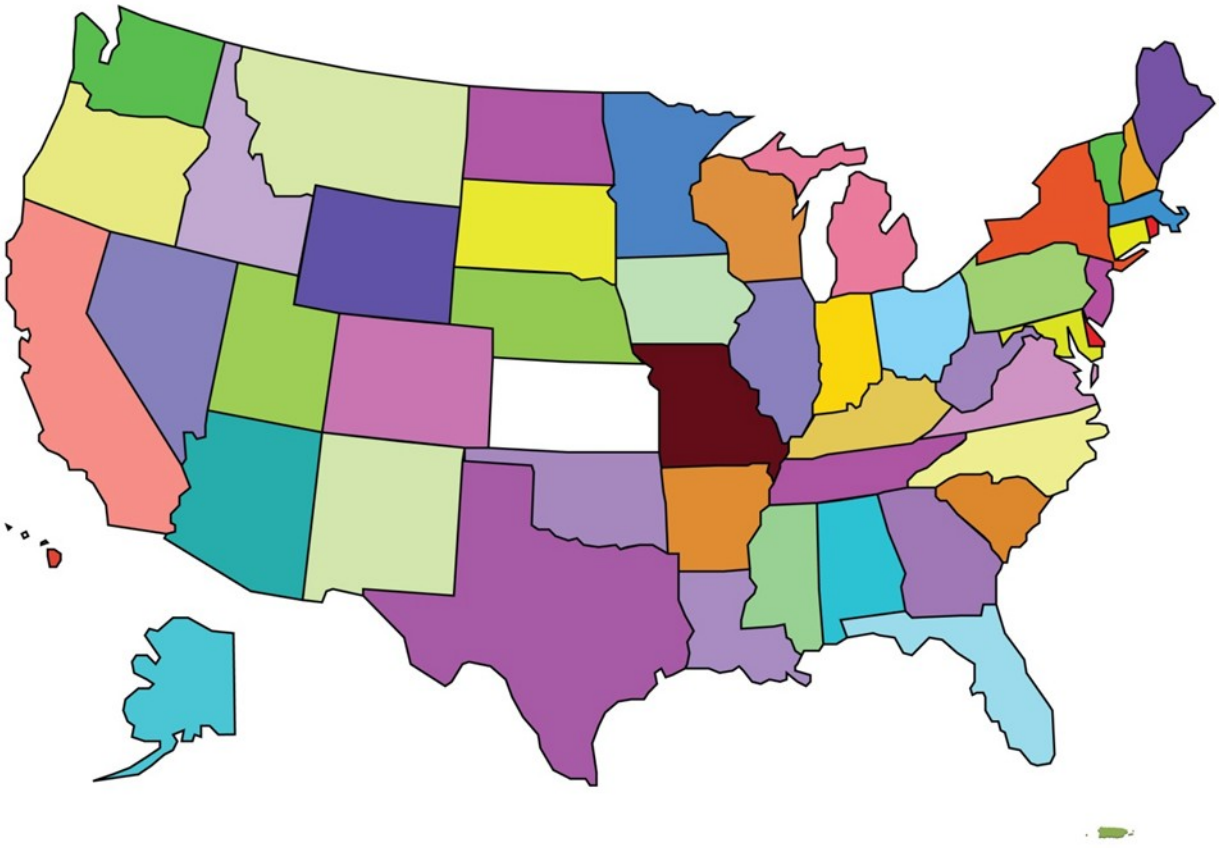
Medicare Advantage Prescription Drug State User Guide

Version 11.0

February 6, 2023



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Change Log

Section	Changes
Global	Updated the version to 11.0. Updated the publication date to February X, 2023. Updated Table of Contents, Figures, and Tables.
1 – Introduction	
2 – Using MARx UI	
3 – Entitlement, Enrollment, Disenrollment Codes	• Added Enrollment Reason Code ‘P,’ Medicare Part B Immunosuppressive Drug (Part B-ID).
4 – Technical Instructions for Submitting Files	
5 – State MMA Request File Timing and Content	• Added new Section 5.8: Part B Immunosuppressive Drug (Part B-ID).
6 – MMA Request File	
7 – MMA Response File	• Added Part B Enrollment Reason Code ‘P,’ Medicare Part B Immunosuppressive Drug (Part B-ID), to the MMA Response File Detail Layout.
8 – BEQ Request File	
9 – BEQ Response File	
10 – TBQ Request File	
11 – TBQ Response File	• Added Part B Enrollment Reason Code ‘P’, Medicare Part B Immunosuppressive Drug (Part B-ID), to the TBQ Response File Detail Layout.
12 – Puerto Rico Dual Eligibles File	
13 – Glossary, Acronyms, State Codes	

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1 Introduction

1.1 Document Overview

The Medicare Advantage Prescription Drug (MAPD) State User Guide (SUG) provides information for all of the fifty states, the District of Columbia, and the US Territory Medicaid Agency users regarding the use of the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Prescription Drug System (MARx). CMS developed the SUG specifically for individuals with the "**state user**" role in MARx.

The SUG provides instructions for use of the MARx User Interface (UI) System, including screenshots and screen content descriptions. States may use the MARx UI to obtain online Medicare eligibility, enrollment, and prescription drug information for beneficiaries.

Beginning with the May 2017, Version 6.0, the SUG also contains information about the data files that are exchanged between the states and CMS to submit the monthly dually eligible enrollment, and to request eligibility, entitlement, and enrollment information.

1.2 Document Organization

Section 1 Introduction- provides general information about the organization and content of this document.

Section 2 Using the Medicare Advantage Prescription Drug User Interface (MARx UI) System- provides information for state users to access enrollment, eligibility, and 4Rx information for beneficiaries.

Section 3 Entitlement Status, Enrollment, and Disenrollment Reason Codes- provides Medicare Part A and Part B Entitlement, Non-Entitlement, Enrollment, and Disenrollment codes.

Section 4 Technical Instructions for Submitting State Data for Medicare Modernization Act (MMA) Provisions- provides information for the States when exchanging files with CMS.

Section 5 State MMA Request File Timing and Content- provides information about the timing and content for the MMA Request File.

Section 6 MMA Request File- provides file layout information for the MMA Request File, the monthly file(s) the states must send with the dual eligible individuals enrolled in their state.

Section 7 **MMA Response File**- provides file layout information for the MMA Response File sent by CMS to the state in response to their MMA Request file.

Section 8 **Batch Eligibility Query (BEQ) Request File**- provides information about the BEQ Request File sent by the state to request eligibility information.

Section 9 **Batch Eligibility Query (BEQ) Response File**- provides information about the BEQ Response File sent by CMS to the state in response to its BEQ Request file.

Section 10 **Territory Beneficiary Query (TBQ) Request File**- provides information about the TBQ Request File sent by the state & territories to request entitlement and enrollment information.

Section 11 **Territory Beneficiary Query (TBQ) Response File**- provides information about the TBQ Response File sent by CMS to the state & territories in response to its TBQ Request file. Note: Territories receive the TBQ, which is the territory equivalent to the plan/state BEQ.

Section 12 **Puerto Rico Dual Eligibles File Process**- provides information about the specific process for Puerto Rico Dual Eligibles Request and Response file data exchanges.

Section 13 **Glossary, List of Acronyms, and State Codes-** provides a glossary, list of acronyms, and state codes used throughout the SUG.

1.3 Contacting the MAPD Help Desk

The MAPD Help Desk provides technical system support to states for the use of the MARx UI and file exchanges.

Contact the MAPD Help Desk at mapdhelp@cms.hhs.gov or 1-800-927-8069.

Visit the MAPD Help Desk website at http://go.cms.gov/mapdhelpdesk.

2 Medicare Advantage Prescription Drug User Interface (MARx UI) System

This section provides information necessary to conduct online operations in the MARx UI:

- Getting Started.
- Using the MARx UI Screens.
- Navigating the MARx UI.
- Viewing Beneficiary Information

2.1 Getting Started

A new state user must follow the steps below to be granted access to MARx UI:

- Register for a User ID in the Identity Management (IDM) system.
- Request the state user role for appropriate access to MARx UI.
- Log into MARx UI as a state user.

2.1.1 Register in IDM

CMS has established the Identity Management (IDM) system to provide MAPD Business Partners with a means to apply for, obtain approval, and receive a single User ID they can use to access one (1) or more CMS applications.

For more information about IDM, visit the IDM page on the CMS.gov website at this link:

https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/IdentityManagement/IDM-Overview.

In the left navigation panel, click the **Guides and Documentation** link and review the CMS IDM User Guide for complete instructions on registering in IDM, performing Remote Identity Proofing (RIDP), and Multi-factor Authentication (MFA).

Note: IDM has password requirements that are noted when entering your password. MARx UI has an additional requirement limiting the password to **exactly 8 characters and cannot contain any special characters.**

2.1.2 Request the State User role for MARx UI

To fulfill security goals, MARx UI is a role-based system that provides functionality and data filtering based on the user role.

The state users' role is for an individual who works for or on behalf of a state Medicaid agency. State users can access Medicare eligibility, Low-Income subsidy (LIS) status, and detailed health and drug Plan enrollment information at a beneficiary level.

Below are the key steps to request a state user role for MARx UI:

1. After you have created your IDM User ID and password, navigate to the CMS Enterprise Portal: https://portal.cms.gov.
2. Enter your User ID and password and check the box, "**I agree to the Terms & Conditions**."
3. On the **My Portal** page, select **+ Add Application**.
4. The **Request Application Access** screen is displayed; **Select an Application** for MARx UI in the 'MARx – Medicare Advantage & Prescription Drug System' box. See **Figure 2-1.**

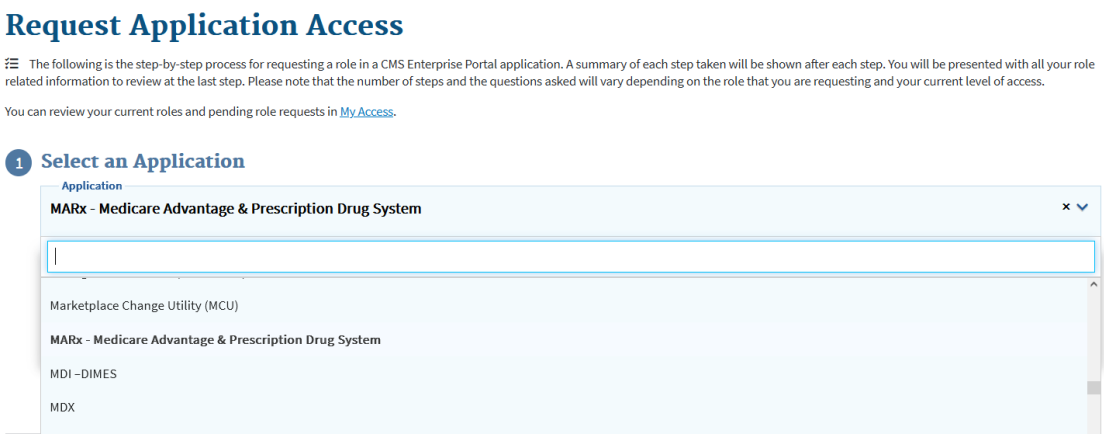


Figure 2-1 Request Access to MARx UI

5. Select the **MA state/territory user** role from the **Select a Role:** drop-down menu in **Figure 2-2**.

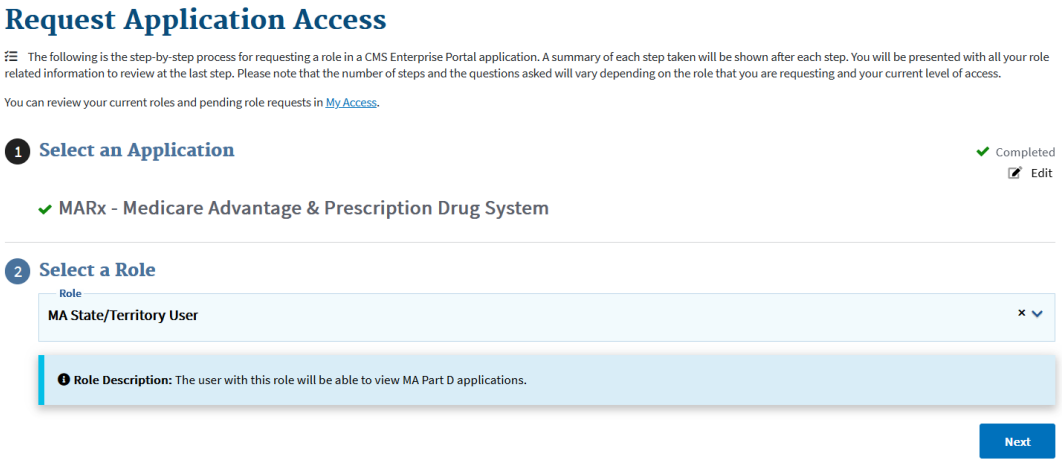


Figure 2-2: Request New Application Access

6. Complete "Identity Verification" by selecting **Launch**. Read through the information on the next screen (Step #1) and select **Next**. "Accept Terms & Conditions" on Step 2. Enter and/or verify your information on the next page (Step #3). Once your identity has been verified, return to the "Request Application Access" page.
7. Complete Step 4 (Enter Business Contact Information), Step 5 (Enter Role Details), Step 6 (Enter Reason for Request).
8. Upon approval of your request, you will have access to the MARx UI.

Note: These instructions are outlined in more detail on pages 9 – 15 in the ***CMS Enterprise Portal User Guide***.

2.1.3 Logging into MARx UI as a State User

1. Upon receiving the confirmation email of access to MARx UI, navigate to the MARx URL: https://marx.cms.hhs.gov.
2. **Accept** the Terms and Conditions.
3. Enter your **IDM User ID** and **password**.
4. Obtain and enter your **MFA code.**
5. The User Security Role Selection (M002) screen is presented with the state user role preselected.

2.2 Using the MARx UI Screens

2.2.1 General Properties of Screens

MARx UI screens share many properties. Once users understand the screens' organization, they can access information quickly and easily.

There are two main types of general screen layouts: primary and secondary. The principal differences between a primary window and a secondary window are the header design and content and how the screens are navigated. A third special screen type, the log-out window, remains in the background for the duration of the session.

2.2.2 Common Features of the Screens

Below the headings, most of the screens are in the same format. The top of the screen contains a title line with the following information:

- Screen name, which describes the screen's purpose.
- Primary screen's name reflects the navigation to the screen using the menu and submenu.
- Screen identifier, which starts with an M. This identifier is useful when asking for help, reporting a problem to the MAPD Help Desk, or using the SUG.
- User ID.
- User's current role.
- Current date.
- [Print] and [Help] buttons (and the [Close] and other buttons for secondary windows).

The message line appears below the title line. Error messages display in red and success messages display in green. If there is no message, this area of the screen is blank.

Many screens include instructions at the top, which are displayed on the screen with a yellow background to provide information on using the screen. Additional information is available by clicking on the [Help] button. A screen may contain input (data entry fields), output (information fields), and links to other screens and tables, etc.

2.2.3 Common Characteristics of the Screens

Screens may carry out one (1) or more of the following functions:

- Find specific information.
- Display information.
- Provide links/buttons to additional functions.

Many screens contain fields that the user must populate and buttons that the user must click on to carry out an action. A red asterisk (*****) appears next to an input field label to indicate that it is required. If more than one of those fields is required, a red plus sign (**+**) appears next to field labels.

Sometimes there are additional rules regarding the combination of acceptable fields; those rules are often indicated in instructions on the screen.

There are different options for entering information into a field:

- **Text entry**: Most fields, such as beneficiary identifier or contract, allow the user to type in the information.
- **Dropdown list**: Some fields, such as file type, provide a list of values from which to select. The user clicks on the down arrow next to the field to display the list, and then clicks on a value to select it.
- **Radio buttons**: The user chooses one of the items in a group by clicking on the circle next to that item.
- **Check boxes**: The user selects any number of the items in a group by clicking on the box next to each item.

Some fields are initialized with default values. For example, date fields are often initialized with the current date. The information that the user enters in a field is validated to ensure the request is valid, and an error message is displayed to inform the user of an error.

2.2.4 Typographical Conventions

Table 2-1: Typographical Conventions

Typographical Conventions	
Example	**Description**
<Alt-P>	**Keystroke**. Less than and greater than signs (< >) are placed around any keyboard entries. For instance, <ENTER> means pressing the Enter key.
[Find]	**Button Name.** Square brackets ([ ]) are placed around the references to all button names displayed on the screen.
|Beneficiaries|	**Menu or Submenu Name.** Menus are shown with bars on either side as a horizontal list at the top of a screen. Submenus list items below the menu; items vary based on the menu item selected.
Beneficiaries: Find(M201)	**Screen Name**. All screen names are shown in the top left corner of each screen.
Label Names	**Label Name**. All field labels, for input and output, referenced in the text are shown as mixed-case alphanumeric characters.
Smith	**Input**. Input fields are locations that accept input on the screens. The input is in the form of mixed-case alphanumeric characters.
FEMALE	**Selection**. A dropdown list offers a choice of options from which to select. Selections from a dropdown option are generally presented on the screen in upper case.
The claim…	**Error Message.** If a problem occurs after the user clicks on an action button, such as [Find] or [Submit], an error message is provided in red on the upper left-hand corner of the screen.
The request…	**Status Message**. Status messages are provided in green on the upper left corner of the screen.
06/2002	**Link**. A hyperlink is a word or group of words that the user clicks to access additional information in another location. Links are displayed in underlined blue text.
Note	**Note**. Notes indicate important information. The accompanying text is enclosed in a box with Note as a header.
Tip	**Tip**. Tips alert the user to shortcuts and troubleshooting techniques. Accompanying text is enclosed in a box with Tip as a header.

Note: When screens are shown in this document, the browser title, menu, buttons, and other items are hidden to display the content as large as possible.

2.2.5 Common Buttons, Links, and Fields

Table 2-2: Common Buttons and Links

Common Buttons and Links	
Example	**Description**
[Print]	**Print**. Every screen contains a [Print] button. The [Print] button supports printing the entire contents of the active webpage. It displays the 'Printer Options' pop-up screen.

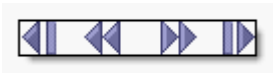
Common Buttons and Links	
Example	**Description**
[Help]	**Help**. Every screen contains a [Help] button, which invokes a menu of topics. At the top of the menu is a link to information specific to the current screen. Below that link are topic links that display for each screen. When the user clicks on a link, the help button displays in a separate window using Adobe Acrobat Reader. The help button provides more instructions for use of the MARx UI
[Close]	**Close**. Closes the pop-up window without submitting the data. This button does not appear on any screens accessed directly from an item on the MARx UI main menu.
[Cancel]	**Cancel**. Closes the pop-up window without submitting the data.
	**Screen navigation arrows.** When all list items do not fit on the screen, use the navigation arrows to scroll through the list. These arrows are shown at the top and the bottom of the list items on the screen. The arrows function as follows:  – go to the first page of items in the list  – go to the previous page of items in the list  – go to the next page of items in the list  – go to the last page of items in the list
	**Go to Page Number.** In addition to the screen navigation arrows, [Go to Page Number] is displayed at the top of the list items. It allows the user to jump directly to a particular page. Select the page number to display, and click on the [Go] button. The page numbers in the dropdown list reflect the actual number of pages in the list.
[Reset]	**Reset**. Resets the entered data to their previous values.

Table 2-3: Common Fields

Common Fields	
Field	**Format**
Claim #	One of two formats is permitted. This field consists of a Claim Account Number (CAN) and a Beneficiary Identification Code (BIC). Whether a BIC is or is not optional depends on the screen and format: Social Security Administration (SSA) – 9-digit Social Security Number is the Claim Account Number (CAN) followed by a 1- or 2-character BIC, where the first character is a letter and the second is a letter or number. Railroad Retirement Board (RRB) – RRB identifier starts with a 1-to-3-character BIC, which has one of these values: CA, A, JA, MA, PA, WA, WCA, WCD, PD, WD, H, MH, PH, WH, WCH, followed by a 6- or 9-digit number, i.e., CAN. The BIC is not optional.

Common Fields	
Field	**Format**
Contract #	Starts with an ‘H’, ‘9’, ‘R’, ’S”, ‘E’, or ‘X’ and is followed by four numbers: H = Local Medicare Advantage (MA), local MAPD, or non-MA Plan. 9 = Non-MA Plan (no longer assigned). R = Regional MA or MAPD Plan. S = Regular standalone Prescription Drug Plan (PDP). E = Employer direct PDP. X = Limited-Income Newly Eligible Transition (LiNET).
Plan Benefit Package (PBP)	Three alphanumeric characters.
Segment #	Three digits. A value of 000 indicates that there is no segment.
Date	Month, day, and four-digit year. A zero in front of a single-digit month or day is optional: (M)M/(D)D/YYYY.
Month/Year	Month and four-digit year. A zero in front of a single-digit month is optional: (M)M/YYYY.
Last Name	May contain letters, upper and lower case; apostrophe; hyphen; and blank; with a maximum length of 40 characters.

2.3 Navigating the MARx UI

2.3.1 How Do I Get Where I Want To Go?

The user has access to certain functions/tasks depending on their role. See **Table 2-4** for the names of the main menu items for state users.

Table 2-4: Main Menu Items

Menu Item	Description
|Welcome|	Messages, current payment month, and calendar.
|Beneficiaries|	Search for beneficiaries and view beneficiary information.

The MARx UI uses the drill-down method. This means that the user starts at a very high level, and drills down to more specific detailed information.

2.3.2 Navigating Menus, Sub-menus, and Screens

The menus and sub-menus all work in the same way, as follows: the first view of the MARx UI main menu appears with the |Welcome| menu item highlighted on the screen.

When the user selects an item from the MARx UI main menu by clicking on the general area, e.g., the |Beneficiaries| menu item, the screen changes.

- The selected menu item; in this case, the |Beneficiaries| menu item, is highlighted in yellow on the screen.
- The associated submenu displays just below the main menu, the first item in the submenu is selected and highlighted in yellow on the screen as well, by default, and the associated screen; in this case, the Beneficiaries: MCO (M201) displays in the form area.
- To view any of the other selections, click the menu or submenu item, e.g. the |Eligibility| menu item, to see the associated screen.

After accessing a screen, the user may search to find information about a particular beneficiary or month. The user can assess more detail by clicking on links and/or buttons that lead to additional screens.

2.3.3 Error Message Screens

If a screen is unavailable for display, the screen displays “Error 404 Page Not Found” notifying the user of the problem. If a time-out occurs during an attempt to display a screen, the screen displays “Error 408: Your request has timed out” notifying the user of the problem.

2.3.4 Screens Available for the State User

MARx UI enables state users to access enrollment, eligibility, and 4Rx information for beneficiaries. **Table 2-5** lists the screens that the state user can view.

Table 2-5: State User Screen Lookup

State User Screen Lookup	
Screen Name	**Screen Number**
Logon and Welcome Screen	
User Security Role Selection	**M002**
Welcome	**M101**
Beneficiaries Screens	
Beneficiaries: Find	**M201**
Beneficiaries: Search Results	**M202**
Beneficiary Detail: Snapshot	**M203**
Beneficiary Detail: Enrollment	**M204**
Enrollment Detail	**M222**
Beneficiaries: Eligibility	**M232**
Rx Insurance View	**M244**
Additional Insurance Information	**M251**
Low-Income Subsidy	**M252**

State User Screen Lookup	
Screen Name	**Screen Number**
Status Activity	**M256**
Status Detail	**M257**

State users are not given access to the Payment, Adjustments, or Premium screens. Information is available for enrollments from the start of the program.

All beneficiary, contract, and user information in the screen snapshots in this document are fictional. Names and Social Security Numbers do not identify any person living or dead. Claim numbers start with '997,' '998,' or '999' because those numbers are never assigned. On certain screens, if no end date displays for the subsidy period, this does not mean the beneficiary's status is terminated; rather, a blank Subsidy End date means that the status rolled over to the current year.

The MARx UI meets U.S. Regulations, Section 508 of the Rehabilitation Act Amendments of 1998, requiring all U.S. Federal agencies to make their Information Technology accessible to their employees and customers with disabilities.

The System meets the following criteria for users employing assisting technologies, such as screen readers:

- Text equivalents are provided for non-text elements such as graphics.
- All information conveyed with color is also available without color.
- Web-based reporting tools and Hypertext Markup Language (HTML) generated data support the use of row and column headings.
- HTML 4 tagging format is used.
- The System is designed to allow users to skip repetitive navigation links. A link, which is only visible with a screen reader, is placed at the start of the page. When clicked, the link skips over the menu and submenu.

2.3.5 Logging on and Viewing Messages

The user will access the MARx UI via https://marx.cms.hhs.gov and enter their User ID and password. The User Security Role Selection (M002) screen displays, **Figure 2-3**, and the state user role is preselected. The screen displays the last successful login date and time. If the system is down when the user tries to log on, the browser displays a message that the Page is Unavailable or the Page cannot be found. The content of this message is dependent on the browser, not on the system. **Table 2-6** describes these messages.

Figure 2-3: User Security Role Selection (M002) Screen

If the system is up and the logon is unsuccessful, the Logon Error (M009) screen displays an error message describing why the logon failed. See below verbiage**:**

The following error has occurred during the logon process. Close or exit the current window and go to the Portal Window and click on the MARx-UI application again.

Table 2-6: M002 Screen Messages

M002 Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Workstation setup	Click on the message 'Pop-up blocked. To see this pop-up or additional options click 'here…,' then click 'Always Allow Pop-ups from This Site…'	Follow the directions in the message to enable pop-ups from the MARx UI. When a message is displayed asking if the user wants to allow pop-ups from the site, click [Yes]. The next message asks if the user wants to close the window. Click [No]. The Welcome (M101) screen then displays.
Software or Database Error	No security roles are defined for your user ID	Contact the MAPD Help Desk.
Software or Database Error	Error retrieving your security roles from the database	Contact the MAPD Help Desk.
Software or Database Error	Your user ID does not exist	Contact the MAPD Help Desk.
Software or Database Error	Your user ID was not supplied	Enter your user id, if you did enter a user id, contact the MAPD Help Desk.
Software or Database Error	Your user ID profile is inactive	Contact the MAPD Help Desk.
Software or Database Error	Unexpected error code from the database while retrieving your security roles	Contact the MAPD Help Desk.

M002 Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Software or Database Error	Error retrieving the expected number of security setting results. Retrieved <# of results sets retrieved> out of <# of results sets expected>	Contact the MAPD Help Desk.
Software or Database Error	No screen items defined for this role	Contact the MAPD Help Desk.
Software or Database Error	Error retrieving your security settings	Contact the MAPD Help Desk.
Software or Database Error	Unexpected error code from the database while retrieving your security settings	Contact the MAPD Help Desk.
Software or Database Error	Error retrieving the expected number of dropdown list results. Retrieved <# of results sets retrieved> out of <# of results sets expected>	Contact the MAPD Help Desk.
Software or Database Error	The dropdown lists result set is empty	Contact the MAPD Help Desk.
Software or Database Error	Error retrieving dropdown lists from the database	Contact the MAPD Help Desk.
Software or Database Error	No current payment month has been set	Contact the MAPD Help Desk.
Software or Database Error	Unexpected error code from the database while retrieving the dropdown lists	Contact the MAPD Help Desk.
Software or Database Error	Connection error	Contact the MAPD Help Desk.

The user clicks on the [Logon with Selected Role] button and the Welcome (M101) screen appears, as shown in **Figure 2-4** and described in **Table 2-7**, with error and validation messages provided in **Table 2-8**.

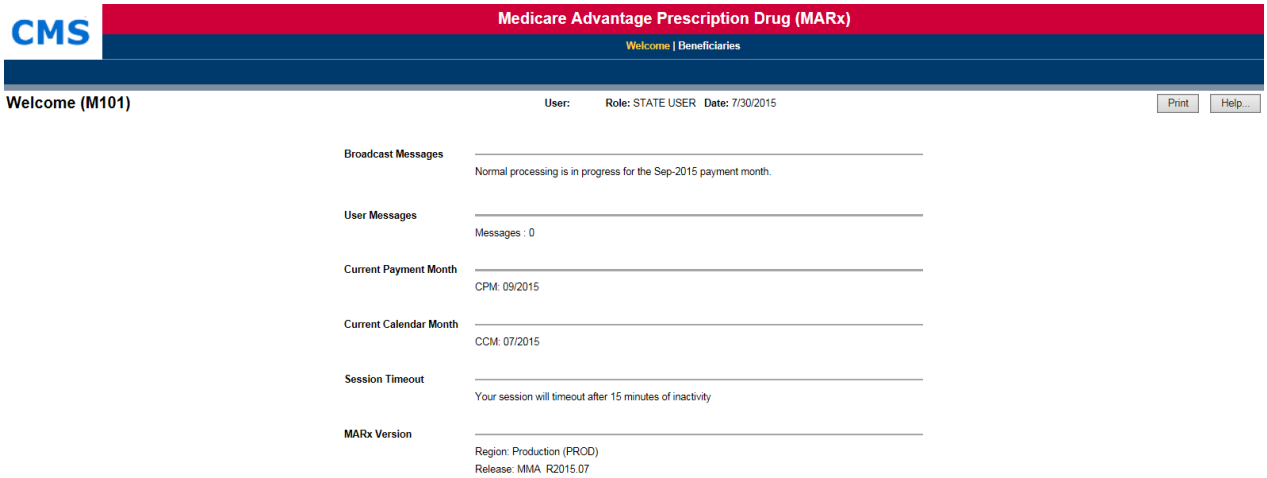


Figure 2-4: State User Welcome (M101) Screen

Table 2-7: State User (M101) Field Descriptions and Actions

State User (M101) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Broadcast Messages	Output	Provides general information about the system's actions, e.g. month-end processing started. The list of messages refreshes every time the user returns to the screen.
User Messages	Output	Indicates if there are any messages for the user.
Current Payment Month (CPM)	Output	The payment month/year currently being processed by the system. All payments and adjustments calculated will affect the payment the Plan receives for this month.
Current Calendar Month (CCM)	Output	The calendar month/year currently being processed by the system. This is the actual month in place today. All enrollment edits are based on CCM.
Session Timeout	Output	After 15 minutes of inactivity, you will be logged out of MARx UI. You will need to go through the login process to regain access.
MARx Version	Output	The region and release information of the MARx UI display.
MARx Calendar	Link	Provides general information about what is happening in the system, e.g. month-end processing started. The list of messages refreshes every time the user returns to the screen.

Table 2-8: State User (M101) Screen Messages

State User (M101) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Software or Database Error	The result set that contains the system message is empty.	Contact the MAPD Help Desk.
Software or Database Error	Database errors occur in retrieving the system messages.	Contact the MAPD Help Desk.

State User (M101) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Software or Database Error	Invalid input.	Contact the MAPD Help Desk.
Software or Database Error	Unexpected error code from database.	Contact the MAPD Help Desk.
Software or Database Error	Connection error.	Contact the MAPD Help Desk.

2.4 Viewing Beneficiary Information

2.4.1 Finding a Beneficiary

To find information about a beneficiary who is enrolled in a contract, either currently, in the past, or in the future, the user accesses the Beneficiaries: Find (M201) screen. Once the beneficiary is located, the user can view information on that beneficiary.

STEP 1: Accessing the Beneficiaries: Find (M201) Screen

From the main menu, the user clicks on the |Beneficiaries| menu item. The |Find| submenu item is already selected and displays the Beneficiaries: Find (M201) screen as shown in **Figure 2-5.** It is described in **Table 2-9**, with screen messages provided in **Table 2-10**.

STEP 2: Using the Beneficiaries: Find (M201) Screen

The MARx UI allows a user with the state user role to:

- Search for beneficiaries by claim number OR last name, first name, and date of birth (DOB). Note: The state user is not required to enter the contract number or other fields when searching with the name and DOB.
- View detailed Low-Income Subsidy (LIS) information with historical information, including valid and audited periods and denied LIS information.
- View detailed Medicare Secondary Payer (MSP) information for both Medical and Drug coverage.

Please note that the above search is restricted to returning a single beneficiary. If more than one beneficiary meets the last name, first name, and date of birth search criteria, the user is prompted to enter additional selection criteria or the claim number.

The user enters search criteria and clicks on the [Find] button.

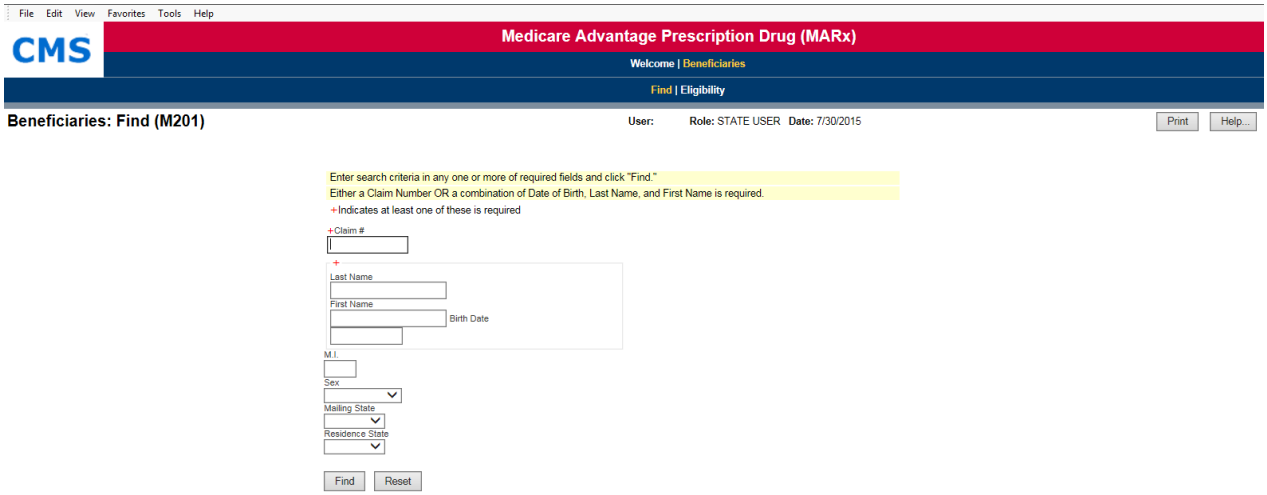


Figure 2-5: State User Beneficiaries: Find (M201) Screen

Table 2-9: State User (M201) Field Descriptions and Actions

State User (M201) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Claim #	Required data entry field	The user finds beneficiaries with this claim number. **Note:** The BIC is optional except when an RRB number is entered.
Last Name	Required data entry field if Claim # is not entered.	The user finds beneficiaries with this Last Name, the entered First Name, and Birth Date. (Note: All 3 fields are required.)
First Name	Required data entry field if Claim # is not entered.	The user finds beneficiaries with this First Name, the entered Last Name, and Birth Date. (Note: All 3 fields are required.)
Birth Date	Required data entry field if Claim # is not entered.	The user finds beneficiaries with this Birth Date, the entered Last Name, and First Name. (Note: All 3 fields are required.)
M.I.	Optional data entry field	The Middle Initial is added to the required information to narrow the beneficiary search.
Sex	Optional data entry field	The Sex is added to the required information to narrow the beneficiary search.
Mailing State	Optional data entry field	The state of the beneficiary's mailing address is added to the required information to narrow the beneficiary search.
Residence State	Optional data entry field	The state of the beneficiary's residence address is added to the required information to narrow the beneficiary search.
[Find]	Button	After entering a claim number or combination of other fields, the user clicks this button to initiate the search for beneficiaries.
[Reset]	Button	This button clears the information already entered on the screen.

Table 2-10: State User (M201) Screen Messages

State User (M201) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Missing entry	Enter a claim number.	The user must enter a valid claim number or a combination of Last Name, First Name, and Birth Date.
Invalid format	The claim number is not a valid SSA, RRB, or CMS internal number.	The user re-enters the claim number.
No data	No beneficiary records were found for the search criteria.	The user should verify the accuracy of the information entered. The user should perform a more general search, in case the constraints are too restricting.
Software or Database Error	Error occurred while retrieving beneficiary search results.	Contact the MAPD Help Desk.
Software or Database Error	Error occurred while retrieving beneficiary records.	Contact the MAPD Help Desk.
Software or Database Error	Missing input.	Contact the MAPD Help Desk.
Software or Database Error	Unexpected error code from database=<error code>.	Contact the MAPD Help Desk.
Software or Database Error	Connection error.	Contact the MAPD Help Desk.

2.4.2 Viewing Summary Information about a Beneficiary

Beneficiaries meeting the search criteria display on the Beneficiaries: Search Results (M202) screen.

STEP 3: Using the Beneficiaries: Search Results (M202) Screen

If the search is successful, the Beneficiaries: Search Results (M202) screen displays as in **Figure 2-6** and as described by **Table 2-11**. For state users, only one beneficiary will be returned. Because any error associated with the search would display on the Beneficiaries: Find (M201) screen, no error messages are displayed on the M202 screen. If a user enters an inactive Claim Number for the Beneficiary, a message displays to indicate the beneficiary's active claim number, as shown in **Table 2-12**.

Figure 2-6: State User Beneficiaries: Search Results (M202) Screen

Table 2-11: State User (M202) Field Descriptions and Actions

State User (M202) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Claim #	Link	The user clicks on the beneficiary's Claim # link to display the Beneficiary Detail: Snapshot (M203) screen.
Name	Output	Name of the beneficiary.
Birth Date column	Output	DOB of the beneficiary.
Date of Death column	Output	DOD, if applicable, of the beneficiary.
Sex column	Output	Sex of the beneficiary.
State column	Output	State of residence of the beneficiary.
County column	Output	County of residence of the beneficiary.

Table 2-12: State User (M202) Screen Messages

State User (M202) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Informational	The beneficiary's active claim number is displayed for the claim number entered	None needed.

2.4.3 Viewing Detailed Information for a Beneficiary

The user finds the beneficiary on the Beneficiaries: Search Results (M202) screen and drills down for more information.

Table 2-13: Menu Items for Viewing Beneficiary Detail Information

Menu Items for Viewing Beneficiary Detail Information		
Menu Item	**Screen Name**	**Description**
|Snapshot|	Beneficiary Detail: Snapshot (M203)	Displays an overall information summary for the beneficiary as of the date specified. If the beneficiary is not currently enrolled, the summary of the last available information displays. When the screen first displays, the date defaults to the current date.
|Enrollment|	Beneficiary Detail: Enrollment (M204)	Displays a summary list of enrollment information, by contract, for the enrollments to which the user has access. It also provides links to drill down to more detailed enrollment information for the beneficiary on a selected contract.
|Eligibility|	Beneficiary: Eligibility (M232)	Displays information regarding a beneficiary's entitlement for Part A, Plan B, and eligibility for Part D, as applicable and relevant to the Plan. If the beneficiary is eligible for Part D LIS, the number of uncovered months and the details of that subsidy are indicated.
|Rx Information|	Rx Information (M244)	Displays the beneficiary's 4Rx history, both primary and secondary (if applicable) for beneficiaries enrolled in a Plan.
|Additional Insurance Information|	Additional Insurance Information (M251)	Displays detailed Additional Insurance Information for both Medical and Drug coverage.
|Low-Income Subsidy Information|	Low-Income Subsidy (M252)	Displays detailed LIS information with historical information, including valid and audited periods and denied LIS information.
[Status Activity Information]	Status Activity (M256)	Displays a beneficiary's current health status information, as well as current values for eligibility, uncovered months, low-income subsidy, and state and county codes.
[Status Detail Information]	Status Detail (M257)	Displays data specific to each of the special statuses (e.g., ESRD, MSP, etc.) and, if applicable, the data records/periods that are valid and audited.

STEP 4: Viewing Detailed Information for a Beneficiary

To see detailed information about any of the beneficiaries listed in the Beneficiaries: Search Results (M202) screen, the user clicks on the associated Claim #.

Note: Instead of seeing a screen in the same area as previously displayed, a new window with a new screen and a new header appear. This pop-up window displays header information specific to the selected beneficiary. The beneficiary's latest mailing address is displayed, along with the current State and County Code (SCC). The header, by itself, is shown in **Figure 2-7.**

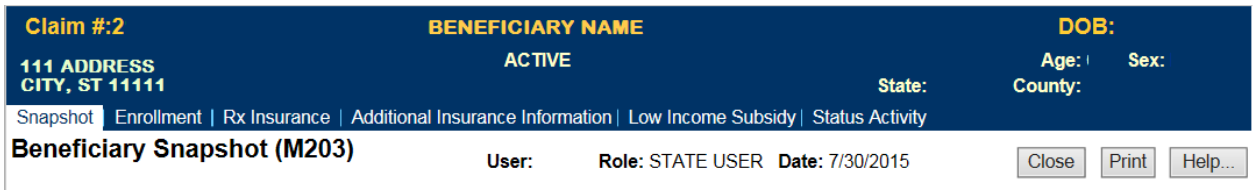


Figure 2-7: Sample Header for the Beneficiary Snapshot (M203) Screen

Directly below the header is a set of menu items, described in **Table 2-13**. The user can switch back and forth among the six different screens by clicking the menu items. Each screen pertains to the beneficiary selected from the Beneficiaries: Search Results (M202) screen. The Beneficiary Snapshot (M203) screen is the default screen displayed when the beneficiary is selected from the Beneficiaries: Search Results (M202) screen.

2.4.4 Viewing a Snapshot of Beneficiary Information

A snapshot provides a summary of the beneficiary's entitlement, eligibility, and enrollment information.

STEP 4a: Viewing the Beneficiary Detail: Snapshot (M203) Screen

The Beneficiary Detail: Snapshot (M203) screen, as shown in **Figure 2-8** and described in **Table 2-14**, provides beneficiary entitlement, eligibility, and enrollment status as of the date the user specifies. **Table 2-15** describes screen messages. If the beneficiary is enrolled in two contracts, one for Part A and/or Part B and the other for Part D, information is displayed on both contracts based on the current date. To view the details of a past or a future date, the user changes the "As of" date to a specific point in time in the "As of" data entry area and clicks on the [Find] button. D

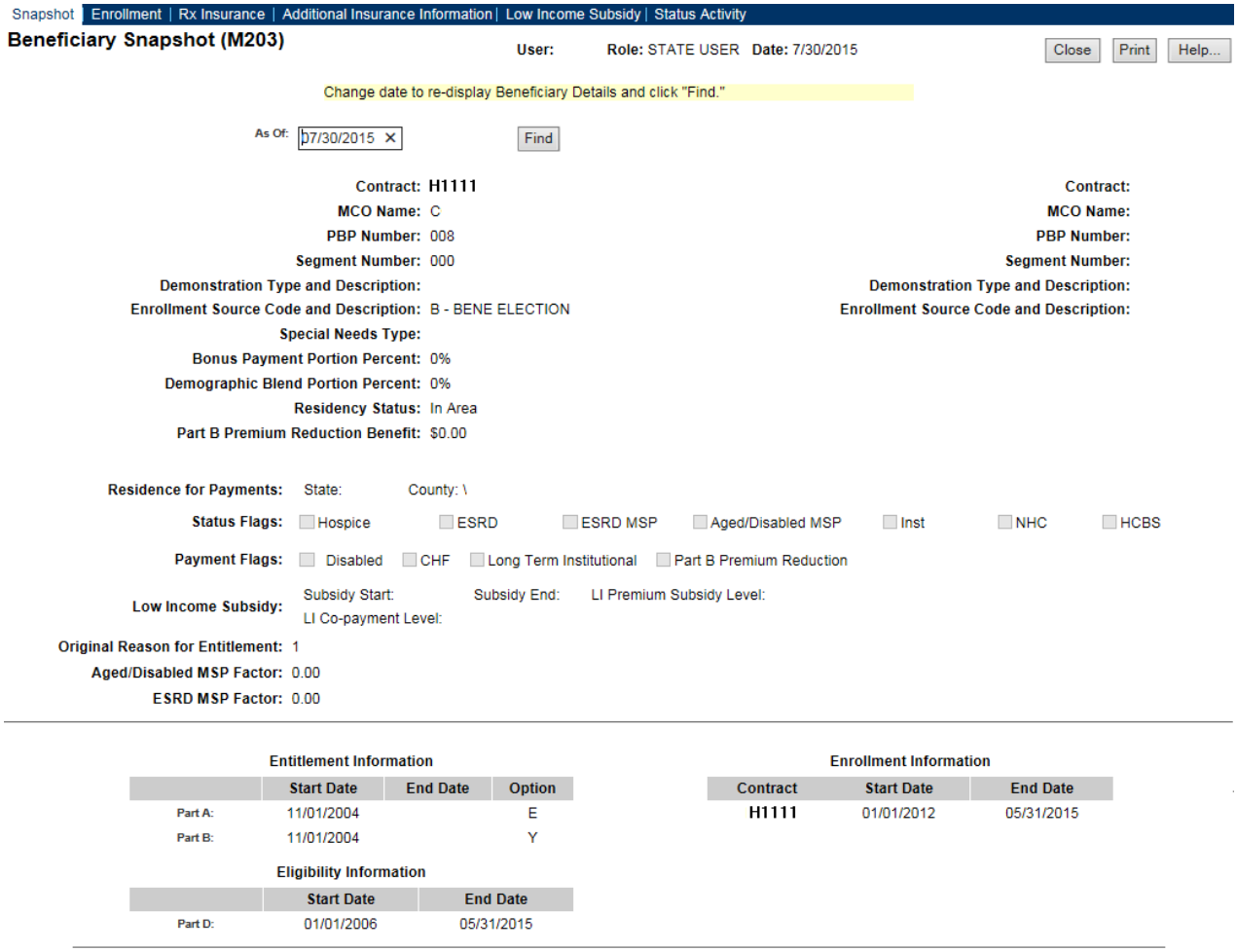


Figure 2-8: State User Beneficiary Detail: Snapshot (M203) Screen

Table 2-14: State User (M203) Field Descriptions and Actions

State User (M203) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
As Of	Optional data entry field	Enter a valid date in the form (M)M/(D)D/YYYY. The user may change the As Of date. After doing so, the user clicks on the [Find] button to bring up the information for that date.
[Find]	Button	Displays the information for the specified As Of date.
The following fields are repeated for each contract, up to two, in which the beneficiary is enrolled		
Contract	Output	Contract number for this beneficiary on the As Of date.
MCO Name	Output	Managed Care Organization (MCO) Contract name for this beneficiary on the As Of date.
PBP Number	Output	PBP number on the contract for this beneficiary on the As Of date.
Segment Number	Output	Segment number on the contract and PBP for this beneficiary on the As Of date.

State User (M203) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Demonstration Type and Description	Output	The two-digit Demo Code for this enrollment and its description.
Enrollment Source Code and Description	Output	The source for this enrollment, along with the associated description. Examples: • B = Beneficiary Election • J = State-submitted Passive Enrollment
Special Needs Type	Output	Indicates the special needs population that the contract serves, if applicable.
Bonus Payment Portion Percent	Output	The percentage is applied to the payment to determine the bonus amount to pay the MCO. This does not apply to a PDP.
Residency Status	Output	The residency status (In Area or Out of Area) for this beneficiary in this Plan on the As of Date and is determined by the current payment month.
Bonus Payment Portion Percent	Output	The percentage applied to the payment to determine the bonus amount to pay the MCO. This does not apply to a PDP.
Residency Status	Output	The residency status (In Area or Out of Area) for this beneficiary in this Plan on the As Of Date and is determined by the current payment month.
Part B Premium Reduction Benefit	Output	The Part B Premium Reduction Benefit amount is shown only for a non-drug contractor. For the Pre-2006 Part B Premium Reduction Benefit, multiply the Benefits Improvement & Protection Act of 2000 (BIPA) amount by 0.80.
Residence for Payments: State	Output	State used for payment calculation, which may differ from the state in the mailing address in the screen header.
Residence for Payments: County	Output	County used for payment calculation, which may differ from the county in the mailing address in the screen header.
Status Flags	Output	The flags set for the beneficiary on the As Of date.
Payment Flags	Output	The flags set for the beneficiary on the As Of date.
Low-Income Subsidy	Output	Date range; subsidy start date and end date, co-payment level, and amount of the LIS on the As Of date.
Original Reason for Entitlement	Output	The reason for the beneficiary's original entitlement to Medicare; disabled or aged.
Aged/Disabled Medicare Secondary Payer (MSP) Factor	Output	Beneficiary's aged/disabled reduction factor.
End State Renal Disease (ESRD) MSP Factor	Output	Beneficiary's ESRD Medicare Secondary Payer reduction factor.
Entitlement, Eligibility, and Enrollment Information		
Entitlement Information	Output	Entitlement Start Date and End Date, as well as Option for Part A and Part B for this beneficiary on the As Of date.

State User (M203) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Eligibility Information	Output	Eligibility Start Date and End Date for Part D for this beneficiary on the As Of date.
Enrollment Information	Output	Provides the Start Date and the End Date for this beneficiary's enrollment under the user's contract on the As Of date.

Table 2-15: State User (M203) Screen Messages

State User (M203) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Missing entry	As of Date must be entered.	The user enters the date.
Invalid format	As of Date is invalid. Must have format (M)M/(D)D/YYYY.	The user re-enters the date in one of the required formats.
Informational	The latest available Snapshot information is for payment month of <actual payment month>.	None.
No data	No payment profile information for claim number <claim number> and coverage date as of <date>.	There is no payment data available for that claim number on the As Of date entered on the screen. If the user expects to see payment data, the user verifies the date and month and re-enters the corrected information. If the date and month are correct, the user contacts the MAPD Help Desk for assistance.
No data	Invalid input for claim number <claim number> and coverage date as of <date>.	There is no payment data available for that claim number on the As Of date entered on the screen. If the user expects to see payment data, the user verifies the date and month and re-enters the corrected information. If the date and month are correct, the user contacts the MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving beneficiary snapshot data for claim number <claim number> and coverage date as of <date>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

2.4.5 Viewing Enrollment Information

An enrollment history displays the beneficiary's past, present, or future enrollment periods in any contract.

STEP 4b: Viewing the Beneficiary Detail: Enrollment (M204) Screen

To access the Beneficiary Detail: Enrollment (M204) screen, the user clicks on the |Enrollment| menu item. This displays a screen, as shown in **Figure 2-9**, with a summary list of the beneficiary's enrollments by contract, PBP, and segment numbers, as applicable. When the beneficiary is enrolled in a contract for Part A and/or Part B and another for Part D, two rows covering the same time period may display. The screen is described in **Table 2-16**, with screen messages provided in **Table 2-17.**

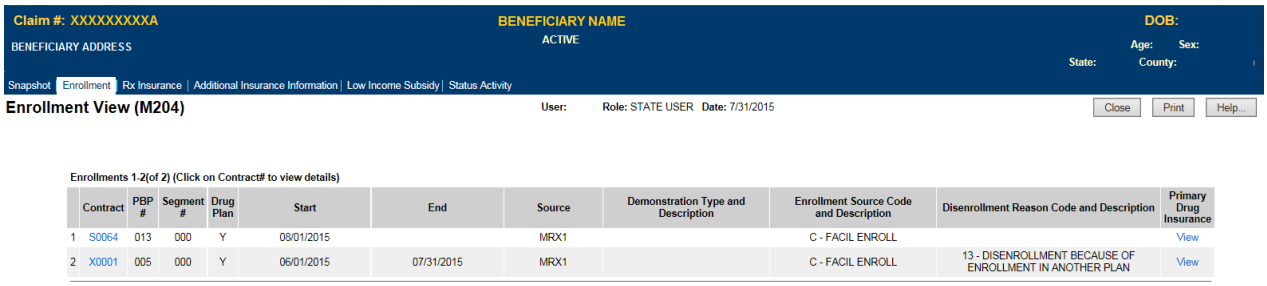


Figure 2-9: State User Beneficiary Detail: Enrollment (M204) Screen

Table 2-16: State User (M204) Field Descriptions and Actions

State User (M204) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Contract	Output	Contract in which the beneficiary is enrolled. The values displayed in this column link to display the *Enrollment Details (M222)* screen for the enrollment on this line.
PBP #	Output	PBP number for the enrollment on this line.
Segment #	Output	Segment number for the enrollment on this line.
Drug Plan	Output	Indicates whether the contract/PBP on this line provides drug insurance coverage. (Y or N).
Start	Output	Start date for the beneficiary's enrollment in this Contract/PBP/Segment.
End	Output	End date for the beneficiary's enrollment in this Contract/PBP/Segment.
Source	Output	The person or system that submitted the enrollment; contract number when entered by an MCO; user ID when entered at CMS, SSA, or Medicare Customer Service Center (MCSC).

State User (M204) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Demonstration Type and Description	Output	The two-digit Demo Code for this enrollment and its description.
Enrollment Source Code and Description	Output	The source for this enrollment, along with the associated description. Examples: • B = Beneficiary Election • J = State-submitted Passive Enrollment • etc.
Disenrollment Reason	Output	If the enrollment on this line includes an end date, the reason for the beneficiary's disenrollment is provided.
Primary Drug Insurance	Link	Click the View link in the Primary Insurance Information column to display all occurrences of primary insurance information associated with the beneficiary's enrollment. This information displays in the bottom portion of the screen.

Table 2-17: State User (M204) Screen Messages

State User (M204) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
No data	No enrollment information found for claim number <claim number> and coverage date <coverage date>.	No corresponding data is available for that claim number on that date. If the user expects to see enrollment data, the user verifies the date and month and re-enters the corrected information. If no enrollments appear, contact MAPD Help Desk for assistance
Software or Database Error	Error occurred while retrieving enrollment results for claim number <claim number> and coverage date <coverage date>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving enrollment history for claim number <claim number> and coverage date <coverage date>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Missing input on retrieval of beneficiary enrollment history.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid screen ID.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

STEP 4c: Viewing the Enrollment Detail (M222) screen

The enrollment details show the enrollment and disenrollment information for a beneficiary.

The Enrollment Detail (M222) screen is accessible by selecting a Contract # link from the Beneficiary Detail: Enrollment (M204) screen.

The screen, as shown in **Figure 2-10**, provides details of the selected enrollment or enrollment period. The screen is described in **Table 2-18**, with screen messages provided in **Table 2-19**.

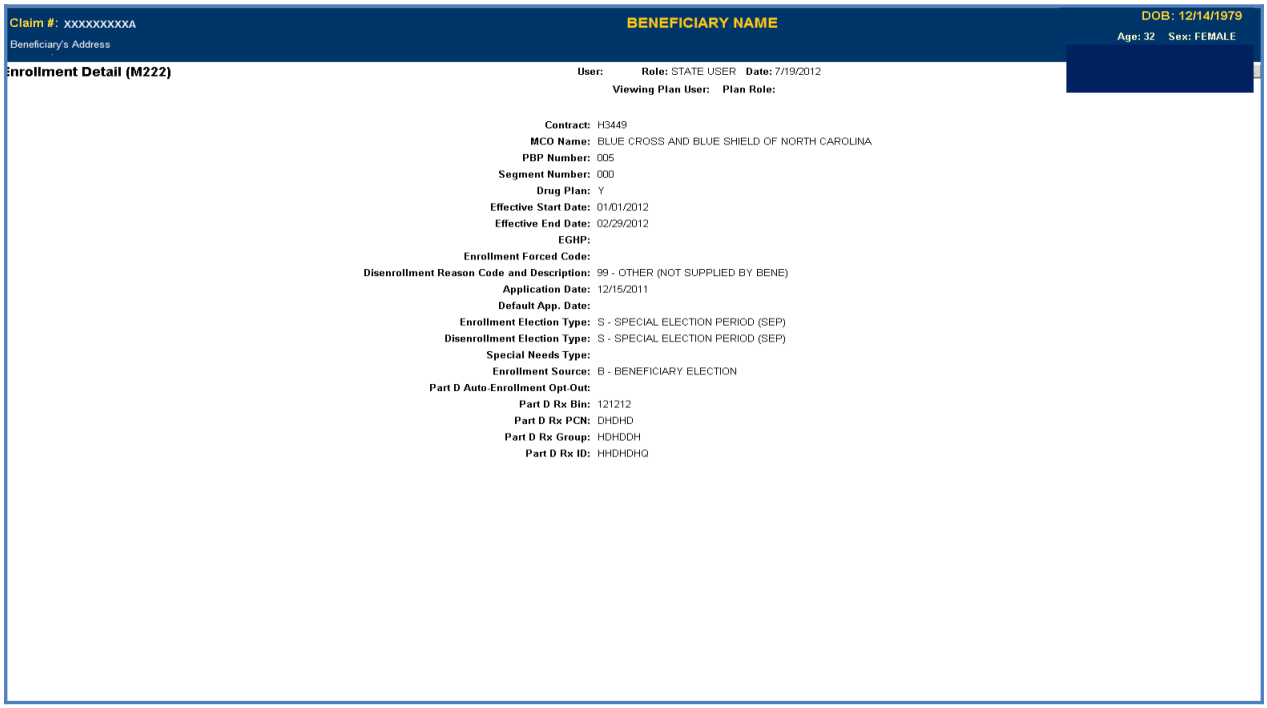


Figure 2-10: State User Detail: Enrollment (M222) Screen

Table 2-18: State User (M222) Field Descriptions and Actions

State User (M222) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Contract	Output	Contract number in which the beneficiary is enrolled.
MCO Name	Output	Name of the contract.
PBP Number	Output	PBP in which the beneficiary is enrolled, when applicable.
Segment Number	Output	Segment in which the beneficiary is enrolled, when applicable.
Drug Plan	Output	Indicates whether the contract provides drug insurance coverage. The user sets to Y or N.
Effective Start Date	Output	Start of enrollment.
Effective End Date	Output	End of enrollment, when applicable.

State User (M222) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
EGHP	Output	Indicates whether the enrollment is an Employer Group Health Plan (EGHP). The user sets to Y or N.
Enrollment Forced Code	Output	Reason for overriding certain membership validation rules, when applicable.
Disenrollment Reason Code	Output	Reason for disenrollment, when applicable.
Application Date	Output	The date the Plan received the beneficiary's completed enrollment application.
Enrollment Election Type	Output	Type of election period when enrollment took place.
Disenrollment Election Type	Output	Type of election period when disenrollment took place.
Special Needs Type	Output	Type of special needs population for which the Plan provides coverage, e.g., Institutional, Dual Eligible, or Chronic or Disabling Condition.
Enrollment Source	Output	The action that triggered the enrollment: automatically enrolled by CMS, beneficiary election, or facilitated enrollment by CMS.
Part D Auto-Enrollment Opt-Out	Output	Indicates whether the beneficiary opted out of Part D coverage. Applies only to automatic enrollments by CMS. Set to Y or N.
Part D Rx Bin	Output	Card issuer identifier or a bank identifying number used for network routing.
Part D Rx PCN	Output	Processing Control Number (PCN) assigned by the processor.
Part D Rx Group	Output	Identifying number assigned to the cardholder group or employer group.
Part D Rx ID	Output	Beneficiary ID assigned to the beneficiary.

Table 2-19: State User (M222) Screen Messages

State User (M222) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Software or Database Error	Error occurred while retrieving beneficiary enrollment information.	Contact the MAPD Help Desk.
Software or Database Error	Invalid input retrieving beneficiary enrollment information.	Contact the MAPD Help Desk.
Software or Database Error	Beneficiary enrollment information is missing.	Contact the MAPD Help Desk.
Software or Database Error	Unexpected error code from database = <error code>.	Contact the MAPD Help Desk.
Software or Database Error	Connection error.	Contact the MAPD Help Desk.

Step 5: Viewing the Rx Information for a Beneficiary

States can access the M244 screen, **Figure 2-11**, to view the Rx Insurance history, both primary and secondary, if applicable, for beneficiaries enrolled in a Plan. To access the Rx Insurance (M244) screen, select the Rx Insurance tab. The screen is described in **Table 2-20**, with screen messages provided in **Table 2-21**.

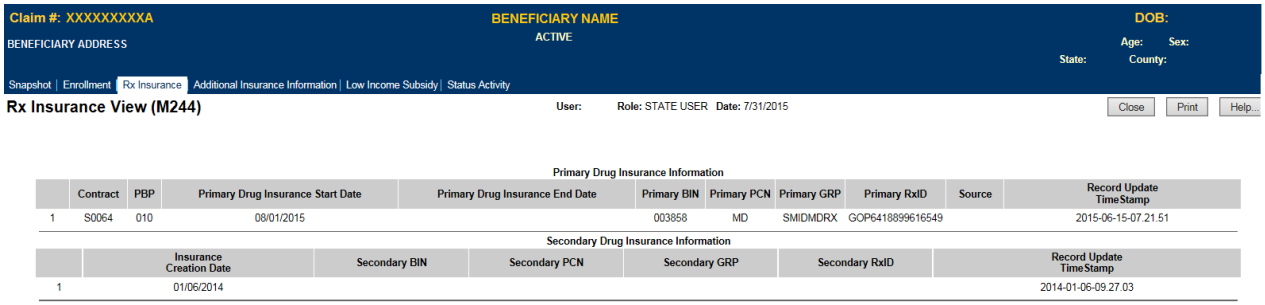


Figure 2-11: Rx Insurance View (M244) Screen

Table 2-20: State User (M244) Field Descriptions and Actions

State User (M244) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Primary Drug Insurance Information This section contains one line for each period that the beneficiary had a unique combination of Contract, PBP, and Primary 4Rx information.		
Contract	Output	The contract for the applicable period.
PBP #	Output	The PBP for the applicable period.
Primary Drug Insurance Start Date	Output	Start date for Primary 4Rx information on this line.
Primary Drug Insurance End Date	Output	End date for the Primary 4Rx information on this line.
Primary BIN	Output	Part D insurance Plan's Beneficiary Identification Number (BIN) for the primary contract, PBP, and period specified.
Primary PCN	Output	Part D insurance Plan's PCN for the primary contract, PBP, and period specified.
Primary GRP	Output	Part D insurance Plan's group (GRP) number for the primary contract, PBP, and period specified.
Primary RxID	Output	Identifier assigned to the beneficiary by the primary Part D insurance plan for drug coverage.
Source	Output	Source of enrollment into the contract and the PBP for period specified.
Record Update Timestamp	Output	Date that Rx insurance information was added or updated.

State User (M244) Field Descriptions and Actions		
Item	**Input/Output**	**Description**
Secondary Drug Insurance Information This section contains one line for each period that the beneficiary had a unique combination of Contract, PBP, and Secondary 4Rx information.		
Insurance Creation Date	Output	Date reported for the initiation of this secondary insurance period.
Secondary BIN	Output	Secondary drug insurance Plan's BIN number.
Secondary PCN	Output	Secondary drug insurance Plan's PCN number.
Secondary GRP	Output	Identifier for a group providing secondary drug insurance.
Secondary RxID	Output	Identifier assigned to a beneficiary by secondary drug insurance.
Record Update Timestamp	Output	Date this row was added or updated.

Table 2-21: State User (M244) Screen Messages

State User (M244) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
No data	No primary drug insurance information found for <claim number>.	No corresponding data is available for the claim number. If the user expects to see data, verify the claim number and try again. If the claim number is correct, the user contacts MAPD Help Desk for assistance.
No data	No secondary drug insurance information found for <claim number>.	No corresponding data is available for the claim number. If the user expects to see data, verify the claim number and try again. If the claim number is correct, the user contacts MAPD Help Desk for assistance.
Software or Database Error	Invalid primary drug insurance results retrieved for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid secondary drug insurance results retrieved for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving drug insurance information for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Invalid input retrieving drug insurance information for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

2.4.6 Viewing Additional Insurance Information

The Additional Insurance Information (M251) screen, **Figure 2-12**, shows a beneficiary's medical insurance and drug insurance information.

Step 6: Viewing the Additional Insurance Information (M251) Screen

To search for a beneficiary, the user logs into the system and navigates to the |Beneficiary| link. Clicking the |Additional Insurance Information| menu item at the top of the screen displays a summary list of medical insurance and drug insurance information by start and end dates. The fields on the screen are described in **Table 2-22**, with screen messages provided in **Table 2-23**.

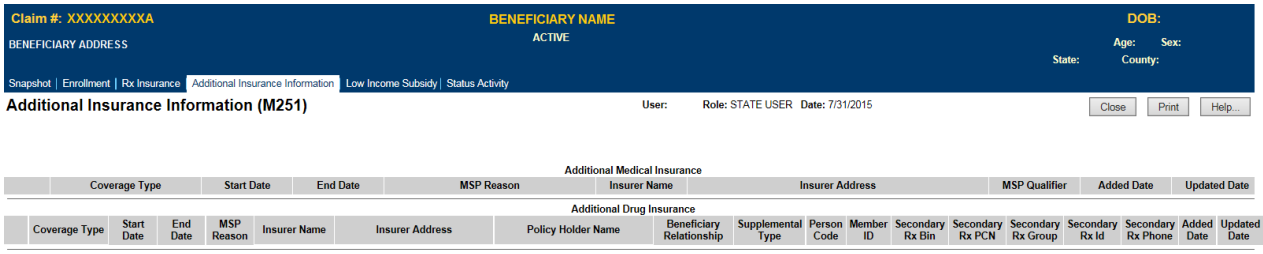


Figure 2-12: Additional Insurance Information (M251) Screen

Table 2-22: Additional Insurance Information (M251) Field Descriptions and Actions

Additional Insurance Information (M251) Field Descriptions and Actions			
Screen Area	**Item**	**Type**	**Description**
Additional Medical Insurance	Coverage Type	Output	Can populate as: • Primary to Medicare. • Secondary to Medicare.
Additional Medical Insurance	Start Date	Output	Start date for each medical insurer for the beneficiary.
Additional Medical Insurance	End Date	Output	End date for each medical insurer for the beneficiary.
Additional Medical Insurance	MSP Reason	Output	Can populate as: • Working Aged. • ESRD. • No-fault Automobile Insurance. • Working Disabled. • Liability. • Worker's Compensation. • Federal (Public Health). • Black Lung. • Veterans.

Additional Insurance Information (M251) Field Descriptions and Actions			
Screen Area	**Item**	**Type**	**Description**
Additional Medical Insurance	Insurer Name	Output	Medical insurance company name.
Additional Medical Insurance	Insurer Address	Output	Address of medical insurance company.
Additional Medical Insurance	MSP Qualifier	Output	MSP Qualifier code assigned by Medicare Beneficiary Database (MBD).
Additional Medical Insurance	Added Date	Output	Date the additional medical insurance was added.
Additional Medical Insurance	Updated Date	Output	Date the additional medical insurance was updated.
Additional Drug Insurance	Coverage Type	Output	Can populate as: • Primary to Medicare. • Secondary to Medicare.
Additional Drug Insurance	Start Date	Output	Start date for each drug insurer for the beneficiary.
Additional Drug Insurance	End Date	Output	End date for each drug insurer for the beneficiary.
Additional Drug Insurance	MSP Reason	Output	Can populate as: • Working Aged. • ESRD. • No-fault Automobile Insurance. • Working Disabled. • Liability. • Worker’s Compensation. • Federal (Public Health). • Black Lung. • Veterans.
Additional Drug Insurance	Insurer Name	Output	Drug insurance company name.
Additional Drug Insurance	Insurer Address	Output	Address of drug insurance company.
Additional Drug Insurance	Policy Holder Name	Output	Name of the policy holder.

Additional Insurance Information (M251) Field Descriptions and Actions			
Screen Area	**Item**	**Type**	**Description**
Additional Drug Insurance	Beneficiary Relationship	Output	Can populate as: • Bene is Policy Holder. • Spouse. • Natural Child. • Insured Financially Responsible. • Insured Not Financially Responsible. • Stepchild. • Foster Child. • Ward of the Court. • Employee. • Unknown. • Handicapped Dependent. • Organ Donor. • Cadaver Donor. • Grandchild. • Niece/Nephew. • Injured Plaintiff. • Sponsored Dependent. • Minor Dependent. • Of A Minor Dependent. • Parent. • Grandparent Dependent. • Life Partner.
Additional Drug Insurance	Supplemental Type	Output	Can populate as: L – Supplemental. M – Medigap. O – Other. P – Patient Assistance Program. Q – Qualified State Pharmaceutical Assistance Program (SPAP). R – Charity. S – AIDS Drug Assistance Program. T – Federal Health Program. 1 – Medicaid. 2 – Tricare.
Additional Drug Insurance	Person Code	Output	The person code assigned by the Drug Plan.
Additional Drug Insurance	Beneficiary ID	Output	Membership ID assigned by the Drug Plan to the beneficiary.
Additional Drug Insurance	Secondary Rx BIN	Output	Identification number for the PDP providing secondary Rx insurance.

Additional Insurance Information (M251) Field Descriptions and Actions			
Screen Area	**Item**	**Type**	**Description**
Additional Drug Insurance	Secondary Rx PCN	Output	Processor control number for the PDP providing secondary Rx insurance.
Additional Drug Insurance	Secondary Rx Group	Output	Identifier for the group providing secondary Rx insurance. Not applicable unless the Secondary Drug Insurance indicator is Yes.
Additional Drug Insurance	Secondary Rx ID	Output	Identifier assigned to a beneficiary by the secondary insurance company for drug coverage. Not applicable unless the Secondary Drug Insurance indicator is Yes.
Additional Drug Insurance	Secondary Rx Phone	Output	The secondary insurance company for drug coverage phone number.
Additional Drug Insurance	Added Date	Output	Date the additional drug insurance was added.
Additional Drug Insurance	Updated Date	Output	Date the additional drug insurance was updated.

Table 2-23: Additional Insurance Information (M251) Screen Messages

Additional Insurance Information (M251) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
No data	No additional insurance information found for <claim number>.	No corresponding data is available for the claim number. If the user expects to see data, verify the claim number and try again. If the claim number is correct, the user contacts MAPD Help Desk for assistance.
Software or Database Error	Invalid additional insurance results retrieved for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Error occurred while retrieving additional insurance information for <claim number>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Unexpected error code from database=<error code>.	Contact MAPD Help Desk for assistance.
Software or Database Error	Connection error.	Contact MAPD Help Desk for assistance.

2.4.7 Viewing Low-Income Subsidy (LIS) Information of a Beneficiary

The Low-Income Subsidy screen shows a beneficiary's valid LIS and LIS denied periods. The Low-Income Subsidy (M252) screen, **Figure 2-13**, is only available to the state user role.

Step 7: Viewing the Beneficiary Detail: Low-Income Subsidy (M252) Screen

The user logs into the system and navigates to the |Beneficiary| link to search for a beneficiary. Then the user clicks the |Low-Income Subsidy| menu item at the top of the screen, which displays the beneficiary's low-income status periods. The fields on the screen are described in **Table 2-23**, with screen messages provided in **Table 2-24.**

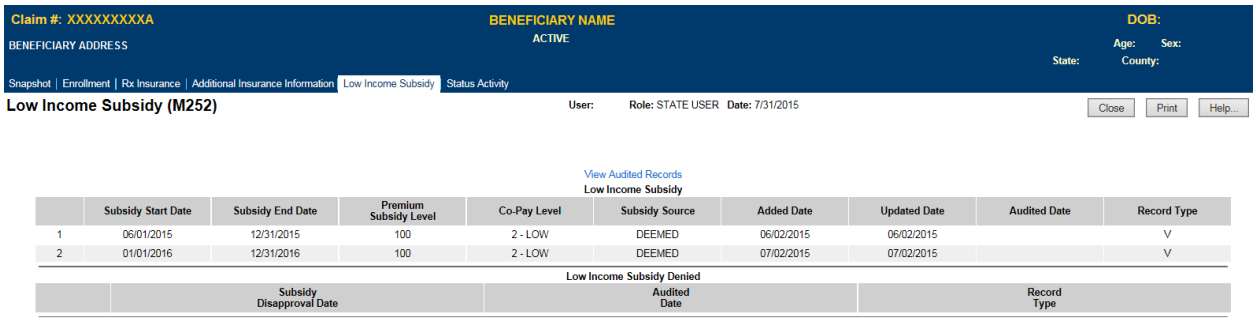


Figure 2-13: Low-Income Subsidy (M252) Screen

Table 2-24: Low-Income Subsidy (M252) Field Descriptions and Actions

Low-Income Subsidy (M252) Field Descriptions and Actions			
Screen Area	**Item**	**Type**	**Description**
Low-Income Subsidy	Subsidy Start Date	Output	Date the beneficiary's LIS period started.
Low-Income Subsidy	Subsidy End Date	Output	Date the beneficiary's LIS period ended.
Low-Income Subsidy	Premium Subsidy Level	Output	Part D premium LIS percent level. Values are: • 100 • 75 • 50 • 25

Low-Income Subsidy (M252) Field Descriptions and Actions			
Screen Area	**Item**	**Type**	**Description**
Low-Income Subsidy	Co-Pay Level	Output	The number to indicate the co-payment level assigned to the beneficiary. 0 – None, not low-income. 1 – High – Assigned to Full Duals with income > 100% FPL, Partial Duals, and Recipients of SSI. 2 – Low – Assigned to Full Duals with income at or below 100% FPL. 3 – No Copay – Assigned to Full Duals who are institutionalized or receiving home and community-based services (HCBS). 4 – 15%. 5 – Unknown. Space – Not applicable.
Low-Income Subsidy	Subsidy Source	Output	A – Approved SSA or state applicant. D – Deemed eligible by CMS. Space – Not applicable.
Low-Income Subsidy	Added Date	Output	Date the low-income subsidy period was added.
Low-Income Subsidy	Updated Date	Output	Date the low-income subsidy period was updated.
Low-Income Subsidy	Audited Date	Output	Date the low-income subsidy period was audited.
Low-Income Subsidy	Record Type	Output	Valid (V) or Audited (A) row.
Low-Income Subsidy Denied	Subsidy Disapproval Date	Output	Date the low-income subsidy period was disapproved.
Low-Income Subsidy Denied	Audited Date	Output	Date the low-income subsidy period was audited
Low-Income Subsidy Denied	Record Type	Output	Valid (V) or Audited (A) row.

Table 2-25: State User (M252) Screen Messages

State User (M252) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
No data	No Low-Income Subsidy information found for claim number	No corresponding data is available for that claim number.
Software or Database Error	Error occurred while retrieving beneficiary results for claim number <claim number>	Contact the MAPD Help Desk.

State User (M252) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Software or Database Error	Error occurred while retrieving beneficiary Low-Income Subsidy history for claim number <claim number>	Contact the MAPD Help Desk.
Software or Database Error	Missing input on retrieval of beneficiary Low-Income Subsidy history	Contact the MAPD Help Desk.
Software or Database Error	Invalid screen ID	Contact the MAPD Help Desk.
Software or Database Error	Unexpected error code from database=<error code>	Contact the MAPD Help Desk.
Software or Database Error	Connection error	Contact the MAPD Help Desk.

2.4.8 Viewing Eligibility Information for Beneficiaries

Step 8: Viewing Beneficiary Eligibility

Beneficiary eligibility provides information regarding a beneficiary's entitlement for Part A, Plan B, and eligibility for Part D, as applicable and relevant to the Plan. If the beneficiary is eligible for Part D LIS, then the number of uncovered months and the details of that subsidy are indicated. Periods, when a beneficiary is covered in a Plan that qualifies for the Retiree Drug Subsidy (RDS), are shown. Periods, when a beneficiary was covered in a Part D Plan, are also shown. A display of all of a beneficiary's enrollments is shown in the Enrollment Information section of the screen with the most recent enrollment as the top row.

Drug Plan information is shown as a column in the Enrollment Information section. Please note that multiple lines do not necessarily mean there were multiple periods of enrollment. The lines denote the timeframes during which the contract provided drug coverage.

STEP 8a: Viewing the Beneficiary: Eligibility (M232) screen

From the main menu, the user clicks on the |Beneficiaries| menu item and then clicks on the |Eligibility| submenu item to view the Beneficiary: Eligibility (M232) screen.

The next step is to identify the beneficiary by claim number on the Beneficiary: Eligibility (M232) screen, **Figure 2-14**. Field descriptions are listed in **Table 2-26**, with screen messages provided in **Table 2-27**.

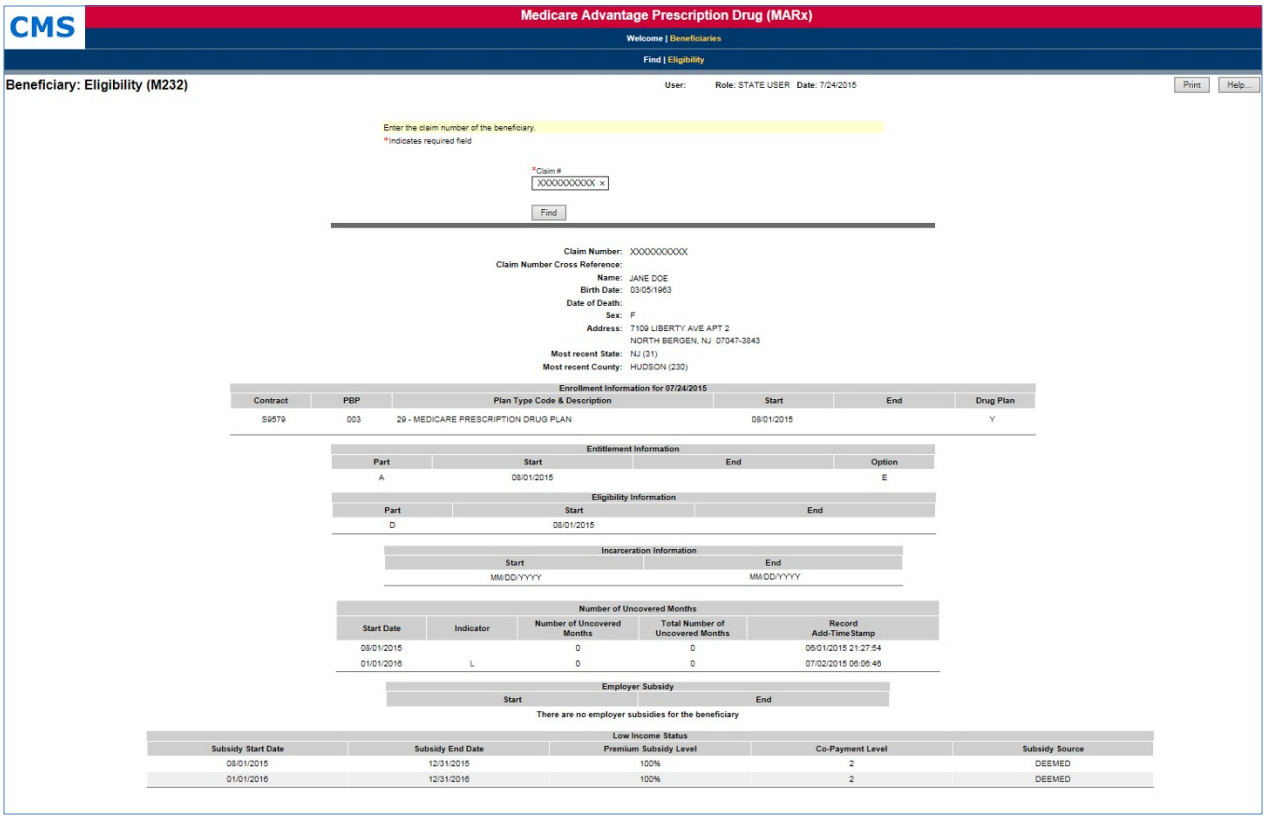


Figure 2-14: State User Beneficiary: Eligibility (M232) Screen

Table 2-26: State User (M232) Field Descriptions and Actions

State User (M232) Field Descriptions and Actions		
Item	**Inputs/Outputs**	**Description**
Search Criteria		
Claim #	Required data entry field	Identifies the beneficiary whose eligibility information displays.
Date	Date field	Provide eligibility information as of this date.
[Find]	Button	The user clicks on this button after entering the beneficiary claim number. If the beneficiary is found, eligibility information for the beneficiary is displayed.
Beneficiary Identification		
Claim Number	Output	Claim number of the beneficiary.
Claim Number Cross Reference	Output	Most recent cross-referenced claim number of the beneficiary.
Name	Output	Name of the beneficiary.
Birth Date	Output	Date of birth of the beneficiary.
Date of Death	Output	Date of death of the beneficiary.
Sex	Output	Sex of the beneficiary.

State User (M232) Field Descriptions and Actions		
Item	**Inputs/Outputs**	**Description**
Address	Output	Mailing address: street, city, state, and zip code of beneficiary.
Most recent state	Output	The most recent state on record for the beneficiary.
Most recent County	Output	The most recent county on record for the beneficiary.
Enrollment Information		
Contract	Output	Contract number for the beneficiary's enrollment(s).
PBP	Output	PBP number for the beneficiary's enrollment(s).
Start	Output	Start date of the beneficiary's enrollment(s).
End	Output	End date of the beneficiary's enrollment(s).
Drug Plan	Output	Drug Plan indicator for the beneficiary's enrollment(s).
Entitlement Information		
Part column	Output	Entitlement information that applies to the Part A and Part B of Medicare.
Start column	Output	When the entitlement period began.
End column	Output	When the entitlement period ended, as applicable.
Option column	Output	Option selected for this part. See Section 3 for Entitlement Code values.
Eligibility Information		
Part column	Output	Eligibility information that applies to this Part D of Medicare.
Start column	Output	When the eligibility period began.
End column	Output	When the eligibility period ended, as applicable.
Number of Uncovered Months (NUNCMO)		
Start Date	Output	Start Date for uncovered months' period.
Indicator	Output	Indicator showing record type. Values are: R = Reset L = LIS A = Aged 65 IEP
NUNCMO	Output	Number of Uncovered Months.
Total NUNCMO	Output	Total NUNCMO based on the Indicator.
Record Add-Timestamp	Output	Timestamp for when the record was added.
Employer Subsidy		
Start Date column	Output	When a Retiree Drug Subsidy (RDS) coverage period began.
End Date column	Output	When an RDS coverage period ended.
Part D Enrollment		
Start Date column	Output	When a Part D enrollment began for the beneficiary.

State User (M232) Field Descriptions and Actions		
Item	**Inputs/Outputs**	**Description**
End Date column	Output	When a Part D enrollment ended for the beneficiary.
Low-Income Status		
Subsidy Start Date column	Output	When the subsidy of Part D premiums began.
Subsidy End Date column	Output	When the subsidy of Part D premiums ended, as applicable.
Premium Subsidy Level column	Output	Level at which the premiums are subsidized. Values are: • 100 • 75 • 50 • 25
Co-Payment Level column	Output	The number to indicate the co-payment level assigned to the beneficiary. 0 – None, not low-income. 1 – High – Assigned to Full duals with income > 100% FPL, Partial Duals, and Recipients of SSI. 2 – Low – Assigned to Full Duals with income at or below 100% FPL. 3 – No Copay – Assigned to Full Duals who are institutionalized or receiving home and community-based services (HCBS). 4 – 15%. 5 – Unknown. Space – Not applicable.
Subsidy Source Column	Output	A – Approved SSA or state applicant. D – Deemed eligible by CMS. Space – Not applicable.

Table 2-27: State User (M232) Screen Messages

State User (M232) Screen Messages		
Message Type	**Message Text**	**Suggested Action**
No claim number	User must enter a claim number.	The user enters the claim number.
Invalid format	The claim number is not a valid SSA, RRB, or CMS internal number.	The user re-enters the claim number.
Invalid format	The claim number is missing the required BIC.	The user re-enters the claim number to include both CAN and BIC.
Invalid date	Date is invalid. Must have format (M)M/(D)D/YYYY	The user re-enters the date.
Informational	The beneficiary is not enrolled in any Plan for “MM/DD/YYYY.”	None
Informational	There is no eligibility information for the beneficiary.	None
Informational	There are no employer subsidies for the beneficiary	None
Informational	There is no Part D enrollment information for the beneficiary	None
Informational	There are no low-income subsidies for the beneficiary	None
Informational	There are no number of uncovered months for the beneficiary	None
Informational	Pre-enrollment information for the beneficiary is displayed	None
No data	Beneficiary not found	The user checks the claim number. If it is incorrect, the user re-enters it.
Software or Database Error	Error occurred while retrieving beneficiary entitlement information	Contact the MAPD Help Desk.
Software or Database Error	Error occurred while retrieving Part D Enrollment information for claim number<claim number>	Contact the MAPD Help Desk.
Software or Database Error	Error occurred while retrieving the number of uncovered months information for claim number<claim number>	Contact the MAPD Help Desk.
Software or Database Error	Error occurred while retrieving beneficiary low-income status information for claim number<claim number>	Contact the MAPD Help Desk.
Software or Database Error	Unexpected error code from database=<error code>	Contact the MAPD Help Desk.
Software or Database Error	Connection error	Contact the MAPD Help Desk.

Entitlement, Eligibility, employer subsidy, and LIS are displayed as follows:

- If a date is entered, then only the information for that date is shown.
- If a date is not entered and the beneficiary is enrolled in a Plan, then-current, historical, and future information is shown.
- If the beneficiary is not enrolled in a Plan, then only the current information is shown.
- When the beneficiary is not covered by a Plan that received the RDS, a message is displayed in the Employer Subsidy section.
- When the beneficiary does not receive a Part D LIS, a message displays in the LIS section.

NUNCMO section displays as follows:

- The 10 most recent periods of Part D enrollment are shown, including Plans with employer subsidies.
- If there are several Part D enrollments back to back, the screen displays the start date of the first enrollment and the end date of the last enrollment.
- When the beneficiary does not have Part D Enrollment information, a message displays in the Part D Enrollment section.

Tooltips display when hovering over the Indicator and Record Type columns Part D enrollments.

Enrollment Information displays as follows:

- The Contract number, Effective date, PBP, Plan Type Code & Description, and Drug Plan indicator of the beneficiary’s current enrollment in the PBP are displayed.
- If the beneficiary is dual enrolled, the system displays the drug and non-drug Contract information for both of the beneficiary’s current enrollments in PBPs.
- If the beneficiary is enrolled in a Plan that does not have PBPs, the Contract, Drug Plan indicator, and the Effective Date of the beneficiary’s current enrollment are displayed.
- If the user enters a date in the “Date” field, the system considers the entered date as the current date when displaying the beneficiary’s current enrollment information.

2.4.9 Viewing Status Activity and Detail Information for Beneficiaries

Step 9: Viewing Status Activity

The Status Activity (M256) screen, **Figure 2-15**, displays a beneficiary's current health status information, as well as current values for eligibility, uncovered months, low-income subsidy, and state and county codes. Field descriptions are listed in **Table 2-28**.

The following special status categories will display on the screen:

- SSA State and County Codes
- Low-Income Subsidy
- Number of Uncovered Months
- Health Status Flags (ESRD, MSP, Home and Community Based Services (HCBS), Medicaid)
- Eligibility Status Flags (Part A, Part B, and Part D)
- Incarceration
- Not Lawfully Present
- Employer Subsidy
- IC Model Status
- Opt-Out Part D
- Opt-Out MMP

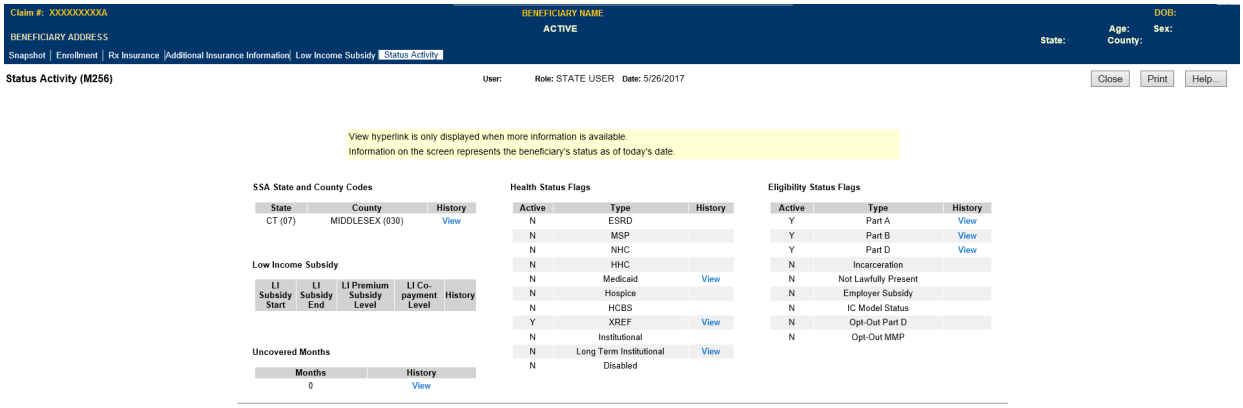


Figure 2-15: State User Status Activity (M256) Screen

If a beneficiary has a history of special status, a "View" hyperlink will be displayed in the history column for that special status. When the user selects the hyperlink, the user can view the special status history on the Status Detail screen.

Table 2-28: Status Activity (M256) Field Descriptions and Actions

Status Activity (M256) Field Descriptions and Actions		
Item	**Type**	**Description**
[Close]	Button	Click this button to exit the active window.
[Print]	Button	Click this button to produce a paper-based copy of the screen content
[Help]	Button	Click this button to open the MARx Help system
SSA State and County Codes-State	Output	Current state of residence abbreviation and number as provided by SSA
SSA State and County Codes-County	Output	Current county of residence abbreviation and number as provided by SSA.
SSA State and County Codes-History	Link	**View** link appears for the user to access the Status Detail: [status category] (M257) screen, when detailed information exists for a specific beneficiary's status. Otherwise, this field is blank.
Health Status Flags-Active	Output	A yes or no indicator to show that the status is either active or audit information for the beneficiary as of today. 'Y' = status active. 'N' = status is not active.
Health Status Flags-Type	Output	Current health status information for these special status subcategories: • ESRD (End-Stage Renal Disease) • MSP (Medicare Secondary Payer) • NHC (Nursing Home Certifiable) • HHC (Home Health Care) • Medicaid • Hospice • HCBS (Home and Community Based Services) • XREF (Cross Reference) • Institutional • Long Term Institutional • Disabled
Health Status Flags-History	Output	**View** link appears for the user to access the Status Detail: [status category] (M257) screen, when detailed information exists for a specific beneficiary's status. Otherwise, this field is blank.
Eligibility Status Flags – Active	Output	A yes or no indicator to show that the status is either active or audit information for the beneficiary as of today. 'Y' = status active. 'N' = status is not active.

Status Activity (M256) Field Descriptions and Actions		
Item	**Type**	**Description**
Eligibility Status Flags-Type	Output	Current active or audit eligibility status listed for each of these eligibility subcategories: • Part A • Part B • Part D • Incarceration • Not Lawfully Present • Employer Subsidy • IC Model Status • Opt-Out Part D • Opt-Out MMP
Eligibility Status Flags-History	Output	**View** link appears for the user to access the Status Detail: [status category] (M257) screen, when detailed information exists for an eligibility type. Otherwise, this field is blank.
Low-Income Subsidy-LI Subsidy Start	Output	The effective date (MM/DD/YYYY) when this LIS begins.
Low-Income Subsidy-LI Subsidy End	Output	The effective date (MM/DD/YYYY) when this LIS ends.
Low-Income Subsidy-LI Premium Subsidy Level	Output	Percentage of LI subsidy for this LIS event expressed as ###%, where values are: • 100 • 75 • 50 • 25
Low-Income Subsidy-Co-payment Level	Output	The number to indicate the co-payment level assigned to the beneficiary. 0 – None, not low-income. 1 – High – Assigned to Full duals with income > 100% FPL, Partial Duals, and Recipients of SSI. 2 – Low – Assigned to Full Duals with income at or below 100% FPL. 3 – No Copay – Assigned to Full Duals who are institutionalized or receiving home and community-based services (HCBS). 4 – 15%. 5 – Unknown. Space – Not applicable.
Low-Income Subsidy-History	Link	**View** link appears for the user to access the Status Detail: [status category] (M257) screen, when detailed information exists for an eligibility type. Otherwise, this field is blank.
Uncovered Months-Months	Output	The current and total number of months that a beneficiary was without creditable coverage.

Status Activity (M256) Field Descriptions and Actions		
Item	**Type**	**Description**
Uncovered Months-History	Link	**View** link appears for the user to access the Status Detail: [status category] (M257) screen, when detailed information exists for an eligibility type. Otherwise, this field is blank.

Step 9a: Viewing Status Detail

The Status Detail: Medicaid (M257) screen, **Figure 2-16**, displays data specific to each of the special statuses (e.g., ESRD, MSP, Medicaid, HCBS, Incarceration, etc.) and, if applicable, the data records/periods that are valid and audited. The most common data values populated on the Status Detail screen are:

- Status Start and End Date
- Valid/Audit Record
- Record Add Timestamp
- Record Update Timestamp
- Record Audit Timestamp

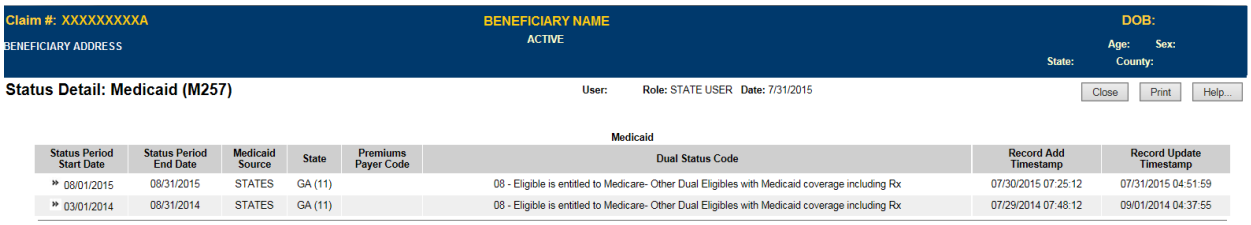


Figure 2-16: State User Status Detail: Medicaid (M257) Screen - Valid Record

If an entry contains audited information, the user can select the “View Audit” link to view the audited information history for most of the statuses, **Figure 2-17**.

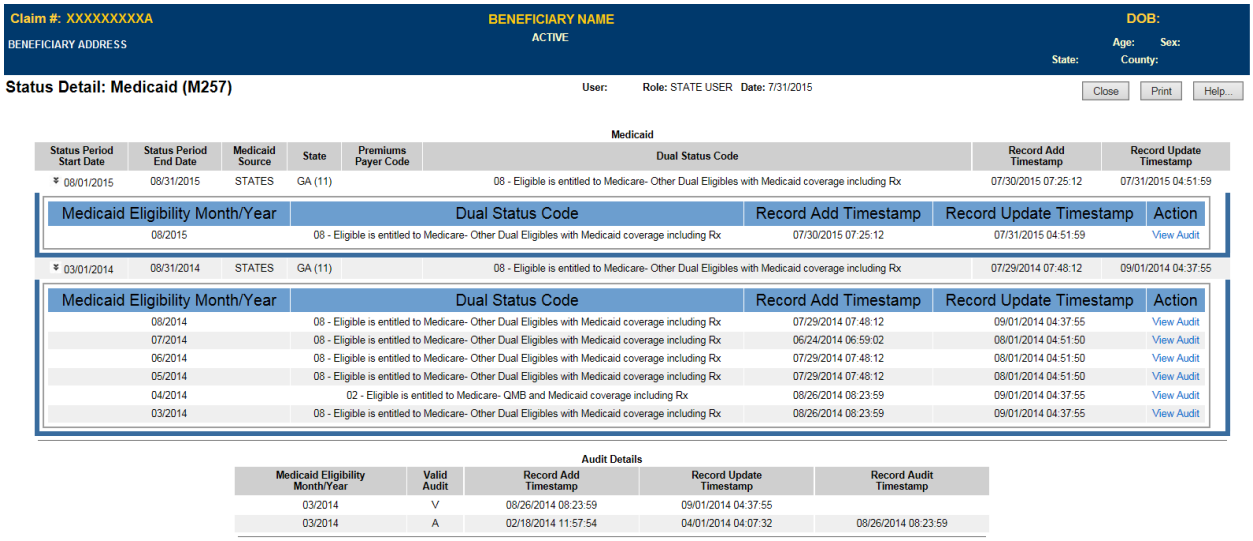


Figure 2-17: State User Status Detail: Medicaid (M257) - Audited Record

The Status Detail Screen also contains information on periods of incarceration and not lawfully present that restricts the beneficiary's eligibility for enrollment. The screen displays the start and end dates of ineligibility from Medicare Plan enrollment and the start and end dates of SSA benefits suspension. If applicable, the Status Detail: Incarceration (M257) screen, **Figure 2-18**, displays by selecting the "Incarceration" Eligibility Status Flag from the Status Activity (M256) Screen. Field descriptions are listed in **Table 2-29**, with screen messages provided in **Table 2-30**.

Figure 2-18: State User Status Detail: Incarceration (M257) Screen

Table 2-29: Status Detail (M257) Field Descriptions and Actions

Status Detail (M257) Field Descriptions and Actions		
Item	**Type**	**Description**
[Close]	Button	Click this button to exit the active window
[Print]	Button	Click this button to produce a paper-based copy of the screen content.

Status Detail (M257) Field Descriptions and Actions		
Item	**Type**	**Description**
[Help]	Button	Click this button to open the MARx Help system.
View Audit/Hide Audit	Link	Click this link to change the default display of valid records to display both valid and audited records for this status category/subcategory
Status Period Start Date	Output	The effective date (MM/DD/YYYY) for this status record.
Status Period End Date	Output	The effective date (MM/DD/YYYY) for this status record.
State	Link	State of residence abbreviation and number as provided by SSA.
County	Output	County of residence abbreviation and number as provided by SSA.
Valid/Audit	Output	A 1-letter indicator to show that the record is valid or audited information. 'V' = Valid information. 'A' = Audited information/
Record Add Timestamp	Output	Date and time (MM/DD/YYYY HH:MM:SS) the record was added.
Record Update Timestamp	Output	Date and time (MM/DD/YYYY HH:MM:SS) the record was updated.
Record Audit Timestamp	Output	Date and time (MM/DD/YYYY HH:MM:SS) the record was audited. Only displays for records with a Valid/Audit status of 'A'.
Premium Subsidy Level	Output	Level at which the premiums are subsidized. Values are: • 100 • 75 • 50 • 25
Co-Payment Level	Output	The number to indicate the co-payment level assigned to the beneficiary. 0 – None, not low-income. 1 – High – Assigned to Full duals with income > 100% FPL, Partial Duals, and Recipients of SSI. 2 – Low – Assigned to Full Duals with income at or below 100% FPL. 3 – No Copay – Assigned to Full Duals who are institutionalized or receiving home and community-based services (HCBS). 4 – 15%. 5 – Unknown. Space – Not applicable.
Subsidy Source	Output	A – Approved SSA or state applicant. D – Deemed eligible by CMS. Space – Not applicable.
Indicator	Output	NUNCMO indicator showing record type. Values are: R = Reset L = LIS A = Aged 65 IEP

Status Detail (M257) Field Descriptions and Actions		
Item	**Type**	**Description**
Number of Uncovered Months	Output	Number of Uncovered Months.
Total Number of Uncovered Months	Output	Total number of Uncovered Months based on the Indicator.
Primary Insurance Code	Output	A 2-digit code and description of the primary insurer.
Source Code	Output	A 5-digit code to identify the MSP source.
COB Contractor Code	Output	A 5-digit code to identify the Coordination of Benefits (COB) contractor.
Coverage Type Code	Output	A 1-letter code and description of the type of coverage.
Start Source	Output	Name of entity (contract or system) that provided notification that the NHC period began.
End Source	Output	Name of entity (contract or system) that provided notification that the NHC period stopped.
Earliest Bill Date	Output	First date (MM/DD/YYYY) that HHC billed.
Latest Bill Date	Output	Last date (MM/DD/YYYY) that HHC billed.
Contractor Number	Output	A 5-digit number to identify the HHC contractor.
Status Code	Output	A 2-digit code and description to identify the status code for the selected status category.
Provider Number	Output	A 7-character alphanumeric code to identify the HHC provider.
Medicaid Source	Output	The source of Medicaid.
State	Output	Current state of residence abbreviation and number as provided by SSA.
Premiums Payer Code	Output	A 3-digit code to identify the premium payer.
Dual Status Code	Output	A 2-digit code and description to identify the dual element status.
Revocation Code	Output	A 1-character code and description to identify Hospice revoked.
XREF Date	Output	Date (MM/DD/YYYY) that the cross-reference event occurred.
XREF Claim #	Output	Claim number related to the cross-reference event.
Change/Merge	Output	Identifies the cross-reference event as either a change or a record merge.
Status Switch	Output	A 1-character code to identify a status switch event for the status detail category. ‘Y’ = Status switch occurred. ‘N’ = Status switch did not occur.
Coverage Year	Input	Defaults to the current year. Optionally, select the desired Long-Term Institutional (LTI) year.
Status Month	Output	Name of the month for which the LTI status is being reported.
Entitlement Start Date	Output	Date (MM/DD/YYYY) entitlement began for this status record.
Entitlement End Date	Output	Date (MM/DD/YYYY) entitlement ended for this status record.
Enrollment Reason	Output	A 1-character code and description to identify the reason for enrollment.

Status Detail (M257) Field Descriptions and Actions		
Item	**Type**	**Description**
Non-Entitlement Reason	Output	A 1-character code and description to identify the reason a beneficiary was not entitled to enrollment.
Entitlement Status	Output	A 1-character code and description to identify the reason for entitlement.
Eligibility Start Date	Output	Date (MM/DD/YYYY) eligibility began for this status record.
Eligibility End Date	Output	Date (MM/DD/YYYY) eligibility stopped for this status record.
Eligibility Reason	Output	A 1-character code and description to identify the reason for eligibility.
Stop Reason	Output	A 1-character code and description to identify the reason that eligibility stopped.
Medicare Plan Ineligibility Start Date	Output	Date (MM/DD/YYYY) ineligibility began for this status record.
Medicare Plan Ineligibility End Date	Output	Date (MM/DD/YYYY) ineligibility ended for this status record.
SSA Benefit Suspension Start Date	Output	Date (MM/DD/YYYY) SSA benefit suspension began for this status record.
SSA Benefit Suspension End Date	Output	Date (MM/DD/YYYY) SSA benefit suspension ended for this status record.
Resumption Date Present	Output	A 1-character code to identify the presence of a resumption date for the status detail category. The presence of a resumption date indicates that the incarceration period was removed. ‘Y’ = Resumption date is present. ‘N’ = Resumption date is not present.

Table 2-30: Status Detail (M257) Screen Messages

Status Detail (M257) Screen Messages		
Message Type	Message Text	Suggested Action
No data	No status information found for <claim number>	No corresponding data is available for that contract number.
Software or Database Error	Error occurred retrieving beneficiary results	Contact the MAPD Help Desk to report the error.
Software or Database Error	Error occurred retrieving beneficiary status history	Contact the MAPD Help Desk to report the error.
Software or Database Error	Missing input on retrieval of the beneficiary status history	Contact the MAPD Help Desk to report the error.

Status Detail (M257) Screen Messages		
Message Type	Message Text	Suggested Action
Software or Database Error	Invalid screen ID	Contact the MAPD Help Desk to report the error.
Software or Database Error	Unexpected error code from database=<error code>	Contact the MAPD Help Desk to report the error.
Software or Database Error	Connection error	Contact the MAPD Help Desk to report the error.

2.4.10 Logging Out of the Medicare Advantage and Part D Inquiry System

When the user is finished with all activities, the user should log out. If the user does not log completely out, the session eventually times out. Logging out as soon as the user is finished with the system is a more secure process to follow and is therefore recommended.

If the browser window is closed, the user is logged out automatically. To simplify logging out, the user may use the logout screen to close all windows in one step.

When the user logs on to the system, the logon screen is replaced with a logout screen as shown in **Figure 2-19** and described in **Table 2-31**, with screen messages provided in **Table 2-32**. This logout screen is behind the MARx UI primary window and the user may access it at any time by selecting the window.

The user clicks on the [Logout] button; the browser asks if the user wants to close the window.

Figure 2-19: State User Logout Screen

Table 2-31: State User Logout Screen Field Descriptions and Actions

State User Logout Screen Field Descriptions and Actions		
Item	**Input/Output**	**Description**
[Logout]	Button	The user clicks on this button to log out of the system, closing all windows.

Table 2-32: State User Logout Screen Messages

State User Logout Screen Messages		
Message Type	**Message Text**	**Suggested Action**
Process	The webpage you are viewing is trying to close the window. Do you want to close this window? [Yes] or [No]	The user clicks on the [Yes] button to close the window. The user clicks on the [No] button to keep the window open.

2.4.11 Validation Messages

Table 2-33 lists validation messages that appear directly on the screen during data entry/processing in the status line (the line just below the title line, as in **Figure 2-20**)

Figure 2-20: Validation Message Placement on Screen

These are common validation messages, not specific to a single screen but related to the fields that appear on many screens. Note that screen/function-specific messages appear in the section related to the specific function and are associated with the specific screen.

Table 2-33: Validation Messages

Validation Messages	
Error Messages	**Suggested Action**
User must enter a contract number	Enter the field specified by the message.
A contract number must start with an ‘E’, ‘H’, ‘R’, ‘S’, ‘X,’ or ‘9’, followed by four characters	Re-enter the field and follow the format indicated in the message.
User must enter a sex	Enter the field specified by the message.
User must select a state	Enter the field specified by the message.
Invalid Contract/PBP combination	Check the combination and re-enter.
Invalid Contract/PBP/segment combination	Check the combination and re-enter.
<kind-of-date> is invalid. Must have the format (M)M/(D)D/YYYY	Re-enter the field and follow the format indicated in the message.
User must enter <kind of date>	Enter the field specified by the message.
PBP number must have three alphanumeric characters	Re-enter the field and follow the format indicated in the message.
Please enter at least one of the required fields	Make sure to enter all the required fields.
Please enter user ID or password	Make sure to enter one of the fields specified by the message.

Validation Messages	
Error Messages	**Suggested Action**
Segment number must have three digits	Re-enter the field and follow the format indicated in the message.
The claim number is not a valid SSA or RRB number, or CMS Internal number	Re-enter the field in SSA, RRB, or CMS Internal format.
The last name contains invalid characters	Re-enter the field using only letters, apostrophes, hyphens, or blanks.
The user ID contains invalid characters	Re-enter the field and follow the format indicated in the message.

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3 Entitlement Status, Enrollment, and Disenrollment Reason Codes

The tables below list the codes for Part A and Part B Entitlement Status, Non-Entitlement Status, Enrollment, and Disenrollment Reasons.

Table 3-34: Part A – Entitlement Status Codes

Part A Entitlement Status Codes	
Code	**Definition**
Entitlement Date is Present and Termination Date is Blank	
E	Free Part A Entitlement
G	Entitled due to good cause
Y	Currently entitled, premium is payable
Entitlement Date and Termination Date are Present	
C	No longer entitled due to disability cessation
S	Terminated, no longer entitled under ESRD provision
T	Terminated for non-payment of premiums
W	Voluntary withdrawal from premium Part A coverage
X	Free Part A terminated because of Title II termination

Table 3-35: Part A – Non-Entitlement Status Codes

Part A Non-Entitlement Status Codes	
Code	**Definition**
Both Entitlement Date and Termination Date are Blank	
D	Coverage denied
F	Terminated due to invalid enrollment or enrollment voided
H	Ineligible for free Part A, or did not enroll for premium Part A
N	Not valid SSA HIC, used by CMS 3rd party sys for potential PTA entitled date
R	Refused benefits

Table 3-36: Part A – Enrollment Reason Codes

Part A – Enrollment Reason Codes	
Code	**Definition**
A	Attainment of age 65.
B	Equitable relief.
D	Disability – Under age 65 entitlement.
G	General Enrollment Period.
I	Initial Enrollment Period.

Part A – Enrollment Reason Codes	
Code	**Definition**
J	MQGE entitlement.
K	Renal disease not reason for entitled prior to 65 or 25th month of disability.
L	Late filing.
M	Termination based on renal entitlement but disability based on entitlement 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.
T	Disabled working individual.
U	Unknown blank = not applicable; e.g. Part A data is generated at age 64 years, 8 months.

Table 3-37: Part B – Entitlement Status Codes

Part B Entitlement Status Codes	
Code	**Definition**
Entitlement Date is Present and Termination Date is Blank	
G	Entitled due to good cause
Y	Currently entitled, premium is payable
Entitlement Date and Termination Date is Present	
C	No longer entitled due to cessation of disability
F	Terminated due to invalid enrollment or enrollment voided
S	Terminated, no longer entitled under ESRD provision
T	Terminated for non-payment of premiums
W	Voluntary withdrawal from coverage

Table 3-38: Part B – Non-Entitlement Reason Codes

Part B Non-Entitlement Status Codes	
Code	**Definition**
Both Entitlement Date and Termination Date are Blank	
D	Coverage denied
N	No Foreign/Puerto Rican Beneficiary is not entitled to SMI or dually/Technically entitled Beneficiary ID not entitled to SMI.
R	Refused benefits

Table 3-39: Part B - Enrollment Reason Codes

Part B - Enrollment Reason Codes	
Code	**Definition**
B	Equitable relief.
C	Good cause.
D	Deemed date of birth.
F	Working aged.
G	General enrollment period.
H	Entitlement based on health hazard.
I	Initial enrollment period.
K	Renal disease was a reason for entitlement prior to age 65 or prior to the 25th month of disability.
M	Renal entitlement terminated, but disability-based entitlement continues.
P	Medicare Part B Immunosuppressive Drug (Part B-ID)
R	Residency requirements are involved.
S	State buy-in.
T	Disabled working individual *. * = future – current CMS program edits do not create this code.
U	Unknown.

Table 3-40: Disenrollment Reason Codes

Disenrollment Reason Codes	
Code	**Definition**
01	Failure to pay Premiums
02	Relocation out of Plan Service Area (No special provisions)
03	Failure to convert to Risk Provisions
04	Fraud
05	Loss of Park B Entitlement
06	Loss of Part A Entitlement (Plan-specific)
07	For cause
08	Report of death
09	Termination of Contract (CMS-initiated)
10	Termination of Contract/Plan Benefit Package (PBP)/Segment (Plan withdrawal)
11	Voluntary disenrollment through Plan
12	Voluntary disenrollment through District Office
13	Disenrollment because of enrollment in another Plan
14	Retroactive
15	Terminated in error by CMS system
16	End of State and County Code (SCC) Conditional Enrollment Period
17	Beneficiary does not meet Age Criterion (Plan-specific)
18	Rollover
19	Terminated by Social Security Administration (SSA) District Office

Disenrollment Reason Codes	
Code	**Definition**
20	Invalid enrollment with End-Stage Renal Disease (ESRD)
21	Cannot Travel/Poor Health/ to Health Maintenance Organization (HMO)/Plan Doctors
22	Spouse is no longer a Member of HMO/Plan
23	Couldn't use Medicare Card to see other Plans
24	Did not know I joined this HMO
25	Difficulty reaching HMO/Plan Doctor by phone problem
26	Called HMO/Plan could not get help with the problem
27	Dissatisfied with Medical Care/Doctors or Hospital
28	Told by Plan Doctors or Staff I should disenroll
29	Prefer Traditional Medicare
30	Have other Health Insurance benefits available
31	Found HMO/Plan to be too confusing
32	My Claims/Bills were not paid
33	Had little or no choice of Specialist
34	Treated discourteously by Doctor/Nurse/Staff
35	Doctor could not improve my condition
36	HMO/Plan Medical Group was located too far away
37	Had limited or no choice of my Primary Doctor
41	You moved permanently out of area where Plan provides service
42	Your Doctor or the Plan told you to disenroll
43	Your Doctor did not give you good quality care
44	You used up the Prescription Allowance
45	The Plan cost you too much
46	You could not get care when you needed it
47	Your Doctor is not in the Plan
48	You did not know you signed up for this Plan
49	You did not like how the Plan worked
50	Rolled-over enrollment removed/audited
54	Part A or B start date change
56	Beneficiary Medicaid period received
57	Beneficiary Hospice period received
59	Invalid enrollment with Hospice
60	Beneficiary lives in the USA less than 183 days a year
61	Loss of Part D eligibility
62	Part D disenrollment due to failure to pay IRMAA
63	MMP (Medicare and Medicaid Plan) Opt-Out after enrolled
64	Loss of demonstration eligibility
65	Loss of Employer Group Plan eligibility
70	Confirmed Incarceration
71	Not Lawfully Present
72	Disenrollment due to Plan-submitted Rollover

Disenrollment Reason Codes	
Code	**Definition**
88	Conversion
90	Enrollment cancelled due to Beneficiary Merge
91	Failure to Pay Premiums
92	Relocation out of Plan Service Area
93	Lost specific Plan eligibility; Special Needs Plan (SNP) only
99	Other (Not supplied by Beneficiary)
Y8	Report of a death date change

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4 Submitting State Data for Medicare Modernization Act (MMA) Provisions

Note: The state monthly file is often referred to as the MMA file, the State Phased-Down (SPD) file, or the Enrollment File. For purposes of consistency, the SUG uses the term **MMA file**.

4.1 State Monthly MMA File Submission Requirements

Since 2005, states have been submitting files at least monthly to CMS to identify all dually eligible beneficiaries. This includes full-benefit dually eligible beneficiaries and partial-benefit dually eligible beneficiaries (i.e., those who get Medicaid help with Medicare premiums, and often for cost-sharing).

The file is called the "MMA file" (after the Medicare Prescription Drug, Improvement and Modernization Act of 2003), but is occasionally referred to as the "state phase-down file." However, federal regulations at 42 CFR 423.910 now require states, effective April 1, 2022, to submit files daily. Territories do not participate in this data exchange with CMS.

CMS data collection according to MMA requirement implementation will be met by each of the fifty states and the District of Columbia Medicaid agencies (hereafter referred to as **states**) submitting at least one monthly file, including all known dually eligible beneficiaries and subsequent daily files that provide updates for changes in dual eligibility status (accretions, deletions, and changes).

Daily submission means every business day, but if a state has no new transactions to transmit, data would not need to be submitted on a given business day. Daily submission allows the states to provide current information on updated dual eligibility status and helps promote administrative efficiencies while also benefiting dually eligible beneficiaries and providers.

The MMA files address the following Medicare program needs based on dual-status:

- Dual Eligible Enrollment
  - Parts A and B: QMB status and related protections
  - Part C: Plan risk adjustment
  - Part D: Auto-enrollment and LIS deeming
- State Phased-Down Calculation
- State Low-Income Subsidy (LIS) Applications

4.2 Dual Eligible Enrollment

The MMA file submittals will include all full-benefit Medicare-Medicaid dually eligible beneficiaries in the state as well as those only eligible as:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualifying Individual (QI) (partial-benefit dually eligible)
- Retroactive (Retro) records, Prospective (PRO) records
- State Low-Income Subsidy (LIS) applications for Part D subsidy processed since the last MMA file was created

This will allow CMS to establish the LIS status of dually eligible beneficiaries and to auto-assign beneficiaries to Medicare Part D plans. In addition, CMS uses QMB status to alert providers (via HETS provider eligibility query and via the Remittance Advice) as well as beneficiaries (via Medicare Summary Notice) of prohibitions on collecting cost-sharing for Medicare A/B services. Finally, CMS uses dual status to risk adjustment payments to Part C Medicare Advantage plans.

4.3 State Phased-Down Calculation

CMS uses the state's MMA file submission to calculate the State Phased-Down contribution payment. The Phased-Down process requires a monthly count of all full-benefit dually eligible beneficiaries 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 dually eligible beneficiaries (codes 02, 04, and 08).

For more information on the State Phased-Down contribution payment, click here.

In the case wherein a given month, multiple records were submitted for the same beneficiary in multiple file submittals, CMS uses the last record submitted for that beneficiary to determine the final effect on the Phased-Down count.

4.4 State Low-Income Subsidy (LIS) Applications

The file may also include records for those beneficiaries for whom the state has made a low-income subsidy determination for an individual applying to the state, i.e., since the last file was created. A record for each Medicare Part D LIS application processed during the month by the state must be included in the file.

CMS strongly encourages states to use the SSA subsidy application (SSA-1020) for subsidy applicants unless a beneficiary 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 a beneficiary requests a state determination or refuses to use the SSA application, the state must use its application and process the case using federal LIS income, family size, and resource rules. Refer to 42 CFR § 423.904 (c). 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. For more information, please refer to section 10.3.3, The State Application in the CMS Guidance to States on the Low-Income Subsidy.

5 State MMA Request File Timing and Content

Sections 5 through 11 pertain to the fifty states and the District of Columbia process of exchanging data with CMS. Section 12 provides information specific to the process for Puerto Rico to exchange data with CMS.

5.1 MMA Request File Timing

Each state will send at least one comprehensive MMA Request file to CMS between the start and the end of the enrollment month including all known dually eligible beneficiaries and subsequent daily files that include only file accretions, deletions, and changes in dual eligibility status. Daily means every business day, but if no new transactions are available to transmit, data would not need to be submitted on a given business day.

By month's end, all file submissions for the month will result in a complete representation of all dually eligible beneficiaries enrolled in the state for that month.

- States submit a full monthly file and subsequent daily (accretions, deletions, and changes) MMA Request files during the month. 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 an MMA Response file within 24-48 hours.
    - Note: State MMA Request files submitted successfully between 6:00 a.m. – 5:30 p.m. (ET) will be processed the same day. MMA Response files are processed and sent to states between 9:00 a.m. -10:00 a.m. (ET) the following day.
    - Files received after 5:30 p.m. (ET) will be processed the following day and the response file sent the next day.
    - Example: The state submits an MMA request file to CMS and it is received at 6 pm on 6/21 after the cutoff processing time of 5:30 p.m. The file is processed on the next day 6/22 and the response file is sent on 6/23.
- Unexpected system issues or planned outages will cause delays in states receiving the MMA Response File within the 24-48-hour window. CMS issues a notification to states via email advising of all delays. If you are not receiving the notifications, contact the MAPD Help Desk at 800-927-8069.
- CMS will process all files nightly for the LIS deeming and auto-assignment process. The resulting enrollment transactions shall be sent daily (except for Sundays) to the Part D Plans.

- 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 CMS receives it on or after the cutoff processing time, CMS will process the file on the first day of the subsequent month.

The cutoff processing times are:

State File Cutoff Processing Times	
Last Day of Month	**Cutoff Processing Time**
Weekday (including holidays)	5:30 p.m. Eastern Time
Saturday or Sunday	1:00 p.m. Eastern Time

If a file is submitted to CMS on January 31, 2021, at 11:00 p.m. Eastern Standard Time (EST), it would not be processed until February 1, 2021, and all enrollment detail (DET) records submitted as 'current' for January 2021would now be treated as retroactive records, any 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 Phased-Down calculation.

5.2 MMA Request File Content

The Record Identification Code field will identify if the record is an enrollment detail record (DET) for a known dually eligible beneficiary or future Medicaid eligible (not to exceed one month into the future), a prospective full-benefit dually eligible beneficiary (PRO), or a Low-Income Subsidy (LIS) determination record. Medically-needy and other spend-down beneficiaries who have not met their incurred liability for the month and are in inactive enrollment status for the reporting month should not be included. Below are the types of records states should include in their file:

- Current DET Records
- Retro DET Records
- Future DET Records
- LIS Records
- PRO Records

5.2.1 Current DET Records

States must include a person-month record for each dually eligible beneficiary for the current reporting month. A person-month record is a full detail record per beneficiary for the current month.

5.2.2 Retro DET Records

The retroactive detail record allows the state to report information on changes in beneficiaries' circumstances that were effective in one or more prior months. Retroactive records will be identified in the MMA Request file by the effective month and year to which the retroactive record data are to be applied. CMS requires states to submit retroactive records in their files to cover any unreported prior-month changes in one or more of the following values as soon as possible:

- Eligibility status (including Medicaid eligibility and dual status)
- Institutional status indicator (including Home- and Community-Based Services (HCBS))
- Federal Poverty Level (FPL) percentage indicator

The following are examples of the most common situations that would lead to retroactive changes. In each of these cases, the MMA Request file will include a complete person-month record for that beneficiary for the current month, if applicable, and a subsequent record (s) providing a replacement record for each effective month and year of the change.

1. A state has reported a beneficiary as having eligibility status for the first time in February 2020. The state later determines that the first full month of eligibility was January 2020 and that no other data for January was different. The state sends a retroactive detail record showing this update; the record would change only the eligibility month/year field and maintain all other fields from the February 2020 record.

In the following illustration of this example, you will see that a state would identify the retroactive records in the MMA Request file by the effective month and year to which the retroactive record data are to be applied. The state would submit a detail record for the current month and a new record for the effective month(s) of change. The state corrects the "Elig M/Y," which should be the only field that changes. All other data fields remain the same.

February File Submission for Current Month

Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	22020	Y	4K88L84HXXX	F	12011950	2	1	Y

March File Submission for Current Month

Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	32020	Y	4K88L84HXXX	F	12011950	2	1	Y
DET	12020	Y	4K88L84HXXX	F	12011950	2	1	Y
DET	22020	Y	4K88L84HXXX	F	12011950	2	1	Y

Abbreviated MMA Request file layout for demonstration purposes.

2. *A state has reported a beneficiary as having a dual-status code of 02 (QMB-plus) in February 2020. The state later determines that a change in the beneficiary's dual status code occurred 2 months before the reporting month and their dual status code was 08 (Other full benefit dually eligible) beginning in December 2019. The state sends a retroactive detail record showing this update; the file would maintain all fields from December 2019 to February 2020 records and change only the dual status code field.*

As you can see in the following graphic, a state would identify the retroactive records in the MMA Request file by the effective month and year to which the retroactive record data are to be applied. The state would submit a detail record for the current month, if applicable, and a new record for the effective months of change (i.e., December 2019 to February 2020). The state would correct the "Elig M/Y" and "Dual-Status Code" fields, while all other fields would remain the same.

February File Submission for Current Month								
Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	22020	Y	4K88L84HXXX	F	12011950	2	1	Y
March File Submission for Current Month								
Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	32020	Y	4K88L84HXXX	F	12011950	8	1	Y
DET	22020	Y	4K88L84HXXX	F	12011950	8	1	Y
DET	12020	Y	4K88L84HXXX	F	12011950	8	1	Y
DET	122019	Y	4K88L84HXXX	F	12011950	8	1	Y

3. A state has reported a beneficiary as having eligibility in March but was discovered in February to be deceased during the full month of March would have a change record for March showing an eligibility status of 'N' for the March enrollment month.

A state would identify the retroactive records in the MMA Request file by the effective month and year to which the retroactive record data are to be applied. The state would submit a detail record for the current month, if applicable, and a new record for the effective month(s) of change (i.e., March). The state corrects the "Elig M/Y," which should be the only field that changes. All other data fields remain the same.

February File Submission for Current Month								
Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	22020	Y	4K88L84HXXX	F	12011950	2	1	Y
DET	32020	Y	4K88L84HXXX	F	12011950	2	1	Y
March File Submission for Current Month								
Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	22020	Y	4K88L84HXXX	F	12011950	2	1	Y
DET	22020	N	4K88L84HXXX	F	12011950	2	1	Y

4. If a beneficiary was submitted as a current DET record in a previous submission during the *current reporting month* as a 'Y', but the state discovered the beneficiary was not Medicaid eligible, the state may correct the eligibility status by resubmitting the beneficiary's record with an 'N' in the Medicaid Eligibility Status field for the *current reporting month within the same month*.

A state would identify the retroactive records in the MMA Request file by the effective month and year to which the retroactive record data are to be applied. The state would submit a detail record for the current month and a new record for the effective month(s) of change. The state corrects the Eligibility Status field which should be the only field that changes. All other data fields remain the same.

February File Submission for Current Month								
Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	22020	Y	4K88L84HXXX	F	12011950	2	1	Y
February File Submission for Current Month								
Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	22020	N	4K88L84HXXX	F	12011950	2	1	Y

NOTE: CMS can automatically process records up to 36 months of retroactivity from the current reporting month. On an exceptional basis, states are allowed to correct information submitted on the MMA file with eligibility months prior to 36 months and not exceeding 120 months. All state submissions meeting these criteria will require prior approval by the Medicare-Medicaid Coordination Office (MMCO) via a request to MMCO_MMA@cms.hhs.gov.

5.2.3 Future DET Records

The file(s) may also include Medicare beneficiaries who will be identified as Medicaid beneficiaries one month into the future.

5.2.4 LIS Records

The MMA Request file submittal may also include all state LIS applications for Part D subsidy processed since the last file was created.

5.2.5 PRO Records

States should include beneficiaries in state Medicaid programs who are not known to be full-benefit dually eligible but are Medicaid eligible and 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 dually eligibility. See **Sections 5.3 – 5.6** for detailed information on PRO Records.

5.3 Prospective Full-Benefit Dually Eligible Individuals

One of the concerns related to the monthly MMA reporting cycle is the effect on Medicaid-only beneficiaries who transition to dually 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 beneficiaries with full Medicaid benefits, i.e., beneficiaries who, if they have Medicare coverage, would be full-benefit dually eligible. Do not include beneficiaries who would only be partial-benefit dually eligible, i.e., QMB-only, SLMB-only, or QI. In the dual status code field in the PRO record, include the full-benefit dually eligible status code 08 which best describes the dual status assuming that the beneficiary is Medicare eligible.

5.4 PRO Enrollment Process

By including these prospective beneficiaries on the MMA Request file(s), CMS will be able to return information to the states in the MMA Response files for beneficiaries already in Medicare and those projected to receive Medicare coverage within two months prior to the enrollment effective date. CMS will also be able to set up LIS status and auto-enroll beneficiaries into a Part D plan so their coverage will be in place when they become Part D eligible.

This process will help minimize the transitional drug coverage issues for beneficiaries becoming eligible for Part D. This process also provides an opportunity to better synchronize state information on Medicare enrollment.

5.5 Submission of PRO Records

For CMS to successfully process a PRO record the following field requirement must be met in the MMA Request Detail Record (See **Section 6.4**):

- Record Identification Code (item 1, positions 1-3) must contain ‘PRO’.
- Eligibility Month/Year (item 2, positions 4-9) of submission must be the CURRENT PROCESSING MONTH/YEAR. CMS will reject past or future dates.
- A record must contain a ‘Y’ in the Eligibility Status field (item 3, position 10)
- A record must contain a valid Social Security Number (item 6, positions 27-35). This field cannot be 9-filled or blank.
- A record must contain a valid Date of Birth (item 13, positions 108-115). If the date of birth is unknown, enter the best available data. This policy applies to DET records as well. CMS will reject records containing no date of birth or an incorrect birth date format.

- A record must contain a valid Dual Status Code (item 14, positions 116-117) of ‘02’, ’04’ or ‘08’. CMS will reject dual-status codes 01, 03, 05, and 06.

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 CMS to prospectively auto-enroll these beneficiaries 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 MMA Request 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, item 1 (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. For records that 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 a beneficiary is identified as a prospective full dual, the beneficiary should be submitted with a Record Identification Code of ‘DET’ in the first month Medicare eligibility is effective. If a beneficiary 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.

5.6 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 Summary Record, **Section 7.6**. The layout has been changed to accommodate PRO processing.

Record Return Summary Codes 000009 – 000012 apply to PRO records only. See Record Return Summary Code (item 55, positions 229-234) in **Section 7.5** for descriptions.

Valid PRO records that have been matched to the database will contain the same information as matched DET records: Part A/B/C Entitlement dates, Beneficiary Identifier (MBI), 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. 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 = '000000' or '000001') and the Part A/B/D Entitlement Start Date is 01/01/2021, it is anticipated that a DET record will be submitted for this beneficiary in the January 2021 file.

Valid PRO records which were matched and are found to be Part A and/or 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 2020 state request file and was found to be Part A and/or B entitled effective 03/01/2021, the beneficiary would be submitted to the LIS deeming process the evening of file submission, and be returned in the MMA Response file within 24-48 hours with a deeming onset date of 03/01/2021.

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 2021).

Deeming, however, will occur when the record is received for the appropriate period, regardless of the onset being more than two months into the future.

Already existing Medicare eligibility/enrollment may be returned for beneficiaries 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 MMA Request file submission.

5.7 Dual Status Codes

Dually eligible beneficiaries include beneficiaries enrolled in Medicare Part A and/or Part B and getting full Medicaid benefits and/or assistance with Medicare premiums or cost-sharing through the Medicare Savings Program (MSP). For each beneficiary, the state includes a dual-status code, and for full-benefit dually eligible beneficiaries, whether their income is over or under 100% FPL, and whether they are institutionalized or qualify for certain home and community-based services (HCBS).

Full-benefit dually eligible beneficiaries are Medicare beneficiaries who qualify for the full package of Medicaid benefits. They often separately qualify for assistance with Medicare premiums and cost-sharing through the MSPs. Full-benefit dually eligible beneficiaries are dual-status codes: 02, 04, and 08.

Partial-benefit dually eligible beneficiaries are enrolled only in Medicare and an MSP. Partial-benefit dually eligible beneficiaries are dual-status codes: 01, 03, 05, and 06.

The following chart summarizes the dual status codes for the seven eligibility categories for dually eligible beneficiaries, including each category's benefits and basic qualifications. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_DualEligibleDefinition.pdf

Dual status codes 09/99 (unknown) are not valid codes to submit on the MMA Request file. 09/99 codes existed for a processing need long ago but no longer serve a purpose for this file today and may be eliminated as a value in the future. A record should always contain a valid dual-status code (01, 02, 03, 04, 05, 06, and 08).

5.8 Part B Immunosuppressive Drug (Part B-ID)

Starting January 1, 2023, certain individuals who lose End-Stage Renal Disease (ESRD) Medicare coverage after a successful kidney transplant are eligible for a limited benefit that covers immunosuppressive drug therapy under Medicare Part B (Part B-ID), as required by section 402 of the Consolidated Appropriations Act, 2021.

The Part B-ID benefit solely covers immunosuppressive drugs and no other Medicare items, services, or prescription drugs.

Individuals enrolled in Part B-ID are now considered QMBs, SLMBs and QIs (not just those enrolled in regular Part A and B) if they otherwise meet the eligibility requirements of QMB, SLMB and QI. States would report them with the appropriate dual status codes for QMB-only, SLMB-only, and QI apply per section 5.7.

Individuals are charged a monthly premium for Part B-ID through direct billing by CMS. Individuals eligible for the MSP QMB, SLMB or QI eligibility groups can receive coverage for the Medicare Part B-ID premium and, for QMBs, Part B-ID cost sharing, including the deductible and coinsurance.

On or after January 1, 2023, individuals are eligible for Part B-ID if they:

- Lose Medicare entitlement on the basis of ESRD 36 months after a successful kidney transplant;
- Are not otherwise eligible for Medicare; and
- Complete an attestation through SSA certifying that they do not have or expect to obtain certain other forms of health coverage, including, but not limited to, employer coverage, Medicaid that includes immunosuppressive drugs, and marketplace coverage.

For more information about the Part B-ID benefit, see chapter 2, section 40.9 of the Medicare General Information, Eligibility and Entitlement Manual (IOM 100-01).

6 MMA Request File

6.1 Special Key Fields/User Tips for the MMA Request File

6.1.1 Beneficiary Matching Criteria

Key beneficiary fields are used to perform a match between the state's incoming beneficiary records to the CMS Medicare Beneficiary Database (MBD).

Primary Match Routine

The Primary Match routine uses the values for the following demographic fields from the beneficiary's MMA Request record to find a match for the beneficiary in the Medicare database:

- Beneficiary Identifier (HICN, RRB, or MBI)
- Individual SSN
- Date of Birth
- Sex code

After searching to find a match for the beneficiary, the primary match routine returns a response to the MBD State Phased-Down process indicating the outcome of the search.

Secondary Match Routine

The secondary match routine uses the values for the following demographic fields from the beneficiary's MMA Request file record to find a match for the beneficiary in the Medicare database:

- Beneficiary Identifier (HICN, RRB, or MBI)
- Individual SSN
- First six (6) characters of the Individual Last Name
- First character of the Individual First Name
- Sex code

After searching to find a match for the beneficiary, the secondary match routine returns a response to the MBD State Phased-Down process indicating the outcome of the search.

An unsuccessful beneficiary match prevents CMS from sending beneficiary information back to the state in the MMA Response File.

6.1.2 Institutional Status Indicator

The indicator represents a full-benefit dually eligible beneficiary who receives Medicaid-covered nursing facility, inpatient psychiatric hospital, or certain HCBS care. This field, located at item

17 on the MMA Request File, establishes which full-benefit dually eligible beneficiaries (dual status codes 02, 04, 08) qualify for $0 Part D co-payments.

Most non-institutionalized dually eligible beneficiaries pay small co-payments for prescription drugs covered under Medicare Part D. However, section 1860D-14 (a)(1)(D)(i) of the Social Security Act eliminates Medicare Part D co-payments for full-benefit dual eligible beneficiaries who would be institutionalized if they were not receiving services under a home and community-based waiver authorized by a state under section 1115, or subsections (c) or (d) of section 1915, or under a state plan amendment under section 1915(i), or if such services are provided through enrollment in a Medicaid managed care organization with a contract under section 1903(m) or under section 1932.

Since January 1, 2012, states have identified their full-benefit dually eligible beneficiaries (dual status codes 02, 04, 08) who are receiving certain home- and community-based services (HCBS) and coded these beneficiary's "H" for HCBS in the Institutional Indicator field on the MMA file.

- Y – Indicates that a full-benefit dually eligible beneficiary is enrolled in a Medicaid-paid institution for the full reporting month, or is projected by the state to be in the institution for the remainder of the month.
- H (HCBS) – Indicates that a full-benefit dually eligible beneficiary receives HCBS.

States need to submit not only accurate current-month institutional status but retroactive records reflecting institutional status changes (including H codes) in prior months. This is important so beneficiaries are charged the correct Part D copay amount. Errors in coding this field can have significant financial impacts on beneficiaries. This is also necessary to ensure that there is closure on the Part D Plan's responsibility for copay amounts during the span of coverage.

For example, if a state has reported a beneficiary 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. For more information on submitting retro DET records, refer to section 5.2.2, Retro DET records.

6.2 MMA Request File Dataset Naming Conventions

System	Type	Size	Frequency
MBD	Data File	180	PRN (States can send multiple files in a day)

This file includes the following records:

- **MMA Request File Header Record**
- **MMA Request File Detail Record**
- **MMA Request File Trailer Record**

6.3 MMA Request File Header Record Layout

MMA Request File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Record Identification Code	3	1-3	CHAR	MMA.
2	State Code	2	4-5	CHAR	US Postal Service State Abbreviation. Example = MD. See **Table 15-3, State Codes**.
3	Create Month	2	6-7	NUM	Month the file is created.
4	Create Year	4	8-11	NUM	Year the file is created.
5	Filler	169	12-180	CHAR	Spaces

6.4 MMA Request File Detail Record Layout

MMA Request File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Record Identification Code	3	1-3	CHAR	DET – Beneficiary is eligible for Medicare and is currently eligible for Medicaid or will be eligible for Medicaid within the next month. PRO – Beneficiary 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. LIS – Beneficiary has undergone a low-income subsidy determination within the current month.
2	Eligibility Month/Year	6	4-9	NUM	Calendar month/year for applicable Medicaid eligibility for DET and PRO records; MMCCYY. 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. • HICN/RRB/MBI. • 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.
3	Eligibility Status	1	10	CHAR	For DET and PRO records Y – Beneficiary is eligible for Medicaid for that eligibility Month/Year. N – Beneficiary is not eligible for Medicaid for that eligibility Month/Year. CMS will reject a PRO record with ‘N’ in this field.

MMA Request File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
4	Beneficiary's Identifier	15	11-25	CHAR	• Health Insurance Claim Number (HICN) • Railroad Retirement Board (RRB) Number • Medicare Beneficiary Identifier (MBI) Whichever the State has active and available for the beneficiary.
5	Beneficiary Identifier Indicator Code	1	26	CHAR	A code that indicates the type of identifier used for the beneficiary. The value should be one of the following. • H (HICN). • R (RRB Number). • M (MBI). • Space (Unknown).
6	Social Security Number	9	27-35	NUM	Beneficiary's SSN. CMS will reject a record with no SSN if there is no Beneficiary Identifier (Field 4) reported.
7	State Medicaid Agency (SMA) Identifier	20	36-55	CHAR	Beneficiary's State Medicaid Agency Enrollee Identifier. This field is optional as CMS does not use it.
8	Beneficiary's First Name	12	56-67	CHAR	Beneficiary's first name (first 12 letters). This entry is used only for a beneficiary secondary match.
9	Beneficiary's Last Name	20	68-87	CHAR	Beneficiary's last name (first 20 letters). This entry is used only for a beneficiary secondary match.
10	Beneficiary's Middle Name	15	88-102	CHAR	Beneficiary's middle name (first 15 letters).
11	Beneficiary's Suffix Name	4	103-106	CHAR	Beneficiary's suffix name (first four letters). Examples – 'JR', 'III'.
12	Beneficiary's Gender	1	107	CHAR	Beneficiary's gender: M = Male. F = Female. U = Unknown. 9 = Unknown. Note: U and 9 can be used interchangeably. This entry is used for a beneficiary match.

MMA Request File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
13	Beneficiary's Date of Birth	8	108-115	NUM	Enter the beneficiary's date of birth; MMDDCCYY. CMS will reject a detail record without a date of birth or with an invalid date of birth.
14	Beneficiary's Dual Status Code	2	116-117	NUM	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. 5 – Eligible is entitled to Medicare – QDWI. 6 – Eligible is entitled to Medicare – Qualifying beneficiaries. 8 – Eligible is entitled to Medicare –Other Full Dually Eligibles with full Medicaid coverage. States should submit a PRO record only for a beneficiary with full Medicaid benefits, that is, a beneficiary who if he /she had Medicare would qualify for a full dual-status code of '08'. CMS will reject PRO records with any other dual codes.
15	Federal Poverty Level Percentage Indicator	1	118	NUM	Enter one of the following values for DET and PRO record types: 1 – Beneficiary's income at or below 100% FPL. 2 – Beneficiary's income above 100% FPL. 9 – Unknown. Do not derive this value from the Dual Status Code.
16	Drug Coverage Indicator	1	119	NUM	Enter '9' in this field. This field is not used by CMS.

MMA Request File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
17	Institutional Status Indicator	1	120	CHAR	Enter one of the following values for DET and PRO records: Y – Beneficiary 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 – Beneficiary 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) – Beneficiary 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.) 9 – Unknown.
18	LIS Application Approval Code	1	121	CHAR	For LIS records Y – Beneficiary's subsidy application is approved. N – Beneficiary's subsidy application is not approved.
19	LIS Approved/ Disapproved Date	8	122-129	NUM	MMDDCCYY For LIS records, enter the date that state-approved or disapproved the low-income subsidy application.
20	LIS Start Date	8	130-137	NUM	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.

MMA Request File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
21	LIS End Date	8	138-145	NUM	MMDDCCYY For LIS records, enter the date that the subsidy ends. The day of this entry must be the last day of the month in which the subsidy ends. This field is not required and should be left blank or filled with 9s unless the state has definite knowledge of when the subsidy award ends.
22	Income as % of FPL	3	146-148	NUM	For LIS records Enter the percentage of income to Federal Poverty Level (FPL) as defined by the Federal LIS income determination policy.
23	LIS Level	3	149-151	NUM	For LIS records Enter one of the following values to describe the portion of Part D premium subsidized, based on a sliding scale linked to FPL %: 100 – under 136 % FPL, 075 – 136%-140%, 050 – 141%-145%, and 025 – 146%-149%.
24	Income Used for Determination	1	152	CHAR	For LIS records 1 – Income used for determination is based on the beneficiary. 2 – Income used for determination is based on the couple.
25	Resource Level	1	153	CHAR	For LIS records 1 – Beneficiary's resource limit is over the limit. 2 – Beneficiary's resource limit is under the limit.
26	Basis of Part D Subsidy Denial	1	154	CHAR	For LIS records Enter the reason that the State denied the subsidy application: 1 – Not enrolled in Medicare Part A or Part B (NAB). 2 – Does not reside in the USA (NUS). 3 – Failure to cooperate (FTC). 4 – Resources too high (RES). 5 – Income too high (INC).

MMA Request File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
27	Result of an Appeal	1	155	CHAR	For LIS records Y – This record is the result of an appeal. N – If a Y is not entered.
28	Change to Previous Determination	1	156	CHAR	For LIS records Y – This record changes a determination sent previously. N or 9 – This record does not change a determination sent previously. This is a future element.
29	Determination Cancelled	1	157	CHAR	For LIS records Y – This record cancels the previously sent record. N – If Y is not entered.
30	Filler	23	158-180	CHAR	Spaces

6.5 MMA Request File Trailer Record Layout

MMA Request File Trailer Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Record Identification Code	3	1-3	CHAR	TRL
2	Record Count	8	4-11	NUM	Total number of DET, PRO, and LIS records in the file.
3	State Code	2	12-13	CHAR	US Postal Service State Abbreviation. Example = MD. See Table **15-3, State Codes.**
4	Create Month	2	14-15	NUM	Month the file is created.
5	Create Year	4	16-19	NUM	Year the file is created.
6	Filler	161	20-180	CHAR	Spaces.

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7 MMA Response File

7.1 MMA Response File Specifications

This file will be automatically returned to the state upon the successful processing of an MMA Request File through the same electronic file transfer used to submit the file to CMS.

Unexpected system issues or planned outages will cause delays in states receiving the MMA Response File within the 24-48-hour window. CMS issues a notification to states via email advising of all delays. Notifications are posted on the State Data Resource Center website and can be found here: Medicare Data -> Data File Exchange-> MMA Information -> MMA Announcements or by clicking here.

The content of the MMA Response file will include the following:

1. **7.4 – MMA Response File Header Record** with identifying information, record count summaries, and a copy of the incoming MMA Request file header record, position 116-118.
2. **7.5 – MMA Response File Detail Record:**
    a. Copy of the incoming MMA Request file detail record, position 1-180.
    b. Series of edit error return codes, position 181-228.
    c. Data from the MBD, position 229-4000.
3. **7.6 – MMA Response File Summary Record** including record validation and matching outcomes, position 1-4000.
4. **7.7 – MMA Response File Monthly Summary Record** count by month for each month of enrollment information on the MMA Request file, position 1-4000.
5. **7.8 – MMA Response File Trailer Record** with identifying information and a copy of the incoming MMA Request file trailer record, position 1-4000.

7.2 Special Key Fields/User Tips for the MMA Response File

7.2.1 Medicare Part D Enrollment Indicator

The Medicare Part D Enrollment Indicator, item 57, position 236 on the MMA Response Detail record, can have the following values:

- Value will be ‘0’ for dual beneficiaries who are enrolled in a Part D plan during eligibility month/year.
- Value will be ‘1’ for dual beneficiaries who are not enrolled in a Part D Plan during eligibility month/year.

7.2.2 Managed Care Organization (MCO) (10 Occurrences)

The MCO Occurrences, items 143-154 on the MMA Response Detail record 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 occur, 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 Beneficiary MCO Number (contract level) (field 145, positions 1479-1483):

H – Local Medicare Advantage (MA), local MAPD, MMP, or non-MA Plan
9 – Non-MA Plan (no longer assigned)
R – Regional MA or MAPD Plan
S – Regular standalone Prescription Drug Plan (PDP)
E – Employer direct PDP
X – Limited-Income Newly Eligible Transition (LiNET)

7.2.3 Plan Benefit Package Enrollment (10 Occurrences)

The Plan Benefit Package Enrollment Occurrence, items 155-168, lists 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.
- A beneficiary can 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 Coverage Type Code (item 159, positions 1700-1701):
  NF – Pay bill option was not found for the contract.
  03 – Coordinated Care Plan (CCP)
  04 – Medicare Medical Savings Account (MSA)
  05 – Private Fee-for-Service (PFFS)
  06 – Program of All-Inclusive Care for the Elderly (PACE)
  07 – Regional Plan
  08 – Demonstration (DEMO)

10 – Health Care Prepayment Plan (HCPP)
11 – Part D Drug Plan Election (PDP)
12 – Chronic Care Demo
13 – Medicare Medical Savings Account Demonstration (MSA Demo)

7.2.4 Part D Plan Benefit Package (10 Occurrences)

The Part D Plan Benefit Package Occurrences (items 207-220) will list the Part D Plans which also triggers the Medicare Part D Eligibility Indicator (item 56) 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 plans offering drug coverage as well as Part D standalone plans
- A beneficiary can 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.

7.3 MMA Response File Dataset Naming Conventions

System	Type	Size	Frequency
MBD	Data File	4000	Response to MMA Request File.

This file includes the following records:

- **MMA Response File Header Record**
- **MMA Response File Detail Record**
- **MMA Response File Summary Record**
- **MMA Response File Monthly Summary Record**
- **MMA Response File Trailer Record**

7.4 MMA Response File Header Record Layout

MMA Response File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Identification Code	3	1-3	CHAR	SRF
2	File Process Timestamp	26	4-29	CHAR	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.
3	File Accept Indicator	1	30	CHAR	Y – The State file to CMS is accepted.
4	Filler	1	31	CHAR	
5	Total Records in State File	8	32-39	NUM	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

MMA Response File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
6	Duplicate Records in State File	8	40-47	NUM	The total number of duplicate DET and LIS records in the State file. This count excludes PRO records.
7	Non-Duplicate Records in State File	8	48-55	NUM	The total number of non-duplicate DET and LIS detail records in the State file. This count excludes PRO records.
8	Valid Records in State File	8	56-63	NUM	The total number of valid DET and LIS records in the State file. This count excludes PRO records.
9	Invalid Records in State File	8	64-71	NUM	The total number of invalid DET and LIS records in the State file. This count excludes PRO records.
10	Matched Records in State File	8	72-79	NUM	The total number of DET and LIS records in the files that are successfully matched to a beneficiary on the Active Medicare Beneficiary Database. This count excludes PRO records.
11	Not Matched Records in State File	8	80-87	NUM	The total number of DET and LIS records in the files that are not matched to a beneficiary on the Active Medicare Beneficiary Database. This count excludes PRO records.
12	File Create Month	2	88-89	NUM	Month the file is created.
13	File Create Year	4	90-93	NUM	Year the file is created.
14	Filler	22	94-115	CHAR	
Start of Original MMA Request File Header Record					
15	Record Identification Code	3	116-118	CHAR	A copy of the header record in the incoming file is displayed in positions 116-295.
16	State Code	2	119-120	CHAR	
17	Create Month	2	121-122	NUM	
18	Create Year	4	123-126	NUM	
19	Filler	169	127-295	CHAR	
End of Original MMA Request File Header Record					

MMA Response File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
20	Filler	3705	296-4000	CHAR	

7.5 MMA Response File Detail Record Layout

Note: The Medicare Beneficiary Identifier (MBI), items 312 – 321, will not be populated until February 2018.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
Start of Original MMA Request File Detail Record					
1	Record Identification Code	3	1-3	CHAR	A copy of the detail record in the incoming file is displayed in positions 1-180.
2	Eligibility Month/Year	6	4-9	NUM	MMCCYY
3	Eligibility Status	1	10	CHAR	
4	Beneficiary's Identifier	15	11-25	CHAR	
5	Beneficiary Identifier Indicator Code	1	26	CHAR	
6	Beneficiary's Social Security Number	9	27-35	NUM	
7	SMA Identifier	20	36-55	CHAR	
8	Beneficiary's First Name	12	56-67	CHAR	
9	Beneficiary's Last Name	20	68-87	CHAR	
10	Beneficiary's Middle Name	15	88-102	CHAR	
11	Beneficiary's Suffix Name	04	103-106	CHAR	
12	Beneficiary's Gender	01	107	CHAR	
13	Beneficiary's Date of Birth	8	108-115	NUM	MMDDCCYY
14	Dual Status Code	2	116-117	NUM	
15	FPL Percentage Indicator	1	118	NUM	
16	Drug Coverage Indicator	1	119	NUM	
17	Institutional Status Indicator	1	120	CHAR	
18	LIS Application Approval Code	1	121	CHAR	
19	LIS Approved/Disapproved Date	8	122-129	NUM	MMDDCCYY
20	LIS Start Date	8	130-137	NUM	MMDDCCYY
21	LIS End Date	8	138-145	NUM	MMDDCCYY
22	Income as % of FPL	3	146-148	NUM	
23	LIS Level	3	149-151	NUM	
24	Income used for Determination	1	152	CHAR	
25	Resource Level	1	153	CHAR	

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
26	Basis of LIS Denial	1	154	CHAR	
27	Result of an Appeal	1	155	CHAR	
28	Change to Previous Determination	1	156	CHAR	
29	Determination Cancelled	1	157	CHAR	
30	Filler	23	158-180	CHAR	
End of Original MMA Request File Detail Record					
Start of Error Return Codes (ERC)					
31	Record Identification Code ERC	2	181-182	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. Note: Detail record is valid if ERC = 00.
32	Eligibility Month/Year ERC	2	183-184	CHAR	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 the range of 01-12. 20 – Year < 2004. 37 – Month/year combination > 36 months. 99 – LIS record not scanned. Note: Detail record is valid if ERC = 00 or 99.
33	Eligibility Status ERC	2	185-186	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 06 – PRO record Eligibility Status ≠ 'Y'. 99 – LIS record not scanned. Note: Detail record is valid if ERC = 00 or 99.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
34	Beneficiary's Identifier ERC	2	187-188	CHAR	00 – Value is valid. 01 – Value is not in the 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.
35	Beneficiary Identifier Indicator Code ERC	2	189-190	CHAR	CMS does not use Beneficiary Identifier Indicator Code.
36	Beneficiary's SSN ERC	2	191-192	CHAR	00 – Value is valid. 01 – Value is not in the 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 Beneficiary's Identifier ERC = 00.
37	Beneficiary's Gender ERC	2	193-194	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. Note: Detail record is valid if ERC = 00.
38	Beneficiary's Date of Birth ERC	2	195-196	CHAR	00 – Value is valid. 02 – Value is not numeric. 04 – Date is unknown. 10 – Value is future. 11 – Month value is not within the range of 01-12. 12 – Day value is out of range. 21 – Year < 1899. Note: Detail record is valid if ERC = 00 or 21.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
39	Dual Status Code ERC	2	197-198	CHAR	00 – Value is valid. 01 – Value is not in the 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.
40	FPL % Indicator ERC	2	199-200	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 99 – LIS record not scanned. Note: Detail record is valid if ERC = 00 or 99.
41	Drug Coverage Indicator ERC	2	201-202	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 99 – LIS record not scanned. Note: Detail record is valid if ERC = 00 or 99.
42	Institutional Status Indicator ERC	2	203-204	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 99 – LIS record not scanned. Note: Detail record is valid if ERC = 00 or 99.
43	LIS Application Approval Code ERC	2	205-206	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 98 – DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
44	LIS Approved/Disapproved Date ERC	2	207-208	CHAR	00 – Value is valid. 02 – Value is not numeric. 04 – Date is unknown. 10 – Value is future. 11 – Month value is not within the 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.
45	LIS Start Date ERC	2	209-210	CHAR	00 – Value is valid. 02 – Value is not numeric. 04 – Date is unknown. 11 – Month value is not within the 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 the first day of the month. 98 – DET or PRO record not scanned. Note: Detail record is valid if ERC = 00, 37 or 98.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
46	Part D End Date ERC	2	211-212	CHAR	00 – Value is valid. 02 – Value is not numeric. 04 – Date is unknown. 11 – Month value is not within the 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.
47	Income as % of FPL ERC	2	213-214	CHAR	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.
48	LIS Level ERC	2	215-216	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 98 – DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.
49	Income Used for Determination ERC	2	217-218	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 98 – DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
50	Resource Level ERC	2	219-220	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 98 – DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.
51	Basis of Part D Subsidy Denial ERC	2	221-222	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 98 – DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.
52	Result of an Appeal ERC	2	223-224	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 98 – DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.
53	Change to Previous Determination ERC	2	225-226	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 98 – DET or PRO record not scanned Note: Detail record is valid if ERC = 00 or 98.
54	Determination Cancelled ERC	2	227-228	CHAR	00 – Value is valid. 01 – Value is not in the Valid Value Set. 98 – DET or PRO record not scanned. Note: Detail record is valid if ERC = 00 or 98.
End of Error Return Codes (ERC)					
Start of CMS Response fields from MBD					

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
55	Record Return Summary Code	6	229-234	CHAR	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 an entry that does not pass validation edits. **000005**: LIS record is rejected: record has no entry in required field or has an 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 an entry that does not pass validation edits. **000010**: PRO record is rejected: record is a duplicate of another PRO record.
55 Cont.	Record Return Summary Code Cont.				**000011**: PRO Record is rejected: record is a duplicate of a DET record in the same file. **000012:** PRO record is rejected: record is a duplicate of a DET record in the previous file.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
56	Medicare Part D Eligibility Indicator	1	235	CHAR	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.
57	Medicare Part D Enrollment Indicator	1	236	CHAR	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 Identification – The remainder of this record is filled if the beneficiary is found in the active MBD. The remainder of the record is filled with spaces (alpha-numeric fields) and zeroes (numeric fields) if the beneficiary is not found in the active MBD. Additionally, the Archive Indicator is set to 'A' if the beneficiary is found in the Archived Database.					
58	Beneficiary's Claim Account Number	9	237-245	CHAR	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.
59	Beneficiary's Identification Code (BIC)	2	246-247	CHAR	A code that is used in conjunction with the Beneficiary CAN 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.
60	Beneficiary's Birth Date	8	248-255	NUM	MMDDCCYY
61	Beneficiary's Death Date	8	256-263	NUM	MMDDCCYY

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
62	Beneficiary's Gender	1	264	CHAR	Values: 0 – Unknown 1 – Male 2 – Female
63	Beneficiary's First Name	30	265-294	CHAR	First name of the Medicare beneficiary
64	Beneficiary's Middle Name	1	295	CHAR	Middle initial of the Medicare beneficiary
65	Beneficiary's Last Name	40	296-335	CHAR	Last name of the Medicare beneficiary including any titles or suffixes.
Cross Reference Numbers (10 occurrences). The first occurrence is the active/most recent cross-reference Medicare number.					
66	Cross-Reference Beneficiary Claim Account Number (Occurrence 1)	9	336-344	CHAR	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.
67	Cross-Reference Beneficiary Identification Code (Occurrence 1)	2	345-346	CHAR	The beneficiary's identification code associated with the Medicare beneficiary's cross-referenced claim account number.
68	Cross-Reference Beneficiary Claim Account Number (Occurrence 2)	9	347-355	See item 66.	
69	Cross-Reference Beneficiary Identification Code (Occurrence 2)	2	356-357	See item 67.	
70	Cross-Reference Beneficiary Claim Account Number (Occurrence 3)	9	358-366	See item 66.	
71	Cross-Reference Beneficiary Identification Code (Occurrence 3)	2	367-368	See item 67.	
72	Cross-Reference Beneficiary Claim Account Number (Occurrence 4)	9	369-377	See item 66.	
73	Cross-Reference Beneficiary Identification Code (Occurrence 4)	2	378-379	See item 67.	

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
74	Cross-Reference Beneficiary Claim Account Number (Occurrence 5)	9	380-388	See item 66.	
75	Cross-Reference Beneficiary Identification Code (Occurrence 5)	2	389-390	See item 67.	
76	Cross-Reference Beneficiary Claim Account Number (Occurrence 6)	9	391-399	See item 66.	
77	Cross-Reference Beneficiary Identification Code (Occurrence 6)	2	400-401	See item 67.	
78	Cross-Reference Beneficiary Claim Account Number (Occurrence 7)	9	402-410	See item 66.	
79	Cross-Reference Beneficiary Identification Code (Occurrence 7)	2	411-412	See item 67.	
80	Cross-Reference Beneficiary Claim Account Number (Occurrence 8)	9	413-421	See item 66.	
81	Cross-Reference Beneficiary Identification Code (Occurrence 8)	2	422-423	See item 67.	
82	Cross-Reference Beneficiary Claim Account Number (Occurrence 9)	9	424-432	See item 66.	
83	Cross-Reference Beneficiary Identification Code (Occurrence 9)	2	433-434	See item 67.	
84	Cross-Reference Beneficiary Claim Account Number (Occurrence 10)	9	435-443	See item 66.	
85	Cross-Reference Beneficiary Identification Code (Occurrence 10)	2	444-445	See item 67.	
Social Security Numbers (5 most recent occurrences)					
86	Beneficiary Social Security Number (Occurrence 1)	9	446-454	NUM	The beneficiary's identification number was assigned by SSA.
87	Beneficiary Social Security Number (Occurrence 2)	9	455-463	See item 86.	

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
88	Beneficiary Social Security Number (Occurrence 3)	9	464-472	See item 86.	
89	Beneficiary Social Security Number (Occurrence 4)	9	473-481	See item 86.	
90	Beneficiary Social Security Number (Occurrence 5)	9	482-490	See item 86.	
Mailing Address – This may be the mailing address of the beneficiary or the mailing address of his/her representative payee.					
91	Mailing Address Line 1	40	491-530	CHAR	1st line of address
92	Mailing Address Line 2	40	531-570	CHAR	2nd line of address
93	Mailing Address Line 3	40	571-610	CHAR	3rd line of address
94	Mailing Address Line 4	40	611-650	CHAR	4th line of address
95	Mailing Address Line 5	40	651-690	CHAR	5th line of address
96	Mailing Address Line 6	40	691-730	CHAR	6th line of address
97	Mailing Address City Name	40	731-770	CHAR	City name
98	Mailing Address State Code	2	771-772	CHAR	Postal state code
99	Mailing Address Zip Code	9	773-781	CHAR	ZIP
100	Mailing Address Change Date	8	782-789	NUM	MMDDCCYY The date a new or corrected address becomes effective for a Medicare beneficiary.
Residence Address The beneficiary's most recent residence address					
101	Residence Address Line 1	60	790-849	CHAR	
102	Filler	180	850-1029	CHAR	Spaces
103	Residence Address City Name	40	1030-1069	CHAR	
104	Residence Address State Code	2	1070-1071	CHAR	
105	Residence Address Zip code	9	1072-1080	CHAR	
106	Residence Address Change Date	8	1081-1088	NUM	MMDDCCYY
107	Beneficiary Representative Payee Switch	1	1089	CHAR	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.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
108	Part A Non-Entitlement Status Code	1	1090	CHAR	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.
109	Part B Non-Entitlement Status Code	1	1091	CHAR	Indicator/reason for a beneficiary's current non-entitlement status to Part B Medicare benefits. Values are: D – Coverage was denied. N – Not entitled. R – Refused benefits. Space – No non-entitlement reason applies to the beneficiary.
Entitlement Reason (five most recent occurrences)					
110	Beneficiary Entitlement Reason Code Change Date (Occurrence 1)	8	1092-1099	NUM	MMDDCCYY
111	Beneficiary' Entitlement Reason Code (Occurrence 1)	4	1100-1103	CHAR	
112	Beneficiary Entitlement Reason (Occurrence 2)	12	1104-1115	See items 110 and 111	

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
113	Beneficiary Entitlement Reason (Occurrence 3)	12	1116-1127	See items 110 and 111	
114	Beneficiary Entitlement Reason (Occurrence 4)	12	1128-1139	See items 110 and 111	
115	Beneficiary Entitlement Reason (Occurrence 5)	12	1140-1151	See items 110 and 111	
Part A Entitlement (five most recent occurrences)					
116	Beneficiary Part A Entitlement Start Date (Occurrence 1)	8	1152-1159	NUM	MMDDCCYY. The date beneficiary became entitled to Medicare benefits. This field is filled with zeroes if no Part A Entitlement Start Date is found.
117	Beneficiary Part A Entitlement End Date (Occurrence 1)	8	1160-1167	NUM	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.

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

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
119	Beneficiary Part A Entitlement Status Code (Occurrence 1)	1	1169	CHAR	Values: E – Free Part A Entitlement. G – Entitled due to good cause. Y – Currently entitled, premium is payable. Values when there is a termination date: C – No longer entitled due to disability cessation. S – Terminated, no longer entitled under ESRD provision. T – Terminated for non-payment of premiums. W – Voluntary withdrawal from premium coverage. X – Free Part A terminated or refused HI. This field is filled with a space if no entitlement period is found.
120	Part A Entitlement (Occurrence 2)	18	1170-1187	See items 116 – 119	Same as Occurrence 1.
121	Part A Entitlement (Occurrence 3)	18	1188-1205	See items 116 – 119	Same as Occurrence 1.
122	Part A Entitlement (Occurrence 4)	18	1206-1223	See items 116 – 119	Same as Occurrence 1.
123	Part A Entitlement (Occurrence 5)	18	1224-1241	See items 116 – 119	Same as Occurrence 1.
Part B Entitlement (five occurrences)					
124	Beneficiary Part B Enrollment Start Date (Occurrence 1)	8	1242-1249	NUM	MMDDCCYY This field is filled with zeroes if no Part B enrollment period is found.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
125	Beneficiary Part B Enrollment End Date (Occurrence 1)	8	1250-1257	NUM	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.
126	Beneficiary Part B Enrollment Reason Code (Occurrence 1)	1	1258	CHAR	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. P -–Medicare Part B Immunosuppressive Drug (Part B-ID) R – Residency requirements are involved. S – State buy-in. T – Disabled working beneficiary. U –Unknown. This field is filled with a space if no enrollment is found.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
127	Beneficiary Part B Enrollment Status Code (Occurrence 1)	1	1259	CHAR	Values when there is a Part B Enrollment Start Date and no Part B Enrollment End Date: G – Enrolled due to good cause. Y – Currently enrolled, premium is payable. Values when Part B Enrollment End Date is present: C – No longer entitled due to disability cessation. F – Terminated due to invalid enrollment or enrollment voided. S – Terminated, no longer entitled under ESRD provision. T – Terminated for non-payment of premiums. W – Voluntary withdrawal from premium coverage. This field is filled with a space if no enrollment is found.
128	Part B Enrollment (Occurrence 2)	18	1260-1277	See items 124 – 127.	Same as Occurrence 1.
129	Part B Enrollment (Occurrence 3)	18	1278-1295	See items 124 – 127.	Same as Occurrence 1.
130	Part B Enrollment (Occurrence 4)	18	1296-1313	See items 124 – 127.	Same as Occurrence 1.
131	Part B Enrollment (Occurrence 5)	18	1314-1331	See items 124 – 127.	Same as Occurrence 1.
Hospice Coverage (five most recent occurrences)					
132	Beneficiary Hospice Coverage Start Date (Occurrence 1)	8	1332-1339	NUM	MMCCDDYY. This field is filled with zeroes if the beneficiary has no hospice benefit or coverage.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
133	Beneficiary Hospice Coverage End Date (Occurrence 1)	8	1340-1347	NUM	MMDDCCYY If hospice coverage has a valid Hospice Start Date and no Hospice End Date, then this field is filled with 9s. If there is no Hospice Start Date, then this field is filled with zeroes.
134	Beneficiary Hospice Coverage (Occurrence 2)	16	1348-1363	See items 132 – 133.	Same as Occurrence 1.
135	Beneficiary Hospice Coverage (Occurrence 3)	16	1364-1379	See items 132 – 133.	Same as Occurrence 1.
136	Beneficiary Hospice Coverage (Occurrence 4)	16	1380-1395	See items 132 – 133.	Same as Occurrence 1.
137	Beneficiary Hospice Coverage (Occurrence 5)	16	1396-1411	See items 132 – 133.	Same as Occurrence 1.
Disability Insurance Benefits (3 most recent occurrences)					
138	Beneficiary Disability Insurance Benefits (DIB) Entitlement Start Date (Occurrence 1)	8	1412-1419	NUM	MMDDCCYY. The date that a beneficiary covered by the SSA disability program becomes entitled to Medicare benefits. If no DIB Entitlement Start Date is found, then this field is filled with zeroes.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
139	Beneficiary DIB Entitlement End Date (Occurrence 1)	8	1420-1427	NUM	MMDDCCYY The date that a beneficiary covered by the SSA disability program is no longer entitled to Medicare benefits. If there is a valid DIB Entitlement Start Date and no DIB Entitlement End Date, then this field is filled with 9s. If there is no DIB Entitlement Start Date and no DIB Entitlement End Date, then this field is filled with zeroes.
140	Beneficiary DIB Entitlement Date Justification Code (Occurrence 1)	1	1428	CHAR	The justification code for a beneficiary's Part A and /or Part B Medicare benefit dates based upon the 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. H – Beneficiary is entitled to Medicare due to health hazards. This field will have a space if no DIB is found.
141	Beneficiary DIB Entitlement (Occurrence 2)	17	1429-1445	See items 138 – 140.	Same as Occurrence 1.
142	Beneficiary DIB Entitlement (Occurrence 3)	17	1446-1462	See items 138 – 140.	Same as Occurrence 1.
Managed Care Organization (10 most recent occurrences)					

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
143	Beneficiary Managed Care Organization (MCO) Enrollment Start Date (Occurrence 1)	8	1463-1470	NUM	MMDDCCYY. This field is filled with zeroes if no managed care organization enrollment is found.
144	Beneficiary MCO Enrollment End Date (Occurrence 1)	8	1471-1478	NUM	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 an MCO Contract Enrollment Start Date and no MCO Contract Enrollment End Date.
145	Beneficiary MCO Number (contract level) (Occurrence 1)	5	1479-1483	CHAR	Unique identification for an agreement between CMS and an MCO. The organizations can be distinguished by the first position: H – Local MA, local MAPD, or non-MA Plan. 9 – Non-MA Plan (no longer assigned). R – Regional MA or MAPD Plan. S – Regular standalone Prescription Drug Plan (PDP). E – Employer direct PDP. X – Limited-Income Newly Eligible Transition (LiNET). Note: Stand-alone plans are not included in this section. This field is filled with spaces if no enrollment is found.
146	Beneficiary MCO (Occurrence 2)	21	1484-1504	See items 143 – 145.	Same as Occurrence 1.
147	Beneficiary MCO (Occurrence 3)	21	1505-1525	See items 143 – 145.	Same as Occurrence 1.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
148	Beneficiary MCO (Occurrence 4)	21	1526-1546	See items 143 – 145.	Same as Occurrence 1.
149	Beneficiary MCO (Occurrence 5)	21	1547-1567	See items 143 – 145.	Same as Occurrence 1.
150	Beneficiary MCO (Occurrence 6)	21	1568-1588	See items 143 – 145.	Same as Occurrence 1.
151	Beneficiary MCO (Occurrence 7)	21	1589-1609	See items 143 – 145.	Same as Occurrence 1.
152	Beneficiary MCO (Occurrence 8)	21	1610-1630	See items 143 – 145.	Same as Occurrence 1.
153	Beneficiary MCO (Occurrence 9)	21	1631-1651	See items 143 – 145.	Same as Occurrence 1.
154	Beneficiary MCO (Occurrence 10)	21	1652-1672	See items 143 – 145.	Same as Occurrence 1.
Plan Benefits Package Election (10 most recent occurrences)					
155	Group Health Plan Enrollment Start Date (Occurrence 1)	8	1673-1680	NUM	MMDDCCYY. The date of the beneficiary's enrollment at the contract level. This field is filled with zeroes if there is no enrollment found.
156	Plan Benefit Package (PBP) Enrollment Start Date (Occurrence 1)	8	1681-1688	NUM	MMDDCCYY. The date of the beneficiary's enrollment at the PBP level. This field is filled with zeroes if the beneficiary has no PBP enrollment.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
157	Plan Benefit Package Enrollment End Date (Occurrence 1)	8	1689-1696	NUM	MMDDCCYY. 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.
158	Plan Benefit Package Number (Occurrence 1)	3	1697-1699	CHAR	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'.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
159	Plan Benefit Package Coverage Type Code (Occurrence 1)	2	1700-1701	CHAR	Identifies the type of managed care plan benefit package in which the beneficiary is enrolled. Values: NF – Pay bill option not found for this contract. 03 – CCP (Coordinated Care Plan). 04 – MSA (Medicare Medical Savings Account). 05 – PFFS (Private Fee for Service). 06 – PACE (Program of All-Inclusive Care for the Elderly). 07 – Regional. 08 – Demo (Demonstration). 09 – FFS (Fee for Service). 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. 14 – MMP (Medicare/Medicaid Plan). This field is filled with spaces if no PBP enrollment is found.
160	PBP Enrollment (Occurrence 2)	29	1702-1730	See items 155 – 159.	Same as Occurrence 1.
161	PBP Enrollment (Occurrence 3)	29	1731-1759	See items 155 – 159.	Same as Occurrence 1.
162	PBP Enrollment (Occurrence 4)	29	1760-1788	See items 155 – 159.	Same as Occurrence 1.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
163	PBP Enrollment (Occurrence 5)	29	1789-1817	See items 155 – 159.	Same as Occurrence 1.
164	PBP Enrollment (Occurrence 6)	29	1818-1846	See items 155 – 159.	Same as Occurrence 1.
165	PBP Enrollment (Occurrence 7)	29	1847-1875	See items 155 – 159.	Same as Occurrence 1.
166	PBP Enrollment (Occurrence 8)	29	1876-1904	See items 155 – 159.	Same as Occurrence 1.
167	PBP Enrollment (Occurrence 9)	29	1905-1933	See items 155 – 159.	Same as Occurrence 1.
168	PBP Enrollment (Occurrence 10)	29	1934-1962	See items 155 – 159.	Same as Occurrence 1.
End-Stage Renal Disease Coverage					
169	Beneficiary ESRD Coverage Start Date	8	1963-1970	NUM	MMDDCCYY. The date on which the beneficiary is entitled to Medicare in some part because of a diagnosis of End-Stage Renal Disease. This field is filled with zeroes if the beneficiary has no ESRD coverage.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
170	Beneficiary ESRD Coverage End Date	8	1971-1978	MMDD CCYY	MMDDCCYY. The date on which the beneficiary is no longer entitled to Medicare under ESRD provision. This field is filled with zeroes if the beneficiary has no ESRD coverage. This field is filled with 9s if there is no ESRD Coverage End Date.
171	Beneficiary ESRD Termination Reason Code	1	1979	CHAR	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 the beneficiary has no ESRD coverage or if there is no ESRD Coverage End Date.
End-Stage Renal Disease Clinical Dialysis Dates. See items 267 – 271 (positions 3114 through 3193) for occurrences 2 – 6, sorted in descending order by Start Date.					
172	Beneficiary ESRD Clinical Dialysis Start Date (Occurrence 1) Occurrence 1 is the latest dialysis period if multiple periods exist.	8	1980-1987	NUM	MMDDCCYY. The date when ESRD dialysis starts. This field is filled with zeroes if the beneficiary has no ESRD Dialysis Start Date.
173	Beneficiary ESRD Clinical Dialysis End Date (Occurrence 1)	8	1988-1995	NUM	MMDDCCYY. The date when ESRD dialysis ends. This field is filled with zeroes if the beneficiary has no ESRD Dialysis Start Date. This field is filled with 9s if there is no ESRD Dialysis End Date.
End-Stage Renal Disease Transplant					

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
174	Beneficiary ESRD Transplant Start Date	8	1996-2003	NUM	MMDDCCYY. The date that a kidney transplant operation occurred. This field is filled with zeroes when no ESRD Transplant Start Date is found.
175	Beneficiary ESRD Transplant End Date	8	2004-2011	NUM	MMDDCCYY. The date that a kidney transplant fails or transplant benefit ends. This field is filled with zeroes when no ESRD Transplant Start Date is found. This field is filled with 9s when there is a valid ESRD Transplant Start Date and there is no ESRD Transplant End Date.
Third-Party Part A History (5 most recent occurrences)					
176	Beneficiary Part A Third-Party Start Date (Occurrence 1)	8	2012-2019	NUM	MMDDCCYY. The start date of a private third-party group's or State's liability for a beneficiary's Part A premium. This field is filled with zeroes if there is no Part A Third-Party Start Date.
177	Beneficiary Part A Third-Party Premium Payer Code (Occurrence 1)	3	2020-2022	CHAR	The identifier for a third-party agency (either a private group or State buy-in agency) responsible for paying a beneficiary's Medicare Part A premium. Values: S01 thru S99 – State Billing and T01 thru Z98 – Private Third-Party Billing

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
178	Beneficiary Part A Third-Party End Date (Occurrence 1)	8	2023-2030	NUM	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.
179	Beneficiary Part A Third-Party Buy-in Eligibility Code (Occurrence 1)	1	2031	CHAR	This data element is obsolete.
180	Third-Party Part A History (Occurrence 2)	20	2032-2051	See items 176 – 179.	Same as Occurrence 1.
181	Third-Party Part A History (Occurrence 3)	20	2052-2071	See items 176 – 179.	Same as Occurrence 1.
182	Third-Party Part A History (Occurrence 4)	20	2072-2091	See items 176 – 179.	Same as Occurrence 1.
183	Third-Party Part A History (Occurrence 5)	20	2092-2111	See items 176 – 179.	Same as Occurrence 1.
Third-Party Part B History (5 most recent occurrences)					
184	Beneficiary Part B Third-Party Start Date (Occurrence 1)	8	2112-2119	NUM	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.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
185	Beneficiary Part B Third-Party Premium Payer Code (Occurrence 1)	3	2120-2122	CHAR	The identifier for a third-party agency (either a private group, state buy-in agency or the Office of Personnel Management (OPM)) is 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.
186	Beneficiary Part B Third-Party Termination Date (Occurrence 1)	8	2123-2130	NUM	MMDDCCYY. The end date of a private third-party group's or state's liability for a beneficiary's Part B premium. This field is filled with zeroes if no Part B Third-Party Start Date is found. This field is filled with 9s if there is a Third-Party Start Date and no Third-Party End Date.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
187	Beneficiary Part B Third-Party Buy-in Eligibility Code (Occurrence 1)	1	2131	CHAR	Reason for Part B State buy-in eligibility. Values: A – Aged recipient of SSI payments (CMS to State). B – Blind recipient of SSI payments (CMS to State). C – Entitled to Part A of Title IV (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). Z – Deemed categorically needy (State to CMS). Note: States can use any other alphabetic character.
188	Third-Party Part B History (Occurrence 2)	20	2132-2151	See items 184 – 187.	Same as Occurrence 1.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
189	Third-Party Part B History (Occurrence 3)	20	2152-2171	See items 184 – 187.	Same as Occurrence 1.
190	Third-Party Part B History (Occurrence 4)	20	2172-2191	See items 184 – 187.	Same as Occurrence 1.
191	Third-Party Part B History (Occurrence 5)	20	2192-2211	See items 184 – 187.	Same as Occurrence 1.
Part D Data Elements					
192	Beneficiary Part D Eligibility Start Date	8	2212-2219	NUM	MMDDCCYY. 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.
193	Beneficiary Part D Opt-Out Indicator	1	2220	CHAR	An indicator that the beneficiary chooses not to be automatically enrolled by CMS into a Part D plan. Values: Y – Yes. N – No. Space – No.
Beneficiary's Co-Payment History (10 occurrences) The first occurrence is the active/most recent co-payment period.					

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
194	Beneficiary Co-Payment Type (Occurrence 1)	1	2221	CHAR	A code indicating whether the beneficiary was determined eligible for low-income subsidy (LIS) or deemed eligible. Values: L – Determined eligible. D – Deemed.
195	Beneficiary Co-Payment Level (Occurrence 1)	1	2222	CHAR	An indicator providing the level of co-payment granted to the beneficiary. Values: If bene co-pay type is 'L', then 1 – high. 4 – 15%. If bene co-pay type is 'D', then: 1 – high. 2 – low. 3 – 0 (zero).
196	Beneficiary Co-Payment Start Date (Occurrence 1)	8	2223-2230	NUM	MMDDCCYY. The effective date of the co-payment period. This field is filled with zeroes if there is no Co-Payment Start Date.
197	Beneficiary Co-Payment End Date (Occurrence 1)	8	2231-2238	NUM	MMDDCCYY. 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.
198	Beneficiary Co-Payment History (Occurrence 2)	18	2239-2256	See items 194 – 197.	Same as Occurrence 1.
199	Beneficiary Co-Payment History (Occurrence 3)	18	2257-2274	See items 194 – 197.	Same as Occurrence 1.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
200	Beneficiary Co-Payment History (Occurrence 4)	18	2275-2292	See items 194 – 197.	Same as Occurrence 1.
201	Beneficiary's Co-Payment History (Occurrence 5)	18	2293-2310	See items 194 – 197.	Same as Occurrence 1.
202	Beneficiary's Co-Payment History (Occurrence 6)	18	2311-2328	See items 194 – 197.	Same as Occurrence 1.
203	Beneficiary's Co-Payment History (Occurrence 7)	18	2329-2346	See items 194 – 197.	Same as Occurrence 1.
204	Beneficiary's Co-Payment History (Occurrence 8)	18	2347-2364	See items 194 – 197.	Same as Occurrence 1.
205	Beneficiary's Co-Payment History (Occurrence 9)	18	2365-2382	See items 194 – 197.	Same as Occurrence 1.
206	Beneficiary's Co-Payment History (Occurrence 10)	18	2383-2400	See items 194 – 197.	Same as Occurrence 1.
Part D Plan Benefit Package (10 most recent occurrences)					
207	Beneficiary Contract Number (Occurrence 1)	5	2401-2405	CHAR	Unique identification for an agreement between CMS and an MCO or PDP sponsor enabling the Plan to provide Medicare Part D prescription drug coverage.
208	Beneficiary Part D PBP Enrollment Start Date (Occurrence 1)	8	2406-2413	NUM	MMDDCCYY. 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

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
209	Beneficiary Part D PBP Enrollment End Date (Occurrence 1)	8	2414-2421	NUM	MMDDCCYY. The end date of the beneficiary's enrollment in the plan benefit package. This field is filled with zeroes if there is no Part D PBP Enrollment Start Date. This field is filled with 9s if there is a Part D PBP Enrollment Start Date and no Part D PBP Enrollment End Date.
210	Beneficiary Part D PBP Plan Number (Occurrence 1)	3	2422-2424	CHAR	A unique identifier for the managed care benefit package.
211	Beneficiary Enrollment Type Code (Occurrence 1)	1	2425	CHAR	An indicator providing the type of enrollment performed. Values: A: Auto enrolled by CMS. B: Beneficiary election. C: Facilitated enrollment by CMS. D: CMS Annual Rollover. E: Plan submitted auto-enrollments. F: Plan submitted facilitated enrollments. G: Point of Sale (POS) submitted enrollments. H: CMS or plan submitted re-assignment enrollments. I: Invalid Submitted Value. J: State-submitted MMP passive enrollment. K: CMS-submitted MMP passive enrollment. L: Beneficiary MMP election. M: Default for Financial Alignment Demo Plan enrollments submitted without an Enrollment Source Code (M is not submitted on an enrollment). N: Rollover by plan transaction.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
212	Part D Plan Benefit Package (Occurrence 2)	25	2426-2450	See items 207 – 211.	Same as Occurrence 1.
213	Part D Plan Benefit Package (Occurrence 3)	25	2451-2475	See items 207 – 211.	Same as Occurrence 1.
214	Part D Plan Benefit Package (Occurrence 4)	25	2476-2500	See items 207 – 211.	Same as Occurrence 1.
215	Part D Plan Benefit Package (Occurrence 5)	25	2501-2525	See items 207 – 211.	Same as Occurrence 1.
216	Part D Plan Benefit Package (Occurrence 6)	25	2526-2550	See items 207 – 211.	Same as Occurrence 1.
217	Part D Plan Benefit Package (Occurrence 7)	25	2551-2575	See items 207 – 211.	Same as Occurrence 1.
218	Part D Plan Benefit Package (Occurrence 8)	25	2576-2600	See items 207 – 211.	Same as Occurrence 1.
219	Part D Plan Benefit Package (Occurrence 9)	25	2601-2625	See items 207 – 211.	Same as Occurrence 1.
220	Part D Plan Benefit Package (Occurrence 10)	25	2626-2650	See items 207 – 211.	Same as Occurrence 1.
221	Part C Organization Name (contract level)	55	2651-2705	CHAR	Relates to the first occurrence of the beneficiary's MCO contract number in item 145 (positions 1479-1483).
222	Part C PBP Name	50	2706-2755	CHAR	Relates to the first occurrence of the beneficiary's PBP in item 158 (positions 1697-1699).

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
223	Part D Organization Name (contract level)	55	2756-2810	CHAR	Relates to the first occurrence of the beneficiary's contract number in Part D PBP in item 207 (positions 2401-2405).
224	Part D PBP Name	50	2811-2860	CHAR	Relates to the first occurrence of the beneficiary's PBP in item 210 (positions 2422-2424).
225	Part D Organization Plan Benefit	1	2861	CHAR	This field is filled with a space.
226	Beneficiary Language Indicator	1	2862	CHAR	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 and Spanish assumed for Puerto Rican ZIP codes. E – English requested (allowed only for Puerto Rican ZIP codes). S – Spanish requested.
227	Special Needs Plan (SNP) Indicator (Occurrence 1)	1	2863	CHAR	Indicates that the beneficiary is enrolled in a special needs plan. Values: Y – SNP, and N – Not SNP. Corresponds to the first occurrence of plan benefit package in item 159 (positions 1700-1701).
228	SNP Indicator (Occurrence 2)	1	2864	See item 227.	Same as Occurrence 1. Corresponds to Occurrence 2 of plan benefit package in item 160 (positions 1702-1730).
229	SNP Indicator (Occurrence 3)	1	2865	See item 227.	Same as Occurrence 1. Corresponds to Occurrence 3 of plan benefit package in item 161 (positions 1731-1759).
230	SNP Indicator (Occurrence 4)	1	2866	See item 227.	Same as Occurrence 1. Corresponds to Occurrence 4 of plan benefit package in item 162 (positions 1760-1788).

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
231	SNP Indicator (Occurrence 5)	1	2867	See item 227.	Same as Occurrence 1. Corresponds to Occurrence 5 of plan benefit package in item 163 (positions 1789-1817).
232	SNP Indicator (Occurrence 6)	1	2868	See item 227.	Same as Occurrence 1. Corresponds to Occurrence 6 of plan benefit package in item 164 (positions 1818-1846).
233	SNP Indicator (Occurrence 7)	1	2869	See item 227.	Same as Occurrence 1. Corresponds to Occurrence 7 of plan benefit package in item 165 (positions 1847-1875).
234	SNP Indicator (Occurrence 8)	1	2870	See item 227.	Same as Occurrence 1. Corresponds to Occurrence 8 of plan benefit package in item 166 (positions 1876-1904).
235	SNP Indicator (Occurrence 9)	1	2871	See item 227.	Same as Occurrence 1. Corresponds to Occurrence 9 of plan benefit package in item 167 (positions 1905-1933).
236	SNP Indicator (Occurrence 10)	1	2872	See item 227.	Same as Occurrence 1. Corresponds to Occurrence 10 of plan benefit package in item 168 (positions 1934-1962).
Medicare Plan Ineligibility Due to Incarceration Periods, Ten Occurrences (sorted from latest to earliest based on Medicare Plan Ineligibility Due to Incarceration Start Date). See items 274 – 291 (positions 3196-3339) for occurrences 2-10.					
237	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 1)	8	2873-2880	NUM	MMDDCCYY. This date is provided solely to show why a dual eligible is not auto-enrolled. If there is no Medicare Plan Ineligibility Due to Incarceration Start Date, then this field is filled with zeroes.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
238	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 1)	8	2881-2888	NUM	MMDDCCYY. This date is provided solely to show why a dual eligible is not auto-enrolled. If there is no Medicare Plan Ineligibility Due to Incarceration Start Date and no Medicare Plan Ineligibility Due to Incarceration End Date, then this field is filled with zeroes. If there is a Medicare Plan Ineligibility Due to Incarceration Start Date and no Medicare Plan Ineligibility Due to Incarceration End Date, then this field is filled with 9s.
239	Filler	11	2889-2899	CHAR	Spaces.
240	Previous Month SPD Calculation Code	1	2900	CHAR	Code that indicates how beneficiary was last classified in enrollment and disenrollment counts for the Eligibility Month/Year of 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 indicates future Medicaid DET records), P – Prospective Duals, not considered in Clawback counts, and Space – No historical entries found for this Eligibility Month/Year.
Special Codes					

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
241	Secondary Match Indicator	1	2901	CHAR	This field indicates if the process was able to match the Detail record in the related Request file under the Secondary Beneficiary Match algorithm. This algorithm uses values for the following fields from the beneficiary's Detail record in the Request file: • Individual Medicare Identifier (i.e., the HICN, RRB Number, or MBI) and/or the Individual SSN. • First six characters of the Individual Last Name. • First letter of the Individual First Name. • Sex Code. The process will return one of the following values: • Space – The process found a match for the beneficiary, but it did not use the Secondary Beneficiary Match algorithm to do so or the process did not find a match for the beneficiary. • S – The process used the Secondary Beneficiary Match algorithm to match the beneficiary). **Note**: A matched detail record is indicated by the presence of alphanumeric values in the fields 'Beneficiary Claim Account Number' and 'Beneficiary Identification Code' (fields 58 and 59) and a Record Return Code (RRC) of '000000' or '000001'.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
242	Daily State Phase-Down Calculation Code	1	2902	CHAR	Code that indicates how the 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) Coverage Periods (5 most recent occurrences)					
243	RDS Start Date (Occurrence 1)	8	2903-2910	NUM	MMDDCCYY. The start date of the beneficiary's enrollment in an employer plan. If there is no RDS Start Date, then this field is filled with zeroes.
244	RDS Termination Date (Occurrence 1)	8	2911-2918	NUM	MMDDCCYY. The end date of the beneficiary's enrollment in an employer plan. If there are multiple RDS coverage periods, overlapping dates are possible. If there is no RDS Start Date, then this field is filled with zeroes. If there is an RDS Start Date and no RDS End Date, then this field is filled with 9s.
245	RDS Coverage Period (Occurrence 2)	16	2919-2934	See items 243 – 244.	Same as Occurrence 1.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
246	RDS Coverage Period (Occurrence 3)	16	2935-2950	See items 243 – 244.	Same as Occurrence 1.
247	RDS Coverage Period (Occurrence 4)	16	2951-2966	See items 243 – 244.	Same as Occurrence 1.
248	RDS Coverage Period (Occurrence 5)	16	2967-2982	See items 243 – 244.	Same as Occurrence 1.
249	Filler	1	2983	CHAR	Spaces.
Part D Eligibility (5 most recent occurrences)					
250	Part D Eligibility Start Date (Occurrence 1)	8	2984-2991	NUM	MMDDCCYY. Indicates the date that the beneficiary became eligible for Part D benefits. This field is filled with zeroes if no Part 8D Eligibility Start Date is found.
251	Part D Eligibility End Date (Occurrence 1)	8	2992-2999	NUM	Indicates the date that the 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.
252	Part D Eligibility Dates (Occurrence 2)	16	3000-3015	See items 250 – 251.	Same as Occurrence 1.
253	Part D Eligibility Dates (Occurrence 3)	16	3016-3031	See items 250 – 251.	Same as Occurrence 1.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
254	Part D Eligibility Dates (Occurrence 4)	16	3032-3047	See items 250 – 251.	Same as Occurrence 1.
255	Part D Eligibility Dates (Occurrence 5)	16	3048-3063	See items 250 – 251.	Same as Occurrence 1.
Beneficiary Part D Low-Income Subsidy Information (10 most recent occurrences)					
256	Subsidy Level (Occurrence 1)	3	3064-3066	CHAR	Identifies the portion of the Part D Premium subsidized. Values: 100 075 050 025 Relates to the numbered occurrences of the Beneficiary Co-Payment History, e.g. first occurrence here relates to the first occurrence of Co-Payment in item 195 (position 2222).
257	LIS/Deem Source code (Occurrence 1)	2	3067-3068	CHAR	Indicates the source of the LIS/Deeming action found in Co-Payment History Occurrence, item 194 (position 2221) and Subsidy Level, item 256 (position3064). Values for D (Deemed): 01 – MBD Third Party. 02 – EEVS (State data baseline). 03 – SSA. 04 – State. 05 – Point of Sale. 06 – CMS User. Values for L (LIS): SS – SSA. <ST> – Postal State Code Abbreviation.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
258	Beneficiary LIS Premium Percentage and Source (Occurrence 2)	5	3069-3073	See items 256 – 257.	Same as Occurrence 1.
259	Beneficiary LIS Premium Percentage and Source (Occurrence 3)	5	3074-3078	See items 256 – 257.	Same as Occurrence 1.
260	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 4)	5	3079-3083	See items 256 – 257.	Same as Occurrence 1.
261	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 5)	5	3084-3068	See items 256 – 257.	Same as Occurrence 1.
262	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 6)	5	3069-3093	See items 256 – 257.	Same as Occurrence 1.
263	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 7)	5	3094-3098	See items 256 – 257.	Same as Occurrence 1.
264	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 8)	5	3099-3103	See items 256 – 257.	Same as Occurrence 1.
265	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 9)	5	3104-3108	See items 256 – 257.	Same as Occurrence 1.
266	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 10)	5	3109-3113	See items 256 – 257.	Same as Occurrence 1.
Beneficiary ESRD Clinical Dialysis Dates Occurrences 2 – 6, sorted from latest to earliest based on ESRD start date (refer to items 172-173, position 1980 for the first occurrence).					
267	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 2)	16	3114-3129	See items 172 – 173.	Same as Occurrence 1.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
268	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 3)	16	3130-3145	See items 172 – 173.	Same as Occurrence 1.
269	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 4)	16	3146-3161	See items 172 – 173.	Same as Occurrence 1.
270	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 5)	16	3162-3177	See items 172 – 173.	Same as Occurrence 1.
271	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 6)	16	3178-3193	See items 172 – 173.	Same as Occurrence 1.
272	Beneficiary Archive Indicator	1	3194	CHAR	Indicates that beneficiary is in Archived Medicare Beneficiary Database. A – Archived space – Not archived or not found in database
273	Medicare-Medicaid Plan (MMP) Opt-Out Indicator	1	3195	CHAR	Indicates that the beneficiary has opted out of an MMP Y – Beneficiary has affirmatively opted out of the Financial Alignment Demonstration. N – Beneficiary has not opted out of the Financial Alignment Demonstration. Space – There is no opt-out information available (should be interpreted as the beneficiary has not opted out).
274	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 2)	8	3196-3203	See item 237.	MMDDCCYY.
275	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 2)	8	3204-3211	See item 238.	MMDDCCYY.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
276	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 3)	8	3212-3219	See item 237.	MMDDCCYY.
277	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 3)	8	3220-3227	See item 238.	MMDDCCYY.
278	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 4)	8	3228-3235	See item 237.	MMDDCCYY.
279	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 4)	8	3236-3243	See item 238.	MMDDCCYY.
280	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 5)	8	3244-3251	See item 237.	MMDDCCYY.
281	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 5)	8	3252-3259	See item 238.	MMDDCCYY.
282	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 6)	8	3260-3267	See item 237.	MMDDCCYY.
283	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 6)	8	3268-3275	See item 238.	MMDDCCYY.
284	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 7)	8	3276-3283	See item 237.	MMDDCCYY.
285	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 7)	8	3284-3291	See item 238.	MMDDCCYY.
286	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 8)	8	3292-3299	See item 237.	MMDDCCYY.
287	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 8)	8	3300-3307	See item 238.	MMDDCCYY.
288	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 9)	8	3308-3315	See item 237.	MMDDCCYY.
289	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 9)	8	3316-3323	See item 238.	MMDDCCYY.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
290	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 10)	8	3324-3331	See item 237.	MMDDCCYY.
291	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 10)	8	3332-3339	See item 238.	MMDDCCYY.
292	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 1)	8	3340-3347	NUM	MMDDCCYY. This date is provided solely to show why a dual eligible is not auto-enrolled. If there is no Medicare Plan Ineligibility Due to Not Lawful Presence Start Date and no Medicare Plan Ineligibility Due to Not Lawful Presence End Date, then this field is filled with zeroes. If there is a Medicare Plan Ineligibility Due to Not Lawful Presence Start Date and no Medicare Plan Ineligibility Due to Not Lawful Presence End Date, then this field is filled with nines.
293	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 1)	8	3348-3355	NUM	MMDDCCYY. This date is provided solely to show why a dual eligible is not auto-enrolled. If there is no Medicare Plan Ineligibility Due to Not Lawful Presence Start Date and no Medicare Plan Ineligibility Due to Not Lawful Presence End Date, then this field is filled with zeroes. If there is a Medicare Plan Ineligibility Due to Not Lawful Presence End Date, then this field is filled with nines.
294	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 2)	8	3356-3363	See item 292.	MMDDCCYY

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
295	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 2)	8	3364-3371	See item 293.	MMDDCCYY
296	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 3)	8	3372-3379	See item 292.	MMDDCCYY
297	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 3)	8	3380-3387	See item 293.	MMDDCCYY
298	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 4)	8	3388-3395	See item 292.	MMDDCCYY
299	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 4)	8	3396-3403	See item 293.	MMDDCCYY
300	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 5)	8	3404-3411	See item 292.	MMDDCCYY
301	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 5)	8	3412-3419	See item 293.	MMDDCCYY
302	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 6)	8	3420-3427	See item 292.	MMDDCCYY
303	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 6)	8	3428-3435	See item 293.	MMDDCCYY
304	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 7)	8	3436-3443	See item 292.	MMDDCCYY

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
305	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 7)	8	3444-3451	See item 293.	MMDDCCYY
306	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 8)	8	3452-3459	See item 292.	MMDDCCYY
307	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 8)	8	3460-3467	See item 293.	MMDDCCYY
308	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 9)	8	3468-3475	See item 292.	MMDDCCYY
309	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 9)	8	3476-3483	See item 293.	MMDDCCYY
310	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 10)	8	3484-3491	See item 292.	MMDDCCYY
311	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 10)	8	3492-3499	See item 293.	MMDDCCYY
Medicare Beneficiary Identifier (MBI) Data (6 most recent occurrences). Note: These fields will not be populated until February 2018.					
312	Beneficiary's MBI (Occurrence 1)	11	3500-3510	CHAR	The MBI from the beneficiary's most recent Beneficiary MBI period. The value is a system-generated identifier used by CMS to uniquely identify the beneficiary in the Medicare database.
313	Beneficiary's MBI Effective Date (Occurrence 1)	8	3511-3518	NUM	MMDDCCYY. The Effective Date of the beneficiary's most recent Beneficiary MBI period.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
314	Beneficiary's MBI Effective Reason Code (Occurrence 1)	5	3519-3523	CHAR	The Effective Reason Code from the beneficiary's most recent Beneficiary MBI period. The value indicates the reason an MBI was assigned to the beneficiary. Values: A – Accretion. I – Initial bulk MBI assignment. BA – Special authorized. BB – Breach. BP – Provider issue. BR – Religious/cultural. BT – Medical/Identity theft. BZ – Other. CA – Special authorized. CB – CMS breach. CE – Entitlement and casework issues. CF – Confirmed fraud. CT – Medical/Identity theft. CZ' – Other.
315	Beneficiary's MBI End Date (Occurrence 1)	8	3524-3531	NUM	MMDDCCYY. The End Date of the beneficiary's most recent Beneficiary MBI period. The field is populated with the End Date from the beneficiary's record if a date exists. The field is filled with nines if no value exists for the End Date in the beneficiary's record.

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
316	Beneficiary's MBI End Reason Code (Occurrence 1)	5	3532-3536	CHAR	The End Reason Code from the beneficiary's most recent Beneficiary MBI period. The value indicates the reason an MBI was deactivated for the beneficiary. Values: X – Cross-Reference merge. BA – Special authorized. BB – Breach. BP – Provider issue. BR – Religious/cultural. BT – Medical/Identity theft. BZ – Other. CA – Special authorized. CB – CMS breach. CE – Entitlement and casework issues. CF – Confirmed fraud. CT – Medical/Identity theft. CZ – Other.
317	Beneficiary MBI (Occurrence 2)	37	3537-3573	See items 312 – 316	Same as Occurrence 1.
318	Beneficiary MBI (Occurrence 3)	37	3574-3610	See items 312 – 316	Same as Occurrence 1.
319	Beneficiary MBI (Occurrence 4)	37	3611-3647	See items 312 – 316	Same as Occurrence 1.
320	Beneficiary MBI (Occurrence 5)	37	3648-3684	See items 312 – 316	Same as Occurrence 1.
321	Beneficiary MBI (Occurrence 6)	37	3685-3721	See items 312 – 316	Same as Occurrence 1.
322	CARA Status Start Date (1)	8	3722-3729	NUM	MMDDCCYY
323	CARA Status End Date (1)	8	3730-3737	NUM	MMDDCCYY

MMA Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
324	CARA Status Start Date (2)	8	3738-3745	NUM	MMDDCCYY
325	CARA Status End Date (2)	8	3746-3753	NUM	MMDDCCYY
326	CARA Status Start Date (3)	8	3754-3761	NUM	MMDDCCYY
327	CARA Status End Date (3)	8	3762-3769	NUM	MMDDCCYY
328	CARA Status Start Date (4)	8	3770-3777	NUM	MMDDCCYY
329	CARA Status End Date (4)	8	3778-3785	NUM	MMDDCCYY
330	CARA Status Start Date (5)	8	3786-3793	NUM	MMDDCCYY
331	CARA Status End Date (5)	8	3794-3801	NUM	MMDDCCYY
332	CARA Status Start Date (6)	8	3802-3809	NUM	MMDDCCYY
333	CARA Status End Date (6)	8	3810-3817	NUM	MMDDCCYY
334	CARA Status Start Date (7)	8	3818-3825	NUM	MMDDCCYY
335	CARA Status End Date (7)	8	3826-3833	NUM	MMDDCCYY
336	CARA Status Start Date (8)	8	3834-3841	NUM	MMDDCCYY
337	CARA Status End Date (8)	8	3842-3849	NUM	MMDDCCYY
338	CARA Status Start Date (9)	8	3850-3857	NUM	MMDDCCYY
339	CARA Status End Date (9)	8	3858-3865	NUM	MMDDCCYY
340	CARA Status Start Date (10)	8	3866-3873	NUM	MMDDCCYY
341	CARA Status End Date (10)	8	3874-3881	NUM	MMDDCCYY
342	Date Beneficiary Last Used the Dual/LIS Special Election Period (Election Type “L”)	8	3882-3889	NUM	Format is MMDDCCYY If the beneficiary has not used the DUAL/LIS SEP, then this field is filled with zeroes (00000000).
343	Filler	111	3890-4000	CHAR	Spaces

7.6 MMA Response File Summary Record Layout

MMA Response File Summary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Identification Code	3	1-3	CHAR	'FSM'.
2	State Code	2	4-5	CHAR	US Postal Service State Abbreviation. See Table 15-3, State Codes.
3	File Process Timestamp	26	6-31	CHAR	The exact time that the MMA Request 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.
4	File Create Month	2	32-33	NUM	The month that the MMA Request file is created
5	File Create Year	4	34-37	NUM	The year that the MMA Request file is created
6	Total Number of Records	8	38-45	NUM	The total number of DET records in the MMA Request file. This count does not include PRO records.
7	Total Number of Duplicate Records	8	46-53	NUM	The total number of duplicate DET records in the MMA Request file. This count does not include PRO records.
8	Total Number of Non-Duplicate Records	8	54-61	NUM	The total number of non-duplicate valid DET records in the MMA Request file. This count does not include PRO records.

MMA Response File Summary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
9	Total Number of Valid Records	8	62-69	NUM	The total number of valid DET records in the MMA Request file. This count does not include PRO records.
10	Total Number of Invalid Records	8	70-77	NUM	The total number of invalid DET records in the MMA Request file. This count does not include PRO records.
11	Total Number of Matched Records	8	78-85	NUM	The total number of DET records that could be matched to a beneficiary on the Active Medicare Beneficiary Database. This count does not include PRO records.
12	Total Number of Unmatched Records	8	86-93	NUM	The total number of DET records that could not be matched to a beneficiary on the Active Medicare Beneficiary Database. This count includes invalid records because a match is not attempted on invalid records. This count does not include PRO records.
13	Filler	47	94-140	CHAR	
14	Total Number of Valid Dual Records	8	141-148	NUM	The total number of valid DET records in the file. This count does not include PRO records.
15	Total Number of Valid Dual Matches	8	149-156	NUM	The total number of DET records that are matched to a beneficiary on the Medicare Active Beneficiary Database. This count does not include PRO records.

MMA Response File Summary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
16	Total Number of Valid Dual Non-Matches	8	157-164	NUM	The total number of valid DET records that are not matched to a beneficiary on the Active Medicare Beneficiary Database. This count does not include PRO records.
17	Total Number of Valid LIS Records	8	165-172	NUM	The total number of valid LIS records.
18	Total Number of Valid Current Duals	8	173-180	NUM	The total number of valid DET records with Eligibility Month/Year = File Create Month/Year. This count does not include PRO records.
19	Total Number of Valid Retro Duals	8	181-188	NUM	The total number of valid DET records with Eligibility Month/Year < File Create Month/Year. This count does not include PRO records.
20	Total Eligibility Months	2	189-190	NUM	The total number of Eligibility Months in the file. This count does not include PRO records.
21	Total Valid PRO Records	8	191-198	NUM	The total number of valid PRO records in the file.
22	Total Invalid PRO Records	8	199-206	NUM	The total number of invalid PRO records in the file.
23	Total Matched PRO Records	8	207-214	NUM	The total number of valid PRO records that are matched to a beneficiary on the Active Medicare Beneficiary Database.
24	Filler	3786	215-4000	CHAR	Spaces.

7.7 MMA Response File Monthly Summary Record Layout

MMA Response File Monthly Summary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
1	Record Identification Code	3	1-3	CHAR	MSM.
2	State Code	2	4-5	CHAR	US Postal Service State Abbreviation. **See Table 15-3, State Codes.**
3	File Process Timestamp	26	6-31	CHAR	The exact time that the MMA Request 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.
4	File Create Month	2	32-33	NUM	The month that the MMA Request file is created.
5	File Create Year	4	34-37	NUM	The year that the MMA Request file is created.
6	Eligibility Month	2	38-39	NUM	Month for applicable Medicaid eligibility.
7	Eligibility Year	4	40-43	NUM	Year for applicable Medicaid eligibility.
8	Calculation Switch	1	44	CHAR	Y – The enrollment and disenrollment count 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'.

MMA Response File Monthly Summary Record					
Item	**Field**	**Size**	**Position**	**Format**	**Description**
9	Total Valid Records	8	45-52	NUM	The total number of valid DET records for this Eligibility Month/Year. This count does not include PRO records.
10	Total Valid Full Dual Records	8	53-60	NUM	The total number of valid full dual beneficiary records. This count does not include PRO records.
11	Total Valid Non-Full Dual Records	8	61-68	NUM	The total number of valid non-full dual beneficiary records. This count does not include PRO records.
12	Net Total Valid Full Dual Enrollments	8	69-76	NUM	The net total number of valid Full Dual Eligible enrollments counted for this Eligibility Month/Year. This count does not include PRO records.
13	Net Total Valid Full Dual Disenrollments	8	77-84	NUM	The net total number of valid Full Dual Eligible disenrollments counted for this Eligibility Month/Year. This count does not include PRO records.
14	Filler	3916	85-4000	CHAR	Spaces.

7.8 MMA Response File Trailer Record Layout

MMA Response File Trailer Record					
Item	**Data Element Name**	**Size**	**Position**	**Format**	**Description**
1	Record Identification Code	3	1-3	CHAR	TRL.
2	File Process Timestamp	26	4-29	CHAR	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.
3	File Create Month	2	30-31	NUM	Month that the MMA Request file is created.
4	File Create Year	4	32-35	NUM	Year that MMA Request file is created.
5	File Accept Indicator	1	36	CHAR	Y – The MMA Request file is accepted.
6	Filler	7	37-43	CHAR	
7	Record Identification Code	3	44-46	CHAR	A copy of the trailer record in the incoming file is displayed in items 7 – 12 (positions 44-223).
8	Beneficiary Record Count	8	47-54	NUM	
9	State Code	2	55-56	CHAR	
10	File Create Month	2	57-58	NUM	
11	File Create Year	4	59-62	NUM	
12	Filler	161	63-223	CHAR	
13	Filler	3377	224-4000	CHAR	

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8 Batch Eligibility Query (BEQ) Request File

The BEQ Request File includes transactions submitted by states to request eligibility information for beneficiaries. The file is used to conduct initial eligibility checks against the CMS MBD system to verify the beneficiary is Part A / B eligible.

Note: The date in the file name defaults to “01” denoting the first day of the CCM.

8.1 BEQ Request File Dataset Naming Conventions

System	Type	Size	Frequency
MBD	Data File	750	PRN (states can send multiple files in a day)

This file includes the following records:

- **BEQ Request File Header Record**
- **BEQ Request File Detail Record**
- **BEQ Request File Trailer Record**

See **Section 8.5** for a sample of the BEQ Request File Pass and Fail Acknowledgements.

8.2 BEQ Request File Header Record Layout

BEQ Request File Header Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	File ID Name	8	1- 8	CHAR	MMABEQRH	Critical Field: This code identifies the file as a BEQ Request File and this record as the Header Record of the file.

BEQ Request File Header Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
2	Sending Entity: CMS	8	9-16	CHAR	Sending Organization (left-justified space filled) Acceptable Values: 5-position Contract. (3 Spaces are for Future use)	Critical Field: This field provides CMS with the identification of the entity that is sending the BEQ Request File. The value for this field is provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Trailer Record. The Sending Entity may participate in Part D.
3	File Creation Date	8	17-24	CHAR	YYYYMMDD	Critical Field: The date that the Sending Entity created the BEQ Request File. For example, January 3 2010 is the value 20100103. This value should agree with the corresponding value in the Trailer Record. CMS returns this information to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File.
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity	Critical Field The specific Control Number assigned by the Sending Entity to the BEQ Request File. CMS returns this information to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Trailer Record.
5	Filler	717	34-750	CHAR	Spaces	

8.3 BEQ Request File Detail Record Layout

BEQ Request File Detail Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	Record Type	5	1-5	CHAR	DTL01 = BEQ Transaction Note: The value above is DTL-zero-one.	Critical Field This code identifies the record as a detail record for processing specifically for BEQ Service.
2	Beneficiary ID	12	6-17	CHAR	Beneficiary ID, HICN, or RRB	Critical Field • Before the Medicare Beneficiary Identifier (MBI) Transition period, the acceptable values are the Health Insurance Claim Number (HICN), and the Railroad Retirement Board (RRB) Number. • During the MBI Transition period, the acceptable values are the HICN, RRB Number, and MBI. • When the MBI Transition period ends, the acceptable value is the MBI. The last position may be a space.
3	Filler	9	18-26	CHAR	Spaces	
4	DOB	8	27-34	CHAR	YYYYMMDD	Critical Field The date of the beneficiary's birth. The value should not include dashes, decimals, or commas. The value should include only numbers.
5	Gender Code	1	35	CHAR	0 – Unknown 1 – Male 2 – Female	Not Critical Field The gender of the beneficiary.
6	Detail Record Sequence Number	7	36-42	NUM	Seven-byte number unique within the BEQ Request File	Critical Field A unique number assigned by the Sending Entity to the Transaction (Detail Record). This number should uniquely identify the Transactions (Detail Record) within the BEQ Request File.
7	Filler	708	43-750	CHAR	Spaces	

8.4 BEQ Request File Trailer Record Layout

BEQ Request File Trailer Record						
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**	**Description**
1	File ID Name	8	1-8	CHAR	MMABEQRT	Critical Field This code identifies the record as the Trailer Record of a BEQ Request File.
2	Sending Entity (CMS)	8	9-16	CHAR	Sending Organization (left-justified space filled) Acceptable Values: 5-position Contract Identifier + 3 Spaces (3 Spaces for Future use)	Critical Field This field provides CMS with the identification of the entity that is sending the BEQ Request File. The value for this field is provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Header Record. The Sending Entity may participate in Part D.
3	File Creation Date	8	17-24	CHAR	YYYYMMDD	Critical Field The date when the Sending Entity created the BEQ Request File. For example, January 3, 2010, is the value 20100103. This value should agree with the corresponding value in the Header Record. CMS will pass this information back to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File.
4	File Control Number	9	25-33	CHAR	Assigned by Sending Entity	Critical Field The specific Control Number assigned by the Sending Entity to the BEQ Request File. CMS will return this information to the Sending Entity on all Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Header Record.
5	Record Count	7	34-40	NUM	Numeric value greater than Zero, with leading zeroes.	Critical Field The total number of Transactions (Detail Records) supplied on the BEQ Request File.
6	Filler	710	41-750	CHAR	Spaces	

8.5 Sample BEQ Request File E-mail Acknowledgments

The Medicare enrollment system issues an e-mail acknowledgment of receipt and status to the state. If the status is accepted, the file is processed. If the status is rejected, the e-mail informs the state of the first File Error Condition that caused the BEQ Request File's rejection. A rejected file is not returned.

Sample e-mail of a Pass and Fail Acknowledgement appear below:

Example of BEQ Request File "Pass" Acknowledgment

TO: Jim.Doe@xxs.net

TO: Chris.Doe@dxxx.org

TO: Falcon.Doe@xxxx.org

FROM: MBD#BQ94.HCFJES@cms.hhs.gov

Subject: CMS MMA DATA EXCHANGE FOR MMABTCH

MMABTCH file has been received and passed surface edits by CMS.

QUESTIONS? Contact 1-800-927-8069 or E-mail mapdhelp@cms.hhs.gov

INPUT HEADER RECORD

MMABEQRHS0094 20070306F20070306

INPUT TRAILER RECORD

MMABEQRTS0094 20070306F200703060000074

Example of BEQ Request File "Fail" Acknowledgment

TO: Jim.Doe@xxs.net

TO: Chris.Doe@dxxx.org

TO: Falcon.Doe@xxxx.org

FROM: MBD#BQ30.HCFJES@cms.hhs.gov

Subject: CMS MMA DATA EXCHANGE FOR MMABTCH

MMABTCH file has been received and failed surface edits by CMS.

QUESTIONS? Contact 1-800-927-8069 or E-mail mapdhelp@cms.hhs.gov

INPUT HEADER RECORD

MMABEQRHH0030 20070228 84433346

INPUT TRAILER RECORD

MMABEQRTH0030 20070221 844333460074065

THE TRAILER RECORD IS INVALID

9 Batch Eligibility Query (BEQ) Response File

The BEQ Response File contains records produced from processing the transactions of accepted BEQ Request files. Detail records for all submitted records that are successfully processed contain Processed Flag = Y. Detail records for all submitted records that are not successfully processed contain Processed Flag = N.

9.1 BEQ Response File Dataset Naming Conventions

System	Type	Size	Frequency
MBD	Data File	2000	Response to BEQ Request File.

The following records are included in this file:

- **BEQ Response File Header Record**
- **BEQ Response File Detail Record**
- **BEQ Response File Trailer Record**

9.2 BEQ Response File Header Record Layout

BEQ Response File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Header Code	8	1 – 8	CHAR	CMSBEQRH
2	Sending Entity	8	9 – 16	CHAR	MBD (MBD + five spaces)
3	File Creation Date	8	17 – 24	CHAR	CCYYMMDD
4	File Control Number	9	25 – 33	CHAR	
5	Filler	1967	34 - 2000	CHAR	Spaces

9.3 BEQ Response File Detail Record Layout

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Record Type	3	1 – 3	CHAR	DTL
Start of Original Detail Record					
2	Record Type	5	4 – 8	CHAR	
3	Beneficiary ID	12	9 – 20	CHAR	This field will contain exactly what is received in the same field of the beneficiary's Detail record in the related BEQ Request file.
4	Filler	9	21 –29	CHAR	
5	Beneficiary's Date of Birth	8	30 – 37	CHAR	
6	Beneficiary's Gender Code	1	38	CHAR	
7	Detail Record Sequence Number	7	39 – 45	NUM	
End of Original Detail Record					
8	Processed Flag	1	46	CHAR	Y or N
9	Beneficiary Match Flag	1	47	CHAR	Y or N
Medicare Part A Entitlement Dates (2nd occurrence in Positions 1735 – 1750)		**16**	**48 – 63**	**NUM**	**N/A**
10	Medicare Part A Entitlement Start Date	8	48 – 55	CHAR	CCYYMMDD
11	Medicare Part A Entitlement End Date	8	56 – 63	CHAR	CCYYMMDD
Medicare Part B Entitlement Dates (2nd occurrence in Positions 1751 – 1766)		**16**	**64 – 79**	**NUM**	**N/A**
12	Medicare Part B Entitlement Start Date	8	64 – 71	CHAR	CCYYMMDD
13	Medicare Part B Entitlement End Date	8	72 – 79	CHAR	CCYYMMDD
14	Medicaid Indicator	1	80	CHAR	0 or 1
15	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 1)	8	81 – 88	CHAR	CCYYMMDD
16	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 1)	8	89 – 96	CHAR	CCYYMMDD
17	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 2)	8	97 – 104	See item 15	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
18	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 2)	8	105 – 112	See item 16	CCYYMMDD
19	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 3)	8	113 – 120	See item 15	CCYYMMDD
20	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 3)	8	121 – 128	See item 16	CCYYMMDD
21	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 4)	8	129 – 136	See item 15	CCYYMMDD
22	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 4)	8	137 – 144	See item 16	CCYYMMDD
23	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 5)	8	145 – 152	See item 15	CCYYMMDD
24	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 5)	8	153 – 160	See item 16	CCYYMMDD
25	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 6)	8	161 – 168	See item 15	CCYYMMDD
26	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 6)	8	169 – 176	See item 16	CCYYMMDD
27	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 7)	8	177 – 184	See item 15	CCYYMMDD
28	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 7)	8	185 – 192	See item 16	CCYYMMDD
29	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 8)	8	193 – 200	See item 15	CCYYMMDD
30	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 8)	8	201 – 208	See item 16	CCYYMMDD
31	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 9)	8	209 – 216	See item 15	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
32	Part D Disenrollment Date or Employer Subsidy End Date (Occurrence 9)	8	217 – 224	See item 16	CCYYMMDD
33	Part D Enrollment Effective Date or Employer Subsidy Start Date (Occurrence 10)	8	225 – 232	See item 15	CCYYMMDD
34	Part D Disenrollment Date or Employer Subsidy End Date (occurrence 10)	8	233 – 240	See item 16	CCYYMMDD
35	Sending Entity	8	241 – 248	CHAR	
36	File Control Number	9	249 – 257	CHAR	
37	File Creation Date	8	258 – 265	CHAR	CCYYMMDD
38	Part D Eligibility Start Date	8	266 – 273	CHAR	
39	Deemed / Low-Income Subsidy Effective Date (Occurrence 1)	8	274 – 281	CHAR	CCYYMMDD
40	Deemed / Low-Income Subsidy End Date (Occurrence 1)	8	282 – 289	CHAR	CCYYMMDD
41	Co-Payment Level Identifier (Occurrence 1)	1	290	CHAR	1, 2, 3, 4 or 5
42	Part D Premium Subsidy Percent (Occurrence 1)	3	291 – 293	CHAR	100, 075, 050, or 025
43	Deemed / Low-Income Subsidy Effective Date (Occurrence 2)	8	294 – 301	See item 39	CCYYMMDD
44	Deemed / Low-Income Subsidy End Date (Occurrence 2)	8	302 – 309	See item 40	CCYYMMDD
45	Co-Payment Level Identifier (Occurrence 2)	1	310	See item 41	1, 2, 3, 4 or 5
46	Part D Premium Subsidy Percent (Occurrence 2)	3	311 – 313	See item 42	100, 075, 050, or 025
Part D/RDS Indicator (10 occurrences)					
47	RDS/Part D Indicator (Occurrence 1)	1	314	CHAR	D or R
48	RDS/Part D Indicator (Occurrence 2)	1	315	CHAR	D or R
49	RDS/Part D Indicator (Occurrence 3)	1	316	CHAR	D or R
50	RDS/Part D Indicator (Occurrence 4)	1	317	CHAR	D or R
51	RDS/Part D Indicator (Occurrence 5)	1	318	CHAR	D or R
52	RDS/Part D Indicator (Occurrence 6)	1	319	CHAR	D or R
53	RDS/Part D Indicator (Occurrence 7)	1	320	CHAR	D or R
54	RDS/Part D Indicator (Occurrence 8)	1	321	CHAR	D or R

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
55	RDS/Part D Indicator (Occurrence 9)	1	322	CHAR	D or R
56	RDS/Part D Indicator (Occurrence 10)	1	323	CHAR	D or R
Uncovered Months Data (20 occurrences)					
57	Start Date (Occurrence 1)	8	324 – 331	CHAR	CCYYMMDD
58	Number of Uncovered Months (Occurrence 1)	3	332 – 334	NUM	
59	Number of Uncovered Months Status Indicator (Occurrence 1)	1	335	CHAR	
60	Total Number of Uncovered Months (Occurrence 1)	3	336 – 338	NUM	
61	Uncovered Months (Occurrence 2)	15	339 – 353	See items 57 – 60	
62	Uncovered Months (Occurrence 3)	15	354 – 368	See items 57 – 60	
63	Uncovered Months (Occurrence 4)	15	369 – 383	See items 57 – 60	
64	Uncovered Months (Occurrence 5)	15	384 – 398	See items 57 – 60	
65	Uncovered Months (Occurrence 6)	15	399 – 413	See items 57 – 60	
66	Uncovered Months (Occurrence 7)	15	414 – 428	See items 57 – 60	
67	Uncovered Months (Occurrence 8)	15	429 – 443	See items 57 – 60	
68	Uncovered Months (Occurrence 9)	15	444 – 458	See items 57 – 60	
69	Uncovered Months (Occurrence 10)	15	459 – 473	See items 57 – 60	
70	Uncovered Months (Occurrence 11)	15	474 – 488	See items 57 – 60	

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
71	Uncovered Months (Occurrence 12)	15	489 – 503	See items 57 – 60	
72	Uncovered Months (Occurrence 13)	15	504 – 518	See items 57 – 60	
73	Uncovered Months (Occurrence 14)	15	519 – 533	See items 57 – 60	
74	Uncovered Months (Occurrence 15)	15	534 – 548	See items 57 – 60	
75	Uncovered Months (Occurrence 16)	15	549 – 563	See items 57 – 60	
76	Uncovered Months (Occurrence 17)	15	564 – 578	See items 57 – 60	
77	Uncovered Months (Occurrence 18)	15	579 – 593	See items 57 – 60	
78	Uncovered Months (Occurrence 19)	15	594 – 608	See items 57 – 60	
79	Uncovered Months (Occurrence 20)	15	609 – 623	See items 57 – 60	
80	Beneficiary's Retrieved Date of Birth (as retrieved from CMS database for matching beneficiary)	8	624 – 631	CHAR	CCYYMMDD
81	Beneficiary's Retrieved Gender Code (as retrieved from CMS database for matching beneficiary)	1	632	CHAR	0 – Unknown 1 – Male 2 – Female
82	Last Name	40	633 – 672	CHAR	
83	First Name	30	673 – 702	CHAR	
84	Middle Initial	1	703	CHAR	
85	Current State Code	2	704 – 705	CHAR	
86	Current County Code	3	706 – 708	CHAR	
87	Date of Death	8	709 – 716	CHAR	CCYYMMDD
88	Part C/D Contract Number (if available)	5	717 – 721	CHAR	

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
89	Part C/D Enrollment Start Date (if available)	8	722 – 729	CHAR	CCYYMMDD
90	Part D Indicator (if available)	1	730	CHAR	Y – Yes N – No Space
91	Part C Contract Number (if available)	5	731 – 735	CHAR	
92	Part C Enrollment Start Date (if available)	8	736 – 743	CHAR	
93	Part D Indicator (if available)	1	744	CHAR	N – No Space
94	ESRD Indicator	1	745	CHAR	End-Stage Renal Disease Indicator 0 – No ESRD 1 – ESRD
95	PBP Number (associated with contract number in item 88, positions 717 – 721)	3	746 – 748	CHAR	Plan Benefit Package number

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
96	Plan Type Code (associated with PBP number in item 95, positions 746 – 748)	2	749 – 750	CHAR	Type of plan 01 – HMO 02 – HMOPOS 04 – Local PPO 05 – PSO (State License) 07 – MSA 08 – RFB PFFS 09 – PFFS 18 – 1876 Cost 19 – HCPP 1833 Cost 20 – National PACE 28 – Chronic Care 29 – Medicare Prescription Drug Plan 30 – Employer/ Union Only Direct Contract PDP 31 – Regional PPO 40 – Employer/ Union Only Direct Contract PFFS 42 – RFB HMO 43 – RFB HMOPOS 44 – RFB Local PPO 45 – RFB PSO (State License) 46 – Point-of-Sale Contractor 47 – Employer/ Union Only Direct Contract PPO 48 – Medicare-Medicaid Plan HMO 49 – Medicare-Medicaid Plan HMOPOS 50 – Medicare-Medicaid Plan PPO 99 – Undefined Historical Data
97	EGHP Indicator (associated with PBP number in item 95, positions 746 – 748)	1	751	CHAR	EGHP Switch Y – EGHP N – not EGHP

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
98	PBP Number (associated with contract number in item 91, positions 731 – 735)	3	752 – 754	CHAR	Plan Benefit Package number
99	Plan Type Code (associated with PBP number in item 98, positions 752 – 754)	2	755 – 756	CHAR	See values in item 96, positions 749 – 750.
100	EGHP Indicator (associated with PBP number in item 98, positions 752 – 754)	1	757	CHAR	Employer Group Health Plan Switch Y – EGHP N – not EGHP
101	Mailing Address Line 1	40	758 – 797	CHAR	
102	Mailing Address Line 2	40	798 – 837	CHAR	
103	Mailing Address Line 3	40	838 – 877	CHAR	
104	Mailing Address Line 4	40	878 – 917	CHAR	
105	Mailing Address Line 5	40	918 – 957	CHAR	
106	Mailing Address Line 6	40	958 – 997	CHAR	
107	Mailing Address City	40	998 – 1037	CHAR	
108	Mailing Address Postal State Code	2	1038-1039	CHAR	
109	Mailing Address ZIP Code	9	1040– 1048	CHAR	
110	Mailing Address Start Date	8	1049– 1056	CHAR	CCYYMMDD
111	Residence Address Line 1	60	1057– 1116	CHAR	
112	Residence Address City	40	1117– 1156	CHAR	
113	Residence Address Postal State Code	2	1157– 1158	CHAR	
114	Residence Address ZIP Code	9	1159– 1167	CHAR	
115	Residence Address Start Date	8	1168- 175	CHAR	CCYYMMDD
116	Medicare Plan Ineligibility Due to Incarceration Start Date (1)	8	1176– 1183	CHAR	CCYYMMDD
117	Medicare Plan Ineligibility Due to Incarceration End Date (1)	8	1184– 1191	CHAR	CCYYMMDD
118	Medicare Plan Ineligibility Due to Incarceration Start Date (2)	8	1192– 1199	CHAR	CCYYMMDD
119	Medicare Plan Ineligibility Due to Incarceration End Date (2)	8	1200– 1207	CHAR	CCYYMMDD
120	Medicare Plan Ineligibility Due to Incarceration Start Date (3)	8	1208– 1215	CHAR	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
121	Medicare Plan Ineligibility Due to Incarceration End Date (3)	8	1216–1223	CHAR	CCYYMMDD
122	Medicare Plan Ineligibility Due to Incarceration Start Date (4)	8	1224–1231	CHAR	CCYYMMDD
123	Medicare Plan Ineligibility Due to Incarceration End Date (4)	8	1232–1239	CHAR	CCYYMMDD
124	Medicare Plan Ineligibility Due to Incarceration Start Date (5)	8	1240–1247	CHAR	CCYYMMDD
125	Medicare Plan Ineligibility Due to Incarceration End Date (5)	8	1248–1255	CHAR	CCYYMMDD
126	Medicare Plan Ineligibility Due to Incarceration Start Date (6)	8	1256–1263	CHAR	CCYYMMDD
127	Medicare Plan Ineligibility Due to Incarceration End Date (6)	8	1264–1271	CHAR	CCYYMMDD
128	Medicare Plan Ineligibility Due to Incarceration Start Date (7)	8	1272–1279	CHAR	CCYYMMDD
129	Medicare Plan Ineligibility Due to Incarceration End Date (7)	8	1280–1287	CHAR	CCYYMMDD
130	Medicare Plan Ineligibility Due to Incarceration Start Date (8)	8	1288–1295	CHAR	CCYYMMDD
131	Medicare Plan Ineligibility Due to Incarceration End Date (8)	8	1296–1303	CHAR	CCYYMMDD
132	Medicare Plan Ineligibility Due to Incarceration Start Date (9)	8	1304–1311	CHAR	CCYYMMDD
133	Medicare Plan Ineligibility Due to Incarceration End Date (9)	8	1312–1319	CHAR	CCYYMMDD
134	Medicare Plan Ineligibility Due to Incarceration Start Date (10)	8	1320–1327	CHAR	CCYYMMDD
135	Medicare Plan Ineligibility Due to Incarceration End Date (10)	8	1328–1335	CHAR	CCYYMMDD
136	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (1)	8	1336-1343	CHAR	CCYYMMDD
137	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (1)	8	1344-1351	CHAR	CCYYMMDD
138	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (2)	8	1352-1359	CHAR	CCYYMMDD
139	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (2)	8	1360-1367	CHAR	CCYYMMDD
140	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (3)	8	1368-1375	CHAR	CCYYMMDD
141	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (3)	8	1376-1383	CHAR	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
142	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (4)	8	1384-1391	CHAR	CCYYMMDD
143	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (4)	8	1392-1399	CHAR	CCYYMMDD
144	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (5)	8	1400-1407	CHAR	CCYYMMDD
145	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (5)	8	1408-1415	CHAR	CCYYMMDD
146	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (6)	8	1416-1423	CHAR	CCYYMMDD
147	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (6)	8	1424-1431	CHAR	CCYYMMDD
148	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (7)	8	1432-1439	CHAR	CCYYMMDD
149	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (7)	8	1440-1447	CHAR	CCYYMMDD
150	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (8)	8	1448-1455	CHAR	CCYYMMDD
151	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (8)	8	1456-1463	CHAR	CCYYMMDD
152	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (9)	8	1464-1471	CHAR	CCYYMMDD
153	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (9)	8	1472-1479	CHAR	CCYYMMDD
154	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (10)	8	1480-1487	CHAR	CCYYMMDD
155	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (10)	8	1488-1495	CHAR	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
156	Current Enrollment Source Type Code (associated with PBP number in item 95, positions 746 – 748)	1	1496	CHAR	An indicator providing the type of enrollment performed. Values: A: Auto enrolled by CMS. B: Beneficiary election. C: Facilitated enrollment by CMS. D: CMS Annual Rollover. E: Plan submitted auto-enrollments. F: Plan submitted facilitated enrollments. G: Point of Sale (POS) submitted enrollments. H: CMS or plan submitted re-assignment enrollments. I: Invalid Submitted Value. J: State-submitted MMP passive enrollment. K: CMS-submitted MMP passive enrollment. L: Beneficiary MMP election. M: Default for Financial Alignment Demo Plan enrollments submitted without an Enrollment Source Code (M is not submitted on an enrollment). N: Rollover by plan transaction.

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
157	Current Enrollment Source Type Code (associated with PBP number in item 98, positions 752– 754)	1	1497	CHAR	See values in item 156, position 1496.
158	Prior Part C/D Contract Number	5	1498-1502	CHAR	
159	Prior Part C/D Enrollment Start Date (associated with PBP Number in item 162, positions 1520-1522)	8	1503-1510	CHAR	CCYYMMDD
160	Prior Part C/D Disenrollment Date (associated with PBP Number in item 162, positions 1520-1522)	8	1511-1518	CHAR	CCYYMMDD
161	Prior Part D Indicator (associated with PBP Number in item 162, positions 1520-1522)	1	1519	CHAR	Y – Yes N – No Space
162	Prior PBP Number (associated with Contract Number in item 158, positions 1498-1502)	3	1520-1522	CHAR	Plan Benefit Package number
163	Prior Plan Type Code (associated with PBP Number in item 162, positions 1520-1522)	2	1523-1524	CHAR	See values in item 96 (positions 749-750).
164	Prior EGHP Indicator (associated with PBP Number in item 162, positions 1520-1522)	1	1525	CHAR	Employer Group Health Plan Switch Y – EGHP N – not EGHP
165	Prior Enrollment Source Type Code (associated with PBP Number in positions 1520-1522)	1	1526	CHAR	See values in item 156 (position 1496).
166	Prior Part C Contract Number	5	1527-1531	CHAR	
167	Prior Part C Enrollment Start Date (associated with PBP Number in item 170, positions 1549-1551)	8	1532-1539	CHAR	CCYYMMDD
168	Prior Part C Disenrollment Date (associated with PBP Number in item 170, positions 1549-1551)	8	1540-1547	CHAR	CCYYMMDD
169	Prior Part D Indicator (associated with PBP Number in item 170, positions 1549-1551)	1	1548	CHAR	N – No Space
170	Prior PBP Number (associated with Contract Number in item 166, positions 1527-1531)	3	1549-1551	CHAR	Plan Benefit Package number
171	Prior Plan Type Code (associated with PBP Number in item 170, positions 1549-1551)	2	1552-1553	CHAR	See values in item 96 (positions 749-750).

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
172	Prior EGHP Indicator (associated with PBP Number in item 170, positions 1549-1551)	1	1554	CHAR	Employer Group Health Plan Switch Y – EGHP N – not EGHP
173	Prior Enrollment Source Type Code (associated with PBP Number in item 170, positions 1549-1551)	1	1555	CHAR	See values in item 156 (position 1496).
174	Active MBI	11	1556-1566	CHAR	The MBI field will be populated during and after MBI Transition.
175	Most Recent Duals SEP Use Date	8	1567-1574	NUM	CCYYMMDD
176	CARA Status Start Date (1)	8	1575-1582	NUM	CCYYMMDD
177	CARA Status End Date (1)	8	1583-1590	NUM	CCYYMMDD
178	CARA Status Start Date (2)	8	1591-1598	NUM	CCYYMMDD
179	CARA Status End Date (2)	8	1599-1606	NUM	CCYYMMDD
180	CARA Status Start Date (3)	8	1607-1614	NUM	CCYYMMDD
181	CARA Status End Date (3)	8	1615-1622	NUM	CCYYMMDD
182	CARA Status Start Date (4)	8	1623-1630	NUM	CCYYMMDD
183	CARA Status End Date (4)	8	1631-1638	NUM	CCYYMMDD
184	CARA Status Start Date (5)	8	1639-1646	NUM	CCYYMMDD
185	CARA Status End Date (5)	8	1647-1654	NUM	CCYYMMDD
186	CARA Status Start Date (6)	8	1655-1662	NUM	CCYYMMDD
187	CARA Status End Date (6)	8	1663-1670	NUM	CCYYMMDD
188	CARA Status Start Date (7)	8	1671-1678	NUM	CCYYMMDD
189	CARA Status End Date (7)	8	1679-1686	NUM	CCYYMMDD
190	CARA Status Start Date (8)	8	1687-1694	NUM	CCYYMMDD
191	CARA Status End Date (8)	8	1695-1702	NUM	CCYYMMDD
192	CARA Status Start Date (9)	8	1703-1710	NUM	CCYYMMDD
193	CARA Status End Date (9)	8	1711-1718	NUM	CCYYMMDD
194	CARA Status Start Date (10)	8	1719-1726	NUM	CCYYMMDD
195	CARA Status End Date (10)	8	1727-1734	NUM	CCYYMMDD
Medicare Part A Entitlement Dates (1st occurrence in Positions 48 – 63)		**16**	**1735-1750**	**NUM**	**N/A**
196	Medicare Part A Entitlement Start Date (occurrence two)	8	1735-1742	NUM	CCYYMMDD
197	Medicare Part A Entitlement End Date (occurrence two)	8	1743-1750	NUM	CCYYMMDD

BEQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
Medicare Part B Entitlement Dates (1st occurrence in Positions 64 – 79)		**16**	**1751-1766**	**NUM**	**N/A**
198	Medicare Part B Entitlement Start Date (occurrence two)	8	1751-1758	NUM	CCYYMMDD
199	Medicare Part B Entitlement End Date (occurrence two)	8	1759-1766	NUM	CCYYMMDD
200	Filler	234	1767-2000	CHAR	Spaces

9.4 BEQ Response File Trailer Record Layout

BEQ Response File Trailer Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Trailer Code	8	1 – 8	CHAR	CMSBEQRT
2	Sending Entity	8	9 – 16	CHAR	‘MBD ‘ (MBD + five spaces)
3	File Creation Date	8	17 – 24	CHAR	CCYYMMDD
4	File Control Number	9	25 – 33	CHAR	
5	Record Count	7	34 – 40	NUM	Right justified
6	Filler	1960	41 – 2000	CHAR	Spaces

10 Territory Beneficiary Query (TBQ) Request File

The TBQ is a data exchange between CMS and the states. To determine beneficiary entitlement and enrollment information as part of the process for Low-Income Subsidy (LIS) enrollment, participating States will request information from MBD. MBD will validate the incoming file and send an email to the state indicating acceptance or rejection of the file. If the file is rejected, no further action is taken. If the file is accepted, MBD will send a file containing the latest entitlement data for the matched beneficiaries.

10.1 TBQ Request File Dataset Naming Conventions

System	Type	Size	Frequency
MBD	Data File	100	PRN (states can send multiple files in a day)

The following records are included in this file:

- **TBQ Request File Header Record**
- **TBQ Request File Detail Record**
- **TBQ Request File Trailer Record**

10.2 TBQ Request File Header Record Layout

TBQ Request File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Header Code	8	1 – 8	CHAR	MMATBQH
2	State Code	2	9 – 10	CHAR	See Table 15-3, State Codes.
3	Create Month	2	11 – 12	NUM	MM.
4	Create Year	4	13 – 16	NUM	CCYY.
5	Filler	84	17 – 100	CHAR	Spaces.

10.3 TBQ Request File Detail Record Layout

TBQ Request File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Record Type	3	1 – 3	CHAR	DTL.
2	Beneficiary's Social Security Number	9	4 – 12	NUM	
3	Beneficiary's First Name	15	13 – 27	CHAR	The value should not be blank and should be upper case only.
4	Beneficiary's Last Name	20	28 – 47	CHAR	The value should not be blank and should be upper case only.
5	Beneficiary's Middle Initial (Optional)	1	48	CHAR	The first character, upper case only, of the beneficiary's middle name.
6	Beneficiary's Date of Birth	8	49 – 56	CHAR	CCYYMMDD.
7	Beneficiary's Gender Code	1	57	CHAR	M, F, or U.
8	Family ID	11	58 – 68	CHAR	The TBQ process does not require or evaluate any value it receives in this field.
9	Beneficiary Suffix	2	69 – 70	CHAR	The TBQ process does not require or evaluate any value it receives in this field.
10	MPI	13	71 – 83	CHAR	The TBQ process does not require or evaluate any value it receives in this field.
11	Filler	17	84 – 100	CHAR	Spaces.

10.4 TBQ Request File Trailer Record Layout

TBQ Request File Trailer Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Trailer Code	8	1 – 8	CHAR	MMATBQT.
2	Detail Record Count	9	9 – 17	NUM	
3	Filler	83	18 – 100	CHAR	Spaces.

11 Territory Beneficiary Query (TBQ) Response File

The MBD creates a TBQ Response file for each corresponding TBQ Request file from a State. The TBQ Response file contains beneficiary entitlement information for each matched beneficiary TBQ Request file. The response file is transmitted to the State via CMS' Enterprise File Transfer (EFT) process.

11.1 TBQ Response File Dataset Naming Conventions

System	Type	Size	Frequency
MBD	Data File	4000	Response to TBQ Request File.

The following records are included in this file:

- **TBQ Response File Header Record**
- **TBQ Response File Detail Record**
- **TBQ Response File Trailer Record**

11.2 TBQ Response File Header Record Layout

TBQ Response File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Header Code	8	1 – 8	CHAR	MMATBQRH.
2	File Creation Date	8	9 – 16	NUM	CCYYMMDD.
3	Filler	3984	17 – 4000	CHAR	Spaces.

11.3 TBQ Response File Detail Record Layout

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
Start of Original Detail Record					
1	Record Type	3	1 – 3	CHAR	DTL
2	Beneficiary's Social Security Number	9	4 – 12	CHAR	
3	Beneficiary's First Name	15	13 – 27	CHAR	
4	Beneficiary's Last Name	20	28 – 47	CHAR	
5	Beneficiary's Middle Initial	1	48	CHAR	
6	Beneficiary's Date of Birth	8	49 – 56	CHAR	CCYYMMDD.
7	Beneficiary's Gender Code	1	57	CHAR	M, F, or U.
8	Family ID	11	58 – 68	CHAR	
9	Beneficiary Suffix	2	69 – 70	CHAR	
10	MPI	13	71 – 83	CHAR	
End of Original Detail Record					
11	Processed Flag	2	84 – 85	CHAR	00 – Successfully Processed. 01 – Detail Record Identifier not DTL. 02 – SSN Missing. 03 – First Name Missing. 04 – Last Name Missing. 05 – Gender Code Missing. 06 – Date of Birth Missing. 07 – Beneficiary Not Found. 08 – Successfully processed, but beneficiary not entitled to Part A and/or Part B. 09 – More than One Beneficiary Found.
12	Filler	151	86 – 236	CHAR	Spaces.
Beneficiary Information					
13	Beneficiary's Claim Account Number	9	237 – 245	CHAR	
14	Beneficiary's Identification Code	2	246 – 247	CHAR	
15	Beneficiary's Date of Birth	8	248 – 255	NUM	MMDDCCYY.
16	Beneficiary's Date of Death	8	256 – 263	NUM	MMDDCCYY.
17	Beneficiary's Gender Code	1	264	CHAR	0, 1, or 2.
18	Beneficiary's First Name	30	265 – 294	CHAR	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
19	Beneficiary's Middle Initial	1	295	CHAR	
20	Beneficiary's Last Name	40	296 – 335	CHAR	
Cross Reference Numbers (10 occurrences)					
21	Cross Reference Beneficiary's Claim Account Number (Occurrence 1)	9	336 – 344	CHAR	Previous Claim Account Number Identifying Beneficiary
22	Cross Reference Beneficiary's Identification Code (Occurrence 1)	2	345 – 346	CHAR	Previous Beneficiary Identification Code Identifying Beneficiary
23	Cross Reference (Occurrence 2)	11	347 – 357	See items 21 – 22	
24	Cross Reference (Occurrence 3)	11	358 – 568	See items 21 – 22	
25	Cross Reference (Occurrence 4)	11	369 – 379	See items 21 – 22	
26	Cross Reference (Occurrence 5)	11	380 – 390	See items 21 – 22	
27	Cross Reference (Occurrence 6)	11	391 – 401	See items 21 – 22	
28	Cross Reference (Occurrence 7)	11	402 – 412	See items 21 – 22	
29	Cross Reference (Occurrence 8)	11	413 – 423	See items 21 – 22	
30	Cross Reference (Occurrence 9)	11	424 – 434	See items 21 – 22	
31	Cross Reference (Occurrence 10)	11	435 – 445	See items 21 – 22	
Social Security Numbers (5 occurrences)					
32	Social Security Number (Occurrence 1)	9	446 – 454	CHAR	
33	Social Security Number (Occurrence 2)	9	455 – 463	CHAR	
34	Social Security Number (Occurrence 3)	9	464 – 472	CHAR	
35	Social Security Number (Occurrence 4)	9	473 – 481	CHAR	
36	Social Security Number (Occurrence 5)	9	482 – 490	CHAR	
Mailing Address					
37	Mailing Address Line 1	40	491 – 530	CHAR	
38	Mailing Address Line 2	40	531 – 570	CHAR	
39	Mailing Address Line 3	40	571 – 610	CHAR	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
40	Mailing Address Line 4	40	611 – 650	CHAR	
41	Mailing Address Line 5	40	651 – 690	CHAR	
42	Mailing Address Line 6	40	691 – 730	CHAR	
43	Mailing Address City Name	40	731 – 770	CHAR	
44	Mailing Address State Code	2	771 – 772	CHAR	
45	Mailing Address Zone Improvement Plan (Zip) Code	9	773 – 781	CHAR	
46	Mailing Address Change Date	8	782 – 789	NUM	MMDDCCYY.
Residence Address					
47	Residence Address Line 1	60	790 – 849	CHAR	
48	Filler	180	850–1029	CHAR	
49	Residence Address City Name	40	1030 – 1069	CHAR	
50	Residence Address State Code	2	1070 – 1071	CHAR	
51	Residence Address Zip Code	9	1072 – 1080	CHAR	
52	Residence Address Change Date	8	1081 – 1088	NUM	MMDDCCYY.
Representative Payee					
53	Beneficiary's Representative Payee Switch	1	1089	CHAR	Y, N, or space.
Non-Entitlement Status					
54	Part A Non-Entitlement Status Code	1	1090	CHAR	D, F, H, N, R, or space.
55	Part B Non-Entitlement Status Code	1	1091	CHAR	D, N, R, or space.
Entitlement Reason (5 occurrences)					
56	Beneficiary's Entitlement Reason Code Change Date (Occurrence 1)	8	1092 – 1099	NUM	Zeroes.
57	Beneficiary's Entitlement Reason Code (Occurrence 1)	4	1100 – 1103	CHAR	Spaces.
58	Entitlement Reason (Occurrence 2)	12	1104 – 1115	See items 56 – 57	
59	Entitlement Reason (Occurrence 3)	12	1116 – 1127	See items 56 – 57	
60	Entitlement Reason (Occurrence 4)	12	1128 – 1139	See items 56 – 57	
61	Entitlement Reason (Occurrence 5)	12	1140 – 1151	See items 56 – 57	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
Part A Entitlement (5 occurrences)					
62	Beneficiary's Part A Entitlement Start Date (Occurrence 1)	8	1152 – 1159	NUM	MMDDCCYY.
63	Beneficiary's Part A Entitlement End Date (Occurrence 1)	8	1160 – 1167	NUM	MMDDCCYY.
64	Beneficiary's Part A Enrollment Reason Code (Occurrence 1)	1	1168	CHAR	Values: A – Attainment of age 65. B – Equitable relief. D – Disability (under age 65 entitlement). G – General enrollment period. H – Entitlement based on health hazards. I – Initial enrollment period. J – Medicare Qualified Government Employee entitlement. K – Renal disease is or was a reason for entitlement prior to age 65 or prior to the 25th month of disability. L – Late filing. M – Entitlement based on ESRD is terminated, but entitlement based on disability continues. N – Age 65 and uninsured. P – Potentially insured beneficiary is enrolled for Medicare coverage only. Q – Quarters of coverage requirements are involved. R – Residency requirements are involved. S – State buy-in. T – Disabled working individual. U – Unknown. Space – No value exists.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
65	Beneficiary's Part A Enrollment Status Code (Occurrence 1)	1	1169	CHAR	Values: C – No longer entitled due to disability cessation. E – Free Part A Entitlement. G – Entitled due to good cause. S – Terminated. No longer entitled under End-Stage Renal Disease provision. T – Terminated for non-payment of premiums. W – Voluntary withdrawal from premium coverage. X – Free Part A terminated or refused Hospital Insurance. Y – Currently entitled. Premium is payable. Space – No value exists.
66	Part A Entitlement (Occurrence 2)	18	1170 – 1187	See items 62 – 65	
67	Part A Entitlement (Occurrence 3)	18	1188 – 1205	See items 62 – 65	
68	Part A Entitlement (Occurrence 4)	18	1206 – 1223	See items 62 – 65	
69	Part A Entitlement (Occurrence 5)	18	1224 – 1241	See items 62 – 65	
Part B Entitlement (5 occurrences)					
70	Beneficiary's Part B Entitlement Start Date (Occurrence 1)	8	1242 – 1249	NUM	MMDDCCYY.
71	Beneficiary's Part B Entitlement End Date (Occurrence 1)	8	1250 – 1257	NUM	MMDDCCYY.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
72	Beneficiary's Part B Enrollment Reason Code (Occurrence 1)	1	1258	CHAR	Values: B – Equitable relief. C – Good cause. D – Deemed Date of Birth. F – Working aged. G – General enrollment period. H – Entitlement based on health hazards. I – Initial enrollment period. K – Renal disease is or was a reason for entitlement prior to age 65 or prior to the 25th month of disability. M – Entitlement based on ESRD is terminated, but entitlement based on disability continues. P – Medicare Part B Immunosuppressive Drug (Part B-ID). R – Residency requirements are involved. S – State buy-in. T – Disabled working individual. U – Unknown. Space – No value exists.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
73	Beneficiary's Part B Enrollment Status Code (Occurrence 1)	1	1259	CHAR	Values: C – No longer entitled due to disability cessation. F – Terminated due to invalid enrollment or enrollment voided. G – Entitled due to good cause. S – Terminated. No longer entitled under ESRD provision. T – Terminated for non-payment of premiums. W – Voluntary withdrawal from premium coverage. Y – Currently entitled. Premium is payable. Space – No value exists.
74	Part B Entitlement (Occurrence 2)	18	1260 – 1277	See items 70 – 73	
75	Part B Entitlement (Occurrence 3)	18	1278 – 1295	See items 70 – 73	
76	Part B Entitlement (Occurrence 4)	18	1296 – 1313	See items 70 – 73	
77	Part B Entitlement (Occurrence 5)	18	1314 – 1331	See items 70 – 73	
Hospice Coverage (5 occurrences)					
78	Beneficiary Hospice Coverage Start Date (Occurrence 1)	8	1332 – 1339	NUM	MMDDCCYY.
79	Beneficiary Hospice Coverage End Date (Occurrence 1)	8	1340 – 1347	NUM	MMDDCCYY.
80	Hospice Coverage (Occurrence 2)	16	1348 – 1363	See items 78 – 79	
81	Hospice Coverage (Occurrence 3)	16	1364 – 1379	See items 78 – 79	
82	Hospice Coverage (Occurrence 4)	16	1380 – 1395	See items 78 – 79	
83	Hospice Coverage (Occurrence 5)	16	1396 – 1411	See items 78 – 79	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
84	Beneficiary Disability Insurance Benefits Entitlement Start Date (Occurrence 1)	8	1412 – 1419	NUM	MMDDCCYY.
85	Beneficiary Disability Insurance Benefits Entitlement End Date (Occurrence 1)	8	1420 – 1427	NUM	MMDDCCYY.
86	Beneficiary Disability Insurance Benefits Entitlement Justification Code (Occurrence 1)	1	1428	CHAR	1, A, H, or space.
87	Disability Insurance Benefits (Occurrence 2)	17	1429 – 1445	See items 84 – 86	
88	Disability Insurance Benefits (Occurrence 3)	17	1446 – 1462	See items 84 – 86	
89	Beneficiary's Managed Care Organization Enrollment Start Date (Occurrence 1)	8	1463 – 1470	NUM	MMDDCCYY.
90	Beneficiary's Managed Care Organization Enrollment End Date (Occurrence 1)	8	1471 – 1478	NUM	MMDDCCYY.
91	Beneficiary's Managed Care Organization Contract Number (Occurrence 1)	5	1479 – 1483	CHAR	
92	Managed Care Organization (Occurrence 2)	21	1484 – 1504	See items 89 – 91	
93	Managed Care Organization (Occurrence 3)	21	1505 – 1525	See items 89 – 91	
94	Managed Care Organization (Occurrence 4)	21	1526 – 1546	See items 89 – 91	
95	Managed Care Organization (Occurrence 5)	21	1547 – 1567	See items 89 – 91	
96	Managed Care Organization (Occurrence 6)	21	1568 – 1588	See items 89 – 91	
97	Managed Care Organization (Occurrence 7)	21	1589 – 1609	See items 89 – 91	
98	Managed Care Organization (Occurrence 8)	21	1610 – 1630	See items 89 – 91	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
99	Managed Care Organization (Occurrence 9)	21	1631 – 1651	See items 89 – 91	
100	Managed Care Organization (Occurrence 10)	21	1652 – 1672	See items 89 – 91	
Plan Benefits Package Election (10 occurrences)					
101	Group Health Plan Enrollment Effective Date (Occurrence 1)	8	1673 – 1680	NUM	MMDDCCYY.
102	Plan Benefits Package Start Date (Occurrence 1)	8	1681 – 1688	NUM	MMDDCCYY.
103	Plan Benefits Package End Date (Occurrence 1)	8	1689 – 1696	NUM	MMDDCCYY.
104	Plan Benefits Package Number (Occurrence 1)	3	1697 – 1699	CHAR	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
105	Plan Benefits Package Coverage Type Code (Occurrence 1)	2	1700 – 1701	CHAR	Identifies the type of managed care plan benefit package in which the beneficiary is enrolled. Values: NF – Pay bill option not found for this contract. 03 – CCP (Coordinated Care Plan). 04 – MSA (Medicare Medical Savings Account). 05 – PFFS (Private Fee for Service). 06 – PACE (Program of All-Inclusive Care for the Elderly). 07 – Regional. 08 – Demo (Demonstration). 09 – FFS (Fee for Service). 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. 14 – MMP (Medicare/Medicaid Plan). This field is filled with spaces if no PBP enrollment is found.
106	PBP Election (Occurrence 2)	29	1702 – 1730	See items 101 – 105	
107	PBP Election (Occurrence 3)	29	1731 – 1759	See items 101 – 105	
108	PBP Election (Occurrence 4)	29	1760 – 1788	See items 101 – 105	
109	PBP Election (Occurrence 5)	29	1789 – 1817	See items 101 – 105	
110	PBP Election (Occurrence 6)	29	1818 – 1846	See items 101 – 105	
111	PBP Election (Occurrence 7)	29	1847 – 1875	See items 101 – 105	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
112	PBP Election (Occurrence 8)	29	1876 – 1904	See items 101 – 105	
113	PBP Election (Occurrence 9)	29	1905 – 1933	See items 101 – 105	
114	PBP Election (Occurrence 10)	29	1934 – 1962	See items 101 – 105	
End-Stage Renal Disease Coverage					
115	Beneficiary's ESRD Coverage Start Date	8	1963 – 1970	NUM	MMDDCCYY.
116	Beneficiary's ESRD Coverage End Date	8	1971 – 1978	NUM	MMDDCCYY.
117	Beneficiary's ESRD Termination Reason Code	1	1979	CHAR	A, B, C, D, E, or space.
End-Stage Renal Disease Clinical Dialysis Dates Occurrence 1 (refer to items 211 – 215, position 3114 – 3193 for 5 remaining occurrences)					
118	Beneficiary's ESRD Clinical Dialysis Start Date	8	1980 – 1987	NUM	MMDDCCYY.
119	Beneficiary's ESRD Clinical Dialysis End Date	8	1988 – 1995	NUM	MMDDCCYY.
End-Stage Renal Disease Transplant					
120	Beneficiary's ESRD Transplant Start Date	8	1996 – 2003	NUM	MMDDCCYY.
121	Beneficiary's ESRD Transplant End Date	8	2004 – 2011	NUM	MMDDCCYY.
Third-Party Part A History (5 occurrences)					
122	Beneficiary's Part A Third-Party Start Date (Occurrence 1)	8	2012 – 2019	NUM	MMDDCCYY.
123	Beneficiary's Part A Third-Party Premium Payer Code (Occurrence 1)	3	2020 – 2022	CHAR	S01 – S99 and T01 – Z98.
124	Beneficiary's Part A Third-Party End Date (Occurrence 1)	8	2023 – 2030	NUM	MMDDCCYY.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
125	Beneficiary's Part A Third-Party Buy-In Eligibility Code (Occurrence 1)	1	2031	CHAR	Values: A – Aged recipient of Supplemental Security Income (SSI) payments. B – Blind recipient of SSI payments. C – Entitled to Part A of Title IV (Aid to Families with Dependent Children (AFDC)). D – Disabled recipient of SSI payments. E – Aged recipient of supplemental payment administered by SSA. F – Blind recipient of supplemental payment administered by SSA. G – Disabled recipient of supplemental payment administered by SSA. H – Aged, blind, or disabled recipient. M – Entitled to Medical Assistance only (MAO), non-cash recipient. Z – Deemed categorically needy. Space – No eligibility reason exists.
126	Third-Party Part A History (Occurrence 2)	20	2032 – 2051	See items 122 – 125	
127	Third-Party Part A History (Occurrence 3)	20	2052 – 2071	See items 122 – 125	
128	Third-Party Part A History (Occurrence 4)	20	2072 – 2091	See items 122 – 125	
129	Third-Party Part A History (Occurrence 5)	20	2092 – 2111	See items 122 – 125	
Third-Party Part B History (5 occurrences)					
130	Beneficiary's Part B Third-Party Start Date (Occurrence 1)	8	2112 – 2119	NUM	MMDDCCYY.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
131	Beneficiary's Part B Third-Party Premium Payer Code (Occurrence 1)	3	2120 – 2122	CHAR	000, 001, 005, 006, 007, 008, 010 – 650, 700, A01 – R99 or spaces.
132	Beneficiary's Part B Third-Party Termination Date (Occurrence 1)	8	2123 – 2130	NUM	MMDDCCYY.
133	Beneficiary's Part B Third-Party Buy-In Eligibility Code (Occurrence 1)	1	2131	CHAR	Values: A – Aged recipient of Supplemental Security Income (SSI) payments. B – Blind recipient of SSI payments. C – Entitled to Part A of Title IV (Aid to Families with Dependent Children (AFDC)). D – Disabled recipient of SSI payments. E – Aged recipient of supplemental payment administered by SSA. F – Blind recipient of supplemental payment administered by SSA. G – Disabled recipient of supplemental payment administered by SSA. H – Aged, blind, or disabled recipient. M – Entitled to Medical Assistance only (MAO), non-cash recipient. Z – Deemed categorically needy. Space – No eligibility reason exists.
134	Third-Party Part B History (Occurrence 2)	20	2132 – 2151	See items 130 – 133	
135	Third-Party Part B History (Occurrence 3)	20	2152 – 2171	See items 130 – 133	
136	Third-Party Part B History (Occurrence 4)	20	2172 – 2191	See items 130 – 133	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
137	Third-Party Part B History (Occurrence 5)	20	2192 – 2211	See items 130 – 133	
Part D Data Elements					
138	Beneficiary's First Eligibility Part D Date	8	2212 – 2219	NUM	MMDDCCYY.
139	Beneficiary's Affirmatively Decline Indicator	1	2220	CHAR	Y, N, or space.
Beneficiary's Co-Payment History (10 occurrences)					
140	Beneficiary's LIS Type (Occurrence 1)	1	2221	CHAR	L or D.
141	Beneficiary's Co-Payment Level (Occurrence 1)	1	2222	CHAR	1, 2, 3, or 4.
142	Beneficiary's Co-Payment Start Date (Occurrence 1)	8	2223 – 2230	NUM	MMDDCCYY.
143	Beneficiary's Co-Payment End Date (Occurrence 1)	8	2231 – 2238	NUM	MMDDCCYY.
144	Co-Payment History (Occurrence 2)	18	2239 – 2256	See items 140 – 143	
145	Co-Payment History (Occurrence 3)	18	2257 – 2274	See items 140 – 143	
146	Co-Payment History (Occurrence 4)	18	2275 – 2292	See items 140 – 143	
147	Co-Payment History (Occurrence 5)	18	2293 – 2310	See items 140 – 143	
148	Co-Payment History (Occurrence 6)	18	2311 – 2328	See items 140 – 143	
149	Co-Payment History (Occurrence 7)	18	2329 – 2346	See items 140 – 143	
150	Co-Payment History (Occurrence 8)	18	2347 – 2364	See items 140 – 143	
151	Co-Payment History (Occurrence 9)	18	2365 – 2382	See items 140 – 143	
152	Co-Payment History (Occurrence 10)	18	2383 – 2400	See items 140 – 143	
Part D Plan Benefit Package (10 occurrences)					
153	Beneficiary's Contract Number (Occurrence 1)	5	2401 – 2405	CHAR	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
154	Beneficiary's Part D Enrollment Start Date (Occurrence 1)	8	2406 – 2413	NUM	MMDDCCYY.
155	Beneficiary's Part D Enrollment End Date (Occurrence 1)	8	2414 – 2421	NUM	MMDDCCYY.
156	Beneficiary's Part D PBP Plan Number (Occurrence 1)	3	2422 – 2424	CHAR	
157	Beneficiary's Enrollment Type Indicator (Occurrence 1)	1	2425	CHAR	A, B, C, D, E, F, G, H, I, J, K, L, M or N
158	Part D Plan Benefit Package (Occurrence 2)	25	2426 – 2450	See items 153 – 157	
159	Part D Plan Benefit Package (Occurrence 3)	25	2451 – 2475	See items 153 – 157	
160	Part D Plan Benefit Package (Occurrence 4)	25	2476 – 2500	See items 153 – 157	
161	Part D Plan Benefit Package (Occurrence 5)	25	2501 – 2525	See items 153 – 157	
162	Part D Plan Benefit Package (Occurrence 6)	25	2526 – 2550	See items 153 – 157	
163	Part D Plan Benefit Package (Occurrence 7)	25	2551 – 2575	See items 153 – 157	
164	Part D Plan Benefit Package (Occurrence 8)	25	2576 – 2600	See items 153 – 157	
165	Part D Plan Benefit Package (Occurrence 9)	25	2601 – 2625	See items 153 – 157	
166	Part D Plan Benefit Package (Occurrence 10)	25	2626 – 2650	See items 153 – 157	
167	Part C Organization Name	55	2651 – 2705	CHAR	
168	Part C Plan Name	50	2706 – 2755	CHAR	
169	Part D Organization Name	55	2756 – 2810	CHAR	
170	Part D Organization Plan Name	50	2811 – 2860	CHAR	
171	Part D Organization Plan Benefit	1	2861	CHAR	*future use*
172	Beneficiary Language Indicator	1	2862	CHAR	C, D, E, F, G, I, J, N, P, R, S, V, W, or space.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
173	Special Needs Plan Indicator (Occurrence 1)	1	2863	CHAR	Y or N or Space (not applicable).
174	Special Needs Plan Indicator (Occurrence 2)	1	2864	CHAR	Y or N or Space (not applicable).
175	Special Needs Plan Indicator (Occurrence 3)	1	2865	CHAR	Y or N or Space (not applicable).
176	Special Needs Plan Indicator (Occurrence 4)	1	2866	CHAR	Y or N or Space (not applicable).
177	Special Needs Plan Indicator (Occurrence 5)	1	2867	CHAR	Y or N or Space (not applicable).
178	Special Needs Plan Indicator (Occurrence 6)	1	2868	CHAR	Y or N or Space (not applicable).
179 180	Special Needs Plan Indicator (Occurrence 7)	1	2869	CHAR	Y or N or Space (not applicable).
181	Special Needs Plan Indicator (Occurrence 8)	1	2870	CHAR	Y or N or Space (not applicable).
182	Special Needs Plan Indicator (Occurrence 9)	1	2871	CHAR	Y or N or Space (not applicable).
183	Special Needs Plan Indicator (Occurrence 10)	1	2872	CHAR	Y or N or Space (not applicable).
184	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 1)	8	2873 – 2880	NUM	MMDDCCYY.
185	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 1)	8	2881 – 2888	NUM	MMDDCCYY.
186	Filler	14	2889 – 2902	CHAR	Spaces.
RDS Coverage Periods (5 occurrences)					
187	RDS Start Date (Occurrence 1)	8	2903 – 2910	NUM	MMDDCCYY.
188	RDS Termination Date (Occurrence 1)	8	2911 – 2918	NUM	MMDDCCYY.
189	RDS Coverage Period (Occurrence 2)	16	2919 – 2934	See items 187 – 188	
190	RDS Coverage Period (Occurrence 3)	16	2935 – 2950	See items 187 – 188	
191	RDS Coverage Period (Occurrence 4)	16	2951 – 2966	See items 187 – 188	
192	RDS Coverage Period (Occurrence 5)	16	2967 – 2982	See items 187 – 188	
193	Filler	1	2983	CHAR	Spaces.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
Part D Eligibility Dates (5 occurrences)					
194	Part D Eligibility Start Date (Occurrence 1)	8	2984 – 2991	NUM	MMDDCCYY.
195	Part D Eligibility Termination Date (Occurrence 1)	8	2992 – 2999	NUM	MMDDCCYY.
196	Part D Eligibility Dates (Occurrence 2)	16	3000 – 3015	See items 194 – 195	
197	Part D Eligibility Dates (Occurrence 3)	16	3016 – 3031	See items 194 – 195	
198	Part D Eligibility Dates (Occurrence 4)	16	3032 – 3047	See items 194 – 195	
199	Part D Eligibility Dates (Occurrence 5)	16	3048 – 3063	See items 194 – 195	
Beneficiary Subsidy Information (10 occurrences)					
200	Subsidy Level (Occurrence 1)	3	3064 – 3066	NUM	100, 075, 050, or 025.
201	LIS DEEM Source Code (Occurrence 1)	2	3067 – 3068	CHAR	01, 02, 03, 04, 05, 06, SS or <ST> valid state code.
202	Beneficiary Subsidy Information (Occurrence 2)	5	3069 – 3073	See items 200 – 201	
203	Beneficiary Subsidy Information (Occurrence 3)	5	3074 – 3078	See items 200 – 201	
204	Beneficiary Subsidy Information (Occurrence 4)	5	3079 – 3083	See items 200 – 201	
205	Beneficiary Subsidy Information (Occurrence 5)	5	3084 – 3088	See items 200 – 201	
206	Beneficiary Subsidy Information (Occurrence 6)	5	3089 – 3093	See items 200 – 201	
207	Beneficiary Subsidy Information (Occurrence 7)	5	3094 – 3098	See items 200 – 201	
208	Beneficiary Subsidy Information (Occurrence 8)	5	3099 – 3103	See items 200 – 201	
209	Beneficiary Subsidy Information (Occurrence 9)	5	3104 – 3108	See items 200 – 201	
210	Beneficiary Subsidy Information (Occurrence 10)	5	3109 – 3113	See items 200 – 201	
Beneficiary ESRD Clinical Dialysis Dates occurrences 2 through 6 (refer to items 118 – 119, position 1980 – 1995 for the first occurrence).					
211	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 2)	16	3114 – 3129	See items 118 – 119	

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
212	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 3)	16	3130 – 3145	See items 118 – 119	
213	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 4)	16	3146 – 3161	See items 118 – 119	
214	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 5)	16	3162-3177	See items 118 – 119	
215	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 6)	16	3178-3193	See items 118 – 119	
216	Filler	1	3194-3194	CHAR	Spaces.
217	MMP Opt-Out Indicator	1	3195-3195	CHAR	Y, N, or space.
218	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 2)	8	3196-3203	NUM	MMDDCCYY.
219	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 2)	8	3204-3211	NUM	MMDDCCYY.
220	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 3)	8	3212-3219	NUM	MMDDCCYY.
221	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 3)	8	3220-3227	NUM	MMDDCCYY.
222	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 4)	8	3228-3235	NUM	MMDDCCYY.
223	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 4)	8	3236-3243	NUM	MMDDCCYY.
224	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 5)	8	3244-3251	NUM	MMDDCCYY.
225	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 5)	8	3252-3259	NUM	MMDDCCYY.
226	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 6)	8	3260-3267	NUM	MMDDCCYY.
227	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 6)	8	3268-3275	NUM	MMDDCCYY.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
228	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 7)	8	3276-3283	NUM	MMDDCCYY.
229	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 7)	8	3284-3291	NUM	MMDDCCYY.
230	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 8)	8	3292-3299	NUM	MMDDCCYY.
231	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 8)	8	3300-3307	NUM	MMDDCCYY.
232	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 9)	8	3308-3315	NUM	MMDDCCYY.
233	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 9)	8	3316-3323	NUM	MMDDCCYY.
234	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 10)	8	3324-3331	NUM	MMDDCCYY.
235	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 10)	8	3332-3339	NUM	MMDDCCYY.
236	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 1)	8	3340-3347	NUM	MMDDCCYY.
237	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 1)	8	3348-3355	NUM	MMDDCCYY.
238	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 2)	8	3356-3363	NUM	MMDDCCYY.
239	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 2)	8	3364-3371	NUM	MMDDCCYY.
240	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 3)	8	3372-3379	NUM	MMDDCCYY.
241	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 3)	8	3380-3387	NUM	MMDDCCYY.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
242	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 4)	8	3388-3395	NUM	MMDDCCYY.
243	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 4)	8	3396-3403	NUM	MMDDCCYY.
244	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 5)	8	3404-3411	NUM	MMDDCCYY.
245	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 5)	8	3412-3419	NUM	MMDDCCYY.
246	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 6)	8	3420-3427	NUM	MMDDCCYY.
247	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 6)	8	3428-3435	NUM	MMDDCCYY.
248	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 7)	8	3436-3443	NUM	MMDDCCYY.
249	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 7)	8	3444-3451	NUM	MMDDCCYY.
250	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 8)	8	3452-3459	NUM	MMDDCCYY.
251	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 8)	8	3460-3467	NUM	MMDDCCYY.
252	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 9)	8	3468-3475	NUM	MMDDCCYY.
253	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 9)	8	3476-3483	NUM	MMDDCCYY.
254	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 10)	8	3484-3491	NUM	MMDDCCYY.
255	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 10)	8	3492-3499	NUM	MMDDCCYY.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
Beneficiary MBI: Up to six occurrences listed in descending order by the date the occurrence was added to the beneficiary's record.					
256	Beneficiary's MBI (Occurrence 1)	11	3500-3510	CHAR	The MBI from the beneficiary's most recent Beneficiary MBI period. The value is a system-generated identifier used by CMS to uniquely identify the beneficiary in the Medicare database.
257	Beneficiary's MBI Effective Date (Occurrence 1)	8	3511-3518	NUM	The Effective Date of the beneficiary's most recent Beneficiary MBI period. The format is MMDDCCYY.
258	Beneficiary's MBI Effective Reason Code (Occurrence 1)	5	3519-3523	CHAR	The Effective Reason Code from the beneficiary's most recent Beneficiary MBI period. The value indicates the reason an MBI was assigned to the beneficiary. The valid values are the following. A – Accretion. I – Initial bulk MBI assignment. BA – Special authorized. BB – Breach. BP – Provider issue. BR – Religious/cultural. BT – Medical/Identity theft. BZ – Other. CA – Special authorized. CB – CMS breach. CE – Entitlement and casework issues. CF – Confirmed fraud. CT – Medical/Identity theft. CZ' – Other.

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
259	Beneficiary's MBI End Date (Occurrence 1)	8	3524-3531	NUM	The End Date of the beneficiary's most recent Beneficiary MBI period. The format is MMDDCCYY. The valid values are the following. • The field is populated with the End Date from the beneficiary's record if a date exists; or • The field is filled with nines if no value exists for the End Date in the beneficiary's record.
260	Beneficiary's MBI End Reason Code (Occurrence 1)	5	3532-3536	CHAR	The End Reason Code from the beneficiary's most recent Beneficiary MBI period. The value indicates the reason an MBI was deactivated for the beneficiary. The valid values are the following. X – Cross-Reference merge. BA – Special authorized. BB – Breach. BP – Provider issue. BR – Religious/cultural. BT – Medical/Identity theft. BZ – Other. CA – Special authorized. CB – CMS breach. CE – Entitlement and casework issues. CF – Confirmed fraud. CT – Medical/Identity theft. CZ – Other.
261	Beneficiary MBI (Occurrence 2)	37	3537-3573	See items 256 – 260	
262	Beneficiary MBI (Occurrence 3)	37	3574-3610	See items 256 – 260	
263	Beneficiary MBI (Occurrence 4)	37	3611-3647	See items 256 – 260	
264	Beneficiary MBI (Occurrence 5)	37	3648-3684	See items 256 – 260	
265	Beneficiary MBI (Occurrence 6)	37	3685-3721	See items 256 – 260	
266	CARA Status Start Date (1)	8	3722-3729	NUM	MMDDCCYY

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
267	CARA Status End Date (1)	8	3730-3737	NUM	MMDDCCYY
268	CARA Status Start Date (2)	8	3738-3745	NUM	MMDDCCYY
2695	CARA Status End Date (2)	8	3746-3753	NUM	MMDDCCYY
270	CARA Status Start Date (3)	8	3754-3761	NUM	MMDDCCYY
271	CARA Status End Date (3)	8	3762-3769	NUM	MMDDCCYY
272	CARA Status Start Date (4)	8	3770-3777	NUM	MMDDCCYY
273	CARA Status End Date (4)	8	3778-3785	NUM	MMDDCCYY
274	CARA Status Start Date (5)	8	3786-3793	NUM	MMDDCCYY
275	CARA Status End Date (5)	8	3794-3801	NUM	MMDDCCYY
276	CARA Status Start Date (6)	8	3802-3809	NUM	MMDDCCYY
277	CARA Status End Date (6)	8	3810-3817	NUM	MMDDCCYY
278	CARA Status Start Date (7)	8	3818-3825	NUM	MMDDCCYY
279	CARA Status End Date (7)	8	3826-3833	NUM	MMDDCCYY
280	CARA Status Start Date (8)	8	3834-3841	NUM	MMDDCCYY
281	CARA Status End Date (8)	8	3842-3849	NUM	MMDDCCYY
282	CARA Status Start Date (9)	8	3850-3857	NUM	MMDDCCYY
283	CARA Status End Date (9)	8	3858-3865	NUM	MMDDCCYY
284	CARA Status Start Date (10)	8	3866-3873	NUM	MMDDCCYY
285	CARA Status End Date (10)	8	3874-3881	NUM	MMDDCCYY

TBQ Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
286	Date Beneficiary Last Used the Dual/LIS SEP (Election Type "L")	8	3882-3889	NUM	Format is MMDDCCYY. If the beneficiary has not used the DUAL/LIS SEP, then this field is filled with zeroes (00000000).
287	Filler	111	3890-4000	CHAR	Spaces

11.4 TBQ Response File Trailer Record Layout

TBQ Response File Trailer Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Trailer Code	8	1 – 8	CHAR	MMATBQRT.
2	Detail Record Count	9	9 – 17	NUM	
3	Filler	3983	18 – 4000	CHAR	Spaces.

12 Puerto Rico Dual Eligibles File Process

This section describes the Dual Eligible Beneficiaries data exchange between the Medical Assistance Program of Puerto Rico (known by its Spanish acronym, PAM) and CMS.

Medicare Beneficiary Database Suite of Systems (MBDSS) builds a risk adjustment period for a beneficiary living in Puerto Rico based on the beneficiary's eligibility for Medicaid. Puerto Rico sends a Dual Eligibles File to CMS monthly that contains a record for each beneficiary who is eligible for Medicaid during the current month. Records for retroactive Medicaid eligibility may also be included in the file.

MBDSS creates a response file for each file received from Puerto Rico. The response file includes the original beneficiary record in addition to a processing indicator that describes the disposition of the record.

Section 12.1 through 12.4 covers the Request File layouts from Puerto Rico to CMS and Sections 12.5 through 12.9 covers the Response File layouts from CMS to Puerto Rico.

12.1 Puerto Rico Dual Eligibles Request File Dataset Naming Conventions

System	Type	Size	Frequency
MBD	Data File	129	Monthly

The following records are included in this file:

- Puerto Rico Dual Eligible Request File Header Record
- Puerto Rico Dual Eligible Request File Detail Record
- Puerto Rico Dual Eligible Request File Trailer Record

12.2 Puerto Rico Dual Eligibles Request File Header Record Layout

Puerto Rico Dual Eligibles Request File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	File ID Name	8	1-8	CHAR	MMATMA1H
2	State Code	2	9-10	CHAR	PR
3	File Creation Month	2	11-12	NUM	MM
4	File Creation Year	4	13-16	NUM	CCYY

5	Filler	113	17-129	CHAR	Spaces

12.3 Puerto Rico Dual Eligibles Request File Detail Record Layout

Puerto Rico Dual Eligibles Request File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Record Type	3	1-3	CHAR	DTL
2	Eligibility Month	2	4-5	NUM	MM
3	Eligibility Year	4	6-9	NUM	CCYY
4	Eligibility Status	1	10-10	CHAR	Y – Eligible N – Not Eligible
5	Beneficiary's Identifier	12	11-22	CHAR	The beneficiary's identifier, which is used by CMS to identify the beneficiary in the Medicare database. The acceptable values are the following: • Health Insurance Claim Number (HICN); • Railroad Retirement Board (RRB) Number; or • Medicare Beneficiary Identifier (MBI).
6	Beneficiary's Social Security Number	9	23-31	CHAR	
7	Medicaid Identifier	24	32-55	CHAR	
8	Beneficiary's First Name	15	56-70	CHAR	
9	Beneficiary's Last Name	20	71-90	CHAR	
10	Beneficiary's Middle Name	15	91-105	CHAR	
11	Beneficiary's Gender Code	1	106-106	CHAR	F – Female M – Male U – Unknown
12	Beneficiary's Date of Birth	8	107-114	CHAR	CCYYMMDD
13	Filler	15	115-129	CHAR	Spaces

12.4 Puerto Rico Dual Eligibles Request File Trailer Record Layout

Puerto Rico Dual Eligibles Request File Trailer Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Trailer Code	8	1-8	CHAR	MMATMA1T
2	Detail Record Count	9	9-17	NUM	Right justified
3	Filler	112	18-129	CHAR	Spaces

12.5 Puerto Rico Dual Eligibles Response File Dataset Naming Conventions

System	Type	Size	Frequency
MBD	Data File	129	Monthly

The following records are included in this file:

- Puerto Rico Dual Eligible Response File Header Record
- Puerto Rico Dual Eligible Response File Detail Record
- Puerto Rico Dual Eligible Response File Trailer Record

12.6 Puerto Rico Dual Eligibles Response File Header Record Layout

Puerto Rico Dual Eligibles Response File Header Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	File ID Name	8	1-8	CHAR	MMATMA1H
2	File Creation Date	8	9-16	NUM	CCYYMMDD
3	Filler	113	17-129	CHAR	Spaces

12.7 Puerto Rico Dual Eligibles Response File Detail Record Layout

Puerto Rico Dual Eligibles Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
Start of Original Transaction Detail Record					
1	Record Type	3	1-3	CHAR	DTL
2	Eligibility Month	2	4-5	NUM	MM
3	Eligibility Year	4	6-9	NUM	CCYY
4	Eligibility Status	1	10-10	CHAR	Y – Eligible N – Not Eligible

Puerto Rico Dual Eligibles Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
5	Beneficiary's Identifier	12	11-22	CHAR	The field is populated with the value for the same field from the related Puerto Rico to CMS Monthly Dual Eligibles file.
6	Beneficiary's Social Security Number	9	23-31	CHAR	
7	Medicaid Identifier	24	32-55	CHAR	
8	Beneficiary's First Name	15	56-70	CHAR	
9	Beneficiary's Last Name	20	71-90	CHAR	
10	Beneficiary's Middle Name	15	91-105	CHAR	
11	Beneficiary's Gender Code	1	106-106	CHAR	F – Female M – Male U – Unknown
12	Beneficiary's Date of Birth	8	107-114	CHAR	CCYYMMDD
End of Original Transaction Detail Record					
13	Processing Response Code	2	115-116	CHAR	00 – Record processed successfully. 01 – HICN/RRB/MBI number missing. 02 – Reserved. 03 – Eligibility Month Missing or Invalid. 04 – Eligibility Year Missing or Invalid. 05 – Beneficiary Not Found. 06 – Beneficiary Not Eligible for Part D. 07 – Future Eligibility Month/Year. 08 – Multiple Match. 09 – Eligibility Month/Year Earlier Than January 2006. 10 – Detail Record Identifier Not 'DTL'.
14	Archive Indicator	1	117-117	CHAR	A – Archived Space – Not Archived or not found in database.

Puerto Rico Dual Eligibles Response File Detail Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
15	Beneficiary's MBI	11	118-128	CHAR	The MBI from the beneficiary's most recent Beneficiary MBI period. The value is a system-generated identifier used internally and externally to uniquely identify the beneficiary in the Medicare database.
16	Filler	1	129-129	CHAR	Space

12.8 Puerto Rico Dual Eligibles Response File Trailer Record Layout

Puerto Rico Dual Eligibles Response File Trailer Record					
Item	**Field**	**Size**	**Position**	**Format**	**Valid Values**
1	Trailer Code	8	1-8	CHAR	MMATMA1T
2	Detail Record Count	9	9-17	NUM	Right justified
3	Filler	112	18-129	CHAR	Spaces

12.9 Puerto Rico Dual Eligibles File – E-mail Acknowledgement

If the incoming files pass all validation tests, an e-mail acknowledgment will be sent to Puerto Rico. A template of the e-mail text is as follows:

This e-mail is to confirm that CMS has received your recent file submission.

If the incoming file is rejected for file format errors, a file rejection will be sent to Puerto Rico. A template of the e-mail text is as follows:

This e-mail is to inform you that your recently submitted file was rejected.

This file must be corrected and resubmitted

If the incoming file is rejected because the error count has exceeded the allowable threshold limit a file rejection will be sent to Puerto Rico. A template of the e-mail text is as follows:

This e-mail is to inform you that your recently submitted file has exceeded the allowable threshold limit for edit errors.

Header name: MMATMA1HPR102014
Maximum Allowable Rejection Limit is 10.00%
Total Description
000000000 HIC/RRB# Missing
000000000 Invalid Eligibility Status
000000000 Eligibility Month Invalid
000000000 Eligibility Year Invalid
000000000 Beneficiary Not Found
000000000 Beneficiary Not Eligible for Part D
000000000 Future Eligibility Month/Year
000000000 Disposition of Record Pending
000000000 Eligibility Date Earlier 01/01/2006

000000000 Detail Record Identifier Not DTL
000000000 Total Records Read
000000000 Total Records Failed”

13 Glossary, List of Acronyms, and State Codes

Table 13-41: Glossary

Glossary	
Term	**Definition**
Application Date	The date that the beneficiary applies to enroll in a Plan. Enrollments submitted by CMS or its contractors, such as the Medicare Beneficiary Contact Center, do not need application dates.
Beneficiary Identification Code (BIC)	The portion of the Medicare health insurance claim number that identifies a specific beneficiary.
Button	A rectangular icon on a screen that, when clicked, engages an action. The button is labeled with the word(s) that describe the action, such as Find or Update.
Checkbox	A field that is part of a group of options, for which the user may select any number of options. Each option is represented with a small box, where 'x' means "on" and an empty box means "off." When a checkbox is clicked, an 'x' appears in the box. When the checkbox is clicked again, the 'x' is removed.
Correction	A record submitted by a Plan or CMS office to correct or update existing Beneficiary data.
Current Calendar Month (CCM)	Represents the calendar month and year at the time of transaction submission. For batch, the current month is derived from the batch file transmission date; for User Interface transactions, the current month is derived from the system data at the time of transaction submission.
Current Payment Month (CPM)	The month for which Plans receive payment from CMS, not the current calendar month.
Creditable Coverage	Prescription drug coverage, generally from an employer or union, that is equivalent to, or better than, Medicare standard prescription drug coverage.
Data entry field	A field that requires the user to enter information.
Disenrollment	A record submitted by a Plan, Social Security Administration District Office (SSA DO), Medicare Customer Service Center (MCSC), or CMS when a beneficiary discontinues membership in the Plan.
Dropdown list	A field that contains a list of values from which the user chooses. Clicking on the down arrow on the right of the field enables the user to view the list of values, and then click on a value to select it.
Dually Eligible	Beneficiaries entitled to both Medicare and Medicaid benefits.
Election Period	Periods during which a Beneficiary may elect to join, change, or leave Medicare Part C and/or Part D Plans. These periods are fully defined in CMS Enrollment and Disenrollment guidance for Part C and D Plans available on the CMS website at: http://www.cms.gov/home/medicare.asp under "Eligibility and Enrollment."
Enrollment	A record is submitted when a Beneficiary joins an MCO or a Drug Plan.
Enrollment Process	A process in which a Plan submits a request to enroll in a Plan, change enrollment, or disenroll.
Hospice	A health facility for the terminally ill.

Glossary	
Term	**Definition**
Logoff	The method of exiting an online system.
Logon	The method for gaining entry to an online system.
Lookup field	A field that provides a list of possible values. When the user clicks on the “binocular” button next to the field, a window pops up with a list of values for that field. Clicking on one of those values closes the pop-up window and the field is filled with the value chosen.
Managed Care Organization (MCO)	A type of Medicare Part C or D contract under which CMS pays for each beneficiary, based on demographic characteristics and health status; also referred to as Risk contract. In a Risk contract, the MCO accepts the risk if the payment does not cover the cost of services, but keeps the difference (subject to any risk corridors) if the payment is greater than the cost of services.
Medicaid	A jointly funded, Federal-State health insurance program for certain low-income people. It covers approximately 72.2 million beneficiaries.
Menu	A horizontal list of items at the top of a screen. Clicking on a menu item displays a screen and may display a submenu of items corresponding to the selected menu item.
Nursing Home Certifiable (NHC)	A code that reflects the relative frailty of a beneficiary. NHC beneficiaries are those whose condition would ordinarily require nursing home care. The code is only acceptable for certain social health maintenance organization (SHMO)-type Plans.
Online	An automated system approach that interactively processes data, normally through computer input.
Program for All-Inclusive Care for the Elderly (PACE) Plans	PACE is a unique capitated managed care benefit for the frail elderly provided by an entity that offers a comprehensive medical and social service delivery system. It uses a multidisciplinary team approach in an adult day health center, supplemented by in-home and referral services in accordance with participants' needs.
Radio button	A field that is part of a group of options, of which the user may only select one option. A radio button is represented with a small circle; a filled circle indicates the button is selected, and an empty circle means it is not selected. Clicking a radio button selects that option and deselects the existing selection.
Required field	A field that the user must complete before a button is clicked to engage an action. If the button is clicked and the field is not filled in, an error message displays and the action does not occur. There are two types of required fields: • Always required, which are marked with an asterisk (*) • Conditionally required, where the user must fill in at least one or only one of the conditionally required fields. These are marked with a plus sign (+).
Special Needs Plan (SNP)	A certain type of MA Plan that serves a limited population of beneficiaries in CMS special-needs categories, as defined in CMS Part C Enrollment and Eligibility Guidance. This Plan is fully defined on the CMS website at: http://www.cms.gov/home/medicare.asp under “Health Plans.”
Submenu	A horizontal list of items below the screen’s menu. Clicking on a submenu item displays a screen.
User ID	Valid IDM user identification code used for accessing MARx.

Glossary	
Term	**Definition**
User Interface	The screens, forms, and menus that display to a user logged on to an automated system.

Table 13-42: Acronyms Used in this Document

Acronyms Used in this Document	
Acronym	**Definition**
BEQ	Batch Eligibility Queries
BIC	Beneficiary Identification Code
BIN	Beneficiary Identification Number
BIPA	Benefits Improvement & Protection Act
CAN	Claim Account Number
CCM	Current Calendar Month
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COM	Current Operation Month
CPM	Current Payment Month
DET	Detail Record
DOB	Date of Birth
DOD	Date of Death
DTL	Detail
EFT	Enterprise File Transfer
EGHP	Employer Group Health Plan
ESRD	End Stage Renal Disease
EUA	Enterprise User Administration
FFS	Fee-For-Service
GHP	Group Health Plan
GRP	Group
HCBS	Home and Community-Based Services
HICN	Health Insurance Claim Number
HMO	Health Maintenance Organization
HTML	Hypertext Markup Language
ID	Identification
IDM	Identity Management
LI	Low-Income
LIS	Low-Income Subsidy
LTI	Long-Term Institutional
MA	Medicare Advantage
MAPD	Medicare Advantage Prescription Drug
MARx	Medicare Advantage Prescription Drug System
MBD	Medicare Beneficiary Database
MBI	Medicare Beneficiary Identifier

Acronyms Used in this Document	
Acronym	**Definition**
MBR	Master Beneficiary Record
MCO	Managed Care Organization
MMA	Medicare Modernization Act
MMP	Medicare and Medicaid Plan
MSA	Medical Savings Account
MSP	Medicare Secondary Payer
NHC	Nursing Home Certifiable
NUNCMO	Number of Uncovered Months
PACE	Program of All-Inclusive Care for the Elderly
PAM	Medical Assistance Program of Puerto Rico
PBP	Plan Benefit Package
PCN	Processing Control Number
PDP	Prescription Drug Plan
PFFS	Private Fee-for-Service
POS	Point-of-Sale
PRO	PROspective Record
QI	Qualified Individual
QMB	Qualified Medicare Beneficiary Program
RACF	Resource Access Control Facility
RDS	Retiree Drug Subsidy
RRB	Railroad Retirement Board
SCC	State and County Code
SLMB	Specified Low-Income Medicare Beneficiary Program
SNP	Special Needs Plan
SPAP	State Pharmaceutical Assistance Program
SSA	Social Security Administration
SSN	Social Security Number
TBQ	Territory Beneficiary Query
UI	User Interface
XREF	Cross Reference

Table 13-43: State Codes

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