Medicare Modernization Act (MMA) State File Specifications and Data Dictionary

Version 2.3

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06/11/2008	1.1	Revisions to the output detail record for valid values.	Marie Pusloskie
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11/16/2010	2.3	Updated document to address 508 Compliance identified by CMS.	NGC

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1. Technical Instructions for Submitting State Data for Medicare Modernization Act (MMA) Provisions

1.1 State Monthly MMA File Submission Requirements

CMS data collection for MMA implementation will be met by States submitting at least one monthly file. States have the option to submit a single monthly file including all known dual eligibles, or multiple files throughout the month (up to one per day). Multiple files are intended to give the States the opportunity to provide current information on updated dual eligibility status. Multiple submittals should represent only those individual person-months with changes in status. We expect that many States will opt to submit a large initial file including the bulk of enrollments for the reporting month, and smaller incremental files providing updates for changes in dual eligibility status (additions, deletions, or changes). States should not submit multiple full replacement files as CMS will not be able to process the files.

The monthly files will address the following program needs:

1.2 Dual Eligible Enrollment

The monthly file submittals will include all Medicare/Medicaid dual eligibles in the State (full benefit) as well as QMB, SLMB, and QI (partial benefits), PROspective (PRO) records, and State Low Income Subsidy (LIS) applications for Part D subsidy processed through the file creation date. This will allow CMS to establish the low-income-subsidy (LIS) status of dual eligibles, and to perform auto-assignment of individuals to Medicare Part D plans.

1.3 Phased Down State Calculation

One of the purposes for which the State's monthly MMA file submission will be used is to calculate the State's phasedown contribution payment. The phasedown process requires a monthly count of all full benefit dual eligibles with an active Part D plan enrollment in the month. CMS will make this selection of records using dual eligibility status codes contained in the person-month record to identify all full-benefit dual eligibles (codes 02, 04 and 08). In the case where in a given month, multiple records were submitted for the same client in multiple file submittals, the last record submitted for that client shall be used to determine the final effect on the Phasedown count.

1.4 State LIS Applications

The file may also include records for those individuals for whom the State has made a low income subsidy determination. A record for each Medicare Part D low income subsidy application processed by the State must be included in the file.

States are strongly encouraged to use the SSA's subsidy application (SSA-1020) for subsidy applicants unless an individual specifically requests the State make the subsidy determination using a State application form. States should ask applicants if they have already applied for the subsidy with SSA and, if so, urge them to wait for a decision from SSA. However, if the applicant insists on filing with the State prior to an SSA decision, the State must comply. If an individual requests a State determination or refuses to use the SSA application, the State must use its own application and process the case using Federal Low-Income Subsidy income, family size, and resource rules. The State follows its process for taking applications. The State is then

responsible for notices, appeals, and redeterminations for subsidy cases it has determined using a State application form.

2. State Enrollment File(s) Timing and Content

2.1 Enrollment File Timing

Each month's enrollment file(s) is sent to CMS between the 1st and the end (i.e. 30th or 31st) of the enrollment month. If a State submits only one file, this submittal must be a complete monthly dual eligible enrollment file. If a State chooses to submit multiple files, a State may either submit one complete enrollment file and submit subsequent files including only file accretions and deletions, or a State may conceivably also submit multiple files throughout the month each consisting only of partial enrollments, as long as the accrual of all those file submission would deliver, by month's end, a complete representation of all dual eligible enrollment in the State for that month.

If the State submits multiple enrollment files per any given month, once a file has been accepted, any subsequent submissions in the same month will be treated as a unique submission and processed like the first file. For each State file accepted and processed successfully, CMS will send a response file within 24 to 48 hours. CMS will process all files nightly for the deeming and auto-assignment process. Resulting enrollment transactions shall be sent weekly on Sundays to the Part D plans.

Files that are rejected based on data quality validation must be received in CMS by the last day of the month if this is to be the sole submission of the month. If a State submits an additional file on the last day of the month, and it is received on or after our cutoff processing time of 6 p.m. Eastern Standard Time (EST), the file will be processed the first day of the subsequent month. Thus if a file of end of month updates is submitted to CMS on January 31st, 2010, at 11pm EST, it would not be processed until February 1 and all DETail records submitted as "current" for January 2010 would now be treated as retroactive records, any (one month into the future) DETail records would be processed as current records. If no file is successfully submitted for the month, CMS will project enrollment from the prior month's file and apply retroactive updates based on the subsequent months' submittals for the purpose of the phasedown calculation.

2.2 Enrollment File Content

The Record Identifier field will identify if the record is an enrollment detail record ("DET") for a known dual eligible or future Medicaid eligible (not to exceed one month into the future), a prospective full dual ("PRO") or a low-income subsidy determination ("LIS") record. Medically-needy and other spend-down individuals who have not met their incurred liability for the month and are in inactive enrollment status for the reporting month should not be included. Below are the types of records States should include in their file:

- **Current DET records** – States must include a person-month record for each individual eligible for the current reporting month. If a State submits only one file per month, the Medicaid Eligibility Status Field must be populated with "Y". If a State submits multiple files per month, the Medicaid Eligibility Status Field can be populated with a "Y" or "N". For example, if a client was submitted as a Current DET record in a previous submission during the current reporting month as a "Y", but the State discovered the client was not Medicaid eligible, the State may correct the eligibility status by

resubmitting the client's record with an "N" in the Medicaid Eligibility Status Field for the current reporting month within the same month.

- **Retro DET records** – Additionally, all files will include a full person-month record to report information on changes in the circumstances for individuals that were effective in a prior month. These records are referred to as "**retroactive**" records and will be identified in the monthly file by the effective month and year to which the retroactive record data are to be applied. Illustrative examples of possible situations that would lead to retroactive changes include:
    1. an individual not previously reported who was determined by the State to be retroactively eligible three months prior to the reporting month,
    2. an individual having a change in dual status code two months prior to the reporting month, but for whom the State was not aware of the change until the reporting month.
    3. an individual who was previously reported eligible but is deceased or ineligible for another reason.

In each of these cases, the state file will include a complete person-month record for that individual for the current month, and a second (or more, as needed) record providing a replacement record for the effective month and year of the change.

For example, in the January 2010 reporting month file due by January 31, a dual eligible that became retroactively eligible in October 2009, the State would submit a full, complete record for each month of eligibility through the reporting month i.e., 4 records (October 2009 – January 2010). Since this is a replacement record, the record will include data in **all required fields**; not just those fields that have changed. A person who was reported eligible for November but was discovered in December to be deceased during the **full month** of November would have a change record for November showing an eligibility status of ineligible (coded value of "N") for the November enrollment month.

NOTE: CMS is only able to process records up to 36 months of retroactivity from the current reporting month. Any records older than 36 months will be rejected.

- **Future DET records** – The file(s) may also include Medicare beneficiaries who will be identified as Medicaid beneficiaries **one** month into the future.
- **LIS records** – The monthly file submittal may also include all State LIS applications for Part D subsidy processed through the file creation date.
- **PRO records** – States should include individuals in state Medicaid programs who are not known to be full dual eligibles, but are Medicaid eligibles approaching an age (64 and 7 months or older in the reporting month) or disability status that is likely to lead to a future determination of full dual eligibility. **(See Section 2.3 – 2.6 for detailed information on PRO Records).**

2.3 PROspective Full Dual Eligibles

One of the concerns related to the monthly MMA reporting cycle is the effect on Medicaid-only individuals who transition to dual eligible status and the difficulty in ensuring a seamless

transition in drug coverage. This section will clarify a few key elements that are part of the submission, as well as processing, of these PROspective records.

Only submit PROspective records for individuals with full Medicaid benefits; i.e., individuals who, if they have Medicare coverage, would be full dual eligibles. Do not include individuals who would only represent partial dual eligibles; i.e., QMB-only, SLMB-only, or QI s. In the Dual Status Code field in the PRO record, include a full dual eligible status code (i.e., 02-QMB plus, 04-SLMB plus, or 08-Other) which best describes the dual status assuming that individual is Medicare eligible.

2.4 PRO Enrollment Process

By including these PROspective individuals on the monthly files, CMS will be able to return information to the States on the response files for individuals already in Medicare and those projected to get Medicare coverage in the near future. We will also be able to set up subsidy status and auto-enroll individuals into a Part D plan so their coverage will be in place when they become Part D eligible.

This is a process that has been advocated by many States to help minimize the transitional drug coverage issues for individuals becoming eligible for Part D. This process also provides an opportunity to better synchronize State information on Medicare enrollment.

2.5 Submission of PRO Records

In order for CMS to successfully process a PRO record the following conditions must be met/elements must be in place**:**

- RECORD IDENTIFIER CODE field (position 1-3) must contain 'PRO'.
- ELIGIBILITY MONTH/YEAR (position 4-9) of submission must be the CURRENT PROCESSING MONTH/YEAR. CMS will reject past or future dates.
- Record must contain a "Y" in the ELIGIBILITY STATUS field (position 10)
- Record must contain a valid SSN (position 27-35). This field cannot be 9-filled or blank.
- Record must contain a valid DATE OF BIRTH (position 108-115). If date of birth is unknown, enter best available data. This policy applies to DET records as well. Records containing no date of birth will be ignored.
- Record must contain a valid, two byte DUAL STATUS CODE (position 116-117) of a '02', '04' or '08'. CMS will reject any other dual status codes.

Based on this coding, these records will be subjected to special processing. This processing will bypass counting for the phased-down State contribution but will allow us to prospectively auto-enroll these individuals and to establish an appropriate Part D low-income subsidy level. These records will also be excluded from the file acceptance threshold for a 90-percent Medicare match rate.

PRO records may be submitted in any order within the monthly MMA File(s). They may be intermingled with the monthly DET records or separated. CMS will sort the file upon receipt and process each record per the record descriptor located in the first 3 bytes of the record (i.e. DET, PRO, etc).

The information on Medicare status (for Medicare Parts A, B, C and D) will be returned to the State in the normal response file format (see **Section 2.7,** Enrollment Return File Specifications

for details). For records which do not match Medicare records, the Medicare enrollment information will be blank. For records having current Medicare enrollment, all available enrollment information will be returned on the response file, including any prospective enrollment dates derived from the SSA prospective enrollment information. NOTE: Medicare enrollment systems can only return auto-enrollment information for prospective periods two months prior to the enrollment effective date.

Once an individual is identified as a prospective full dual, the person should be submitted with a Record Identifier of "DET" in the first month Medicare eligibility is effective. If an individual is identified on the response file as having current or retroactive Medicare coverage, submit retroactive "DET" records covering the missed months of dual eligibility status. Full duals submitted as "DET" records should not be submitted as "PRO" records for the same eligibility month.

2.6 Processing of Returned PRO Records

Once the State has submitted their PRO records to CMS for processing, CMS will respond by returning a PRO record for each PRO record submitted, regardless if found on CMS MBD Database. A State will receive PRO statistics in the FILE SUMMARY RECORD. The layout has been changed to accommodate PRO processing.

According to match result, VALID MATCHED records are marked with a '000000' or '000001' in the RECORD RETURN CODE FIELD (positions 229-234). VALID records for which no match was found are marked with a '000003'. INVALID DUPLICATE PRO RECORDS are marked with '000010'. INVALID and thus NON-MATCHED records are marked with a '000009'. INVALID PRO RECORD is a DUPLICATE DET RECORD in **current file** are marked with a '000011'. INVALID PRO RECORD is a DUPLICATE OF DET RECORD from a **previous file** are marked with a '000012'.

Valid PRO records that have been matched to the database will contain the same information as matched DETail records: PART A/B/C Entitlement dates, HICN, SSNs, and ESRD, PART C, Part D, etc.

For matched PRO records, a State should submit a DET record once the period of current dual eligibility has been reached and the beneficiary is assigned to a PDP. This information is contained in the Eligibility Information for Parts A/B and D in the MMA Response File. If, for example, a PRO record is returned in the December Response File as matched (Record Return Code Field = '000001' or '000000') and the Part A/ B/D Entitlement Start Date is 01/01/2010, it is anticipated that a DETail record will be submitted for this beneficiary in the January 2010 file.

Valid PRO records which were matched and are found to be PART A/B entitled within two months of submission, will be auto-assigned to a PDP. Auto-assignment may only occur up to two months into the future. For example, if a beneficiary PRO record was submitted in a December 2009 State File and was found to be PART A/B/D entitled 03/01/2010, the member would be submitted to the deeming process the evening of file submission, and be returned in the RESPONSE FILE within 24 – 48 hours with a deeming onset date of 03/01/2010. The enrollment information would be available in any January created response file, given the beneficiary is submitted by the State at some point in January. This auto-assignment would occur even if the member is not resubmitted after December's submission.

If the eligibility date is more than two months into the future, CMS will not auto-assign them until the appropriate time frame has been reached (for this example, any record with a future entitlement date beyond March 2010). Deeming, however, will occur at the same time for the appropriate time span, regardless if onset is more than two months into the future.

Already existing eligibility / enrollment may be returned for individuals submitted by a State on a PRO record that a State was otherwise not aware of. When that occurs, the State should submit retroactive monthly DET records covering the newly-identified period of dual eligibility in the following month's MMA file submission.

2.7 Enrollment File and Record Specifications

This specification document defines the process for this file submittal process in the following sections:

1. State Enrollment File Specifications
2. Enrollment Return File Specifications

The State Enrollment File(s) will be transferred using Gentran, Cyberfusion (via SSA) or Connect:Direct (C:D) electronic file transfer. The Enrollment Return File from CMS will be transferred to the State using the same electronic file transfer the State used to submit their file to CMS.

For technical support questions or file transmission issues, refer to **"Appendix A"** for a list of CMS Central Office MMA contacts.

2.7.1 Data Types:

9(x) = Numeric characters; where "9" indicates a numeric data type and "x" is the field length
X(x) = Alphanumeric characters with field length (x)
DATES = ALL DATES WILL BE IN MMDDCCYY FORMAT (month, day, century, year)

NOTE: Entries of numeric data fields will be right-justified within the field and entries alphanumeric data fields will be left-justified within the field.

2.7.2 File Format:

- File naming standard for **Cyberfusion and Connect:Direct (C:D)** electronic file transfers – P#EFT.IN.ELIGIBLE.CMSxx.Dyymmdd.Thhmmsst

- File naming standard for **GENTRAN** electronic file transfers – Guid.NONE.MBD.M.CMSxx.ELIGIBLE.P

Where "xx" = State abbreviation
Where "GUID" = IACS ID

Mainframe with EBCDIC data format. File format is "FB" (fixed block) and record length is 180 (LRECL=180)

3. Special Key Fields/User Tips

3.1 Fields submitted by the State on monthly MMA File

3.1.1 Beneficiary date of birth

- Key field used to corroborate match between State incoming beneficiary record to CMS' MBD (Medicare Beneficiary Database), which receives this date from the Social Security Administration's MBR (Master Beneficiary Record)
- **PRIMARY MATCHING Criteria is based on the following algorithm:**

  EITHER

  - (SSN 5.0 points

  OR

  - BENE CAN Number (1st 9 positions of HIC) 3.5 points
  - BENE BIC CODE 1.2 points

  AND

  - BENE DOB CCYY 3.25 points
  - BENE DOB MM 3.0 points
  - BENE DOB DD 2.25 points
  - GENDER 2.5 points

  A score of 12.25 must be attained for a record to be successfully matched. If the primary matching is unsuccessful, a secondary matching is entered:

  SECONDARY MATCHING Criteria is based on:
  - 1st 6 positions of the last name
  - 1st position of the first name
  - CAN or SSN
  - Exact Gender

3.2.2 Institutional Status Indicator

(Indicator of nursing facility, ICFMR or inpatient psychiatric hospital) or **starting January 1, 2012**, home and community based services)

- Values are 'Y' or 'N' – A value of 'Y' indicates that the individual was enrolled in a Medicaid paid institution for the full reporting month, or is projected by the State to remain in the institution for the remainder of the month.

- **Starting January 1, 2012**, there will be a new valid value of 'H.' This value should be submitted by States for DET and PRO records submitted for an eligibility month/year no earlier than January 2012, in which a full-benefit dual eligible individual received home and community based services. This includes home and community based services delivered under a section 1115 demonstration, under a 1915(c) or (d) waiver, under a State plan amendment under 1915(i), or through

enrollment in a Medicaid managed care organization with a contract under section 1903(m) or under section 1932 of the Social Security Act.

- This is a key field in establishing correct beneficiary copays. States need to submit not only accurate current-month institutional status, but **retroactive records** reflecting institutional status changes in prior months. This is necessary to ensure that there is closure on the Part D plan's responsibility for copay amounts during the span of coverage. We ask that States submit retroactive records in their files to cover any unreported past changes in institutional status. For example, if a State has reported an individual for the first time as having institutional status in February, even though the first full month in the institution was January, we need a retroactive enrollment record showing this update.

3.2 Fields Received by the State on monthly MMA Response File:

3.2.1 Medicare Part D Eligibility Indicator

(Part D Payment Switch or MARx Payment Switch)

- Value will be '0' for dual eligibles who are enrolled in a Part D plan during eligibility month/year
- Value will be '1' for dual eligibles who are not enrolled in a Part D Plan during eligibility month/year

3.2.2 Group Health Organization: GHO (10 Occurrences)

(Prior to the onset of Part D benefits, this part of the record only contained Part C MA Organizations)

(This area of the response file contains both Medicare Advantage Plans, PACE and Demo Enrollments offering and not offering Part D drug benefits. The information represents the overall contract/organization within which a beneficiary may have a choice of plans (PBPs). If a rollover from a non drug covering plan into one that did occurs, the enrollment effective date of the GHO/GHP would not change but the enrollment periods of the affected PBPs would be updated)

- The first occurrence is the active (current or future) or most recent Medicare Group Health Organization coverage (i.e. plan enrollment). Presently, this section is populated with Medicare Part C and Medicare Part D Organizations enrollments. The organizations can be distinguished by the first position of 'BENE GHO CNTRCT NUM':
  - H# is for local MA and MA-PDs; PACE, Cost Plans, and Demos
  - S# is for STAND ALONE PDP'S
  - R# is for Regional MA and MA-PDs
  - [9 in the first position may denote a Demo Plan; or a Chronic Care Improvement Pilot]

- E# -- an employer sponsored prescription drug plan (began with contract year 2007).
- Contract number "X0001" is for the new Limited Income Newly Eligible Transition (NET) program

3.2.3 Plan Benefit Package Election (10 Occurrences)

(This area of the response file describes the various PBP (plan) enrollments within the given GHO periods mentioned above)

- The most active plan enrollment will reside in occurrence 1, followed by historical enrollments.
- Presently, this section is populated with Medicare Part C offering no drug coverage as well as offering drug coverage and Part D standalone plans
- It is possible for a beneficiary to have two open enrollment periods, one signifying a managed care plan offering no drug coverage and a PDP standalone. In that case, the GHP contract numbers will be different.
- Updated list of values for the
  PBP ORG CVRG TYPE CD:

  NF = invalid coverage type code

3 = CCP	COORDINATED CARE PLAN
4 = MSA	MEDICARE MEDICAL SAVINGS ACCOUNT
5 = PFFS	PRIVATE FEE FOR SERVICE
6 = PACE	PACE PGM OF ALL INCLUSIVE CARE FOR THE ELDERLY
7 = Regional MA (MEDICARE ADVANTAGE) or Regional MAPD	(MEDICARE ADVANTAGE & PART D)
8 =DEMO	DEMONSTRATION
9 = FFS	FEE FOR SERVICE
10 = Cost/HCPP	COST/HEALTH CARE PREPAYMENT PLAN
11=PDP	Part D Drug Plan ELECTION
12= Chronic Care Demo	
13 = MSA Demo	MEDICARE MEDICAL SAVINGS ACCOUNT DEMO

3.2.4 Part D Plan Benefit Package (10 Occurrences)

This portion of the record will list the Part D Plans which also trigger the MEDICARE PART D ELIGIBILITY INDICATOR to reflect a '0', denoting "Part D Enrollment found"

(This area of the response file describes the various PBP (plan) enrollments within the given PDP only periods)

- The most active plan enrollment will reside in occurrence 1, followed by historical enrollments.
- Presently, this section is populated with Medicare Part C offering drug coverage as well as Part D standalone plans
- It is possible for a beneficiary to have two open enrollment periods, one signifying a managed care plan offering no drug coverage and a PDP standalone. In that case, the GHP contract numbers will be different.

- Updated list of values enrollment type code:

-Values for Enrollment Type Code:

A - Beneficiary was auto-enrolled thru CMS (full duals)
B - Beneficiary elected plan (overrides auto enrolled plan)
C - Facilitated enrollment: CMS facilitates enrollment of partial duals into a PDP
D - System (plan's) generated enrollment: the beneficiary is in a plan and either the contract or PBP # is changing and they are rolled over automatically into the new number. This usually occurs at the end of the calendar year (which coincides with contract year), when contracts/plans may transition to new numbers
E - Plan submitted auto-enrollments
F - Plan submitted facilitated enrollments
G - Point of Sale (POS) submitted enrollments
H - CMS or Plan submitted reassignment enrollments
I - Assigned to Plan submitted transactions with enrollment source other than any of the following: B, E, F, G, H, and blank.

4. Enrollment File to CMS

Table 1: Enrollment File to CMS Header Record

Data Element Name	Position	Format	Instructions
Record Identification Code	1-3	X(03)	Enter 'MMA'.
State Code	4-5	X(02)	Enter US Postal Service State Abbreviation. Example = 'MD'. See Appendix B State Codes.
Create Month	6-7	9(02)	Enter month that the file is created. Examples, if month is May, enter '05'.
Create Year	8-11	9(04)	Enter year that the file is created. Example = '2010'.
Filler	12-180	X(169)	Enter spaces.

Table 2: Enrollment File to CMS Detail Record

Data Element Name	Position	Format	Instructions
Record Identification Code	1-3	X(03)	Enter 'DET' if individual is eligible for Medicare and is currently eligible for Medicaid or will be eligible for Medicaid within the next month. Enter "PRO' if individual is eligible for full Medicaid benefits and although not known to the State as dually eligible is at least 64 years and seven months old or has a disability-related condition. Enter "LIS' if individual has undergone a low income subsidy determination within the current month.
Eligibility Month/Year	4-9	MMCC YY	Enter calendar month/year for applicable Medicaid eligibility. Enter the effective month/year of the changes for each retroactive record. Retroactive changes must be submitted to reflect prior month changes in one or more of the following fields: - Eligibility Status - HICN/RRB - Social Security Number - Sex - Date of Birth - Dual Status Code - FPL% Indicator - Institutional Status Indicator Retroactive records must include replacement values for ALL fields for that record, NOT just for the fields that have changed.

Data Element Name	Position	Format	Instructions
Eligibility Status	10	X(01)	Enter 'Y' (Yes) if individual is eligible for Medicaid for that Eligibility Month/Year. Enter 'N' (No) if individual is not eligible for Medicaid for that Eligibility Month/Year. CMS will reject a PRO record with 'N' in this field.
HICN/RRB	11-25	X(15)	Enter the Medicare Health Insurance Claim Number (HICN) or the Railroad Retirement Board Number (RRB) whichever the State has active and available for the individual.
HICN/RRB Indicator	26	X(01)	This field is not used by CMS.
Social Security Number	27-35	9(09)	Enter the individual's SSN. CMS will reject a record with no SSN if there is no HICN reported.
SMA Identifier	36-55	X(20)	Enter the individual's State Medicaid Agency Enrollee Identifier. This field is optional as CMS does not use.
Individual's First Name	56-67	X(12)	Enter the individual's first name (first 12 letters). This entry is used only for beneficiary secondary match.
Individual's Last Name	68-87	X(20)	Enter the individual's last name (first 20 letters). This entry is used only for beneficiary secondary match.
Individual's Middle Name	88-102	X(15)	Enter the individual's middle name (first 15 letters).
Individual's Suffix Name	103-106	X(04)	Enter the individual's suffix name (first four letters). Examples - 'JR', 'III'.

Data Element Name	Position	Format	Instructions
Individual's Gender	107	X(01)	Enter the individual's gender: M = Male F = Female U = Unknown This entry is used for beneficiary secondary match.
Individual's Date of Birth	108-115	MMDD CCYY	Enter the individual's date of birth. CMS will not match a detail record without a date of birth to a beneficiary on the Medicare database.
Individual's Dual Status Code	116-117	9(02)	Enter one of the following values for DET records: 01 - Eligible is entitled to Medicare - QMB only 02 - Eligible is entitled to Medicare - QMB and full Medicaid coverage 03 - Eligible is entitled to Medicare - SLMB only 04 - Eligible is entitled to Medicare - SLMB and full Medicaid coverage 05 - Eligible is entitled to Medicare - QDWI 06 - Eligible is entitled to Medicare - Qualifying individuals 08 - Eligible is entitled to Medicare -Other Full Dual Eligibles with full Medicaid coverage 09 - Eligible is entitled to Medicare -Other Dual eligibles but without Medicaid coverage, includes Pharmacy Plus and 1115 drug-only demonstration. States should submit a PRO record only for an individual with full Medicaid benefits, that is, an individual who if he /she had Medicare would qualify for a full dual status code of '02' , '04' or '08'. CMS will reject PRO records with any other dual codes.

Data Element Name	Position	Format	Instructions
Federal Poverty Level Percentage Indicator	118	9(01)	Enter one of the following values for DET and PRO record types: 1- Individual 's income at or below 100% FPL. 2 - Individual's income above 100% FPL. Do not derive this value from the Dual Status Code.
Drug Coverage Indicator	119	9(01)	This field is not used by CMS.
Institutional Status Indicator **NOTE: States should not include "H" value on file until January 2012.**	120	X(01)	Enter one of the following values: 'Y' (Yes) - Individual is institutionalized in a nursing facility, intermediate care facility or inpatient psychiatric hospital for the entire span of eligibility for the month. **Only full-benefit dual eligibles will receive the $0 co-pay.** 'N' (No) - Individual is not institutionalized in a nursing facility, intermediate care facility or inpatient psychiatric hospital for the entire span of eligibility for the month. For DET and PRO records for eligibility month/year starting January 2012 and later, 'H' (Home and Community Based) - Individual is receiving home and community based services at any period during the month.
Low Income Subsidy Application Approval Code	121	X(01)	Enter 'Y' (Yes) if individual's subsidy application is approved. Enter 'N' (No) if individual's subsidy application is not approved.
Low Income Subsidy Approved/Disapproved Date	122-129	MMDD CCYY	Enter date that State approved or disapproved low income subsidy application.

Data Element Name	Position	Format	Instructions
Low Income Subsidy Effective Date	130-137	MMDD CCYY	Enter the date that the subsidy begins. The day of this entry must be the first day of the month in which the State received the application.
Low Income Subsidy End Date	138-145	MMDD CCYY	Enter the date that the subsidy ends. The day of this entry must be the last day of the month in which the subsidy ends. This field is not required and should be left blank or filled with 9's unless the State has a definite knowledge of when the subsidy award ends.
Income as % of FPL	146-148	9(03)	Enter percentage of income to Federal Poverty Level as defined by Federal LIS income determination policy.
Low Income Subsidy Level Identifies portion of Part D premium subsidized, based on sliding scale linked to income as % of FPL.	149-151	9(03)	Enter one of the following values to describe the portion of Part D premium subsidized, based on sliding scale linked to FPL %: 100- under 136 % FPL 075 - 136- 140% 050 - 141- 145 025 - 146-149 If individual's FPL% is 150 or over, then subsidy award will be rejected by CMS.
Income Used for Determination	152	X(01)	Enter '1' if income used for determination is based on that of individual. Enter '2' if income used for determination is based on that of couple.
Resource Level	153	X(01)	Enter '1' if individual's resource limit is over the limit. Enter '2' if individual's resource limit is under the limit.

Data Element Name	Position	Format	Instructions
Basis of Low Income Subsidy Denial	154	X(01)	Enter the reason that the State denied the subsidy application: 1 = NAB (Not enrolled in Medicare Part A or Part B) 2 = NUS (Does not reside in the USA) 3 = FTC (Failure to cooperate) 4 = RES (Resources too high) 5 = INC (Income too high)
Result of an Appeal	155	X(01)	Enter 'Y' (Yes) if this record is the result of an appeal. Enter 'N' (No) if 'Y' not entered.
Change to Previous Determination	156	X(01)	This is a future element.
Determination Cancelled	157	X(01)	Enter 'Y' (Yes) if this record cancels previously sent record. Enter 'N' (No) if 'Y' not entered.
Filler	158-180	X(23)	Enter spaces.

Table 3: Enrollment File to CMS Trailer Record

Data Element Name	Position	Format	Instructions
Record Identification Code	1-3	X(03)	Enter 'TRL'.
Record Count	4-11	9(08)	Enter total number of DET, PRO and LIS records in the file.
State Code	12-13	X(02)	Enter US Postal Service State Abbreviation. Example = 'MD'. See Appendix B State Codes.
Create Month	14-15	9(02)	Enter month that the file is created. Example, if month is May, enter '05'.
Create Year	16-19	9(04)	Enter year that the file is created. Example = '2010'.
Filler	20-180	X(161)	Enter spaces.

5. Enrollment Return File Specifications

This file will be automatically returned to the State upon the successful processing of a State Enrollment File through the same electronic file transfer used to submit the file to CMS [i.e. Gentran, Cyberfusion (via SSA) or the Connect:Direct (C:D]. There may be a delay in sending the response file based upon other scheduling issues.

The content of the enrollment return file will include the following:

1. Header Record with identifying information, record count summaries, and a copy of the incoming header record
2. Detail Record
    a. Copy of the incoming State detail record
    b. Series of edit error return codes
    c. Data from the Medicare Beneficiary Database
3. File summary including record validation and matching outcomes
4. Summary enrollment count record by month for each month of enrollment information on the incoming file, and
5. Trailer Record with identifying information and a copy of the incoming trailer record.

Table 4: Enrollment Return File Specifications Header Record

Data Element Name	Position	Format	Description
Record Identification Code	1-3	X(03)	SRF'
File Process Timestamp	4-29	X(26)	The exact time that the State file is processed. Format: CCYY-MM-DD-hh.mm.ss.nnnnnn CCYY - Year MM - Month DD - Day hh - Hour mm - Minute ss - Second nnnnnn - Microsecond
File Accept Indicator	30	X(01)	Y - The State file to CMS is accepted. N - The State file to CMS is not accepted.
Filler	31	X(01)	

Data Element Name	Position	Format	Description
Total Records in State File	32-39	9(08)	The total number of DET and LIS records in the file. Note: This count excludes PRO records. Total Records = Valid Records + Invalid Records. Total Records = Matched Records + Not Matched Records
Duplicate Records in State File	40-47	9(08)	The total number of duplicate DET and LIS records in the State file. This count excludes PRO records.
Non-Duplicate Records in State File	48-55	9(08)	The total number of non-duplicate DET and LIS detail records in the State file. This count excludes PRO records.
Valid Records in State File	56-63	9(08)	The total number of valid DET and LIS records in the State file. This count excludes PRO records.
Invalid Records in State File	64-71	9(08)	The total number of invalid DET and LIS records in the State file. This count excludes PRO records.
Matched Records in State File	72-79	9(08)	The total number of DET and LIS records in the files that are successfully matched to an individual on the Medicare Beneficiary Database. This count excludes PRO records.

Data Element Name	Position	Format	Description
Not Matched Records in State File	80-87	9(08)	The total number of DET and LIS records in the files that are not matched to an individual on the Medicare Beneficiary Database. This count excludes PRO records.
File Create Month	88-89	9(02)	Month that file is created
File Create Year	90-93	9(04)	Year that file is created
Filler	94-115	X(22)	
Record Identification Code	116-118	X(03)	
State Code	119-120	X(02)	
Create Month	121-122	9(02)	
Create Year	123-126	9(04)	
Filler	127-295	X(169)	
Filler	296-3400	X(3105)	

Table 5: Enrollment Return File Specifications Detail Record

Data Element Name	Position	Format	Description
Record Identification Code	1-3	X(03)	
Eligibility Month/Year	4-9	MMCCYY	
Eligibility Status	10	X(01)	
HICN/RRB	11-25	X(15)	
HICN/RRB Indicator	26	X(01)	
Social Security Number	27-35	9(09)	
SMA Identifier	36-55	X(20)	
First Name	56-67	X(12)	
Last Name	68-87	X(20)	
Middle Name	88-102	X(15)	
Suffix Name	103-106	X(04)	

Data Element Name	Position	Format	Description
Gender	107	X(01)	
Date of Birth	108-115	MMDDCCYY	
Dual Status Code	116-117	9(02)	
Federal Poverty Level Percentage Indicator	118	9(01)	
Drug Coverage Indicator	119	9(01)	
Institutional Status Indicator	120	X(01)	
Low Income Subsidy Application Approval Code	121	X(01)	
Low Income Subsidy Approved/Disapproved Date	122-129	MMDDCCYY	
Low Income Subsidy Effective Date	130-137	MMDDCCYY	
Low Income Subsidy End Date	138-145	MMDDCCYY	
Income as % of FPL	146-148	9(03)	
Low Income Subsidy Level Identifies portion of Part D premium subsidized, based on sliding scale linked to income as % of FPL.	149-151	9(03)	
Income used for Determination	152	X(01)	
Resource Level	153	X(01)	
Basis of Low Income Subsidy Denial	154	X(01)	
Result of an Appeal	155	X(01)	
Change to Previous Determination	156	X(01)	
Determination Cancelled	157	X(01)	
Filler	158-180	X(23)	
Record Identification Code Error Code	181-182	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. Note: Detail record is valid if ERC = 00.

Data Element Name	Position	Format	Description
Eligibility Month/Year Error Code	183-184	X(02)	00 - Value is valid. 02 - Value is not numeric. 04 - Date is unknown. 05 - Eligibility Month/Year combination for PRO record not current month/year. 10 - Value is future. 11 - Month value is not within range of 01-12. 20 - Year < 2004. 37 - Month/year combination > 36 months. 99 - LIS record not scanned. Note: Detail record is valid if ERC = 00 or 99.
Eligibility Status Error Code	185-186	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 06 - PRO record Eligibility Status ≠ 'Y' 99 - LIS record not scanned Note: Detail record is valid if ERC = 00 or 99.
HICN/RRB Error Code	187-188	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 03 - Field is empty. Note: Detail record is valid if ERC = 00. Detail record is also valid if ERC = 01 or 03 and Social Security ERC = 00.
HICN/RRB Indicator Error Code	189-190	X(02)	00 - Value is valid.01 - Value is not in Valid Value Set. Note: Detail record is valid if ERC = 00.

Data Element Name	Position	Format	Description
Social Security Number Error Code	191-192	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 02 - Value is not numeric. 03 - Value is missing. Note: Detail record is valid if ERC = 00. Detail record is also valid if ERC = 01, 02 or 03 and HICN/RRB ERC = 00.
Gender Error Code	193-194	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. Note: Detail record is valid if ERC = 00.
Date of Birth Error Code	195-196	X(02)	00 - Value is valid. 02 - Value is not numeric. 04 - Date is unknown. 10 - Value is future. 11 - Month value is not within range of 01-12. 12 - Day value is out of range. 21 - Year < 1899. Note: Detail record is valid if ERC = 00 or 21.
Dual Status Code Error Code	197-198	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 07 - PRO record with Dual Status Code ≠ 02, 04 or 08 40 - DET record has dual status code of 99 99 - LIS record not scanned. Note: Detail record is valid if ERC = 00, 40 or 99.

Data Element Name	Position	Format	Description
FPL % Indicator Error Code	199-200	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 99 - LIS record not scanned. Note: Detail record is valid if ERC = 00 or 99 .
Drug Coverage Indicator Error Code	201-202	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 99 - LIS record not scanned. Note: Detail record is valid if ERC = 00 or 99.
Institutional Status Indicator Error Code	203-204	X(02)	00 - Value is valid.01 - Value is not in Valid Value Set.99 - LIS record not scanned.Note: Detail record is valid if ERC = 00 or 99.
Low Income Subsidy Application Approval Code Error Code	205-206	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 98 - DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98 .
Low Income Subsidy Approved/Disapproved Date Error Code	207-208	X(02)	00 - Value is valid. 02 - Value is not numeric. 04 - Date is unknown. 10 - Value is future. 11 - Month value is not within range of 01-12. 12 - Day value is out of range. 31 - Value is later than Low Income Subsidy End Date. 98 - DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.

Data Element Name	Position	Format	Description
Low Income Subsidy Effective Date Error Code	209-210	X(02)	00 - Value is valid. 02 - Value is not numeric. 04 - Date is unknown. 10 - Value is future. 11 - Month value is not within range of 01-12. 12 - Day value is out of range. 31 - Value is later than Low Income Subsidy End Date. 36 - Value is earlier than January 1, 2006. 37 - Day value is not first day of the month. 98 - DET or PRO record not scanned. Note: Detail record is valid if ERC = 00, 37 or 98.

Data Element Name	Position	Format	Description
Low Income Subsidy End Date Error Code	211-212	X(02)	00 - Value is valid. 02 - Value is not numeric. 04 - Date is unknown. 10 - Value is future. 11 - Month value is not within range of 01-12. 12 - Day value is out of range. 33 - Value is earlier than Low Income Subsidy Approved/Disapproved Date. 34 - Value is earlier than Low Income Subsidy Effective Date. 35 - Value is earlier than Low Income Subsidy Approved/Disapproved Date and Low Income Subsidy Effective Date 98 - DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.
Income as % of FPL Error Code	213-214	X(02)	00 - Value is valid.01 - Value is not in Valid Value Set.98 - DET or PRO record not scanned.Note: Detail record is valid if ERC = 00 or 98.
Low Income Subsidy Level Error Code	215-216	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 98 - DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.

Data Element Name	Position	Format	Description
Income Used for Determination Error Code	217-218	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 98 - DET or PRO record not scanned. Note: Detail record is invalid if ERC ≠ 00 or 98
Resource Level Error Code	219-220	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 98 - DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.
Basis of Low Income Subsidy Denial Error Code	221-222	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 98 - DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.
Result of an Appeal Error Code	223-224	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 98 - DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.
Change to Previous Determination Error Code	225-226	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 98 - DET or PRO record not scanned Note: Detail record is valid if ERC = 00 or 98.

Data Element Name	Position	Format	Description
Determination Cancelled Error Code	227-228	X(02)	00 - Value is valid. 01 - Value is not in Valid Value Set. 98 - DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.

Data Element Name	Position	Format	Description
Record Return Summary Code	229-234	X(06)	This field is an assessment of the detail record. **000000**: Record is valid with no errors or warnings. **000001**: Record is valid with warnings. **000002:** Record is invalid. Invalid Record Identification Code. **000003**: Record is invalid: Insufficient valid identifying information [May indicate a mismatch on the submitted date of birth.] **000004**: Record is invalid: DET record has invalid required fields. **000005**: Record is invalid: LIS record has invalid required fields. **000006:** Record is invalid: DET Record is duplicate of another DET record. **000007**: Record is invalid: LIS Record is duplicate of another LIS record. **000009**: Record is invalid: PRO Record has invalid required fields. **000010**: Record is invalid: PRO Record is duplicate of another PRO record. **000011**: Record is invalid: PRO Record is duplicate of a DET record in same file. **000012** - Record is invalid: PRO Record is duplicate of a DET record in a previous file.

Data Element Name	Position	Format	Description
Medicare Part D Eligibility Indicator	235	X(01)	Values: 0 - Beneficiary is eligible for Medicare Part D. 1 - Beneficiary is not eligible for Medicare Part D. For DET and PRO records, this field indicates the presence of Medicare Part D eligibility during the Eligibility Month/Year.
Medicare Part D Enrollment Indicator	236	X(01)	Values: 0 - Beneficiary is enrolled in a Medicare Part D plan. 1 - Beneficiary is not enrolled in a Medicare Part D plan. For DET and PRO records, this field indicates Medicare Part D enrollment during the Eligibility Month/Year.
Beneficiary Claim Account Number	237-245	X(09)	The number identifying the primary Medicare beneficiary under the SSA or RRB programs. This number along with the Beneficiary Identification Code uniquely identifies a Medicare beneficiary.
Beneficiary Identification Code	246-247	X(02)	A code that is used in conjunction with the Beneficiary Claim Account Number to uniquely identify a Medicare beneficiary. The BIC Code establishes the beneficiary's relationship to a primary Social Security Administration (SSA) or Railroad Retirement Board (RRB) wage earner and is used to justify entitlement to Medicare benefits.

Data Element Name	Position	Format	Description
Beneficiary Birth Date	248-255	MMDDCCYY	
Beneficiary Death Date	256-263	MMDDCCYY	
Beneficiary Sex Identification Code	264	X(01)	Values: 0 - Unknown 1 - Male 2 - Female
Beneficiary First Name	265-294	X(30)	First name of the Medicare beneficiary
Beneficiary Middle Name	295	X(01)	Middle initial of the Medicare beneficiary
Beneficiary Last Name	296-335	X(40)	Last name of the Medicare beneficiary including any titles or suffixes.
Cross-Reference Beneficiary Claim Account Number (Occurrence 1)	336-344	X(09)	An additional beneficiary claim account number associated with the Medicare beneficiary. The beneficiary's entitlement has been cross-referenced from this number to the beneficiary's active claim account number.
Cross-Reference Beneficiary Identification Code (Occurrence 1)	345-346	X(02)	The beneficiary's identification code associated with the Medicare beneficiary's cross-referenced claim account number.
Cross-Reference Beneficiary Claim Account Number (Occurrence 2)	347-355	X(09)	
Cross-Reference Beneficiary Identification Code (Occurrence 2)	356-357	X(02)	
Cross-Reference Beneficiary Claim Account Number (Occurrence 3)	358-366	X(09)	
Cross-Reference Beneficiary Identification Code (Occurrence 3)	367-368	X(02)	
Cross-Reference Beneficiary Claim Account Number (Occurrence 4)	369-377	X(09)	

Data Element Name	Position	Format	Description
Cross-Reference Beneficiary Identification Code (Occurrence 4)	378-379	X(02)	
Cross-Reference Beneficiary Claim Account Number (Occurrence 5)	380-388	X(09)	
Cross-Reference Beneficiary Identification Code (Occurrence 5)	389-390	X(02)	
Cross-Reference Beneficiary Claim Account Number (Occurrence 6)	391-399	X(09)	
Cross-Reference Beneficiary Identification Code (Occurrence 6)	400-401	X(02)	
Cross-Reference Beneficiary Claim Account Number (Occurrence 7)	402-410	X(09)	
Cross-Reference Beneficiary Identification Code (Occurrence 7)	411-412	X(02)	
Cross-Reference Beneficiary Claim Account Number (Occurrence 8)	413-421	X(09)	
Cross-Reference Beneficiary Identification Code (Occurrence 8)	422-423	X(02)	
Cross-Reference Beneficiary Claim Account Number (Occurrence 9)	424-432	X(09)	
Cross-Reference Beneficiary Identification Code (Occurrence 9)	433-434	X(02)	
Cross-Reference Beneficiary Claim Account Number (Occurrence 10)	435-443	X(09)	
Cross-Reference Beneficiary Identification Code (Occurrence 10)	444-445	X(02)	
Beneficiary Social Security Number (Occurrence 1)	446-454	9(09)	The beneficiary's identification number that was assigned by the Social Security Administration.
Beneficiary Social Security Number (Occurrence 2)	455-463	9(09)	

Data Element Name	Position	Format	Description
Beneficiary Social Security Number (Occurrence 3)	464-472	9(09)	
Beneficiary Social Security Number (Occurrence 4)	473-481	9(09)	
Beneficiary Social Security Number (Occurrence 5)	482-490	9(09)	
Mailing Address Line 1	491-530	X(40)	1st line of address
Mailing Address Line 2	531-570	X(40)	2nd line of address
Mailing Address Line 3	571-610	X(40)	3rd line of address
Mailing Address Line 4	611-650	X(40)	4th line of address
Mailing Address Line 5	651-690	X(40)	5th line of address
Mailing Address Line 6	691-730	X(40)	6th line of address
Mailing Address City Name	731-770	X(40)	City name
Mailing Address State Code	771-772	X(02)	Postal state code
Mailing Address Zip Code	773-781	X(09)	ZIP
Mailing Address Change Date	782-789	MMDDCCYY	The date a new or corrected address becomes effective for a Medicare beneficiary.
Residence Address Line 1	790-829	X(40)	
Residence Address Line 2	830-869	X(40)	
Residence Address Line 3	870-909	X(40)	
Residence Address Line 4	910-949	X(40)	
Residence Address Line 5	950-989	X(40)	
Residence Address Line 6	990-1029	X(40)	
Residence Address City Name	1030-1069	X(40)	
Residence Address State Code	1070-1071	X(02)	
Residence Address Zip code	1072-1080	X(09)	
Residence Address Change Date	1081-1088	X(08)	

Data Element Name	Position	Format	Description
Beneficiary Representative Payee Switch	1089	X(01)	A switch indicating whether the beneficiary has a representative payee according to SSA. Values are: Y - beneficiary has a designated representative payee N or space - beneficiary has no designated representative payee
Part A Non-Entitlement Status Code	1090	X(01)	Indicator/reason for the beneficiary's current non-entitlement status to Part A Medicare benefits. Values are: D - Coverage was denied F - Terminated due to invalid enrollment or enrollment voided H - Not eligible for free Part A, or did not enroll for premium Part A N - Not valid SSA HIC, but used by CMS Third Party system to indicate potential Part A entitlement date R - Refused benefits Space - No non-entitlement reason applies

Data Element Name	Position	Format	Description
Part B Non-Entitlement Status Code	1091	X(01)	Indicator/reason for a beneficiary's current non-entitlement status to Part B Medicare benefits. Values are: D - Coverage was denied N - Not entitled R- Refused benefits Space - No non-entitlement reason applies to the beneficiary.
Beneficiary Entitlement Reason Code Change Date (Occurrence 1)	1092-1099	9(08)	
Beneficiary' Entitlement Reason Code (1)	1100-1103	X(04)	
Beneficiary Entitlement Reason Code 2)	1104-1115	9(08) + X(04)	
Beneficiary Entitlement Reason Code (3)	1116-1127	9(08) + X(04)	
Beneficiary's Entitlement Reason Code (4)	1128-1139	9(08) + X(04)	
Beneficiary Entitlement Reason Code (5)	1140-1151	9(08) + X(04)	
Beneficiary Part A Entitlement Start Date (Occurrence 1)	1152-1159	MMDDC CYY	The date beneficiary became entitled to Medicare benefits. This field is filled with zeroes if no Part A Entitlement Start Date is found.

Data Element Name	Position	Format	Description
Beneficiary Part A Entitlement End Date (Occurrence 1)	1160-1167	MMDDCCYY	The last day that beneficiary is entitled to Medicare benefits. If both the Part A Entitlement Start and End Dates are filled with zeroes, then no entitlement period was found. If the Part A Entitlement Start Date is a valid date and the Part A Entitlement End Date is filled with 9s, then the entitlement has not ended.

Data Element Name	Position	Format	Description
Beneficiary Part A Entitlement Reason Code (Occurrence 1)	1168	X(01)	Values: A - Attainment of age 65 B - Equitable relief D - Disability G - General enrollment period I - Initial enrollment period J - MQGE entitlement K - Renal disease is or was a reason for entitlement prior to age 65 or 25th month of disability L - Late filing M - Termination based on renal entitlement but entitlement based on disability continues. N - Age 65 and uninsured P - Potentially insured beneficiary is enrolled for Medicare coverage only. Q - Quarters of coverage requirements are involved. R - Residency requirements are involved. S - State buy-in T - Disabled working individual U – unknown. This field is filled with a space if no entitlement is found.

Data Element Name	Position	Format	Description
Beneficiary Part A Entitlement Status Code (Occurrence 1)	1169	X(01)	Values: E - Free Part A Entitlement G - Entitled due to good cause Y - Currently entitled, premium is payable Values when there is a termination date: C - No longer entitled due to disability cessation S - Terminated, no longer entitled under ESRD provision T - Terminated for non-payment of premiums W - Voluntary withdrawal from premium coverage X - Free Part A terminated or refused HI. This field is filled with a space if no entitlement period is found.
Part A Entitlement (Occurrence 2)	1170 - 1187	X(18)	Same as Occurrence 1
Part A Entitlement (Occurrence 3)	1188 - 1205	X(18)	Same as Occurrence 1
Part A Entitlement (Occurrence 4)	1206 - 1223	X (18)	Same as Occurrence 1
Part A Entitlement (Occurrence 5)	1224 - 1241	X (18)	Same as Occurrence 1
Beneficiary Part B Enrollment Start Date (Occurrence 1)	1242 - 1249	MMDDCCYY	This field is filled with zeroes if no Part B enrollment period is found.

Data Element Name	Position	Format	Description
Beneficiary Part B Enrollment End Date (Occurrence 1)	1250 - 1257	MMDDCCYY	When no Part B enrollment period is found, this field and the Part B Enrollment Start Date are filled with zeroes. If there is a valid Part B Enrollment Start Date and the period is still active,, then this field is filled with 9s.
Beneficiary Part B Enrollment Reason Code (Occurrence 1)	1258	X(01)	Values: B - Equitable relief C - Good cause D - Deemed date of birth F - Working aged G - General enrollment period I - Initial enrollment period K - Renal disease is or was a reason for enrollment prior to age 65 or 25th month of disability. M -Termination based on renal enrollment but enrollment based on disability continues. R - Residency requirements are involved. S - State buy-in T - Disabled working beneficiary U -Unknown This field is filled with a space if no enrollment is found.

Data Element Name	Position	Format	Description
Beneficiary Part B Enrollment Status Code (Occurrence 1)	1259	X(01)	Values when there is a Part B Enrollment Start Date and no Part D Enrollment End Date: G - Enrolled due to good cause Y - Currently enrolled, premium is payable. Values when Part B Enrollment End Date is present: C -No longer entitled due to disability cessation. F - Terminated due to invalid enrollment or enrollment voided. S - Terminated, no longer entitled under ESRD provision. T - Terminated for non-payment of premiums. W - Voluntary withdrawal from premium coverage. This field is filled with a space if no enrollment is found.
Part B Entitlement (Occurrence 2)	1260 - 1277	X(18)	Same as Occurrence 1
Part B Entitlement (Occurrence 3)	1278 - 1295	X(18)	Same as Occurrence 1
Part B Entitlement(Occurrence 4)	1296 - 1313	X(18)	Same as Occurrence 1
Part B Entitlement (Occurrence 5)	1314 - 1331	X(18)	Same as Occurrence 1
Beneficiary Hospice Coverage Start Date (Occurrence 1)	1332 - 1339	MMDDCCYY	This field is filled with zeroes if beneficiary has no hospice benefit or coverage.

Data Element Name	Position	Format	Description
Beneficiary Hospice Coverage End Date (Occurrence 1)	1340 - 1347	MMDDCCYY	If hospice coverage has a valid Hospice Start Date and no Hospice End Date, then this field is filled with 9s. If there is no Hospice Start Date, then this field is filled with zeroes.
Beneficiary Hospice Coverage (Occurrence 2)	1348 - 1363	9(16)	Same as Occurrence 1
Beneficiary Hospice Coverage (Occurrence 3)	1364 - 1379	9(16)	Same as Occurrence 1
Beneficiary Hospice Coverage (Occurrence 4)	1380 - 1395	9(16)	Same as Occurrence 1
Beneficiary Hospice Coverage (Occurrence 5)	1396 - 1411	9(16)	Same as Occurrence 1
Beneficiary DIB Entitlement Start Date (Occurrence 1)	1412-1419	MMDDCCYY	The date that a beneficiary covered by the SSA disability program becomes entitled to Medicare benefits If no DIB Entitlement Start Date is found, then this field is filled with zeroes.
Beneficiary DIB Entitlement End Date (Occurrence 1)	1420 - 1427	MMDDCCYY	The date that a beneficiary covered by the SSA disability program is no longer entitled to Medicare benefits If there is a valid DIB Entitlement Start Date and no DIB Entitlement End Date, then this field is filled with 9s. If there is no DIB Entitlement Start Date and no DIB Entitlement End Date, then this field is filled with zeroes.

Data Element Name	Position	Format	Description
Beneficiary DIB Entitlement Date Justification Code (Occurrence 1)	1428	X(01)	The justification code for a beneficiary's Part A and /or Part B Medicare benefit dates based upon beneficiary's disability insurance benefits (DIB) status. Values:1 - Beneficiary is entitled to Medicare coverage due to prior periods of SSA disability entitlement.A - Beneficiary is entitled to Medicare based upon SSA disability and the 24 month waiting period has been waived. This field will have a space if no DIB is found.
Beneficiary DIB Entitlement (Occurrence 2)	1429 - 1445		Same as Occurrence 1
Beneficiary DIB Entitlement (Occurrence 3)	1446 - 1462		Same as Occurrence 1
Beneficiary GHO Contract Effective Date (Occurrence 1)	1463 - 1470	MMDDCCYY	This field is filled with zeroes if no health organization enrollment is found.
Beneficiary GHO Contract End Date (Occurrence 1)	1471 - 1478	MMDDCCYY	This field is filled with zeroes if there is no health organization enrollment found. This field is filled with 9s if there is a GHO Contract Effective Date and no GHO Contract End Date.

Data Element Name	Position	Format	Description
Beneficiary GHO Contract Number (Occurrence 1)	1479 - 1483	X(05)	Unique identification for an agreement between CMS and a Managed Care Organization. Generally the following assumptions can be made about contract numbers, but there may be exceptions: A contract number starting with **'H'** indicates local MA (Medicare Advantage) plans, MA-PD (Medicare Advantage with Prescription Drug) plans, PACE organizations, cost plans and some demonstrations. A contract number starting with **'R'** indicates regional MA and MA-PD plans. A contract number starting with **'9'** indicates a Medicare Demonstration. A contract number starting with **'E'** indicates an employer-sponsored prescription drug plan. A contract number starting with **'S'** indicates a stand-alone PDP (Prescription Drug Plan).Note: Stand-alone plans are not included in this section. This field is filled with spaces if no enrollment is found.
Beneficiary GHO (Occurrence 2)	1484 - 1504		Same as Occurrence 1
Beneficiary GHO (Occurrence 3)	1505 - 1525		Same as Occurrence 1

Data Element Name	Position	Format	Description
Beneficiary GHO (Occurrence 4)	1526 - 1546		Same as Occurrence 1
Beneficiary GHO (Occurrence 5)	1547 - 1567		Same as Occurrence 1
Beneficiary GHO (Occurrence 6)	1568 - 1588		Same as Occurrence 1
Beneficiary GHO (Occurrence 7)	1589 - 1609		Same as Occurrence 1
Beneficiary GHO (Occurrence 8)	1610 - 1630		Same as Occurrence 1
Beneficiary GHO (Occurrence 9)	1631 - 1651		Same as Occurrence 1
Beneficiary GHO (Occurrence 10)	1652 - 1672		Same as Occurrence 1
Group Health Plan Enrollment Effective Date (Occurrence 1)	1673 - 1680	MMDDCCYY	The date of the beneficiary's enrollment at the contract level. This field is filled with zeroes if there is no enrollment found.
Plan Benefit Package (PBP) Start Date (Occurrence 1)	1681 - 1688	MMDDCCYY	The date the PBP enrollment starts. This field is filled with zeroes if the beneficiary has no plan benefit package (PBP) enrollment.
Plan Benefit Package End Date (Occurrence 1)	1689 - 1696	MMDDCCYY	The date the PBP enrollment ends. This field is filled with zeroes if there is no PBP Start Date. This field is filled with 9s if there is a PBP Start Date and no PBP End Date.
Plan Benefit Package Number (Occurrence 1)	1697 - 1699	X(03)	A unique identifier for the managed care plan benefit package. This field is filled with spaces if beneficiary has no PBP.

Data Element Name	Position	Format	Description
Plan Benefit Package Coverage Type Code (Occurrence 1)	1700 - 1701	X(02)	Identifies the type of managed care plan benefit package in which the beneficiary is enrolled Values: NF – Invalid coverage type code 3 - CCP (Coordinated Care Plan) 4 – MSA (Medicare Medical Savings Account0 5 - PFFS (Private Fee For Service) 6 - PACE (Program of All Inclusive Care for the Elderly) 7 – Regional MA (Medicare Advantage) or Regional MAPD (Medicare Advantage & Part D) 8 - Demo (Demonstration) 9 - FFS (Fee For Service) 10 - Cost / HCPPCost (Health Care Prepayment Plan) 11 - PDP (Part D Drug Plan) Election 12- Chronic Care Demo 13 – MSA (Medicare Medical Savings Account) Demo This field is filled with spaces if no PBP enrollment is found.
PBP Enrollment (Occurrence 2)	1702 - 1730		Same as Occurrence 1
PBP Enrollment (Occurrence 3)	1731 - 1759		Same as Occurrence 1
PBP Enrollment (Occurrence 4)	1760 - 1788		Same as Occurrence 1
PBP Enrollment (Occurrence 5)	1789 - 1817		Same as Occurrence 1
PBP Enrollment (Occurrence 6)	1818 - 1846		Same as Occurrence 1
PBP Enrollment (Occurrence 7)	1847 - 1875		Same as Occurrence 1
PBP Enrollment (Occurrence 8)	1876 - 1904		Same as Occurrence 1
PBP Enrollment (Occurrence 9)	1905 - 1933		Same as Occurrence 1

Data Element Name	Position	Format	Description
PBP Enrollment (Occurrence 10)	1934 - 1962		Same as Occurrence 1
Beneficiary ESRD Coverage Start Date	1963 - 1970	MMDDCCYY	The date on which the beneficiary is entitled to Medicare in some part because of a diagnosis of End Stage Renal Disease. This field is filled with zeroes if beneficiary has no ESRD coverage.
Beneficiary ESRD Coverage End Date	1971 - 1978	MMDDCCYY	The date on which the beneficiary is no longer entitled to Medicare under ESRD provision. This field is filled with zeroes if beneficiary has no ESRD coverage. This field is filled with 9s if there is no ESRD Coverage End Date.
Beneficiary ESRD Termination Reason Code	1979	X(01)	The reason Medicare ESRD coverage was terminated. Values: A - Month of transplant plus 36 months. B - Last month of chronic dialysis C - Part A termination D - Death E - ESRD ended This field is filled with spaces if beneficiary has no ESRD coverage or if there is no ESRD Coverage End Date.

Data Element Name	Position	Format	Description
Beneficiary ESRD Dialysis Start Date	1980 - 1987	MMDDCCYY	The date when ESRD dialysis starts. This field is filled with zeroes if beneficiary has no ESRD Dialysis Start Date.
Beneficiary ESRD Dialysis End Date	1988 - 1995	MMDDCCYY	The date when ESRD dialysis ends. This field is filled with zeroes if beneficiary has no ESRD Dialysis Start Date. This field is filled with 9s if there is no ESRD Dialysis End Date.
Beneficiary ESRD Transplant Start Date	1996 - 2003	MMDDCCYY	The date that a kidney transplant operation occurred. This field is filled with zeroes when no ESRD Transplant Start Date is found,
Beneficiary ESRD Transplant End Date	2004 - 2011	MMDDCCYY	The date that a kidney transplant fails or transplant benefit ends.This field is filled with zeroes when no ESRD Transplant Start Date is found. This field is filled with 9s when there is a valid ESRD Transplant Start Date and there is no ESRD Transplant End Date.
Beneficiary Part A Third Party Start Date (Occurrence 1)	2012 - 2019	MMDDCCYY	The start date of a private third party group's or State's liability for a beneficiary's Part A premium. This field is filled with zeroes if there is no Part A Third Party Start Date..

Data Element Name	Position	Format	Description
Beneficiary Part A Third Party Premium Payer Code (Occurrence 1)	2020 - 2022	X(03)	The identifier for a third party agency (either a private group or State buy-in agency) responsible for paying a beneficiary's Medicare Part A premium. Values: S01 thru S99 - State Billing T01 thru Z98 - Private Third Part Billing Z99 - Conditional State Group Payer Enrollment
Beneficiary Part A Third Party End Date (Occurrence 1)	2023 - 2030	MMDDCCYY	The end date of a private third party group's or State's liability for a beneficiary's Part A premium. This field is filled with zeroes if no Part A Third Party Start Date was found. This field is filled with 9s if there is a Third Party Start Date and no Third Party End Date.

Data Element Name	Position	Format	Description
Beneficiary Part A Third Party Buy-in Eligibility Code (Occurrence 1)	2031	X(01)	A code that indicates the reason for Part A State buy-in eligibility.Values: A - Aged recipient of SSI payments (CMS to State) B - Blind recipient of SSI payments (CMS to State) C - Entitled to Part A of Title IV (AFDC) (State to CMS). D - Disabled recipient of SSA payments (CMS to State) E - Aged recipient of supplemental payment administered by SSA (CMS to State) F - Blind recipient of supplemental payment administered by SSA (CMS to State) G - Disabled recipient of supplemental payment administered by SSA (CMS to State) H - Aged, blind, or disabled recipient of a one-time payment (OTP) (CMS to State) M - Entitled to medical assistance only (MAO), non-cash recipient (State to CMS) Z - Deemed categorically needy (State to CMS)
Third Party Part A History (Occurrence 2)	2032 - 2051		Same as Occurrence 1
Third Party Part A History (Occurrence 3)	2052 - 2071		Same as Occurrence 1
Third Party Part A History (Occurrence 4)	2072 - 2091		Same as Occurrence 1
Third Party Part A History (Occurrence 5)	2092 - 2111		Same as Occurrence 1

Data Element Name	Position	Format	Description
Beneficiary Part B Third Party Start Date (Occurrence 1)	2112 - 2119	MMDDCCYY	The start date of a private third party group's or State's liability for a Part B premium. This field is filled with zeroes if no Part B Third party benefit is found for the beneficiary.
Beneficiary Part B Third Party Premium Payer Code (Occurrence 1)	2120 - 2122	X(03)	The identifier for a third party agency (either a private group, State buy-in agency or the Office of Personnel Management (OPM)) responsible for paying a beneficiary's Medicare Part B premium. Values: 000 - Beneficiary is having Part B premium deducted from Title II check 001 - Uninsured beneficiary 005 - Insured beneficiary 006 - Program Service Center control, no bill 007 - Special age 72 enrollee 008 - PSC annual billing 010 - 650 - State billing 700 - Office of Personnel Management (OPM) A01 - R99 - Group payers for Part B premiums
Beneficiary Part B Third Party Termination Date (Occurrence 1)	2123 - 2130	MMDDCCYY	The end date of a private third party group's or State's liability for a beneficiary's Part B premium.This field is filled with zeroes if no Part B Third Party Start Date is found.This field is filled with 9s if there is a Third Party Start Date and no Third Party End Date.

Data Element Name	Position	Format	Description
Beneficiary Part B Third Party Buy-in Eligibility Code (Occurrence 1)	2131	X(01)	A code that indicates the reason for Part B State buy-in eligibility. Values: A - Aged recipient of SSI payments (CMS to State) B - Blind recipient of SSI payments (CMS to State) C - Entitled to Part A of Title IV (AFDC) (State to CMS). D - Disabled recipient of SSI payments (CMS to State) E - Aged recipient of supplemental payment administered by SSA (CMS to State) F - Blind recipient of supplemental payment administered by SSA (CMS to State) G - Disabled recipient of supplemental payment administered by SSA (CMS to State) H - Aged, blind, or disabled recipient of a one-time payment (OTP) (CMS to State) M - Entitled to medical assistance only (MAO), non-cash recipient (State to CMS) P - Qualified Medicare Beneficiary (QMB) Z - Deemed categorically needy (State to CMS)
Third Party Part B History (Occurrence 2)	2132 - 2151		Same as Occurrence 1
Third Party Part B History (Occurrence 3)	2152 - 2171		Same as Occurrence 1
Third Party Part B History (Occurrence 4)	2172 - 2191		Same as Occurrence 1

Data Element Name	Position	Format	Description
Third Party Part B History (Occurrence 5)	2192 - 2211		Same as Occurrence 1
Beneficiary Part D Eligibility Start Date	2212 - 2219	MMDD CCYY	The date when the beneficiary becomes eligible for Part D benefits.This field is filled with zeroes if no Part D Start Date is found.This field indicates eligibility only, not enrollment in a plan with drug coverage.If there are multiple Part D eligibility periods, then this field will contain the earliest Part D Eligibility Start Date.
Beneficiary Part D Opt-Out Indicator	2220	X(01)	An indicator that beneficiary chooses not to be automatically enrolled by CMS into a Part D plan. Values: Y - Yes N - No Space - No
Beneficiary Co-Payment Type (Occurrence 1)	2221	X(01)	A code indicating whether the beneficiary was determined eligible for low income subsidy (LIS) or deemed eligible. Values: L - Determined eligible D - Deemed

Data Element Name	Position	Format	Description

Beneficiary Co-Payment Level (Occurrence 1)	2222	X(01)	An indicator providing the level of co-payment granted to the beneficiary.
			
			Values:
			If bene co-pay type is 'L', then
			1 - high
			4 - 15% subsidy
			If bene co-pay type is 'D', then
			1 - high
			2 - low
			3 - 0 (zero)

Beneficiary Co-Payment Start Date (Occurrence 1)	2223 - 2230	MMDDCCYY	The effective date of the co-payment period. This field is filled with zeroes if there is no Co-Payment Start Date.
Beneficiary Co-Payment End Date (Occurrence 1)	2231 - 2238	MMDDCCYY	The end date of the co-payment period. The field is filled with zeroes if there is no Co-Payment Start Date. This field is filled with 9s if there is a Co-Payment Start Date and no Co-Payment End Date..
Beneficiary Co-Payment History (Occurrence 2)	2239 - 2256		Same as Occurrence 1
Beneficiary Co-Payment History (Occurrence 3)	2257 - 2274		Same as Occurrence 1
Beneficiary Co-Payment History (Occurrence 4)	2275 -2292		Same as Occurrence 1
Beneficiary's Co-Payment History (Occurrence 5)	2293 - 2310		Same as Occurrence 1
Beneficiary's Co-Payment History (Occurrence 6)	2311 - 2328		Same as Occurrence 1
Beneficiary's Co-Payment History (Occurrence 7)	2329 - 2346		Same as Occurrence 1
Beneficiary's Co-Payment History (Occurrence 8)	2347 - 2364		Same as Occurrence 1
Beneficiary's Co-Payment History (Occurrence 9)	2365 - 2382		Same as Occurrence 1
Beneficiary's Co-Payment History (Occurrence 10)	2383 - 2400		Same as Occurrence 1

Data Element Name	Position	Format	Description
Beneficiary Contract Number (Occurrence 1)	2401 - 2405	X(05)	Unique identification for an agreement between CMS and a managed care organization (MCO) or Part D Prescription (PDP) sponsor enabling the plan to provide Medicare Part D prescription drug coverage.
Beneficiary Part D PBP Enrollment Start Date (Occurrence 1)	2406 - 2413	MMDDCCYY	The date that the beneficiary was enrolled in the plan benefit package. This field is filled with zeroes if no MA-PD or Part D PBP enrollment is found for the beneficiary
Beneficiary Part D PBP Enrollment End Date (Occurrence 1)	2414 - 2421	MMDDCCYY	The end date of the beneficiary's enrollment in the plan benefit package.This field is filled with zeroes if there is no Part D PBP Enrollment Start Date.This field is filled with 9s if there is a Part D PBP Enrollment Start Date and no Part D PBP Enrollment End Date.
Beneficiary Part D PBP Plan Number (Occurrence 1)	2422 - 2424	X(03)	A unique identifier for the managed care benefit package.

Data Element Name	Position	Format	Description
Beneficiary Enrollment Type Code (Occurrence 1)	2425	X(01)	An indicator providing the type of enrollment performed. Values: A - Auto enrolled B - Beneficiary election C - Facilitated enrollment D - System-generated enrollment (Rollover) E - Plan submitted auto-enrollments F - Plan submitted facilitated enrollments G - Point of sale (POS) submitted enrollments H - CMS or plan submitted re-assignment enrollments I - Assigned to plan submitted transactions with enrollment source other than any of the following: B, E, F, G, H, and blank.
Part D Plan Benefit Package (Occurrence 2)	2426 - 2450		Same as Occurrence 1
Part D Plan Benefit Package (Occurrence 3)	2451 - 2475		Same as Occurrence 1
Part D Plan Benefit Package (Occurrence 4)	2476 -2500		Same as Occurrence 1
Part D Plan Benefit Package (Occurrence 5)	2501 - 2525		Same as Occurrence 1
Part D Plan Benefit Package (Occurrence 6)	2526 - 2550		Same as Occurrence 1
Part D Plan Benefit Package (Occurrence 7)	2551 - 2575		Same as Occurrence 1
Part D Plan Benefit Package (Occurrence 8)	2576 - 2600		Same as Occurrence 1
Part D Plan Benefit Package (Occurrence 9)	2601 - 2625		Same as Occurrence 1
Part D Plan Benefit Package (Occurrence 10)	2626 - 2650		Same as Occurrence 1

Data Element Name	Position	Format	Description
Part C Organization Name	2651 - 2705	X(55)	Relates to the first occurrence of the beneficiary's Group Health Organization contract number in positions 1479-1483.
Part C Plan Name	2706 - 2755	X(50)	Relates to the first occurrence of the beneficiary's plan benefit package in positions 1697-1699.
Part D Organization Name	2756 - 2810	X(55)	Relates to the first occurrence of the beneficiary's contract number in Part D Plan Benefit Package in positions 2401-2405.
Part D Organization Plan Name	2811 - 2860	X(50)	Relates to the first occurrence of the beneficiary's plan benefit package in positions 2422-2424.
Part D Organization Plan Benefit	2861	X(01)	This field is filled with a space.

Data Element Name	Position	Format	Description
Beneficiary Language Indicator	2862	X(01)	A code that identifies the language that the beneficiary requested SSA to use for beneficiary notices. Values: E - English requested C - Chinese D - German F - French G - Greek I - Italian J - Japanese N - Norwegian P - Polish R - Russian S - Spanish V - Swedish W - Serb-Croatian Blank - English assumed
SNP Indicator (Occurrence 1)	2863	X(01)	Indicates that beneficiary is enrolled in a special needs plan Values: Y - SNP N - not SNP Corresponds to the first occurrence of plan benefit package in positions 1673-1701
SNP Indicator (Occurrence 2)	2864	X(01)	Same as Occurrence 1 Corresponds to the second occurrence of plan benefit package in positions 1702-1730

Data Element Name	Position	Format	Description
SNP Indicator (Occurrence 3)	2865	X(01)	Same as Occurrence 1 Corresponds to the third occurrence of plan benefit package in positions 1731-1759
SNP Indicator (Occurrence 4)	2866	X(01)	Same as Occurrence 1 Corresponds to the fourth occurrence of plan benefit package in positions 1760-1788
SNP Indicator (Occurrence 5)	2867	X(01)	Same as Occurrence 1Corresponds to the fifth occurrence of plan benefit package in positions 1789-1817
SNP Indicator (Occurrence 6)	2868	X(01)	Same as Occurrence 1 Corresponds to the sixth occurrence of plan benefit package in positions 1818-1846
SNP Indicator (Occurrence 7)	2869	X(01)	Same as Occurrence 1 Corresponds to the seventh occurrence of plan benefit package in positions 1847-1875
SNP Indicator (Occurrence 8)	2870	X(01)	Same as Occurrence 1 Corresponds to the eighth occurrence of plan benefit package in positions 1876-1904
SNP Indicator (Occurrence 9)	2871	X(01)	Same as Occurrence 1 Corresponds to the ninth occurrence of plan benefit package in positions 1905-1933

Data Element Name	Position	Format	Description
SNP Indicator (Occurrence 10)	2872	X(01)	Same as Occurrence 1 Corresponds to the tenth occurrence of plan benefit package in positions 1934-1962
Incarceration Start Date	2873 - 2880	MMDDCCYY	This date is provided solely to show why a dual eligible is not auto-enrolled. If there is no Incarceration Start Date, then this field is filled with zeroes.
Incarceration End Date	2881 - 2888	MMDDCCYY	This date is provided solely to show why a dual eligible is not auto-enrolled. If there is no Incarceration Start Date and no Incarceration End Date, then this field is filled with zeroes. If there is an Incarceration Start Date and no Incarceration End Date, then this field is filled with 9s.
FILLER	2889 - 2899	X(11)	Spaces

Data Element Name	Position	Format	Description
Previous Month SPD Calculation Code	2900	X(01)	Code to indicate how the individual beneficiary was used for calculations for State enrollment and disenrollment in a prior month's entry Values: E - Enrollment count D - Disenrollment count C - Carry forward enrollment count M -Missing state file (counted as enrollment) N - Not counted (this also indicates future Medicaid DET records) P - Prospective Duals, not considered in Clawback counts Space - Historical entries before code was added

Data Element Name	Position	Format	Description
Secondary Match Indicator	2901	X(01)	This field indicates if a matched detail record was matched under the Secondary Match algorithm of HICN and/or SSN and the first 6 characters of the last name and the 1st letter of the first name and the gender code. ** A matched detail record is indicated by the presence of alphanumeric values in the fields 'Beneficiary Claim Account Number' and 'Beneficiary Identification Code' (columns 237 - 247) and a Record Return Code (RRC) of '000000' or '000001'. Values: Space - Default for either primary match located beneficiary (if RRC = '000000' or '000001') or neither primary or secondary match was successful (if RRC = '000003'). S - Match accomplished by Secondary Match algorithm.

Data Element Name	Position	Format	Description
Daily State Phasedown Calculation Code	2902	X(01)	Code to indicate if the individual beneficiary was used for calculations for State enrollment and disenrollment in a current file's entry. (This entry will relate to the latest beneficiary information provided by the State.) Values: E - Enrollment count D - Disenrollment count C - Carry forward enrollment count M - Missing state file (counted as enrollment) N - Not counted (This also includes future Medicaid DET records) P - Prospective Duals, not considered in Clawback counts Space - Historical entries before code was added
RDS Start Date (Occurrence 1)	2903 - 2910	MMDDCCYY	The start date of the beneficiary's enrollment in employer plan. If there is no RDS Start Date, then this field is filled with zeroes.

Data Element Name	Position	Format	Description
RDS Termination Date (Occurrence 1)	2911 - 2918	MMDDCCYY	The end date of the beneficiary's enrollment in employer plan. If there are multiple RDS coverage periods, overlapping dates are possible. If there is no RDS Start Date, then this field is filled with zeroes. If there is a RDS Start Date and no RDS End Date, then this field is filled with 9s.
RDS Coverage Period (Occurrence 2)	2919 - 2934	9(16)	Same as Occurrence 1
RDS Coverage Period (Occurrence 3)	2935 - 2950	9(16)	Same as Occurrence 1
RDS Coverage Period (Occurrence 4)	2951 - 2966	9(16)	Same as Occurrence 1
RDS Coverage Period (Occurrence 5)	2967 - 2982	9(16)	Same as Occurrence 1
FILLER	2983	X(01)	Spaces
Part D Eligibility Start Date (Occurrence 1)	2984 - 2991	MMDDCCYY	Indicates the date that beneficiary became eligible for Part D benefits. This field is filled with zeroes if no Part D Eligibility Start Date is found.

Data Element Name	Position	Format	Description
Part D Eligibility End Date (Occurrence 1)	2992 - 2999	MMDDCCYY	Indicates the date that beneficiary is no longer eligible for Part D benefits. This field is filled with zeroes if no Part D Eligibility Start Date is found. This field is filled with 9s if there is a Part D Eligibility Start Date and no Part D Eligibility End Date.
Part D Eligibility Dates (Occurrence 2)	3000 - 3015	9(16)	Same as Occurrence 1
Part D Eligibility Dates (Occurrence 3)	3016 - 3031	9(16)	Same as Occurrence 1
Part D Eligibility Dates (Occurrence 4)	3032 - 3047	9(16)	Same as Occurrence 1
Part D Eligibility Dates (Occurrence 5)	3048 - 3063	9(16)	Same as Occurrence 1
Subsidy Level (Occurrence 1)	3064 - 3066	X(03)	Identifies the portion of the Part D Premium subsidized Values: 100 075 050 025 Relates to the numbered occurrences of the Beneficiary Co-Payment History, e.g. first occurrence here relates to first occurrence of Co-Payment in position 2222.

Data Element Name	Position	Format	Description
LIS/Deem Source code (Occurrence 1)	3067 - 3068	X(02)	Indicates the source of the LIS/Deeming action found in position 2221 (Co-Payment history occurrence) and 3064 (Premium percentage occurrence). Values for D (Deemed): 01 - MBD Third Party 02 - EEVS (State data baseline) 03 - SSA 04 - State 05 - Point of Sale 06 - CMS User Values for L (LIS): SS - SSA <st> - Postal State Code Abbreviation
Beneficiary Low Income Subsidy Premium Percentage and Source (Occurrence 2)	3069 - 3073	X(05)	Same as Occurrence 1
Beneficiary Low Income Subsidy Premium Percentage and Source (Occurrence 3)	3074 - 3078	X(05)	Same as Occurrence 1
Beneficiary Low Income Subsidy Premium Percentage and Source (Occurrence 4)	3079 - 3083	X(05)	Same as Occurrence 1
Beneficiary Low Income Subsidy Premium Percentage and Source (Occurrence 5)	3084 - 3068	X(05)	Same as Occurrence 1
Beneficiary Low Income Subsidy Premium Percentage and Source (Occurrence 6)	3069 - 3093	X(05)	Same as Occurrence 1
Beneficiary Low Income Subsidy Premium Percentage and Source (Occurrence 7)	3094 - 3098	X(05)	Same as Occurrence 1

Data Element Name	Position	Format	Description
Beneficiary Low Income Subsidy Premium Percentage and Source (Occurrence 8)	3099 - 3103	X(05)	Same as Occurrence 1
Beneficiary Low Income Subsidy Premium Percentage and Source (Occurrence 9)	3104 - 3108	X(05)	Same as Occurrence 1
Beneficiary Low Income Subsidy Premium Percentage and Source (Occurrence 10)	3109 - 3113	X(05)	Same as Occurrence 1
FILLER	3114 - 3400	X(287)	

6. File Summary Record

Table 6: File Summary Record

Data Element Name	Position	Format	Description
Record Identification Code	1-3	X(03)	'FSM'
State Code	4-5	X(02)	US Postal Service State Abbreviation. See Appendix B State Codes
File Process Timestamp	6-31	X(26)	The exact time that the State file is processed Format: CCYY-MM-DD-hh.mm.ss.nnnnnn CCYY - Year MM - Month DD - Day hh - Hour mm - Minute ss - Second nnnnnn - Microsecond
File Create Month	32-33	9(02)	The month that the State file to CMS is created
File Create Year	34-37	9(04)	The year that the State file to CMS is created
Records Total	38-45	9(08)	The total number of DET records in the State file This count does not include PRO records.

Data Element Name	Position	Format	Description
Records Duplicate	46-53	9(08)	The total number of duplicate DET records in the State file This count does not include PRO records.
Records Non-Duplicate	54-61	9(08)	The total number of non-duplicate valid DET records in State file This count does not include PRO records.
Records Valid	62-69	9(08)	The total number of valid DET records in the State File to CMS This count does not include PRO records.
Records Invalid	70-77	9(08)	The total number of invalid DET records in the State File to CMS This count does not include PRO records.
Records Matched	78-85	9(08)	The total number of DET records that could be matched to an individual on the Medicare Beneficiary DatabaseThis count does not include PRO records.
Records Not Matched	86-93	9(08)	The total number of DET records that could not be matched to an individual on the Medicare Beneficiary Database This count includes invalid records because match is not attempted on invalid records. This count does not include PRO records.
Filler	94-140	X(47)	

Data Element Name	Position	Format	Description
Valid Dual Records	141-148	9(08)	The total number of valid DET records in the file This count does not include PRO records.
Valid Dual Matches	149-156	9(08)	The total number of DET records that are matched to an individual on the Medicare Beneficiary Database This count does not include PRO records.
Valid Dual Non-Matches	157-164	9(08)	The total number of valid DET records that are not matched to an individual on the Medicare Beneficiary Database This count does not include PRO records.
Valid LIS Records	165-172	9(08)	The total number of valid LIS records in the State to CMS file
Valid Current Duals	173-180	9(08)	The total number of valid DET records with Eligibility Month/Year = File Create Month/Year This count does not include PRO records.
Valid Retro Duals	181-188	9(08)	The total number of valid DET records with Eligibility Month/Year < File Create Month/Year This count does not include PRO records.
Total Eligibility Months	189-190	9(02)	The total number of Eligibility Months in the State to CMS file This count does not include PRO records.

Data Element Name	Position	Format	Description
Total Valid PRO Records	191-198	9(08)	The total number of valid PRO records in the State to CMS File.
Total Invalid PRO Records	199-206	9(08)	The total number of invalid PRO records in the State to CMS File
Total Matched PRO Records	207-214	9(08)	The total number of valid PRO records that are matched to an individual on the Medicare Beneficiary Database
Filler	215-3400	X(3186)	

7. Month Summary Record

Table 7: Month Summary Record

Data Element Name	Position	Format	Description
Record Identification Code	1-3	X(03)	'MSM'
State Code	4-5	X(02)	US Postal Service State Abbreviation. See Appendix B (State Codes)
File Process Timestamp	6-31	X(26)	The exact time that the State file is processed. Format: CCYY-MM-DD-hh.mm.ss.nnnnnn CCYY - Year MM - Month DD - Day hh - Hour mm - Minute ss - Second nnnnnn - Microsecond
File Create Month	32-33	9(02)	The month that the State MMA file to CMS is created
File Create Year	34-37	9(04)	The year that the State MMA file to CMS is created
Eligibility Month	38-39	9(02)	Month for applicable Medicaid eligibility
Eligibility Year	40-43	9(04)	Year for applicable Medicaid eligibility
Calculation Switch	44	X(01)	'Y' - This Eligibility Month/Year was used in the State phase-down calculation. 'N' - This Eligibility Month/Year was not used in the State phase-down calculation.
Total Valid Records	45-52	9(08)	The total number of valid DET records found in the MMA State File to CMS for this Eligibility Month/Year. This count does not

Data Element Name	Position	Format	Description
			include PRO records.
Total Valid Full Dual Records	53-60	9(08)	The total number of valid full dual beneficiary records. This count does not include PRO records.
Total Valid Non-Full Dual Records	61-68	9(08)	The total number of valid non-full dual beneficiary records. This count does not include PRO records.
Net Total Valid Full Dual Enrollments	69-76	9(08)	The net total number of valid Full Dual Eligible enrollments counted for this Eligibility Month/Year. This count does not include PRO records.
Net Total Valid Full Dual Disenrollments	77-84	9(08)	The net total number of valid Full Dual Eligible disenrollments counted for this Eligibility Month/Year. This count does not include PRO records.
Filler	85-3400	X(3316)	

8. Trailer Record:

Table 8: Trailer Record

Data Element Name	Position	Format	Description
Record Identification Code	1-3	X(03)	'TRL'
File Process Timestamp	4-29	X(26)	The exact time that the State file is processed. Format: CCYY-MM-DD-hh.mm.ss.nnnnnn CCYY - Year MM - Month DD - Day hh - Hour mm - Minute ss - Second nnnnnn - Microsecond
File Create Month	30-31	9(02)	Month that MMA State file to CMS is created
File Create Year	32-35	9(04)	Year that MMA State file to CMS is created
File Accept Indicator	36	X(01)	'Y' - The MMA State file to CMS is accepted. 'N' - The MMA State file to CMS is not accepted.
Filler	37-43	X(07)	
Record Identification Code	44-46	X(03)	
Beneficiary Record Count	47-54	9(08)	
State Code	55-56	X(02)	
File Create Month	57-58	9(02)	
File Create Year	59-62	9(04)	
Filler	63-223	X(161)	
Filler	224-3400	X(3177)	

9. APPENDIX A CMS Central Office Contacts

CMS CENTRAL OFFICE MMA CONTACTS
TBQ Query Process: Main: mailto:Carolyn.Lawson@cms.hhs.gov; (410) 786.0704; **Secondary**: mailto:Goldy.Austen@cms.hhs.gov; (410) 786.6450
MMA EFT Test Files: **Main**: mailto:Carolyn.Lawson@cms.hhs.gov; (410) 786.0704; **Secondary**: mailto:Goldy.Austen@cms.hhs.gov; (410) 786.6450
All Other MMA File Issues: Contact your CMS Central Office (CO) MMA Contact: Carolyn Lawson or mailto:Vasanthi.Kandasamy@cms.hhs.gov; (410) 786.0433

STATE	CMS CO CONTACT		STATE	CMS CO CONTACT
Alabama	Carolyn Lawson		Montana	Carolyn Lawson
Alaska	Vasanthi Kandasamy		Nebraska	Carolyn Lawson
Arizona	Vasanthi Kandasamy		Nevada	Carolyn Lawson
Arkansas	Vasanthi Kandasamy		New Hampshire	Carolyn Lawson
California	Vasanthi Kandasamy		New Jersey	Carolyn Lawson
Colorado	Vasanthi Kandasamy		New Mexico	Carolyn Lawson
Connecticut	Vasanthi Kandasamy		New York	Carolyn Lawson
Delaware	Vasanthi Kandasamy		North Carolina	Vasanthi Kandasamy
District Of Columbia	Vasanthi Kandasamy		North Dakota	Vasanthi Kandasamy
Florida	Carolyn Lawson		Ohio	Vasanthi Kandasamy
Georgia	Carolyn Lawson		Oklahoma	Carolyn Lawson
Hawaii	Vasanthi Kandasamy		Oregon	Vasanthi Kandasamy
Idaho	Vasanthi Kandasamy		Pennsylvania	Carolyn Lawson
Illinois	Carolyn Lawson		Rhode Island	Carolyn Lawson
Indiana	Carolyn Lawson		South Carolina	Carolyn Lawson
Iowa	Carolyn Lawson		South Dakota	Vasanthi Kandasamy
Kansas	Carolyn Lawson		Tennessee	Vasanthi Kandasamy
Kentucky	Vasanthi Kandasamy		Texas	Carolyn Lawson
Louisiana	Carolyn Lawson		Utah	Vasanthi Kandasamy
Maine	Vasanthi Kandasamy		Vermont	Vasanthi Kandasamy
Maryland	Vasanthi Kandasamy		Virginia	Vasanthi Kandasamy
Massachusetts	Carolyn Lawson		Washington	Carolyn Lawson
Michigan	Carolyn Lawson		West Virginia	Carolyn Lawson
Minnesota	Carolyn Lawson		Wisconsin	Vasanthi Kandasamy
Mississippi	Carolyn Lawson		Wyoming	Vasanthi Kandasamy
Missouri	Vasanthi Kandasamy			

10. APPENDIX B State Codes

Data Element Name	Specifications			
STATE CODE	**State Code - Valid Code**			
	Alabama	AL	Missouri	MO
	Alaska	AK	Montana	MT
	Arizona	AZ	Nebraska	NE
	Arkansas	AR	Nevada	NV
	California	CA	New Hampshire	NH
	Colorado	CO	New Jersey	NJ
	Connecticut	CT	New Mexico	NM
	Delaware	DE	New York	NY
	District of Columbia	DC	North Carolina	NC
			North Dakota	ND
	Florida	FL	Ohio	OH
	Georgia	GA	Oklahoma	OK
	Hawaii	HI	Oregon	OR
	Idaho	ID	Pennsylvania	PA
	Illinois	IL	Rhode Island	RI
	Indiana	IN	South Carolina	SC
	Iowa	IA	South Dakota	SD
	Kansas	KS	Tennessee	TN
	Kentucky	KY	Texas	TX
	Louisiana	LA	Utah	UT
	Maine	ME	Vermont	VT
	Maryland	MD	Virginia	VA
	Massachusetts	MA	Washington	WA
	Michigan	MI	West Virginia	WV
	Minnesota	MN	Wisconsin	WI
	Mississippi	MS	Wyoming	WY