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

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REVISION HISTORY

Date	Version	Reason for Change	Author
04/18/2008	1.0	Initial Draft	Marie Pusloskie
06/11/2008	1.1	Revisions to the output detail record for valid values.	Marie Pusloskie
08/30/2010	2.0	Incorporate CMCS Changes.	Nancy Porter
09/17/2010	2.1	Incorporate additional CMCS Changes.	Nancy Porter
11/03/2010	2.2	Updated document to 508-Compliant version.	NGC
11/16/2010	2.3	Updated document to address 508-Compliance identified by CMS.	NGC
01/20/2012	2.4	Updated document to address additions to ESRD dates for MAPD2182.	Nancy Porter
07/12/2013	2.5	Incorporate changes since January 2012, including the addition of the archive and MMP opt out indicators.	NGC
09/05/2013	2.6	Replaced section 2.1 to specify weekend last day of month cutoffs.	NGC
04/04/2014	2.7	Added explanation for PBP number '999' for Position 1697 on page 45. Revised explanation based on C. Lawson's comments.	NGC
5/19/2015	2.8	Changed title for 3.2.1, Updated PBP Coverage Type Codes, Enrollment Type Codes, Beneficiary Language Indicator Codes, Part B Third Party Eligibility Codes, DIB Justification Codes, Part A Entitlement Reason Codes, and Part B Enrollment Reason Codes. Added obsolete designation to TP Part A Buy-In Eligibility Code.	NGC

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1. <u>**Technical Instructions for Submitting State Data for Medicare Modernization Act**</u>
   <u>**(MMA) Provisions**</u>

   1.1   *State Monthly MMA File Submission Requirements*

   The Centers for Medicare & Medicaid Services (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. CMS expects 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 Qualified Medicare Beneficiary (QMB), Specified Low-
   Income Medicare Beneficiary (SLMB), and Qualified Individual (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 Phase-Down contribution payment. The Phase-Down 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 individual in multiple file submittals, the last record
   submitted for that individual shall be used to determine the final effect on the Phase-
   Down 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 LIS application
   processed during the month by the State must be included in the file.

States are strongly encouraged to use the Social Security Administration's (SSA) 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 LIS 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 first and the end 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 daily with the exception of Sundays to the Part D plans. CMS does not change the 180 bytes of data sent by the States.

Files that are rejected based on data quality validation must be resubmitted to CMS by the last day of the month if this is to be the sole submission of the month.

If a State submits a file on the last day of the month, and it is received on or after our cutoff processing time, the file will be processed the first day of the subsequent month. The cutoff processing times are:

If Last Day of Month Is A:	Cutoff Processing Time
Weekday (including holidays)	6:00 PM Eastern Time
Saturday or Sunday	1:00 PM Eastern Time

Thus if a file is submitted to CMS on January 31, 2013, at 11 pm Easter Standard Time (EST), it would not be processed until February 1, and all DETail (DET) records submitted as 'current' for January 2013 would now be treated as retroactive records,

any (one month into the future) DET 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 Phase-Down calculation.

2.2   *Enrollment File Content*

The Record Identification Code 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 its 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 <u>one</u> file per month, the Medicaid Eligibility Status Field must be populated with 'Y'. If a State submits <u>multiple </u>files per month, the Medicaid Eligibility Status Field can be populated with a 'Y' or 'N'. For example, if an individual was submitted as a Current DET record in a previous submission during the current reporting month as a 'Y', but the State discovered the individual was not Medicaid eligible, the State may correct the eligibility status by resubmitting the individual'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, and
    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 2013 reporting month file due by January 31, a dual eligible that became retroactively eligible in October 2012, the State would submit a full, complete record for each month of eligibility through the reporting month i.e., four records (October 2012 – January 2013). Since this is a replacement record, the record will include data in **all required fields**; not just those fields that have changed. An

individual 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 seven 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.

The State should 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 QIs. 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. CMS 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 IDENTIFICATION 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 Social Security Number (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 or incorrect birth date format will be rejected.
- Record must contain a valid, two byte DUAL STATUS CODE (position 116-117) of '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 LIS 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 identification code located in the first three bytes of the record (i.e. DET, PRO, LIS).

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 Identification Code 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 its PRO records to CMS for processing, CMS will respond by returning a PRO record for each PRO record submitted, regardless if found

on CMS Medicare Beneficiary Database (MBD). A State will receive PRO statistics in the FILE SUMMARY RECORD. The layout has been changed to accommodate PRO processing.

Record Return Summary Codes 000009 – 000012 apply to PRO records only. See data element 'Record Return Summary Code' (Positions 229-234) in Table 5 for descriptions.

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, Health Insurance Claim Number (HICN), SSNs, End Stage Renal Disease (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 Part D Plan (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 = '000000' or '000001') and the Part A/B/D Entitlement Start Date is 01/01/2013, it is anticipated that a DETail record will be submitted for this beneficiary in the January 2013 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 2012 State File and was found to be PART A/B/D entitled 03/01/2013, 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 03/01/2013. 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 to a Part D Plan (PDP) 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 2013). Deeming, however, will occur when the record is received 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 of which a State was otherwise not aware. When that occurs, the State should submit retroactive monthly DET records covering the newly-identified period of dual eligibility in the following month's Enrollment File submission.

2.7   *Enrollment File and Record Specifications*

2.7.1   File Transfer Methods

The State Enrollment File(s) will be transferred using Gentran, Managed File Transfer (MFT) Platform Server, MFT Internet Server, 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.

2.7.2   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), and
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

The following file formats are used:

* File naming standard for **MFT Platform Server and Connect:Direct (C:D)** electronic file transfers –
  P#EFT.IN.ELIGIBLE.CMSxx.Dyymmdd.Thhmmsst, and
* File naming standard for **GENTRAN and MFT Internet Server** electronic file transfers – Guid.NONE.MBD.M.CMSxx.ELIGIBLE.P.

Where 'xx' = State abbreviation, and
Where 'GUID' = EIDM ID/System 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

A Key field used to corroborate a match between the State's incoming beneficiary record to CMS' MBD, which receives this date from the SSA's Master Beneficiary Record (MBR). The following is the matching criteria logic used:

* **PRIMARY MATCHING Criteria is based on the following algorithm:**

  EITHER
  o   SSN   5.0 points

OR

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

AND

- o   BENE DOB CCYY   3.25 points
- o   BENE DOB MM   3.0 points
- o   BENE DOB DD   2.25 points
- o   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:**
  - o   First six positions of the Last Name,
  - o   First position of the First Name,
  - o   Claim Account Number (CAN) or SSN, and
  - **o**   Exact Gender.

3.1.2   Institutional Status Indicator

An indicator of nursing facility, ICFMR or inpatient psychiatric hospital) or home and community based services. Information about the indicator:

- • Values are 'Y', 'N' or 'H' – 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.

- • A value of 'H' (HCBS) is valid for an eligibility month/year no earlier than January 2012, in which a <u>full-benefit dual eligible</u> 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. States that submit retroactive records in their files are asked 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, a retroactive enrollment record is needed showing this update.

3.2   Fields Received by the State on monthly MMA Response File

3.2.1   Medicare Part D Enrollment Indicator

Information about the indicator:
- 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   Managed Care Organization (MCO) (10 Occurrences)

This area of the response file contains both Medicare Advantage Plans, Program for All Inclusive Care for the Elderly (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 (Plan Benefit Packages or PBPs). If a rollover from a non-drug covering plan into one that does occurs, the enrollment effective date of the MCO 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 MCO 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 MCO CNTRCT NUM':
   - H# is for local Medicare Advantage (MA) and Medicare Advantage Part D (MAPD); PACE, Cost Plans, and Demos
   - S# is for STAND ALONE PDPs
   - R# is for Regional MA and MAPDs
   - 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 Limited Income – Newly Eligible Transition (LI-NET) program.

3.2.3   Plan Benefit Package Enrollment (10 Occurrences)

This area of the response file describes the various PBP enrollments within the given MCO periods mentioned above:

- The most recent 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 MCO contract numbers will be different.
- Updated list of values for the **PBP ORG CVRG TYPE CD:**

NF = Pay bill option was not found for the contract,
3 = CCP – Coordinated Care Plan,
4 = MSA – Medicare Medical Savings Account,
5 = PFFS – Private Fee For Service,
6 = PACE – Program Of All Inclusive Care For The Elderly,
7 = Regional Plan,
8 = DEMO – Demonstration,
10 = Cost/HCPP – Cost/Health Care Prepayment Plan,
11 = PDP Election – Part D Drug Plan Election,
12 = Chronic Care Demo,
13 = MSA Demo – Medicare Medical Savings Account Demonstration, and
14 = MMP – Medicare Medicaid Plan.

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 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 MCO contract numbers will be different.
- Updated list of values Enrollment Type Code:

Values for Enrollment Type Code:

A – Beneficiary was auto-enrolled by 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) 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 re-assignment enrollments.
I – Non-MMP Plan submitted transactions with enrollment source other than any of the following: B, E, F, G, and blank.
J – State submitted MMP passive enrollment.

K – CMS submitted MMP passive enrollment.
L – Beneficiary MMP election.

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 A 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 = '2013'.
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	MMCCYY	Enter calendar month/year for applicable Medicaid eligibility for DET and PRO records.
			
			Enter the effective month/year of the change for each retroactive record.
			
			Retroactive changes must be submitted to reflect prior month changes in one or more of the following fields:
			
			   – Eligibility Status
			   – Health Insurance Claim Number / Railroad Retirement Board Number HICN/RRB
			   – Social Security Number
			   – Sex
			   – Date of Birth
			   – Dual Status Code
			   – Federal Poverty Level (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)	For DET and PRO records 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 HICN or the RRB, whichever the State has active and available for the individual.
HICN/RRB Indicator	26	X(01)	Enter 'H' for HICN or 'R' for RRB # 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.
State Medicaid Agency (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'.

Individual's Gender	107	X(01)	Enter the individual's gender:
			
			    M = Male
			    F = Female
			
			This entry is used for beneficiary secondary match.

Individual's Date of Birth	108-115	MMDDCC	Enter the individual's date of birth.

Data Element Name	Position	Format	Instructions
		YY	CMS will reject a detail record without a date of birth or with an invalid date of birth.
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 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.
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)	Enter '9' in this field. This field is not used by CMS.

Data Element Name	Position	Format	Instructions
Institutional Status Indicator	120	X(01)	Enter one of the following values for DET and PRO records: '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. 'H' (Home and Community Based) – Individual is receiving home and community based services at any period during the month ('H' can be used for Eligibility Month/Year of January 2012 and later.)
Low-Income Subsidy Application Approval Code	121	X(01)	For LIS records 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	MMDDCCYY	For LIS records Enter date that State approved or disapproved low-income subsidy application.
Low-Income Subsidy Start Date	130-137	MMDDCCYY	For LIS records 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	MMDDCCYY	For LIS records Enter the date that the subsidy ends. The day of this entry must be the last

Data Element Name	Position	Format	Instructions
			day of the month in which the subsidy ends. This field is not required and should be left blank or filled with 9s unless the State has a definite knowledge of when the subsidy award ends.
Income as % of FPL	146-148	9(03)	For LIS records 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)	For LIS records 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%, and 025 – 146%-149%.
Income Used for Determination	152	X(01)	For LIS records 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)	For LIS records Enter '1' if individual's resource limit is over the limit. Enter '2' if individual's resource limit is under the limit.
Basis of Low-Income Subsidy Denial	154	X(01)	For LIS records 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

Data Element Name	Position	Format	Instructions
			USA), 3 = FTC (Failure to cooperate), 4 = RES (Resources too high), and 5 = INC (Income too high).
Result of an Appeal	155	X(01)	For LIS records 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)	For LIS records Enter 'Y' if this record changes a determination sent previously. Enter 'N' or '9' if this record does not change a determination sent previously. This is a future element.
Determination Cancelled	157	X(01)	For LIS records 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 A State Codes.
Create Month	14-15	9(02)	Enter month that the file is created. Example: if month is January, enter '01'.
Create Year	16-19	9(04)	Enter year that the file is created. Example = '2013'.
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, MFT Platform Server, MFT Internet Server or 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 MBD

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.
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 Active 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 Active 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)	A copy of the header record in the incoming file is displayed in positions 116-295.
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)	A copy of the detail record in the incoming file is displayed in positions 1-180.
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)	
Gender	107	X(01)	
Date of Birth	108-115	MMDDCCYY	
Dual Status Code	116-117	9(02)	
Federal Poverty Level Percentage	118	9(01)	

Data Element Name	Position	Format	Description
Indicator			
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.
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

Data Element Name	Position	Format	Description
Eligibility Month/Year Error Code Cont.			> 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.
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.

Data Element Name	Position	Format	Description
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.
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	203-204	X(02)	00 – Value is valid.

Data Element Name	Position	Format	Description
Code			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.
Low-Income Subsidy Effective Date Error Code	209-210	X(02)	00 – Value is valid. 02 – Value is not numeric. 04 – Date is unknown. 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.

Data Element Name	Position	Format	Description
Low-Income Subsidy Effective Date Error Code Cont.			98 – DET or PRO record not scanned. Note: Detail record is valid if ERC = 00, 37 or 98.
Low-Income Subsidy End Date Error Code	211-212	X(02)	00 – Value is valid. 02 – Value is not numeric. 04 – Date is unknown. 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. 02 – Value is not numeric 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 valid 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.
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.

Data Element Name	Position	Format	Description
Determination Cancelled Error Code Cont.			Note: Detail record is valid if ERC = 00 or 98.
Record Return Summary Code	229-234	X(06)	This field is an assessment of the detail record. **000000**: DET, PRO or LIS record is accepted with no errors or warnings. **000001**: DET, PRO or LIS record is accepted with warnings. **000002:** Detail record is rejected because Record Identification Code is not DET, PRO or LIS. **000003**: DET, PRO or LIS record is rejected because it was not matched. (May indicate a mismatch on the submitted date of birth.) **000004**: DET record is rejected: record has no entry in required field or has entry that does not pass validation edits. **000005**: LIS record is rejected: record has no entry in required field or has entry that does not pass validation edits. **000006:** DET record is rejected: record is a duplicate of another DET record. **000007**: LIS record is rejected: record is a duplicate of another LIS record. **000009**: PRO record is rejected: record has no entry in required field or has entry that does not pass validation edits.

Data Element Name	Position	Format	Description
			000010: PRO record is rejected: record is a duplicate of another PRO record.
Record Return Summary Code Cont.			**000011**: PRO Record is rejected: record is a duplicate of a DET record in same file. **000012:** PRO record is rejected: record is a duplicate of a DET record in previous file.
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.

Data Element Name	Position	Format	Description
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 SSA or RRB wage earner and is used to justify entitlement to Medicare benefits.
Beneficiary Birth Date	248-255	MMDDCC YY	
Beneficiary Death Date	256-263	MMDDCC YY	

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)	

Data Element Name	Position	Format	Description
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)	
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	433-434	X(02)	

Data Element Name	Position	Format	Description
9)			
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 SSA.
Beneficiary Social Security Number (Occurrence 2)	455-463	9(09)	
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)	

Data Element Name	Position	Format	Description
Residence Address Zip code	1072-1080	X(09)	
Residence Address Change Date	1081-1088	X(08)	
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
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

Data Element Name	Position	Format	Description
Part B Non-Entitlement Status Code Cont.			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 (Occurrence 1)	1100-1103	X(04)	
Beneficiary Entitlement Reason Code Occurrence 2)	1104-1115	9(08) + X(04)	
Beneficiary Entitlement Reason Code (Occurrence 3)	1116-1127	9(08) + X(04)	
Beneficiary's Entitlement Reason Code (Occurrence 4)	1128-1139	9(08) + X(04)	
Beneficiary Entitlement Reason Code (Occurrence 5)	1140-1151	9(08) + X(04)	
Beneficiary Part A Entitlement Start Date (Occurrence 1)	1152-1159	MMDDCCYY	The date beneficiary became entitled to Medicare benefits. This field is filled with zeroes if no Part A Entitlement Start Date is found.
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.
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,

Data Element Name	Position	Format	Description
			H – Entitled based on health hazard, I – Initial enrollment period,
Beneficiary Part A Entitlement Reason Code (Occurrence 1) Cont.			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, and U – Unknown. This field is filled with a space if no entitlement is found.
Beneficiary Part A Entitlement Status Code (Occurrence 1)	1169	X(01)	Values: E – Free Part A Entitlement, G – Entitled due to good cause, and 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,

Data Element Name	Position	Format	Description
			T – Terminated for non-payment of premiums, W – Voluntary withdrawal
Beneficiary Part A Entitlement Status Code (Occurrence 1) Cont.			from premium coverage, and 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.
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, H – Health hazard, 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,

Data Element Name	Position	Format	Description
			R – Residency requirements are involved, S – State buy-in,
Beneficiary Part B Enrollment Reason Code (Occurrence 1) Cont.			T – Disabled working beneficiary, and U –Unknown. This field is filled with a space if no enrollment is found.
Beneficiary Part B Enrollment Status Code (Occurrence 1)	1259	X(01)	Values when there is a Part B Enrollment Start Date and no Part B Enrollment End Date: G – Enrolled due to good cause, and 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, and W – Voluntary withdrawal from premium coverage. This field is filled with a space if no enrollment is found.
Part B Enrollment (Occurrence 2)	1260-1277	X(18)	Same as Occurrence 1
Part B Enrollment (Occurrence 3)	1278-1295	X(18)	Same as Occurrence 1
Part B Enrollment	1296-1313	X(18)	Same as Occurrence 1

Data Element Name	Position	Format	Description
(Occurrence 4)			
Part B Enrollment (Occurrence 5)	1314-1331	X(18)	Same as Occurrence 1
Beneficiary Hospice Coverage Start Date (Occurrence 1)	1332-1339	MMDDCC YY	This field is filled with zeroes if beneficiary has no hospice benefit or coverage.
Beneficiary Hospice Coverage End Date (Occurrence 1)	1340-1347	MMDDCC YY	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 Disability Insurance Benefits (DIB) Entitlement Start Date (Occurrence 1)	1412-1419	MMDDCC YY	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	MMDDCC YY	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

Data Element Name	Position	Format	Description
			no DIB Entitlement End Date, then this field is filled with zeroes.
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 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, and
H – Beneficiary is entitled to Medicare due to health hazard.

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 MCO (contract level) Enrollment Start Date (Occurrence 1)	1463-1470	MMDDCCYY	This field is filled with zeroes if no managed care organization enrollment is found.
Beneficiary MCO (contract level) Enrollment End Date (Occurrence 1)	1471-1478	MMDDCCYY	This field is filled with zeroes if there is no managed care organization enrollment found.

This field is filled with 9s if there is a MCO Contract Enrollment Start Date and no MCO Contract Enrollment End Date. |
| Beneficiary MCO Number | 1479-1483 | X(05) | Unique identification for an |

Data Element Name	Position	Format	Description
(contract level) (Occurrence 1)			agreement between CMS and a Managed Care Organization. Generally the
Beneficiary MCO Number (contract level) (Occurrence 1) Cont.			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, MAPD (Medicare Advantage with Prescription Drug) plans, PACE organizations, cost plans and some demonstrations. A contract number starting with **'R'** indicates regional MA and MAPD 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 MCO (Occurrence 2)	1484-1504		Same as Occurrence 1
Beneficiary MCO (Occurrence 3)	1505-1525		Same as Occurrence 1
Beneficiary MCO (Occurrence 4)	1526-1546		Same as Occurrence 1

Data Element Name	Position	Format	Description
Beneficiary MCO (Occurrence 5)	1547-1567		Same as Occurrence 1
Beneficiary MCO (Occurrence 6)	1568-1588		Same as Occurrence 1
Beneficiary MCO (Occurrence 7)	1589-1609		Same as Occurrence 1
Beneficiary MCO (Occurrence 8)	1610-1630		Same as Occurrence 1
Beneficiary MCO (Occurrence 9)	1631-1651		Same as Occurrence 1
Beneficiary MCO (Occurrence 10)	1652-1672		Same as Occurrence 1
MCO Enrollment Start Date (Occurrence 1)	1673-1680	MMDDCC YY	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) Enrollment Start Date (Occurrence 1)	1681-1688	MMDDCC YY	The date of the beneficiary's enrollment at the PBP level. This field is filled with zeroes if the beneficiary has no PBP enrollment.
Plan Benefit Package Enrollment End Date (Occurrence 1)	1689-1696	MMDDCC YY	The date the beneficiary's 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 contains spaces if the managed care plan has no PBP. If a Cost Plan has no PBP, the field contains '999'.

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
Plan Benefit Package Coverage Type Code (Occurrence 1) Cont.			package in which the beneficiary is enrolled Values: NF – Pay bill option not found for this contract, 3 – CCP (Coordinated Care Plan), 4 – MSA (Medicare Medical Savings Account), 5 – PFFS (Private Fee For Service), 6 – PACE (Program of All Inclusive Care for the Elderly), 7 – Regional, 8 – Demo (Demonstration), 10 – Cost / HCPP (Health Care Prepayment Plan), 11 – PDP (Part D Drug Plan) Election), 12– Chronic Care Demo, 13 – MSA (Medicare Medical Savings Account) Demonstration, and 14 – MMP (Medicare/Medicaid Plan). 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	MMDDCC YY	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	MMDDCC YY	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, and E – ESRD ended. This field is filled with spaces if beneficiary has no ESRD coverage or if there is no ESRD Coverage End Date.
Beneficiary ESRD Clinical Dialysis Start Date (Occurrence 1) Occurrence 1 is the latest dialysis period if multiple periods exist.	1980-1987	MMDDCC YY	The date when ESRD dialysis starts. This field is filled with zeroes if beneficiary has no

Data Element Name	Position	Format	Description
See positions 3114 through 3193 for additional occurrences, sorted in descending order by Start Date.			ESRD Dialysis Start Date.
Beneficiary ESRD Clinical Dialysis End Date (Occurrence 1)	1988-1995	MMDDCC YY	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	MMDDCC YY	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	MMDDCC YY	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	MMDDCC YY	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.
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.

Data Element Name	Position	Format	Description
			Values: S01 thru S99 – State Billing, T01 thru Z98 – Private Third
Beneficiary Part A Third Party Premium Payer Code (Occurrence 1) Cont.			Party Billing, and 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.
Beneficiary Part A Third Party Buy-in Eligibility Code (Occurrence 1)	2031	X(01)	This data element is obsolete.
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.
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

Data Element Name	Position	Format	Description
			Management (OPM))
Beneficiary Part B Third Party Premium Payer Code (Occurrence 1) Cont.			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), and A01 – R99 – Group payers for Part B premiums.
Beneficiary Part B Third Party Termination Date (Occurrence 1)	2123-2130	MMDDCC YY	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.
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

Data Element Name	Position	Format	Description
			State),
Beneficiary Part B Third Party Buy-in Eligibility Code (Occurrence 1) Cont.			B – Blind recipient of SSI payments (CMS to State), C – Entitled to Part A of Title IV (TANF) (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), L – Specified Low Income Beneficiary (SLMB), M – Entitled to medical assistance only (MAO), non-cash recipient (State to CMS), P – Qualified Medicare Beneficiary (QMB), U – Qualified Individual One (QI-1), and Z – Deemed categorically needy (State to CMS). Note: States can use any other alphabetic character.
Third Party Part B History (Occurrence 2)	2132-2151		Same as Occurrence 1.

Data Element Name	Position	Format	Description
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.
Third Party Part B History (Occurrence 5)	2192-2211		Same as Occurrence 1.
Beneficiary Part D Eligibility Start Date	2212-2219	MMDDCC YY	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, and 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, and D – Deemed.
Beneficiary Co-Payment Level (Occurrence 1)	2222	X(01)	An indicator providing the level of co-payment granted to the beneficiary.

Data Element Name	Position	Format	Description
			Values:
			If bene co-pay type is 'L', then
Beneficiary Co-Payment Level (Occurrence 1) Cont.			1 – high, and 4 – 15%. If bene co-pay type is 'D', then: 1 – high, 2 – low, and 3 – 0 (zero).
Beneficiary Co-Payment Start Date (Occurrence 1)	2223-2230	MMDDCC YY	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	MMDDCC YY	The end date of the co-payment period. This 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.

Data Element Name	Position	Format	Description
Beneficiary's Co-Payment History (Occurrence 10)	2383-2400		Same as Occurrence 1.
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 Plan (PDP) sponsor enabling the plan to provide Medicare Part D prescription drug coverage.
Beneficiary Part D PBP Enrollment Start Date (Occurrence 1)	2406-2413	MMDDCC YY	The date that the beneficiary was enrolled in the plan benefit package. This field is filled with zeroes if no MAPD or Part D PBP enrollment is found for the beneficiary
Beneficiary Part D PBP Enrollment End Date (Occurrence 1)	2414-2421	MMDDCC YY	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.
Beneficiary Enrollment Type Code (Occurrence 1)	2425	X(01)	An indicator providing the type of enrollment performed. Values: A – Auto enrolled by CMS, B – Beneficiary election, C – Facilitated enrollment by CMS, D – System-Generated

Data Element Name	Position	Format	Description
			enrollment (Rollover), E – Plan submitted auto-enrollments,
Beneficiary Enrollment Type Code (Occurrence 1) Cont.			F – Plan submitted facilitated enrollments, G – Point of Sale (POS) submitted enrollments, H – CMS or plan submitted re-assignment enrollments, I – Non-MMP Plan submitted transactions with enrollment source other than any of the following: B, E, F, G, and blank, J – State submitted MMP passive enrollment, K – CMS submitted MMP passive enrollment, and L – Beneficiary MMP election.
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.
Part C MCO Name (contract level)	2651-2705	X(55)	Relates to the first occurrence of the beneficiary's Managed Care

Data Element Name	Position	Format	Description
			Organization contract number in positions 1479-1483.
Part C PBP Name	2706-2755	X(50)	Relates to the first occurrence of the beneficiary's plan benefit package in positions 1697-1699.
Part D MCO Name (contract level)	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 PBP 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.
Beneficiary Language Indicator	2862	X(01)	A code that identifies the language that the beneficiary requested SSA to use for beneficiary notices. Values: Blank – English assumed for Non-Puerto Rican ZIP codes, Spanish assumed for Puerto Rican ZIP codes, E – English requested (allowed only for Puerto Rican ZIP codes), and S – Spanish requested.
Special Needs Plan (SNP) Indicator (Occurrence 1)	2863	X(01)	Indicates that beneficiary is enrolled in a special needs plan. Values: Y – SNP, and N – not SNP.

Data Element Name	Position	Format	Description
			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.
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 1. Corresponds 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

Data Element Name	Position	Format	Description
			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.
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.
Previous Month SPD Calculation Code	2900	X(01)	Code that indicates how beneficiary was last classified in enrollment and disenrollment counts for the Eligibility Month/Year of this record. Values:

Data Element Name	Position	Format	Description
			E – Enrollment count, D – Disenrollment count, C – Carry forward enrollment
Previous Month SPD Calculation Code Cont.			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, and Space – No historical entries found for this Eligibility Month/Year.
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 six characters of the last name and the first 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 nor

Data Element Name	Position	Format	Description
			secondary match was successful (if RRC = '000003'), and S – Match accomplished by Secondary Match algorithm.
Daily State Phase-Down Calculation Code Cont.	2902	X(01)	Code that indicates how beneficiary is counted in enrollment and disenrollment counts for this record. 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), and P – Prospective Duals, not considered in Clawback counts.
Retiree Drug Subsidy (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.
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.

Data Element Name	Position	Format	Description
			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.
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.

Data Element Name	Position	Format	Description
			Values: 100, 075, 050, and 025.
Subsidy Level (Occurrence 1) Cont.			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.
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, and 06 – CMS User. Values for L (LIS): SS – SSA, and <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.

Data Element Name	Position	Format	Description
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.
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.
Beneficiary ESRD Clinical Dialysis Dates (Occurrence 2)	3114-3129	9(16)	Same as Occurrence 1.
Beneficiary ESRD Clinical Dialysis Dates (Occurrence 3)	3130-3145	9(16)	Same as Occurrence 1.
Beneficiary ESRD Clinical Dialysis Dates (Occurrence 4)	3146-3161	9(16)	Same as Occurrence 1.
Beneficiary ESRD Clinical Dialysis Dates (Occurrence 5)	3162-3177	9(16)	Same as Occurrence 1.
Beneficiary ESRD Clinical Dialysis Dates (Occurrence 6)	3178-3193	9(16)	Same as Occurrence 1.
Beneficiary Archive Indicator	3194	X(01)	Indicates that beneficiary is in Archived Medicare Beneficiary Database 'A' – Archived ' ' – Not archived or not found in database
Medicare-Medicaid Plan (MMP) Opt Out Indicator	3195		Indicates that beneficiary has opted out of an MMP 'Y' – Beneficiary has affirmatively opted out

Data Element Name	Position	Format	Description
			of the Financial Alignment Demonstration. 'N' – Beneficiary has not opted out of the Financial Alignment Demonstration.
Medicare-Medicaid Plan (MMP) Opt Out Indicator Cont.			' ' – There is no opt out information available (should be interpreted as the beneficiary has not opted out).
Filler	3196-3400	X(205)	

6. <u>File Summary Record</u>

<div align="center">Table 6: File Summary Record</div>

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, and 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

Data Element Name	Position	Format	Description
Records Total	38-45	9(08)	The total number of DET records in the State file. This count does not include PRO records.
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 Active Medicare Beneficiary Database. This 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 Active Medicare Beneficiary Database. This count includes invalid records because match is not attempted on invalid records. This count does not include

Data Element Name	Position	Format	Description
			PRO records.
Filler	94-140	X(47)	
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 Active 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 Active 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 Active 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 A (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, and 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' – The enrollment and disenrollment counts for this Eligibility Month/Year have been included in the clawback counts. Note: Eligibility Month/Year less than 1/1/2006 was never included in clawback count. Records older than 36 months are now rejected so entry will always be 'Y'.

Data Element Name	Position	Format	Description
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 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. <u>**Trailer Record**</u>

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, and 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.
Filler	37-43	X(07)	
Record Identification Code	44-46	X(03)	A copy of the trailer record in the incoming file is displayed in positions 44-223.
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 – 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		North Carolina	NC
	Columbia	DC	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