in Adult Model	Total count of unique males in the adult model for a distinct plan.	Rating Area	1	malesCountAdultModel	Integer	minInclusive = 0; maxInclusive = 999999999
Female	Total count of unique female enrollees for a distinct plan.	Rating Area	1	totalCountFemale	Integer	minInclusive = 0; maxInclusive = 999999999
Females with Payment HCCs	Total count of unique female enrollees with payment HCCs for a distinct plan.	Rating Area	1	femaleCountWithConditionCategoryHCC	Integer	minInclusive = 0; maxInclusive = 999999999
FemalesFemale Adults with Payment RXCs	Total count of unique adult model female enrollees with payment RXCs for a distinct plan.	Rating Area	1	femaleCountWithRxc	Integer	minInclusive = 0; maxInclusive = 999999999

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Females in Infant Model	Total count of unique females in the infant model for a distinct plan.	Rating Area	1	femaleCountInfantModel	Integer	minInclusive = 0; maxInclusive = 999999999
Females in Child Model	Total count of unique females in the child model for a distinct plan.	Rating Area	1	femaleCountChildModel	Integer	minInclusive = 0; maxInclusive = 999999999
Females in Adult Model	Total count of unique females in the adult model for a distinct plan.	Rating Area	1	femaleCountAdultModel	Integer	minInclusive = 0; maxInclusive = 999999999
Infant Count	Total count of unique infant enrollees for a distinct issuer. < two (2) – Infant.	Rating Area	1	infantCount	Integer	minInclusive = 0; maxInclusive = 999999999
Child Count	Total count of unique child enrollees for a distinct issuer. >= two (2) & <=20 – Child.	Rating Area	1	childCount	Integer	minInclusive = 0; maxInclusive = 999999999
Adult Count	Total count of unique adult enrollees for a distinct issuer. >=21 – Adult.	Rating Area	1	adultCount	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 0–20	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge0To20	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 21	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge21	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 22	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge22	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 23	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge23	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 24	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge24	Integer	minInclusive = 0; maxInclusive = 999999999

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
ARF Age 25	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge25	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 26	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge26	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 27	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge27	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 28	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge28	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 29	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge29	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 30	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge30	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 31	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge31	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 32	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge32	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 33	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge33	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 34	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge34	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 35	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge35	Integer	minInclusive = 0; maxInclusive = 999999999

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
ARF Age 36	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge36	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 37	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge37	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 38	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge38	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 39	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge39	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 40	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge40	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 41	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge41	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 42	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge42	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 43	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge43	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 44	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge44	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 45	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge45	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 46	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge46	Integer	minInclusive = 0; maxInclusive = 999999999

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
ARF Age 47	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge47	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 48	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge48	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 49	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge49	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 50	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge50	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 51	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge51	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 52	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge52	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 53	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge53	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 54	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge54	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 55	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge55	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 56	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge56	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 57	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge57	Integer	minInclusive = 0; maxInclusive = 999999999

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
ARF Age 58	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge58	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 59	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge59	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 60	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge60	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 61	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge61	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 62	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge62	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 63	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge63	Integer	minInclusive = 0; maxInclusive = 999999999
ARF Age 64 and older	Total count of unique members in this ARF bucket for a distinct plan.	Rating Area	1	arfAge64AndOlder	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Enrollee Count	Total count of unique enrollees that have at least one (1) system generated cross year enrollment period for the Plan ID and Rating Area.	Rating Area	1	crossYearEnrolleeCount	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Enrollment Period Count	Total count of unique system generated cross year enrollment periods for the Plan ID and Rating Area.	Rating Area	1	crossYearEnrollmentPeriodCount	Integer	minInclusive = 0; maxInclusive = 999999999
System Generated Cross Year Member Month Count	Total sum of member months for all system generated cross year enrollment periods for the Plan ID and Rating Area.	Rating Area	1	crossYearMemberMonthCount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Diagnosis Code Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Diagnosis Code	1 or more per enrollment period per enrollee per insurance plan in the reported submission file	includedDiagnosisCodeCategory	RiskScoreSummaryDiagnosisCodeCategory	None
Payment HCC Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Payment HCC	1 or more per enrollment period per enrollee per insurance plan in the reported submission file	includedPaymentHccCategory	RiskScoreSummaryPaymentHccCategory	none
Payment RXC Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Payment RXC	1 or more per enrollment period per enrollee per insurance plan in the reported submission file	includedPaymentRxcCategory	RiskScoreSummaryPlanPaymentRxcCategory	none
Severity Level (Infant model includes maturity level)	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	Severity Level	1 or more per insurance plan per issuer in the reported submission file	includedSeverityLevelCategory	RiskScoreSummarySeverityLevelCategory	none

Table 44: RARSS Risk Score Summary Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
HCC Group Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	HCC Group	1 or more per insurance plan per issuer in the reported submission file	includedHccGroupCategory	RiskScoreSummaryHccGroupCategory	None
HCC Interaction Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	HCC Interaction	0 or more per insurance plan per issuer in the reported submission file	includedHccInteractionCategory	RiskScoreSummaryHccInteractionCategory	none
CSR Factor Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	CSR Factor	0 or more per insurance plan per issuer in the reported submission file	includedCsrFactorCategory	RiskScoreSummaryCsrFactorCategoryCategory	none
HCC Dropped Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the risk score section of the report.	HCC Dropped	1 or more per insurance plan per issuer in the reported submission file	includedHCCDroppedCategory	RiskScoreSummaryHccDropCategory	none
RXC to HCC Interaction Category	This XML element describes the risk score related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business	RXC To HCC Interaction	1 or more per insurance plan per issuer in the reported submission file	includedRxcToHccInteractionCategory	RiskScoreSummaryPlanRxcToHccInteractionCategory	none

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	meaning. It should be processed to identify the risk score section of the report.					

The data characteristics for the RARSS Risk Score Summary Diagnosis Code category are as shown in Table 45. These elements are defined in the *RiskScoreSummaryPlanDiagnosisCodeCategory.xsd*.

Table 45: RARSS Risk Score Summary Plan Diagnosis Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Diagnosis Code	De-duped when Diagnosis Codes occurs multiple times for a benefit year; attributed to the risk score for the enrollment period; includes unique diagnoses for a distinct plan.	Diagnosis Code	1	diagnosisCode	String	minLength = 0, maxLength = 30
Diagnosis Code Count	Number of unique enrollees with RA payment HCCs with the Diagnosis Code. Total RA Dx counts for unique enrollees with Payment HCCs.	Diagnosis Code	1	diagnosisCodeCount	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary Payment HCC category are as shown in Table 46. These elements are defined in the *RiskScoreSummaryPlanPaymentHccCategory.xsd.*

Table 46: RARSS Risk Score Summary Plan Payment HCC

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Payment HCC	HCC Hierarchy Imposed.	Payment HCC	1	paymentHcc	String	minLength = 0; maxLength = 10

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Number of Unique RA Users with the HCC	Number of unique enrollees with at least one (1) payment HCC.	Payment HCC	1	numberOfUniqueRaUsersWHcc	Integer	minInclusive = 0; maxInclusive = 999999999
Mean number of co-Occurring HCCs with the HCC	Mean Number of co-occurring HCCs with the HCC defined.	Payment HCC	1	meanNumberOfCooccuringHccsWHcc	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Three (3) Most Frequent Co-Occurring HCCs with the HCC Defined	Three (3) most frequently co-occurring HCCs with the HCC defined.	Payment HCC	1	threeMostFrequentCooccuringHccsWHcc	String	minLength = 0; maxLength = 30 Format: Comma separated values

The data characteristics for the RARSS Risk Score Summary Payment RXC category are as shown in Table 47. These elements are defined in the *RiskScoreSummaryPlanPaymentRxcCategory.xsd*.

Table 47: RARSS Risk Score Summary Plan Payment RXC

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Payment RXC	RXC Hierarchy imposed.	Payment RXC	1	paymentRxc	String	minLength = 0; maxLength = 10
Number of unique RA users with the RXC	Number of unique adult model enrollees with at least one (1) instance of the payment RXC.	Payment RXC	1	numberOfUniqueRaUsersWRxc	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary Severity category are as shown in Table 48. These elements are defined in the *RiskScoreSummarySeverityLevelCategory.xsd*.

Table 48: RARSS Risk Score Summary Severity

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
IHCC Severity Level	Severity and maturity level assigned for the infant age model.	Severity Level	0..1	hccSeverity	String	minLength = 0 Enumeration Values: "1": Extremely Immature & Severity 1 "2": Extremely Immature & Severity 2 "3": Extremely Immature & Severity 3 "4": Extremely Immature & Severity 4 "5": Extremely Immature & Severity 5 "6": Immature & Severity 1 "7": Immature & Severity 2 "8": Immature & Severity 3 "9": Immature & Severity 4 "10": Immature & Severity 5 "11": Premature Multiples & Severity 1 "12": Premature Multiples & Severity 2 "13": Premature Multiples & Severity 3 "14": Premature Multiples & Severity 4 "15": Premature Multiples & Severity 5 "16": Term & Severity 1 "17": Term & Severity 2 "18": Term & Severity 3 "19": Term & Severity 4 "20": Term & Severity 5 "21": One Year Old & Severity 1 "22": One Year Old & Severity 2 "23": One Year Old & Severity 3 "24": One Year Old & Severity 4 "25": One Year Old & Severity 5 NULL: No enrollees in the infant model to report
Enrollee Severity Count	Count of infant model enrollees with the defined severity level.	Severity Level	1	enrolleeSeverityCount	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary HCC Group category are as shown in Table 49. These elements are defined in the *RiskScoreSummaryPlanHccGroupCategory.xsd*.

Table 49: RARSS Risk Score Summary Plan HCC Group

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
HCC Group	Lists the groups which have been assigned for the enrollment period.	HCC Group	1	hccGroup	String	minLength = 0 maxLength = 10
HCC Group Count	Total number of members in each HCC Group for a distinct plan.	HCC Group	1	hccGroupCount	Integer	minInclusive = 0 maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary Interaction Group category are as shown in Table 50. These elements are defined in the *RiskScoreSummaryHccInteractionCategory.xsd*.

Table 50: RARSS Risk Score Summary HCC Interaction Group

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Interaction Group	Interaction group H or M.	HCC Interaction	1	interactionGroup	String	minLength = 0 maxLength = 1 Enumeration Values: "H","M"
Interaction Group Count	Total count of members interaction group H or M.	HCC Interaction	1	interactionGroupCount	Integer	minInclusive= 0 maxInclusive = 9999999

The data characteristics for the RARSS Risk Score Summary CSR Factor category are as shown in Table 51. These elements are defined in the *RiskScoreSummaryCsrFactorCategory.xsd*.

Table 51: RARSS Risk Score Summary CSR Factor

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
CSR Factor	CSR factor for a distinct issuer.	CSR Factor	1	membersbyCsrFactor	Decimal	minInclusive = 0 maxInclusive = 99.99
Members by CSR Factor Count	Total Count of members with the defined CSR factor.	CSR Factor	1	membersbyCsrFactorCount	Integer	minInclusive = 0 maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary CSR Factor category are as shown in Table 52. These elements are defined in the *RiskScoreSummaryHccDropCategory.xsd*.

Table 52: RARSS Risk Score Summary HCC Dropped

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Dropped HCC	HCCx dropped across all RA Payment HCC Enrollees, due to HCC hierarchy, HCC Group, and/or HCC interaction for a distinct user (*repeat for each HCC).	HCC Dropped	1	droppedHCCs	String	minLength = 0 maxLength = 10
Frequency of HCC	Frequency of HCCx dropped across all RA Payment HCC Enrollees, due to HCC hierarchy, HCC Group, and/or HCC interaction for a distinct user (*repeat for each HCC).	HCC Dropped	1	frequencyDroppedHCCs	Integer	minInclusive = 0 maxInclusive = 999999999

The data characteristics for the RARSS Risk Score Summary RXC to HCC interaction category are as shown in Table 53. These elements are defined in the *RiskScoreSummaryPlanRxcToHccInteractionCategory.xsd*.

Table 53: RARSS Risk Score Summary Plan RXC to HCC Interaction

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
RXC to HCC Interaction	Unique RXC to HCC Interaction from Adult Model Enrollees	RXC to HCC Interaction	1	rxcToHccInteraction	String	minLength = 0 maxLength = 30
RXC to HCC Interaction Count	Total count of unique adult model enrollees with at least one instance of the RXC to HCC interaction	RXC to HCC Interaction	1	rxcToHccInteractionCount	Integer	minInclusive= 0; maxInclusive = 9999999

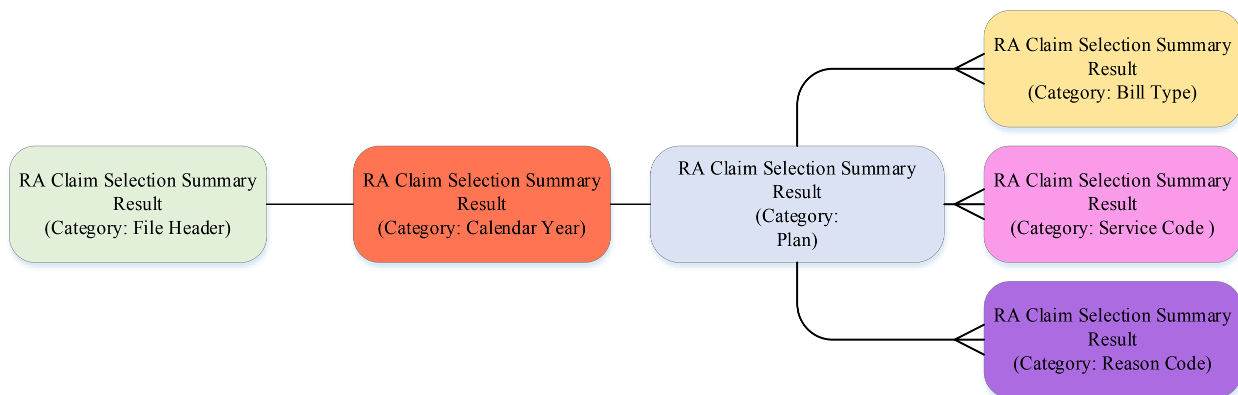
RA Claim Selection Summary Report (RACSS) Message Format (or Record Layout) and Required

The outbound RACSS Report is available to CMS and the issuer/submitting organization. This report contains the included and excluded medical claim summary data. The RACSS Report will be generated with the risk score and transfer extract batch job.

5.1.1.8File Layout

This section specifies the file layout for the RACSS Report. At a high level, it consists of six (6) record types or categories of information, as shown in Figure 4.

Figure 4: EDGE Server RA Claim Selection Summary Report Data Categories



The RACSS XSD Report consists of report File Header, Calendar Year, Plan, Bill Type, Service Code and Reason Code categories.

The RACSS XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.9Field/Data Elements and Descriptions

The data characteristics for the RACSS Claim Selection Summary File Header Result category are as shown in Table 54. The root element of the RACSS in the XSD is ClaimSelectionSummaryReport (*ClaimSelectionSummaryReport.xsd*). This element is required and all the other elements defined in this section for the RACSS are embedded within this element start and end tags.

Table 54: RACSS Claim Selection Summary File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader.xsd	none
Calendar Year Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Year	1 or more per insurance plan per issuer in the reported submission file	includedCalendarYearCategory	ClaimSelectionSummaryCalendaryearCategory	none

The data characteristics for the RA Claim Selection Summary (RACSS) Claim Selection Summary Calendar Year category are as shown in Table 55. These elements are defined in the *ClaimSelectionSummaryCalendaryearCategory.xsd*.

Table 55: RACSS Claim Selection Summary Calendar Year

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Calendar Year	The calendar year associated with the claims as determined by the Statement Covers Through date/Prescription Fill date.	Calendar Year	1	calendarYear	String	Strict: YYYY minLength = 0 maxLength = 4
Total Unique Enrollees with Active Medical Claims	Total enrollees with at least one (1) medical claim for all plans for the issuer.	Calendar Year	1	totalEnrolleesWithMedicalClaims	Integer	minInclusive = 0 maxInclusive = 999999999

Table 55: RACSS Claim Selection Summary Calendar Year (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Enrollees with Active Pharmacy Claims	Total enrollees with at least one (1) pharmacy claim for all plans for the issuer.	Calendar Year	1	totalEnrolleesWithPharmacyClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Total Medical Claims Included	Total count of medical claims included for RA claim selection for all plans for the Issuer.	Calendar Year	1	medicalClaimsIncluded	Integer	minInclusive = 0 maxInclusive = 999999999
Total Medical Claims Excluded	Total count of medical claims excluded from RA claim selection for all plans for the issuer.	Calendar Year	1	medicalClaimsExcluded	Integer	minInclusive = 0 maxInclusive = 999999999
Total Count of Supplemental Records Included	Total count of Supplemental Record ID's included for RA claim selection across all plans belonging to the Issuer.	Calendar Year	1	supplementalRecordsIncluded	Integer	minInclusive = 0 maxInclusive = 999999999
Total Count of Supplemental Records Excluded	Total count of Supplemental Records ID's excluded for RA claim selection across all plans belonging to the Issuer.	Calendar Year	1	supplementalRecordsExcluded	Integer	minInclusive = 0 maxInclusive = 999999999
Total Enrollees with RA Eligible Claims	Total enrollees with RA claims included for all plans for the Issuer.	Calendar Year	1	totalEnrolleesWRaEligibleclaims	Integer	minInclusive = 0 maxInclusive = 999999999
Total RA Eligible Pharmacy Claims Included	Total count of pharmacy claims included for RA claim selection for all plans for the Issuer.	Calendar Year	1	pharmacyClaimsIncluded	Integer	minInclusive = 0 maxInclusive = 999999999

Table 55: RACSS Claim Selection Summary Calendar Year (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Pharmacy Claims Excluded	Total count of pharmacy claims excluded from RA claim selection for all plans for the Issuer.	Calendar Year	1	pharmacyClaimsExcluded	Integer	minInclusive = 0 maxInclusive = 999999999
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Plan	1 or more per insurance plan in the reported submission file	includedPlanCategory	ClaimSelectionSummaryPlanCategory	none

The data characteristics for the RA Claim Selection Summary (RACSS) Claim Selection Summary Plan category are as shown in Table 56. These elements are defined in the *ClaimSelectionSummaryPlanCategory.xsd*.

Table 56: RACSS Claim Selection Summary Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique identifier for the plan.	Plan	1	planIdentifier	String	minLength = 0 maxLength = 16
Total Enrollees	Total enrollees for the plan.	Plan	1	totalEnrollees	Integer	minInclusive = 0 maxInclusive = 999999999
Total Medical Claims Included	Total count of medical claims included for RA claim slection for the plan.	Plan	1	medicalClaimsIncluded	Integer	minInclusive = 0 maxInclusive = 999999999
Total Medical Claims Excluded	Total count of medical claims excluded from claim selection.	Plan	1	medicalClaimsExcluded	Integer	minInclusive = 0 maxInclusive = 999999999

Table 56: RACSS Claim Selection Summary Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Count of Supplemental Records Included	Total count of Supplemental Record ID's included for RA claim selection belonging to the Plan.	Plan	1	supplementalRecordsIncluded	Integer	minInclusive = 0 maxInclusive = 999999999
Total Count of Supplemental Records Excluded	Total count of Supplemental Records ID's excluded for RA claim selection belonging to the Plan.	Plan	1	supplementalRecordsExcluded	Integer	minInclusive = 0 maxInclusive = 999999999
Total Enrollees with RA Eligible Claims	Total enrollees with RA claims included.	Plan	1	totalEnrolleesWRaEligibleclaims	Integer	minInclusive = 0 maxInclusive = 999999999
Tota RA Eligible Pharmacy Claims Included	Total count of pharmacy claims included for RA for the plan.	Plan	1	pharmacyClaimsIncluded	Integer	minInclusive = 0 maxInclusive = 999999999
Total Pharmacy Claims Excluded	Total count of pharmacy claims excluded from RA for the plan.	Plan	1	pharmacyClaimsExcluded	Integer	minInclusive = 0 maxInclusive = 999999999
Bill Type Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Bill Type	1 or more per bill type per insurance plan in the reported submission file	includedBilltypeCategory	ClaimSelectionSummaryBillTypeCategory	none

Table 56: RACSS Claim Selection Summary Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Service Code Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Service Code	1 or more per service code per insurance plan in the reported submission file	includedServiceCodeCategory	ClaimSelectionSummaryServiceCodeCategory	None
Reason Code Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Reason Code	1 or more per Reason Code per insurance plan in the reported submission file	includedReasonCodeCategory	ClaimSelectionSummaryReasonCodeCategory	none

The data characteristics for the RA Claim Selection Summary (RACSS) Claim Selection Summary Bill Type category are as shown in Table 57. These elements are defined in the *ClaimSelectionSummaryBillTypeCategory.xsd*.

Table 57: RACSS Claim Selection Summary Bill Type

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Bill Type Code	Bill Type Code for the medical claim (only include the Bill Types for RA claim selection).	Bill Type	0..1	billTypeCode	String	minLength = 0 maxLength = 3
Number of Claims Included	Number of medical claims included for RA claim selection with the Bill Type Code.	Bill Type	0..1	claimsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999
Number of Claims Excluded	Number of medical claims excluded for RA claim selection with the Bill Type Code.	Bill Type	0..1	claimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RA Claim Selection Summary (RACSS) Claim Selection Service Code category are as shown in Table 58. These elements are defined in the *ClaimSelectionSummaryServiceCodeCategory.xsd*.

Table 58: RACSS Claim Selection Summary Service Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Service Code	Service Code for the medical claim (only include Service Codes flagged for RA claim selection).	Service Code	0..1	serviceCode	String	minLength = 0; maxLength = 80
Number of Claims Included	Number of medical claims included for RA claim selection with the Service Code.	Service Code	0..1	claimsIncluded	Integer	minInclusive = 0; maxInclusive = 999999999
Number of Claims Excluded	Number of medical claims excluded for RA claim selection with the Service Code.	Service Code	0..1	claimsExcluded	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the RA Claim Selection Summary (RACSS) Claim Selection Summary Reason Code category are as shown in Table 59. These elements are defined in the *ClaimSelectionSummaryReasonCodeCategory.xsd*.

Table 59: RACSS Claim Selection Summary Reason Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Medical Reason Code	Reason Code why the medical claim was excluded from RA claim selection.	Reason Code	0..1	medicalReasonCode	String	minLength = 0 maxLength = 10
Total Medical Claims Excluded	Total count of medical claims excluded for RA claim selection.	Reason Code	0..1	medicalClaimsExcluded	Integer	minInclusive = 0 maxInclusive = 999999999
Pharmacy Reason Code	Reason Code why the pharmacy claim was excluded from RA claim selection.	Reason Code	0..1	pharmacyReasonCode	String	minLength = 0 maxLength = 10
Total RA Eligible Pharmacy Claims Excluded	Total count of pharmacy claims excluded for RA claim selection.	Reason Code	0..1	pharmacyClaimsExcluded	Integer	minInclusive = 0 maxInclusive = 999999999
Supplemental Reason Code	Reason Code why the supplemental record was excluded from RA claim selection.	Reason Code	0..1	supplementalReasonCode	String	minLength = 0 maxLength = 10
Total Supplemental Records Excluded	Total count of supplemental records excluded for RA claim selection.	Reason Code	0..1	supplementalRecordsExcluded	Integer	minInclusive = 0 maxInclusive = 999999999

RA Transfer Elements Extract (RATEE)Message Format (or Record Layout) and Required Protocols

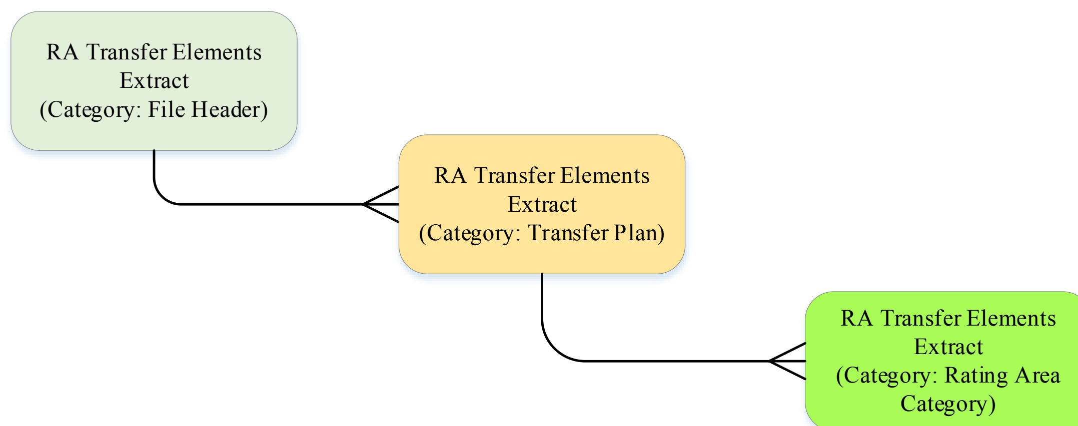
The outbound RATEE Report is available to CMS and the issuer/submitting organization. This report contains information relating to plan inputs to the payment transfers, which will be aggregated and transmitted to CMS to be used to calculate the transfer payment amount. The RATEE report will be generated with the risk score and transfer extract batch job.

Note – System generated cross year enrollment periods, created during the RA calculation in order to include qualifying cross year claims, are included by the system when calculating the values in this report.

5.1.1.10 File Layout

This section specifies the file layout for the RATEE Report. At a high level, it consists of three (3) record types or categories of information, as shown in Figure 5.

Figure 5: EDGE Server RA Transfer Elements Extract Report Data Categories



The RATEE Report consists of a report File Header category, Transfer Plan category, and Rating Area Category.

The RATEE XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.11 Field/Data Elements and Descriptions

The data characteristics for the RATEE category are as shown in Table 60. The root element of the RATEE in the XSD is RATransferReport (*RATransferReport.xsd*). This element is required and all the other elements defined in this section for the RATEE are embedded within this element start and end tags.

Table 60: RATEE RA Transfer File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader.xsd	none
State	State code where the plan is offered.	File Header	1	State	String	minLength = 0 maxLength = 2
Calendar Year	The calendar year/quarter.	File Header	1	calendarYear	String	Strict: YYYY
Execution Type	Designate preliminary or final run.	File Header	1	executionType	String	minLength = 1; maxLength = 30 Enumeration Values: “P”: Preliminary “F”: Final
Transfer Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Plan	1 or more per insurance plan in the reported submission file	includedPlanIdentifierCategory	RATransferPlanCategory	none

The data characteristics for the RA Transfer Elements Extract (RATEE) RA Transfer Plan category are as shown in Table 61. These elements are defined in the *RATransferPlanCategory.xsd*.

Table 61: RATEE RA Transfer Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique identifier for the plan.	Plan	1	planIdentifier	String	minLength = 0 maxLength = 14
Plan Market Type	Market in the State where the plan is offered; Individual or Small Group.	Plan	1	planMarketType	String	minLength = 0; maxLength = 30 Enumeration Value: "1": Individual "2": Small Group
Exchange (FFM, SBM, OFF)	FFM, SBM, SPM, SSBM, off-Exchange.	Plan	1	Exchange	String	minLength = 0, maxLength = 30
Plans Metal Level	Plan level that determines an enrollee's risk level (Bronze, Silver, Gold, Platinum, and Catastrophic).	Plan	1	plansMetalLevel	String	minLength = 0; maxLength = 30 Enumeration Values: "Catastrophic" "Bronze" "Silver" "Gold" "Platinum"
Rating Area Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Rating Area	1 or more per insurance plan in the reported submission file	includedRatingAreaCategory	RATransferRatingAreaCategory	none

The data characteristics for the RA Transfer Elements Extract (RATEE) RA Transfer Rating Area category are as shown in Table 62. These elements are defined in the *RATransferRatingAreaCategory.xsd*.

Table 62: RATEE RA Transfer Rating Area Category

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Rating Area	Plan Rating Area.	Rating Area	1	ratingArea	String	maxLength = 3
Enrollee Member Months (Me)	Total number of member months an enrollee is enrolled in a plan during the benefit year.	Rating Area	1	enrolleeMemberMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Enrollee Billable Months (Mb)	Billable Member Months for a billable member.	Rating Area	1	enrolleeBillableMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Enrollee Subscriber Months (Ms)	Billable member months attributed to the individual policy subscriber.	Rating Area	1	enrolleeSubscriberMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Plan (PLRSi)	Plan's average plan liability risk score. = (sum of the Product of enrollment months and individual plan liability risk score)/ (Sum of all billable member months for all billable members in a plan).	Rating Area	1	planLiabilityRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Plan Allowable Rating Factor (ARFi)	Plan allowable rating factor for use in RA payments and charges calculation.	Rating Area	1	planAllowableRatingFactor	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Plan Average Premium (Pi)	Plan average premium.	Rating Area	1	planAveragePi	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Pi^{AS}	Plan age standardized average premium.	Rating Area	1	planAgeAvePremium	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999

RADV Population Summary Statistics Report (RADVPS) Message Format (or Record Layout) and Required Protocols

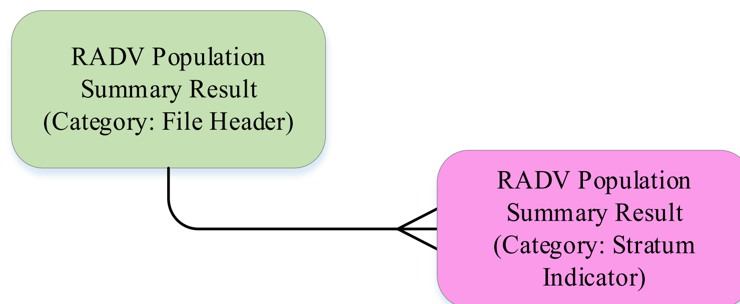
The outbound RADVPS Report is available to CMS and the issuer/submitting organization. This report contains population statistics calculated per stratum for the total population of the issuer from all risk pool market types (individual, small group, catastrophic). The RADVPS Report will be generated with the risk score and transfer element extract batch job.

Note – System generated cross year enrollment periods, created during the RA calculation in order to include qualifying cross year claims, are included by the system when calculating the values in this report.

5.1.1.12 File Layout

This section specifies the file layout for the RADVPS Report. At a high level, it consists of two (2) record types or categories of information, as shown in Figure 6.

Figure 6: EDGE Server RADV Population Summary Statistics



The RADVPS Report consists of a report File Header category and an Stratum Indicator data category.

The RADVPS XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.13 Field/Data Elements and Descriptions

The data characteristics for the RADV Population Summary Statistics category are as shown in Table 63. The root element of the RADVPS in the XSD is radvPopulationSummaryStatistics (*radvPopulationSummaryStatistics.xsd*). This element is required and all the other elements defined in this section for the RADVPS are embedded within this element start and end tags.

Table 63: RADVPS Population Summary Statistics Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFIleHeader	none
Payment Year	For example, 2014 or 2015.	File Header	1	paymentYear	String	Length = 4 Strict: YYYY
Preliminary/Final Run	Designate preliminary or final run.	File Header	1	preliminaryFinalRun	String	Length = 1 Enumeration Values: “P”: Preliminary “F”: Final
Total Number of Plan IDs	Total number of 16-digit Plan IDs for the risk score calculation.	File Header	1	totalNumberOfPlanIds	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees	Total number of unique enrollees selected for the risk score calculation.	File Header	1	totalNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999

Table 63: RADVPS Population Summary Statistics Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Enrollees from Individual Risk Pool Market	Total number of unique enrollees selected from the Individual Risk Pool Market that were included in the RA calculation.	File Header	1	totalIndividualNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees from Small Group Risk Pool Market	Total number of unique enrollees selected from the Small Group Risk Pool Market that were included in the RA calculation.	File Header	1	totalSmallGroupNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees from Catastrophic Risk Pool Market	Total number of unique enrollees selected from the Catastrophic Risk Pool Market that were included in the RA calculation.	File Header	1	totalCatastrophicNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Stratum Indicator Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Stratum Indicator	1..10	includedStratumLevel	radvpsPopulationStratrumIndicatorCategory	none

The data characteristics for the RADVPS Population Summary Stratum Indicator category are as shown in Table 64. These elements are defined in the *radvpsPopulationStratumIndicatorCategory.xsd*.

Table 64: RADVPS Population Summary Stratum Indicator

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Stratum Indicator	Strata 1-9 represent low, medium and high-risk enrollees with at least one (1) HCC or at least one (1) RXC for each age model. Stratum 10 includes enrollees that have no HCCs and no RXCs. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 can have a pharmacy claim count > 0. Strata 4-10 Total Pharmacy Claims = 0.	Stratum Type	1	stratumLevel	String	minLength = 0 Enumeration Values: “1: Adult – Low” “2: Adult – Medium” “3: Adult – High” “4: Child – Low” “5: Child - Medium” “6: Child – High” “7: Infant – Low” “8: Infant – Medium” “9: Infant – High” “10: No HCCs and No RXCs”
Stratum Size	The total number of Enrollee IDs from the issuer’s population that were selected for this stratum.	Stratum Type	1	stratumSize	Integer	minInclusive = 0; maxInclusive = 999999999
Mean Risk Score	The weighted average of the risk score using member months. This is using the risk score calculated for RADV based on the demographic, CSR, enrollment duration, RXC (and interaction) and HCC (and interaction) factors.	Stratum Type	1	meanRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Min Risk Score	The minimum of the weighted average risk score using member months. This is using the risk score calculated for RADV based on the demographic, CSR, enrollment duration, RXC (and interaction) and HCC (and interaction) factors	Stratum Type	1	minRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 64: RADVPS Population Summary Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Max Risk Score	The maximum of the weighted average risk score using member months. This is using the risk score calculated for RADV based on the demographic, CSR, enrollment duration, RXC (and interaction) and HCC (and interaction) factors.	Stratum Type	1	maxRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Standard Deviation Risk Score	The standard deviation of the weighted average risk score using member months. This is using the risk score calculated for RADV based on the demographic, CSR, enrollment duration, RXC (and interaction) and HCC (and interaction) factors.	Stratum Type	1	stdDevRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Minimum Date of Birth	Minimum date of birth of enrollees selected for the risk score calculation.	Stratum Type	1	minDateOfBirth	String	Length = 10 Strict: YYYY-MM-DD
Maximum Date of Birth	Maximum date of birth of enrollees selected for the risk score calculation.	Stratum Type	1	maxDateOfBirth	String	Length = 10 Strict: YYYY-MM-DD
Mean Age	Mean Age of enrollees selected for the risk score calculation (age as of the last day of the last enrollment period).	Stratum Type	1	meanAge	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 64: RADVPS Population Summary Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Average Premium	Weighted average premium, using member months, of enrollees selected for the risk score calculation. This element is calculated by dividing the total premium paid (totalPremiumAmount) by the total number of member months in the payment year of all enrollees in the stratum. Note: Non-billable member months are included in the denominator when performing the weighted average.	Stratum Type	1	averagePremium	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Premium Amount	Total premium amount paid in the payment year for all enrollment periods in the stratum. The paid amount for each enrollment period is calculated by multiplying the monthly premium by the number of member months of the enrollment period within the payment year. Note: Non-subscriber enrollment periods do not contribute to the total premium amount.	Stratum Type	1	totalPremiumAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Medical Claims	Total medical claims for all enrollees in the defined strata. This only includes all active, RA eligible medical claims.	Stratum Type	1	totalMedicalClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Medical Plan Paid Amount	Total amount paid for all active, RA eligible medical claims for all enrollees in the defined strata.	Stratum Type	1	totalMedicalPlanPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 64: RADVPS Population Summary Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Number of Diagnoses Codes	Total number of Diagnosis Codes for all enrollees in the defined strata contained on RA eligible claims. Duplicate codes are counted for an individual enrollee.	Stratum Type	1	totalNumberDiagnosisCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of RA Diagnoses Codes	Total number of RA Diagnosis Codes that map to an HCC for all enrollees in the defined strata contained on RA eligible claims. Duplicate codes are counted for an individual enrollee.	Stratum Type	1	totalNumberRADiagnosisCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of HCCs	Total number of HCCs de-duplicated for each enrollee within the strata after the HCC hierarchy is applied.	Stratum Type	1	totalNumberOfHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Unique Diagnosis Codes	Total number of Diagnosis Codes, de-duplicated for enrollee in the defined strata contained on RA eligible claims. Duplicate codes are only counted once for an individual enrollee.	Stratum Type	1	totalNumberUniqueDiagnosis	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Unique RA Diagnosis Codes	Total number of RA Diagnosis Codes, de-duplicated for each enrollee, that map to an HCC for all enrollees in the defined strata contained on RA eligible claims. Duplicate codes are only counted once for an individual enrollee.	Stratum Type	1	totalNumberUniqueRADiagnosis	Integer	minInclusive = 0; maxInclusive = 999999999
Total Pharmacy Claims	Total pharmacy claims for all enrollees in the defined strata. This only includes RA eligible pharmacy claims. Note: Only the adult RA model includes RXCs therefore only the	Stratum Type	1	totalRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	adult strata 1-3 can have a pharmacy claim count > 0. Strata 4-10 Total Pharmacy Claims = 0.					
Total Pharmacy Plan Paid Amount	Total plan paid amount from all RA eligible pharmacy claims for enrollees belonging to the stratum. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 will have a Total Pharmacy Plan Paid amount > 0. Strata 4-10 Total Pharmacy Plan Paid Amount = 0.	Stratum Type	1	totalRxPlanPaidAmountok	Decimal	minInclusive = 0; maxInclusive = 999999999999.99
Total Number of RA NDC Codes	Total number of RA NDC Codes that map to an RXC for all enrollees in the defined strata contained on RA eligible pharmacy claims. Duplicate codes are counted for an individual enrollee.	Stratum Type	1	totalRANdcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Number of RA NDC Codes	Total number of RA NDC Codes, de-duplicated for each enrollee, that map to an RXC for all enrollees in the defined strata contained on RA eligible pharmacy claims. Duplicate codes are counted once for an individual enrollee.	Stratum Type	1	totalUniqueRANdcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Payment RXCs	Total number of RXCs de-duplicated for each enrollee within the strata after the RXC hierarchy is applied.	Stratum Type	1	totalPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique HCPCS That Created Payment RXCs	Total service codes from medical claims, de-duplicated for each enrollee within the strata that created payment RXCs (i.e, after imposing hierarchy) for enrollees in the defined strata	Stratum Type	1	totalUniqueHcpcsThatCreatedPmtRxcs	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Payment RXCs Created By HCPCS	Total number of RXCs de-duplicated for each enrollee within the strata after the RXC hierarchy is applied, that are created by a HCPCS service code on medical claim mapping to the RXC.	Stratum Type	1	totalUniquePmtRxcsCreatedByHcpcs	Integer	minInclusive = 0; maxInclusive = 999999999

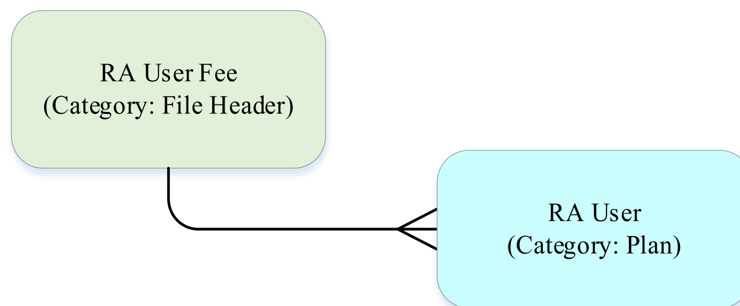
RA User Fee (RAUF) Message Format (or Record Layout) and Required Protocols

The outbound RAUF Report is available to CMS and the issuer/submitting organization. This report contains information on RA User Fee amounts calculated on each issuer's edge server and is an input sent to the edge calculation module. RA User Fee is calculated on each issuer's EDGE server. The RAUF Report will be generated with the RA User Fee batch job.

5.1.1.14 File Layout

This section specifies the file layout for the RAUF Report. At a high level, it consists of two (2) record types or categories of information, as shown in Figure 7.

Figure 7: EDGE Server RA User Fee Categories



The RAUF Report consists of a report File Header category and a Plan category.

The RAUF XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.15 Field/Data Elements and Descriptions

The data characteristics for the RAUF RA File Header category are as shown in Table 65. The root element of the RAUF in the XSD is RaUserFeeReport (*RaUserFeeReport.xsd*). This element is required and all the other elements defined in this section for the RAUF are embedded within this element start and end tags.

Table 65: RAUF RA User Fee File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	RARICommonOutboundFileHeader	Report Header	none
Calendar Year	For example, 2014 or 2015	File Header	1	calendarYear	String	Strict: YYYY
Execution Type	Designate preliminary or final run.	File Header	1	executionType	String	minLength = 1; maxLength = 30 Enumeration Values: "P": Preliminary "F": Final
Total Enrollees	Total count of enrollees for a distinct plan.	File Header	1	uniqueEnrollees	Integer	minInclusive = 1; maxInclusive = 999999999
Total Billable Member Months	Total count of billable member months for all enrollees in a distinct plan at the issuer level, reflected using 15 decimal places.	File Header	1	totalBillableMemberMonths	Decimal	None
Total RA User Fee	Sum of all calculated UF across all plans for an issuer, reflected using 15 decimal places.	File Header	1	totalRAUserFee	Decimal	None
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Plan	1 or more per insurance plan in the reported submission file	includedPlanidentifier	RaUserFeePlanCategory.xsd	None

The data characteristics for the RAUF RA User Fee Plan category are as shown in Table 66. These elements are defined in the *RaUserFeePlanCategory.xsd*.

Table 66: RAUF User Fee Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique identifier for insurance plan offered by issuer that the enrollee is covered under. The Plan ID includes the CSR variant.	Plan	1	planIdentifier	String	Length = 16
State	State where the plan is offered.	Plan	1	State	String	Length = 2
Total enrollees	Total count of enrollees for a distinct plan.	Plan	1	totalEnrollees	Integer	minInclusive = 1; maxInclusive = 999999999
Total billable member months	Total count of billable member months for all enrollees in a distinct plan, reflected using 15 decimal places.	Plan	1	totalBillableMemberMonths	Decimal	None
Total RA User Fee	Total enrollee billable member months x UF rate for a distinct plan, reflected using 15 decimal places.	Plan	1	totalRAUserFee	Decimal	None

RA Payment HCC Enrollee Report (RAPHCCER)Message Format (or Record Layout) and Required Protocols

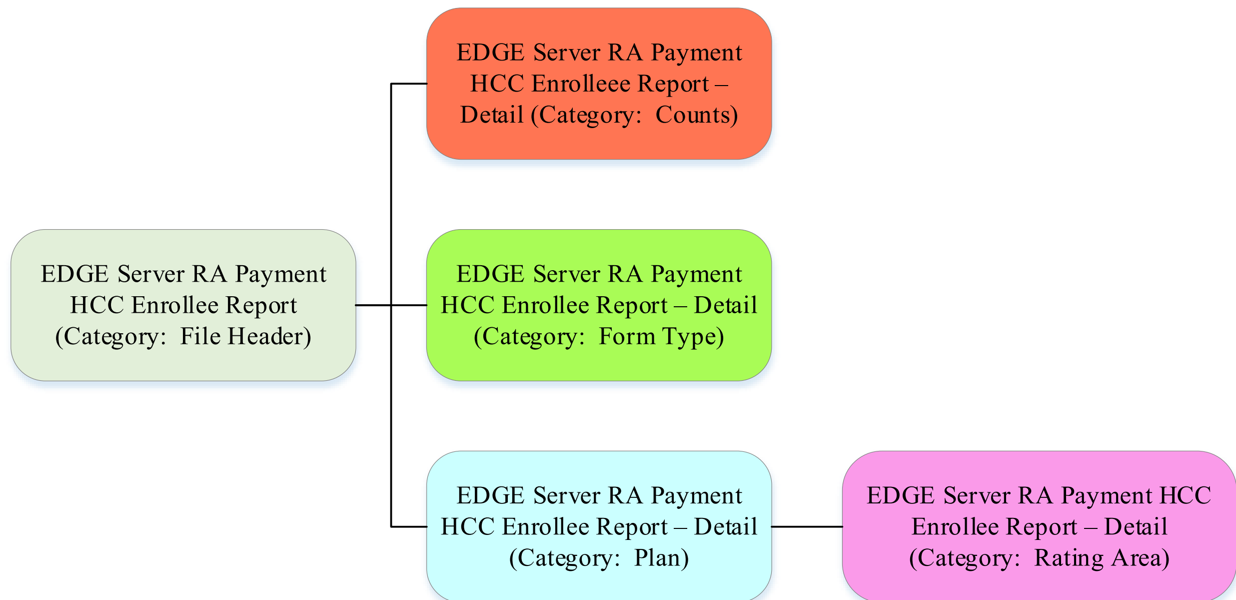
The outbound RAPHCCER Report is available to CMS and the issuer/submitting organization. This report contains information on total counts in relation to RA HCC claims and enrollees. The RAPHCCER Report will be generated each time the RA calculation process is executed.

Note – System generated cross year enrollment periods, created during the RA calculation in order to include qualifying cross year claims, are included by the system when calculating the values in this report.

5.1.1.16 File Layout

This section specifies the file layout for the RAPHCCER Report. At a high level, it consists of Five (5) record types or categories of information, as shown in Figure 20.

Figure 8: EDGE RA Payment HCC Enrollee Report



The RAPHCCER Report consists of report File Header, Counts, Form Type, Plan, and Rating Area categories.

The RAPHCCER XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix B.

5.1.1.17 Field/Data Elements and Descriptions

The data characteristics for the EDGE Server RA Payment HCC Enrollee Report (RAPHCCER) category are as shown in Table 67. The root element of the RAPHCCER in the XSD is RAPaymentHCCEnrolleeReport (RAPaymentHCCEnrolleeReport.xsd). This element is required

and all the other elements defined in this section for the RAPHCCER are embedded within this element start and end tags.

Table 67: EDGE Server RA Payment HCC Enrollee Report Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader.xsd	none
Calendar Year	The calendar year in which RA was executed.	File Header	1	calendarYear	String	Length = 4 Strict: YYYY
State	The issuer state.	File Header	1	State	String	minLength = 0 maxLength = 2
Total Member Months for All Enrollees with Payment HCCs	Total member months for all enrollees with payment HCCs. This count includes all member months for enrollment periods for which the enrollee has at least 1 payment HCC applied for the payment year and the enrollment period has at least 1 day of enrollment in the payment year. Note: Member months for included enrollment periods that fall outside the payment year are included.	File Header	1	totalMemberMonthsEnrolleePmtHCC	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Number of Enrollees with Payment HCCs	Number of Unique Enrollee IDs for the issuer with payment HCCs.	File Header	1	numberOfEnrolleesPmtHCC	Integer	minInclusive = 0 maxInclusive = 999999999

Table 67: EDGE Server RA Payment HCC Enrollee Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Amount for RA Payment HCC Enrollees	Total allowed amount for all accepted medical claims for RA payment HCC enrollees (not limited to RA included medical claims) (issuer level).	File Header	1	totalAllowedAmountRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Total Paid Amount for RA Payment HCC Enrollees	Total paid amount for all accepted medical claims for RA payment HCC Enrollees (not limited to RA included medical claims) (issuer level).	File Header	1	totalPaidAmountRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
RA Diagnoses per RA Payment HCC Enrollee	The average number for unique RA Diagnoses Codes per RA Payment HCC Enrollee. (Count of the unique RA Diagnosis Codes for each unique RA payment HCC Enrollee ID /Total unique RA Payment HCC Enrollee ID) (**note**: diagnoses are de-duplicated at the each level of summation) (Issuer level).	File Header	1	raDiagnosesPerRAHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Counts Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Counts	1	includedCountsCategory	RAPaymentHCCEnrolleeReportCountsCategory.xsd	none
Form Type Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Form Type	2	includedFormTypeCategory	RAPaymentHCCEnrolleeReportFormTypeCategory.xsd	none
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Plan	1 or more	includedPlanCategory	RAPaymentHCCEnrolleeReportPlanCategory.xsd	none

The data characteristics for the EDGE Server RA Payment HCC Enrollee Report Counts are as shown in Table 68. These elements are defined in the RAPaymentHCCEnrolleeReportCountsCategory.xsd.

Table 68: EDGE Server RA Payment HCC Enrollee Report Counts

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Claims Not Acceptable for RA Utilizers	The total count of RA ineligible medical claims for enrollees that are RA utilizers. RA Utilizer has at least one (1) RA Claim.	Counts	1	totalClaimsNotAcceptableRAUtilizers	Integer	minInclusive = 0 maxInclusive = 999999999
Total Claims Not Acceptable for RA Payment HCC Enrollees	The total count of RA ineligible medical claims for enrollees that are RA Payment HCC Enrollees.	Counts	1	totalClaimsNotAcceptableRAPmtHCCEnr	Integer	minInclusive = 0 maxInclusive = 999999999
Diagnoses per All Claims	The average number of Diagnosis Codes per medical claims.	Counts	1	diagnosesPerAllClaim	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Diagnoses per RA Claim	The average number of Diagnosis Codes per RA claim.	Counts	1	diagnosesPerRAClaim	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
RA Diagnoses per RA Claim	The average RA Diagnoses Codes (found in the reference data) per RA claim.	Counts	1	raDiagnosesPerRAClaim	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99

The data characteristics for the EDGE Server RA Payment HCC Enrollee Report Form Type are as shown in Table 69. These elements are defined in the RAPaymentHCCEnrolleeReportFormTypeCategory.xsd.

Table 69: EDGE Server RA Payment HCC Enrollee Report Form Type

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Form Type	The form type code related to the following calculations.	Form Type	1	formType	String	minLength = 0 maxLength = 1 "I" = Institutional "P" = Professional
Total Allowed Amount for RA Payment HCC Enrollees	Total allowed amount for all accepted medical claims by form type for RA payment HCC enrollees (not limited to RA included medical claims).	Form Type	1	totalAllowedAmtRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Total Plan Paid Amount for RA Payment HCC Enrollees	Total paid amount for all accepted medical claims by form type for RA payment HCC Enrollees (not limited to RA included medical claims).	Form Type	1	totalPlanPaidAmtRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Claims per RA Payment HCC Enrollee	The average medical claims per RA payment HCC enrollee.	Form Type	1	claimsPerRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
RA Claims per RA Payment HCC Enrollee	The average RA claims per RA payment HCC enrollee.	Form Type	1	raClaimsPerRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99

The data characteristics for the EDGE Server RA Payment HCC Enrollee Report Plan are as shown in **Table 70**. These elements are defined in the RAPaymentHCCEnrolleeReportPlanCategory.xsd.

Table 70: EDGE Server RA Payment HCC Enrollee Report Plan						
Business Data Element	**Description**	**Data Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Plan ID	14-digit plan identifier.	Plan	1	planID	String	minLength = 0 maxLength = 14
Total Member Months for All Enrollees with Payment HCCs	Total member months for all enrollees with payment HCCs. This count includes all member months for enrollment periods for which the enrollee has at least 1 payment HCC applied for the payment year and the enrollment period has at least 1 day of enrollment in the payment year. Note: Member months for included enrollment periods that fall outside the payment year are included.	Plan	1	totalMemberMonthsEnrolleePmtHCC	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Number of Enrollees with Payment HCCs	Number of Unique Enrollee IDs with payment HCCs.	Plan	1	numberOfEnrolleesPmtHCC	Integer	minInclusive = 0 maxInclusive = 999999999
Total Allowed Amount for RA Payment HCC Enrollees	Total allowed amount for all accepted medical claims by plan ID for RA payment HCC enrollees (not limited to RA included medical claims).	Plan	1	totalAllowedAmountRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Total Paid Amount for RA Payment HCC Enrollees	Total paid amount for all accepted medical claims by plan ID for RA payment HCC Enrollees (not limited to RA included medical claims).	Plan	1	totalPaidAmountRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
RA Diagnoses per RA Payment HCC Enrollee	The average number for Diagnosis Codes per unique RA payment HCC Enrollee ID (count of the unique RA Diagnoses Codes for each Unique Enrollee ID for all plans/Total Unique Enrollee IDs in the plan with an RA Payment HCC in any plan). (Note: diagnoses are de-duplicated at the each level of summation and counted for medical claims in all plans).	Plan	1	raDiagnosesPerRAHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Rating Area Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Rating Area	1 or more	includedRatingAreaCategory	RAPaymentHCCEnrolleeReportRatingAreaCategory.xsd	none

The data characteristics for the EDGE Server RA Payment HCC Enrollee Report Rating Area are as shown in Table 71. These elements are defined in the RAPaymentHCCEnrolleeReportRatingAreaCategory.xsd.

Table 71: EDGE Server RA Payment HCC Enrollee Report Rating Area

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Rating Area	Rating Area associated with the Plan ID.	Rating Area	1	ratingArea	String	maxLength = 3
Total Member Months for All Enrollees with Payment HCCs	Total member months for all enrollees with payment HCCs. This count includes all Member Months for enrollment periods for which the enrollee has at least 1 payment HCC applied for the payment year and the enrollment period has at least 1 day of enrollment in the payment year. Note: Member Months for included enrollment periods that fall outside the payment year are included.	Rating Area	1	totalMemberMonthsEnrolleePmtHCC	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Number of Enrollees with Payment HCCs	Number of enrollees with payment HCCs.	Rating Area	1	numberOfEnrolleesPmtHCC	Integer	minInclusive = 0 maxInclusive = 999999999
Total Allowed Amount for RA Payment HCC Enrollees	Total allowed amount for RA payment HCC enrollees.	Rating Area	1	totalAllowedAmountRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99

Table 71: EDGE Server RA Payment HCC Enrollee Report Rating Area (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Paid Amount for RA Payment HCC Enrollees	Total paid amount for RA payment HCC enrollees.	Rating Area	1	totalPaidAmountRAPmtHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
RA Diagnoses per RA Payment HCC Enrollee	The average number for diagnoses codes per unique RA payment HCC Enrollee ID (count of the unique RA Diagnoses Codes for each Unique Enrollee ID for all plans by Rating Area/Total Unique Enrollee IDs in the plan with an RA Payment HCC in any plan by Rating Area). (Note: diagnoses are de-duplicated at the each level of summation and counted for medical claims in all plans).	Rating Area	1	raDiagnosesPerRAHCCEnr	Decimal	minInclusive = 0.00 maxInclusive = 999999999.99
Counts Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Counts	1	includedCountsCategory	RAPaymentHCCEnrolleeReportCountsCategory.xsd	none
Form Type Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Form Type	2	includedFormTypeCategory	RAPaymentHCCEnrolleeReportFormTypeCategory.xsd	none

Communication Methods

This section describes the communication methods for the EDGE server. All communication between the EDGE server and CMS Management Console will use Secure Sockets Layer (SSL), namely Secure Shell (SSH)/Secure File Transfer Protocol (SFTP) and Hyper Text Transfer Protocol Secure (HTTPS). Further, all Web browser communication with the EDGE server will also be done using HTTPS. Internet Protocol (IP) Tables will be configured for the EDGE server to restrict incoming and outgoing network traffic across the server only for specific ports.

- Interface Initiation

The system operates on a SFTP interface along with user interface for lightweight submission and report access with 24/7 availability.

- Flow Control

Prior to start of the submission file structure and data validations, the system will create a backup of the inbound file and the data repository. After the data processing logic is executed, the system will create another backup of the outbound files and the data processing. This allows the system to recover from any failures and minimize reprocessing of data.

Notification of failures will be communicated to the EDGE server user through email. Detailed processing reports will sent to the issuer/submitter to correct the erroneous data and allow for resubmittal of the corrected information. The detailed error report will identify the records that are in error including the data element, submitted value and the detailed error message flagging the error. This allows the user to quickly identify their errors and apply the appropriate data corrections. The issuer/submitter can view the reports or data files using their Web browser user interface. Alternatively, they can download the files using SFTP either manually or as part of an automated process. The error reports will be placed in the output folder of the EDGE server application.

Security Requirements

The security requirements for accessing the outbound files are described in the existing EDGE server ICD published on REGTAP, document number: *0.0.4-CMSES-ICD-4763*.

Acronyms

Table 72: Acronyms

Acronym	Literal Translation
ACA	Affordable Care Act of 2010
APTC	Advanced Premium Tax Credit
CCIIO	Center for Consumer Information and Insurance Oversight
CEFR	EDGE Server Claim and Enrollee Frequency Report
CMS	Centers for Medicare & Medicaid Services
CMS-ES	CMS-EDGE Server
CPT/HCPCS	Current Procedural Terminology/ Healthcare Common Procedure Coding System
CSR	Cost Sharing Reduction
DOB	Date Of Birth
Dx	Diagnosis
ECD	Enrollee Claims Detail
ECS	Enrollee Claims Summary
EDI	Electronic Data Interchange
ES	EDGE Server
ESES	EDGE Server Enrollment Submission
ESMCS	EDGE Server Medical Claims Submission
ESPCS	EDGE Server Pharmacy Claims Submission
ESSFS	EDGE Server Supplemental File Submission
FDEEAF	Frequency by Data Element for Enrollment Accepted Files Report
FDEPAF	Frequency by Data Element for Pharmacy Accepted Files Report
FDEMAF	Frequency by Data Element for Medical Accepted Files Report
FDESAF	Frequency by Data Element for Supplemental Accepted Files Report
HCC	Hierarchical Condition Category
HHS	Health & Human Services
HIPAA	Health Insurance Portability and Accountability Act
HTTPS	Hypertext Transfer Protocol Secure
ICD	Interface Control Document
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
IP	Internet Protocol
IVA	Initial Validation Audit
IVAS	Initial Validation Audit Statistics
MC	Medical Claim
MOOP	Maximum Out Of Pocket
MR	Medical Record
NDC	National Drug Code

Acronym	Literal Translation
NPI	National Provider Identifier
PHI	Protected Health Information
RA	Risk Adjustment
RACSD	Risk Adjustment Claim Selection Detail Report
RACSS	Risk Adjustment Claim Selection Summary Report
RADV	Risk Adjustment Data Validation
RADVDE	Risk Adjustment Data Validation Detailed Enrollee Report
RADVEE	Risk Adjustment Data Validation Enrollment Extract Report
RADVIVAS	Risk Adjustment Data Validation Initial Validation Audit Statistics Report
RADVMCE	Risk Adjustment Data Validation Medical Claim Extract Report
RADVPS	Risk Adjustment Data Validation Population Summary Statistics Report
RADVSE	Risk Adjustment Data Validation Supplemental Extract Report
RARSD	RA Risk Score Detail Report
RARSS	Risk Adjustment Risk Score Summary Report
RATEE	Risk Adjustment Transfer Elements Extract
RAUF	Risk Adjustment User Fee
RI	Reinsurance
RIDE	Reinsurance Detail Enrollee Report
RISR	Reinsurance Summary Report
RxC	Pharmacy Claim
SE	EDGE Server System Error Report
SFTP	Secure File Transfer
SSH	Secure Shell
SSL	Secure Sockets Layer
XML	Extensible Markup Language
XSD	XML Schema Definition

Appendix A EDGE Server Outbound Reports XSDs

This section presents the XSD schema for the outbound reports generated by the EDGE server. The issuer/submitter will utilize these files to process the XML instance of these reports. These files are located in the REGTAP Library at https://www.REGTAP.info/.

- RA Claim Selection Detail
- RA Claim Selection Summary
- RA Risk Score – Detail
- RA Risk Score – Summary
- RA User Fee
- RA Transfer Elements Extract
- RADV Population Statistics Summary

Appendix B Referenced Documents

Table 73: Referenced Documents

Document Name	Document Number / URL	Issuance Date
Interface Control Document (ICD) Version 02.01.07	URL: https://www.REGTAP.info Document Number: 0.0.4-CMSES-ICD-4763	8/11/2015

Appendix C System Error Codes

This section defines the Error Codes that will be used for the EDGE Server System Error outbound Report. The table below specifies the Error Codes:

Table 74: System Error Codes

Unique Error Code	Error Code Description
100	Java.lang.OutOfMemoryError: Java heap space

Appendix D Document Control History

The table below records information regarding changes made to this document prior to the most recent maintenance release of this ICD Addendum.

Version Number	Date	Author/Owner	Description of Change
01.00.00	12/14/2014	Accenture / CCIIO	Initial Version

Centers for Medicare & Medicaid Services

CMS-EDGE Server / CMS-ES

Risk Adjustment and Reinsurance (RARI) Interface Control Document – Risk Adjustment Data Validation (RADV) Addendum

Feb 11, 2019

Document Version History – Recent changes

The table below reflects the summary of changes incorporated in the most recent maintenance release of this ICD addendum.

Version Number	Date	Author/Owner	Description of Change
05.00.22	10/23/18	Accenture / CCIIO	Create separate ICD Addendum for RADV **For changes prior to version 05.00.22, refer to the RARI ICD Consolidated Version History
05.00.22	10/26/18	Accenture / CCIIO	**EDGE Q1 2019/ EDGE 30.0 release updates** **For CR FFMFM-585:** **(Section 5.1.1.7):** **Added the following elements to the RADVDE report :** • Total Pharmacy Claims • Total Payment RXCs • Total Number of RA NDC Codes • RXC • Unique RA NDC Code **Updated stratum Indicator description enumeration for stratum 10 to say "No HCCs and No RXCs" in RADVDE report (Section 5.1.1.7)** **For CR FFMFM-586:** **Sections 5.1.1.3 and 5.1.1.5:** **Updated RADVIVAS and RADVPSF reports to include the new parmacy elements that were added to RADVPS** • Total Pharmacy Claims • Total Pharmacy Plan Paid Amount • Total Number of RA NDC Codes • Total Unique Number of RA NDC Codes • Total Number of Payment RXCs • Total Unique HCPCS That Created Payment RXCs • Total Unique Payment RXCs Created By HCPCS **Updated field names for following elements:** • Total Medical Claims • Total Medical Plan Paid Amount **Updated stratum Indicator description enumeration for stratum 10 to say "No HCCs and No RXCs"** **Updated the following field descriptions to specify RXC and interaction factors:** • Mean Risk Score • Min Risk Score • Max Risk Score • Standard Deviation Risk Score

Version Number	Date	Author/Owner	Description of Change
			Section 5.1.1.13: Created EDGE Server RADV Pharmacy Claim Extract Report (RADVPCE) **For CR FFMFM-656:** **Section 5.1.1.9** Added language to section 5.1.1.9 RADVEE report to specify it will now include all enrollment periods for enrollees tht are in the IVA sample
05.00.22	11/5/18	Accenture / CCIIO	**EDGE Q1 2019/ EDGE 30.0 release updates** **For all CRs:** Specified in Sections 5.1.1.1-5.1.1.14 thatreports from prelim runs are not sent to issuers Updated section 1 to specify that the ICD addendum was split into 5 different ICDs Updated Functional Allocation section in Section 4 Updated FileNaming Convention Example in Section 5 to include RADV example Updated the description for the following field in Section 5.1.1.7 (Table 9) for RADVDE report: • Total Enrollment Periods Addd the following field in Section 5.1.1.9 (Table 12) for RADVEE report: • Market Type
05.00.22	11/15/18	Accenture / CCIIO	**EDGE Q1 2019/ EDGE 30.0 release updates** **For all CRs:** Updated verbiage in introductory Sections 1 and 4 Updated the description, length restriction and enumeration for the following field in section 5.1.1.9 (Table 12) for the RADVEE report: • Market Type Updated field description for the following field in sections 5.1.1.3 (Table 5) and 5.1.1.5 (Table 7) for RADVPSF and RADVIVAS report • Stratum Indicator Updated the minLength on the following field in section 5.1.1.13 (Table) for RADVPCE report: • voidReplaceCode • dispensingStatusCode Removed the following field in section 5.1.1.13 (Table) for RADVPCE report:

Version Number	Date	Author/Owner	Description of Change
			• policyPaidTotalAmount
05.00.22	12/11/18	Accenture / CCIIO	**EDGE Q1 2019/ EDGE 30.0 release updates** **For all CRs:** Updated fieldname for the following field in section 5.1.1.3 (Table 5) for RADVPSF report: • totalMedicalClaims Updated fieldname for the following field in sections 5.1.1.3 (Table 5) and 5.1.1.5 (Table 7) for RADVPSF and RADVIVAS report • totalMedicalPlanPaidAmount Removed the following field in section 5.1.1.13 (Table) for RADVPCE report: • originalClaimIdentifier
05.00.23	2/5/19	Accenture / CCIIO	**EDGE Q1 2019/ EDGE 30.0 release updates** **Table 14: RADVMCE RADV Medical Claim Extract Insurance Plan Category Data** Updated the description of the Plan ID field. Added two new fields: • RA Eligible Flag • RX Eligible Flag

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1 Purpose of Interface Control Document

This Interface Control Document (ICD) Addendum was created from the consolidated Risk Adustment (RA) and Reinsurance (RI) ICD Addendum that was separated into the following five documents:

- RARI ICD- RA Addendum,
- RARI ICD- RADV Addendum,
- RARI ICD- RI Addendum,
- RARI ICD- High Cost Risk Pool (HCRP) Addendum, and
- RARI ICD- Issuer Frequency Report Addendum.

This RARI ICD Addendum is for the Risk Adjustment Data Validation (RADV) outbound reports, and does not contain information regarding the remaining four (4) ICDs listed above. Following is the link to the Registration For Technical Assistance Portal (REGTAP) library for the five (5) ICD Addendums listed above: https://www.regtap.info/reg_library.php.

The RARI ICD (and its accompanying addenda) documents and tracks the necessary information required to effectively define the Centers for Medicare & Medicaid Services (CMS) External Data Gathering Environment (EDGE) server system interface, as well as any rules for communicating with the EDGE servers, to give the development team guidance on the architecture of the system to be developed. In addition, the purpose of the ICD is to clearly communicate all possible inputs for all potential actions. The RARI ICD helps ensure compatibility between system segments and components.

The RARI ICD does not include information about specific business rules or how the verification edits included within this document affect the file processing logic. Additional information can be found in the EDGE Server Business Rules (ESBR) document available at : https://www.regtap.info/reg_librarye.php?i=2673

2 Introduction

This is one of five addendum to the existing RARI ICD, which describes the relationship between CMS and the issuer's EDGE server. This document serves to define additional reports that will be produced by the issuer's EDGE servers as a supplement to the ICD, currently published in the Registration for Technical Assistance Portal (REGTAP) Library. These reports include the risk adjustment and reinsurance calculation reports that are used for payment processing, as well as additional analytic reports.

The CMS-EDGE server interface is only necessary when CMS is operating the Risk Adjustment and/or Reinsurance programs on behalf of a state.

The following information, with respect to the interface, is described further in this document:

- Additional EDGE server outbound report formats.

3 Overview

As part of the Affordable Care Act (ACA), two (2) programs were identified to mitigate the impact of adverse selection of plans and provide stability for issuers. States have the option to operate the following programs themselves or have the Department of Health and Human Services (HHS) operate the programs on their behalf.

Section 1343 of the ACA created the Risk Adjustment (RA) program to better spread the financial risk borne by health insurance issuers in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. Under the RA program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Non-grandfathered, Individual and Small Group Market plans, irrespective of whether they are a part of the Marketplace, will submit RA data (claims and enrollee data) that will be used to determine individual-level risk scores, plan average actuarial risk and associated payments and charges.

Section 1341 of the ACA establishes the Reinsurance (RI) program as a temporary three-year program that commences in 2014. RI provides funds to issuers that incur high costs for claims in the Individual Market. In accordance with the final rule, RI payments are based on a coinsurance rate or proportion of an issuer's claims costs that are above an attachment point and below a RI cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for RI payments, while the RI cap is the dollar limit at which point an issuer is no longer eligible for RI payments. The attachment point, coinsurance rate and RI cap are calculated based on an issuer's total incurred costs for an individual enrollee in a given calendar year. Non-grandfathered, Individual Market plans, both on and off the Marketplace, will submit RI data (claims and enrollee data) that will be used to determine if an individual market plan issuer is eligible for RI.

CMS' Center for Consumer Information and Insurance Oversight (CCIIO) on behalf of HHS will develop the software to evaluate and perform the RA and RI calculations.

When evaluating the model for collecting and processing the data received from issuers, it was determined that a distributed data collection model would prove the most effective. Specifically, this model would ensure:

- Issuer proprietary data would not be transmitted to HHS;
- Minimal transfer of protected health information (PHI) to lower privacy and data security risks;
- Standardization of business processes, timing and rules.

These factors resulted in the concept of the EDGE server. Issuers, in states where HHS is operating an RA and/or RI program, will submit enrollee, pharmacy claim, medical claim and supplemental diagnosis information from their proprietary systems to an issuer-owned or Third Party Administrator (TPA)-hosted EDGE server. The EDGE server will run HHS-developed software designed to verify submitted data and execute the RA and RI processes. Issuers will have the option to own and operate the server themselves, or to have a third-party entity operate the server. Detailed data, file processing metrics and outbound data files will be provided to insurance companies/issuers. Only plan summarized data and file processing metrics will be provided to HHS.

4 General Interface Requirements

Interface Overview

This section describes updates to the EDGE server interface as a result of the additional reports defined in this document. For a complete description of the general interface requirements, refer to the existing EDGE server ICD, published in the REGTAP Library (Interface Control Document, document number: *0.0.4-CMSES-ICD-4763*).

Functional Allocation

The primary responsibility of the EDGE server is to provide distributed data processing capabilities to support RA and RI. The results of the data processing are available to CMS, insurance companies and their associated issuers through reports in the form of data files. Output reports can be generated in the Production, Test or Validation zones.

The RADV reports defined in this document can only be initiated by CMS Initiated Remote Command.

Transactions

The following reports are defined in this document. Once executed, all files only from the RADV final run are provided to the issuer/submitter and all files from both the preliminiary and final runs are provided to CMS for review.

RADV Population Summary Statistics Final Report
RADV IVA Statistics Report
RADV Detailed Enrollee Report
RADV Enrollment Extract Report
RADV Medical Claim Extract Report
RADV Pharmacy Claim Extract Report
RADV Supplemental Extract Report

Note – The Risk Adjustment Data Validation (RADV) Detailed Enrollee Report, RADV Enrollment Extract Report, RADV Medical Claim Extract Report, RADV Pharmacy Claim Extract Report, and RADV Supplemental Extract Report all contain detailed enrollee level data that is provided to CMS in order to support the RADV audit.

Note – The Risk Adjustment Data Validation Population Summary Statistics (RADVPS) report is generated with the RA job and can be found in the RARI ICD- RA Addendum.

There are several types of outbound data files that will be sent to the issuer/submitter and to CMS as part of this process, including the following:

- Process Oriented Reports

- Operations Analytics Reports
- Management Reports
- Payment Processing Reports
- Data Validation Sampling Reports

The recipient of these outbound files is restricted by the content level of the files as specified by the table below.

Table 1: Report Type and Recipient

Report Type	Report Recipient
File Level Reports	Issuer/Submitter and CMS
Detail Reports	Issuer/Submitter*
Summary Reports	Issuer/Submitter and CMS
Activity To Date Reports	Issuer/Submitter and CMS

Note: RADV sampling detail reports are sent to Issuer/Submitter and CMS

Process Oriented Reports are data files generated for the issuer/submitter based on the results of the data processing of the submitted data file. This category includes the following report types:

Operations Analytics Reports are data files that help the user in understanding various operational metrics identified, thereby allowing process improvements. This also helps CMS/CCIIO in reaching out to the issuer/submitter to address any aberrant patterns.

Management Reports are outbound files of summary data used by management to gauge the execution of the overall process.

Payment Process Outputs are outbound files used to calculate the RA and RI payment amounts that will be applied for each issuer.

Data Validation Sampling Reports are outbound files indicating data to be validated on a sample of enrollees from the issuer's EDGE server. These reports are used by the issuer and CMS to conduct the RADV audit.

5 Detailed Interface Requirements

This section specifies the requirements for the interface between the insurance company/ submitting organization and the EDGE server. This includes explicit definitions of the content and format of every message or file that is expected to be transmitted between the insurance company/submitting organizations and the EDGE server and the conditions under which each file is to be sent.

Requirements for Additional EDGE Server Outbound Reports

This section describes the additional outbound report formats that will be made available to the issuer and CMS to review and analyze the processing results of the enrollment, claims and supplemental diagnosis information submitted RA processing. The files will be eXtensible Markup Language (XML) based and as per the XML Schema Definition (XSD) defined in this document.

This document describes the following reports:

- RADV Population Summary Statistics Final Report
- RADV IVA Statistics Report
- RADV Detailed Enrollee Report
- RADV Enrollment Extract Report
- RADV Medical Claim Extract Report
- RADV Pharmacy Claim Extract Report
- RADV Supplemental Extract Report

Assumptions

The assumptions for the delivery of the EDGE server outbound files are as follows:

- Outbound reports are posted to the issuer's Amazon Web Services (AWS) S3 file repository or On-Premise server output directory designated for the remote command execution zone, as described for each report in the below sections.
- Issuers will have a separate Amazon Web Services (AWS) S3 file repository or On-Premise server output directory for the validation zone, independent of the file repositories or output directories for the production and test zone.
- The data files defined to date are XML documents. As the requirements are refined, this section will be updated to reflect the final file layout and data characteristics.

General Processing Steps

After the enrollee and claim files have been validated, designated entities, as determined by the insurance company/issuer administrator, will receive information about the status of their submission through a series of file processing reports. Similarly, CMS/CCIIO will be issued summary reports which provide the status and metrics of the data being processed. All insurance company/issuer reports will be delivered to the AWS S3 bucket configured for the issuer for AWS servers or the server's output directory for On-Premise servers. Summary reports will be delivered to the CMS/CCIIO AWS S3 bucket.

File Naming Convention

All files produced will follow the standard naming convention outlined below.

File Format Mask:

<Submitting Entity ID>.<File Type>.D<YYYYMMDD>T<hhmmss>.<Execution Zone>.xml

Example File Name:

12345. RADVMCE.D20140402T091533.P.xml

Table 2 : File Name Parameters

Parameter	Description	Enumeration Values
Submitting Entity ID	Must be the 5 digit HIOS assigned Issuer ID.	**Example:** 12345
Date Timestamp	The date timestamp of when the file was generated.	**Example:** For April 2, 2014 at 9:15:33 AM

Parameter	Description	Enumeration Values
		Date Timestamp: D20140402T091533
Execution Zone	One (1) letter code indicating the execution zone where the file is to be processed.	Production:' P' Test: 'T' Local: 'L' Validation: 'V'

Outbound Report Data Components Message Format (or Record Layout) and Required Protocols

The structure of the EDGE server output reports has two (2) components:

Common Header category that is reused across the defined output reports; and

- Data elements/structures that are specific to a given report

5.1.1.1 Record Layout and Required Protocols for Common Outbound File Header Record

The data contents of the common outbound file header record data structure include report file identifier, report execution date, file identifier included in the submitted file, date of submission file generated by issuer/submitter, date of submission file received by the EDGE server, report type, sender identifier (EDGE server identifier) and submitter identifier associated with the submission.

5.1.1.1.1 Business Data Element Descriptions and Technical Characteristics

The data characteristics for the Common Outbound File Header Data Structure are as shown in Table 3. These elements are defined in the *RARICommonOutboundFileHeader.xsd*.

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
File ID	The CMS system generated unique identifier of a report file.	File Header	1	outboundFileIdentifier	String	minLength = 1 maxLength = 80
CMS Batch ID	CMS generated identifier to uniquely identify a batch job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsBatchIdentifier	String	minLength = 1 maxLength = 50
CMS Job ID	CMS generated identifier to uniquely identify the job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsJobIdentifier	String	minLength = 1 maxLength = 50

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Snap Shot File Name	File name of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileName	String	none
Snap Shot File Hash	Hash value of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileHash	String	none
Run Date	The date and time when the CMS processed file is generated.	File Header	1	outboundFileGenerationDateTime	String	Strict: YYYY-MM-DDTHH:mm:SS
Interface Control Release Number	Denotes the version number of the ICD that the file corresponds to as identified on page one (1) of this document.	File Header	1	interfaceControlReleaseNumber	String	Length = 8
EDGE Server Version	Version number that corresponds to the Application, Database, Operating System, and reference table versions that were used to process the inbound file and produce the report. The application version in the execution zone for which the report is generated, will be displayed in this field.	File Header	1	edgeServerVersion	String	minLength = 0; maxLength = 75

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Job ID	System generated unique identifier for job executed on the EDGE server.	File Header	0… 1	edgeServerProcessIdentifier	String	minLength = 0; maxLength= 12
Report Type	Defines values of outbound validation report.	File Header	1	outboundFileTypeCode	String	minLength = 1 maxLength = 30
Server ID	The unique identifier of an EDGE server.	File Header	1	edgeServerIdentifier	String	minLength = 1 maxLength = 12
Issuer ID	The unique identifier for an issuer.	File Header	1	issuerIdentifier	String	Length = 5

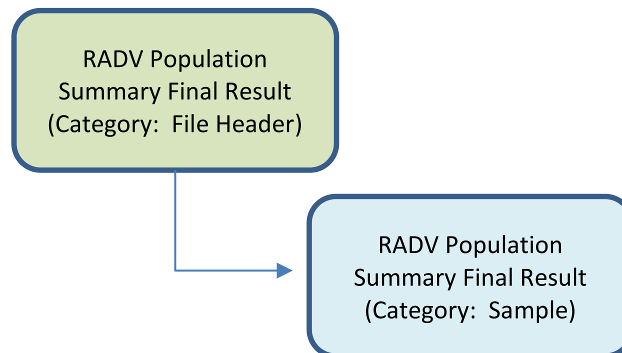
RADV Population Summary Statistics Final (RADVPSF) Report Message Format (or Record Layout and Required Protocols

The outbound RADVPSF Report is available to CMS from both the preliminary and the final run. The RADVPSF report is available to the issuer/submitting organization, only from the RADV final run. This report will be generated with the RADV batch job. The RADVPSF Report has the same field elements as the RADVPS report, however the RADVPSF Report will include only enrollees in a risk pool market where a risk adjustment transfer occurs, and excludes enrollees in a risk pool market if the issuer is the only issuer in that risk pool market. This report contains population statistics calculated per stratum for the population of the issuer from the risk pool markets included in the RADV sample calculation. Additionally, the total enrollees used in the RADV sample calculation are provided by risk pool market (individual, small group, catastrophic) in the RADVPSF report.

5.1.1.2File Layout

This section specifies the file layout for the RADVPSF Report. At a high level, it consists of two (2) record types or categories of information as showin in Figure 1.

Figure 1 : EDGE Server RADV Population Summary Statistics Final Report



The RADVPSF Report consists of a report File Header category and an issuer Summary Result data category.

The RADVPSF XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.3Field/Data Elements and Descriptions

The data characteristics for the RADV Population Summary Statistics Final category are as shown in Table 4. The root element of the RADVPSF in the XSD is radvPopulationSummaryStatisticsFinal (*radvPopulationSummaryStatisticsFinal.xsd*). This element is required and all the other elements defined in this section for the RADVPSF are embedded within this element start and end tags

Table 4: RADVPSF RADV Populations Summary Statistics Final File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFIleHeader	none
Payment Year	For example, 2014 or 2015.	File Header	1	paymentYear	String	Length = 4 Strict: YYYY
Preliminary/Final Run	Designate preliminary or final run.	File Header	1	preliminaryFinalRun	String	Length = 1 Enumeration Values: “P”: Preliminary “F”: Final
Total Number of Plan IDs	Total number of 16-digit Plan IDs for the risk score calculation. Note: This field is populated with the actual number of plans from the risk pool markets included in RADV.	File Header	1	totalNumberOfPlanIds	Integer	minInclusive = 0; maxInclusive = 999999999

Table 4: Table 4: RADVPSF RADV Populations Summary Statistics Final File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Enrollees	Total number of unique enrollees selected for the risk score calculation. Note: This field is populated with the actual number of enrollees used in the RADV sample calculation.	File Header	1	totalNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees from Individual Risk Pool Market	Total number of unique enrollees selected from the Individual Risk Pool Market that were included in the RA calculation. Note: This field is populated with the actual number of enrollees in the individual market, if used in the RADV sample calculation.	File Header	1	totalIndividualNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees from Small Group Risk Pool Market	Total number of unique enrollees selected from the Small Group Risk Pool Market that were included in the RA calculation. Note: This field is populated with the actual number of enrollees in the small group market, if used in the RADV sample calculation.	File Header	1	totalSmallGroupNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999

Table 4: RADVPSF RADV Populations Summary Statistics Final File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Enrollees from Catastrophic Risk Pool Market	Total number of unique enrollees selected from the Catastrophic Risk Pool Market that were included in the RA calculation. Note: This field is populated with the actual number of enrollees in the catastrophic risk pool, if used in the RADV sample calculation.	File Header	1	totalCatastrophicNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Stratum Indicator Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Stratum Indicator	1..10	includedStratumLevel	radvpsPopulationStratrumIndicatorCategory	none

The data characteristics for the RADVPSF Population Summary Stratum Indicator category are as shown in Table 5. These elements are defined in the *radvpsPopulationFinalStratumIndicatorCategory.xsd*

Table 5: RADVPSF Population Summary Statistics Final Stratum Indicator

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Stratum Indicator	Strata 1-9 represent low, medium and high-risk enrollees with at least one (1) HCC or at least one (1) RXC for each age model. Stratum 10 includes enrollees that have no HCCs and no RXCs. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 will include enrollees with RXCs. Note: Stratums in this report must only include enrollees that have at least one enrollement period belonging to a market that has an "Include in RADV" indicator of "Y" in the EDGE Calculaulation Module (ECM) Issuer Reference Table (IRT). Stratums in this report must exclude enrollment periods belonging to markets that have an Include in RADV" indicator of "N" in the ECM IRT table.	Stratum Type	1	stratumLevel	String	minLength = 0 Enumeration Values: "1: Adult – Low" "2: Adult – Medium" "3: Adult – High" "4: Child – Low" "5: Child - Medium" "6: Child – High" "7: Infant – Low" "8: Infant – Medium" "9: Infant – High" "10: No HCCs and No RXCs"
Stratum Size	The total number of Enrollee IDs from the issuer's population included in the RADV population that were selected for this stratum.	Stratum Type	1	stratumSize	Integer	minInclusive = 0; maxInclusive = 999999999
Mean Risk Score	The weighted average of the risk score using member months. This is using the risk score calculated for RADV based on the demographic, CSR, enrollment duration, RXC (and interaction) and HCC (and interaction) factors.	Stratum Type	1	meanRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 5: RADVPSF Population Summary Statistics Final Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Min Risk Score	The minimum of the weighted average risk score using member months. This is using the risk score calculated for RADV based on the demographic, CSR, enrollment duration, RXC (and interaction) and HCC (and interaction) factors.	Stratum Type	1	minRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Max Risk Score	The maximum of the weighted average risk score using member months. This is using the risk score calculated for RADV based on the demographic, CSR, enrollment duration, RXC (and interaction) and HCC (and interaction) factors.	Stratum Type	1	maxRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Standard Deviation Risk Score	The standard deviation of the weighted average risk score using member months. This is using the risk score calculated for RADV based on the demographic, CSR, enrollment duration, RXC (and interaction) and HCC (and interaction) factors.	Stratum Type	1	stdDevRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Minimum Date of Birth	Minimum date of birth of enrollees selected for the risk score calculation.	Stratum Type	1	minDateOfBirth	String	Length = 10 Strict: YYYY-MM-DD
Maximum Date of Birth	Maximum date of birth of enrollees selected for the risk score calculation.	Stratum Type	1	maxDateOfBirth	String	Length = 10 Strict: YYYY-MM-DD
Mean Age	Mean Age of enrollees selected for the risk score calculation (age as of the last day of the last enrollment period	Stratum Type	1	meanAge	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 5: RADVPSF Population Summary Statistics Final Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Average Premium	Weighted average premium, using member months, of enrollees selected for the risk score calculation. This element is calculated by dividing the total premium paid (totalPremiumAmount) by the total number of member months in the payment year of all enrollees in the stratum. Note: Non-billable member months are included in the denominator when performing the weighted average.	Stratum Type	1	averagePremium	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Premium Amount	Total premium amount paid in the payment year for all enrollment periods in the stratum. The paid amount for each enrollment period is calculated by multiplying the monthly premium by the number of member months of the enrollment period within the payment year. Note: Non-subscriber enrollment periods do not contribute to the total premium amount.	Stratum Type	1	totalPremiumAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Medical Claims	Total medical claims for all enrollees in the defined strata. This only includes all active, RA eligible medical claims.	Stratum Type	1	totalMedicalClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Medical Plan Paid Amount	Total amount paid for all active, RA eligible medical claims for all enrollees in the defined strata.	Stratum Type	1	totalMedicalPlanPaidAmoun t	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 5: RADVPSF Population Summary Statistics Final Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Number of Diagnoses Codes	Total number of Diagnosis Codes for all enrollees in the defined strata contained on RA eligible claims. Duplicate codes are counted for an individual enrollee.	Stratum Type	1	totalNumberDiagnosisCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of RA Diagnoses Codes	Total number of RA Diagnosis Codes that map to an HCC for all enrollees in the defined strata contained on RA eligible claims. Duplicate codes are counted for an individual enrollee.	Stratum Type	1	totalNumberRADiagnosisCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of HCCs	Total number of HCCs de-duplicated for each enrollee within the strata after the HCC hierarchy is applied.	Stratum Type	1	totalNumberOfHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Unique Diagnosis Codes	Total number of Diagnosis Codes, de-duplicated for enrollee in the defined strata contained on RA eligible claims. Duplicate codes are only counted once for an individual enrollee.	Stratum Type	1	totalNumberUniqueDiagnosis	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Unique RA Diagnosis Codes	Total number of RA Diagnosis Codes, de-duplicated for each enrollee, that map to an HCC for all enrollees in the defined strata contained on RA eligible claims. Duplicate codes are only counted once for an individual enrollee.	Stratum Type	1	totalNumberUniqueRADiagnosis	Integer	minInclusive = 0; maxInclusive = 999999999
Total Pharmacy Claims	Total pharmacy claims for all enrollees in the defined strata. This only includes RA eligible pharmacy claims. Note: Only the adult RA model includes RXCs therefore only the	Stratum Type	1	totalRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	adult strata 1-3 can have a pharmacy claim count > 0. Strata 4-10 Total Pharmacy Claims = 0.					
Total Pharmacy Plan Paid Amount	Total plan paid amount from all RA eligible pharmacy claims for enrollees belonging to the stratum. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 will have a Total Pharmacy Plan Paid amount > 0. Strata 4-10 Total Pharmacy Plan Paid Amount = 0.	Stratum Type	1	totalRxPlanPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999999.99
Total Number of RA NDC Codes	Total number of RA NDC Codes that map to an RXC for all enrollees in the defined strata contained on RA eligible pharmacy claims. Duplicate codes are counted for an individual enrollee.	Stratum Type	1	totalRANdcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Number of RA NDC Codes	Total number of RA NDC Codes, de-duplicated for each enrollee, that map to an RXC for all enrollees in the defined strata contained on RA eligible pharmacy claims. Duplicate codes are counted once for an individual enrollee.	Stratum Type	1	totalUniqueRANdcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Payment RXCs	Total number of RXCs de-duplicated for each enrollee within the strata after the RXC hierarchy is applied.	Stratum Type	1	totalPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique HCPCS That Created Payment RXCs	Total service codes from medical claims, de-duplicated for each enrollee within the strata that created RXCs for enrollees in the defined strata	Stratum Type	1	totalUniqueHcpcsThatCreatedPmtRxcs	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Payment RXCs Created By HCPCS	Total number of RXCs de-duplicated for each enrollee within the strata after the RXC hierarchy is applied, that are created by a HCPCS service code on medical claim mapping to the RXC.	Stratum Type	1	totalUniquePmtRxcsCreatedByHcpcs	Integer	minInclusive = 0; maxInclusive = 999999999

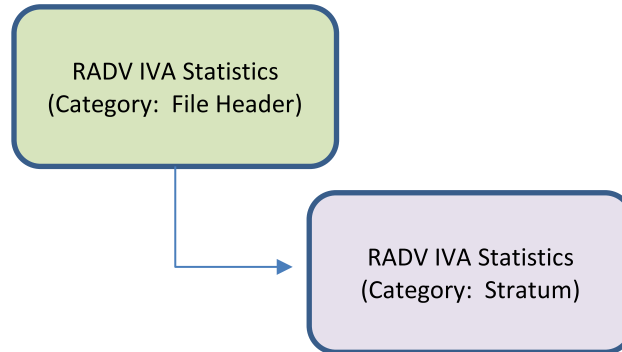
RADV IVA Statistics (RADVIVAS) Report Message Format (or Record Layout) and Required Protocols

The outbound RADVIVAS Report is available to CMS from both, the preliminary run, and the final run. The RADVIVAS is available to the issuer/submitting organization, only from the RADV final run. This report contains sample statistics calculated per stratum for the RADV initial validation audit (IVA) sample. The RADVIVAS Report will be generated with the RADV batch job.

5.1.1.4File Layout

This section specifies the file layout for the RADVIVAS Report. At a high level, it consists of two (2) record types or categories of information, as shown in Figure 2.

Figure 2 : EDGE Server RADV IVA Statistics Report



The RADVIVAS Report consists of a report File Header category and a Stratum data category.

The RADVIVAS XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.5Field/Data Elements and Descriptions

The data characteristics for the RADV IVA Statistics category are as shown in Table 6. The root element of the RADVIVAS in the XSD is radvIVAStatistics (*radvIVAStatistics.xsd*). This element is required and all the other elements defined in this section for the RADVIVAS are embedded within this element start and end tags.

Table 6: RADVIVAS RADV IVA Statistics File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFIleHeader	none
Payment Year	For example, 2014 or 2015.	File Header	1	paymentYear	String	Length = 4 Strict: YYYY
Total Number of Plan IDs	Total number of 16-digit Plan IDs used for the risk score calculation.	File Header	1	totalNumberOfPlanIds	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees	Total number of unique enrollees selected for the audit sample.	File Header	1	totalNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees from Individual Risk Pool Market	Total number of unique enrollees included in the RADV sample from the Individual Risk Pool Market	File Header	1	totalIndividualNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees from Small Group Risk Pool Market	Total number of unique enrollees included in the RADV sample from the Small Group Risk Pool Market	File Header	1	totalSmallGroupNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees from Catastrophic Risk Pool Market	Total number of unique enrollees included in the RADV sample from the Catastrophic Risk Pool Market	File Header	1	totalCatastrophicNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999

Table 6: RADVIVAS RADV IVA Statistics File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Stratum Indicator Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	File Header	1..10	includedStratumLevel	radvIVAStatisticsStratumIndicatorCategory	none

The data characteristics for the RADV IVA Statistics Stratum Indicator category are as shown in Table 7. These elements are defined in the *radvIVAStatisticsStratumIndicatorCategory.xsd*.

Table 7: RADVIVAS RADV IVA Statistics Stratum Indicator

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Stratum Indicator	Strata 1-9 represent low, medium and high-risk enrollees that are selected for the IVA sample, with at least one (1) HCC or at least one (1) RXC for each age model. Stratum 10 includes enrollees that have no HCCs and no RXCs. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 will include enrollees with RXCs..	Stratum Type	1	stratumLevel	String	minLength = 0 Enumeration Values: "1: Adult – Low" "2: Adult – Medium" "3: Adult – High" "4: Child – Low" "5: Child – Medium" "6: Child – High" "7: Infant – Low" "8: Infant – Medium" "9: Infant – High" "10: No HCCs and No RXCs"

Table 7: RADVIVAS RADV IVA Statistics Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Stratum Size	The total number of Enrollee IDs (sample size) that were selected for the IVA sample for this stratum. Note: The target stratum size calculated during the RADV sampling job is always rounded up to the next whole number. For example, 184.2 would be rounded to 185.	Stratum Type	1	stratumSize	Integer	minInclusive = 0; maxInclusive = 999999999
Mean Risk Score	The weighted average of the risk score using member months of the enrollees in the IVA sample, assigned to this stratum. This is using the risk score calculated for RADV based on the demographic, CSR enrollment duration, RXC (and interaction) and HCC (and interaction) factors of the enrollees assigned to this stratum.	Stratum Type	1	meanRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Min Risk Score	The minimum of the weighted average risk score using member months of the enrollees in the IVA sample, assigned to this stratum. This is using the risk score calculated for RADV based on the demographic CSR, enrollment duration, RXC (and interaction) and HCC (and interaction) factors of the enrollees assigned to this stratum.	Stratum Type	1	minRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 7: RADVIVAS RADV IVA Statistics Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Max Risk Score	The maximum of the weighted average risk score using member months of the enrollees in the IVA sample, assigned to this stratum. This is using the risks score calculated for RADV based on the demographic, CSR enrollment duration, RXC (and interaction) and HCC (and interaction) factors of the enrollees assigned to this stratum.	Stratum Type	1	maxRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Standard Deviation Risk Score	The standard deviation of the weighted average risk score using member months of the enrollees in the IVA sample, assigned to this stratum. This is using the risks score calculated for RADV based on the demographic, CSR enrollment duration, RXC (and interaction) and HCC (and interaction) factors of the enrollees assigned to this stratum. Note: As this represents the standard deviation of a sample, a value of one (1) less than the sample size is used in the denominator of the standard deviation calculation.	Stratum Type	1	stdDevRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Minimum Date of Birth	Minimum date of birth of enrollees in the IVA sample selected for this stratum.	Stratum Type	1	minDateOfBirth	String	Strict - YYYY-MM-DD
Maximum Date of Birth	Maximum date of birth of enrollees in the IVA sample selected for this stratum.	Stratum Type	1	maxDateOfBirth	String	Strict - YYYY-MM-DD

Table 7: RADVIVAS RADV IVA Statistics Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Mean Age	Mean age of enrollees in the IVA sample selected for this stratum (age as of the last day of the last enrollment period).	Stratum Type	1	meanAge	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Average Premium	Weighted average premium, using member months, of enrollees the IVA sample selected for this stratum. This element is calculated by dividing the total premium paid (totalPremiumAmount) by the total number of member months in the payment year of all enrollee's in the stratum. Note: Non-billable members are included in the denominator when performing the weighted average.	Stratum Type	1	averagePremium	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Premium Amount	Total premium amount paid in the payment year for all enrollment periods in the IVA sample for the stratum. The paid amount for each enrollment period is calculated by multiplying the monthly premium by the number of member months of the enrollment period within the payment year. Note: Non-subscriber enrollment periods do not contribute to the total premium amount	Stratum Type	1	totalPremiumAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Medical Claims	Total medical claims for all enrollees in the IVA sample selected for the defined strata. This only includes all active, RA eligible medical claims.	Stratum Type	1	totalMedicalClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Medical Plan Paid Amount	Total amount paid for all active, RA eligible medical claims for all enrollees in the IVA sample selected for the defined strata.	Stratum Type	1	totalMedicaPlanPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 7: RADVIVAS RADV IVA Statistics Stratum Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Number of Diagnoses Codes	Total number of Diagnosis Codes for all enrollees in the IVA sample selected for the defined strata contained on RA eligible claims. Duplicate codes for an individual enrollee are counted.	Stratum Type	1	totalNumberDiagnosisCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of RA Diagnoses Codes	Total number of RA Diagnosis Codes that map to an HCC for all enrollees in the IVA sample selected for the defined strata contained on RA eligible claims. Duplicate codes for an individual enrollee are counted.	Stratum Type	1	totalNumberRADiagnosisCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of HCCs	Total number of HCCs de-duplicated for each enrollee within the strata after the HCC hierarchy is applied.	Stratum Type	1	totalNumberOfHCCs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Unique Diagnosis Codes	Total number of de-duplicated Diagnosis Codes in the IVA sample selected for the defined strata contained on RA eligible claims. Duplicate codes are counted only once for an individual enrollee.	Stratum Type	1	totalNumberUniqueDiagnosis	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Unique RA Diagnosis Codes	Total number of de-duplicated RA Diagnosis Codes for each enrollee that map to an HCC for all enrollees in the IVA sample selected for the defined strata contained on RA eligible claims. Duplicate codes are counted only once for an individual enrollee.	Stratum Type	1	totalNumberUniqueRADiagnosis	Integer	minInclusive = 0; maxInclusive = 999999999
Total Pharmacy Claims	Total pharmacy claims for all enrollees in the IVA sample in the defined strata. This	Stratum Type	1	totalRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	only includes RA eligible pharmacy claims. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 can have a pharmacy claim count > 0. Strata 4-10 Total Pharmacy Claims = 0.					
Total Pharmacy Plan Paid Amount	Total plan paid amount from all RA eligible pharmacy claims for enrollees in the IVA sample belonging to the stratum. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 will have a Total Pharmacy Plan Paid amount > 0. Strata 4-10 Total Pharmacy Plan Paid Amount = 0.	Stratum Type	1	totalRxPlanPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999999.99
Total Number of RA NDC Codes	Total number of RA NDC Codes that map to an RXC for all enrollees in the IVA sample in the defined strata contained on RA eligible pharmacy claims. Duplicate codes are counted for an individual enrollee.	Stratum Type	1	totalRANdcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Number of RA NDC Codes	Total number of RA NDC Codes, (de-duplicated for each enrollee in the IVA sample), that map to an RXC for all enrollees in the IVA sample in the defined strata contained on RA eligible pharmacy claims. Duplicate codes are counted once for an individual enrollee.	Stratum Type	1	totalUniqueRANdcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Payment RXCs	Total number of RXCs de-duplicated for each enrollee in the IVA sample within the strata after the RXC hierarchy is applied.	Stratum Type	1	totalPaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique HCPCS That Created Payment RXCs	Total service codes from medical claims, de-duplicated for each enrollee in the IVA sample within the strata that created RXCs for enrollees in the defined strata	Stratum Type	1	totalUniqueHcpcsThatCreatedPmtRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Payment RXCs Created By HCPCS	Total number of RXCs de-duplicated for each enrollee in the IVA sample within the strata after the RXC hierarchy is applied, that are created by a HCPCS service code on medical claim mapping to the RXC.	Stratum Type	1	totalUniquePmtRxcsCreatedByHcpcs	Integer	minInclusive = 0; maxInclusive = 999999999

RADV Detailed Enrollee (RADVDE) Report Message Format (or Record Layout) and Required Protocols

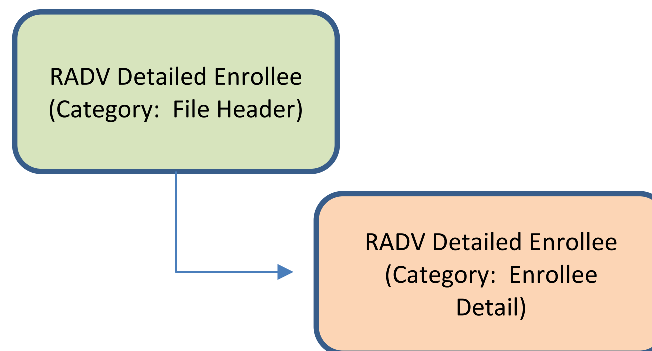
The outbound RADVDE Report is available to CMS from both, the preliminary run, and the final run. The RADVDE is available to the issuer/submitting organization, only from the RADV final run. This report contains enrollee level data for each enrollee included in the RADV IVA sample. The RADVDE Report will be generated with RADV batch job.

This report contains detailed enrollee data and is transmitted to CMS in order to support the RADV audit process.

5.1.1.6File Layout

This section specifies the file layout for the RADVDE Report. At a high level, it consists of two (2) record types or categories of information, as shown in Figure 3.

Figure 3 : EDGE Server RADV Detailed Enrollee Report



The RADVDE Report consists of a report File Header category and an Enrollee Detail category.

The RADVDE XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.7 Field/Data Elements and Descriptions

The data characteristics for the RADV Detailed Enrollee category are as shown in Table 8. The root element of the RADVDE Report in the XSD is radvDetailedEnrollee (*radvDetailedEnrollee.xsd*). This element is required and all the other elements defined in this section for the RADVDE Report are embedded within this element start and end tags.

Table 8: RADVDE RADV Detailed Enrollee File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFIleHeader	none
Payment Year	For example, 2014 or 2015.	File Header	1	paymentYear	String	Strict: YYYY
Total Number of Plan IDs	Total number of 16-digit Plan IDs for the risk score calculation.	File Header	1	totalNumberOfPlanIds	Integer	minInclusive = 0; maxInclusive = 999999999
Total Enrollees	Total number of unique enrollees selected for the audit sample.	File Header	1	totalNumberEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollee Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	File Header	1 or more (unbounded)	includedEnrolleeLevel	radvDetailedEnrolleeCategory	none

The data characteristics for the RADV Detailed Enrollee category are as shown in Table 9. These elements are defined in the *radvDetailedEnrolleeCategory.xsd*.

Table 9: RADVDE RADV Detailed Enrollee

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique Enrollee ID	Unique identifier for the enrollee. This represents the MASKED identifier submitted by the issuer to the EDGE server.	Enrollee Detail	1	enrolleeIdentifier	String	minLength = 2; maxLength = 80
Risk Score	Risk score calculated for the enrollee.	Enrollee Detail	1	enrolleeRiskScore	Decimal	minInclusive = 0; maxInclusive = 999999999.999999999999999
Total Professional Claims	Count of active, RA eligible professional claims selected for the audit sample for the enrollee.	Enrollee Detail	1	totalProfessionalClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Institutional Inpatient Claims	Count of active, RA eligible institutional inpatient claims selected for the audit sample for the enrollee.	Enrollee Detail	1	totalInpatientClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Institutional Outpatient Claims	Count of active, RA eligible institutional outpatient claims selected for the audit sample for the enrollee.	Enrollee Detail	1	totalOutpatientClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Supplemental Records	Count of active supplemental records linked to active, RA eligible claims that were selected for the audit sample for the enrollee.	Enrollee Detail	1	totalSupplementalRecords	Integer	minInclusive = 0; maxInclusive = 999999999
Total Pharmacy Claims	Count of active, RA eligible pharmacy claims selected for the audit sample for the enrollee. Note : Only the adult RA model includes RXCs therefore only enrollees in the adult strata 1-3 can	Enrollee Detail	1	totalRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	have a pharmacy claim count > 0. Enrollees in Strata 4-10 Total Pharmacy Claims = 0.					
Total Enrollment Periods	Count of enrollment periods with at least one day in the payment year selected for the audit sample for the enrollee, that are included in the RADVEE report.	Enrollee Detail	1	totalEnrollmentPeriods	Integer	minInclusive = 0; maxInclusive = 999999999
Date of Birth	Date of birth of the enrollee.	Enrollee Detail	1	enrolleeDateOfBirth	String	Strict: YYYY-MM-DD

Table 9: RADVDE RADV Detailed Enrollee (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Payment HCCs	Count of payment HCCs for the enrollee. This is the count of unique payment HCCs for the enrollee, after the hierarchy is applied.	Enrollee Detail	1	enrolleePaymentHccs	Integer	minInclusive = 0; maxInclusive = 999999999
Total Payment RXCs	Count of payment RXCs for the enrollee. This is the count of unique payment RXCs for the enrollee, after the hierarchy is applied. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 can have a Total Payment RXCs > 0. Strata 4-10 Total Payment RXCs = 0.	Enrollee Detail	1	enrolleePaymentRxcs	Integer	minInclusive = 0; maxInclusive = 999999999
Stratum Indicator	The stratum indicator of the stratum in which the enrollee was included. Strata 1-9 represent low, medium and high-risk enrollees with at least one (1) HCC or (1) RXC for each age model. Stratum 10 includes enrollees with no HCCs and no RXCs. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 will include enrollees with RXCs..	Enrollee Detail	1	stratumLevel	String	minLength = 0 Enumeration Values: “1: Adult – Low” “2: Adult – Medium” “3: Adult – High” “4: Child – Low” “5: Child – Medium” “6: Child – High” “7. Infant – Low” “8: Infant – Medium” “9: Infant – High” “10: No HCCs and No RXCs”
Random Number	The random number assigned to the enrollee when generating the random sample.	Enrollee Detail	1	randomNumber	Decimal	minInclusive = 0; maxInclusive = 9999999999999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Number of Unique Diagnoses Codes	Total number of unique Diagnosis Codes on any active, RA eligible medical claims and their associated supplemental records for the benefit year. Duplicate codes are counted only once.	Enrollee Detail	1	totalNumberUniqueDiagnosisCodes	Integer	minInclusive = 0; maxInclusive = 999999999

Table 9: RADVDE RADV Detailed Enrollee (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Number of RA Diagnoses Codes	Total number of unique RA Diagnosis Codes on any active, RA eligible medical claims and their associated supplemental records for the benefit year. An RA Diagnosis Code is a Diagnosis Code that mapped to a condition category (CC) for the enrollee.	Enrollee Detail	1	totalNumberRADiagnosisCodes	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of RA NDC Codes	Total number of unique RA NDC Codes on any active, RA eligible pharmacy claims and their associated supplemental records for the benefit year. An RA Diagnosis Code is a Diagnosis Code that mapped to a condition category (CC) for the enrollee Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 can have a count > 0. Strata 4-10 can have a count = 0..	Enrollee Detail	1	totalNumberRANdcCodes	Integer	minInclusive = 0; maxInclusive = 999999999
HCC	HCC assigned to the enrollee. This includes all HCCs identified after the HCC hierarchy is applied.	Enrollee Detail	1 or more	enrolleeHCC	String	minLength = 0; maxLength = 10
Unique Diagnosis Code	All unique Diagnosis Codes included for the enrollee on any active, RA eligible claims and their associated supplemental records for the benefit year.	Enrollee Detail	1 or more	uniqueDiagnosisCode	String	minLength = 0; maxLength = 30
Unique RA Diagnosis Code	All unique RA eligible Diagnosis Codes included for the enrollee on any active, RA eligible medical claims and their associated	Enrollee Detail	1 or more	uniqueRADiagnosisCode	String	minLength = 0; maxLength = 30

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	supplemental records for the benefit year. An RA Diagnosis Code is a Diagnosis Code that maps to a condition category (CC) for the enrollee.					
RXC	Payment RXC assigned to the enrollee. This includes all RXCs identified after the RXC hierarchy is applied. Note: Only the adult RA model includes RXCs therefore only the adult strata 1-3 can have RXCs listed but. Strata 4-10 will have blank enrolleePaymentRXC field	Enrollee Detail	1 or more	enrolleePaymentRXC	String	minLength = 0; maxLength = 10
Unique RA NDC Code	All unique RA eligible NDC Codes included for the enrollee on any active, RA eligible pharmacy claims for the benefit year. An RA NDC Code is an NDC Code that maps to a prescription drug category (RXC) for the enrollee.	Enrollee Detail	1 or more	uniqueRANDCCode	String	minLength = 0; maxLength = 30

RADV Enrollment Extract (RADVEE) Message Format (or Record Layout) and Required Protocols

The outbound RADVEE Report is available to CMS from both, the preliminary run, and the final run. The RADVEE is available to the issuer/submitting organization, only from the RADV final run. This report contains enrollment periods belonging to enrollees in the IVA sample that are enrolled in at least one risk pool market that were included in RADV for each enrollee.

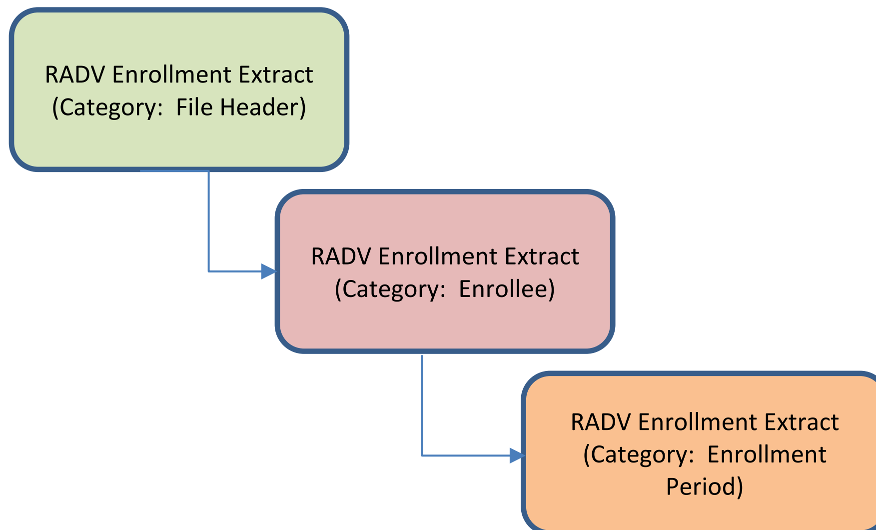
As long as the enrollee is included in the IVA sample, the RADVEE report will extract all active enrollement periods for the enrollee in the payment year that RA calculated a risk score for. The RADVEE Report will be generated with RADV batch job.

This report contains detailed enrollee data and is transmitted to CMS in order to support the RADV audit process.

5.1.1.8 File Layout

This section specifies the file layout for the RADVEE file. At a high level it consists of the three (3) record types or categories of information as shown in Figure 4.

Figure 4: EDGE Server RADV Enrollment Extract Data Categories



The RADVEE Report consists of a report File Header category, an Enrollee category, and an Enrollment Period category.

The RADVEE XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.9 Field/Data Elements and Descriptions

The data characteristics for the RADV Enrollment Extract category are as shown in Table 10. The root element of the RADVEE Report in the XSD is radvEnrollmentExtract (*radvEnrollmentExtract.xsd*). This element is required and all the other elements defined in this section for the RADVEE Report are embedded within this element start and end tags.

Table 10: RADVEE RADV Enrollment Extract File Header Category Data

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFIleHeader	none
Payment Year	For example, 2014 or 2015.	File Header	1	paymentYear	String	Length = 4 Strict: YYYY
Total Number of Enrollee Records	Total count of enrollee records included in the enrollment extract.	File Header	1	insuredMemberTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Enrollment Period Records	Total count of enrollment period records for all enrollees in the extract file. *(Not a count of member months)*	File Header	1	insuredMemberProfileTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollment Extract	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	File Header	1 or more	includedEnrollmentExtract	radvEnrollmentExtractEnrolleeCategory	none

The data characteristics for the RADV Enrollment Extract Enrollee category are as shown in Table 11. These elements are defined in the *radvEnrollmentExtractEnrolleeCategory.xsd*.

Table 11: RADVEE RADV Enrollment Extract Enrollee Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique Enrollee ID	Unique identifier for the enrollee. This represents the **MASKED identifier** submitted by the issuer to the EDGE server.	Enrollee	1	insuredMemberIdentifier	String	minLength = 2; maxLength = 80 Must use a MASKED identifier Must not begin or end with a space.
Enrollee DOB	Date of birth for enrollee.	Enrollee	1	insuredMemberBirthDate	String	Strict: YYYY-MM-DD
Enrollee Gender	Gender of enrollee.	Enrollee	1	insuredMemberGenderCode	String	Length = 1 Enumeration Values: “M”, “F”, “U” Enumeration Values description: “M” = Male “F” = Female “U” = Unknown
Enrollment Period Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Enrollee	1 or more (unbounded)	includedInsuredMemberProfile	radvEnrollmentExtractProfileCategory	none

The data characteristics for the RADV Enrollment Extract Profile category are as shown in Table 12. These elements are defined in the *radvEnrollmentExtractProfileCategory.xsd*

Table 12: RADVEE RADV Enrollment Extract Profile Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Market Type	Indicates the market that the extracted enrollment period belongs to. Note: The market type for the enrollment period is identified as catastrophic if the market type used for the plan by RA is Individual and the metal level used is Catastrophic. Note: Market type for the extacted issuer submitted or system generated enrollment period should be the same as the market type used by RA for that enrollment period.	Enrollment Period	1	marketType	String	minLength = 0; maxLength = 80 "Individual" OR "Small Group" OR "Catastrophic"
Subscriber Indicator	Indicates when the enrollee linked to this enrollment period record is also the subscriber. A subscriber is defined as the primary insured party.	Enrollment Period	1	subscriberIndicator	String	minLength = 0; maxLength = 1 Enumeration Values: "S" Enumeration Values description: "S" = Subscriber If enumeration value is not applicable, then the value should be empty.

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Subscriber ID	This ID represents a Unique Enrollee ID who is identified as the primary insured party.	Enrollment Period	1	subscriberIdentifier	String	minLength = 0; maxLength = 80 If populated, must match a unique enrollee ID that has been identified as the subscriber on the file. If enumeration value is not applicable, then the value should be empty. Must not begin or end with a space.
Plan ID	Unique 16-digit plan identifier for insurance plan offered by issuer that the enrollee is covered under. The Plan ID includes the CSR variant.	Enrollment Period	1	insurancePlanIdentifier	String	Length = 16 Format: HIOS Issuer ID + State Code + HIOS Product ID + HIOS Component ID + Variant (ex. 12345VA001999901) (only alphanumeric)

Table 12: RADVEE RADV Enrollment Extract Profile Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollment Start Date	The date when the enrollment coverage for the enrollee became effective for the associated plan.	Enrollment Period	1	coverageStartDate	String	Strict: YYYY-MM-DD
Enrollment End Date	The date when the enrollment coverage for the enrollee is no longer effective for the associated plan.	Enrollment Period	1	coverageEndDate	String	Strict: YYYY-MM-DD
Enrollment Period Activity Indicator	Identifies the type of activity associated with the creation of an enrollment period.	Enrollment Period	1	enrollmentMaintenanceTypeCode	String	minLength = 3; maxLength = 6 Enumeration Values Description: “021028”: Initial issuance of the policy “001”: Modification of existing policy “021EC”: Addition of member to an existing policy “021041”:Renewal of an existing policy for the next year. Note: Change in enrollment dates should be treated as an “021028” or “021EC’’.

Table 12: RADVEE RADV Enrollment Extract Profile Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Premium Amount	The Premium Amount is the monthly total rated premium charged by the issuer for a subscriber, including the Advanced Premium Tax Credit (APTC) amount. The Premium Amount may include more than the amount charged directly to a subscriber. The Premium Amount does not represent an amount paid by a subscriber.	Enrollment Period	1	insurancePlanPremiumAmount	Decimal	minInclusive = 0; maxInclusive = 9999999999999999.99 (explicit decimal is required)
Rating Area	Rating Area used for the enrollee in the plan. If enrollee is not rated, use the subscriber Rating Area.	Enrollment Period	1	ratingAreaIdentifier	String	Length = 3 Leading zeros should be included.

RADV Medical Claim Extract Report (RADVMCE) Message Format (or Record Layout) and Required Protocols

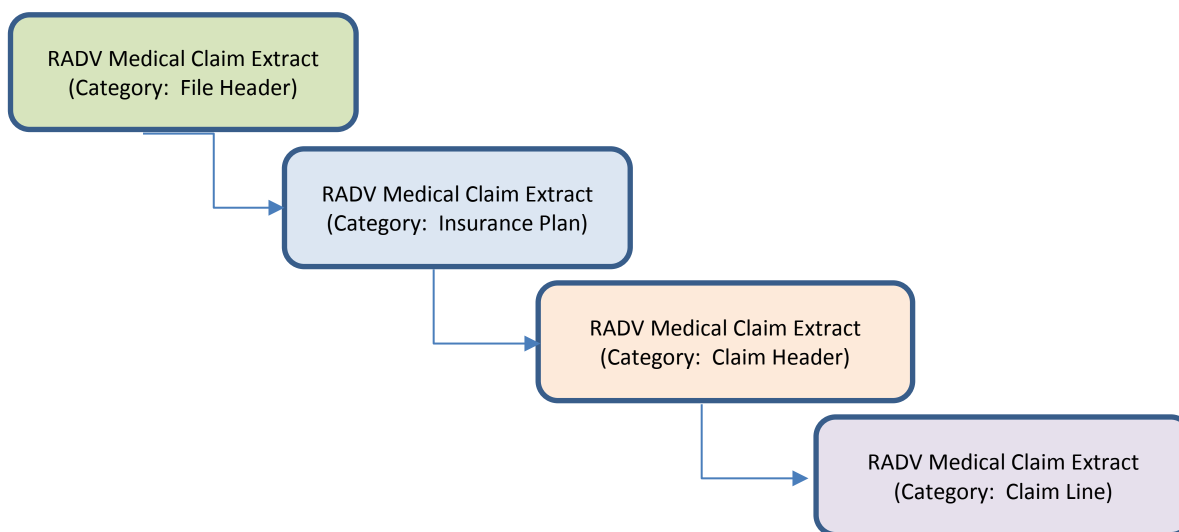
The outbound RADVMCE Report is available to CMS from both, the preliminary run, and the final run. The RADVMCE is available to the issuer/submitting organization, only from the RADV final run. This report contains all active RA eligible and/or RXC eligible medical claims that were submitted by the issuer in the medical claim XML for each enrollee included in the RADV IVA sample. The RADVMCE Report will be generated with RADV batch job.

This report contains detailed medical claim data and is transmitted to CMS in order to support the RADV audit process.

5.1.1.10 File Layout

This section specifies the file layout for the RADVMCE data file. At a high level it consists of four (4) record types or categories of information as shown in Figure 5.

Figure 5: EDGE Server RADV Medical Claim Extract Categories



The RADVMCE Report consists of a report File Header category, an Insurance Plan category, a Claim Header category, and a Claim Line category.

The RADVMCE XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.11 Business Data Elements and Definitions

The data characteristics for the RADV Medical Claim Extract Header category are as shown in Table 13. The root element of the RADVMCE Report in the XSD is radvMedicalClaimExtract

(*radvMedicalClaimExtract.xsd*). This element is required and all the other elements defined in this section for the RADVMCE Report are embedded within this element start and end tags.

Table 13: RADVMCE RADV Medical Claim Extract File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFIleHeader	None
Payment Year	For example, 2014 or 2015.	File Header	1	paymentYear	String	Strict: YYYY
Total Claims	Total count of claims in the file.	File Header	1	claimDetailTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Total Claim Lines	Total count of claim lines in the file.	File Header	1	claimServiceLineTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Medical Claim Extract Plan	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	File Header	1 or more	includedMedicalClaimExtractPlan	radvMedicalClaimExtractPlanCategory	None

The data characteristics for the RADV Medical Claim Extract Insurance Plan category are as shown in Table 14. These elements are defined in the *radvMedicalClaimExtractPlanCategory.xsd*

Table 14: RADVMCE RADV Medical Claim Extract Insurance Plan Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique 16-digit plan identifier for insurance plan offered by issuer, that the RA eligible and/or RXC eligible claim for the sampled enrollee belongs to (Regardless of whether the plan is included in RA) For cross-year claims, the claim will always be linked to the Plan ID that the claim originated from, regardless of whether the plan was included in RA and the RADV enrollment extract.	Insurance Plan	1	insurancePlanIdentifier	String	Length = 16 Format: HIOS Issuer ID + State Code + HIOS Product ID + HIOS Component ID + Variant (ex. 12345VA001999901) (only alphanumeric)
Total Claims	Total count of claims for this plan.	Insurance Plan	1	insurancePlanClaimDetailTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Total Claim Lines	Total count of claim lines for all claims for the plan.	Insurance Plan	1	insurancePlanClaimServiceLineTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Medical ClaimExtract Claim Header	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Insurance Plan	0 or more (unbounded)	includedMedicalClaimExtractDetail	radvMedicalClaimExtractDetailCategory	None

The data characteristics for the RADV Medical Claim Extract Claim Header category are as shown in Table 15. These elements are defined in the *radvMedicalClaimExtractDetailCategory.xsd*

Table 15: RADVMCE RADV Medical Claim Extract Claim Header Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique Enrollee ID	Unique identifier for the enrollee. This represents a **MASKED identifier**; not a medical record number or cardholder ID. Issuers should use the same Unique Enrollee ID if the enrollee switches plans within the issuer.	Claim Header	1	insuredMemberIdentifier	String	minLength = 2; maxLength = 80 Must use a MASKED identifier Must not begin or end with a space.
Form type	Describes claim form type as professional or institutional.	Claim Header	1	formTypeCode	String	Length = 1; Enumeration Values: “I“,“P“ Enumeration Values Description: “I”: Instituitional “P”: Professional
Claim ID	Unique number generated by the issuer adjudication system to uniquely identify the transaction. The issuer adjudicated Claim ID may be de-identified by the issuer.	Claim Header	1	claimIdentifier	String	minLength = 1; maxLength = 50 **Note**: If issuer has multiple platforms that use identical Claim ID numbers, the issuer must make Claim ID unique or rejects for duplicate claims will result. The last character cannot be a space.
Original Claim ID	The Claim ID submitted on a previous claim file that the issuer intends to void or replace.	Claim Header	1	originalClaimIdentifier	String	minLength = 0; maxLength = 50 *NOTE: Used only when submitting a void or replacement claim.* If enumeration value is not applicable, then the value should be empty. The last character cannot be a space.

Table 15: RADVMCE RADV Medical Claim Extract Claim Header Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Claim Processed Date Time	The date and time when the claim was adjudicated and resulted in a paid amount or reported encounter.	Claim Header	1	claimProcessedDateTime	String	Strict: YYYY-MM-DDTHH:mm:SS Note: A default of 00:00:00 for time can be used if no timestamp is available. However, if more than one (1) claim is processed on the same day, the claims will be rejected as we will not know the proper order of processing.
Bill Type	The code indicating a specific type of bill as reported on institutional claims only.	Claim Header	1	billTypeCode	String	minLength = 0; maxLength = 3 Enumeration Values: Values should comply with X12 industry standards. If enumeration value is not applicable, then the value should be empty.
Void/Replace Indicator	Identifies if a previously accepted claim is to be voided or replaced.	Claim Header	1	voidReplaceCode	String	minLength = 0; maxLength = 1 Enumeration Values = “V”,“R” when provided, Enumeration Values Description: “V”: Void “R”: Replace If enumeration value is not applicable, then the value should be empty.

Table 15: RADVMCE RADV Medical Claim Extract Claim Header Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Diagnosis Code Qualifier	Indicates if the Diagnosis Code is International Classification of Diseases, Ninth Revision (ICD-9) or International Classification of Diseases, Tenth Revision (ICD-10). **Note:** X12 standard allows only one (1) qualifier per claim; any single date of service should have either ICD-9 or 10; issuers need to submit separate claims for each type of code.	Claim Header	1	diagnosisTypeCode	String	Length = 2 Enumeration Values: • “01”: ICD - 9-Clinical Modifications • “02”: ICD - 10-Clinical Modifications
Diagnosis Code	Code value for the Diagnosis Code as determined by classification of International Classification of Diseases.	Claim Header	1 to 99 per claim	diagnosisCode	String	minLength = 1; maxLength = 30 Enumeration Values: Values must comply with X12 industry standards. Do not include a decimal. Include all relevant digits.
Discharge Status Code	The facility discharge status of the enrollee.	Claim Header	1	dischargeStatusCode	String	minLength = 0; maxLength = 2 Enumeration Values: Values must comply with X12 industry standards.
Statement Covers From	Earliest date of service on the submitted claim (For inpatient claims this would be the admission date.)	Claim Header	1	statementCoverFromDate	String	Strict: YYYY-MM-DD
Statement Covers Through	Latest date of service on the submitted claim (For inpatient claims this would be the discharge date.)	Claim Header	1	statementCoverToDate	String	Strict: YYYY-MM-DD
Billing Provider ID Qualifier	Identifies the type of Provider ID being submitted in the Billing Provider ID field.	Claim Header	1	billingProviderIDQualifier	String	Length = 2 Enumeration Values: “XX”,“99” Enumeration Values Description: • “XX”: National Provider Identifier (NPI) –A HIPAA-mandated standard unique health identifier for health care providers. • “99”: Other –Different from those implied or specified.

Table 15: RADVMCE RADV Medical Claim Extract Claim Header Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Billing Provider ID	The billing provider's identification (NPI or unique issuer assigned provider ID). This may be a group clinic or other facility.	Claim Header	1	billingProviderIdentifier	String	minLength = 1; maxLength = 15
Date Paid	The date a check or electronic funds transfer was issued for paid claims. For encounters, the date paid means the date of claim adjudication.	Claim Header	1	issuerClaimPaidDate	String	Strict: YYYY-MM-DD If value is not applicable, then the value should be empty.
Total Amount Allowed	Total Amount Allowed for this claim.	Claim Header	1	allowedTotalAmount	Decimal	minInclusive = -9999999999999999.99; maxInclusive = 9999999999999999.99 (explicit decimal is required)
Total Amount Paid	Total paid amount for this claim.	Claim Header	1	policyPaidTotalAmount	Decimal	minInclusive = -9999999999999999.99; maxInclusive = 9999999999999999.99 (explicit decimal is required)
Derived Amount Indicator	Indicator used to distinguish between fee-for-service claims and claims covered under capitation.	Claim Header	1	derivedServiceClaimIndicator	String	Length = 1; Enumeration Values: “Y”,“N” Enumeration Values Description: “Y”: Derived (capitated Service) “N”: Actual (Fee-For-Service)
RA Eligible Flag	Indicates whether the medical claim is RA eligible or not.	Claim Header	1	raEligibleFlag	String	Length = 1; Enumeration Values: “Y”,“N” Enumeration Values Description: “Y”: RA Eligible “N”: Not RA Eligible
RXC Eligible Flag	Indicates whether the medical claim is RXC eligible or not.	Claim Header	1	rxcEligibleFlag	String	Length = 1; Enumeration Values: “Y”,“N” Enumeration Values Description: “Y”: RXC Eligible “N”: Not RXC Eligible

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Medical Claim Extract Service Line	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Claim Header	1 or more (unbounded)	includedMedicalClaim ExtractServiceLine	radvMed icalClai mExtract ServiceL ineCate gory	none

The data characteristics for the RADV Medical Claim Extract Service Line category are as shown in Table 16. These elements are defined in the *radvMedicalClaimExtractServiceLineCategory.xsd*

Table 16: RADVMCE RADV Medical Claim Extract Service Line Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Claim Line Sequence Number	Unique number generated to represent service(s) submitted on the claim.	Claim Service Line	1	serviceLineNumbe r	Integer	minInclusive = 1; maxInclusive = 999
Date of Service – From	Represents the first Date of Service on a submitted claim for a specific claim line. Also represents the service date on an institutional claim.	Claim Service Line	1	serviceFromDate	String	Strict: YYYY-MM-DD **Note:** This data element represents the Service Date on an institutional claim.
Date of Service – To	Represents the last Date of Service on a submitted claim for a specific claim line.	Claim Service Line	1	serviceToDate	String	Strict: YYYY-MM-DD
Revenue Code	Describes the revenue center in which the service was provided.	Claim Service Line	1	revenueCode	String	minLength = 0; maxLength = 4 Enumeration Values: Values must comply with X12 industry standards. If enumeration value is not applicable, then the value should be empty.
Service Code Qualifier	A code that identifies the source of the procedure code (CPT or HCPCS).	Claim Service Line	1	serviceTypeCode	String	minLength = 0; maxLength = 2 Enumeration Values: • “01”: Dental service codes • “03”: Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) If enumeration value is not applicable, then the value should be empty.

Table 16: RADVMCE RADV Medical Claim Extract Service Line Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Service Code	A Procedure Code that identifies the service rendered: CPTor HCPC.	Claim Service Line	1	serviceCode	String	minLength = 0; maxLength = 5 Enumeration Values: Values must comply with X12 industry standards. If enumeration value is not applicable, then the value should be empty.
Service Code Modifier	A two (2)-digit code that may be billed with a CPT/HCPCS Service Code.	Claim Service Line	1 to4 per claim line	serviceModifierCode	String	minLength = 0; maxLength = 2 Enumeration Values: Values must comply with X12 industry standards. If enumeration value is not applicable, then the value should be empty.
Place of Service	A code that identifies where the service was rendered.	Claim Service Line	1	serviceFacilityTypeCode	String	minLength = 0; maxLength = 2 Enumeration Values: Values must comply with X12 industry standards. Modifiers should be used otherwise certain Service Codes may be rejected as duplicates. See the business rules for duplicate logic. If enumeration value is not applicable, then the value should be empty.

Table 16: RADVMCE RADV Medical Claim Extract Service Line Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Rendering Provider ID Qualifier	Identifies the type of Provider ID being submitted in the Rendering Provider ID field.	Claim Service Line	1	renderingProviderIDQualifier	String	Length = 2 Enuemeration Values: "XX","99" Enumeration Values Description: • "XX": National Provider Identifier (NPI) –A HIPAA-mandated standard unique health identifier for health care providers • "99": Other – Different from those implied or specified.
Rendering Provider ID	The rendering provider's identification number. This may be a group clinic or other facility.	Claim Service Line	1	renderingProviderIdentifier	String	minLength = 1; maxLength = 15
Amount Allowed	Total Amount Allowed by plan.	Claim Service Line	1	allowedAmount	Decimal	minInclusive = -9999999999999999.99; maxInclusive = 9999999999999999.99 (explicit decimal is required)
Amount Paid	Total amount paid, or derived, by plan.	Claim Service Line	1	policyPaidAmount	Decimal	minInclusive = -9999999999999999.99; maxInclusive = 9999999999999999.99 (explicit decimal is required)
Derived Amount Indicator	Indicator used to distinguish between fee-for-service claims and claims covered under capitation.	Claim Service Line	1	derivedServiceClaimIndicator	String	Length = 1 Enumeration Values: "Y","N" Enumeration Values Description: • "Y": Derived (capitated Service) • "N": Actual (Fee-For-Service)

RADV Pharmacy Claim Extract Report (RADVPCE) Message Format (or Record Layout) and Required Protocols

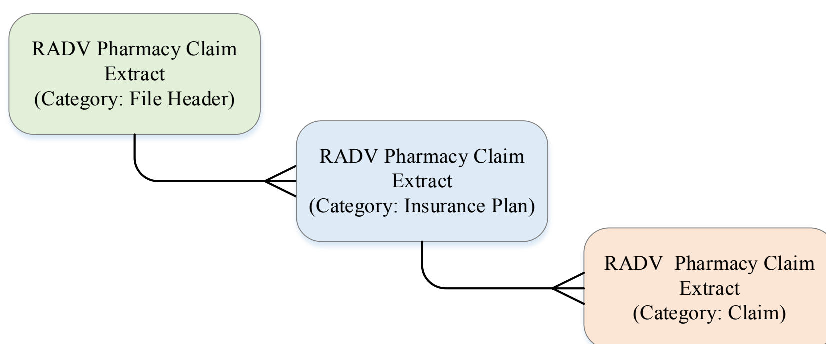
The outbound RADVPCE Report is available to CMS from both, the preliminary run, and the final run. The RADVPCE is available to the issuer/submitting organization, only from the RADV final run. This report contains all active RA eligible pharmacy claims that were submitted by the issuer in the pharmacy claim XML for each enrollee included in the RADV IVA sample. The RADVPCE Report will be generated with RADV batch job.

This report contains detailed pharmacy claim data and is transmitted to CMS in order to support the RADV audit process.

5.1.1.12 File Layout

This section specifies the file layout for the RADVPCE data file. At a high level it consists of three(3) record types or categories of information as shown in Figure 6.

Figure 6: EDGE Server RADV Pharmacy Claim Extract Categories



The RADVPCE Report consists of a report File Header category, an Insurance Plan category, a Claim Header category, and a Claim Line category.

The RADVPCE XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.13 Business Data Elements and Definitions

The data characteristics for the RADV Pharmacy Claim Extract Header category are as shown in Table 17. The root element of the RADVPCE Report in the XSD is radvPharmacyClaimExtract (*radvPharmacyClaimExtract.xsd*). This element is required and all the other elements defined in this section for the RADVPCE Report are embedded within this element start and end tags.

Table 17: RADVPCE RADV Pharmacy Claim Extract File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFIleHeader	None
Payment Year	For example, 2014 or 2015.	File Header	1	paymentYear	String	Strict: YYYY
Total Claims	Total count of claims in the file.	File Header	1	claimDetailTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Pharmacy Claim Extract Plan	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	File Header	1 or more	includedPharmacyClaimExtractPlan	radvPharmacyClaimExtractPlanCategory	None

The data characteristics for the RADV Pharmacy Claim Extract Insurance Plan category are as shown in Table 18. These elements are defined in the *radvPharmacyClaimExtractPlanCategory.xsd*

Table 18: RADVPCE RADV Pharmacy Claim Extract Insurance Plan Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique 16-digit plan identifier for insurance plan offered by issuer, that the RA eligible claim for the sampled enrollee belongs to (Regardless of whether the plan is included in RA)	Insurance Plan	1	insurancePlanIdentifier	String	Length = 16 Format: HIOS Issuer ID + State Code + HIOS Product ID + HIOS Component ID + Variant (ex. 12345VA001999901) (only alphanumeric)
Total Claims	Total count of claims for this plan.	Insurance Plan	1	insurancePlanClaimDetailTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Pharmacy ClaimExtract Claim Header	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Insurance Plan	0 or more (unbounded)	includedPharmacyClaimExtractDetail	radvPharmacyClaimExtractDetailCategory	None

The data characteristics for the RADV Pharmacy Claim Extract Claim Header category are as shown in Table 19. These elements are defined in the *radvPharmacyClaimExtractDetailCategory.xsd*

Table 19: RADVPCE RADV Pharmacy Claim Extract Claim Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique Enrollee ID	Unique identifier of enrollee. This represents a **MASKED identifier**; not a medical record number or cardholder ID. Issuers should use the same Unique Enrollee ID if the enrollee switches plans within the issuer.	Claim	1	insuredMemberIdentifier	String	minLength = 2; maxLength = 80 Must use a MASKED identifier.
Claim ID	Unique number generated by issuer adjudication system to uniquely identify the transaction. The issuer-adjudicated Claim ID may be de-identified by the issuer.	Claim	1	claimIdentifier	String	minLength = 1; maxLength = 50 Note: If issuer has multiple platforms that use identical Claim ID numbers, then the Issuer must make Claim IDs unique or rejects for duplicate claims will result. The last character cannot be a space
In-Network or Out-of-Network Indicator	Indicator to identify if a service was provided by an In-Network or Out-of-Network dispensing provider	Claim	1	pharmacyNetworkIndicator	String	Length = 1 Enumeration Values: 'I','O' Enumeration Values Description: "I" = In-Network "O" = Out-of-Network
Claim Processed Date Time	The date and time when the claim was adjudicated and resulted in a paid amount or reported encounter.	Claim	1	claimProcessedDateTime	String	Strict YYYY-MM-DDTHH:mm:SS Note: A default of 00:00:00 for time can be used if no timestamp is available. However, if more than one (1) claim is processed on the same day, the claims will be rejected as we will not know the proper order of processing.

Table 19: RADVPCE RADV Pharmacy Claim Extract Claim Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Fill Date	Indicates the date that the prescription was dispensed by the dispensing pharmacy.	Claim	1	prescriptionFillDate	String	Strict YYYY-MM-DD
Void/Replace Indicator	Identifies if a previously accepted claim is to be voided or replaced.	Claim	1	voidReplaceCode	String	minLength = 0; maxLength 1 Enumeration Values: 'V', 'R' Enumeration Values Description : V = Void; R = Replace Note: Only required when the submitter intends to void or replace a previously accepted claim. If enumeration value is not applicable, then then the value should be empty.
Dispensing Provider ID Qualifier	Identifies the type of dispensing provider ID being submitted in the Dispensing Provider ID field.	Claim	1	dispensingProviderIDQualifier	string	Length = 2 Enumeration Values: 'XX', '99' Enumeration Values Description: • XX - National Provider Identifier (NPI) –A HIPAA-mandated standard unique health identifier for health care providers • 99 - Other –Different from those implied or specified.
Dispensing Provider ID	The dispensing provider's identification number [National Provider Identifier (NPI) or unique issuer assigned provider ID].	Claim	1	dispensingProviderIdentifier	string	minLength = 1; maxLength = 15
Fill Number	Code identifying whether the prescription is an original (0) or refill (1-999).	Claim	1	prescriptionFillNumber	integer	minInclusive = 0; maxInclusive = 999

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Dispensing Status	Indicates if the prescription was a partial fill (P) or the completion of a partial fill (C).	Claim	1	dispensingStatusCode	string	minLength = 0; maxLength 1 Enumeration Values: ‘ ’, ‘P’, ‘C’ Enumeration Values Description: C – Completion of a partial Fill; P = Partial Fill A blank implies a complete fill at the time dispensed. If enumeration value is not applicable, then the value should be empty.

Table 19: RADVPCE RADV Pharmacy Claim Extract Claim Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Paid Date	The date a check or electronic funds transfer was issued by the insurance company/issuer to the vendor for paid claims. For encounters, the date paid means the date of claim adjudication.	Claim	1	issuerClaimPaidDate	String	Strict YYYY-MM-DD
Prescription/Service Reference Number	Unique number assigned by the pharmacy to the dispensed prescription.	Claim	1	prescriptionServiceRefe renceNumber	string	minLenngth=7; maxLength=12
Total Allowed Cost	Represents the sum of allowed charges for ingredient cost, dispensing fee, and sales tax.	Claim	1	allowedTotalCostAmou nt	decimal	minExclusive = -9999999999999999.99; maxInclusive = 9999999999999999.99 (explicit decimal is required)
Plan Paid Amount	Total paid amount for the claim.	Claim	1	policyPaidAmount	decimal	minInclusive = -9999999999999999.99; maxInclusive = 9999999999999999.99 (explicit decimal is required)
Derived Amount Indicator	Indicator used to distinguish between fee-for-service claims and claims covered under capitation.	Claim	1	derivedServiceClaimInd icator	string	Length = 1; Enumeration Values: ‘’Y’, ‘N’ Enumeration Values Description – ‘’Y’ = Derived (capitated Service) “N” = Actual (Fee-For-Service

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Product/Service ID Qualifier	Identifies whether the Product/Service ID is an National Drug Code or not.	Claim	1	nationalDrugCodeQualifier	string	Length = 2 Enumeration Values: • 01 – Product/Service ID other than National Drug Code • 02 – Product/Service ID is a National Drug Code Claims with qualifier values of 01 and 02 will be considered for inclusion in the High Cost Risk Pool. Only claims with a qualifier value of 02 will be considered for inclusion in Risk Adjustment.

Table 19: RADVPCE RADV Pharmacy Claim Extract Claim Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Product/Service ID	Unique ID of the product or service dispensed [National Drug Code (NDC)].	Claim	1	nationalDrugCode	string	minLength=1; maxLength=11
Days of Supply	Number of days of supply for the product or service dispensed	Claim	1	daysSupply	Integer	minInclusive = 1, maxInclusive = 999

RADV Supplemental Extract Report (RADVSE) Message Format (or Record Layout) and Required Protocols

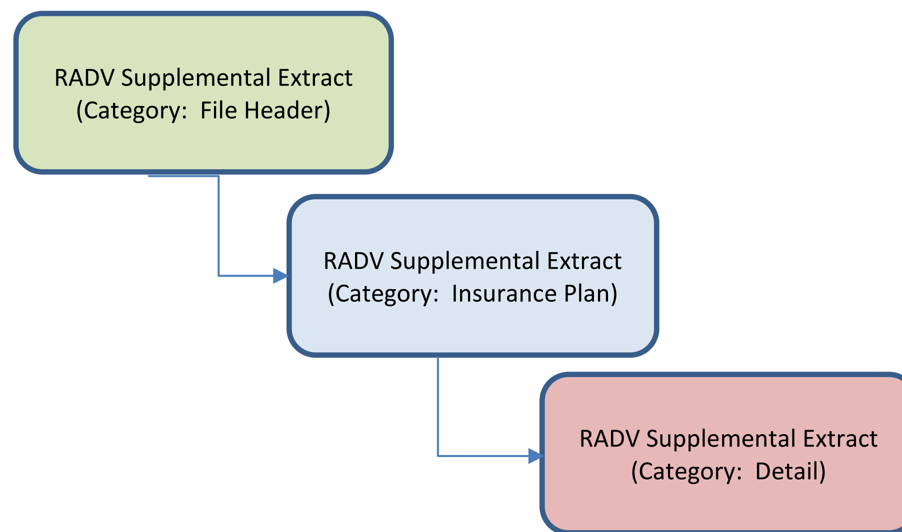
The outbound RADVSE Report is available to CMS and the issuer/submitting organization. This report contains all active supplemental records for active RA eligible medical claims that were submitted by the issuer in the supplemental XML for each enrollee included in the RADV IVA sample. The RADVSE Report will be generated with RADV batch job.

This report contains detailed supplemental record data and is transmitted to CMS in order to support the RADV audit process.

5.1.1.14 File Layout

This section specifies the file layout for the RADVSE data file. At a high level it consists of four (4) record types or categories of information as shown in Figure 7.

Figure 7: EDGE Server RADV Supplemental Extract Data Categories



The RADVSE Report consists of a report File Header category, an Insurance Plan category, and a Detail category.

The RADVSE XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.15 Business Data Elements and Definitions

The data characteristics for the RADV Supplemental Extract Header category are as shown in Table 20. The root element of the RADVSE Report in the XSD is radvSupplementalExtract (*radvSupplementalExtract.xsd*). This element is required and all the other elements defined in this section for the RADVSE Report are embedded within this element start and end tags.

Table 20: RADVSE RADV Supplemental Extract File Header Category Data

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFIleHeader	none
Payment Year	For example, 2014 or 2015.	File Header	1	paymentYear	String	Strict: YYYY
Total Detail Records	Total count of detail records.	File Header	1	fileDetailTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Supplemental Extract Plan	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	File Header	1 or more (unbounded)	includedSupplementalExtractPlan	radvSupplementalExtractPlanCategory	none

The data characteristics for the RADV Supplemental Extract Insurance Plan category are as shown in Table 21. These elements are defined in the *radvSupplementalExtractPlanCategory.xsd*

Table 21: RADVSE RADV Supplemental Extract Insurance Plan Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique identifier for insurance plan offered by issuer that the insured member is covered under. The Plan ID includes the CSR variant.	Insurance Plan	1	insurancePlanIdentifier	String	Length = 16 Format = HIOS Issuer ID + State Code + HIOS Product ID + HIOS Component ID + Variant (ex. 12345VA001999901) (only alphanumeric)
Total Detail Records	Total count of detail records for this plan.	Insurance Plan	1	insurancePlanFileDetailTotalQuantity	Integer	minInclusive = 0; maxInclusive = 999999999
Supplemental Extract Detail	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Insurance Plan	0 or more (unbounded)	includedSupplementalExtractDetail	radvSupplementalExtractDetailCategory	none

The data characteristics for the RADV Supplemental Extract Detail category are as shown in Table 22. These elements are defined in the *radvSupplementalExtractDetailCategory.xsd*

Table 22: RADVSE RADV Supplemental Extract Detail Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique Enrollee ID	Unique identifier for the enrollee. This represents a **MASKED identifier**; not a medical record number or cardholder ID. Issuers should use the same Unique Enrollee ID if the enrollee switches plans within the issuer.	Detail	1	insuredMemberIdentifier	string	minLength = 2; maxLength = 80 Must use a MASKED identifier Must not begin or end with a space.
Supplemental Diagnosis Detail Record ID	Unique number generated by the issuer to uniquely identify the supplemental diagnosis transaction.	Detail	1	supplementalDiagnosisDetailRecordIdentifier	string	minLength = 1; maxLength = 50 **Note:** issuer must make identifier unique. The last character cannot be a space
Original Medical Claim ID	The medical Claim ID to which the supplemental claim corresponds that was submitted on a previous claim file and was accepted by the EDGE server.	Detail	1	originalClaimIdentifier	string	minLength = 1; maxLength = 50 The last character cannot be a space
Detail Record Processed Date Time	The date and time when the Supplemental Diagnosis Detail Record was created by the issuer.	Detail	1	detailRecordProcessedDateTime	String	Strict: YYYY-MM-DDTHH:mm:SS **Note:** A default of 00:00:00 for time can be used if no timestamp is available. However, if more than one (1) claim is processed on the same day, the claims will be rejected as we will not know the proper order of processing.

Table 22: RADVSE RADV Supplemental Extract Detail Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Add/Delete/Void Indicator	Identifies if a supplemental diagnosis is added; identifies if a previously submitted diagnosis is deleted; and identifies if a previously accepted supplemental diagnosis file is to be voided.	Detail	1	addDeleteVoidCode	string	Length = 1 Enumeration Values: “A”, “D”,“V” Enumeration Values description: “A”: Add “D”: Delete “V”: Void
Original Supplemental Diagnosis Detail ID	Identifies the original Supplemental Diagnosis Detail Record when processing a VOID Supplemental Detail record.	Detail	1	originalSupplementalDetailID	string	minLength = 0; maxLength = 50 The last character cannot be a space
Date of Service – From	Indicates the first day the service occurred that supports the submission of a supplemental diagnosis.	Detail	1	serviceFromDate	String	Strict: YYYY-MM-DD **Note:** Represents the date of service if there is no service to date.
Date of Service – To	Indicates the last day the service occurred that supports the submission of a supplemental diagnosis.	Detail	1	serviceToDate	String	Strict: YYYY-MM-DD
Supplemental Diagnosis Code Qualifier	Indicates if the Diagnosis Code is International Classification of Diseases, Ninth Revision-CM (ICD - 9-CM) or International Classification of Diseases, Tenth Revision - CM (ICD-10-CM). **Note:** X12 standard allows only one (1) qualifier per claim; any single Date of Service should have either ICD-9-CM or ICD-10-CM; issuers need to submit separate claims for each type of code.	Detail	1	diagnosisTypeCode	String	Length = 2 Enumeration Values: • “01”: ICD-9-Clinical Modifications • “02”: ICD-10-Clinical Modifications

Table 22: RADVSE RADV Supplemental Extract Detail Category Data (continued)

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Supplemental Diagnosis Code	Code value for the Diagnosis Code as determined by classification of International Classification of Diseases.	Detail	1 to 99 per claim	supplementalDiagnosisCode	String	minLength = 1; maxLength = 30 Enumeration Values: Values should comply with X12 industry standards. Explicit decimal is not required. Include all relevant digits.
Supplemental Diagnosis Source	Identifies the source of the supplemental diagnosis. MR for medical record EDI for electronic data interchange Only one (1) code per supplmental diagnosis.	Detail	1	sourceCode	String	Enumeration Values: • “MR”: medical record • “EDI”:electronic data interchange

Communication Methods

This section describes the communication methods for the EDGE server. All communication between the EDGE server and CMS Management Console will use Secure Sockets Layer (SSL), namely Secure Shell (SSH)/Secure File Transfer Protocol (SFTP) and Hyper Text Transfer Protocol Secure (HTTPS). Further, all Web browser communication with the EDGE server will also be done using HTTPS. Internet Protocol (IP) Tables will be configured for the EDGE server to restrict incoming and outgoing network traffic across the server only for specific ports.

- Interface Initiation

The system operates on a SFTP interface along with user interface for lightweight submission and report access with 24/7 availability.

- Flow Control

Prior to start of the submission file structure and data validations, the system will create a backup of the inbound file and the data repository. After the data processing logic is executed, the system will create another backup of the outbound files and the data processing. This allows the system to recover from any failures and minimize reprocessing of data.

Notification of failures will be communicated to the EDGE server user through email. Detailed processing reports will sent to the issuer/submitter to correct the erroneous data and allow for resubmittal of the corrected information. The detailed error report will identify the records that are in error including the data element, submitted value and the detailed error message flagging the error. This allows the user to quickly identify their errors and apply the appropriate data corrections. The issuer/submitter can view the reports or data files using their Web browser user interface. Alternatively, they can download the files using SFTP either manually or as part of an automated process. The error reports will be placed in the output folder of the EDGE server application.

Security Requirements

The security requirements for accessing the outbound files are described in the existing EDGE server ICD published on REGTAP, document number: *0.0.4-CMSES-ICD-4763*.

Acronyms

Table 23: Acronyms

Acronym	Literal Translation
ACA	Affordable Care Act of 2010
APTC	Advanced Premium Tax Credit
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
CMS-ES	CMS-EDGE Server
CPT/HCPCS	Current Procedural Terminology/ Healthcare Common Procedure Coding System
CSR	Cost Sharing Reduction
DOB	Date Of Birth
Dx	Diagnosis
EDI	Electronic Data Interchange
ES	EDGE Server
ESES	EDGE Server Enrollment Submission
ESMCS	EDGE Server Medical Claims Submission
ESPCS	EDGE Server Pharmacy Claims Submission
ESSFS	EDGE Server Supplemental File Submission
HCC	Hierarchical Condition Category
HHS	Health & Human Services
HIPAA	Health Insurance Portability and Accountability Act
HTTPS	Hypertext Transfer Protocol Secure
ICD	Interface Control Document
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
IP	Internet Protocol
IVA	Initial Validation Audit
IVAS	Initial Validation Audit Statistics
MC	Medical Claim
MOOP	Maximum Out Of Pocket
MR	Medical Record
NDC	National Drug Code
NPI	National Provider Identifier
PHI	Protected Health Information
RA	Risk Adjustment
RADV	Risk Adjustment Data Validation
RADVDE	Risk Adjustment Data Validation Detailed Enrollee Report
RADVEE	Risk Adjustment Data Validation Enrollment Extract Report
RADVIVAS	Risk Adjustment Data Validation Initial Validation Audit Statistics Report

Acronym	Literal Translation
RADVMCE	Risk Adjustment Data Validation Medical Claim Extract Report
RADVPCE	Risk Adjustment Data Validation Pharmacy Claim Extract Report
RADVPS	Risk Adjustment Data Validation Population Summary Statistics Report
RADVPSF	Risk Adjustment Data Validation Population Summary Statistics Final Report
RADVSE	Risk Adjustment Data Validation Supplemental Extract Report
RI	Reinsurance
RxC	Pharmacy Claim
SE	EDGE Server System Error Report
SFTP	Secure File Transfer
SSH	Secure Shell
SSL	Secure Sockets Layer
XML	Extensible Markup Language
XSD	XML Schema Definition

Appendix A EDGE Server Outbound Reports XSDs

This section presents the XSD schema for the outbound reports generated by the EDGE server. The issuer/submitter will utilize these files to process the XML instance of these reports. These files are located in the REGTAP Library at https://www.regtap.info/reg_library.php.

Appendix B Referenced Documents

Table 24: Referenced Documents

Document Name	Document Number / URL	Issuance Date
Interface Control Document (ICD)	URL: https://www.REGTAP.info Document Number: 0.0.4-CMSES-ICD-4763	8/11/2015

Appendix C System Error Codes

This section defines the Error Codes that will be used for the EDGE Server System Error outbound Report. The table below specifies the Error Codes:

Table 25: System Error Codes

Unique Error Code	Error Code Description
100	Java.lang.OutOfMemoryError: Java heap space

Appendix D Document Control History

The table below records information regarding changes made to this document prior to the most recent maintenance release of this ICD Addendum.

Version Number	Date	Author/Owner	Description of Change
05.00.22	10/23/18	Accenture / CCIIO	Separate ICD Document

Centers for Medicare & Medicaid Services

CMS-EDGE Server / CMS-ES

Risk Adjustment and Reinsurance (RARI) Interface Control Document – High Cost RISK Pool (HCRP) Addendum

Version 05.00.22

February 11, 2019

Document Version History– Recent changes

The table below reflects the summary of changes incorporated in the most recent maintenance release of this ICD addendum.

Version Number	Date	Author/Owner	Description of Change
05.00.22	12/10/18	Accenture / CCIIO	Create separate ICD Addendum for Frequency Reports **For changes prior to version 05.00.22, refer to the RARI ICD Consolidated Version History

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1 Purpose of Interface Control Document

This Interface Control Document (ICD) Addendum was created from the consolidated Risk Adustment (RA) and Reinsurance (RI) ICD Addendum that was separated into the following five documents:

- RARI ICD- RA Addendum,
- RARI ICD- Risk Adjustment Data Validation (RADV) Addendum,
- RARI ICD- RI Addendum,
- RARI ICD- HCRP Addendum, and
- RARI ICD- Issuer Frequency Report Addendum.

This RARI ICD Addendum is for the High Cost Risk Pool outbound reports, and does not contain information regarding the remaining four (4) ICDs listed above. Following is the link to the Registration For Technical Assistance Portal (REGTAP) library for the five (5) ICD Addendums listed above: https://www.regtap.info/reg_library.php.

The RARI ICD (and its accompanying addenda) documents and tracks the necessary information required to effectively define the Centers for Medicare & Medicaid Services (CMS) External Data Gathering Environment (EDGE) server system interface, as well as any rules for communicating with the EDGE servers, to give the development team guidance on the architecture of the system to be developed. In addition, the purpose of the ICD is to clearly communicate all possible inputs for all potential actions. The RARI ICD helps ensure compatibility between system segments and components.

The RARI ICD does not include information about specific business rules or how the verification edits included within this document affect the file processing logic. Additional information can be found in the EDGE Server Business Rules (ESBR) document available at https://www.regtap.info/reg_librarye.php?i=2673

.

2 Introduction

This is one of five addenda to the existing RARI ICD, which describes the relationship between CMS and the issuer’s EDGE server. This document serves to define additional reports that will be produced by the issuer’s EDGE servers as a supplement to the ICD, currently published in the Registration for Technical Assistance Portal (REGTAP) Library. These reports include the risk adjustment and reinsurance calculation reports that are used for payment processing, as well as additional analytic reports.

The CMS-EDGE server interface is only necessary when CMS is operating the Risk Adjustment and/or Reinsurance programs on behalf of a state.

The following information, with respect to the interface, is described further in this document:

- Additional EDGE server outbound report formats.

3 Overview

As part of the Affordable Care Act (ACA), two (2) programs were identified to mitigate the impact of adverse selection of plans and provide stability for issuers. States have the option to operate the following programs themselves or have the Department of Health and Human Services (HHS) operate the programs on their behalf.

- Section 1343 of the ACA created the Risk Adjustment (RA) program to better spread the financial risk borne by health insurance issuers in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. Under the RA program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Non-grandfathered, Individual and Small Group Market plans, irrespective of whether they are a part of the Marketplace, will submit RA data (claims and enrollee data) that will be used to determine individual-level risk scores, plan average actuarial risk and associated payments and charges.
- Section 1341 of the ACA establishes the Reinsurance (RI) program as a temporary three-year program that commences in 2014. RI provides funds to issuers that incur high costs for claims in the Individual Market. In accordance with the final rule, RI payments are based on a coinsurance rate or proportion of an issuer’s claims costs that are above an attachment point and below a RI cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for RI payments, while the RI cap is the dollar limit at which point an issuer is no longer eligible for RI payments. The attachment point, coinsurance rate and RI cap are calculated based on an issuer’s total incurred costs for an individual enrollee in a given calendar year. Non-grandfathered, Individual Market plans, both on and off the Marketplace, will submit RI data (claims and enrollee data) that will be used to determine if an individual market plan issuer is eligible for RI.

CMS’ Center for Consumer Information and Insurance Oversight (CCIIO) on behalf of HHS will develop the software to evaluate and perform the RA and RI calculations.

When evaluating the model for collecting and processing the data received from issuers, it was determined that a distributed data collection model would prove the most effective. Specifically, this model would ensure:

- Issuer proprietary data would not be transmitted to HHS;
- Minimal transfer of protected health information (PHI) to lower privacy and data security risks;
- Standardization of business processes, timing and rules.

These factors resulted in the concept of the EDGE server. Issuers, in states where HHS is operating an RA and/or RI program, will submit enrollee, pharmacy claim, medical claim and supplemental diagnosis information from their proprietary systems to an issuer-owned or Third Party Administrator (TPA)-hosted EDGE server. The EDGE server will run HHS-developed software designed to verify submitted data and execute the RA and RI processes. Issuers will have the option to own and operate the server themselves, or to have a third-party entity operate the server. Detailed data, file processing metrics and outbound data files will be

provided to insurance companies/issuers. Only plan summarized data and file processing metrics will be provided to HHS.

4 General Interface Requirements

Interface Overview

This section describes updates to the EDGE server interface as a result of the additional reports defined in this document. For a complete description of the general interface requirements, refer to the existing EDGE server ICD, published in the REGTAP Library (Interface Control Document, document number: *0.0.4-CMSES-ICD-4763*).

Functional Allocation

The primary responsibility of the EDGE server is to provide distributed data processing capabilities to support RA and RI. The results of the data processing are available to CMS, insurance companies and their associated issuers through reports in the form of data files. Output reports can be generated in the Production, Test or Validation zones.

The reports defined in this document can be initiated by one (1) or more of the following methods:

- CMS Initiated Remote Command
- Issuer Executed EDGE Server Command

Transactions

The following reports are defined in this document. Once executed, all files are provided to the issuer/submitter and files with summary data only are provided to CMS for review.

- HCRP Detail Enrollee Report (HCRPDE)
- HCRP Summary Report (HCRPDS)

There are several types of outbound data files that will be sent to the issuer/submitter and to CMS as part of this process, including the following:

- Process Oriented Reports
- Operations Analytics Reports
- Management Reports
- Payment Processing Reports

The recipient of these outbound files is restricted by the content level of the files as specified by the table below.

Table 1: Report Type and Recipient

Report Type	Report Recipient
File Level Reports	Issuer/Submitter and CMS
Detail Reports	Issuer/Submitter
Summary Reports	Issuer/Submitter and CMS
Activity To Date Reports	Issuer/Submitter and CMS

Process Oriented Reports are data files generated for the issuer/submitter based on the results of the data processing of the submitted data file. This category includes the following report types:

Operations Analytics Reports are data files that help the user in understanding various operational metrics identified, thereby allowing process improvements. This also helps CMS/CCIIO in reaching out to the issuer/submitter to address any aberrant patterns.

Management Reports are outbound files of summary data used by management to gauge the execution of the overall process.

Payment Process Outputs are outbound files used to calculate the RA and RI payment amounts that will be applied for each issuer.

5 Detailed Interface Requirements

This section specifies the requirements for the interface between the insurance company/ submitting organization and the EDGE server. This includes explicit definitions of the content and format of every message or file that is expected to be transmitted between the insurance company/submitting organizations and the EDGE server and the conditions under which each file is to be sent.

Requirements for Additional EDGE Server Outbound Reports

This section describes the additional outbound report formats that will be made available to the issuer and CMS to review and analyze the processing results of the enrollment, claims and supplemental diagnosis information submitted for RI and RA processing. The files will be eXtensible Markup Language (XML) based and as per the XML Schema Definition (XSD) defined in this document.

This document describes the following reports:

- Reports sent to the insurance company/issuer administrator only:
  - HCRP Detail Enrollee Report
- Reports sent to both the insurance company/issuer administrator and CMS:
  - HCRP Summary Report

Assumptions

The assumptions for the delivery of the EDGE server outbound files are as follows:

- Outbound reports are posted to the issuer’s Amazon Web Services (AWS) S3 file repository or On-Premise server output directory designated for the remote command

execution zone, as described for each report in the below sections.

- Issuers will have a separate Amazon Web Services (AWS) S3 file repository or On-Premise server output directory for the validation zone, independent of the file repositories or output directories for the production and test zone.
- The data files defined to date are XML documents. As the requirements are refined, this section will be updated to reflect the final file layout and data characteristics.

General Processing Steps

After the enrollee and claim files have been validated, designated entities, as determined by the insurance company/issuer administrator, will receive information about the status of their submission through a series of file processing reports. Similarly, CMS/CCIIO will be issued summary reports which provide the status and metrics of the data being processed. All insurance company/issuer reports will be delivered to the AWS S3 bucket configured for the issuer for AWS servers or the server's output directory for On-Premise servers. Summary reports will be delivered to the CMS/CCIIO AWS S3 bucket.

File Naming Convention

All files produced will follow the standard naming convention outlined below.

File Format Mask:

<Submitting Entity ID>.<File Type>.D<YYYYMMDD>T<hhmmss>.<Execution Zone>.xml

Example File Name:

12345. HCRPS.D20140402T091533.P.xml

Table 2: File Name Parameters

Parameter	Description	Enumeration Values
Submitting Entity ID	Must be the 5 digit HIOS assigned Issuer ID.	**Example:** 12345
Date Timestamp	The date timestamp of when the file was generated.	**Example:** For April 2, 2014 at 9:15:33 AM Date Timestamp: D20140402T091533
Execution Zone	One (1) letter code indicating the execution zone where the file is to be processed.	Production:' P' Test: 'T' Local: 'L' Validation: 'V'

Shared Outbound Report Data Components Message Format (or Record Layout) and Required Protocols

The structure of the EDGE server output reports has two (2) components:

Common Header category that is reused across the defined output reports; and

- Data elements/structures that are specific to a given report

1.1.1.1 Record Layout and Required Protocols for Common Outbound File Header Record

The data contents of the common outbound file header record data structure include report file identifier, report execution date, file identifier included in the submitted file, date of submission file generated by issuer/submitter, date of submission file received by the EDGE server, report type, sender identifier (EDGE server identifier) and submitter identifier associated with the submission.

1.1.1.1.1 Business Data Element Descriptions and Technical Characteristics

The data characteristics for the Common Outbound File Header Data Structure are as shown in Table 3. These elements are defined in the *RARICommonOutboundFileHeader.xsd*.

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
File ID	The CMS system generated unique identifier of a report file.	File Header	1	outboundFileIdentifier	String	minLength = 1 maxLength = 80
CMS Batch ID	CMS generated identifier to uniquely identify a batch job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsBatchIdentifier	String	minLength = 1 maxLength = 50
CMS Job ID	CMS generated identifier to uniquely identify the job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsJobIdentifier	String	minLength = 1 maxLength = 50

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Snap Shot File Name	File name of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileName	String	none
Snap Shot File Hash	Hash value of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileHash	String	none
Run Date	The date and time when the CMS processed file is generated.	File Header	1	outboundFileGenerationDateTime	String	Strict: YYYY-MM-DDTHH:mm:SS
Interface Control Release Number	Denotes the version number of the ICD that the file corresponds to as identified on page one (1) of this document.	File Header	1	interfaceControlReleaseNumber	String	Length = 8
EDGE Server Version	Version number that corresponds to the Application, Database, Operating System, and reference table versions that were used to process the inbound file and produce the report. The application version in the execution zone for which the report is generated, will be displayed in this field.	File Header	1	edgeServerVersion	String	minLength = 0; maxLength = 75

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Job ID	System generated unique identifier for job executed on the EDGE server.	File Header	0… 1	edgeServerProcessIdentifier	String	minLength = 0; maxLength= 12
Report Type	Defines values of outbound validation report.	File Header	1	outboundFileTypeCode	String	minLength = 1 maxLength = 30
Server ID	The unique identifier of an EDGE server.	File Header	1	edgeServerIdentifier	String	minLength = 1 maxLength = 12
Issuer ID	The unique identifier for an issuer.	File Header	1	issuerIdentifier	String	Length = 5

High Cost Risk Pool Summary (HCRPSR)

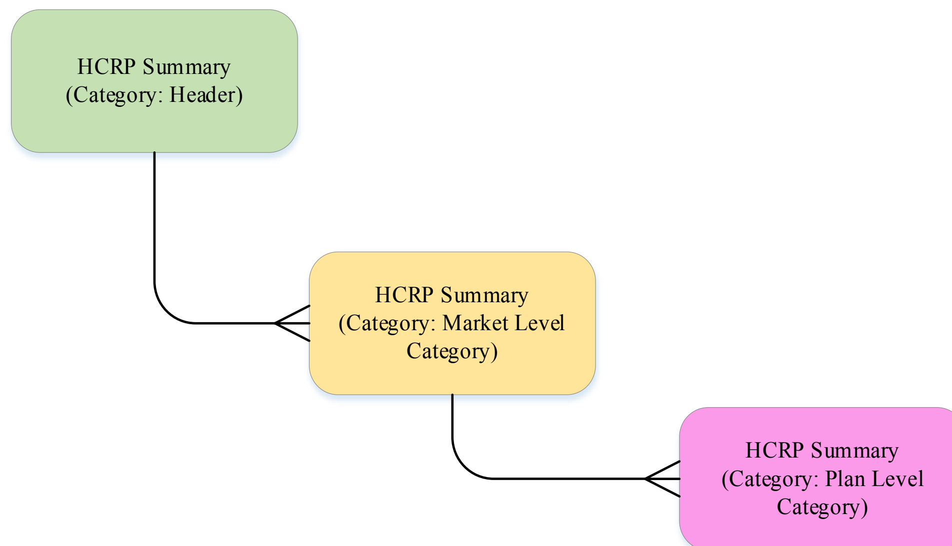
Message Format (or Record Layout) and Required Protocols

The outbound HCRPS Report is available to CMS and the issuer/submitting organization. This report contains issuer, market, and plan level details used for the HCRP calculation. The HCRPS Report will be generated with the HCRP batch job.

1.1.1.2 File Layout

This section specifies the file layout for the HCRP summary data file. At a high level it consists of four (3) record types or categories of information as shown in Figure 1.

Figure 1: EDGE Server HCRP Summary Report Data Categories



The HCRP Summary Report XSD consists of report File Header Category, Market Level Header Category, and Plan Level Header Category.

The HCRP XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

1.1.1.3 Business Data Elements and Definitions

The data characteristics for the HCRP Summary Report Header category are as shown in Table 138. The root element of the HCRP Summary Report in the XSD is HCRPSummaryReport.xsd (*HCRPSummaryReport.xsd*). This element is required and all the other elements defined in this section for the HCRP Summary Report are embedded within this element start and end tags.

The HCRP Summary and Detail reports only include HCRP eligible enrollees and claims. HCRP eligible Claims and enrollees in the HCRP Summary and Detail report refer to all claims and enrollees that meet the standard HCRP claim/enrollee selection criteria for EDGE. System-generated enrollment periods are not required for EDGE to select cross-year claims for HCRP and are hence not selected.

“HCRP Payment Enrollees” refers only to those who qualified for HCRP payment – i.e., met standard selection criteria AND whose total paid claims amount from both markets (MOOP-adjusted where applicable) exceeded the HCRP attachment point. For more information on claim and enrollee selection for HCRP, please see Appendix D.

The data characteristics for the HCRP Summary Report File Header level category are as shown in **Table 4**. These elements are defined in the *HCRPSummaryReport.xsd*

Table 4: HCRP Summary Report File Header Category Data

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFIleHeader	none
Calendar Year	The calendar year for which HCRP command was executed	File Header	1	calendarYear	String	Strict: YYYY
Execution Type	Designate preliminary or final run	File Header	1	executionType	String	minLength = 1 maxLength = 30 Enumeration Values: “P”: Preliminary “F”: Final
Issuer Legal Name	The issuer's legal name.	File Header	1	issuerLegalName	String	minLength = 0, maxLength = 80
State	The state the HIOS ID belongs to	File Header	1	state	String	Length = 2
Job Type	Determines if the HCRP job was executed using national level or state level HCRP parameters	File Header	1	jobType	String	Length = 1 N”: National “S”: State
Co-insurance Rate	The percent applied to the dollar amount between the attachment point and the cap to determine the enrollee’s HCRP payment for the year.	File Header	1	coInsuranceRate	Decimal	minInclusive = 0 maxInclusive = 1.00

Table 4: HCRP Summary Report File Header Category Data

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Cap	The upper dollar amount above which the enrollee's total claims not included for the HCRP payment Note: This field will be blank until the HCRP logic is updated to account for CAP	File Header	1	cap	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Attachment Point	The lower dollar amount above which an enrollee's total claims are include for the HCRP Payment	File Header	1	attachmentPoint	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Enrollee Count	Total number of all active unique enrollee IDs associated with the issuer	File Header	1	totEnrCnt	Integer	minInclusive = 0 maxInclusive = 999999999
Total Member Months	Total member months for the issuer = Total Member Months from small group market header level + Total Member Months from individual market header level	File Header	1	totMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Subscriber Member Months	Total subscriber member months for the issuer = Subscriber Member Months at small group market header level + Subscriber Member Months at individual market header level	File Header	1	totSubscrMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Premium	Sum of total premium for the issuer = Total Premium from small group market header level + Total Premium from individual market header level	File Header	1	totPremium	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 4: HCRP Summary Report File Header Category Data

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total MOOP Adjusted Individual and Small Group Paid Claim Amount	Total paid claim amount for the issuer = Total Paid Amount from small group market header level + Total MOOP-Adjusted Paid Amount from individual market header level Note: MOOP adjustment is only applied to Individual market claims when the MOOP flag is "ON". MOOP adjustment is not applied to small group market claims	File Header	1	totMoopAdjIndSGPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Allowed Claims Amount	Total allowed claims amount for the issuer = Total Allowed Claims Amount from small group market header level + Total Allowed Claims Amount from individual market header level	File Header	1	totAllowedAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Claim Count	Total count of claims for the issuer = Total Claim Count from small group market header level + Total Claim Count from individual market header level	File Header	1	totClaimCnt	Integer	minInclusive = 0 maxInclusive = 999999999
HCRP Enrollee Count	Number of all unique active enrollee IDs whose paid claim amount in small group market + MOOP-adjusted paid claim amount in individual market exceeds the attachment point, thereby qualifying for HCRP payment	File Header	1	hcrpEnrCnt	Integer	minInclusive = 0 maxInclusive = 999999999
Member Months for HCRP Enrollees	Member months for issuer's HCRP payment enrollees = Total Member Months for HCRP payment Enrollees from small group market header level + Total Member Months for HCRP payment Enrollees from individual market header level	File Header	1	hcrpTotMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 4: HCRP Summary Report File Header Category Data						
Business Data Element	**Description**	**Data Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Subscriber Member Months For HCRP enrollees	Subscriber member months for issuer's HCRP payment enrollees = Subscriber Member Months for HCRP payment Enrollees from small group market header level + Subscriber Member Months for HCRP payment Enrollees from individual market header level	File Header	1	hcrpSubscrMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total paid Claim Amount for HCRP enrollees	Total paid claim amount for issuer's HCRP payment enrollees = Individual market header level MOOP-Adjusted Total paid claim amount for HCRP payment Enrollees + small group market header level total paid claim amount for HCRP payment enrollees. Note: this includes the amount of paid claims below the attachment point for HCRP payment enrollees	File Header	1	hcrpPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Allowed Claim Amount for HCRP Enrollees	Allowed Claims Amount Forclaims amount for issuer's HCRP payment Enrollees enrollees = Total Allowed Claim Amount from small group market header level + Total Allowed Claim Amount from individual market header level	File Header	1	hcrpAllowedAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count for HCRP Enrollees	Count of claims for issuer's HCRP payment enrollees = Claim Count for HCRP payment Enrollees from small group market header level + Claim Count for HCRP payment Enrollees from individual market header level	File Header	1	hcrpClaimCnt	Integer	minInclusive = 0 maxInclusive = 999999999

Table 4: HCRP Summary Report File Header Category Data						
Business Data Element	**Description**	**Data Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Total Paid Claim Amount Above Attachment Point	Total amount of paid claims that exceeds attachment point = Paid Claim Amount Above Attachment Point from small group market header level + Paid Claim Amount Above Attachment Point from individual market header level	File Header	1	paidAmtAboveAP	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
HCRP Payment	HCRP payment for the issuer = HCRP Payment from small group market header level + HCRP Payment from individual market header level	File Header	1	hcrpPayment	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Paid Claim Amount Cross Year for HCRP Enrollees	Amount of paid cross-year claims for issuer's HCRP payment enrollees = Paid Claim Amount Cross Year for HCRP payment Rnrollees from small group market header level + Paid Claim Amount Cross Year for HCRP Payment Enrollees from individual market header level Note: Plan reference check to determine which market type the claim belongs to, is done using the plan ID on the claim and the year of the start date/FillDate of the claim	File Header	1	hcrpPaidAmtCY	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count Cross Year for HCRP Enrollees	Count of cross-year claims for issuer's HCRP Payment enrollees = Claim Count Cross Year for HCRP Payment Enrollees for the issuer from small group market header level + Claim Count Cross Year for HCRP Payment Enrollees individual market header level	File Header	1	hcrpClaimCountCY	Integer	minInclusive = 0 maxInclusive = 999999999

Table 4: HCRP Summary Report File Header Category Data						
Business Data Element	**Description**	**Data Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Paid Claim Amount Cross Year With No EP in Current Payment Year for HCRP Enrollees	Amount of paid cross-year claims with no associated enrollment period in the current payment year (for claims linked to HCRP Payment enrollees only) in both markets	File Header	1	hcrpPaidClaimAmtCYNoEp	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count Cross Year No EP in Current Payment Year for HCRP Enrollees	Count of paid cross-year claims with no associated enrollment period in the current payment year (for claims linked to HCRP Payment enrollees only) in both markets	File Header	1	hcrpClaimCountCYNoEp	Integer	minInclusive = 0 maxInclusive = 999999999
Paid Claim amount for Enrollees Not Meeting AP	Amount of paid claims (including cross-year claims) for enrollees that did not exceed the AP in both markets	File Header	1	claimAmtUnderAP	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count for Enrollees Not Meeting AP	Count of paid claims (including cross-year claims) for enrollees that did not exceed the AP in both markets	File Header	1	claimCntUnderAP	Integer	minInclusive = 0 maxInclusive = 999999999
Market Header	This XML element describes the Individual Market type header related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning.	Market Header	1 or more per market type	includedMarketType	HCRPSummaryMarketTypeCategory	none

The data characteristics for the HCRP Summary Report Market level category are as shown in Table 5. These elements are defined in the *HCRPSummaryMarketTypeCategory.xsd*

Table 5: HCRP Summary Report Market Level Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Market Type	Market type for the plan: Individual or Small Group. Note: On EDGE, individual includes catastrophic plans, as well as plans in merged markets with plan IDs identifying them as individual market	Market	1	marketType	String	minLength = 0; maxLength = 30 Enumeration Value: "1": Individual "2": Small Group
Total Enrollee Count	Total number of all active unique enrollee IDs associated with <market type> plans for the issuer	Market	1	totEnrCnt	Integer	minInclusive = 0; maxInclusive = 999999999
Total Subscriber Member Months	Total subscriber member months for all <market type> plans	Market	1	totMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Member Months	Total member months for all <market type> plans	Market	1	totSubscrMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Premium	Sum of total premium for all <market type> plans	Market	1	totPremium	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Paid Claim Amount	Total paid claim amount for all <market type> plans	Market	1	totPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Individual MOOP Adjustment	Sum of MOOP Adjustment from all <market type> plans. Note: Will only be nonzero for individual market type when MOOP adustment flag is ON.This field will always be 0 for small group market type	Market	1	indMOOPAdj	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 5: HCRP Summary Report Market Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
MOOP Adjusted Total Paid Claim Amount	Sum of MOOP-adjusted total paid claim amount for all <market type> plans. Note: MOOP Adjusted Total Paid Claim Amount will be equal to Total Paid Claim Amount for individual market plans when the MOOP flag is OFF. For the small group market MOOP Adjusted Total Paid Claim amount will always be equal to Total Paid Claim Amount	Market	1	mOOPAdjTotPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Allowed Claims Amount	Sum of total allowed claim amount for all <market type> plans	Market	1	totAllowedAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Claim Count	Total count of claims for all <market type> plans	Market	1	totClaimCnt	Integer	minInclusive = 0; maxInclusive = 999999999

Table 5: HCRP Summary Report Market Level Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
HCRP Enrollee Count	Number of all unique active enrollee IDs belonging to <market type> whose MOOP-adjusted total paid claim amount in individual market + total paid claim amount in small group market exceeds the attachment point, hereby qualifying for HCRP payment Note: An enrollee can be considered belonging to the <market type> if the enrollee either has active enrollment in payment year in the <market type> plan or has an active claim belonging to the <market type> plan as of the year of the start date/Fill Date of the claim	Market	1	hcrpEnrCnt	Integer	minInclusive = 0; maxInclusive = 999999999
Member Months for HCRP Enrollees	Total Member Months fromfor HCRP payment enrollees in all <market type> plans	Market	1	hcrpTotMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Subscriber Member Months for HCRP Enrollees	Total subscriber member months for HCRP payment enrollees in all <market type> plans	Market	1	hcrpSubscrMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Paid Claim Amount for HCRP Enrollees	Total paid claim amount for HCRP payment enrollees in all <market type> plans	Market	1	hcrpPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 5: HCRP Summary Report Market Level Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Individual MOOP Adjustment for HCRP Enrollees	Sum of MOOP adjustment for HCRP payment enrollees in all <market type> plans Note: Will only be nonzero for individual market type when MOOP adustment flag is ON.This field will always be 0 for small group market type	Market	1	hcrpIndMOOPAdj	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
MOOP Adjusted Claim Paid Amount for HCRP Enrollees	Sum of MOOP-adjusted total paid claim amount for HCRP payment enrollees in all <market type> plans Note: MOOP Adjusted Total Paid Claim Amount will be equal to Total Paid Claim Amount for the individual market when the MOOP flag is OFF. For the small group market MOOP Adjusted Total Paid Claim amount will always be equal to Total Paid Claim Amount	Market	1	hcrpMOOPAdjTotPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Allowed Claims Amount for HCRP Enrollees	Allowed claims amount for HCRP payment enrollees in all <market type> plans	Market	1	hcrpAllowedAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count for HCRP Enrollees	Count of claims for HCRP payment enrollees in all <market type> plans	Market	1	hcrpClaimCnt	Integer	minInclusive = 0; maxInclusive = 999999999
Total Paid Claim Amount Above Attachment Point	Sum of Total Paid Claim Amount Above Attachment Point field from all <market type> plans	Market	1	paidAmtAboveAP	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
HCRP Payment	Sum of HCRP payment from all <market type> plans	Market	1	hcrpPayment	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 5: HCRP Summary Report Market Level Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
HCRP Payment Market percent	Proportion of total paid claim paid amount in the market for HCRP payment enrollees, calculated using the formula below: % paid claims in individual market = Total MOOP adjusted claim paid amount from HCRP payment enrollees in the individual market /(Total MOOP adjusted claim paid amount from HCRP payment enrollees in the individual market + Total claim paid amount from HCRP payment enrollees in the small group market) % paid claims in small group market = Total claim paid amount from HCRP payment enrollees in the small group market /(Total MOOP adjusted claim paid amoun from HCRP payment enrollees t in the individual market + Total claim paid amount from HCRP payment enrollees in the small group market)	Market	1	hcrpPayMktPct	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Paid Claim Amount Cross Year for HCRP enrollees	Sum of paid claim amount from cross-year claims for HCRP Payment enrollees in all <market type> plans Note: Plan reference check to determine which market type the claim belongs to, is done using the plan ID on the claim and the year of the start date/FillDate of the claim	Market	1	hcrpPaidAmtCY	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 5: HCRP Summary Report Market Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Claim Count Cross Year for HCRP Enrollees	Count of cross-year claims for HCRP payment enrollees in all <market type> plans Note: Plan reference check to determine which market type the claim belongs to, is done using the plan ID on the claim and the year of the start date/FillDate of the claim	Market	1	hcrpClaimCountCY	Integer	minInclusive = 0 maxInclusive = 999999999
Paid Claim amount Cross Year With No EP in Payment Year for HCRP Enrollees	Sum of paid claim amount from cross-year claims belonging to <market type> plans for HCRP payment enrollees with no associated enrollment period in the current payment year Note: Only claims belonging to <market type> plans for HCRP payment enrollees with no enrollment in the payment year in any plan belonging to any market type are considered for this field	Market	1	hcrpPaidClaimAmtCYNoEp	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 5: HCRP Summary Report Market Level Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Claim Count Cross Year No EP in Payment Year for HCRP Enrollees	Count of paid cross-year claims belonging to <market type> plans for HCRP payment enrollees with no associated enrollment period in the current payment year Note: Only claims belonging to <market type> plans for HCRP payment enrollees with no enrollment in the payment year in any plan belonging to any market type are considered for this field	Market	1	hcrpClaimCountCYNoEp	Integer	minInclusive = 0 maxInclusive = 999999999
Paid Claim amount for Enrollees Not Meeting AP	Amount of paid claims (including cross-year claims) for enrollees that did not exceed the AP in the <market type>	Market	1	claimAmtUnderAP	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count for Enrollees Not Meeting AP	Count of paid claims (including cross-year claims) for enrollees that did not exceed the AP in the <market type>	Market	1	claimCntUnderAP	Integer	minInclusive = 0 maxInclusive = 999999999maxInclusive = 999999999
Plan	This XML element describes the Individual Market type header related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning.	Plan	1 or more per plan belonging to HCRP selected enrollee	includedPlanIdentifier	HCRPSummaryPlanCategory	none

The data characteristics for the HCRP Summary Plan level category are as shown in Table 6. These elements are defined in the *HCRPSummaryPlanCategory.xsd*

Table 6: HCRP Summary Report Plan Level Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan Identifier	Unique identifier for the plan.	Plan	1	insurancePlanIdentifier	String	Length = 16 Format: HIOS Issuer ID + State Code + HIOS Product ID + HIOS Component ID + Variant (ex. 12345VA001999901) (only alphanumeric)
Total Enrollee Count	Total number of all active unique enrollee IDs associated with the plan	Plan	1	totEnrCnt	Integer	minInclusive = 0; maxInclusive = 999999999
Total Member Months	Total member months for all enrollees in the plan for the payment year in which HCRP is executed. For each enrollee, member months are calculated by dividing the days in enrollment period in the payment year in the plan by 30	Plan	1	totMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Subscriber Member Month	Total subscriber member month for all enrollees in the plan for the payment year for which HCRP is executed For each enrollee, subscriber member months are calculated by dividing the days in subscriber enrollment period in the payment year in the plan by 30	Plan	1	totSubscrMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 6: HCRP Summary Report Plan Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Total Premium	Sum of total premium, for all subscriber enrollment periods in the payment year in the plan. Total premium for each subscriber enrollment period is calculated by multiplying subscriber member months in the payment year by the monthly premium for the period	Plan	1	totPremium	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Paid Claim Amount	Sum of all paid claim amounts for claims (including cross year claims) that belong to the plan	Plan	1	totPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Individual MOOP Adjustment	Sum of MOOP adjustments from all subpolicies belonging to the plan Note: Will only be nonzero for individual market plans " when MOOP adustment flag is ON.This field will always be 0 for small group market plans	Plan	1	indMOOPAdj	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 6: HCRP Summary Report Plan Level Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
MOOP Adjusted Total Paid Claim amount	Subtraction of Individual MOOP Adjustment field from the Total Paid Claim Amount field Note: MOOP Adjusted Total Paid Claim amount will be equal to Total Claim Paid Amount for individual market plans when the MOOP flag is OFF. For the small group market plans MOOP Adjusted Total Paid Claim amount willalways equal the Total Paid Claim amount	Plan	1	mOOPAdjTotPaidAm t	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Allowed Claims Amount	Sum of total allowed claim amounts for the plan	Plan	1	totAllowedAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Claim Count	Total unique count of claims in the plan	Plan	1	totClaimCnt	Integer	minInclusive = 0; maxInclusive = 999999999
HCRP Enrollee Count	Number of all unique active enrollee IDs belonging to plan whose MOOP-adjusted total paid claim amount in individual market + total paid claim amount in small group market exceeds the attachment point, hereby qualifying for HCRP payment Note: An enrollee can be considered belonging to the plan if the enrollee either has active enrollment in payment year in the plan or has an HCRP eligble active claim belonging to the plan as of the year of the start date/Fill Date of the claim	Plan	1	hcrpEnrCnt	Integer	minInclusive = 0; maxInclusive = 999999999

Table 6: HCRP Summary Report Plan Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Total Member Months for HCRP Enrollees	Total member months for HCRP payment enrollees in the plan Member months in the plan for the payment year for an HCRP payment enrollee are calculated by dividing the total days of enrollment in payment year in the plan by 30	Plan	1	hcrpTotMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Subscriber Member Months for HCRP Enrollees	Total subscriber member months for HCRP payment enrollees in the plan for the payment year Subscriber member months in the plan for the payment year for an HCRP payment enrollee are calculated by dividing the total days of enrollment in payment year in the plan by 30	Plan	1	hcrpSubscrMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Paid Claim amount for HCRP Enrollees	Total claim paid amount (both above and below the attachment point) for HCRP payment enrollees in the plan	Plan	1	hcrpPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 6: HCRP Summary Report Plan Level Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Individual MOOP Adjustment for HCRP Enrollees	Sum of all CSR MOOP adjustments from all subpolicies belonging to the plan's HCRP payment enrollees only Note: Will only be non zero for individual market plans " when MOOP adustment flag is ON.This field will always be 0 for small group market plans	Plan	1	hcrpIndMOOPAdj	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
MOOP Adjusted Total Paid Claim Amount for HCRP Enrollees	Subtraction of Individual MOOP Adjustment for HCRP payment enrollees from the Paid Claim amount for HCRPpayment enrollees in the plan Note: HCRP MOOP Adjusted Total Paid Claim amount will be equal to HCRP Total Claim Paid Amount for the individual market plan when the MOOP flag is OFF. For small group market plans MOOP Adjusted Total Paid Claim amount will always equal the Total Paid Claim amount	Plan	1	hcrpMOOPAdjTotPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Allowed Claims Amount for HCRP Enrollees	Sum of allowed claim amounts from all claims that belong to the plan from HCRP payment enrollees only	Plan	1	hcrpAllowedAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count for HCRP Enrollees	Total unique count of claims in the plan for HCRP payment enrollees only	Plan	1	hcrpClaimCnt	Integer	minInclusive = 0; maxInclusive = 999999999

Total Paid Claim Amount Above Attachment Point	Total Paid Claim Amount Above Attachment Point, from all HCRP payment enrollees in the plan prorated by enrollees' percent of total paid claims in the plan.. To calculate this, the following formulas are implemented for all HCRP payment enrollees in the plan, and the Plan level Total Paid Claim Above Attachment Point is summed up from all those enrollees to the plan: Enrollee level Total Paid Claim Above Attachment Point = ((Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) – AP) % paid claims in the plan for the enrollee(If individual)= Total MOOP adjusted claim paid amount in the plan/(Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) % paid claims in the plan for the enrollee (If small group)= Total claim paid amount in the plan /(Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) Total Paid Claims Above Attachment Point for the enrollee's plan = % paid claims in the plan * Enrollee level Total	Plan	1	paidAmtAboveAP	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 6: HCRP Summary Report Plan Level Category Data						
Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	Paid Claim Above Attachment Point					

HCRP Payment	HCRP payments from all HCRP payment enrollees in the plan prorated by enrollees' percent of total paid claims in the plan. To calculate this, the following formulae are implemented for all HCRP payment enrollees in the plan, and the Plan level HCRP payment is summed up from all those enrollees to the plan: Enrollee level HCRP Payment = ((Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) – AP)*Co-insurance rate % paid claims in the plan for the enrollee(If individual)= Total MOOP adjusted claim paid amount in the plan/(Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) % paid claims in the plan for the enrollee (If small group)= Total claim paid amount in the plan /(Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) Plan level HCRP payment for the enrollee = % paid claims in the plan * Enrollee level HCRP Payment	Plan	1	hcrpPayment	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 6: HCRP Summary Report Plan Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
HCRP Payment Plan Percent	Percent of a plan's total paid amount attributable to HCRP payment enrollees, as calculated using the formula below: % total paid amount of all HCRP enrollees attributable to this plan = total MOOP-adjusted paid amount for HCRP enrollees in this plan / total MOOP-adjusted paid amount for all HCRP payment enrollees Note: If the MOOP adjustment flag is off, the system shall use total claim paid amount in the individual market plan instead of total MOOP Adjusted claim amount in the above formulas. If the plan has no HCRP payment enrollees, then this field will be zero.	Plan	1	hcrpPmtPlanPct	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Paid Claim amount Cross Year for HCRP Enrollees	An aggregation of Total Paid Claim Amount from all cross year claims in the plan from HCRP payment enrollees only	Plan	1	hcrpPaidAmtCY	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count Cross Year for HCRP Enrollees	Count of cross year claims in the plan from HCRP payment enrollees only	Plan	1	hcrpClaimCountCY	Integer	minInclusive = 0; maxInclusive = 999999999

Table 6: HCRP Summary Report Plan Level Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Paid Claim amount Cross Year No EP for HCRP Enrollees	An aggregation of TotalPaidClaimAmt from cross year claims in the plan from HCRP payment enrollees that do not have any enrollment in the payment year Note: Only claims belonging to the plan for HCRP payment enrollees with no enrollment in the payment year in any plan belonging to any market type are considered for this field	Plan	1	hcrpPaidClaimAmtCYNoEp	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count Cross Year No EP for HCRP Enrollees	Count of cross year claims in the plan from HCRP payment enrollees that do not have any enrollment in the payment year Note: Only claims belonging to the plan for HCRP payment enrollees with no enrollment in the payment year in any plan belonging to any market type are considered for this field	Plan	1	hcrpClaimCountCYNoEp	Integer	minInclusive = 0; maxInclusive = 999999999
HCRP Claim Paid Amount Above Coinsurance	Calculated using the following formula for each plan: Total Paid Claim Amount Above Attachment Point - HCRP Payment	Plan	1	hcrpPaidClaimAmtAboveCoinsurance	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 6: HCRP Summary Report Plan Level Category Data						
Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Paid Claim amount for Enrollees Not Meeting AP	Sum of claim paid amount from claims (including cross-year claims) for all HCRP selected enrollees who did not exceed the AP in the plan.t	Plan	1	claimAmtUnderAP	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count for Enrollees Not Meeting AP	A unique count of paid claims (including cross-year claims) from all enrollees who did not exceed the AP in the plan	Plan	1	claimCntUnderAP	Integer	minInclusive = 0 ; maxInclusive = 999999999

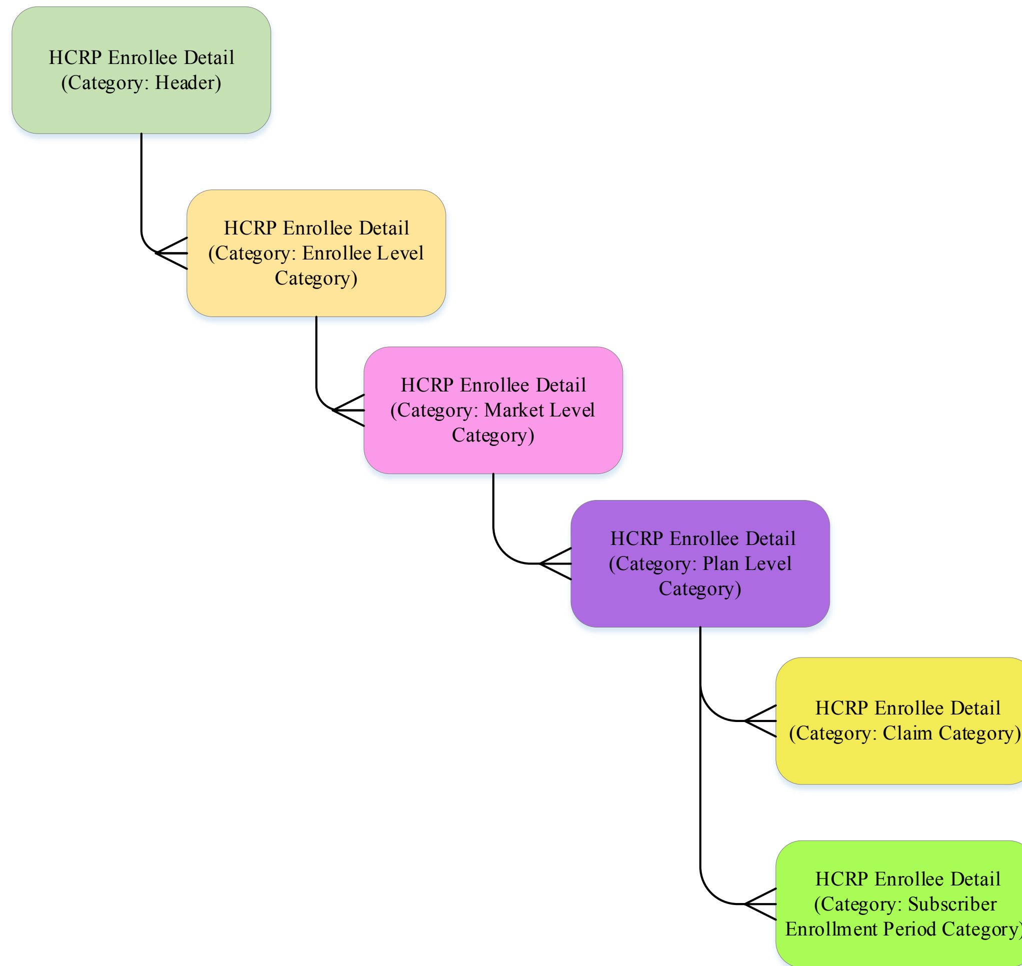
High Cost Risk Pool Detail Enrollee (HCRPDE) Message Format (or Record Layout) and Required Protocols

The outbound HCRPD Report is available to the issuer/submitting organization. This report contains issuer, market, plan, and enrollee level details used for the HCRP calculation. The HCRPD Report will be generated with the HCRP batch job.

1.1.1.4 File Layout

This section specifies the file layout for the HCRPD data file. At a high level it consists of five (5) record types or categories of information as shown in Figure 2.

Figure 2: EDGE Server HCRP Detai Enrolleel Report Data Categories



The HCRPD Report XSD consists of report File Header Category, Market Level Header Category, Plan Level Header Category, and Enrollee Level Header Category.

The HCRPD XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

1.1.1.5 Business Data Elements and Definitions

The data characteristics for the HCRP Detail Report Header category are as shown in Table 7. The root element of the HCRP Detail Report in the XSD is HCRPDetailReport.xsd (HCRPDetailReport.xsd). This element is required and all the other elements defined in this section for the HCRP Detail Report are embedded within this element start and end tags**.**

The HCRP Summary and Detail reports only include HCRP eligible enrollees and claims. HCRP eligible Claims and enrollees in the HCRP Summary and Detail report refer to all claims and enrollees that meet the standard HCRP claim/enrollee selection criteria for EDGE. System-generated enrollment periods are not required for EDGE to select cross-year claims for HCRP and are hence not selected.

“HCRP Payment Enrollees” refers only to those who qualified for HCRP payment – i.e., met standard selection criteria AND whose total paid claims amount from both markets (MOOP-adjusted where applicable) exceeded the HCRP attachment point. For more information on claim and enrollee selection for HCRP, please see Appendix D.

Table 7: HCRP Detail Report File Header Category Data

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify	File Header	1	includedFileHeader	RARICommonOutboundFile Header.xsd	none

Table 7: HCRP Detail Report File Header Category Data

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	the file header section of the report.					
Calendar Year	The calendar year for which HCRP was executed.	File Header	1	calendarYear	String	Strict: YYYY
Execution Type	Designate preliminary or final run.	File Header	1	executionType	String	minLength = 1; maxLength = 30 Enumeration Values: “P”: Preliminary “F”: Final
Enrollee	This XML element describes the Individual Market type header related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning.	Enrolee	1 or more per HCRP eligibleselected enrollee	includedInsuredMemberIdentifier	HCRPDetailEnrolleeReportEnrolleeCategory	none

The data characteristics for the HCRP Detail Report Enrollee Level Header category are as shown in Table 8. These elements are defined in the HCRP*DetailEnrolleeReportEnrolleeCategory.xsd*

Table 8: HCRP Detail Report Enrollee Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Unique Enrollee ID	Unique identifier for the enrollee.	Enrollee	1	insuredMemberIdentifier	String	minLength = 0; maxLength = 80
Total Member Months	Total member months for the enrollee =Sum of Total Member Months from enrollee's individual and small group market header levels	Enrollee	1	totMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Subscriber Member Month	Total subscriber member months for the enrollee = Sum of Subscriber Member Months from enrollee's individual and small group market header levels	Enrollee	1	totSubscrMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Premium	Sum of total premium for the enrollee = Total Premium from individual and small group market header level	Enrollee	1	totPremium	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total MOOP Adjusted Individual and Small Group Paid Amount	Sum of Total paid claim amount for the enrollee = Total MOOP Adjusted Claim Paid Amount from enrollee's individual and small group market header levels Note: MOOP adjustment is only applied to Individual market claims when the MOOP flag is "ON". MOOP adjustment is not applied to small group market claims	Enrollee	1	totMoopAdjIndSGPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 8: HCRP Detail Report Enrollee Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Total Allowed Claim Amount	Total allowed claims amount for the enrollee =Sum of Total Allowed Claims Amount from enrollee's from individual and small group market header level + Total Allowed Claims Amount from enrollee's individual market header levell	Enrollee	1	totAllowedAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Claim Count	Total count of claims for the enrollee = Sum of Total Claim Count from enrollee's individual and small group market header levels	Enrollee	1	totClaimCnt	Integer	minInclusive = 0; maxInclusive = 999999999
Total Paid Claim Amount Above Attachment Point	Total amount of paid claims that exceeds attachment point = Paid Claim Amount Above APfrom enrollee's small group market header level + MOOP-adjusted Paid Claim Amount Above AP from enrollee's individual market header level Note: This field will always be 0 for enrollees that are not HCRP payment enrollees	Enrollee	1	paidAmtAboveAP	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 8: HCRP Detail Report Enrollee Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
HCRP Payment	HCRP payment = HCRP Payment from enrollee's small group market header+ Payment enrollee's individual market header level = ((Total MOOP adjusted claim paid amount individual market level for the enrollee+ Total claim paid amount from the small group market level for the enrollee) – AP)*Co-insurance rate Note: This field will always be 0 for enrollees that are not HCRP payment enrollees	Enrollee	1	hcrpPayment	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Paid Claim amount Cross Year	Paid cross-year claims for the enrollee = Sum of Paid Amount of Cross Year claims from enrollee's individual and small group market header level + + Paid Amount of Cross Year claims from enrollee's individual market header level	Enrollee	1	paidAmtCY	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count Cross Year	Count of cross-year claims for the enrollee = Cross year Claim Count from enrollee's small group market header level + Cross year Claim Count from enrollee's individual market header level	Enrollee	1	claimCountCY	Integer	minInclusive = 0; maxInclusive = 999999999
Paid Claim amount Cross Year No EP	Sum of paid cross-year claims with no associated enrollment period in the current payment year for the enrollee Note: If the enrollee has HCRP eligible enrollment in the payment year, this field will have a 0 value	Enrollee	1	paidClaimAmtCYNoEp	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 8: HCRP Detail Report Enrollee Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Claim Count Cross Year No EP	Count of paid cross-year claims with no associated enrollment period in the current payment year for the enrollee Note: If the enrollee has HCRP eligible enrollment in the payment year, this field will have a 0 value	Enrollee	1	claimCountCYNoEp	Integer	minInclusive = 0; maxInclusive = 999999999
Paid Claim Amount Above Coinsurance	Paid Claim Amount Above Coinsurance =Sum of Claim Paid Amount Above Coinsurance values from from enrollee's individual market plans + Paid Claim Amount Above Coinsurance values from enrollee's small group market plans Note: This field will always be 0 for enrollees that are not HCRP payment enrollees	Enrollee	1	paidClaimAmtAbove Coinsurance	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Market Type	This XML element describes the Individual Market type header related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning.	Market	1 or more per market type	includedMarketType	HCRPDetailEnrolleeMarketTypeCategory	none

The data characteristics for the HCRP Detail Enrolee market category are as shown in Table 9. These elements are defined in the HCRPDetailEnrolleeMarketTypeCategory.xsd

Table 9: HCRP Detail Report Market Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Market Type	Market type for the plan: Individual or Small Group	Market	1	marketType	String	minLength = 0; maxLength = 30 Enumeration Values: “1”: Individual “2”: small Group
Total Member Months	Sum of Total member months from all <market type> plans for the enrollee in the payment year for which HCRP is executed.	Market	1	totMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Subscriber Member Months	Sum of all Total subscriber member months for from all <market type> plans for the enrollee in the payment year for which HCRP is executed	Market	1	totSubscrMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Premium	Sum of total premium for all <market type> plans for the enrollee.	Market	1	totPremium	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Claim Paid Amount	Sum of all Total Claim Paid Amounts from all <market type> plans for the enrollee	Market	1	totPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Individual MOOP Adjustment	Sum of all CSR MOOP Adjustment from all <individual market type> plans for the enrollee. Note: Will only be nonzero for individual market type when MOOP adustment flag is ON.This field will always be 0 for small group market typeplans	Market	1	indMOOPAdj	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 9: HCRP Detail Report Market Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
MOOP Adjusted Total Claim Paid Amount	Sum of MOOP-adjusted total paid claim amount for all < individual market type> plans for the enrollee. Note: MOOP Adjusted Total Paid Claim Amount will be equal to Total Paid Claim Paid Amount in the individual market when the MOOP flag is OFF. For small group market, MOOP Adjusted Total Paid Claim amount will always be equal to the Total Paid Claim Amount	Market	1	mOOPAdjTotPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Allowed Claim Amount	Sum of total allowed claim amount for all <market type> plans for the enrollee	Market	1	totAllowedAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Claim Count	Total count of claims for all <market type> plans for the enrollee	Market	1	totClaimCnt	Integer	minInclusive = 0; maxInclusive = 999999999
Total Paid Claim Amount Above Attachment Point	Sum of Total Paid Claim Amount Above Attachment Point from all <market type> plans for the enrollee Note: This field will always be 0 for enrollees that are not HCRP payment enrollees	Market	1	paidAmtAboveAP	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
HCRP Payment	Sum of all HCRP Payments from all <market type> plans for the enrollee. Note: This field will always be 0 for enrollees that are not HCRP payment enrollees	Market	1	hcrpPayment	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 9: HCRP Detail Report Market Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
HCRP Payment Market Percent	Proportion of HCRP payment enrollee's total paid amount from <market type> plans, calculated using the formulae below: % paid claims in individual market = Total MOOP adjusted claim paid amount from HCRP payment enrollees in the individual market /(Total MOOP adjusted claim paid amount from HCRP payment enrollees in the individual market + Total claim paid amount from HCRP payment enrollees in the small group market) % paid claims in small group market = Total claim paid amount from HCRP payment enrollees in the small group market /(Total MOOP adjusted claim paid amount from HCRP payment enrollees in the individual market + Total claim paid amount in the small group market) Note: This field will always be 0 for enrollees that are not HCRP payment enrollees	Market	1	hcrpPayMktPct	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Paid Claim Amount Cross Year	Sum of Cross Year Paid Claim Amount for an enrollee from all <market type> plans Note: Plan reference check to determine which market type for the claim belongs to, is done using the plan ID on the claim and the year of the start date/FillDate of the claim	Market	1	paidAmtCY	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 9: HCRP Detail Report Market Level Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Claim Count Cross Year	Sum of Cross Year Claim counts from all <market type> plans for the enrollee	Market	1	claimCountCY	Integer	minInclusive = 0; maxInclusive = 999999999
Paid Claim amount Cross Year No EP	Sum of paid amounts of cross-year claims with no associated enrollment period in the payment year, in all <market type> plans for an enrollee Note: If the enrollee has any enrollment in payment year in any plan belonging to any market type, this field will have a 0 value.for the enrollee	Market	1	paidClaimAmtCYNoEp	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
HCRP Claim Count Cross Year No EP	Count of cross-year claims with no associated enrollment period in the payment year, in all <market type> plans for an enrollee Note: If the enrollee has any enrollment in payment year in any plan belonging to any market type, this field will have a 0 value	Market	1	claimCountCYNoEp	Integer	minInclusive = 0; maxInclusive = 999999999
HCRP Claim Paid Amount Above Coinsurance	Sum of all HCRP Claim Paid Amount Above Coinsurance values from all <market type> plans for the HCRP payment enrollee Note: This field will be 0 for enrollees that not HCRP payment enrollees	Market	1	paidClaimAmtAboveCoinsurance	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Plan	This XML element describes the Individual Market type header related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning.	Plan	1 or more per plan belonging to HCRP selected enrollee	includedPlanIdentifier	HCRPDetailEnrolleeReportPlanCategory	none

The data characteristics for the HCRP Detail Enrollee Report Plan Level Header category are as shown in **Table 10**. These elements are defined in the *HCRPDetailEnrolleeReportPlanCategory.xsd*

Table 10: HCRP Detail Report Plan Level Header Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan Identifier	Unique identifier for the plan.	Plan	1	insurancePlanIdentifier	String	Length = 16 Format: HIOS Issuer ID + State Code + HIOS Product ID + HIOS Component ID + Variant (ex. 12345VA001999901) (only alphanumeric)
Total Member Months	Total member months for the enrollee in the plan for the payment year for which HCRP is executed. For each enrollee, member months are calculated by dividing the days in enrollment period in the payment year in the plan by 30	Plan	1	totMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Subscriber Member Months	Total Subscriber member months for the enrollee in the plan for the payment year for which HCRP is executed For each enrollee, subscriber member months are calculated by dividing the days in subscriber enrollment period in the payment year in the plan by 30	Plan	1	totSubscrMM	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 10: HCRP Detail Report Plan Level Header Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Total Premium	Sum of total premium, for the subscriber enrollment periods in the payment year in the plan for the enrollee. . Total premium for each subscriber enrollment period is calculated by multiplying subscriber member months in the payment year by the monthly premium for the period	Plan	1	totPremium	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Paid Claim amount	Sum of all paid claim amounts for the claims (including cross year claims) that belong to the plan for the enrollee.	Plan	1	totPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Individual MOOP Adjustment	Sum of all CSR MOOP adjustments from all subpolicies belonging to the plan for the enrollee Note: Will only be non zero for individual market plans " when MOOP adustment flag is ON.This field will always be 0 for small group market plans	Plan	1	indMOOPAdj	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 10: HCRP Detail Report Plan Level Header Category Data						
Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
MOOP Adjusted Total Paid Claim amount	Subtraction of the Individual MOOP Adjustment field for enrollee's plan from the Total Paid Claim Amount field for the enrollee's plan Note: MOOP Adjusted Total Paid Claim amount will be equal to Total Claim Paid Amount for individual market plans when the MOOP flag is OFF. For the small group market plans, MOOP Adjusted Total Paid Claim amount will always equal to the Total Paid Claim amount	Plan	1	mOOPAdjTotPaidAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Allowed Claim Amount	Sum of allowed claim amounts in the plan for the enrollee	Plan	1	totAllowedAmt	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Total Claim Count	Total unique count of claims in the plan for the enrollee	Plan	1	totClaimCnt	Integer	minInclusive = 0; maxInclusive = 999999999

Total Paid Claim Amount Above Attachment Point	Total Paid Claim Amount Above Attachment Point for the enrollee in the plan, prorated by enrollee's percent of total paid claims in the plan To calculate this, the following formulas are implemented for the enrollee's plan Enrollee level Total Paid Claim Amount Above Attachment Point = ((Total MOOP adjusted claim paid amount across all individual market plans for the enrollee+ Total claim paid amount across all small group market plans for the enrollee) – AP) % paid claims in the plan for the enrollee(If individual plan)= Total MOOP adjusted claim paid amount in the plan/(Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) % paid claims in the plan for the enrollee (If small group plan)= Total claim paid amount in the plan /(Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) Plan level Total Paid Claim Amount above AP for the enrollee = % paid claims in the plan * Enrollee level Total Paid Claim Above Attachment Point	Plan	1	paidAmtAboveAP	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
HCRP Payment	HCRP payment of enrollee in plan, prorated by enrollee's percent of total paid claims in the plan	Plan	1	hcrpPayment	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 10: HCRP Detail Report Plan Level Header Category Data

Business Data Element	Description	Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	To calculate this, the following formulae are implemented for the enrollee's plan Enrollee level HCRP Payment = ((Total MOOP adjusted claim paid amount across all individual market plans for the enrollee+ Total claim paid amount across all small group market plans for the enrollee) – AP)*Co-insurance rate % paid claims in the plan for the enrollee(If individual)= Total MOOP adjusted claim paid amount in the plan/(Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) % paid claims in the plan for the enrollee (If small group)= Total claim paid amount in the plan /(Total MOOP adjusted claim paid amount across all individual market plans+ Total claim paid amount across all small group market plans) Plan level HCRP payment for the enrollee = % paid claims in the plan * Enrollee level HCRP Payment					

HCRP Payment Plan Percent	Proportion of HCRP payment enrollee's total paid claim amount attributable to this plan : % paid claims in individual market plan for the enrollee= Total MOOP adjusted claim paid amount from the HCRP payment enrollee in the individual market plan /(Total MOOP adjusted claim paid amount from the HCRP payment enrollee in all individual market plans + Total claim paid amount from the HCRP payment enrollee in all small group market plans) % paid claims in small group market plan for the enrollee= Total claim paid amount from the HCRP payment enrollee in the small group market plan /(Total MOOP adjusted claim paid amount from the HCRP payment enrollee in all individual market plans + Total claim paid amount from the HCRP payment enrollee in all small group market plans) Note: If the MOOP adjustment flag is off, the system shall use total claim paid amount in the individual market plan instead of total MOOP Adjusted claim amount in the above formulas. If the enrollee does not have an HCRP payment, then this field will be zero.	Plan	1	hcrpPmtPlanPct	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Paid Claim amount Cross Year	Sums of paid claim amounts from cross year claims in the plan for the enrollee	Plan	1	paidAmtCY	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count Cross Year	Count of cross year claims in the plan for the enrollee	Plan	1	claimCountCY	Integer	minInclusive = 0; maxInclusive = 999999999

Table 10: HCRP Detail Report Plan Level Header Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Paid Claim amount Cross Year No EP	Sum of enrollee's paid amounts of cross-year claims in the plan that are not associated with an enrollment period in the payment year Note: If the enrollee has any enrollment period in the payment year in any plan belonging to any market type, this field will have a 0 value	Plan	1	paidClaimAmtCYNoEp	Decimal	minInclusive = 0 maxInclusive = 999999999999.99
Claim Count Cross Year No EP	Sum of enrollee's paid amounts of cross-year claims in the plan that are not associated with an enrollment period in the payment year Note: If the enrollee has any enrollment period in the payment year in any plan belonging to any market type, this field will have a 0 value	Plan	1	claimCountCYNoEp	Integer	minInclusive = 0; maxInclusive = 999999999
HCRP Claim Paid Amount Above Coinsurance	Calculated using the following formula for each plan for the enrollee: Total Paid Claim above AP (plan level) - HCRP Payment (plan level) Note: This field will be 0 for enrolleees that are not HCRP payment enrollees	Plan	1	paidClaimAmtAboveCoinsurance	Decimal	minInclusive = 0 maxInclusive = 999999999999.99

Table 10: HCRP Detail Report Plan Level Header Category Data						
Business Data Element	**Description**	**Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Claim	This XML element describes the Individual Market type header related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning.	Claim	1 or more per HCRP selected claim	includedClaimIdentifier	HCRPDetailEnrolleeReportClaimCategory	none
Subscriber Enrollment Period	This XML element describes the Individual Market type header related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning.	Claim	1 or more per HCRP selected Subscriber Enrollment Period for the enrollee	includedSubscriberPeriod	HCRPDetailEnrolleeReportSubcriberPeriodCategory	none

The data characteristics for the HCRP Detail Enrollee Report claim category are as shown in Table 11. These elements are defined in the HCRPDetailEnrolleeReportClaimCategory*.xsd*

Table 11: HCRP Detail Report Claim Category Data						
Business Data Element	**Description**	**Data Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Claim ID	Unique number generated by the issuer adjudication system to uniquely identify the transaction. The issuer adjudicated Claim ID may be de-identified by the issuer.	Claim	1	claimIdentifier	String	minLength = 0; maxLength = 50 **Note**: If issuer has multiple platforms that use identical Claim ID numbers, then the issuer must make Claim IDs unique or rejects for duplicate claims will result.
Claim Paid Amount	Total amount paid by enrollee's plan.	Claim	1	claimPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999999.99
Cross Year Claim Indicator	Identifies if the claim is a cross year claim.	Claim	1	crossYearClaimIndicator	String	Length = 1 Enumeration Values: “Y”, “N”

The data characteristics for the HCRP Detail Enrollee Report subscriber enrollment period category are as shown in T**able 12**. These elements are defined in the *HCRPDetailReportSubscriberEnrollmentPeriodCategory.xsd*

Table 12: HCRP Detail Report Subscriber Enrollment Period Category Data						
Business Data Element	**Description**	**Data Category**	**Frequency of Occurrence**	**XML Element Names**	**Data Type**	**Restrictions**
Coverage Start Date	Coverage start date of the subscriber period.	Subscriber Enrollment Period	1	coverageStartDate	Date	Length = 10 Strict: YYYY-MM-DD
Coverage End Date	Coverage end date of the subscriber period.	Subscriber Enrollment Period	1	coverageEndDate	Date	Length = 10 Strict: YYYY-MM-DD
Subscriber Months	Member months in the subscriber period: calculated by dividing the days in the period by 0	Subscriber Enrollment Period	1	subscriberMonths	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Monthly Premium	Per month premium for the subscriber period	Subscriber Enrollment Period	1	monthlyPremium	Decimal	minInclusive = 0; maxInclusive = 999999999999.99

Communication Methods

This section describes the communication methods for the EDGE server. All communication between the EDGE server and CMS Management Console will use Secure Sockets Layer (SSL), namely Secure Shell (SSH)/Secure File Transfer Protocol (SFTP) and Hyper Text Transfer Protocol Secure (HTTPS). Further, all Web browser communication with the EDGE server will also be done using HTTPS. Internet Protocol (IP) Tables will be configured for the EDGE server to restrict incoming and outgoing network traffic across the server only for specific ports.

- Interface Initiation

The system operates on a SFTP interface along with user interface for lightweight submission and report access with 24/7 availability.

- Flow Control

Prior to start of the submission file structure and data validations, the system will create a backup of the inbound file and the data repository. After the data processing logic is executed, the system will create another backup of the outbound files and the data processing. This allows the system to recover from any failures and minimize reprocessing of data.

Notification of failures will be communicated to the EDGE server user through email. Detailed processing reports will sent to the issuer/submitter to correct the erroneous data and allow for resubmittal of the corrected information. The detailed error report will identify the records that are in error including the data element, submitted value and the detailed error message flagging the error. This allows the user to quickly identify their errors and apply the appropriate data corrections. The issuer/submitter can view the reports or data files using their Web browser user interface. Alternatively, they can download the files using SFTP either manually or as part of an automated process. The error reports will be placed in the output folder of the EDGE server application.

Security Requirements

The security requirements for accessing the outbound files are described in the existing EDGE server RARI ICD published on REGTAP, document number: *0.0.4-CMSES-ICD-4763*.

Acronyms

Table 13: Acronyms

Acronym	Literal Translation
ACA	Affordable Care Act of 2010
APTC	Advanced Premium Tax Credit
CCIIO	Center for Consumer Information and Insurance Oversight
CEFR	EDGE Server Claim and Enrollee Frequency Report
CMS	Centers for Medicare & Medicaid Services
CMS-ES	CMS-EDGE Server
CPT/HCPCS	Current Procedural Terminology/ Healthcare Common Procedure Coding System
CSR	Cost Sharing Reduction
DOB	Date Of Birth
Dx	Diagnosis
ECD	Enrollee Claims Detail
ECS	Enrollee Claims Summary
EDI	Electronic Data Interchange
ES	EDGE Server
ESES	EDGE Server Enrollment Submission
ESMCS	EDGE Server Medical Claims Submission
ESPCS	EDGE Server Pharmacy Claims Submission
ESSFS	EDGE Server Supplemental File Submission
FDEEAF	Frequency by Data Element for Enrollment Accepted Files Report
FDEPAF	Frequency by Data Element for Pharmacy Accepted Files Report
FDEMAF	Frequency by Data Element for Medical Accepted Files Report
FDESAF	Frequency by Data Element for Supplemental Accepted Files Report
HCC	Hierarchical Condition Category
HHS	Health & Human Services
HIPAA	Health Insurance Portability and Accountability Act
HTTPS	Hypertext Transfer Protocol Secure
ICD	Interface Control Document
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
IP	Internet Protocol
IVA	Initial Validation Audit
IVAS	Initial Validation Audit Statistics
MC	Medical Claim
MOOP	Maximum Out Of Pocket
MR	Medical Record
NDC	National Drug Code

Acronym	Literal Translation
NPI	National Provider Identifier
PHI	Protected Health Information
RA	Risk Adjustment
RACSD	Risk Adjustment Claim Selection Detail Report
RACSS	Risk Adjustment Claim Selection Summary Report
RADV	Risk Adjustment Data Validation
RADVDE	Risk Adjustment Data Validation Detailed Enrollee Report
RADVEE	Risk Adjustment Data Validation Enrollment Extract Report
RADVIVAS	Risk Adjustment Data Validation Initial Validation Audit Statistics Report
RADVMCE	Risk Adjustment Data Validation Medical Claim Extract Report
RADVPS	Risk Adjustment Data Validation Population Summary Statistics Report
RADVSE	Risk Adjustment Data Validation Supplemental Extract Report
RARSD	RA Risk Score Detail Report
RARSS	Risk Adjustment Risk Score Summary Report
RATEE	Risk Adjustment Transfer Elements Extract
RAUF	Risk Adjustment User Fee
RI	Reinsurance
RIDE	Reinsurance Detail Enrollee Report
RISR	Reinsurance Summary Report
RxC	Pharmacy Claim
SE	EDGE Server System Error Report
SFTP	Secure File Transfer
SSH	Secure Shell
SSL	Secure Sockets Layer
XML	Extensible Markup Language
XSD	XML Schema Definition

Appendix A EDGE Server Outbound Reports XSDs

This section presents the XSD schema for the outbound reports generated by the EDGE server. The issuer/submitter will utilize these files to process the XML instance of these reports. These files are located in the REGTAP Library at https://www.REGTAP.info/.

- RA Claim Selection Detail
- RA Claim Selection Summary
- RA Risk Score – Detail
- RA Risk Score – Summary
- RA User Fee
- RA Transfer Elements Extract
- RI Summary
- RI Enrollee Detail
- RADV Population Statistics Report
- Enrollee (With and Without) Claims – Detail
- Enrollee (With and Without) Claims – Summary
- Frequency by Data Element for Enrollment Accepted Files
- Frequency by Data Element for Pharmacy Accepted Files
- Frequency by Data Element for Medical Accepted Files
- Frequency by Data Element for Supplemental Accepted Files
- System Error Report
- Claim and Enrollee Frequency Report
- Claim Resubmission Report

Appendix B Referenced Documents

Table 14: Referenced Documents

Document Name	Document Number / URL	Issuance Date
Interface Control Document (ICD) Version 02.01.07	URL: https://www.REGTAP.info Document Number: 0.0.4-CMSES-ICD-4763	8/11/2015

Appendix C System Error Codes

This section defines the Error Codes that will be used for the EDGE Server System Error outbound Report. The table below specifies the Error Codes:

Table 15: System Error Codes

Unique Error Code	Error Code Description
100	Java.lang.OutOfMemoryError: Java heap space

Appendix D HCRP Enrollee and Claim Selection

Table 16: HCRP Enrollee and Claim Selection Criteria

Enrollee/Claim	Selection Criteria
Enrollee	**HCRP Eligible Enrollee – Enrollee that meets all the criteria below:** Enrollees with 1 or more HCRP eligible claims for the payment year OR Enrollees with no HCRP eligible claims and that have an active enrollment period for the payment year as defined by the following rules: 1. Plan is an active plan as defined in the plan reference table. The system will use the 16 digit plan ID of the enrollment period and the payment year for which HCRP was executed to do the plan reference check 2. Enrollment period's enrollment start date =< Dec 31st of the payment year. 3. Enrollment period's enrollment end date => Jan 1st of the payment year. 4. Enrollment period's rating area is active in the rating area reference table for the 14 digit plan on the enrollment period. The system will use the rating area of the enrollment period, 16 digit plan ID of the enrollment period and the payment year for which HCRP was executed to do the rating area reference check **HCRP Payment Enrollee** – HCRP selected enrollees whose sum of MOOP Adjusted Individual Market Paid Claims and Total Small Group Market Paid Claims exceed the attachment point (Note: MOOP adjustment is only applied if the MOOP adjustment flag is on)

<table>
<tr><th>Enrollee/Claim</th><th>Selection Criteria</th></tr>
<tr><td>Claim</td><td>HCRP Eligible Claim -- Claim (this includes cross year claims) that meets all the criteria below:

All Claims:
1. Claim is active
2. Enrollee ID in the claim must match an active Enrollee ID in the enrollment table
3. The 16 digit Plan ID on the claim must match the 16 digit Plan ID of at least one active enrollment period for the enrollee
4. The 16 digit Plan on the claim is an active as defined by the plan reference table for the year of the statement covers from date or Fill date
5. The enrollee has enrollment in at least one rating area for the 16 digit plan on the claim
For Medical Claims:
1. Statement Cover through date must be >= Jan 1st of the Payment Year and <= Dec 31st of the Payment Year.
2. Statement Cover From Date must be >= the enrollment coverage start date of the enrollment period and <= enrollment coverage end date of the enrollment period with the same plan ID and enrollee ID as the claim
For Pharmacy Claims:
1. Fill Date must be >= Jan 1st of the Payment Year and <= Dec 31st of the Payment Year.
2. Fill Date must be >= the enrollment coverage start date of the enrollment period and <= enrollment coverage end date of the enrollment period with the same plan ID and enrollee ID on the claim</td></tr>
</table>

Appendix E Document Control History

The table below records information regarding changes made to this document prior to the most recent maintenance release of this ICD Addendum.

Version Number	Date	Author/Owner	Description of Change
05.00.22	12/110/2014	Accenture / CCIIO	Create separate ICD Addendum for HCRPReports

Centers for Medicare & Medicaid Services

CMS-EDGE Server / CMS-ES

Risk Adjustment and Reinsurance (RARI) Interface Control Document – Enrollee Claims and Frequency Addendum

February 11, 2019

Document Version History – Recent changes

The table below reflects the summary of changes incorporated in the most recent maintenance release of this ICD addendum.

Version Number	Date	Author/Owner	Description of Change
05.00.22	12/7/18	Accenture / CCIIO	Create separate ICD Addendum for Frequency Reports **For changes prior to version 05.00.22, refer to the RARI ICD Consolidated Version History

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1 Purpose of Interface Control Document

This Interface Control Document (ICD) Addendum was created from the consolidated Risk Adustment (RA) and Reinsurance (RI) ICD Addendum that was separated into the following five documents:

- RARI ICD- RA Addendum,
- RARI ICD- Risk Adjustment Data Validation (RADV) Addendum,
- RARI ICD- RI Addendum,
- RARI ICD- High Cost Risk Pool (HCRP) Addendum, and
- RARI ICD- Issuer Frequency Report Addendum.

This RARI ICD Addendum is for the Frequency outbound reports, and does not contain information regarding the remaining four (4) ICDs listed above. Following is the link to the Registration For Technical Assistance Portal (REGTAP) library for the five (5) ICD Addendums listed above: https://www.regtap.info/reg_library.php.

The RARI ICD (and its accompanying addenda) documents and tracks the necessary information required to effectively define the Centers for Medicare & Medicaid Services (CMS) External Data Gathering Environment (EDGE) server system interface, as well as any rules for communicating with the EDGE servers, to give the development team guidance on the architecture of the system to be developed. In addition, the purpose of the ICD is to clearly communicate all possible inputs for all potential actions. The RARI ICD helps ensure compatibility between system segments and components.

The RARI ICD does not include information about specific business rules or how the verification edits included within this document affect the file processing logic. Additional information can be found in the EDGE Server Business Rules (ESBR) document available at https://www.regtap.info/reg_librarye.php?i=2673

.

2 Introduction

This is one of five addenda to the existing RARI ICD, which describes the relationship between CMS and the issuer's EDGE server. This document serves to define additional reports that will be produced by the issuer's EDGE servers as a supplement to the ICD, currently published in the Registration for Technical Assistance Portal (REGTAP) Library. These reports include the risk adjustment and reinsurance calculation reports that are used for payment processing, as well as additional analytic reports.

The CMS-EDGE server interface is only necessary when CMS is operating the Risk Adjustment and/or Reinsurance programs on behalf of a state.

The following information, with respect to the interface, is described further in this document:

- Additional EDGE server outbound report formats.

3 Overview

As part of the Affordable Care Act (ACA), two (2) programs were identified to mitigate the impact of adverse selection of plans and provide stability for issuers. States have the option to operate the following programs themselves or have the Department of Health and Human Services (HHS) operate the programs on their behalf.

- Section 1343 of the ACA created the Risk Adjustment (RA) program to better spread the financial risk borne by health insurance issuers in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. Under the RA program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Non-grandfathered, Individual and Small Group Market plans, irrespective of whether they are a part of the Marketplace, will submit RA data (claims and enrollee data) that will be

used to determine individual-level risk scores, plan average actuarial risk and associated payments and charges.
- Section 1341 of the ACA establishes the Reinsurance (RI) program as a temporary three-year program that commences in 2014. RI provides funds to issuers that incur high costs for claims in the Individual Market. In accordance with the final rule, RI payments are based on a coinsurance rate or proportion of an issuer's claims costs that are above an attachment point and below a RI cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for RI payments, while the RI cap is the dollar limit at which point an issuer is no longer eligible for RI payments. The attachment point, coinsurance rate and RI cap are calculated based on an issuer's total incurred costs for an individual enrollee in a given calendar year. Non-grandfathered, Individual Market plans, both on and off the Marketplace, will submit RI data (claims and enrollee data) that will be used to determine if an individual market plan issuer is eligible for RI.

CMS' Center for Consumer Information and Insurance Oversight (CCIIO) on behalf of HHS will develop the software to evaluate and perform the RA and RI calculations.

When evaluating the model for collecting and processing the data received from issuers, it was determined that a distributed data collection model would prove the most effective. Specifically, this model would ensure:

- Issuer proprietary data would not be transmitted to HHS;
- Minimal transfer of protected health information (PHI) to lower privacy and data security risks;
- Standardization of business processes, timing and rules.

These factors resulted in the concept of the EDGE server. Issuers, in states where HHS is operating an RA and/or RI program, will submit enrollee, pharmacy claim, medical claim and supplemental diagnosis information from their proprietary systems to an issuer-owned or Third Party Administrator (TPA)-hosted EDGE server. The EDGE server will run HHS-developed software designed to verify submitted data and execute the RA and RI processes. Issuers will have the option to own and operate the server themselves, or to have a third-party entity operate the server. Detailed data, file processing metrics and outbound data files will be provided to insurance companies/issuers. Only plan summarized data and file processing metrics will be provided to HHS.

4 General Interface Requirements

Interface Overview

This section describes updates to the EDGE server interface as a result of the additional reports defined in this document. For a complete description of the general interface requirements, refer to the existing EDGE server ICD, published in the REGTAP Library (Interface Control Document, document number: *0.0.4-CMSES-ICD-4763*).

Functional Allocation

The primary responsibility of the EDGE server is to provide distributed data processing capabilities to support RA and RI. The results of the data processing are available to CMS, insurance companies and their associated issuers through reports in the form of data files. Output reports can be generated in the Production, Test or Validation zones.

The reports defined in this document can be initiated by one (1) or more of the following methods:

- CMS Initiated Remote Command
- Issuer Executed EDGE Server Command

Transactions

The following reports are defined in this document. Once executed, all files are provided to the issuer/submitter and files with summary data only are provided to CMS for review.

- Enrollee Claims – Summary
- Enrollee Claims – Detail
- Frequency by Data Element for Enrollment Accepted Files
- Frequency by Data Element for Pharmacy Accepted Files
- Frequency by Data Element for Medical Accepted Files
- Frequency by Data Element for Supplemental Accepted Files
- System Error Report
- Claim and Enrollee Frequency Report
- Claim Resubmission Report

There are several types of outbound data files that will be sent to the issuer/submitter and to CMS as part of this process, including the following:

- Process Oriented Reports
- Operations Analytics Reports
- Management Reports
- Payment Processing Reports

The recipient of these outbound files is restricted by the content level of the files as specified by the table below.

Table 1: Report Type and Recipient

Report Type	Report Recipient
File Level Reports	Issuer/Submitter and CMS
Detail Reports	Issuer/Submitter
Summary Reports	Issuer/Submitter and CMS
Activity To Date Reports	Issuer/Submitter and CMS

Process Oriented Reports are data files generated for the issuer/submitter based on the results of the data processing of the submitted data file. This category includes the following report types:

Operations Analytics Reports are data files that help the user in understanding various operational metrics identified, thereby allowing process improvements. This also helps CMS/CCIIO in reaching out to the issuer/submitter to address any aberrant patterns.

Management Reports are outbound files of summary data used by management to gauge the execution of the overall process.

Payment Process Outputs are outbound files used to calculate the RA and RI payment amounts that will be applied for each issuer.

5 Detailed Interface Requirements

This section specifies the requirements for the interface between the insurance company/ submitting organization and the EDGE server. This includes explicit definitions of the content and format of every message or file that is expected to be transmitted between the insurance company/submitting organizations and the EDGE server and the conditions under which each file is to be sent.

Requirements for Additional EDGE Server Outbound Reports

This section describes the additional outbound report formats that will be made available to the issuer and CMS to review and analyze the processing results of the enrollment, claims and supplemental diagnosis information submitted for RI and RA processing. The files will be eXtensible Markup Language (XML) based and as per the XML Schema Definition (XSD) defined in this document.

This document describes the following reports:

- Reports sent to the insurance company/issuer administrator only:
  - Enrollee Claims Detail
- Reports sent to both the insurance company/issuer administrator and CMS:
  - Enrollee Claims Summary
  - Frequency by Data Element for Enrollment Accepted Files
  - Frequency by Data Element for Pharmacy Accepted Files
  - Frequency by Data Element for Medical Accepted Files
  - Frequency by Data Element for Supplemental Accepted Files
  - System Error Report
  - Claim and Enrollee Frequency Report

– Claim Resubmission Report

As the design of the remaining reports is completed, this document will be updated.

Assumptions

The assumptions for the delivery of the EDGE server outbound files are as follows:

- Outbound reports are posted to the issuer's Amazon Web Services (AWS) S3 file repository or On-Premise server output directory designated for the remote command execution zone, as described for each report in the below sections.
- Issuers will have a separate Amazon Web Services (AWS) S3 file repository or On-Premise server output directory for the validation zone, independent of the file repositories or output directories for the production and test zone.
- The data files defined to date are XML documents. As the requirements are refined, this section will be updated to reflect the final file layout and data characteristics.

General Processing Steps

After the enrollee and claim files have been validated, designated entities, as determined by the insurance company/issuer administrator, will receive information about the status of their submission through a series of file processing reports. Similarly, CMS/CCIIO will be issued summary reports which provide the status and metrics of the data being processed. All insurance company/issuer reports will be delivered to the AWS S3 bucket configured for the issuer for AWS servers or the server's output directory for On-Premise servers. Summary reports will be delivered to the CMS/CCIIO AWS S3 bucket.

File Naming Convention

All files produced will follow the standard naming convention outlined below.

File Format Mask:

<Submitting Entity ID>.<File Type>.D<YYYYMMDD>T<hhmmss>.<Execution Zone>.xml

Example File Name:

12345. ECD.D20140402T091533.P.xml

Table 2: File Name Parameters

Parameter	Description	Enumeration Values
Submitting Entity ID	Must be the 5 digit HIOS assigned Issuer ID.	**Example:** 12345
Date Timestamp	The date timestamp of when the file was generated.	**Example:** For April 2, 2014 at 9:15:33 AM Date Timestamp: D20140402T091533
Execution Zone	One (1) letter code indicating the execution zone where the file is to be processed.	Production:' P' Test: 'T' Local: 'L' Validation: 'V'

Shared Outbound Report Data Components Message Format (or Record Layout) and Required Protocols

The structure of the EDGE server output reports has two (2) components:

Common Header category that is reused across the defined output reports; and

- Data elements/structures that are specific to a given report

5.1.1.1 Record Layout and Required Protocols for Common Outbound File Header Record

The data contents of the common outbound file header record data structure include report file identifier, report execution date, file identifier included in the submitted file, date of submission file generated by issuer/submitter, date of submission file received by the EDGE server, report type, sender identifier (EDGE server identifier) and submitter identifier associated with the submission.

5.1.1.1.1 Business Data Element Descriptions and Technical Characteristics

The data characteristics for the Common Outbound File Header Data Structure are as shown in Table 3. These elements are defined in the *RARICommonOutboundFileHeader.xsd*.

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
File ID	The CMS system generated unique identifier of a report file.	File Header	1	outboundFileIdentifier	String	minLength = 1 maxLength = 80
CMS Batch ID	CMS generated identifier to uniquely identify a batch job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsBatchIdentifier	String	minLength = 1 maxLength = 50
CMS Job ID	CMS generated identifier to uniquely identify the job. Note - This field is only populated for reports executed as a result of a CMS initiated remote command.	File Header	1	cmsJobIdentifier	String	minLength = 1 maxLength = 50

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Snap Shot File Name	File name of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileName	String	none
Snap Shot File Hash	Hash value of the database snap shot generated during the transfer process.	File Header	0…1	snapShotFileHash	String	none
Run Date	The date and time when the CMS processed file is generated.	File Header	1	outboundFileGenerationDateTime	String	Strict: YYYY-MM-DDTHH:mm:SS
Interface Control Release Number	Denotes the version number of the ICD that the file corresponds to as identified on page one (1) of this document.	File Header	1	interfaceControlReleaseNumber	String	Length = 8
EDGE Server Version	Version number that corresponds to the Application, Database, Operating System, and reference table versions that were used to process the inbound file and produce the report. The application version in the execution zone for which the report is generated, will be displayed in this field.	File Header	1	edgeServerVersion	String	minLength = 0; maxLength = 75

Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Job ID	System generated unique identifier for job executed on the EDGE server.	File Header	0… 1	edgeServerProcessIdentifier	String	minLength = 0; maxLength= 12
Report Type	Defines values of outbound validation report.	File Header	1	outboundFileTypeCode	String	minLength = 1 maxLength = 30
Server ID	The unique identifier of an EDGE server.	File Header	1	edgeServerIdentifier	String	minLength = 1 maxLength = 12
Issuer ID	The unique identifier for an issuer.	File Header	1	issuerIdentifier	String	Length = 5

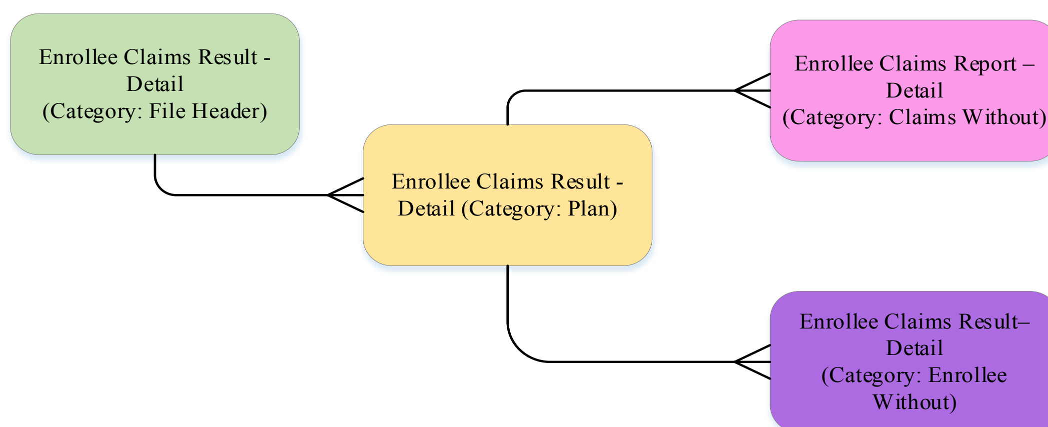
Enrollee Claims Detail (ECD) Message Format (or Record Layout) and Required Protocols

The outbound ECD Report is available only to the issuer/submitting organization. This report contains information on enrollees without linked claims. The ECD Report will be generated independently with the Enrollee Claims Summary (ECS) Report through a remote command.

5.1.1.2 File Layout

This section specifies the file layout for the ECD Report. At a high level, it consists of four (4) record types or categories of information, as shown in Figure 1.

Figure 1: EDGE Server Enrollee Claims Detail



The ECD Report consists of report File Header, Plan, Claims Without and Enrollee Without level categories.

The ECD XSD Report schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.3 Field/Data Elements and Descriptions

The data characteristics for the Enrollee Claims Detail (ECD) category are as shown in Table 4. The root element of the ECD in the XSD is EnrolleeClaimsWithWithoutDetailReport (*EnrolleeClaimsWithWithoutDetailReport.xsd*). This element is required and all the other elements defined in this section for the ECD are embedded within this element start and end tags.

Table 4: ECD Enrollee Claims Detail File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader	none
Calendar Year	This is the calendar year specified by the remote command parameter.	Issuer Year	1	issuerYear	String	Strict: YYYY
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report.	Plan	1 or more per insurance plan per in the reported submission file	includedPlanIdentifier	EnrolleeClaimsWithWithoutDetailPlanCategory	none

The data characteristics for the Enrollee Claims Detail Plan category are as shown in Table 5. These elements are defined in the *EnrolleeClaimsWithWithoutDetailPlanCategory.xsd*.

Table 5: ECD Enrollee Claims Detail Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique identifier for plan.	Plan	1	planIdentifier	String	Length = 16
Total Number of Active Enrollment Records	Total number of all active enrollment records for the Plan ID with at least one (1) day within the calendar year.	Plan	1	totalNumberOfActiveEnrollmentRecords	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Stored Active Claims	Total number of stored active claims for the Plan ID where: Medical/Pharmacy claims; Statement Covers Through date is within the calendar year. Statement Covers From date is with an active enrollment period for the enrollee. Pharmacy Claims; Fill Date within the calendar year, and Fill Date is within an active enrollment period.	Plan	1	totalNumberOfStoredActiveClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Enrollees With Linked Claims	Total number of enrollees with one (1) or more linked claims for the Plan ID; claims are linked by Enrollee ID on the enrollment period where: Medical/Pharmacy claims; Statement Covers Through date is within the calendar year. Statement Covers From date is with an active enrollment period for the enrollee. Pharmacy Claims; Fill Date within the calendar year, and Fill Date is within an active enrollment period.	Plan	1	totalNumberEnrolleesWithLinkedClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Enrollee Linked Claims Flagged for RA Claim Selection	Total number of stored active claims that have been flagged for RA during RA claim selection.	Plan	1	totalNumberEnrolleelinkClaimFlaggedRaClaimSelection	Integer	minInclusive = 0; maxInclusive = 999999999

Table 5: ECD Enrollee Claims Detail Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Number of Enrollees With No Linked Claims	Total number of enrollees with zero (0) linked claims for all enrollment periods in the Plan ID. A claim is considered linked if it meets the criteria described below: Medical/Pharmacy claims; Statement Covers Through date is within the calendar year. Statement Covers From date is with an active enrollment period for the enrollee. Pharmacy Claims; Fill Date within the calendar year, and Fill Date is within an active enrollment period.	Plan	1	totalNumberOfEnrolleesNoLinkedClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Number of Claims With No Linked Enrollee ID	Total number of claims with no linked Enrollee ID for the Plan ID. A claim is considered linked if it meets the criteria described below: Medical/Pharmacy claims; Statement Covers Through date is within the calendar year. Statement Covers From date is with an active enrollment period for the enrollee. Pharmacy Claims; Fill Date within the calendar year, and Fill Date is within an active enrollment period.	Plan	1	totalNumberOfEnrolleesNoLinkedEnrolleeID	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollee without Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report. The XML elements defined in the Supplemental Diagnosis Plan Processing Result category are within this element as defined in the XSD.	Enrollee	1	includedEnrolleeWithout	EnrolleeClaimsWithWithoutDetailEnrolleeCategory	none
Claim without Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report. The XML elements defined in the Supplemental Diagnosis Plan Processing Result category are within this element as defined in the XSD.	Claim	1	includedClaimWithout	EnrolleeClaimsWithWithoutDetailClaimCategory	none

The data characteristics for the Enrollee Claims Detail Enrollee Without category are as shown in Table 6. These elements are defined in the *EnrolleeClaimsWithWithoutDetailEnrolleeCategory.xsd*.

Table 6: ECD Enrollee Claims Detail Enrollee Without

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Active Enrollee IDs Without Claims	Active enrollees with zero (0) linked claims for all enrollment periods in the Plan ID. A claim is considered linked if it meets the criteria described below: Medical/Pharmacy claims; Statement Covers Through date is within the calendar year. Statement Covers From date is with an active enrollment period for the enrollee. Pharmacy Claims; Fill Date within the calendar year, and Fill Date is within an active enrollment period.	Enrollee	0 or more	activeEnrolleeIDswithoutClaims	String	minLength = 0; maxLength = 80

The data characteristics for the Enrollee Claims Detail Claims Without category are as shown in Table 7. These elements are defined in the *EnrolleeClaimsWithWithoutDetailClaimCategory.xsd*.

Table 7: ECD Enrollee Claims Detail Claims Without

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Active Claims IDs Without Enrollee Records	Active Claim IDs within the calendar year that does not fall within an active enrollment period according to the criteria below: Medical/Pharmacy claims; Statement Covers Through date is within the calendar year. Statement Covers From date is with an active enrollment period for the enrollee. Pharmacy Claims; Fill Date within the calendar year, and Fill Date is within an active enrollment period.	Claim	0 or more	activeClaimsIDsWithoutEnrolleeRecords	String	minLength = 0; maxLength = 50

Enrollee Claims Summary (ECS) Message Format (or Record Layout) and Required Protocols

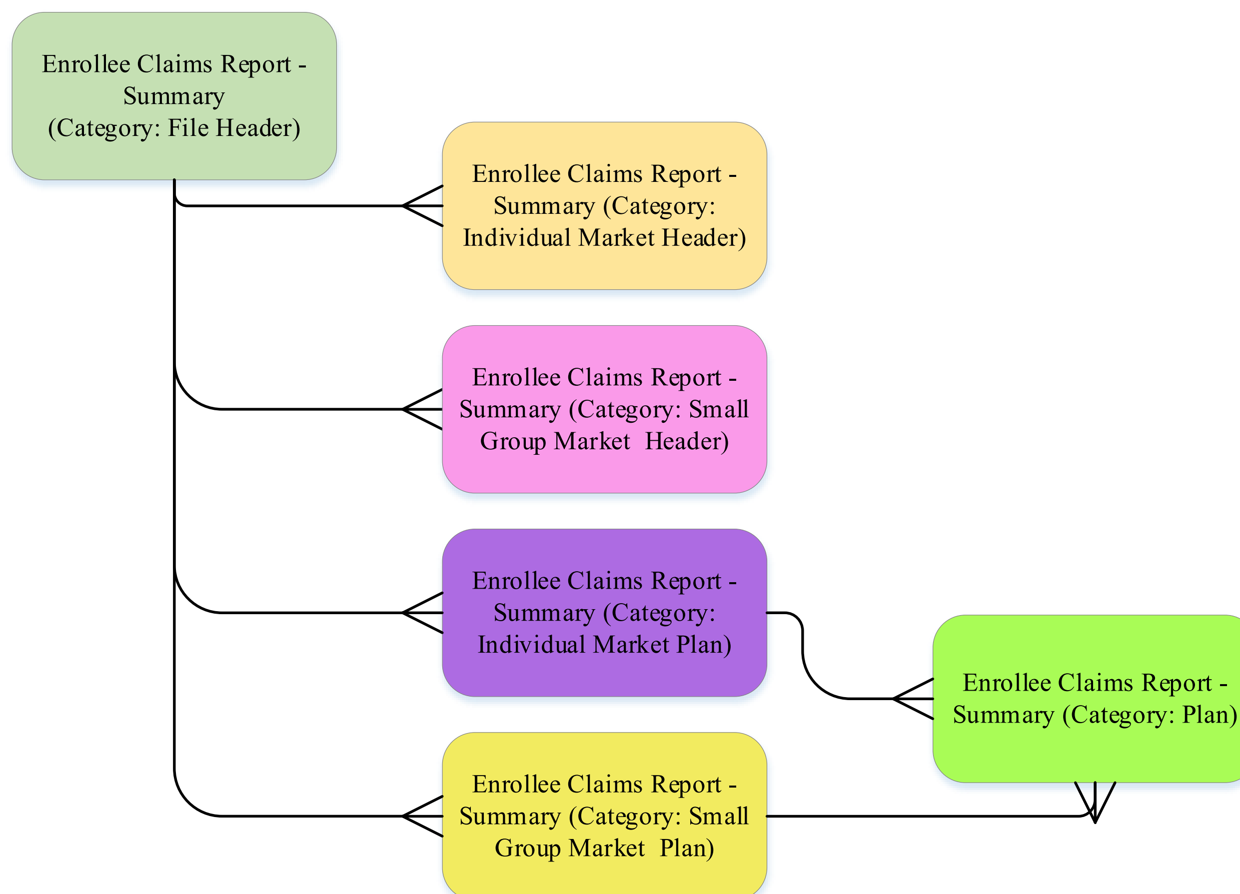
The outbound ECS Report is available to CMS and the issuer/submitting organization. This report contains information on linked and unlinked (orphaned) claims and enrollment. **Note**: unless specifically defined as such, all claim counts and sums in the ECS report refer to active linked claims only and void and replace claims will not be considered.

The ECS Report is generated with a CMS-deployed remote ECS command or local ECS command by the issuer.

5.1.1.4 File Layout

This section specifies the file layout for the ECS Report. At a high level, it consists of six (6) record types or categories of information, as shown in Figure 2.

Figure 2: EDGE Server Enrollee Claims Summary



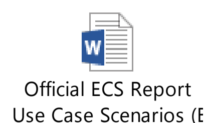
The ECS Report consists of a report File Header category, Individual Market Type Header category, Small Group Market Header category, Individual Market Plan category, Small Group Market Plan category, and Plan category.

The ECS XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.5 Field/Data Elements and Descriptions

The purpose of this document is to provide sample enrollment and cross-year claim scenarios for the Enrollee Claims Summary (ECS) Report.

Figure 3: Official ECS Report Use Case Scenarios



The data characteristics for the ECS Summary File Header category are as shown in Table 8. The root element of the ECS in the XSD is EnrolleeClaimsSummaryReport (*EnrolleeClaimsSummaryReport.xsd*). This element is required and all the other elements defined in this section for the ECS are embedded within this element start and end tags.

Table 8: ECS Enrollee Claims Summary File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader	none

Table 8: ECS Enrollee Claims Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Payment Year	This is the payment year.	Payment Year	1	paymentYear *(calendarYear)*	String	Strict: YYYY
Unique Enrollees	Total number of all active unique enrollee IDs with a coverage start or end date within the payment year.	File Header	1	uniqueEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Unique Enrollment Periods	Total number of all unique active enrollment periods for the issuer with a coverage start or end date within the payment year.	File Header	1	uniqueEnrollmentPeriods *(totalNumberofActiveEnrollmentPeriods)*	Integer	minInclusive = 0; maxInclusive = 999999999
Individual Market Type Header	This XML element describes the Individual Market type header related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning.	Individual Market Type Header	0..1	includedIndividualMarketTypeHeader	EnrolleeClaimsSummaryIndividualMarketTypeHeaderCategory	none

Table 8: ECS Enrollee Claims Summary File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Small Group Market Type Header	This XML element describes the Small Group Market type header related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning.	Small Group Market Type Header	0..1	includedSmallGroupMarketTypeHeader	EnrolleeClaimsSummarySmallGroupIMarketTypeHeaderCategory	None
Individual Market Type Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the Individual Market insurance plan section of the report.	Individual Market Type	0..1	includedIndividualMarketTypePlanCategory	EnrolleeClaimsSummaryIndividualMarketTypePlanCategory	none
Small Group Market Type Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the Small Group Market insurance plan section of the report.	Small Group Market Type	0..1	includedSmallGroupMarketTypePlanCategory	EnrolleeClaimsSummarySmallGroupMarketTypePlanCategory	none

The data characteristics for the ECS Summary Individual Market Type Category are as shown in Table 9. These elements are defined in the EnrolleeClaimsSummaryIndividualMarketTypeHeaderCategory*.xsd.*

Table 9: ECS Enrollee Claims Summary Individual Market Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique Enrollees	Total number of all active unique enrollee IDs associated with Individual Market Plan IDs and a coverage start or end date within the payment year.	Individual Market Header	1	uniqueEnrollees *(totalNumberOfActiveEnrollmentRecords)*	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollees Linked Only to Rx Claims	Total number of all unique active enrollees associated with Individual market plans that are linked to one (1) or more active Rx claims, and are not linked to any active Medical claims; throughout all associated enrollment periods, for every associated 16-digit Individual Market Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Individual Market Header	1	enrolleesLinkedOnlyToRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 9: ECS Enrollee Claims Summary Individual Market Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollees Linked Only to Medical Claims	Total number of all unique active enrollees associated with Individual market plans that are linked to one (1) or more active Medical claims, and are not linked to any active Rx claims; throughout all associated enrollment periods, for every associated 16-digit Individual Market Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Individual Market Header	1	enrolleesLinkedOnlyToMedicalClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 9: ECS Enrollee Claims Summary Individual Market Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollees Linked to Medical and Rx Claims	Total number of all unique active enrollees associated with Individual market plans that are linked to one (1) or more active Rx claims, and one (1) or more active Medical claims; throughout all associated enrollment periods, for every associated 16-digit Individual Market Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Individual Market Header	1	enrolleesLinkedToMedicalAndRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollees With No Linked Claims	Total number of all unique active enrollees associated with Individual market plans that are <u>not</u> linked to any active Medical or Rx claims; throughout all associated enrollment periods, for every associated 16-digit Individual Market Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Individual Market Header	1	enrolleesWithNoLinkedClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 9: ECS Enrollee Claims Summary Individual Market Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Rx Claims Paid Amount	Total cumulative paid amount summed from all unique active non-orphan Rx claims associated with Individual market 16-digit Plan IDs, across all associated enrollment periods, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Individual Market Header	1	rxClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Medical Claims Paid Amount	Total cumulative paid amount of all unique active non-orphan Medical claims associated with Individual market 16-digit Plan IDs, across all associated enrollment periods, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date is within the payment year, and Statement Covers From Date is with an active enrollment period for the same enrollee and Plan ID.	Individual Market Header	1	medicalClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Orphan Rx Claims Paid Amount	Total cumulative paid amount of all unique active orphan Rx claims associated with Individual market 16-digit Plan IDs, across all associated enrollment periods, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Individual Market Header	1	orphanRxClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 9: ECS Enrollee Claims Summary Individual Market Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Orphan Medical Claims Paid Amount	Total cumulative paid amount of all unique active orphan Medical claims associated with Individual market 16-digit Plan IDs, across all associated enrollment periods, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date is within the payment year, and Statement Covers From Date is with an active enrollment period for the same enrollee and Plan ID.	Individual Market Header	1	orphanMedicalClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Subscriber Premium Amount	Total amount paid by all unique subscribers associated with Individual market plans. This element is calculated by summing the total premium amounts paid by all active unique subscribers, throughout all associated enrollment periods, for every associated 16-digit Individual Market Plan ID in the payment year.	Individual Market Header	1	subscriberPremiumAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

The data characteristics for the ECS Summary Small Group Market Type Category are as shown in Table 10. These elements are defined in the EnrolleeClaimsSummarySmallGroupMarketTypeHeaderCategory*.xsd*

Table 10: ECS Enrollee Claims Summary Small Group Market Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Unique Enrollees	Total number of all active unique enrollee IDs associated with Small Group Market Plan IDs and a coverage start or end date within the payment year.	Small Group Market Header	1	uniqueEnrollees	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollees Linked Only to Rx Claims	Total number of all unique active enrollees associated with Small Group market plans that are linked to one (1) or more active Rx claims, and are not linked to any active Medical claims; throughout all associated enrollment periods, for every associated 16-digit Small Group Market Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Small Group Market Header	1	enrolleesLinkedOnlyToRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 10: ECS Enrollee Claims Summary Small Group Market Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollees Linked Only to Medical Claims	Total number of all unique active enrollees associated with Small Group market plans that are linked to one (1) or more active Medical claims, and are not linked to any active Rx claims; throughout all associated enrollment periods, for every associated 16-digit Small Group Market Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Small Group Market Header	1	enrolleesLinkedOnlyToMedicalClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 10: ECS Enrollee Claims Summary Small Group Market Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollees Linked to Medical and Rx Claims	Total number of all unique active enrollees associated with Small Group market plans that are linked to one (1) or more active Rx claims, and one (1) or more active Medical claims; throughout all associated enrollment periods, for every associated 16-digit Small Group Market Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Small Group Market Header	1	enrolleesLinkedToMedicalAndRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollees With No Linked Claims	Total number of all unique active enrollees associated with Small Group market plans that are not linked to any active Medical or Rx claims; throughout all associated enrollment periods, for every associated 16-digit Small Group Market Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Small Group Market Header	1	enrolleesWithNoLinkedClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 10: ECS Enrollee Claims Summary Small Group Market Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Rx Claims Paid Amount	Total cumulative paid amount summed from all unique active non-orphan Rx claims associated with Small Group market 16-digit Plan IDs, across all associated enrollment periods, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Small Group Market Header	1	rxClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Medical Claims Paid Amount	Total cumulative paid amount of all unique active non-orphan Medical claims associated with Small Group market 16-digit Plan IDs, across all associated enrollment periods, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date is within the payment year, and Statement Covers From Date is with an active enrollment period for the same enrollee and Plan ID.	Small Group Market Header	1	medicalClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 10: ECS Enrollee Claims Summary Small Group Market Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Orphan Rx Claims Paid Amount	Total cumulative paid amount of all unique active orphan Rx claims associated with Small Group market 16-digit Plan IDs, across all associated enrollment periods, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Small Group Market Header	1	orphanRxClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Orphan Medical Claims Paid Amount	Total cumulative paid amount of all unique active orphan Medical claims associated with Small Group market 16-digit Plan IDs, across all associated enrollment periods, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date is within the payment year, and Statement Covers From Date is with an active enrollment period for the same enrollee and Plan ID.	Small Group Market Header	1	orphanMedicalClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Subscriber Premium Amount	Total amount paid by all unique subscribers associated with Small Group market plans. This element is calculated by summing the total premium amounts paid by all active unique subscribers, throughout all associated enrollment periods, for every associated 16-digit Small Group Market Plan ID in the payment year.	Small Group Market Header	1	subscriberPremiumAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

The data characteristics for the ECS Summary Individual Market Plan category are as shown in Table 11. These elements are defined in the EnrolleeClaimsSummaryIndividualMarketTypePlanCategory*.xsd*

Table 11: ECS Enrollee Claims Summary Individual Market Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the Plan section of the Individual Market type category of the report.	Plan Category	1 or more	includedPlanCategory	EnrolleeClaimsSummaryPlanCategory	

The data characteristics for the ECS Summary Small Group Market Plan category are as shown in Table 12 . These elements are defined in the EnrolleeClaimsSummarySmallGroupMarketTypePlanCategory*.xsd*

Table 12: ECS Enrollee Claims Summary Small Group Market Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the Plan section of the Small Group Market type category of the report.	Plan Category	1 or more	includedPlanCategory	EnrolleeClaimsSummaryPlanCategory	

The data characteristics for the ECS Summary Plan category are as shown in Table 13. These elements are defined in the EnrolleeClaimsSummaryPlanCategory*.xsd*

Table 13: ECS Enrollee Claims Summary Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique 16-digit identifier for plan.	Plan Category	1	planIdentifier	String	Length = 16
Active Plan Indicator	Plan status indicator used to determine whether the Individual or Small Group Market Plan ID is active or inactive for the payment year, by populating 'Y' for active and 'N' for inactive.	Plan Category	1	activePlan	String	Strict: 'Y' or 'N'
Metal Level Indicator	Metal level indicator used to determine the metal level of the 16-digit Individual or Small Group Market Plan ID for the payment year.	Plan Category	1	metalLevel	String	minLength = 0; maxLength = 30 Enumeration Values: "01-Platinum" "02-Gold" "03-Silver" "04-Bronze" "05-Catastrophic"
Unique Enrollees	Total number of all active unique Enrollee IDs for the Individual or Small Group Market Plan ID with a coverage start or end date within the payment year.	Plan Category	1	uniqueEnrollees *(totalNumberOfActiveEnrollmentRecords)*	Integer	minInclusive = 0; maxInclusive = 999999999

Table 13: ECS Enrollee Claims Summary Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollees Linked Only to Rx Claims	Total number of unique active enrollees associated with an Individual or Small Group market plan that are linked to one (1) or more active Rx claims, and are not linked to any active Medical claims in the 16-digit Individual or Small Group Market Plan ID for the payment year; claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same Plan ID. Statement Covers Through date within the payment year; and Statement Covers From Date is within an active enrollment period for the enrollee, for the same Plan ID.	Plan Category	1	enrolleesLinkedOnlyToRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollees Linked Only to Medical Claims	Total number of unique active enrollees associated with an Individual or Small Group market plan that are linked to one (1) or more active Medical claims, and are not linked to any active Rx claims in the 16-digit Individual or Small Group Market Plan ID for the payment year; claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same Plan ID. Statement Covers Through date within the payment year; and Statement Covers From Date is within an active enrollment period for the enrollee, for the same Plan ID.	Plan Category	1	enrolleesLinkedOnlyToMedicalClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 13: ECS Enrollee Claims Summary Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollees Linked to Medical and Rx Claims	Total number of unique active enrollees associated with an Individual or Small Group market plan that are linked to one (1) or more active Rx claims, and one (1) or more active Medical claims in the 16-digit Individual or Small Group Market Plan ID for the payment year; claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same Plan ID. Statement Covers Through date within the payment year; and Statement Covers From Date is within an active enrollment period for the enrollee, for the same Plan ID.	Plan Category	1	enrolleesLinkedToMedicalAndRxClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollees With No Linked Claims	Total number of unique active enrollees associated with an Individual or Small Group market plan that are not linked to any active claims in the 16-digit Individual or Small Group Market Plan ID for the payment year; claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same Plan ID. Statement Covers Through date within the payment year; and Statement Covers From Date is within an active enrollment period for the enrollee, for the same Plan ID.	Plan Category	1	enrolleesWithNoLinkedClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 13: ECS Enrollee Claims Summary Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Active Enrollment Periods	Total number of all unique active enrollment periods for the Individual or Small Group Market 16-digit Plan ID with a coverage start or end date within the payment year.	Plan Category	1	activeEnrollmentPeriods *(totalNumberofActiveEnrollmentPeriods)*	Integer	minInclusive = 0; maxInclusive = 999999999
Active non-orphan Linked Claims	Total number of stored non-orphan active claims for the Individual or Small Group Market 16-digit Plan ID where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same Enrollee and Plan ID. Statement Covers Through date within the payment year; and Statement Covers From Date is within an active enrollment period for the enrollee, for the same enrollee and Plan ID.	Plan Category	1	activeNonOrphanLinkedClaims *(totalNumberOfStoredActiveClaims)*	Integer	minInclusive = 0; maxInclusive = 999999999
Orphan Claims	Total number of orphaned Medical and Rx claims for the Plan ID. A claim is considered linked if it meets the criteria described below: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same Enrollee and Plan ID. Statement Covers Through date within the payment year; and Statement Covers From Date is within an active enrollment period for the enrollee, for the same enrollee and Plan ID.	Plan Category	1	orphanClaims *(totalNumberOfClaimsNoLinkedEnrolleeID)*	Integer	minInclusive = 0; maxInclusive = 999999999

Table 13: ECS Enrollee Claims Summary Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Orphan Medical Claims	Total number of orphan medical claims for the Plan ID. A claim is considered linked if it meets the criteria described below: Statement Covers Through date is within the payment year; and Statement Covers From Date is within an active enrollment period for the enrollee, for the same enrollee and Plan ID.	Plan Category	1	orphanMedicalClaims *(totalNumberOfMedicalClaimsNoLinkedEnrolleeID)*	Integer	minInclusive = 0; maxInclusive = 999999999
Orphan Rx Claims	Total number of orphan Rx claims for the Plan ID. A claim is considered linked if it meets the criteria described below: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same Enrollee and Plan ID.	Plan Category	1	orphanRxClaims *(totalNumberOfPharmacyClaimsNoLinkedEnrolleeID)*	Integer	minInclusive = 0; maxInclusive = 999999999
Rx Claims Paid Amount	Total cumulative paid amount of all unique active Rx claims for the 16-digit Plan ID associated with an Individual or Small Group Market plan, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Plan Category	1	rxClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 13: ECS Enrollee Claims Summary Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Medical Claims Paid Amount	Total cumulative paid amount of all unique active Medical claims for the 16-digit Plan ID associated with an Individual or Small Group Market plan, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date is within the payment year, and Statement Covers From Date is with an active enrollment period for the same enrollee and Plan ID.	Plan Category	1	medicalClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Orphan Rx Claims Paid Amount	Total cumulative paid amount, of all unique active orphan Rx claims for the 16-digit Plan ID associated with an Individual or Small Group Market plan, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Plan Category	1	orphanRxClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Orphan Medical Claims Paid Amount	Total cumulative paid amount, of all unique active orphan Medical claims for the 16-digit Plan ID associated with an Individual or Small Group Market plan, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date is within the payment year, and Statement Covers From Date is with an active enrollment period for the same enrollee and Plan ID.	Plan Category	1	orphanMedicalClaimsPaidAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 13: ECS Enrollee Claims Summary Plan (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Subscriber Premium Amount	Total amount paid by total unique subscribers associated with an Individual or Small Group market plan. This element is calculated by summing the total premium amounts paid by the total active unique subscribers, for the Individual Market 16-digit Plan ID, for the payment year.	Plan Category	1	subscriberPremiumAmount	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Medical Claims Flagged for RA Selection	Total number of stored active Medical claims that have been flagged for RA during RA claim selection.	Plan Category	1	medicalClaimsFlaggedForRa Selection *(totalNumberEnrolleelinkClai mFlaggedRaClaimSelection)*	Integer	minInclusive = 0; maxInclusive = 999999999
Rx Claims Flagged for RA Selection	Total number of stored active Rx claims that have been flagged for RA during RA claim selection. *The value of this element will not be populated until Rx claims are considered by RA claim selection.*	Plan Category	1	rxClaimsFlaggedForRaSelect ion	Integer	minInclusive = 0; maxInclusive = 999999999

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Frequency by Data Element for Enrollment Accepted Files Report (FDEEAF)

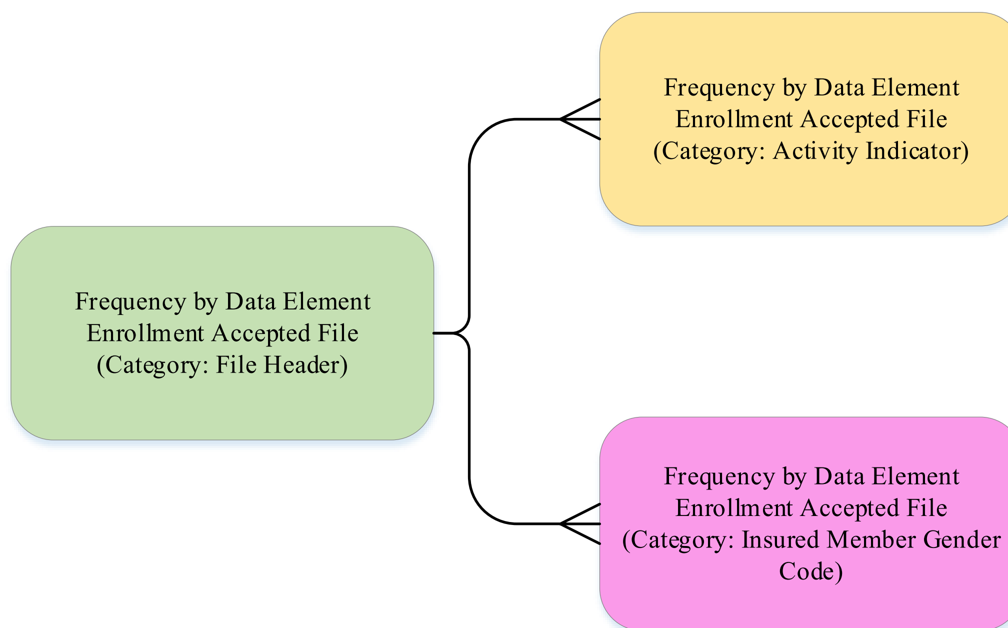
Format (or Record Layout) and Required Protocols

The outbound FDEEAF Report is available to CMS and the issuer/submitting organization. This report contains frequency by data element for accepted enrollment files.; Counts are based on active records unless otherwise noted. The FDEEAF Report will be generated independently with a remote command.

5.1.1.6 File Layout

This section specifies the file layout for the FDEEAF Report. At a high level, it consists of three (3) record type or category as shown in Figure 4.

Figure 4: EDGE Server Frequency by Data Element for Enrollment Accepted Files



The FDEEAF Report consists of a report File Header, Activity Indicator, and Insured Member Gender Code category.

The FDEEAF XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.7 Field/Data Elements and Descriptions

The data characteristics for the FDEEAF Frequency by Data Element for Enrollment Accepted File Header Result category are as shown in Table 14. The root element of the FDEEAF in the XSD is EnrollmentFrequencyReport (*EnrollmentFrequencyReport.xsd*). This element is required and all the other elements defined in this section for the FDEEAF are embedded within this element start and end tags.

Table 14: FDEEAF Frequency by Data Element for Enrollment Accepted File Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader.xsd	none
Calendar Year	Input parameter provided for the report.	File Header	1	calendarYear	String	Strict: YYYY
Total Active Accepted Enrollee Records	Total unique count of active accepted enrollee records in the database.	File Header	1	totalAcceptedEnrolleeRecords	Integer	minInclusive = 0; maxInclusive = 999999999
Total Active Accepted Non-Orphan Enrollee Records	Total number of all unique active accepted enrollees that are linked to at least one (1) active Medical or Rx claim; throughout all associated enrollment periods, for every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	activeAcceptedNonOrphanEnrolleeRecords	Integer	minInclusive = 0; maxInclusive = 999999999

Table 14: FDEEAF Frequency by Data Element for Enrollment Accepted File Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Active Accepted Orphan Enrollee Records	Total number of all unique active accepted enrollees that are not linked to any active Medical or Rx claims; throughout all associated enrollment periods, for every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	activeAcceptedOrphanEnrolleeRecords	Integer	minInclusive = 0; maxInclusive = 999999999
Total Active Accepted Enrollment Periods	Total count of active accepted enrollment periods in the database.	File Header	1	totalAcceptedEnrollmentPeriods	Integer	minInclusive = 0; maxInclusive = 999999999
Enrollment Activity Indicator Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Activity Indicator	4	includedEnrollmentActivityIndicatorCategory	EnrollmentFrequencyActivityIndicator Category	none
Enrollment Insured Member Gender Code Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Gender Code	3	includedEnrollementInsuredMemberGenderCodeCategory	EnrollmentFrequencyInsuredMember GenderCategory	none

The data characteristics for the FDEEAF Frequency by Data Element for Enrollment Accepted File Activity Indicator category are as shown in Table 15. These elements are defined in the *EnrollmentFrequencyActivityIndicatorCategory.xsd*.

Table 15: FDEEAF Frequency by Data Element for Enrollment Accepted File Activity Indicator

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Enrollment Period Activity Indicator	Enrollment Period Indicator: 021028, 021EC, 021041, 001.	Activity Indicator	1	enrollmentActivityIndicator	String	Enumeration Values: “021028”, “021EC”, “021041”, “001”.
Total Counts Activity Indicator (Active)	Total count of active enrollment periods with the above activity indicator in the database.	Activity Indicator	1	totalEnrollmentPeriodCountActivityIndicator	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Active Accepted Enrollees with Linked Claims with Activity Indicator	Total number of all unique active accepted enrollees with the above activity indicator that are linked to at least one (1) active Medical or Rx claim; throughout all associated enrollment periods, for every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Activity Indicator	1	activeNonOrphanEnrolleesCountActivityIndicator	Integer	minInclusive = 0; maxInclusive = 999999999

Table 15: FDEEAF Frequency by Data Element for Enrollment Accepted File Activity Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Active Accepted Enrollees without Linked Claims with Activity Indicator	Total number of all unique active accepted enrollees with the above activity indicator that are not linked to any active Medical or Rx claims; throughout all associated enrollment periods, for every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Activity Indicator	1	activeOrphanEnrolleesCount ActivityIndicator	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the FDEEAF Frequency by Data Element for Enrollment Accepted File Insured Member Gender Code category are as shown in Table 16. These elements are defined in the *EnrollmentFrequencyInsuredMemberGenderCategory.xsd*.

Table 16: FDEEAF Frequency by Data Element for Enrollment Accepted File Insured Member Gender Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Gender	Enrollee gender.	Gender Code	1	genderCode	String	Length = 1 Enumeration Values: “M” = Male “F” = Female “U” = Unknown
Gender Count	Total Gender count in the database.	Gender Code	1	genderCount	Integer	minInclusive = 0; maxInclusive = 999999999

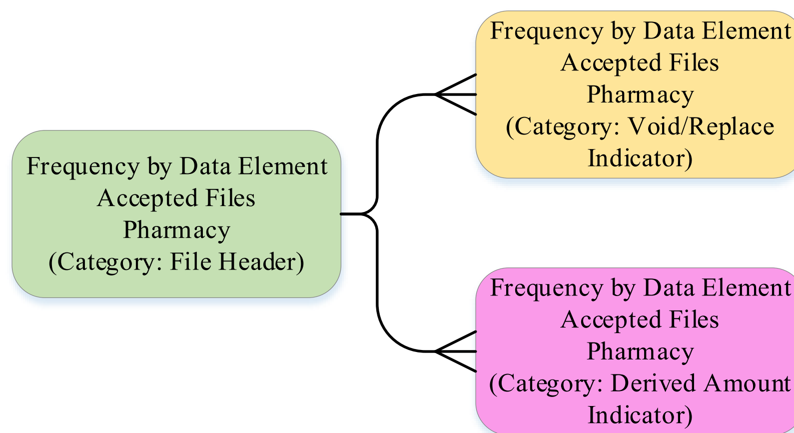
Frequency by Data Element for Pharmacy Accepted Files Report (FDEPAF) Message Format (or Record Layout) and Required Protocols

The outbound FDEPAF Report is available to CMS and the issuer/submitting organization. This report contains frequency by data element for pharmacy accepted files. Claims counts and amounts are based on active records including both derived and non-derived claims, unless otherwise noted. The FDEPAF Report will be generated independently with a remote command.

5.1.1.8 File Layout

This section specifies the file layout for the FDEPAF Report. At a high level, it consists of three (3) record type or category of information as shown in Figure 5.

Figure 5: EDGE Server Frequency by Data Element for Pharmacy Accepted Files



The FDEPAF Report consists of a report File Header, Void/Replace Indicator, and Derived Amount Indicator category.

The FDEPAF XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.9 Field/Data Elements and Descriptions

The data characteristics for the FDEPAF Frequency by Data Element for Pharmacy Accepted Files File Header result category are as shown in Table 17. The root element of the FDEPAF in the XSD is PharmacyFrequencyReport (*PharmacyFrequencyReport.xsd*). This element is required and all the other elements defined in this section for the FDEPAF are embedded within this element start and end tags.

Table 17: FDEPAF Frequency by Data Element for Pharmacy Accepted Files Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader	Length = 16
Calendar Year	Input year that the report is run against.	File Header	1	calendarYear	String	Strict: YYYY
Total Enrollees for Accepted Active Non-Orphan Rx Claims	Total number of all unique active enrollees that are linked to at least one (1) active accepted non-orphan Rx claim; throughout all associated enrollment periods, for every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalEnrolleesForAcceptedNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 17: FDEPAF Frequency by Data Element for Pharmacy Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Enrollees for Accepted Active Orphan Rx Claims	Total count of unique enrollees whose EnrolleeIDs exist on orphan (unlinked) Rx claims, regardless of the enrollees being present in te enrollment data. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period matching the Plan ID on the enrollee record. **Note**: This field also includes enrollees where Enrollee ID on the orphan claim does not exist in the enrollment data, along with enrollees that exist and have their EnrolleeIDs on orphan claims.	File Header	1	totalEnrolleesForAcceptedOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Accepted Active Non-Orphan Rx Claims	Total number of all unique active accepted Rx claims linked to an active Enrollee; throughout all associated enrollment periods, for every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 17: FDEPAF Frequency by Data Element for Pharmacy Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique NDC for Active Non-Orphan Rx Claims	Total unique number of all NDC (first 8 digits) for active accepted Rx claims linked to an active Enrollee; throughout all associated enrollment periods, for every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalNdcCountForNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Accepted Active Orphan Rx Claims	Total number of all unique active accepted Rx Claims not linked to an Enrollee; throughout all associated enrollment periods, for every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique NDC for Active Orphan Rx Claims	Total unique number of all ~~unique~~ NDC (first 8 digits) for active accepted Rx Claims not linked to an Enrollee; throughout all associated enrollment periods, for every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalNdcCountForOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 17: FDEPAF Frequency by Data Element for Pharmacy Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Cost for Active Non-Orphan Rx Claims	Total Allowed Cost for all active accepted Rx Claims linked to an Enrollee; throughout all associated enrollment periods and every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.Note: Includes both derived and non-derived claims	File Header	1	totalAllowedCostForNonOrphanClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Plan Paid Amount for Active Non-Orphan Rx Claims	Total Plan Paid Amount for all active accepted Rx Claims linked to an Enrollee; throughout all associated enrollment periods and every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalPlanPaidAmountForNonOrphanClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 17: FDEPAF Frequency by Data Element for Pharmacy Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Cost for Active Orphan Rx Claims	Total Allowed Cost for all active accepted Rx Claims not linked to an Enrollee; throughout all associated enrollment periods and every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.Note: Includes both derived and non-derived claims	File Header	1	totalAllowedCostForOrphanClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Plan Paid Amount for Active Orphan Rx Claims	Total Plan Paid Amount for all active accepted Rx Claims not linked to an Enrollee; throughout all associated enrollment periods and every associated 16-digit Plan ID, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalPlanPaidAmountForOrphanClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Void/Replace Indicator Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Void Replace	2	includedPharmacyVoidReplaceCodeCategory	PharmacyFrequencyVoidReplaceCategory	none
Derived Amount Indicator Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Derived Amount Indicator	2	includedPharmacyDerivedAmountIndicatorCategory	PharmacyFrequencyDerivedAmountIndicatorCategory	none

The data characteristics for the FDEPAF Frequency by Data Element Accepted Files for Pharmacy Void/Replace category are as shown in Table 18. These elements are defined in the *PharmacyFrequencyVoidReplaceCategory.xsd*.

Table 18: FDEPAF Frequency by Data Element Accepted Files for Pharmacy Void/Replace

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Void/Replace Indicator	Void/Replace Indicator	Void/Replace	1	voidReplaceCode	String	Length = 1 Enumeration Value = "V","R"
Void/Replace Count in Database	Total count of void/replace in the database. Voided claims are inactive; replace count includes active claims only. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period matching the Plan ID on the enrollee record.	Void/Replace	1	totalCountVoidReplaceCode	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the FDEPAF Frequency by Data Element for Pharmacy Derived Amount Indicator category are as shown in Table 19. These elements are defined in the *PharmacyFrequencyDerivedAmountIndicatorCategory.xsd*.

Table 19: FDEPAF Frequency by Data Element for Pharmacy Derived Amount Indicator

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Derived Amount Indicator	Derived Amount Indicator.	Derived Amount Indicator	1	derivedAmountIndicator	String	Length = 1 Enumeration Value = "Y","N"
Derived Amount Indicator Count for Non-Orphan Rx Claims – Claim Level	Total count of Derived Amount Indicator for all active accepted Rx Claims linked to an Enrollee; at the claim level, for the payment year. Claims are linked by Enrollee ID on the enrollment period where:	Derived Amount Indicator	1	totalDerivedAmountIndicatorForNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.					

Table 19: FDEPAF Frequency by Data Element for Pharmacy Derived Amount Indicator (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Derived Amount Indicator Count for Orphan Rx Claims – Claim Level	Total count of Derived Amount Indicator for all active accepted Rx Claims not linked to an Enrollee; at the claim level, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Derived Amount Indicator	1	totalDerivedAmountIndicatorForOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Plan Paid Amount for Non-Orphan Rx Claims – Claim Level	Total Plan Paid Amount for all active accepted Rx Claims linked to an Enrollee at the claim level, with the designated Derived Amount Indicator, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Derived Amount Indicator	1	totalPlanPaidAmountForNonOrphanClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Plan Paid Amount for Orphan Rx Claims – Claim Level	Total Plan Paid Amount for all active accepted Rx Claims not linked to an Enrollee at the claim level, with the designated Derived Amount Indicator, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Derived Amount Indicator	1	totalPlanPaidAmountForOrphanClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99

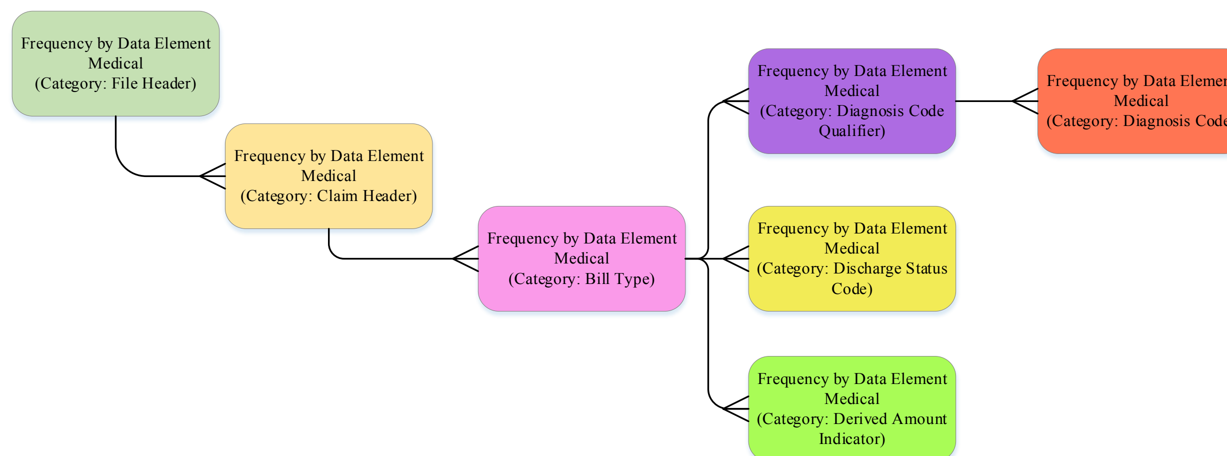
Frequency by Data Element for Medical Accepted Files Report (FDEMAF) Message Format (or Record Layout) and Required Protocols

The outbound FDEMAF Report is available to CMS and the issuer/submitting organization. This report contains frequency by data element for accepted medical files; it states the cumulative counts based on accepted records stored in the medical claim table including the last file ingested. Claims counts and amounts are based on active records including both derived and non-derived claims, unless otherwise noted. The FDEMAF Report will be generated independently with a remote command.

5.1.1.10 File Layout

This section specifies the file layout for the FDEMAF Report. At a high level, it consists of seven (7) record types or categories of information, as shown in Figure 6.

Figure 6: EDGE Server Frequency by Data Element for Medical Accepted Files



The FDEMAF Report consists of a report File Header, Claim Header, Bill Type, Diagnosis Code Qualifier, Diagnosis Code, Discharge Status Code and Derived Amount Indicator category.

The FDEMAF XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.11 Field/Data Elements and Descriptions

The data characteristics for the FDEMAF Frequency by Data Element for Medical Accepted Files category are as shown in

Table 20. The root element of the FDEMAF in the XSD is MedicalFrequencyReport (*MedicalFrequencyReport.xsd*). This element is required and all the other elements defined in this section for the FDEMAF are embedded within this element start and end tags.

Table 20: FDEMAF Frequency by Data Element for Medical Accepted Files Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports.	File Header	1	includedFileHeader	RARICommonOutbound FileHeader	none
Calendar Year	Input parameter provided for the report.	File Header	1	calendarYear	String	Strict: YYYY
Medical Type Claim Header Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Claim Header Category	1..2	includedMedicalClaimHea derCategory	MedicalTypeFrequency ClaimHeaderCategory	none

The data characteristics for the FDEMAF Frequency by Data Element for Medical Type Claim Header category are as shown in Table 21. These elements are defined in the *MedicalTypeFrequencyClaimHeaderCategory.xsd*.

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Medical Type	Institutional or professional claim type.	Medical Type	1	medicalClaimType	String	Enumeration Values: “I”,“P”

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Enrollees for Accepted Active Non-Orphan Claims	Total number of all unique active enrollees with at least one (1) accepted medical claim linked to an Enrollee record for the given medical claim type; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalEnrolleesForAcceptedNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Enrollees for Accepted Active Orphan Claims	Total count of unique enrollee IDs that exist on orphan (unlinked) medical claims, regardless of the enrollee ID being present in the enrollment data. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID **Note**: This field also includes enrollees where Enrollee ID on the orphan claim does not exist in the enrollment data, along with enrollees that exist and have their EnrolleeIDs on orphan claims.	Medical Type	1	totalEnrolleesForAcceptedOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Accepted Diagnosis Codes for Non-Orphan Medical Claims	Total number of accepted unique Diagnosis Codes for medical claimsclaim linked to an enrollee record for the given medical claim type; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID. Diagnosis codes are counted once per enrollee.	Medical Type	1	totalAcceptedDiagnosisCodeWithNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Accepted Diagnosis for Orphan Medical Claims	Total number of accepted unique Diagnosis Codes for medical claims not linked to an Enrollee record for the given medical claim type; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID. Diagnosis codes are counted once per enrollee.	Medical Type	1	totalAcceptedDiagnosisCodeWithOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Accepted Active Non-Orphan Claims	Total number of accepted active medical claims linked to an Enrollee record; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalAcceptedNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Accepted Active Orphan Claims	Total number of accepted active medical claims not linked ; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalAcceptedOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Cost for Active Non-Orphan Claims	Total Sum of Allowed Cost at the claim level for medical claims linked to an Enrollee record; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID. Note: Includes both derived and non-derived claims	Medical Type	0..1	totalAllowedCostForNonOrphanClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Allowed Cost for Active Orphan Claims	Total Sum of Allowed Cost at the claim level for medical claims not linked to an Enrollee record; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID. Note: Includes both derived and non-derived claims	Medical Type	0..1	totalAllowedCostForOrphanClaims	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Non-Orphan Claims with Derived Indicator = Y – Claim Level	Total Count of Claims with Derived Indicator = 'Y' at the claim level for medical claims linked to an Enrollee record; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalNonOrphanClaimsDerivedIndicatorY	Integer	minInclusive = 0; maxInclusive = 999999999
Total Orphan Claims with Derived Indicator = Y – Claim Level	Total Count of Claims with Derived Indicator = 'Y' at the claim level for medical claims not linked to an Enrollee record; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalOrphanClaimsDerivedIndicatorY	Integer	minInclusive = 0; maxInclusive = 999999999

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Plan Paid Amount for Non-Orphan Claims with Derived Indicator = Y – Claim Level	Total Sum of Plan Paid Amount for medical claims linked to an Enrollee record with Derived Indicator = ‘Y’ at the claim level; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalPlanPaidAmountNonOrphanClaimsDerivedIndicatorY	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Plan Paid Amount for Orphan Claims with Derived Indicator = Y – Claim Level	Total Sum of Plan Paid Amount for medical claims not linked to an Enrollee record with Derived Indicator = ‘Y’ at the claim level; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalPlanPaidAmountOrphanClaimsDerivedIndicatorY	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Plan Paid Amount for Non-Orphan Claims with Derived Indicator = N – Claim Level	Total Sum of Plan Paid Amount for medical claims linked to an Enrollee record with Derived Indicator = 'N' at the claim level; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalPlanPaidAmountNonOrphanClaimsDerivedIndicatorN	Decimal	minInclusive = 0; maxInclusive = 999999999.99
Total Plan Paid Amount for Orphan Claims with Derived Indicator = N – Claim Level	Total Sum of Plan Paid Amount for medical claims not linked to an Enrollee record with Derived Indicator = 'N' at the claim level; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalPlanPaidAmountOrphanClaimsDerivedIndicatorN	Decimal	minInclusive = 0; maxInclusive = 999999999.99

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Non-Orphan Claims with Derived Indicator = N – Claim Level	Total Count of medical claims linked to an Enrollee record with Derived Indicator = 'N' at the claim level; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalNonOrphanClaimsDerivedIndicatorN	Integer	minInclusive = 0; maxInclusive = 999999999
Total Orphan Claims with Derived Indicator = N – Claim Level	Total Count of medical claims not linked to an Enrollee record with Derived Indicator = 'N' at the claim level; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalOrphanClaimsDerivedIndicatorN	Integer	minInclusive = 0; maxInclusive = 999999999
Total Void Claims	Total Count of inactive claims with Void/ Replace Indicator = 'V' in the database. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalVoidReplaceCodeV	Integer	minInclusive = 0; maxInclusive = 999999999

Table 21: FDEMAF Frequency by Data Element for Medical Claim Type Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Replace Claims	Total Count of active claims with Void / Replace Indicator = 'R' in the database. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Medical Type	1	totalVoidReplaceCodeR	Integer	minInclusive = 0 maxInclusive = 999999999
Bill Type Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Bill Type Category	0 or more	includedMedicalBillTypeCategory	MedicalFrequencyBillTypeClaimHeaderCategory	none

The data characteristics for the FDEMAF Frequency by Data Element for Medical Bill Type Claim Header category are as shown in Table 22 (This category can be excluded in the absence of bill type codes for professional claim). These elements are defined in the *MedicalFrequencyBillTypeClaimHeaderCategory.xsd*.

Table 22: FDEMAF Frequency by Data Element for Medical Bill Type Claim Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Bill Type Code	Bill Type Code.	Bill Type	0..1	billType	String	minLength = 0 maxLength = 3
Diagnosis Code Qualifier Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Diagnosis Qualifier	0 or more	includedMedicalDiagnosisQualifierCategory	MedicalFrequencyDiagnosisQualifierCategory	none
Discharge Status Code Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Discharge Status Code	0 or more	includedMedicalDischargeStatusCodeCategory	MedicalFrequencyDischargeStatusCodeCategory	none

Table 22: FDEMAF Frequency by Data Element for Medical Bill Type Claim Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Derived Amount Indicator Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Derived Amount Indicator	0..2	includedMedicalDerivedAmountIndicatorCategory	MedicalFrequencyDerivedAmountCategory	none

The data characteristics for the FDEMAF Frequency by Data Element for Medical Diagnosis Qualifier category are as shown in Table 23. These elements are defined in the *MedicalFrequencyDiagnosisQualifierCategory.xsd*.

Table 23: FDEMAF Frequency by Data Element for Medical Diagnosis Qualifier

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Diagnosis Code Qualifier	Medical Diagnosis Code Qualifier indicating whether the code is ICD-9 or ICD-10.	Diagnosis Qualifier	0..1	diagnosisQualifier	String	minLength = 0 maxLength = 2 Enumeration Values: “01” = ICD-9 Codes “02” = ICD-10 Codes
Diagnosis Code Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Diagnosis Code	0 or more	includedMedicalDiagnosisCodeCategory	MedicalFrequencyDiagnosisCodeCategory	none

The data characteristics for the FDEMAF Frequency by Data Element for Medical Diagnosis Code category are as shown in Table 24. These elements are defined in the *MedicalFrequencyDiagnosisCodeCategory.xsd*.

Table 24: FDEMAF Frequency by Data Element for Medical Diagnosis Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Diagnosis Code	Diagnosis Code.	Diagnosis Code	0..1	diagnosisCode	String	minLength = 0; maxLength = 30

Table 24: FDEMAF Frequency by Data Element for Medical Diagnosis Code (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Diagnosis Code Count for Non-Orphan Claims	Total unique count of Diagnosis Codes per claim type and bill type for medical claims linked to an Enrollee record in the database, for the payment year. Each Diagnosis code is counted only one time per Enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Diagnosis Code	0..1	totalDiagnosisCodeWithNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Diagnosis Code Count for Orphan Claims	Total unique count of Diagnosis Codes per claim type and bill type for medical claims not linked to Enrollee records in the database, for the payment year. Each Diagnosis code is counted only one time per Enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Diagnosis Code	0..1	totalDiagnosisCodeWithOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the FDEMAF Frequency by Data Element for Medical Diagnosis Code category are as shown in Table 25. (This category can be excluded in the absence of Discharge Codes). These elements are defined in the *MedicalFrequencyDischargeStatusCodeCategory.xsd*.

Table 25: FDEMAF Frequency by Data Element for Medical Discharge Status Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Discharge Status Code	Discharge Status Code.	Discharge Status Code	0…1	dischargeStatusCode	String	minLength = 0 maxLength = 2
Discharge Status Count for Non Orphan Claims	Total unique count of Discharge Status Codes in the payment year for medical claims linked to Enrollee records. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Discharge Status Code	0…1	totalCountNonOrphanDischargeStatusCode	Integer	minInclusive = 0; maxInclusive = 999999999
Discharge Status Count for Orphan Claims	Total unique count of Discharge Status Codes in the payment year for medical claims not linked to Enrollee records. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Discharge Status Code	0…1	totalCountOrphanDischargeStatusCode	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Enrollees For Discharge Status Code (Non Orphan Claims)	Total unique count of active enrollees in the payment year linked to medical claims linked to an Enrollee record with the above discharge status. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Discharge Status Code	0… 1	totalCountEnrolleeNonOrphanDischargeStatusCode	Integer	minInclusive = 0; maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions

Table 25: FDEMAF Frequency by Data Element for Medical Discharge Status Code (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Enrollees For Discharge Status Code (Orphan Claims)	Total unique count of active enrollees in the payment year for medical claims not linked to the Enrollee Record with the above discharge status. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Discharge Status Code	0… 1	totalCountEnrolleeOrphanDischarge StatusCode	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the FDEMAF Frequency by Data Element for Medical Derived Amount category are as shown in Table 26. These elements are defined in the *MedicalFrequencyDerivedAmountCategory.xsd*.

Table 26: FDEMAF Frequency by Data Element for Medical Derived Amount

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Derived Amount Indicator	Derived Amount Indicator.	Derived Amount Indicator	0…1	derivedAmountIndicator	String	minLength = 0 maxLength = 1 Enumeration Values: “Y”,“N”

Table 26: FDEMAF Frequency by Data Element for Medical Derived Amount (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Derived Amount Indicator Count at Claim Level	Total count of Derived Amount Indicator in the database at the claim level. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Derived Amount Indicator	0…1	totalCountDerivedAmountIndicator ClaimLevel	Integer	minInclusive = 0; maxInclusive = 999999999
Derived Amount Indicator Count at Service Line Level	Total count of Derived Amount Indicator in the database at the service line level. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Derived Amount Indicator	0…1	totalCountDerivedAmountIndicator ServiceLine	Integer	minInclusive = 0; maxInclusive = 999999999

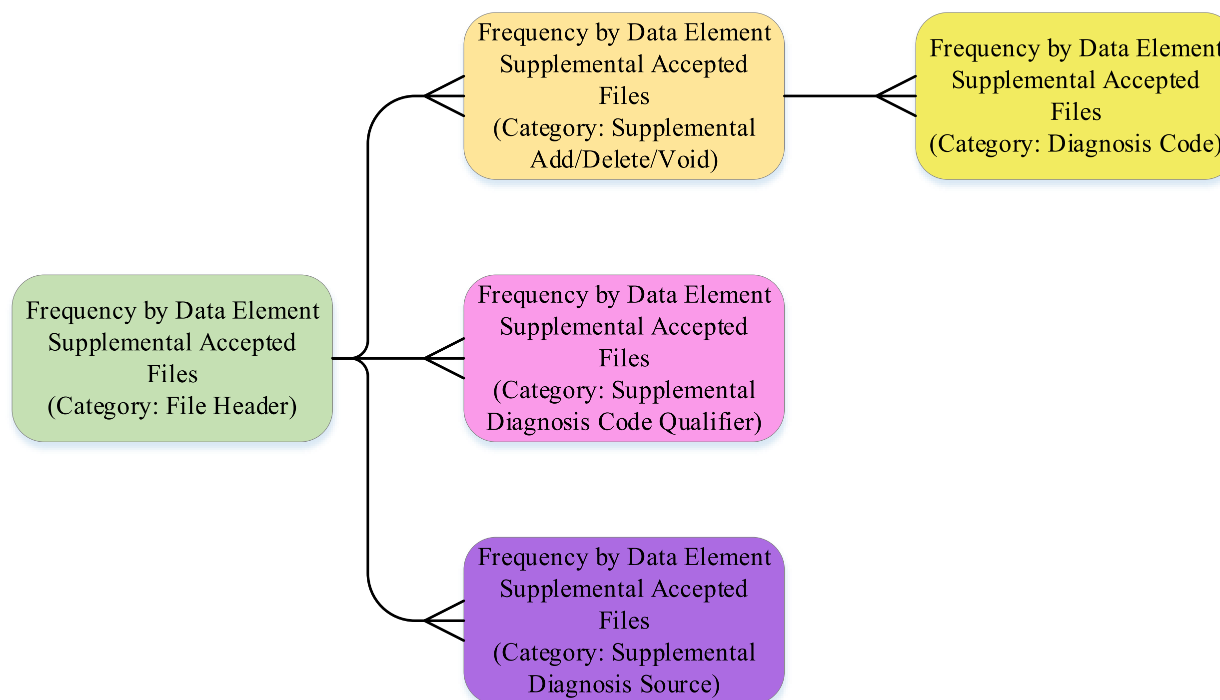
Frequency by Data Element for Supplemental Accepted Files Report (FDESAF)Message Format (or Record Layout) and Required Protocols

The outbound FDESAF Report is available to CMS and the issuer/submitting organization. This report contains frequency by data element for accepted supplemental files; it states the cumulative counts based on accepted records stored in the supplemental tables including the last file ingested. Counts are based on active records unless otherwise noted. The FDESAF Report will be generated independently with a remote command.

5.1.1.12 File Layout

This section specifies the file layout for the FDESAF Report. At a high level, it consists of five (5) record type or category of information as shown in Figure 7.

Figure 7: EDGE Server Frequency by Data Element for Supplemental Accepted Files



The FDESAF Report consists of a report File Header, Supplemental Add/Delete/Void, Diagnosis Code, Supplemental Diagnosis Code Qualifier and Supplemental Diagnosis Source category.

The FDESAF XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.13 Field/Data Elements and Descriptions

The data characteristics for the FDESAF Frequency by Data Element for Supplemental Accepted Files category are as shown in Table 27. The root element of the FDESAF in the XSD is SupplementalFrequencyReport (*SupplementalFrequencyReport.xsd*). This element is required and all the other elements defined in this section for the FDESAF are embedded within this element start and end tags.

Table 27: FDESAF Frequency by Data Element for Supplemental Accepted Files Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
File Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedlFileHeader	RARICommonOutboundFileHeader	none
Calendar Year	Input parameter provided for the report.	File Header	1	calendarYear	String	Strict: YYYY
Total Enrollees for Accepted Active Supplemental Records	Total count of distinct enrollees linked to one (1) or more active Supplemental records in the database.	File Header	1	totalEnrolleesForAcceptedRecords	Integer	minInclusive = 0; maxInclusive = 999999999

Table 27: FDESAF Frequency by Data Element for Supplemental Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Enrollees for Accepted Active Supplemental Records for Non Orphan Claims	Total count of unique enrollees in the payment year linked to one (1) or more active supplemental records for a medical claim linked to an enrollee record. Enrollees must be linked to at least one (1) medical claim with at least one (1) active supplemental record. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalEnrolleesForAcceptedRecordsWithNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 27: FDESAF Frequency by Data Element for Supplemental Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Enrollees for Accepted Active Supplemental Records for Orphan Claims	Total count of unique enrollees with at least one (1) active supplemental records where the Enrollee ID exists on the corresponding orphan (unlinked) medical claim, regardless of the Enrollee ID being present in enrollment data. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID. **Note**: This field also includes enrollees with active supplemental claims where Enrollee ID on the corresponding orphan medical claim does not exist in the enrollment data, along with enrollees that exist and have their Enrollee IDs on the corresponding orphan medical claims.	File Header	1	totalEnrolleesForAcceptedRecordsWithOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Accepted Diagnosis Codes for Non-Orphan Medical Claims	Total count of active accepted Supplemental Diagnosis Codes for medical claims linked to an Enrollee record in the payment year. Duplicated across enrollees and claims. Includes all Diagnosis Codes and is not a unique count. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedDiagnosisCodesWithNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 27: FDESAF Frequency by Data Element for Supplemental Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Accepted Diagnosis Codes for Orphan Medical Claims	Total count of active accepted Supplemental Diagnosis Codes for medical claims not linked to an active Enrollee record in the payment year. Duplicated across enrollees and claims. Includes all Diagnosis Codes and is not a unique count. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedDiagnosisCodesWithOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Accepted Diagnosis Codes for Non-Orphan Medical Claims	Total count of unique active accepted Supplemental Diagnosis Codes for medical claims linked to an active Enrollee record in the payment year. Counts each Diagnosis Code one (1) time per enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedUniqueDiagnosisCodesWithNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 27: FDESAF Frequency by Data Element for Supplemental Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Accepted Diagnosis Codes for Orphan Medical Claims	Total count of unique active accepted Supplemental Diagnosis Codes for medical claims not linked to an active Enrollee record in the payment year. Counts each Diagnosis Code one (1) time per enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedUniqueDiagnosisCodesWithOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Accepted MR Diagnosis Codes for Non-Orphan Medical Claims	Total count of unique active accepted Supplemental Diagnosis Codes for medical claims linked to an active Enrollee record in the payment year where the source is MR. Counts each Diagnosis Code one (1) time per enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedUniqueMrDiagnosisCodesWithNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 27: FDESAF Frequency by Data Element for Supplemental Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Accepted MR Diagnosis Codes for Orphan Medical Claims	Total count of unique active accepted Supplemental Diagnosis Codes for medical claims not linked to an active Enrollee record in the payment year where the source is MR. Counts each Diagnosis Code one (1) time per enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedUniqueMrDiagnosisCodesWithOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Unique Accepted EDI Diagnosis Codes for Non-Orphan Medical Claims	Total count of unique active accepted Supplemental Diagnosis Codes for medical claims linked to an active, Enrollee record in the payment year where the source is EDI. Counts each Diagnosis Code one (1) time per enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedUniqueEdiDiagnosisCodesWithNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 27: FDESAF Frequency by Data Element for Supplemental Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Accepted EDI Diagnosis Codes for Orphan Medical Claims	Total count of unique active accepted Supplemental Diagnosis Codes for medical claims not linked to an active Enrollee record in the payment year where the source is EDI. Counts each Diagnosis Code one (1) time per enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedUniqueEdiDiagnosisCodesWithOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Active Accepted Supplemental Records	Total count of active accepted Supplemental Records in the database For the associated medical claims, claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedRecords	Integer	minInclusive = 0; maxInclusive = 999999999
Total Accepted Supplemental Records for Non-Orphan Medical Claims	Total count of active accepted Supplemental records associated to active medical claims linked to active Enrollee records for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedSupplementalRecordsWithNonOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 27: FDESAF Frequency by Data Element for Supplemental Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Accepted Supplemental Records for Orphan Medical Claims	Total count of active accepted Supplemental records associated with active medical claims not linked to active Enrollee records for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalAcceptedSupplementalRecordsWithOrphanClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Accepted Supplemental Records for Non-Orphan Void Claims	Total count of active accepted Supplemental records associated to void medical claims linked to an active Enrollee record for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalSupplementalForNonOrphanVoidClaims	Integer	minInclusive = 0; maxInclusive = 999999999
Total Accepted Supplemental Records for Orphan Void Claims	Total count of active accepted Supplemental records associated to void medical claims not linked to an active Enrollee record for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalSupplementalForOrphanVoidClaims	Integer	minInclusive = 0; maxInclusive = 999999999

Table 27: FDESAF Frequency by Data Element for Supplemental Accepted Files Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Supplemental Add/Delete/Void Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Add Delete Void	3	includedSupplementalAddDeleteVoidCodeCategory	SupplementalFrequencyAddDeleteVoidCategory	None
Supplemental Diagnosis Code Qualifier Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Supplemental Diagnosis Code Qualifier	1 or more	includedSupplementalDiagnosisQualifierCategory	SupplementalFrequencyDiagnosisQualifierCategory	none
Supplemental Diagnosis Source Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Supplemental Diagnosis Source	1 or more	includedSupplementalDiagnosisSourceCategory	SupplementalFrequencyDiagnosisSourceCategory	none

The data characteristics for the FDESAF Frequency by Data Element for Supplemental Add/Delete/Void category are as shown in Table 28. These elements are defined in the *SupplementalFrequencyAddDeleteVoidCategory.xsd*.

Table 28: FDESAF Frequency by Data Element for Supplemental Accepted Files Add/Delete/Void

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Add/Delete/Void	Identifies if a supplemental diagnosis is added, deleted, or voided.	Add Delete Void	1	addDeleteVoidCode	String	Length = 1 Enumeration Value : “A”,“D”,“V”

Table 28: FDESAF Frequency by Data Element for Supplemental Accepted Files Add/Delete/Void (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Add/Delete/Void Count	Total unique count of active supplemental records added or deleted in the database. Total unique count of Supplemental records in the database voided (inactive). For the associated medical claims, claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Add Delete Void	1	totalCountAddDeleteVoid	Integer	minInclusive = 0; maxInclusive = 999999999

Table 28: FDESAF Frequency by Data Element for Supplemental Accepted Files Add/Delete/Void (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Count of Unique Accepted Diagnosis Codes for Supplemental Records With Non-Orphan Claims	Total unique count of accepted Diagnosis Codes in the payment year with medical claims linked to an active Enrollee record for all Supplemental records in each above category. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Add Delete Void	1	totalDiagnosisCodesNonOrphanClaimsAddDeleteVoid	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Unique Accepted Diagnosis Codes for Supplemental Records With Orphan Claims	Total unique count of accepted Diagnosis Codes in the payment year with medical claims not linked to an active Enrollee record for all Supplemental records in each above category. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Add Delete Void	1	totalDiagnosisCodesOrphanClaimsAddDeleteVoid	Integer	minInclusive = 0; maxInclusive = 999999999
Total Count of Unique, Accepted EDI Diagnosis Codes for Supplemental Records with Non-Orphan Claims	Total unique count of accepted EDI Diagnosis Codes in the payment year with medical claims linked to an active Enrollee record for all Supplemental records in each above category. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Add Delete Void	1	totalDiagnosisCodesEdiAddDeleteVoid	Integer	minInclusive = 0; maxInclusive = 999999999

Table 28: FDESAF Frequency by Data Element for Supplemental Accepted Files Add/Delete/Void (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Count of Unique, Accepted, MR Diagnosis Codes for Supplemental Records with Non-Orphan Claims	Total unique count of accepted MR Diagnosis Codes in the payment year with medical claims for all Supplemental records in each above category. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Add Delete Void	1	totalDiagnosisCodesMrAddDeleteVoid	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the FDESAF Frequency by Data Element for Supplemental Diagnosis Code Qualifier category are as shown in Table 29. These elements are defined in the *SupplementalFrequencyDiagnosisQualifierCategory.xsd*.

Table 29: FDESAF Frequency by Data Element for Supplemental Accepted Files Diagnosis Qualifier

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Diagnosis Code Qualifier	Supplemental Diagnosis Code Qualifier indicating whether code is ICD-9 or ICD-10.	Supplemental Diagnosis Qualifier	1	supplementalDiagnosisCodeQualifier	String	minLength = 0 maxLength = 2 Enumeration Values: “01”,“02”
Supplemental Diagnosis Code Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Supplemental Diagnosis Code Qualifier	1 or more	includedSupplementalDiagnosisCodeCategory	SupplementalFrequencyDiagnosisCodeCategory	none

The data characteristics for the FDESAF Frequency by Data Element for Supplemental Diagnosis Code category are as shown in Table 30. These elements are defined in the *SupplementalFrequencyDiagnosisCodeCategory.xsd*.

Table 30: FDESAF Frequency by Data Element for Supplemental Accepted Files Diagnosis Code

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Supplemental Diagnosis Code	Supplemental Diagnosis Code.	Supplemental Diagnosis Code	1	supplementalDiagnosisCode	String	minLength = 0; maxLength = 30
Supplemental Diagnosis Code Count	Total count of Supplemental Diagnosis Code in the database. Not a unique count. For the associated medical claims, claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Supplemental Diagnosis Code	1	totalCountSupplementalDiagnosisCode	Integer	minInclusive = 0; maxInclusive = 999999999

The data characteristics for the FDESAF Frequency by Data Element for Supplemental Diagnosis Source category are as shown in Table 31. These elements are defined in the *SupplementalFrequencyDiagnosisSourceCategory.xsd*.

Table 31: FDESAF Frequency by Data Element for Supplemental Accepted Files Diagnosis Source

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Supplemental Diagnosis Source	Medical Record (MR) or Electronic Data Interchange (EDI).	Supplemental Diagnosis Source	1	supplementalDiagnosisSource	String	minLength = 0 Enumeration Values: “MR”,“EDI”

Table 31: FDESAF Frequency by Data Element for Supplemental Diagnosis Source (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Supplemental Diagnosis Source Count	Total count of supplemental diagnosis source qualifier in the database. For the associated medical claims, claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Supplemental Diagnosis Source	1	totalCountSupplementalDiagnosisSource	Integer	minInclusive = 0; maxInclusive = 999999999

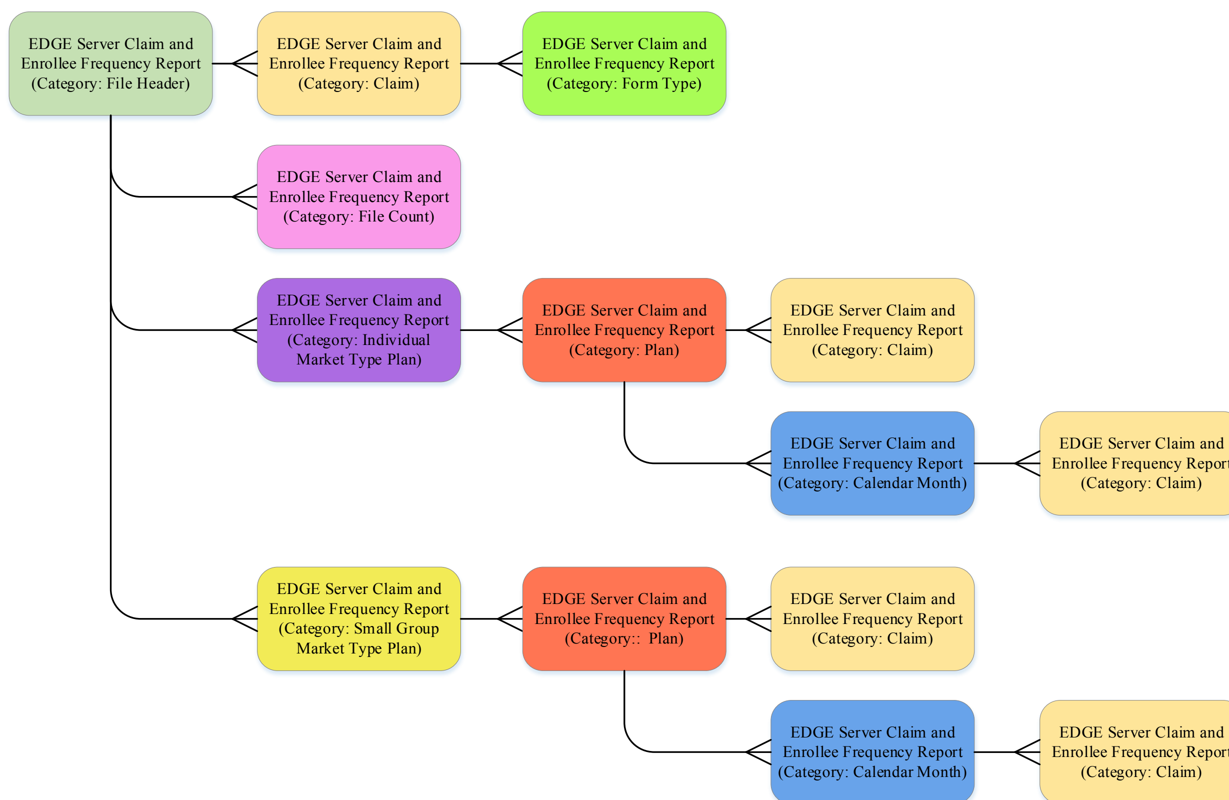
Claim and Enrollee Frequency Report (CEFR) Message Format (or Record Layout) and Required Protocols

The outbound CEFR Report is available to CMS and the issuer/submitting organization. This report contains information on selected data from claims and enrollees. Claims counts and amounts are based on active records non-orphaned claims including both derived and non-derived claims, unless otherwise noted. The CEFR Report will be generated independently with a remote command.

5.1.1.14 File Layout

This section specifies the file layout for the CEFR Report. At a high level, it consists of eight (8) record types or categories of information, as shown in Figure 9.

Figure 8: EDGE Claim and Enrollee Frequency Report



The CEFR Report consists of report File Header, Claim, Form Type, File Count, Plan, and Calendar Month categories.

The CEFR XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix A.

5.1.1.15 Field/Data Elements and Descriptions

The data characteristics for the EDGE Server Claim and Enrollee Frequency Report (CEFR) category are as shown in Table 35. The root element of the CEFR in the XSD is ClaimEnrolleeFrequencyReport (*ClaimEnrolleeFrequencyReport.xsd*). This element is required and all the other elements defined in this section for the CEFR are embedded within this element start and end tags.

Table 32: CEFR Claim and Enrollee Frequency Report Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader	none
Calendar Year	The input parameter for the calendar year for which the report should be run against was executed.	File Header	1	calendarYear	String	Strict: YYYY
Issuer legal name	The issuer's Legal Business Name.	File Header	1	issuerLegalName	String	minLength = 1, maxLength = 80
State	State where the plan is offered.	File Header	1	state	String	minLength = 0 maxLength = 2
Total Unique Enrollees	Total enrollees with enrollment in the payment year	File Header	1	totalEnrollees	Integer	minInclusive = 0 maxInclusive = 999999999

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Unique Enrollee Utilizers	Total number of unique enrollees with at least one (1) active claim type. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalEnrolleeUtilizers	Integer	minInclusive = 0 maxInclusive = 999999999
Male Enrollee Unique Utilizers	Total number of unique males with at least one (1) active claim type. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	maleEnrolleeUtilizers	Integer	minInclusive = 0 maxInclusive = 999999999

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Female Enrollee Unique Utilizers	Total number of unique females with at least one (1) active claim type. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	femaleEnrolleeUtilizers	Integer	minInclusive = 0 maxInclusive = 999999999
Total Claims	Total number of unique active claims linked to an Enrollee in the database. Count includes Medical and Pharmacy claims. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Total Medical Claims Only	Total unique count of active Medical claims linked to an Enrollee Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalMedicalClaims	Integer	minInclusive = 0 maxInclusive = 999999999

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Pharmacy Claims Only	Total unique count of active pharmacy claims linked to an Enrollee in the database. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalPharmacyClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Total Enrollees with Medical Claims	Total number of enrollees linked to at least one (1) active medical claim in the database. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalEnrolleesWithMedicalClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Total Enrollees with Pharmacy Claims	Total number of enrollees linked to at least one (1) activePharmacy claim in the database. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalEnrolleesWithPharmacyClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Number of Enrollees with Medical and Pharmacy Claims	Total number of enrollees linked to at least one (1) active Medical claim and at least one (1) active Pharmacy claim Claims are linked by Enrollee ID on the enrollment period where:. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	numberOfEnrolleesWithMedicalPharmacyClaims	Integer	minInclusive = 0 maxInclusive = 999999999

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Cost for All Claims	Total Allowed Cost for all active medical claims linked to an Enrollee and pharmacy claims linked to an Enrollee in the database Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.Note: Includes both derived and non-derived claims	File Header	1	totalAllowedCostForAllClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Allowed Cost for Inpatient Claims	Total allowed cost on all active Inpatient claims linked to an Enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.Note: Includes both derived and non-derived claims	File Header	1	totalAllowedCostForInpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Allowed Cost for Outpatient Claims	Total allowed cost on all active Outpatient claims linked to an Enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.Note: Includes both derived and non-derived claims	File Header	1	totalAllowedCostForOutpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Cost for Professional Claims	Total allowed cost on all active Professional claims linked to an Enrollee. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.Note: Includes both derived and non-derived claims	File Header	1	totalAllowedCostForPr ofessionalClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Allowed Cost for Pharmacy Claims	Total allowed cost on all active Pharmacy claims linked to an Enrollee. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.Note: Includes both derived and non-derived claims	File Header	1	totalAllowedCostForPh armacyClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Paid Amount for All Claims	Total paid amount on all active medical claims linked to an Enrollee and pharmacy claims linked to an Enrollee. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalPaidAmountForAll Claims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Paid Amount for Inpatient Claims	Total paid amount on all active Inpatient claims linked to an Enrollee . Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalPaidAmountForInpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Paid Amount for Outpatient Claims	Total paid amount on all active Outpatient claims linked to an Enrollee Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalPaidAmountForOutpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Paid Amount for Professional Claims	Total paid amount on all active Professional claims linked to an Enrollee Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalPaidAmountForProfessionalClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Paid Amount for Pharmacy Claims	Total paid amount on all active pharmacy claims & claim lines linked to an Enrollee Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	1	totalPaidAmountForPharmacyClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Allowed Cost for RA Inpatient Claims	Total allowed cost on all active inpatient claims & claims lines linked to an Enrollee included for RA Note: Includes both derived and non-derived claims Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	0..1	totalAllowedCostForRaInpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Cost for RA Outpatient Claims	Total allowed cost on all active outpatient claims & claims lines linked to an Enrollee included for RA Note: Includes both derived and non-derived claims	File Header	0..1	totalAllowedCostForRaOutpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.					
Total Allowed Cost for RA Professional Claims	Total allowed cost on all active professional claims & claims lines linked to an Enrollee included for RA Note: Includes both derived and non-derived claims Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	0..1	totalAllowedCostForRaProfessionalClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Cost for RA Pharmacy Claims	Total allowed cost on all active pharmacy claims & claims lines linked to an Enrollee included for RA *The value of this element will not be populated until Rx claims are considered by RA claim selection.* Note: Includes both derived and non-derived claims	File Header	0..1	totalAllowedCostForRaPharmacyClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
	Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.					
Total Plan Paid Amount for RA Inpatient Claims	Total plan paid amount on all active, inpatient claims & claims lines linked to an Enrollee included for RA Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	0..1	totalPlanPaidAmountForRaInpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Plan Paid Amount for RA Outpatient Claims	Total Plan Paid Amount on all active outpatient accepted claims & claims lines linked to an Enrollee included for RA Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	0..1	totalPlanPaidAmountForRaOutpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Plan Paid Amount for RA Professional Claims	Total plan paid amount on all active professional claims & claims lines linked to an Enrollee included for RA Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	0..1	totalPlanPaidAmountForRaProfessionalClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 35: CEFR Claim and Enrollee Frequency Report Header (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Plan Paid Amount for RA Pharmacy Claims	Total plan paid amount on all active, RA eligible pharmacy claims & claims lines linked to an Enrollee *The value of this element will not be populated until Rx claims are considered by RA claim selection.* Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	File Header	0..1	totalPlanPaidAmountForRaPharmacyClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
File Counts Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report.	File Counts	0..4	includedFileCountsCategory	ClaimEnrolleeFrequencyFileCountsCategory.xsd	none

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Individual Market Type Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the Individual Market insurance plan section of the report.	Individual Market Type	0..1	includedIndividualMarketTypePlanCategory	ClaimEnrolleeFrequencyIndividualTypePlanCategory	none
Small Group Market Type Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the Small Group Market insurance plan section of the report.	Small Group Market Type	0..1	includedSmallGroupMarketTypePlanCategory	ClaimEnrolleeFrequencySmallGroupTypePlanCategory	none
Claim Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report	Claim	1 or more per claim per insurance plan in the reported submission file	includedClaimCategory	ClaimEnrolleeFrequencyClaimCategory.xsd	none

The data characteristics for the EDGE Server Claim and Enrollee Frequency Report File Counts are as shown in Table 36. These elements are defined in the *ClaimEnrolleeFrequencyFileCountsCategory.xsd.*

Table 33: EDGE Server Claim and Enrollee Frequency Report File Counts

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
File type	The file type for which the counts will apply.	File Count	1	fileType	String	Length = 1 “E”: Enrollment “M”: Medical “P”: Pharmacy “S”: Supplemental
Total Number of Files Received	The total number of files received for which the received file’s run date is within the issuer year, as logged in the database.	File Count	1	totalNumberFilesReceived	Integer	minInclusive = 0 maxInclusive = 999999999
Total Number of Files Accepted	The total number of files accepted for which the received file’s run date is within the issuer year, as logged in the database.	File Count	1	totalNumberFilesAccepted	Integer	minInclusive = 0 maxInclusive = 999999999

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Number of Files Rejected	The total number of files rejected for which the received file's run date is within the issuer year, as logged in the database.	File Count	1	totalNumberFilesRejected	Integer	minInclusive = 0 maxInclusive = 999999999

The data characteristics for the EDGE Server Claim and Enrollee Frequency Report File Counts are as shown in TabTable 37. These elements are defined in the *ClaimEnrolleeFrequencyIndividualMarketTypePlanCategory.xsd*.

Table 34: EDGE Server Claim and Enrollee Frequency Report Individual Market Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the Plan section of the Individual Market type category of the report.	Plan Category	1 or more	includedPlanCategory	ClaimEnrolleeFrequencyPlanCategory	

The data characteristics for the Summary Small Group Market Plan category are as shown in Table 38. These elements are defined in the *ClaimEnrolleeFrequencySmallGroupMarketTypePlanCategory.xsd.*

Table 35: EDGE Server Claim and Enrollee Frequency Report Small Group Market Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the Plan section of the Small Group Market type category of the report.	Plan Category	1 or more	includedPlanCategory	ClaimEnrolleeFrequencyPlanCategory	

The data characteristics for the EDGE Server Claim and Enrollee Frequency Report Plan are as shown in Table 39. These elements are defined in the *ClaimEnrolleeFrequencyPlanCategory.xsd*.

Table 36: EDGE Server Claim and Enrollee Frequency Report Plan Category

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique identifier for the plan.	Plan	1	planIdentifier	String	minLength = 0 maxLength = 16
Total Count of Enrollee Records Not Linked to Claims	Total number of all unique active enrollees that are not linked to any active Medical or Rx claims; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Plan	1	orphanEnrolleeRecords	Integer	minInclusive = 0 maxInclusive = 999999999

Table 39: EDGE Server Claim and Enrollee Frequency Report Plan Category (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Count of Enrollee Records Linked to Claims	Total number of all unique active enrollees that are linked to at least (1) active Medical or Rx claim; throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Plan	1	nonOrphanEnrolleeRecords	Integer	minInclusive = 0 maxInclusive = 999999999
Total Count of Medical Orphan Claims	Total number of unique medical claims not linked to an active Enrollee record throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Plan	1	orphanMedicalClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Total Count of Medical Non-Orphan Claims	Total number of unique medical claims linked to an active, Enrollee record throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Plan	1	nonOrphanMedicalClaims	Integer	minInclusive = 0 maxInclusive = 999999999

Table 39: EDGE Server Claim and Enrollee Frequency Report Plan Category (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Count of Orphan Pharmacy Claims	Total number of unique Rx claims not linked to an active Enrollee record throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Plan	1	orphanRxClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Total Count of Non-Orphan Pharmacy Claims	Total number of unique Rx claims linked to an active Enrollee record throughout all associated enrollment periods and associated 16-digit Plan IDs, for the payment year. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.	Plan	1	nonOrphanRxClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Claim Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Claim	1 or more per claim per insurance plan in the reported submission file	includedClaimCategory	ClaimEnrolleeFrequencyClaimCategory	None

Table 39: EDGE Server Claim and Enrollee Frequency Report Plan Category (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Calendar Month Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report **Note:** When assigning data elements to a month, the following dates are used from the claim record. Medical Claims: Statement Covers From date Pharmacy Claims: Prescription Fill Date Supplemental Records: Service To Date	Calendar Month	1 to 12 per claim per insurance plan in the reported submission file	includedCalendarMonthCategory	ClaimEnrolleeFrequencyCalendarMonthCategory	None

The data characteristics for the EDGE Server Claim and Enrollee Frequency Report Claim are as shown in Table 40. These elements are defined in the *ClaimEnrolleeFrequencyClaimCategory.xsd*.

Table 40: CEFR Claim and Enrollee Frequency Report Claim

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Claim Type	Type of Claim: 'P', 'M', 'S'.	Claim	1	claimType	String	minLength = 0 maxLength =1
Count of total Active Claims	Count of all activestored claims linked to an Enrollee for each claim type for the Issuer ID. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	1	countofTotalActiveClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Count of Inactive Void Claims	Count of accepted void claims linked to an Enrollee stored as inactive for each claim type for the Issuer ID. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	1	countofTotalInactiveVoidClaims	Integer	minInclusive = 0 maxInclusive = 999999999

Table 40: CEFR Claim and Enrollee Frequency Report Claim (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Number of Claim Records Accepted	Total unique count of accepted claims linked to an Enrollee per claim type. Count includes both active and inactive claims. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	1	totalClaimRecordsAccepted	Integer	minInclusive = 0 maxInclusive = 999999999
Unique Number of Claim Records Resolved	Total unique number of active claims linked to an Enrollee that were originally rejected, but have now been accepted. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	0..1	uniqueClaimRecordsResolved	Integer	minInclusive = 0 maxInclusive = 999999999

Table 40: CEFR Claim and Enrollee Frequency Report Claim (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Count of Claim Lines Accepted	Total unique count of claim lines from claims linked to an Enrollee. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	0..1	totalClaimLinesAccepted	Integer	minInclusive = 0 maxInclusive = 999999999
Total Allowed Cost for RA Inpatient Claims	Total allowed cost on all active Inpatient claims & claims lines linked to an Enrollee included for RA Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	0..1	totalAllowedCostForRaInpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 40: CEFR Claim and Enrollee Frequency Report Claim (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Cost for RA Outpatient Claims	Total allowed cost on all active Outpatient claims & claims lines linked to an Enrollee included for RA Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	0..1	totalAllowedCostForRaOutpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Allowed Cost for RA Professional Claims	Total allowed cost on all active professional claims & claims lines linked to an Enrollee included for RA Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	0..1	totalAllowedCostForRaProfessionalClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 40: CEFR Claim and Enrollee Frequency Report Claim (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Allowed Cost for RA Pharmacy Claims	Total allowed cost on all active pharmacy claims & claims lines linked to an Enrollee included for RA *The value of this element will not be populated until Rx claims are considered by RA claim selection.* Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	0..1	totalAllowedCostForRaPharmacyClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Plan Paid Amount for RA Inpatient Claims	Total plan paid amount on all active Inpatient claims & claims lines linked to an Enrollee included for RA Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	0..1	totalPlanPaidAmountForRaInpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 40: CEFR Claim and Enrollee Frequency Report Claim (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Plan Paid Amount for RA Outpatient Claims	Total plan paid amount on all active Outpatient claims & claims lines linked to an Enrolleee included for RA Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	0..1	totalPlanPaidAmountForRaOutpatientClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99
Total Plan Paid Amount for RA Professional Claims	Total plan paid amount on all active professional claims & claims lines linked to an Enrolleee included for RA Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Claim	0..1	totalPlanPaidAmountForRaProfessionalClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Table 40: CEFR Claim and Enrollee Frequency Report Claim (continued)

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Total Plan Paid Amount for RA	Total plan paid amount on all active, RA eligible pharmacy accepted claims & claims lines linked to an Enrollee	Claim	0..1	totalPlanPaidAmountForRaPharmacyClaims	Decimal	minInclusive = 0 maxInclusive = 999999999.99

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Pharmacy Claims	*The value of this element will not be populated until Rx claims are considered by RA claim selection.* Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID.					
Form Type Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report.	Form Type	0 or more per claim per insurance plan in the reported submission file	includedFormTypeCategory	ClaimEnrolleeFrequencyFormTypeCategory	none

The data characteristics for the EDGE Server Claim and Enrollee Frequency Report Form Type are as shown in Table 41. These elements are defined in the *ClaimEnrolleeFrequencyFormTypeCategory.xsd*.

Table 41: CEFR Claim and Enrollee Frequency Report Form Type

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Form Type	Form type for Medical claim will be either 'I' (institutional) or "P' (professional) Form type for Pharmacy claim will be Null (pharmacy) and will not appear on the report.	Form Type	0…1	formType	String	minLength = 0 maxLength = 1 "I" = Institutional "P" = Professional
Count of total Active Claims	Count of all active stored claims linked to an Enrollee per claim type for the Issuer ID. Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Form Type	0…1	countofTotalActiveClaims	Integer	minInclusive = 0 maxInclusive = 999999999
Count of Inactive Void Claims	Count of accepted void claims linked to an Enrollee stored as inactive per claim type for the Issuer ID Claims are linked by Enrollee ID on the enrollment period where: Fill Date within the payment year, and Fill Date is within an active enrollment period for the same enrollee and Plan ID. Statement Covers Through date within the payment year, and Statement Covers From Date is within an active enrollment period for the same enrollee and Plan ID.	Form Type	0…1	countofTotalInactiveVoidClaims	Integer	minInclusive = 0 maxInclusive = 999999999

The data characteristics for the EDGE Server Claim and Enrollee Frequency Report Calendar Month are as shown in Table 42. These elements are defined in the *ClaimEnrolleeFrequencyCalendarMonthCategory.xsd.*

Table 42: EDGE Server Claim Enrollee Frequency Calendar Month Category

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Calendar Month	The calendar month in which the pharmacy claim Fill Date occurs and the month in which the medical claim Statement Covers Through date occurs.	Calendar Month	1	calendarMonth	string	minLength = 0; maxLength = 2
Claim Category	This XML element describes the Claim Selection Plan related elements for this report. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the Claim Selection Plan section of the report **Note:** When assigning data elements to a month, the following dates are used from the claim record. Medical Claims: Statement Covers From date Pharmacy Claims: Prescription Fill Date Supplemental Records: Service To Date	Claim	1 or more per claim per insurance plan in the reported submission file	includedClaimCategory	ClaimEnrolleeFrequencyClaimCategory	None

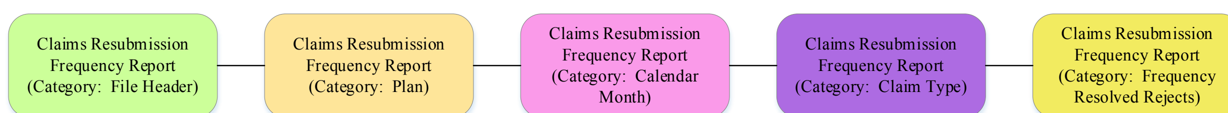
Claim Resubmission Frequency Report (CRFR)Message Format (or Record Layout) and Required Protocols

The outbound CRFR Report is available to CMS and the issuer/submitting organization. This report contains information on selected data from claim resubmissions primarily detailing resolved and unresolved rejected active non-orphan claims counts. The CRFR Report will be generated independently with a remote command.

5.1.1.16 File Layout

This section specifies the file layout for the CRFR Report. At a high level, it consists of five (5) record types or categories of information, as shown in Figure 10.

Figure 9: EDGE Claim Resubmission Frequency Report



The CRFR Report consists of report File Header, Plan, Claim Type, Calendar Month, and Frequency Distribution Resolved Rejects categories.

The CRFR XSD schema that should be utilized for creating and reading from the XML output report is listed in Appendix B.

5.1.1.17 Field/Data Elements and Descriptions

The data characteristics for the EDGE Server Claim Resubmission Frequency Report (CRFR) category are as shown in Table 43. The root element of the CRFR in the XSD is ClaimResubmissionFrequencyReport (ClaimResubmissionFrequencyReport.xsd). This element is required and all the other elements defined in this section for the CRFR are embedded within this element start and end tags.

Table 43: EDGE Server Claim Resubmission Frequency Report Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Report Header	This XML element describes the file processing header related elements for this report. It uses the shared common file header XML elements utilized across the outbound reports. The XML element exists to connect this level of the XML file to the nested common elements and has no business meaning. It should be processed to identify the file header section of the report.	File Header	1	includedFileHeader	RARICommonOutboundFileHeader.xsd	none
Benefit Year	The input parameter year in which the report was run for.	File Header	1	calendarYear	String	YYYY
Resolved Rejects	Total number of unique claims records that were once in rejected status but are now in accepted status.	Claim Type	1	resolvedRejects	Integer	minInclusive = 0
Plan Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Plan	1 or more per claim per insurance plan in the reported submission file	includedPlanCategory	ClaimResubmissionFrequencyReportPlanCategory.xsd	none

The data characteristics for the EDGE Server Claim Resubmission Frequency Report Plan are as shown in Table 44. These elements are defined in the ClaimResubmissionFrequencyReportPlanCategory.xsd.

Table 44: EDGE Server Claim Resubmission Frequency Report Plan

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Plan ID	Unique identifier for insurance plan offered by the issuer that the enrollee is covered under identifier.	Plan	1	planIdentifier	string	minLength = 0 maxLength = 14
Calendar Month Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Calendar Month	Minimum = 1 (inclusive); Maximum = 12 (inclusive)	includedCalendarMonthCategory	ClaimResubmissionFrequencyReportCalendarMonthCategory.xsd	none

The data characteristics for the EDGE Server Claim Resubmission Frequency Report Calendar Month are as shown in Table 45. These elements are defined in the ClaimResubmissionFrequencyReportCalendarMonthCategory.xsd.

Table 42: EDGE Server Claim Resubmission Frequency Report Calendar Month

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Calendar Month	Calendar month associated to Pharmacy/Medical claims, that were once in rejected status but are now in accepted status for the calendar year. Calendar month is derived from the Statement Covers To Date/Fill Date of the accepted Medical/Pharmacy claim. Calendar month shall populate 1-12, January through December respectively, for the calendar year.	Calendar Month	1	calendarMonth	String	minLength = 0; maxLength = 2
Claim Type Category	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Claim Type	1 or more in the reported submission file	includedClaimTypeCategory	ClaimResubmissionFrequencyReportClaimTypeCategory.xsd	none

The data characteristics for the EDGE Server Claim Resubmission Frequency Report Claim Type are as shown in Table 46. These elements are defined in the ClaimResubmissionFrequencyReportClaimTypeCategory.xsd.

Table 46: EDGE Server Claim Resubmission Frequency Report Claim Type

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Claim Type	This field will be populated with the value "M" for medical or "P" for pharmacy regardless of the claim type being Institutional, Outpatient, or Professional. The value "M" will be used when the accepted Medical claim was previously rejected. The value "P" will be used for accepted Pharmacy claim that was previously rejected.	Claim Type	1	claimType	String	minLength = 0 maxLength = 1 "M": Medical "P": Pharmacy

Table 46: EDGE Server Claim Resubmission Frequency Report Claim Type Continued

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Resolved Rejects	Total number of unique claims records that were once in rejected status but are now in accepted status.	Claim Type	1	resolvedRejects	Integer	minInclusive = 0
Frequency Distribution Resolved Rejects	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning.	Frequency Distribution Resolved Rejects Type	1 or more	includedResolvedRejectsCategory	ClaimResubmissionFrequencyReportResolvedRejectsCategory.xsd	none

The data characteristics for the EDGE Server Claim Resubmission Frequency Report Frequency Distribution Resolved Rejects are as shown in Table 47. These elements are defined in the ClaimResubmissionFrequencyReportResolvedRejectsCategory.xsd.

Table 44: EDGE Server Claim Resubmission Frequency Report Frequency Distribution Resolved Rejects

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Resubmission Count	Number of times a unique claim has been resubmitted.	Frequency Distribution Resolved Rejects Type	1	resubmissionCount	Integer	minInclusive = 0
Frequency	Count of claims with this number of resubmissions.	Frequency Distribution Resolved Rejects Type	1	countFrequency	Integer	minInclusive = 0

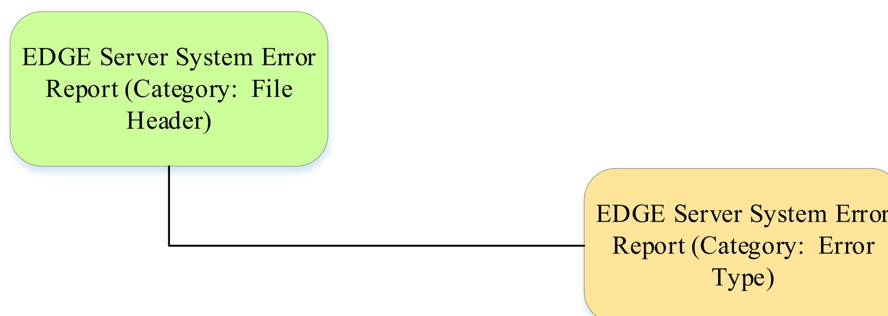
System Error (SE) Report Message Format (or Record Layout) and Required Protocols

The outbound SE Report is available to CMS and the issuer/submitting organization. This report contains information on system-level errors that cause processing to abort on the EDGE server. The SE Report will generate independently when an error occurs.

5.1.1.18 File Layout

This section specifies the file layout for the SE Report. At a high-level the report consists of the two (2) record types or categories of information, as shown in Figure 8.

Figure 10: EDGE Server System Error Report



The SE Report consists of a report File Header category and an Error Type category.

The SE XSD schema utilized for creating and reading from the XML output report is listed in Appendix C.

5.1.1.19 Field/Data Elements and Descriptions

The data characteristics for the EDGE Server System Error (SE) Report category are as shown in Table 32. The root element of the SE in the XSD is EdgeServerErrorStatus (*EdgeServerErrorStatus.xsd*). This element is required and all the other elements defined in this section for the SE are embedded within this element start and end tags.

Table 32: SE System Error Report

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Common System Error Header	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report.	Header	1	commonSystemErrorHeader	CommonSystemErrorHeader	none
System Error Type	It exists to connect this level of the XML file to the next level of nested XML elements and has no business meaning. It should be processed to identify the insurance plan section of the report.	Error	1 or more per insurance plan per in the reported submission file	systemErrorType	SystemErrorType	none

The data characteristics for the SE Report Error Header category are as shown in Table 33. These elements are defined in the *CommonSystemErrorHeader.xsd*.

Table 33: SE Common System Error Header

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
File ID	The CMS system generated unique identifier of a report file.	File Header	1	outboundFileIdentifier	String	minLength = 1 maxLength = 80
Run Date	The date and time when the CMS processed file is generated.	File Header	1	outboundFileGenerationDateTime	String	Strict: YYYY-MM-DDTHH:mm:SS
EDGE Server Version	Version number that corresponds to the Application, Database, Operating System, and Reference Table versions that were used to process the inbound file and produce the report.	File Header	0	edgeServerVersion	String	minLength = 1; maxLength = 75
Report Type	Defines values of outbound validation report.	File Header	1	outboundFileTypeCode	String	minLength = 1 maxLength = 30 Value: “SE”’
Server ID	The unique identifier of an EDGE server.	File Header	1	edgeServerIdentifier	String	minLength = 1 maxLength = 12
Issuer ID	The unique identifier for an issuer.	File Header	1	issuerID	Sting	Length = 5

The data characteristics for the SE Report Error Type category are as shown in Table 34. These elements are defined in the *SystemErrorType.xsd*.

Table 34: SE Server System Error Type

Business Data Element	Description	Data Category	Frequency of Occurrence	XML Element Names	Data Type	Restrictions
Error Code	The unique identifier of the Error Log.	Error	1	errorCode	String	minLength = 1 maxLength = 50
Error Category	The category of the Error Log.	Error	1	errorCategory	String	minLength = 1 maxLength = 100
Error Description	Additional information about the Error Code.	Error	1	errorDescription	String	minLength = 1; maxLength = 500

Communication Methods

This section describes the communication methods for the EDGE server. All communication between the EDGE server and CMS Management Console will use Secure Sockets Layer (SSL), namely Secure Shell (SSH)/Secure File Transfer Protocol (SFTP) and Hyper Text Transfer Protocol Secure (HTTPS). Further, all Web browser communication with the EDGE server will also be done using HTTPS. Internet Protocol (IP) Tables will be configured for the EDGE server to restrict incoming and outgoing network traffic across the server only for specific ports.

Interface Initiation

The system operates on a SFTP interface along with user interface for lightweight submission and report access with 24/7 availability.

Flow Control

Prior to start of the submission file structure and data validations, the system will create a backup of the inbound file and the data repository. After the data processing logic is executed, the system will create another backup of the outbound files and the data processing. This allows the system to recover from any failures and minimize reprocessing of data.

Notification of failures will be communicated to the EDGE server user through email. Detailed processing reports will sent to the issuer/submitter to correct the erroneous data and allow for resubmittal of the corrected information. The detailed error report will identify the records that are in error including the data element, submitted value and the detailed error message flagging the error. This allows the user to quickly identify their errors and apply the appropriate data corrections. The issuer/submitter can view the reports or data files using their Web browser user interface. Alternatively, they can download the files using SFTP either manually or as part of an automated process. The error reports will be placed in the output folder of the EDGE server application.

Security Requirements

The security requirements for accessing the outbound files are described in the existing EDGE server RARI ICD published on REGTAP, document number: *0.0.4-CMSES-ICD-4763*.

Acronyms

Table 48: Acronyms

Acronym	Literal Translation
ACA	Affordable Care Act of 2010
APTC	Advanced Premium Tax Credit
CCIIO	Center for Consumer Information and Insurance Oversight
CEFR	EDGE Server Claim and Enrollee Frequency Report
CMS	Centers for Medicare & Medicaid Services
CMS-ES	CMS-EDGE Server
CPT/HCPCS	Current Procedural Terminology/ Healthcare Common Procedure Coding System
CSR	Cost Sharing Reduction
DOB	Date Of Birth
Dx	Diagnosis
ECD	Enrollee Claims Detail
ECS	Enrollee Claims Summary
EDI	Electronic Data Interchange
ES	EDGE Server
ESES	EDGE Server Enrollment Submission
ESMCS	EDGE Server Medical Claims Submission
ESPCS	EDGE Server Pharmacy Claims Submission
ESSFS	EDGE Server Supplemental File Submission
FDEEAF	Frequency by Data Element for Enrollment Accepted Files Report
FDEPAF	Frequency by Data Element for Pharmacy Accepted Files Report
FDEMAF	Frequency by Data Element for Medical Accepted Files Report
FDESAF	Frequency by Data Element for Supplemental Accepted Files Report
HCC	Hierarchical Condition Category
HHS	Health & Human Services
HIPAA	Health Insurance Portability and Accountability Act
HTTPS	Hypertext Transfer Protocol Secure
ICD	Interface Control Document
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
IP	Internet Protocol
IVA	Initial Validation Audit
IVAS	Initial Validation Audit Statistics
MC	Medical Claim
MOOP	Maximum Out Of Pocket
MR	Medical Record
NDC	National Drug Code

Acronym	Literal Translation
NPI	National Provider Identifier
PHI	Protected Health Information
RA	Risk Adjustment
RACSD	Risk Adjustment Claim Selection Detail Report
RACSS	Risk Adjustment Claim Selection Summary Report
RADV	Risk Adjustment Data Validation
RADVDE	Risk Adjustment Data Validation Detailed Enrollee Report
RADVEE	Risk Adjustment Data Validation Enrollment Extract Report
RADVIVAS	Risk Adjustment Data Validation Initial Validation Audit Statistics Report
RADVMCE	Risk Adjustment Data Validation Medical Claim Extract Report
RADVPS	Risk Adjustment Data Validation Population Summary Statistics Report
RADVSE	Risk Adjustment Data Validation Supplemental Extract Report
RARSD	RA Risk Score Detail Report
RARSS	Risk Adjustment Risk Score Summary Report
RATEE	Risk Adjustment Transfer Elements Extract
RAUF	Risk Adjustment User Fee
RI	Reinsurance
RIDE	Reinsurance Detail Enrollee Report
RISR	Reinsurance Summary Report
RxC	Pharmacy Claim
SE	EDGE Server System Error Report
SFTP	Secure File Transfer
SSH	Secure Shell
SSL	Secure Sockets Layer
XML	Extensible Markup Language
XSD	XML Schema Definition

Appendix A EDGE Server Outbound Reports XSDs

This section presents the XSD schema for the outbound reports generated by the EDGE server. The issuer/submitter will utilize these files to process the XML instance of these reports. These files are located in the REGTAP Library at https://www.REGTAP.info/.

- Enrollee (With and Without) Claims – Detail
- Enrollee (With and Without) Claims – Summary
- Frequency by Data Element for Enrollment Accepted Files
- Frequency by Data Element for Pharmacy Accepted Files
- Frequency by Data Element for Medical Accepted Files
- Frequency by Data Element for Supplemental Accepted Files
- System Error Report
- Claim and Enrollee Frequency Report
- Claim Resubmission Report
  -

Appendix B Referenced Documents

Table 49: Referenced Documents

Document Name	Document Number / URL	Issuance Date
Interface Control Document (ICD)	URL: https://www.REGTAP.info Document Number: 0.0.4-CMSES-ICD-4763	8/11/2015

Appendix C System Error Codes

This section defines the Error Codes that will be used for the EDGE Server System Error outbound Report. The table below specifies the Error Codes:

Table 50: System Error Codes

Unique Error Code	Error Code Description
100	Java.lang.OutOfMemoryError: Java heap space

Appendix D Document Control History

The table below records information regarding changes made to this document prior to the most recent maintenance release of this ICD Addendum.

Version Number	Date	Author/Owner	Description of Change
05.00.22	10/23/18	Accenture / CCIIO	Separate ICD Document

Centers for Medicare & Medicaid Services

CMS-EDGE Server / CMS-ES

Risk Adjustment and Reinsurance (RARI) Interface Control Document Addendum Version History

February 11, 2019

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1 Purpose

This document provides the version history of the Risk Adustment (RA) and Reinsurance (RI) ICD Addendum before it was was separated into the following five documents:

RARI ICD - RA Addendum

RARI ICD - Risk Adjustment Data Validation (RADV) Addendum

RARI ICD - RI Addendum

RARI ICD - High Cost Risk Pool (HCRP) Addendum

RARI ICD - Frequency Addendum

The following is the link to the Registration For Technical Assistance Portal (REGTAP) library for the 5 ICD addenda listed above: https://www.regtap.info/reg_library.php.

2 Introduction

This is a version history RARI ICD Addendum prior to version 5.00.22. The RARI ICD (and its addenda) describe the relationship between CMS and the issuer's EDGE server. Its addenda serve to define additional reports that will be produced by the issuer's EDGE servers as a supplement to the ICD, currently published in the Registration for Technical Assistance Portal (REGTAP) Library. These reports include the risk adjustment and reinsurance calculation reports that are used for payment processing, as well as additional analytic reports.

3 Overview

As part of the Affordable Care Act (ACA), two (2) programs were identified to mitigate the impact of adverse selection of plans and provide stability for issuers. States have the option to operate the following programs themselves or have the Department of Health and Human Services (HHS) operate the programs on their behalf.

- Section 1343 of the ACA created the Risk Adjustment (RA) program to better spread the financial risk borne by health insurance issuers in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. Under the RA program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Non-grandfathered, Individual and Small Group Market plans, irrespective of whether they are a part of the Marketplace, will submit RA data (claims and enrollee data) that will be used to determine individual-level risk scores, plan average actuarial risk and associated payments and charges.
- Included in the RA program is the High Cost Risk Pool (HCRP), which was implemented starting BY2018 to mitigate incentives for risk selection to avoid high-cost enrollees. Beginning BY2018, the HCRP partially reimburses issuers for enrollees'aggregated issuer plan paid claim amounts that are above a certain thresholdattachment point (AP), at a certain coinsurance rate. HCRP applies to allissuers who offer PPACA health insurance coverage in the small groupand/or individual market (including catastrophic and merged), both on and offthe Exchange. HCRP payments are funded by a national

percent of premiumcharge on all issuers by market, and all payments and charges are in additionto any RA transfers. [Note: HCRP information can be found in the 2018Payment Notice (FR 81 94080-94082)]

- Section 1341 of the ACA establishes the Reinsurance (RI) program as a temporary three-year program that commences in 2014. RI provides funds to issuers that incur high costs for claims in the Individual Market. In accordance with the final rule, RI payments are based on a coinsurance rate or proportion of an issuer's claims costs that are above an attachment point and below a RI cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for RI payments, while the RI cap is the dollar limit at which point an issuer is no longer eligible for RI payments. The attachment point, coinsurance rate and RI cap are calculated based on an issuer's total incurred costs for an individual enrollee in a given calendar year. Non-grandfathered, Individual Market plans, both on and off the Marketplace, will submit RI data (claims and enrollee data) that will be used to determine if an individual market plan issuer is eligible for RI.

CMS' Center for Consumer Information and Insurance Oversight (CCIIO) on behalf of HHS will develop the software to evaluate and perform the RA and RI calculations.

When evaluating the model for collecting and processing the data received from issuers, it was determined that a distributed data collection model would prove the most effective. Specifically, this model would ensure:

- Issuer proprietary data would not be transmitted to HHS;
- Minimal transfer of protected health information (PHI) to lower privacy and data security risks;
- Standardization of business processes, timing and rules.

These factors resulted in the concept of the EDGE server. Issuers, in states where HHS is operating an RA and/or RI program, will submit enrollee, pharmacy claim, medical claim and supplemental diagnosis information from their proprietary systems to an issuer-owned or Third Party Administrator (TPA)-hosted EDGE server. The EDGE server will run HHS-developed software designed to verify submitted data and execute the RA and RI processes. Issuers will have the option to own and operate the server themselves, or to have a third-party entity operate the server. Detailed data, file processing metrics and outbound data files will be provided to insurance companies/issuers. Only plan summarized data and file processing metrics will be provided to HHS.

4 Consolidated ICD Addendum Version History

Version Number	Date	Author/Owner	Description of Change
01.00.00	12/14/2014	Accenture / CCIIO	Initial Version

<table>
<tr><th>Version Number</th><th>Date</th><th>Author/Owner</th><th>Description of Change</th></tr>
<tr><td>02.00.00</td><td>1/26/2015</td><td>Accenture / CCIIO</td><td>Restriction Update
Table 3: outboundFileGenerationDateTime
Table 82: edgeServerVersion
New Sections Added
Section 0 Message Format (or Record Layout) and Required Protocols for EDGE Server System Error (SE)
Appendix C</td></tr>
<tr><td>03.00.00</td><td>2/15/2015</td><td>Accenture/CCIIO</td><td>Sections Updated
Section 0 Requirements for Additional EDGE Server Outbound Reports
Section 5.1.1.11 Field/Data Elements and Descriptions
Added Table 41(plan level to RISR Report)
Section 0 Transactions
Section 0 File Naming Convention
Updated Table 2: Added local execution zone
Appendix A
New Section Added
Section 0 Error! Not a valid result for table.
Restriction Update
Table 14: market
Table 40: issuerLegalName
Table 52: market
Table 70: planMarketType</td></tr>
</table>

Version Number	Date	Author/Owner	Description of Change
04.00.00	3/9/2015	Accenture/CCIIO	Tables Updated Table 15: includedEnrolleeCategory placement updated New Fields Added **Error! Reference source not found.** totalNumberofActiveEnrollmentPeriods, totalStoredActiveMedicalClaims, totalStoredActivePharmacyClaims, totalNumberEnrolleesWithLinkedMedicalClaims, totalNumberEnrolleesWithLinkedPharmacyClaims, totalNumberOfMedicalClaimsNoLinkedEnrolleeID, totalNumberOfPharmacyClaimsNoLinkedEnrolleeID **Error! Reference source not found.**: calendarMonth Existing Fields Removed Table 108: totalClaimRecordsReceived, totalClaimRecordsRejected, uniqueClaimRecordsRejected Table 107 uniqueRecordsRejected, unresolvedRejects Element Name/Description Updates Table 37: totalNumberOfEnrolleesNoLinkedClaims, totalNumberOfEnrolleesNoLinkedEnrolleeID Table 38: activeEnrolleeIDswithoutClaims Table 39: activeClaimsIDsWithoutEnrolleeRecords Table 76: totalNumberOfActiveEnrollmentRecords, totalNumberEnrolleelinkClaimFlaggedRaClaimSelection **Error! Reference source not found.**: totalNumberOfActiveEnrollmentRecords, totalNumberOfStoredActiveClaims, totalNumberOfEnrolleesNoLinkedClaims, totalNumberOfClaimsNoLinkedEnrolleeID Element Name/Restriction Updates Table 15: RARSD Risk Score Detail Rating Area ratingArea Table 53: RARSS Risk Score Summary Rating Area ratingArea Table 71: RATEE RA Transfer Rating Area Category ratingArea New Sections Added Section 0: Message Format (or Record Layout) and Required Protocols for EDGE Server Claim Resubmission Frequency Report (CRFR) Section 0 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Payment HCC Enrollee Report (RAPHCCER)

04.01.00	4/1/2015	Accenture/CCIIO	Element Name/Description Updates 0 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Risk Score Detail Report (RARSD) Multiple fields updated 0 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Risk Score Summary Report (RARSS) Multiple fields updated **Error! Reference source not found.** metalLevel 5.1.1.15 Field/Data Elements and Descriptions totalEnrollees Element Restriction Updates Table 5: RACSD Claim Selection Detail Calendar Year Table 6: RACSD Claim Selection Detail Plan Table 8: RACSD Claim Selection Detail Service Code Table 9: RACSD Claim Selection Detail Reason Code Table 12: RACSD Claim Selection Detail Medical Claim Table 13: RARSD Risk Score Detail File Header Table 14: RARSD Risk Score Detail Plan Table 15: RARSD Risk Score Detail Rating Area Table 19: RARSD Risk Score Detail Enrollee Table 20: RARSD Risk Score Detail Diagnosis Code Table 22: RARSD Risk Score Detail Payment HCC Table 24: RARSD Risk Score Detail Severity Table 30: RARSD Risk Score Detail Enrollee Period Category Table 33: RIDE RI Enrollee Detail Enrollee Table 34: RIDE RI Enrollee Detail Report Plan Table 35: RIDE RI Detail Enrollee Report Claim Table 38: ECD Enrollee Claims Detail Enrollee Without Table 39: ECD Enrollee Claims Detail Claims Without Table 40: RISR Summary File Header Table 41: RISR Summary Plan Result Table 42: RARSS Risk Score Summary File Header Table 43: RARSS Risk Score Summary Diagnosis Code Table 44: RARSS Risk Score Summary Payment HCC Table 46: RARSS Risk Score Summary Severity Table 47: RARSS Risk Score Summary HCC Group Table 48: RARSS Risk Score Summary HCC Interaction Group Table 50: RARSS Risk Score Summary HCC Dropped Table 52: RARSS Risk Score Summary Plan Table 53: RARSS Risk Score Summary Rating Area Table 54: RARSS Risk Score Summary Plan Diagnosis Code Table 55: RARSS Risk Score Summary Plan Payment HCC Table 57: RARSS Risk Score Summary Severity Table 58: RARSS Risk Score Summary Plan HCC Group Table 59: RARSS Risk Score Summary HCC Interaction Group Table 60: RARSS Risk Score Summary CSR Factor Table 61: RARSS Risk Score Summary HCC Dropped Table 64: RACSS Claim Selection Summary Calendar Year Table 65: RACSS Claim Selection Summary Plan Table 66: RACSS Claim Selection Summary Bill Type Table 69: RATEE RA Transfer File Header Table 70: RATEE RA Transfer Plan Table 71: RATEE RA Transfer Rating Area Category Table 72: RADVPS Population Summary Statistics Table 73: RADVPS Population Summary Stratum Indicator Table 87: FDEPAF Frequency by Data Element for Pharmacy Derived Amount Indicator Table 90: FDEMAF Frequency by Data Element for Medical Bill Type Claim Header Table 91: FDEMAF Frequency by Data Element for Medical

Version Number	Date	Author/Owner	Description of Change
			Diagnosis Qualifier Table 93: FDEMAF Frequency by Data Element for Medical Discharge Status Code Table 94: FDEMAF Frequency by Data Element for Medical Derived Amount **Error! Reference source not found.** Table 98: FDESAF Frequency by Data Element for Supplemental Diagnosis Code Table 108: CEFR Table 110: EDGE Server Claim Enrollee Frequency Calendar Month Table 112: EDGE Server Claim Resubmission Frequency Report Plan Table 113: EDGE Server Claim Resubmission Frequency Report Calendar Month Table 114: EDGE Server Claim Resubmission Frequency Report Claim Type Table 116: EDGE Server RA Payment HCC Enrollee Report Header Table 117: EDGE Server RA Payment HCC Enrollee Report Counts Table 118: EDGE Server RA Payment HCC Enrollee Report Form Type **Error! Reference source not found.** **Error! Reference source not found.** File Type Updates Table 6: RACSD Claim Selection Detail Plan claimsIncluded, claimsExcluded Table 49: RARSS Risk Score Summary CSR Factor membersbyCsrFactorCount Table 60: RARSS Risk Score Summary CSR Factor membersbyCsrFactorCount Frequency of Occurrence Updates Table 9: reasonCode Table 25: hccGroup Table 29: droppedHCCs Table 89: Bill Type Category Table 90; Diagnosis Code Qualifier Category, Derived Amount Indicator, billType Table 91: diagnosisQualifier Table 92: diagnosisCode, totalCountDiagnosisCode Table 93: dischargeStatusCode, totalCountDischargeStatusCode Table 94: derivedAmountIndicator, totalCountDerivedAmountIndicator Table 109: formType, countofTotalActiveClaims, countofTotalInactiveVoidClaims XML Element Name Change Table 110: calendarMonth to planIdentifier XSD Name Updates Table 54, Table 55, Table 57 Table 42: RARSS Risk Score Summary File Header meanUniqueDiagnosisPerUtilizers, meanUniqueDiagnosisPerRAUtilizers, meanUniqueDiagnosisPerRAPaymentHccEnrollee Table 53: RARSS Risk Score Summary Rating Area meanUniqueDiagnosisPerUtilizers, meanUniqueDiagnosisPerRAUtilizers, meanUniqueDiagnosisPerRAPaymentHccEnrollee

Version Number	Date	Author/Owner	Description of Change
04.01.01	11/2/2015	Accenture/CCIIO	Sections Updated Section 0: Message Format (or Record Layout) and Required Protocols for EDGE Server RA Claim Selection Detail Report (RACSD) Updated when RA Claim Selection Detail report is executed Section 0: Message Format (or Record Layout) and Required Protocols for EDGE Server RA Claim Selection Summary Report (RACSS) Updated when RA Claim Selection Summary report is executed Section 0: Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Enrollment Accepted Files Report (FDEEAF) Corrected report description, as the report description is not cumulative across enrollment files Element Descriptions Updated Table 33: coinsurancePercentPayments

Version Number	Date	Author/Owner	Description of Change
04.02.00	1/22/2016	Accenture/CCIIO	Sections Updated The following report descriptions were updated to indicate that system generated cross year enrollment data is reflected in the report output for these reports. 0: RA Risk Score Detail Report (RARSD) 0: RA Risk Score Summary Report (RARSS) 0: RA Transfer Element Extract Report (RATEE) 0: RA Data Validation Population Summary Statistics Report (RADVPS) 0: RA Payment HCC Enrollee Report (RAPHCCER) New Fields Added Table 13: crossYearEnrolleeCount, crossYearEnrollment PeriodCount, crossYearMemberMonthCount Table 15: crossYearEnrolleeCount, crossYearEnrollmentPeriodCount, crossYearMemberMonthCount Table 30: crossYearEnrollmentIndicator, crossYearClaimIdentifier Table 35: crossYearClaimIndicator Table 42: crossYearEnrolleeCount, crossYearEnrollmentPeriodCount, crossYearMemberMonthCount Table 53: crossYearEnrolleeCount, crossYearEnrollmentPeriodCount, crossYearMemberMonthCount Fields Removed **Error! Reference source not found.**: exchange, metalLevel Fields Updated Table 7: billTypeCode, claimsIncluded, claimsExcluded Table 8: serviceCode, claimsIncluded, claimsExcluded Table 12: billTypeCode, serviceCode Table 24: hccSeverity, enrolleeV3Indicator, interactionGroup Table 46: hccSeverity Table 57: hccSeverity Table 67: serviceCode Table 68: reasonCode, claimsExcluded

Version Number	Date	Author/Owner	Description of Change
04.03.00	3/17/2016	Accenture/CCIIO	Fields Removed Table 15: totalIHCC1, totalIHCC2, totalIHCC3, totalIHCC4, totalIHCC5 Fields Added Table 17: RARSD Risk Score Detail Rating Area Severity Level: hccSeverity , enrolleeSeverityCount Restrictions Modified Table 19: IHCCSeverity Level Element Descriptions Updated Table 73: stratumLevel, totalClaim, totalPlanPaidAmountFile, totalNumberDiagnosisCodes, totalNumberRADiagnosisCodes, totalNumberUniqueDiagnosis, totalNumberUniqueRADiagnosis
04.03.01	3/17/2016	Accenture/CCIIO	Element Descriptions Updated Element descriptions updated in the following reports for clarity and to indicate that counts will no longer be duplicated between plans at the file header level for any fields. Table 13: RARSD Risk Score Detail File Header Table 13: RARSD Risk Score Detail Rating Area Table 42: RARSS Risk Score Summary File Header Table 42: RARSS Risk Score Summary Rating Area Data Type Modified Table 59: Payment Year Restrictions Modified Table 13: calendarYear Table 30: coverageStartDate, coverageEndDate Table 72: paymentYear, preliminaryFinalRun Table 73: minDateOfBirth, maxDateOfBirth Table 116: calendarYear

Version Number	Date	Author/Owner	Description of Change
05.00.00	5/16/2016	Accenture/CCIIO	Sections Updated Section 0: Transactions Section 0: Requirements for Additional EDGE Server Outbound Reports New Sections Added Section 0: **Error! Not a valid result for table.** Section 0: Message Format (or Record Layout) and Required Protocols for EDGE Server RADV Detailed Enrollee (RADVDE) Report Section 0: Message Format (or Record Layout) and Required Protocols for EDGE Server RADV Enrollment Extract (RADVEE) Section **Error! Not a valid result for table.** Section 0: Message Format (or Record Layout) and Required Protocols for EDGE Server RADV Supplemental Extract Report (RADVSE) Element Descriptions Updated Table 73: meanRiskScore, minRiskScore, maxRiskScore, stdDevRiskScore, averagePremium, totalPremiumAmount Table 116: totalMemberMonthsEnrolleePmtHCC **Error! Reference source not found.**: totalMemberMonthsEnrolleePmtHCC **Error! Reference source not found.**: totalMemberMonthsEnrolleePmtHCC
05.00.01	7/08/2016	Accenture/CCIIO	Element Descriptions Updated Table 73: averagePremium, totalPremiumAmount Table 124: averagePremium , totalPremiumAmount, stratumSize Table 103: Standard Deviation Risk Score, Mean Risk Score, Min Risk Score and Max Risk Score
05.00.02	09/02/2016	Accenture/CCIIO	Validation Zone Updated the following sections to include Validation Zone 4.2 Functional Allocation 5.1.1 Assumptions Updated the following tables to include Validation Zone for the Execution Type: Table 2: Execution Zone

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05.00.03	02/09/2017	Accenture	Section 5.1.18.2 Field/Data Elements and Descriptions Updated 2 fields to the table below Table 72: FDEMAF Frequency by Data Element for Medical Claim Type Header Section 5.1.19.2 Field/Data Elements and Descriptions Updated 3 fields to the table below Table 78: FDESAF Frequency by Data Element for Supplemental Accepted Files Header
05.00.04	02/17/2017	Accenture/CCIIO	Section 5.1.25.2 Field/data Elements and Descriptions Updated 1 field to the table below Table 105: RADVDE RADV Detailed Enrollee (continued)
05.00.04	02/28/2017	Accenture/CCIIO	Section 5.1.18.2 Field/Data Elements and Descriptions Updated 2 fields to the table below Table 72: FDEMAF Frequency by Data Element for Medical Claim Type Header Section 5.1.19.2 Field/Data Elements and Descriptions Updated 2 fields to the table below Table 78: FDESAF Frequency by Data Element for Supplemental Accepted Files Header
05.00.05	03/21/2017	Accenture/CCIIO	Section 5.1.14 Field/Data Elements and Descriptions Updated 2 fields to the table below Table 61: RAUF RA User Fee File Header Updated 2 fields to the table below Table 62: RAUF RA User Fee Plan
05.00.06	04/19/2017	Accenture/CCIIO	Section 5.1.15.2 Field/Data Elements and Descriptions Added 19 new fields to the table below Table 63: ECS Enrollee Claims Summary File Header
05.00.07	04/21/2017	Accenture/CCIIO	Section 5.1.14 Field/Data Elements and Descriptions Table 61: RAUF RA User Fee File Header Removed restriction for Billable Member Months Removed restriction for Total RA User Fee Table 62: RAUF RA User Fee Plan Removed restriction for Billable Member Months Removed restriction for Total RA User Fee

Version Number	Date	Author/Owner	Description of Change
05.00.08	05/10/2017	Accenture/CCIIO	Section 5.1.15.2 Field/Data Elements and Descriptions Updated Figure 11 Updated existing table below: Table 63: ECS Enrollee Claims Summary File Header Updated 1 element Added 2 new Market Type Plan Categories Added 2 new Plan Categories Removed old Plan category table Added 4 new tables Table 64: ECS Enrollee Claims Summary Individual Market Header Added 10 new data elements Table 65: ECS Enrollee Claims Summary Small Group Market Header Added 10 new data elements Table 66: ECS Enrollee Claims Summary Individual Market Plan Updated 8 existing elements Added 12 new data elements Table 67: ECS Enrollee Claims Summary Small Group Plan Updated 8 existing elements Added 12 new data elements
05.00.08	05/26/2017	Accenture/CCIIO	Section 5.1.15.2 Field/Data Elements and Descriptions Updated table 66 Updated table 67 Added table 68 Updated language for 14 elements
05.00.09	07/7/2017	Accenture/CCIIO	Section 5.1.15.2 Fields/Data Elements and Descriptions Added Figure 12: Official ECS Report Use Case Scenarios

Version Number	Date	Author/Owner	Description of Change
05.00.10	8/21/2017	Accenture/CCIIO	**Initial changes as per EDGE 25.0** **<u>Section 5.1.5 Fields/Data Elements and Descriptions</u>** **5.1.5 Message Format and Required Protocols for EDGE Server RA Claim Selection Detail Report (RACSD)** Updated overview Updated Figure 1 Updated Table 5 RACSD Claim Selection Detail Calendar Year Updated Table 6: RACSD Claim Selection Detail Plan Updated Table 7: RACSD Claim Selection Detail Bill Type Updated Table 8: RACSD Claim Selection Detail Service Code Updated Table 9: RACSD Claim Selection Detail Reason Code Added new Table 10: RACSD Claim Selection Detail Pharmacy Claim Added new Table 11: RACSD Claim Selection Detail Unlinked Supplemental Updated Table 12: RACSD Claim Selection Detail Medical Claim Added new Table 13: RACSD Claim Selection Detail Supplemental Record **<u>Section 5.1.6 Fields/Data Elements and Descriptions</u>** **5.1.6 Message Format and Required Protocols for EDGE Server RA Risk Score Detail Report (RARSD)** Updated Overview Updated Figure 2 **<u>Section 5.1.6.2 Fields/Data Elements and Descriptions</u>** **Updated 5.1.6.2 Field/Data Elements and Descriptions** Updated Table 15: RARSD Risk Score Detail Plan Updated Table 16: RARSD Risk Score Detail Rating Area Updated Table 19: RARSD Risk Score Detail Enrollee Updated Table 25: RARSD Risk Score Detail Enrollee Period Category Added new Table 26: RARSD Risk Score Detail Sub Policy **<u>Section 5.1.10.2 Fields/Data Elements and Descriptions</u>** **5.1.10.2 Field/Data Elements and Descriptions** Updated Table 45: RARSS Risk Score Summary Plan **<u>Section 5.1.10.2 Fields/Data Elements and Descriptions</u>** **5.1.11.2 Field/Data Elements and Descriptions** Updated Table 55: RACSS Claim Selection Summary Calendar Year Updated Table 56: RACSS Claim Selection Summary Plan Updated Table 59: RACSS Claim Selection Summary Reason Code

Version Number	Date	Author/Owner	Description of Change
05.00.10	8/25/2017	Accenture/CCIIO	**Updated submission for EDGE 25.0 as per CMS feedback** **5.1.5 Message Format and Required Protocols for EDGE Server RA Claim Selection Detail Report (RACSD)** Updated Table 5 RACSD Claim Selection Detail Calendar Year Updated Table 6: RACSD Claim Selection Detail Plan Updated Table 10: RACSD Claim Selection Detail Pharmacy Claim **5.1.6 Message Format and Required Protocols for EDGE Server RA Risk Score Detail Report (RARSD)** Updated Table 19: RARSD Risk Score Detail Enrollee **5.1.18 Message Format and Required Protocols for EDGE Server Frequency by Data Element for Medical Accepted Files Report (FDEMAF)** Updated Table 80: FDEMAF Frequency by Data Element for Medical Claim Type Header **5.1.21 Message Format (or Record Layout) and Required Protocols for EDGE Server Claim and Enrollee Frequency Report (CEFR)** Table 96: CEFR Claim and Enrollee Frequency Report Plan
05.00.10	8/31/2017	Accenture/CCIIO	**Additional updates for EDGE 25.0 as per CMS feedback** **5.1.17 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Medical Accepted Files Report (FDEMAF)** Table 80: FDEMAF Frequency by Data Element for Medical Claim Type Header **6.1.2 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Supplemental Accepted Files Report (FDESAF)** Table 86: FDESAF Frequency by Data Element for Supplemental Accepted Files Header **6.4.1 Message Format (or Record Layout) and Required Protocols for EDGE Server Claim and Enrollee Frequency Report (CEFR)** Table 94: CEFR Claim and Enrollee Frequency Report Header Table 96: EDGE Server Claim and Enrollee Frequency Report Plan Category Table 97: CEFR Claim and Enrollee Frequency Report Claim
05.00.10	9/1/2017	Accenture/CCIIO	**Minor language updates for EDGE 25.0 as per CMS feedback** Updated Table 96: EDGE Server Claim and Enrollee Frequency Report Plan Category Table 80: FDEMAF Frequency by Data Element for Medical Claim Type Header

05.00.10	9/22/2017	Accenture/CCIIO	**Additional updates for EDGE 25.0** **Section 5.1.4 Message Format (or Record Layout) and Required Protocols for Shared Outbound Report Data Components** Updated Table 3: RA RI Common Outbound File Header Record Field Element/Technical Characteristics **Section 5.1.5 Message Format (or Record Layout) and Required Protocols for Shared Outbound Report Data Components** Updated Table 5 RACSD Claim Selection Detail Calendar Year Updated Table 6: RACSD Claim Selection Detail Plan Updated Table 8: RACSD Claim Selection Detail Service Code Updated Table 9: Claim Selection Reason Codes Updated Table 10: RACSD Claim Selection Detail Pharmacy Claim **Section 5.1.10 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Risk Score Summary Report (RARSS)** Updated Figure 6: EDGE Server RA Risk Score Summary Report Data Categories **Section 5.1.11 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Claim Selection Summary Report (RACSS)** Updated Figure 7: EDGE Server RA Claim Selection Summary Report Data Categories Updated Table 55: RACSS Claim Selection Summary Calendar Year Updated Table 58: RACSS Claim Selection Summary Service Code Updated Table 59: RACSS Claim Selection Summary Reason Code **Section 5.1.14 Message Format (or Record Layout) and Required Protocols for EDGE Server RA User Fee (RAUF)** Updated Table 66: RA User Fee Plan **Section 5.1.16 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Enrollment Accepted Files Report (FDEEAF)** Updated Figure 13: EDGE Server Frequency by Data Element for Enrollment Accepted Files Updated Table 73: FDEEAF Frequency by Data Element for Enrollment Accepted File Header Updated Table 74: FDEEAF Frequency by Data Element for Enrollment Activity Indicator Updated Table 75: FDEEAF Frequency by Data Element for Enrollment Insured Member Gender Code **Section 5.1.17 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Pharmacy Accepted Files Report (FDEPAF)** Updated Figure 14: EDGE Server Frequency by Data Element for Pharmacy Accepted Files Updated Table 76: FDEPAF Frequency by Data Element for Pharmacy Accepted Files Header

Version Number	Date	Author/Owner	Description of Change
			Updated Table 78: FDEPAF Frequency by Data Element for Pharmacy Derived Amount Indicator **Section 5.1.18 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Medical Accepted Files Report (FDEMAF)** Updated Figure 15: EDGE Server Frequency by Data Element for Medical Accepted Files Updated Table 80: FDEMAF Frequency by Data Element for Medical Claim Type Header Updated Table 81: FDEMAF Frequency by Data Element for Medical Bill Type Claim Header Updated Table 83: FDEMAF Frequency by Data Element for Medical Diagnosis Code Updated Table 84: FDEMAF Frequency by Data Element for Medical Discharge Status Code Updated Table 85: FDEMAF Frequency by Data Element for Medical Derived Amount **Section 5.1.19 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Supplemental Accepted Files Report (FDESAF)** Updated Figure 16: EDGE Server Frequency by Data Element for Supplemental Accepted Files Updated Table 86: FDESAF Frequency by Data Element for Supplemental Accepted Files Header Updated Table 87: FDESAF Frequency by Data Element for Supplemental Add/Delete/Void **Section 5.1.21 Message Format (or Record Layout) and Required Protocols for EDGE Server Claim and Enrollee Frequency Report (CEFR)** Updated Figure 18: EDGE Claim and Enrollee Frequency Report Added new Table 96: EDGE Server Claim and Enrollee Frequency Report Individual Market Plan Added new Table 97: EDGE Server Claim and Enrollee Frequency Report Small Group Market Plan Updated Table 98: EDGE Server Claim and Enrollee Frequency Report Plan Category Updated Table 99: CEFR Claim and Enrollee Frequency Report Claim Updated Table 100: CEFR Claim and Enrollee Frequency Report Form Type Updated Table 101: EDGE Server Claim Enrollee Frequency Calendar Month Category **Section 5.1.23 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Payment HCC Enrollee Report (RAPHCCER)** Updated Table 111: EDGE Server RA Payment HCC Enrollee Report Rating Area

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05.00.10	10/6/17	Accenture/CCIO	**Additional Changes as part of EDGE 25.0 per agreement with PPFMG.** Accepted minor wording corrections from CMS throughout the document. **Section 5.1.6 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Risk Score Detail Report (RARSD)** Updated Table 26: RARSD Risk Score Detail Sub Policy **Section 5.1.11 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Claim Selection Summary Report (RACSS)** Updated Table 55: RACSS Claim Selection Summary Calendar Year Updated Table 56: RACSS Claim Selection Summary Plan
05.00.10	10/11/17	Accenture/CCIIO	**Additional Language clarifications as part of EDGE 25.0 per discussion with PPFMG** **Section 5.1.17 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Pharmacy Accepted Files Report (FDEPAF)** Updated Table 76: FDEPAF Frequency by Data Element for Pharmacy Accepted Files Header **Section 5.1.18 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Medical Accepted Files Report (FDEMAF)** Updated Table 80: FDEMAF Frequency by Data Element for Medical Claim Type Header **Section 5.1.19 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Supplemental Accepted Files Report (FDESAF)** Updated Table 86: FDESAF Frequency by Data Element for Supplemental Accepted Files Header Message Format (or Record Layout) and Required Protocols for EDGE Server Claim Resubmission Frequency Report (CRFR) Updated Table 102: EDGE Server Claim Resubmission Frequency Report Header Updated Table 104: EDGE Server Claim Resubmission Frequency Report Calendar Month Updated Table 105: EDGE Server Claim Resubmission Frequency Report Claim Type

Version Number	Date	Author/Owner	Description of Change
05.00.11	10/16/17	Accenture/CCIIO	**Additional CMS Feedback as per EDGE 25.0** **Section 5.1.5 Fields/Data Elements and Descriptions** **5.1.5 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Claim Selection Detail Report (RACSD)** Table 5: RACSD Claim Selection Detail Calendar Year Table 6: RACSD Claim Selection Detail Plan Table 7: RACSD Claim Selection Detail Bill Type Table 8: RACSD Claim Selection Detail Service Code Table 9: RACSD Claim Selection Detail Reason Code **Section 5.1.6 Fields/Data Elements and Descriptions** **5.1.6 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Risk Score Detail Report (RARSD)** Table 26: RARSD Risk Score Detail Sub Policy **Section 5.1.11 Fields/Data Elements and Descriptions** **5.1.11 Message Format (or Record Layout) and Required Protocols for EDGE Server RA Claim Selection Summary Report (RACSS)** Table 55: RACSS Claim Selection Summary Calendar Year Table 56: RACSS Claim Selection Summary Plan Table 57: RACSS Claim Selection Summary Bill Type Table 58: RACSS Claim Selection Summary Service Code Table 59: RACSS Claim Selection Summary Reason Code **Section 5.1.17 Fields/Data Elements and Descriptions** **5.1.17 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Pharmacy Accepted Files Report (FDEPAF)** Updated overview section Table 76: FDEPAF Frequency by Data Element for Pharmacy Accepted Files Header **Section 5.1.18 Fields/Data Elements and Descriptions** **5.1.18 Message Format (or Record Layout) and Required Protocols for EDGE Server Frequency by Data Element for Medical Accepted Files Report (FDEMAF)** Updated overview section Table 80: FDEMAF Frequency by Data Element for Medical Claim Type Header **Section 5.1.21 Fields/Data Elements and Descriptions** **5.1.21 Message Format (or Record Layout) and Required Protocols for EDGE Server Claim and Enrollee Frequency Report (CEFR)** Updated overview section

05.00.12	11/27/17	Accenture/CCIIO	**EDGE 26.0 Release Updates** ***CR FFMFM-502 RAUF Data Change*** **Section 5.1.1.21 Field/Data Elements and Descriptions** Updated Table 65 RAUF RA User Fee File Header Total Billable Member Months Description Total RA User Fee Description Updated Table 66 RAUF User Fee Plan Total Billable Member Months Description Total RA User Fee Description ***CR FFMFM-471 Fix RADVMCE Report Logic to Include Cross-Year Claims*** **Section 5.1.1.47 Business Data Elements and Definitions** Updated Table 120 RADVMCE RADV Medical Claim Extract Insurance Plan Category Data Plan ID Description ***CR FFMFM-472 Update RADVDE Report to be Unique RA Diagnosis Codes*** **Section 5.1.1.43 Field/Data Elements and Descriptions** New Field Added in Table 115 RADVDE RADV Detailed Enrollee Unique RA Diagnosis Code ***CR FFMFM-468 update RADVPS and RADVIVAS to include HCCs after the hierarchy is applied*** **Section 5.1.1.19 Field/Data Elements and Descriptions:** Verbiage updated in Total Number of HCCs in table 64 RADVPS Population Summary Stratum Indicator Modified Total Number of HCCs field **Section 5.1.1.41 Field/Data Elements and Descriptions:** Verbiage updated in Total Number of HCCs in Table 113: RADVIVAS RADV IVA Statistics Stratum Indicator ***CR FFMFM-474 Update the RADV Sampling Logic to factor in Market (individual or small group)*** Verbiage updated in Message Format (or Record Layout) and Required Protocols for EDGE Server RADV Population Summary Statistics Report (RADVPS) **Section 5.1.1.19 Field/Data Elements and Descriptions** Three New Fields Added in Table 63 RADVPS Population Summary Statistics Total Enrollees from Individual Risk Pool Market Total Enrollees from Small Group Risk Pool Market Total Enrollees from Catastrophic Risk Pool Market **Section 5.1.1.41 Field/Data Elements and Descriptions** Three New Fields Added in Table 112 RADVIVAS RADV IVA Statistics File Header Total Enrollees from Individual Risk Pool Market Total Enrollees from Small Group Risk Pool Market Total Enrollees from Catastrophic Risk Pool Market

			EDGE 25.0 release related documentation updates to address defect 27385: Frequency Reports: ICD defect for fields using incorrect dates for selecting claims **Section 5.1.1.27 Field/Data Elements and Descriptions** Table 79: FDEPAF Frequency by Data Element for Pharmacy Void/Replace Updated description on Void/Replace Count in Database field **Section 5.1.1.29 Field/Data Elements and Descriptions** Table 80: FDEMAF Frequency by Data Element for Medical Claim Type Header Updated description on Total Void Claims field Updated description on Total Replace Claims field Table 85: FDEMAF Frequency by Data Element for Medical Derived Amount Updated description on Derived Amount Indicator Count at Claim Level field Updated description on Derived Amount Indicator Count at Service Line Level field Table 86: FDEMAF Frequency by Data Element for Supplemental Accepted Files Header Updated description on Total Active Accepted Supplemental Records field Table 87: FDEMAF Frequency by Data Element for Supplemental Add/Delete/Void Updated description on Add/Delete/Void Count field **Section 5.1.1.31 Field/Data Elements and Descriptions** Table 89: FDESAF Frequency by Data Element for Supplemental Diagnosis Code Updated description on Supplemental Diagnosis Code Count field Table 90: FDESAF Frequency by Data Element for Supplemental Diagnosis Source Updated description on Supplemental Diagnosis Source Count field **Section 5.1.1.35 Field/Data Elements and Descriptions** Table 94: CEFR Claim and Enrollee Frequency Report Header Updated description on Total Unique Enrollees field Updated description on Total Unique Enrollee Utilizers field Updated description on Male Enrollee Unique Utilizers field Updated description on Female Enrollee Unique Utilizers field Updated description on Male Enrollee Unique Utilizer field Updated description on Total Claims field Updated description on Total Medical Claims Only field Updated description on Total Pharmacy Claims Only field Updated description on Total Enrollees with Medical Claims field Updated description on Total Enrollees with Pharmacy Claims field Updated description on Number of Enrollees with Medical and Pharmacy Claims field

			Updated description on Total Allowed Cost for All Claims field Updated description on Total Allowed Cost for Inpatient Claims field Updated description on Total Allowed Cost for Outpatient Claims field Updated description on Total Allowed Cost for Professional Claims field Updated description on Total Allowed Cost for Pharmacy Claims field Updated description on Total Paid Amount for All Claims field Updated description on Total Paid Amount for Inpatient Claims field Updated description on Total Paid Amount for Outpatient Claims field Updated description on Total Paid Amount for Professional Claims field Updated description on Total Paid Amount for Pharmacy Claims field Updated description on Total Allowed Cost for RA Inpatient Claims field Updated description on Total Allowed Cost for RA Outpatient Claims field Updated description on Total Allowed Cost for RA Professional Claims field Updated description on Total Allowed Cost for RA Pharmacy Claims field Updated description on Total Plan Paid Amount for RA Outpatient Claims field Updated description on Total Plan Paid Amount for RA Professional Claims field Updated description on Total Plan Paid Amount for RA Pharmacy Claims field Table 99: CEFR Claim and Enrollee Frequency Report Claim Updated description on Count of total Active Claims field Updated description on Count of Inactive Void Claims field Updated description on Total Number of Claim Records Accepted field Updated description on Unique Number of Claim Records Resolved field Updated description on Total Count of Claim Lines Accepted field Updated description on Total Allowed Cost for RA Inpatient Claims field Updated description on Total Allowed Cost for RA Outpatient Claims field Updated description on Total Allowed Cost for RA Professional Claims field Updated description on Total Allowed Cost for RA Pharmacy Claims field Updated description on Total Plan Paid Amount for RA Inpatient Claims field

Version Number	Date	Author/Owner	Description of Change
			Updated description on Total Plan Paid Amount for RA Outpatient Claims field Updated description on Total Plan Paid Amount for RA Professional Claims field Updated description on Total Plan Paid Amount for RA Pharmacy Claims field Table 100: CEFR Claim and Enrollee Frequency Report Form Type Updated description on Count of total Active Claims field Updated description on Count of Inactive Void Claims field ***EDGE 25.0 release related documentation updates to clarify how RARSD Age fields are populated*** **Section 5.1.1.5 Field/Data Elements and Descriptions** Table 19: RARSD Risk Score Detail Enrollee Updated description on Enrollment Age field Updated description on Risk Adjustment Age field Table 26: RARSD Risk Score Detail Sub Policy Updated description on Allowable Rating Factor (ARF) Age field

Version Number	Date	Author/Owner	Description of Change
05.00.12	12/8/17	Accenture/CCIIO	**Additional updates for EDGE 26.0 per CMS feedback.** ***CR FFMFM-474 Update the RADV Sampling Logic to factor in Market (individual or small group)*** Verbiage updated in Message Format (or Record Layout) and Required Protocols for EDGE Server RADV Enrollment Extract Report (RADVEE) Verbiage updated in Message Format (or Record Layout) and Required Protocols for EDGE Server RADV Population Summary Statistics Report (RADVPS) **Section 5.1.1.19 Field/Data Elements and Descriptions** Updated description in Table 63 RADVPS Population Summary Statistics Total Enrollees from Individual Risk Pool Market Total Enrollees from Small Group Risk Pool Market Total Enrollees from Catastrophic Risk Pool Market New RADVPSF section created Added overview section Added new section 5.1.1.40 RADVPSF File Layout Added new section 5.1.1.41 RADVPSF Field Data Elements and Description ***Non-EDGE 26 release related cleanup items:*** Removed duplicate fields in Table 28 RIDE RI Enrollee Detail Enrollee Unique Enrollee ID Member Months Removed duplicate fields in Table 67 ECS Enrollee Claims Summary File Header Report Header Removed duplicate fields in Table 72 ECS Enrollee Claims Summary Plan Plan ID

Version Number	Date	Author/Owner	Description of Change
05.00.12	12/15/17	Accenture/CCIIO	**Additional updates for EDGE 26.0 per CMS feedback** ***CR FFMFM-474 Update the RADV Sampling Logic to factor in Market (individual or small group)*** Updated description in Table 113 RADVPSF RADV Populations Summary Statistics Final File Header Total Number of Plan IDs Total Enrollees Total Enrollees from Individual Risk Pool Market Total Enrollees from Small Group Risk Pool Market Total Enrollees from Catastrophic Risk Pool Market
05.00.13	03/08/18	Accenture/CCIIO	**Additional updates for EDGE 26.0 per CMS feedback** **Section 5.1.1.19 Field/Data Elements and Descriptions** Updated the Frequency of Occurance for all the fields in Table 57 to be 0..1. Updated the Frequency of Occurance for all the fields in Table 58 to be 0..1. **Section 5.1.1.27 Field/Data Elements and Descriptions** Updated to maxInclusive = 999999999 instead of 999999999.99 since the field type is Integer in table 76. **Section 5.1.1.41 Field/Data Elements and Descriptions** Updated root element to radvPopulationSummaryStatisticsFinal instead of radvPopulationSummaryStatistics Updated “RiskPool” to “Risk Pool” throughout the document
05.00.14	03/21/18	Accenture/CCIIO	**Additional updates for EDGE 26.0 per CMS feedback** **5.1.1.19 Field/Data Elements and Descriptions** Updated the “Stratum Size” data element description for the RAVPS Report. **5.1.1.41 Field/Data Elements and Descriptions** Updated the “Stratum Size” data element description for the RADVPSF Report.

05.00.15	04/19/18	Accenture/CCIIO	**EDGE 28.0 Release Updates** ***CR FFMFM-485 RA Model Change (Rx Change)*** **Modified fields added to Table 65: RACSS Claim Selection Summary Calendar Year (these were blank before, but will be populated with this release)** Total RA Eligible Pharmacy Claims Included Total Pharmacy Claims Excluded **Modified fields added to Table 66: RACSS Claim Selection Summary Plan (these were blank before, but will be populated with this release)** Total RA Eligible Pharmacy Claims Included Total Pharmacy Claims Excluded **Modified fields added to Table 69: RACSS Claim Selection Summary Reason Code these were blank before, but will be populated with this release)** Total Count of Pharmacy Claims Excluded Pharmacy Reason Code **Modified fields added to Table 5: RACSD Claim Selection Detail Calendar Year (these were blank before, but will be populated with this release)** Total Count of Pharmacy Claims Included Total Count of Pharmacy Claims Excluded Total Unique Count Of NDCs **Modified fields added to Table 6: RACSD Claim Selection Detail Plan (these were blank before, but will be populated with this release)** Total Count of Pharmacy Claims Included Total Count of Pharmacy Claims Excluded Total Unique Count Of NDCs **Modified fields added to Table 9: RACSD Claim Selection Detail Reason Code** Total Count of Pharmacy Claims Excluded Pharmacy Reason Code **Modified fields added to Table 10: RACSD Claim Selection Detail Pharmacy Claim** Enrollee ID Pharmacy Claim ID Product/Service ID RA Eligible Indicator Policy Paid Amount Reason Code **Added field to Table 12: RACSD Claim Selection Detail Medical Claim** RXC Eligible Indicator **New fields added to Table 14: RARSD Risk Score Detail File Header**

			Total RA NDCs Accepted Total NDCs Accepted Total RXCs Total Enrollees with Payment RXCs Total Enrollees without Payment RXCs Total Payment RXCs Average Number of RXCs per Enrollee By Enrollee (Adult Model) Average Number of Payment RXCs per Enrollee By Enrollee (Adult Model) Average Number of Payment HCCs per Enrollee by all Enrollees (Infant Model) Males with RXCs Females with RXCs **New fields added to Table 16: RARSD Risk Score Detail Rating Area** Total RA NDCs Accepted Total NDCs Accepted Total RXCs Total Payment RXCs Total Enrollees without Payment RXCs Total Enrollees with Payment RXCs Total RXC to HCC interactions Total RXCs Created From Service Codes Total Enrollees With RXC to HCC Interactions Total Enrollees With RXCs Created From Service Codes Average Number of Payment RXCs per Enrollee (all Enrollees): Adult Model Female Adults with Payment RXCs Male Adults With Payment RXCs RXC to HCC Interaction Category **Added Table19: RARSD Risk Score Detail Rating Area RXC to HCC Interaction** RXC to HCC Interaction RXC to HCC Interaction Count **New fields added to Table 20: RARSD Risk Score Detail Enrollee** NDC Code Category Payment RXC Category RXC to HCC Interaction Category RXC Created by Service Code Category Dropped RXC Category Added Table 22: RARSD Risk Score Detail NDC Code NDC Code

			Added Table 24: RARSD Risk Score Detail Payment RXC Payment RXC **Added Table 27: RARSD Risk Score Detail RXC to HCC Interaction** RXC To HCC Interaction **Added Table 28: RARSD Risk Score Detail RXC Created by Service Code** RXC Created **Added Table 29: RARSD Risk Score Detail Enrollee RXC Dropped** Dropped RXC **Updated description in Table 25: RARSD Risk Score Detail Enrollee Period Category** Enrollee Risk Score **New fields added to Table 43: RARSS Risk Score Summary File Header** Total RA Payment RXC Enrollees Mean Risk Score for RA Payment RXC Enrollees Total Enrollees without RA Payment RXCs Total RXC to HCC interactions Total RXCs Created From Service Codes Total Enrollees With RXC to HCC Interactions Total Enrollees With RXCs Created From Service Codes Mean Risk Score for Enrollees Without RA Payments RXCs Percent of total RA Payment RXC Enrollees Who Have CSR Mean Risk Score for Total RA Payment RXC Enrollees Who Have CSR Mean Risk Score for RA Payment RXC Enrollees Who Do Not Have CSR Mean Unique NDC Per Utilizers Mean Unique NDC Per RA Utilizer Mean Unique NDC Per RA Payment RXC Enrollee Total NDC Accepted Total RA NDC Accepted Total RXCs Total Payment RXCs Average Number of RXCs per Enrollee (all Enrollees): Adult Model Average Number of Payment RXCs per Enrollee: Adult Model Number of RA Utilizers With Count of 1 Unique NDC Code Number of RA Utilizers With Count of 2 Unique NDC Codes Number of RA Utilizers with 3–4 Unique NDC Codes Number of RA Utilizers with 5–6 Unique NDC Codes Number of RA Utilizers With 7–9 Unique NDC Codes

			Number of RA Utilizers with >= 10 Unique NDC Codes Number of RA Utilizers With Count of 1 RXC Number of RA Utilizers With Count of 2 RXCs Number of RA Utilizers With 3–4 RXCs Number of RA Utilizers With >=5 RXCs Number of RA Payment RXC Enrollees With Count of 1 RXC Number of RA Payment RXC Enrollees With Count of 2 RXCs Number of RA Payment RXC Enrollees With 3–4 RXCs Number of RA Payment RXC Enrollees With >=5 RXCs Males with Payment RXCs Females with Payment RXCs Payment RXC Category RXC to HCC Interaction Category **Added Table 46: RARSS Risk Score Summary Payment RXC** Payment RXC Number of unique RA users with the RXC **Added Table 52: RARSS Risk Score Summary RXC to HCC Interaction** RXC To HCC Interaction RXC To HCC Interaction Count **New fields added to Table 54: RARSS Risk Score Summary Rating Area** Total RA Payment RXC Enrollees Mean Risk Score for RA Payment RXC Enrollees Total Enrollees Without RA Payment RXCs Mean Risk Score for Enrollees Without RA Payments RXCs Percent of total RA Payment RXCs Who Have CSR Mean Risk Score for Total RA Payment RXC Enrollees Who Have CSR Mean Risk Score for Total RA Payment RXC Enrollees Who Do Not Have CSR Mean Unique NDC per Utilizers Mean Unique NDC per RA Utilizer Mean Unique NDC per RA Payment RXC Enrollee Total NDC Accepted Total Risk Adjustment NDC Accepted Total RXCs Total Payment RXCs Total RXC to HCC interactions Total RXCs Created From Service Codes

			Total Enrollees With RXC to HCC Interactions Total Enrollees With RXCs Created From Service Codes Average Number of RXCs per Enrollee (all Enrollees): Adult Model Average Number of Payment RXCs per Enrollee: Adult Model Number of RA Utilizers with Count of 1 Unique NDC Code Number of RA Utilizers with Count of 2 Unique NDC Codes Number of RA Utilizers with 3-4 Unique NDC Codes Number of RA Utilizers with 5-6 Unique NDC Codes Number of RA Utilizers with 7-9 Unique NDC Codes Number of RA Utilizers with >= 10 unique NDC Codes Number of RA Utilizers with Count of 1 RXC Number of RA Utilizers With Count of 2 RXCs Number of RA Utilizers with 3-4 RXCs Number of RA Utilizers with >=5 RXCs Number of RA Payment RXC Enrollees with Count of 1 RXC Number of RA Payment RXC Enrollees with Count of 2 RXCs Number of RA Payment RXC Enrollees with 3–4 RXCs Number of RA Payment RXC Enrollees with >=5 RXCs Males with Payment RXCs Females with Payment RXCs Payment RXC Category RXC to HCC Interaction Category **Added Table 57: RARSS Risk Score Summary Plan Payment RXC** Payment RXC Number of unique RA users with the RXC **Added Table 63: RARSS Risk Score Summary Plan RXC to HCC Interaction** RXC To HCC Interaction RXC To HCC Interaction Count ***CR FFMFM-486 High Cost Risk Pools*** New HCRPS section created Added overview section Added new section 5.1.1.52 HCRPS File Layout Added new section 5.1.1.53 HCPRS Field Data Elements and Description New HCRPD section created Added overview section

Version Number	Date	Author/Owner	Description of Change
			Added new section 5.1.1.54 HCRPD File Layout Added new section 5.1.1.55 HCPRD Field Data Elements and Description
05.00.16	05/23/18	Accenture/CCIIO	**EDGE 28.0 Release Updates** ***CR FFMFM-485 RA Model Change (Rx Change)*** Table 16 RARSD Risk Score Detail Rating Area Addressed MSI Feedback Table 20 RARSD Risk Score Detail Enrollee Addressed MSI Feedback Table 54 RARSS Risk Score Summary Rating Area Addressed MSI Feedback ***CR FFMFM-486 High Cost Risk Pools*** **Updated section 5.1.1.53 HCPRS Field Data Elements and Description to address CCIIO feedback** **Updated section 5.1.1.55 HCPRD Field Data Elements and Description to address CCIIO feedback** **Added the following fields to the HCRP Summary report File Header level** Job Type Co-insurance Rate Cap Attachment Point **Updated the following fields to the HCRP Summary report File Header, Market level and Plan level** Paid Claim amount for Enrollees Not Meeting AP Claim Count for Enrollees Not Meeting AP

Version Number	Date	Author/Owner	Description of Change
05.00.17	06/07/18	Accenture/CCIIO	**EDGE 28.0 Release Updates** ***CR FFMFM-485 RA Model Change (Rx Change)*** Updated section 5.1.1.5 Field/Data Elements and Descriptions changing XML Data Elements from RXC to Rxc in all XML element names. Updated section 5.1.1.5 Field/Data Elements and Descriptions changing XML Data Elements from NDC to Ndc in all XML element names. Updated section 5.1.1.13 Field/Data Elements and Descriptions changing XML Data Elements from RXC to Rxc in all XML element names. Updated section 5.1.1.13Field/Data Elements and Descriptions changing XML Data Elements from NDC to Ndc in all XML element names. Updated section 5.1.1.53 Business Data Elements and Definitions changing XML Data Elements from Enrolles to Enrollees in all instances of XML element names. Removed payment RXC count from table 21 Added RXC to HCC Category defintion to Table 54: RARSS Risk Score Summary Rating Area. Updated frequency of occurrence on RXC related categories in RARSD section 5.1.1.5 ***CR FFMFM-486 High Cost Risk Pools*** Updated section 5.1.1.53 Business Data Elements and Definitions changing the file name. (HCRPSummaryReport.xsd). Updated section 5.1.1.55 Business Data Elements and Definitions changing the file name (HCRPDetailReport.xsd). Corrected camel case in element names in sections 5.1.1.53 and 5.1.55 Added market type enumeration in Tables 139 and 143
05.00.18	06/20/18	Accenture/CCIIO	**EDGE 28.0/Q3 *CR FFMFM-486 High Cost Risk Pools*** **Corrected XML element names in section 5.1.1.53** hcrpAllowedAmt hcrpClaimCnt hcrpIndMOOPAdj hcrpMOOPAdjTotPaidAmt hcrpClaimCountCYNoEp hcrpPaidClaimAmtCYNoEp

05.00.19	07/11/2018	Accenture/CCIIO	EDGE 28.0 Release Updates *CR FFMFM-485 RA Model Change (Rx Change)* Updated document control for version row 05.00.15 Updated Business Element Names in Table65: RACSS Claim Selection Summary Calendar Year : Total Pharmacy Claims Excluded Updated Business Element Names in Table66: RACSS Claim Selection Summary Plan : Total Pharmacy Claims Excluded EDGE 28.0/Q3 *CR FFMFM-486 High Cost Risk Pools* Increased upper limits on amounts in Table138: HCRP Summary Report File Header Category Data : Total Premium Total MOOP Adjusted Individual and Small Group Paid Claim Amount Total Allowed Claims Amount Paid Claim amount for HCRP enrollees Allowed Claim Amount for HCRP Enrollees Total Paid Claim Amount Above Attachment Point HCRP Payment Paid Claim Amount Cross Year for HCRP Enrollees Paid Claim Amount Cross Year With No EP in Current Payment Year for HCRP Enrollees Paid Claim amount for Enrollees Not Meeting AP Increased upper limits on amounts in Table**139**: HCRP Summary Report Market Level Header Category Data **:** Total Premium Total Paid Claim Amount Individual MOOP Adjustment MOOP Adjusted Total Paid Claim Amount Total Allowed Claims Amount Paid Claim Amount for HCRP Enrollees Individual MOOP Adjustment for HCRP Enrollees MOOP Adjusted Claim Paid Amount for HCRP Enrollees Allowed Claims Amount for HCRP Enrollees Total Paid Claim Amount Above Attachment Point HCRP Payment Paid Claim Amount Cross Year for HCRP enrollees Paid Claim amount Cross Year With No EP in Payment Year for HCRP Enrollees Paid Claim amount for Enrollees Not Meeting AP

			Increased upper limits on amounts in Table**140**: HCRP Summary Report Plan Level Header Category Data: Total Premium Total Paid Claim tAmount Individual MOOP Adjustment MOOP Adjusted Total Paid Claim amount Total Allowed Claim Amount Paid Claim amount for HCRP Enrollees Individual MOOP Adjustment for HCRP Enrollees MOOP Adjusted Total Paid Claim Amount for HCRP Enrollees Allowed Claims Amount for HCRP Enrollees Total Paid Claim Amount Above Attachment Point HCRP Payment Paid Claim amount Cross Year for HCRP Enrollees Paid Claim amount Cross Year No EP for HCRP Enrollees HCRP Claim Paid Amount Above Coinsurance Paid Claim amount for Enrollees Not Meeting AP **Increased upper limits on amounts in Table 142: HCRP Detail Report Enrollee Level Header Category Data** Total Premium Total MOOP Adjusted Individual and Small Group Paid Amount Total Allowed Claim Amount Total Paid Claim Amount Above Attachment Point HCRP Payment Paid Claim amount Cross Year Paid Claim amount Cross Year No EP Claim Paid Amount Above Coinsurance **Increased upper limits on amounts in Table 143: HCRP Detail Report Market Level Category Data** Total Premium Total Claim Paid Amount Individual MOOP Adjustment MOOP Adjusted Total Claim Paid Amount Total Allowed Claim Amount Total Paid Claim Amount Above Attachment Point HCRP Payment Paid Claim Amount Cross Year Paid Claim amount Cross Year No EP HCRP Claim Paid Amount Above Coinsurance **Increased upper limits on amounts in** Table 144: HCRP Detail Report Plan Level Header Category Data

Version Number	Date	Author/Owner	Description of Change
			Total Premium Total Paid Claim amount Individual MOOP Adjustment MOOP Adjusted Total Paid Claim amount Total Allowed Claim Amount Total Paid Claim Amount Above Attachment Point HCRP Payment Paid Claim amount Cross Year Paid Claim amount Cross Year No EP HCRP Claim Paid Amount Above CoinsurancePaid Claim amount for Enrollees Not Meeting AP
5.00.19	8/24/2018	Nirvi Shah	EDGE 28.0/EDGE Q3 2018 Release **Updated the following elements in "RACSD Claim Selection Detail Medical Claim" Table 12:** **Changed the enumeration on the field:** RXCEligibleIndicator **Updated verbiage in the following section to clarify that the HCRPDE will not go to CMS:** Message Format (or Record Layout) and Required Protocols for EDGE Server High Cost Risk Pool Detail Enrollee (HCRPDE) **Updated description on the following element in the table 138 "HCRP Summary Report File Header Category Data":** Total Paid Claim Amount Above Attachment Point **Updated description on the following element in the table 141 "HCRP Detail Report File Header Category Data**": Total Paid Claim Amount Above Attachment Point

5.00.19	9/11/2018	Nirvi Shah	**EDGE 28.0/EDGE Q3 2018 Release** Updated table and figure numbers throughout the document **Updated descriptions (minor wording changes) on following elements in Table 138 HCRP Summary Report File Header Category Data** -Total Paid Claim Amount for HCRP Enrollees - Paid Claim Amount Cross Year for HCRP Enrollees - Paid Claim Amount Cross Year With No EP in Current Payment Year for HCRP Enrollees - Claim Count Cross Year No EP in Current Payment Year for HCRP Enrollees - Paid Claim amount for Enrollees Not Meeting AP - Claim Count for Enrollees Not Meeting AP **Updated descriptions (minor wording changes) on following elements in Table 139 HCRP Summary Report Market Level Category Data:** - Market Type - HCRP Payment Market percent - Paid Claim amount for Enrollees Not Meeting AP - Claim Count for Enrollees Not Meeting AP **Updated descriptions (minor wording changes) on following elements in Table 140 HCRP Summary Report Plan Level Category Data:** - Paid Claim amount for HCRP Enrollees - MOOP Adjusted Total Paid Claim Amount for HCRP Enrollees - Total Paid Claim Amount Above Attachment Point - HCRP Payment - HCRP Payment Plan Percent - Paid Claim amount for Enrollees Not Meeting AP - Claim Count for Enrollees Not Meeting AP **Updated descriptions (minor wording changes) on following elements in Table 142 HCRP Detail Enrollee Report Enrollee Level Category Data:** - Total Member Months - Total Subscriber Member Month - Total Premium - Total MOOP Adjusted Individual and Small Group Paid Amount - Total Claim Count - Total Paid Claim Amount Above Attachment Point - Paid Claim amount Cross Year - Claim Count Cross Year - Paid Claim Amount Above Coinsurance

Version Number	Date	Author/Owner	Description of Change
			Updated descriptions (minor wording changes) on following elements in Table 143 HCRP Detail Enrollee Report Enrollee Level Category Data: - Total Member Months - Total Subscriber Member Months - Total Premium - Individual MOOP Adjustment - MOOP Adjusted Total Claim Paid Amount - Total Allowed Claim Amount - Total Claim Count -HCRP Payment Market Percent - Paid Claim Amount Cross Year - Claim Count Cross Year - Paid Claim amount Cross Year No EP - HCRP Claim Count Cross Year No EP **Updated descriptions (minor wording changes) on following elements in Table 143 HCRP Detail Enrollee Report Plan Level Category Data:** - Total Premium - MOOP Adjusted Total Paid Claim amount - Total Allowed Claim Amount - Total Paid Claim Amount Above Attachment Point - HCRP Payment - HCRP Payment Plan Percent - Paid Claim amount Cross Year No EP - Claim Count Cross Year No EP

Version Number	Date	Author/Owner	Description of Change
05.00.20	06/29/2018	Accenture / CCIIO	**Updates for EDGE 29.0/Q4 release** **Added the following fields Table 73: RADVPS Population Summary Stratum Indicator** **Total Pharmacy Claims** **Total Pharmacy Plan Paid Amount** **Total Number of RA NDC Codes** **Total Unique Number of RA NDC Codes** **Total Number ofPayment RXCs** **Total Unique HCPCS That Created Payment RXCs** **Total Unique Payment RXCs Created By HCPCS** **Updated XML element names and descriptions for the following fields:** **1) Total Claims** **totalClaims→ totalMedicalClaims** **2) Total Plan Paid Amount File** **totalPlanPaidAmountFile→ totalMedicalPlanPaidAmountFile** **3) Stratum**
05.00.21	07/16/2018	Accenture / CCIIO	**Updates for EDGE 29.0/Q4 release** **Merged Q3 ICD updates to this version. See the 05.00.19 in the Document Control History Table at the end of the document, for a full list of changes merged.** **Updated XML element names for following elements:** **1) Total Pharmacy Plan Paid Amount** **totalRxPlanPaidAmountFile → totalRxPlanPaidAmount** **2) Total Medical Plan Paid Amount** **totalMedicalPlanPaidAmountFile →** **totalMedicalPlanPaidAmount**

Version Number	Date	Author/Owner	Description of Change
5.00.21	8/24/2018	Nirvi Shah	**EDGE 29.0/EDGE Q4 2018 Release** **Merged the Q3 changes specified in the full document control history (Appendix E) in the second to last row for version 5.00.19**
5.00.21	10/17/2018	Nirvi Shah	**EDGE 29.0/EDGE Q4 2018 Release** **Merged the Q3 changes specified in the full document control history in the last row for version 5.00.19** **Updated the following field description in Table 73: RADVPS Population Summary Stratum Indicator** **Total Unique HCPCS That Created Payment RXCs** **Added note for stratums 4-9 that these will have 0 pharmacy claims**

Appendix A Acronyms

Acronym	Literal Translation
ACA	Affordable Care Act of 2010
APTC	Advanced Premium Tax Credit
CCIIO	Center for Consumer Information and Insurance Oversight
CEFR	EDGE Server Claim and Enrollee Frequency Report
CMS	Centers for Medicare & Medicaid Services
CMS-ES	CMS-EDGE Server
CPT/HCPCS	Current Procedural Terminology/ Healthcare Common Procedure Coding System
CSR	Cost Sharing Reduction
DOB	Date Of Birth
Dx	Diagnosis
ECD	Enrollee Claims Detail
ECS	Enrollee Claims Summary
EDI	Electronic Data Interchange
ES	EDGE Server
ESES	EDGE Server Enrollment Submission
ESMCS	EDGE Server Medical Claims Submission
ESPCS	EDGE Server Pharmacy Claims Submission
ESSFS	EDGE Server Supplemental File Submission
FDEEAF	Frequency by Data Element for Enrollment Accepted Files Report
FDEPAF	Frequency by Data Element for Pharmacy Accepted Files Report
FDEMAF	Frequency by Data Element for Medical Accepted Files Report
FDESAF	Frequency by Data Element for Supplemental Accepted Files Report

Acronym	Literal Translation
HCC	Hierarchical Condition Category
HCRP	High Cost Risk Pool
HHS	Health & Human Services
HIPAA	Health Insurance Portability and Accountability Act
HTTPS	Hypertext Transfer Protocol Secure
ICD	Interface Control Document
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
IP	Internet Protocol
IVA	Initial Validation Audit
IVAS	Initial Validation Audit Statistics
MC	Medical Claim
MOOP	Maximum Out Of Pocket
MR	Medical Record
NDC	National Drug Code
NPI	National Provider Identifier
PHI	Protected Health Information
RA	Risk Adjustment
RACSD	Risk Adjustment Claim Selection Detail Report
RACSS	Risk Adjustment Claim Selection Summary Report
RADV	Risk Adjustment Data Validation
RADVDE	Risk Adjustment Data Validation Detailed Enrollee Report
RADVEE	Risk Adjustment Data Validation Enrollment Extract Report
RADVIVAS	Risk Adjustment Data Validation Initial Validation Audit Statistics Report
RADVMCE	Risk Adjustment Data Validation Medical Claim Extract Report
RADVPS	Risk Adjustment Data Validation Population Summary Statistics Report
RADVSE	Risk Adjustment Data Validation Supplemental Extract Report
RARSD	RA Risk Score Detail Report
RARSS	Risk Adjustment Risk Score Summary Report
RATEE	Risk Adjustment Transfer Elements Extract
RAUF	Risk Adjustment User Fee
RI	Reinsurance
RIDE	Reinsurance Detail Enrollee Report
RISR	Reinsurance Summary Report
RxC	Pharmacy Claim
SE	EDGE Server System Error Report
SFTP	Secure File Transfer
SSH	Secure Shell
SSL	Secure Sockets Layer

Acronym	Literal Translation
XML	Extensible Markup Language
XSD	XML Schema Definition