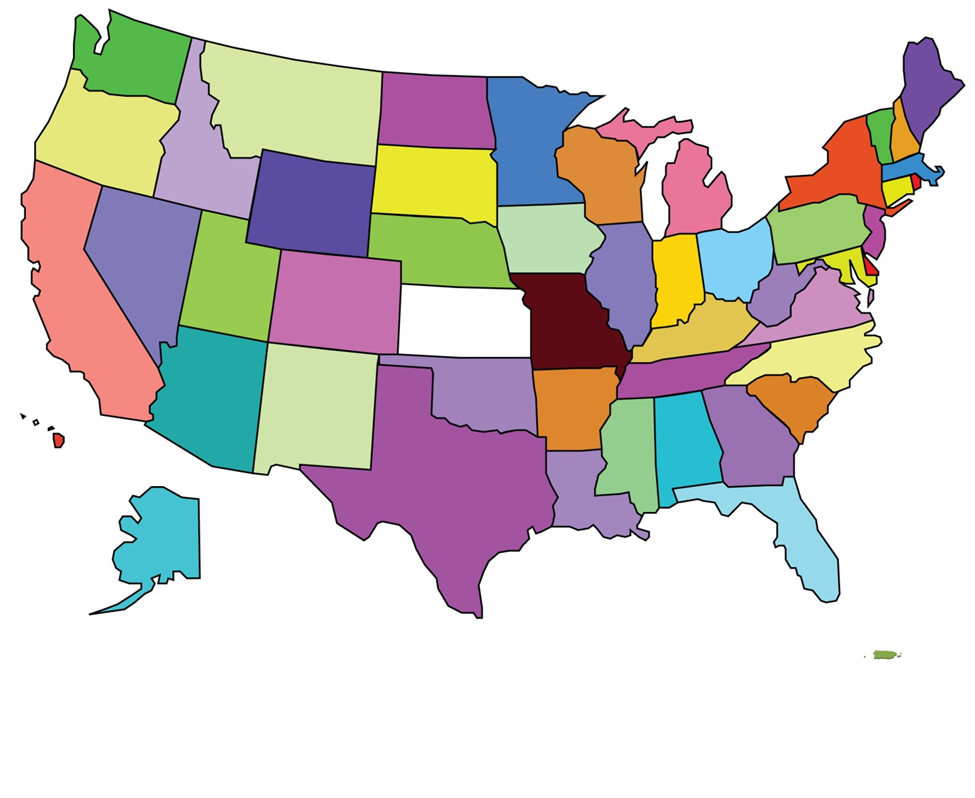
Centers for Medicare and Medicaid Services
Logo 

**Medicare Advantage Prescription Drug**

**State User Guide**

**Version 11.0**

**February X, 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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# Introduction

## 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.

## Document Organization

**Section 1** [**Introduction**](#_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**](#_Using_the_Medicare)**-** provides information for state users toaccess enrollment, eligibility, and 4Rx information for beneficiaries.

**Section 3** [**Entitlement Status, Enrollment, and Disenrollment Reason Codes**](#Entitlement_Status_and_Enrollment_Reason)**-** 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**](#_Technical_Instructions_for)**-** provides information for the States when exchanging files with CMS.

**Section 5** [**State MMA Request File Timing and Content**](#_State_MMA_Request)**-** provides information about the timing and content for the MMA Request File.

**Section 6** [**MMA Request File**](#_MMA_Request_File_1)**-** 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**](#_MMA_Response_File_5)**-** 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**](#_Batch_Eligibility_Query)**-** provides information about the BEQ Request File sent by the state to request eligibility information.

**Section 9** [**Batch Eligibility Query (BEQ) Response File**](#_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**](#_Territory_Beneficiary_Query)**-** 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**](#_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**](#_Glossary,_List_of)**-** 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-**](#_Glossary,_List_of)provides a glossary, list of acronyms, and state codes used throughout the SUG.

## 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](mailto:mapdhelp@cms.hhs.gov) or 1-800-927-8069.

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

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

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

* [Getting Started.](#_Getting_Started)
* [Using the MARx UI Screens.](#_Using_the_MARx)
* [Navigating the MARx UI](#_Navigating_the_System).
* [Viewing Beneficiary Information](#_Viewing_Beneficiary_Information)

## 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.

### 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](https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/EnterpriseIdentityManagement/EIDM-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.**

### 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.](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.**

**Graphical user interface, text, application, email

Description automatically generated**

Figure 2‑1 Request Access to MARx UI

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

Graphical user interface, text, application, email

Description automatically generated

Figure 2‑2: Request New Application Access

1. 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.
2. Complete Step 4 (Enter Business Contact Information), Step 5 (Enter Role Details), Step 6 (Enter Reason for Request).
3. 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***.

### 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.

## Using the MARx UI Screens

### 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.

### 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.

### 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.

### 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.

### 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. |
| [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. |
| Description: screen navigation arrows | **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:  Description: first page arrow– go to the first page of items in the list  Description: previous page arrow– go to the previous page of items in the list  Description: next page arrow– go to the next page of items in the list  Description: last page arrow– go to the last page of items in the list |
| Description: Go to page number | **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. |
| 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. |

## Navigating the MARx UI

### 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.

### 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.

### 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.

### 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**](#Fig2_1) |
| Welcome | [**M101**](#Fig2_2) |
| Beneficiaries Screens | |
| Beneficiaries: Find | [**M201**](#Fig2_3) |
| Beneficiaries: Search Results | [**M202**](#Fig2_4) |
| Beneficiary Detail: Snapshot | [**M203**](#Fig2_5) |
| Beneficiary Detail: Enrollment | [**M204**](#Fig2_7) |
| Enrollment Detail | [**M222**](#Fig2_8) |
| Beneficiaries: Eligibility | [**M232**](#Fig2_12) |
| Rx Insurance View | [**M244**](#Fig2_9) |
| Additional Insurance Information | [**M251**](#Fig2_10) |
| Low-Income Subsidy | [**M252**](#Fig2_11) |
| Status Activity | [**M256**](#Fig2_13) |
| Status Detail | [**M257**](#Fig2_14) |

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.

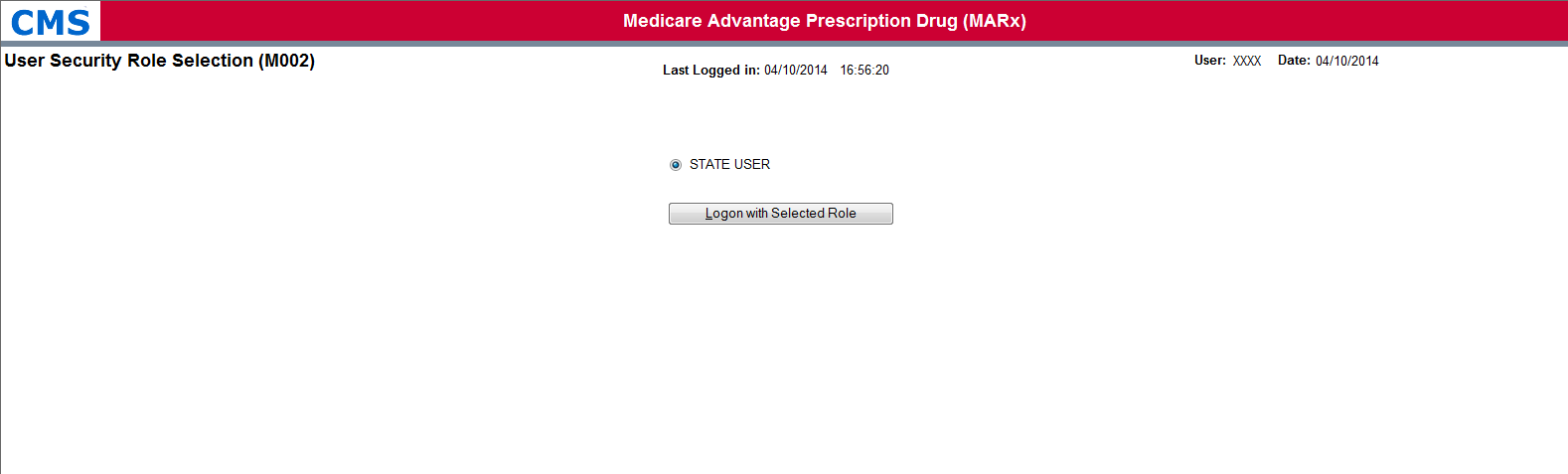
The MARx UI meets U.S. Regulations, Section 508 of the Rehabilitation Act Amendments of 1998, requiring all U.S. Federal agencies to make their Information Technology accessible to their employees and customers with disabilities.

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.

### 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. |
| 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**.

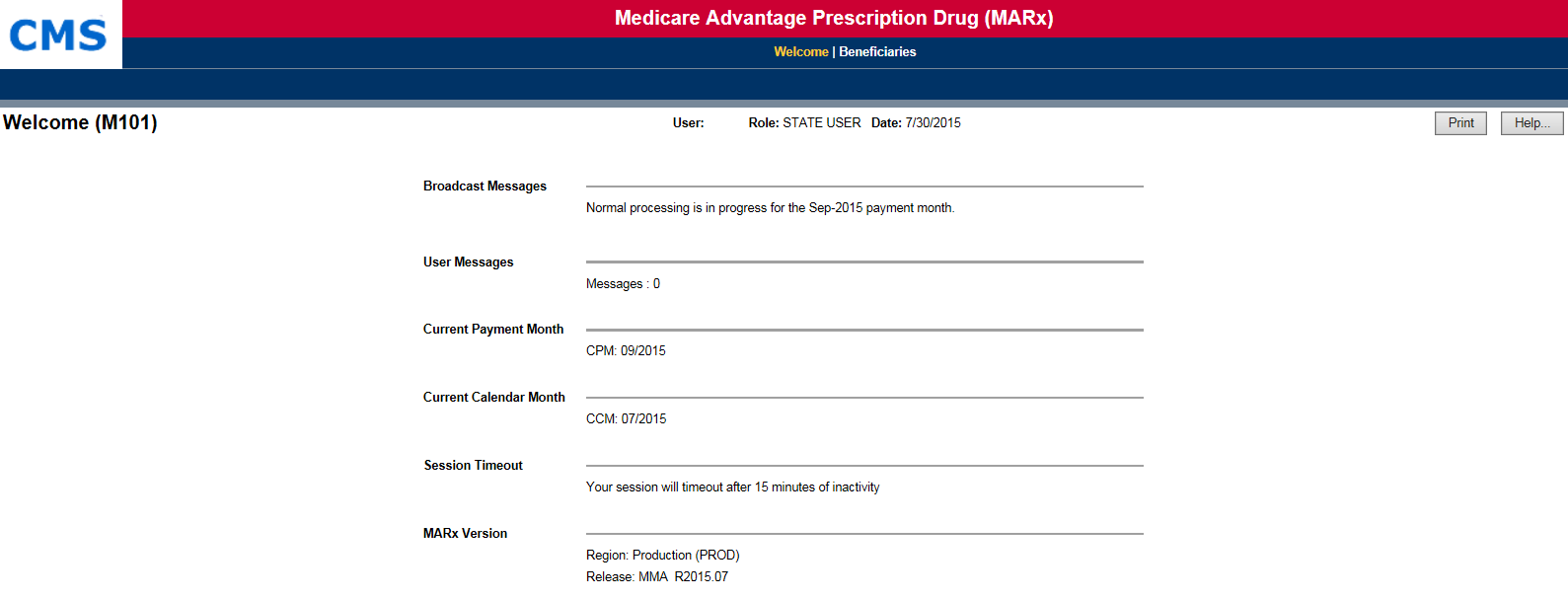


Figure 2‑4: State User Welcome (M101) Screen

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. |
| 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. |

## Viewing Beneficiary Information

### 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.

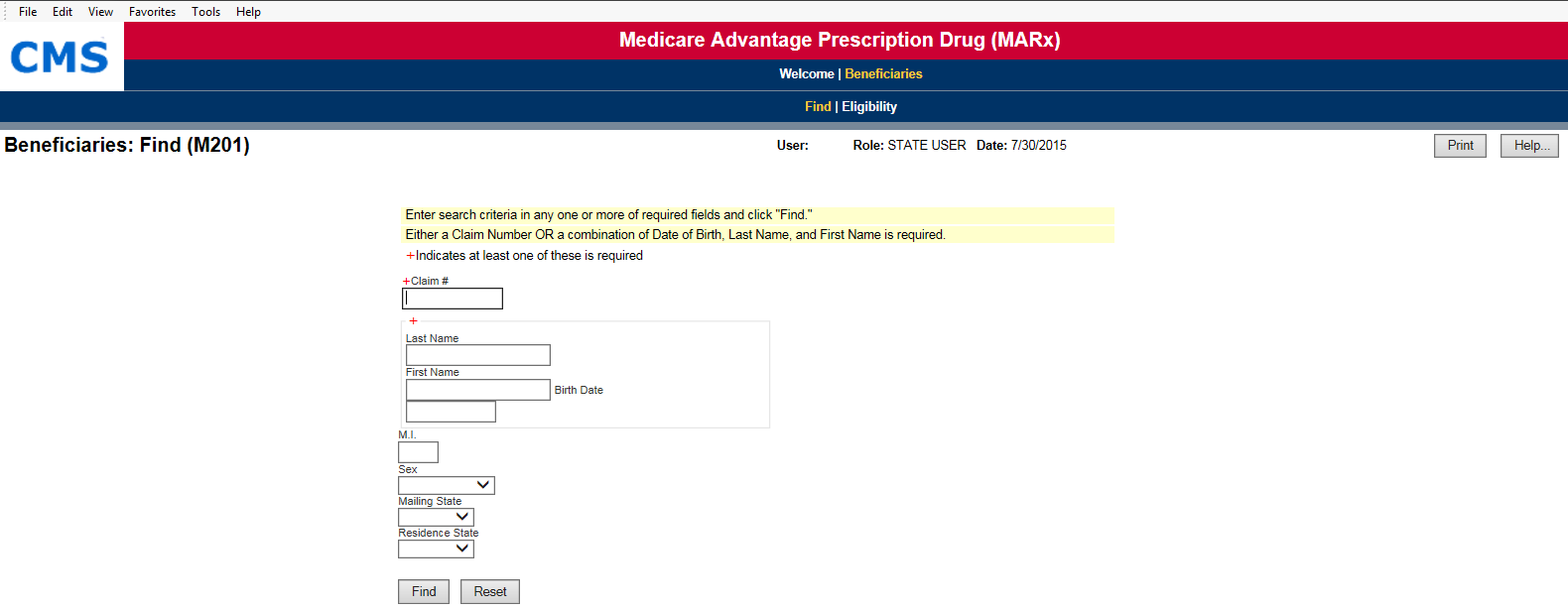


Figure 2‑5: State User Beneficiaries: Find (M201) Screen

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. |

### 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**.

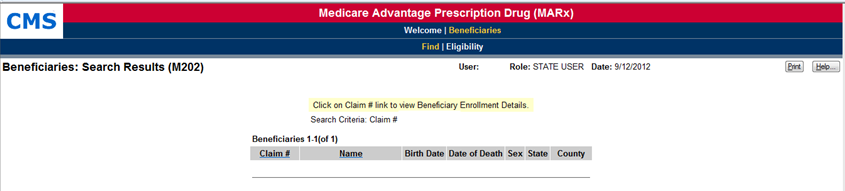


Figure 2‑6: State User Beneficiaries: Search Results (M202) Screen

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. |

### 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.**

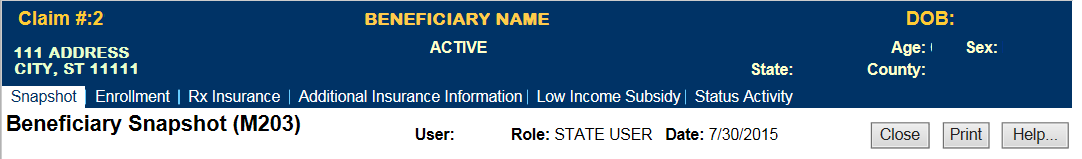


Figure 2‑7: Sample Header for the Beneficiary Snapshot (M203) Screen

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.

### 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

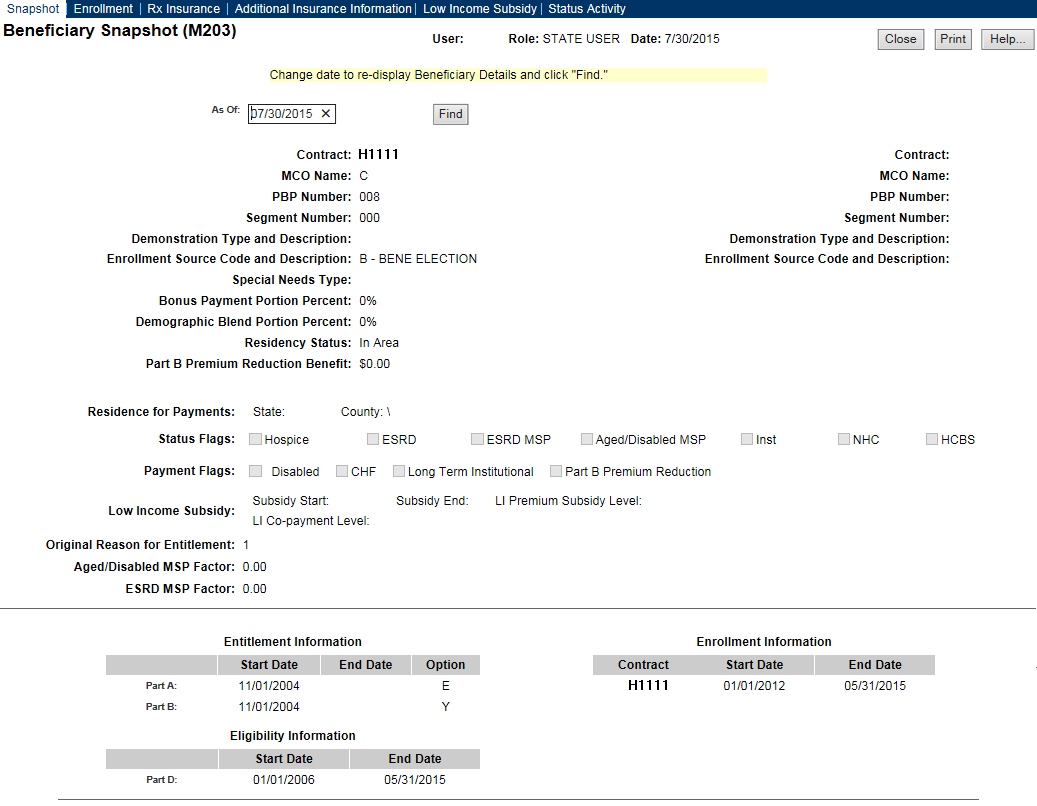
Figure 2‑8: State User Beneficiary Detail: Snapshot (M203) Screen

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. |
| 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. |
| 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. |

### 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.**

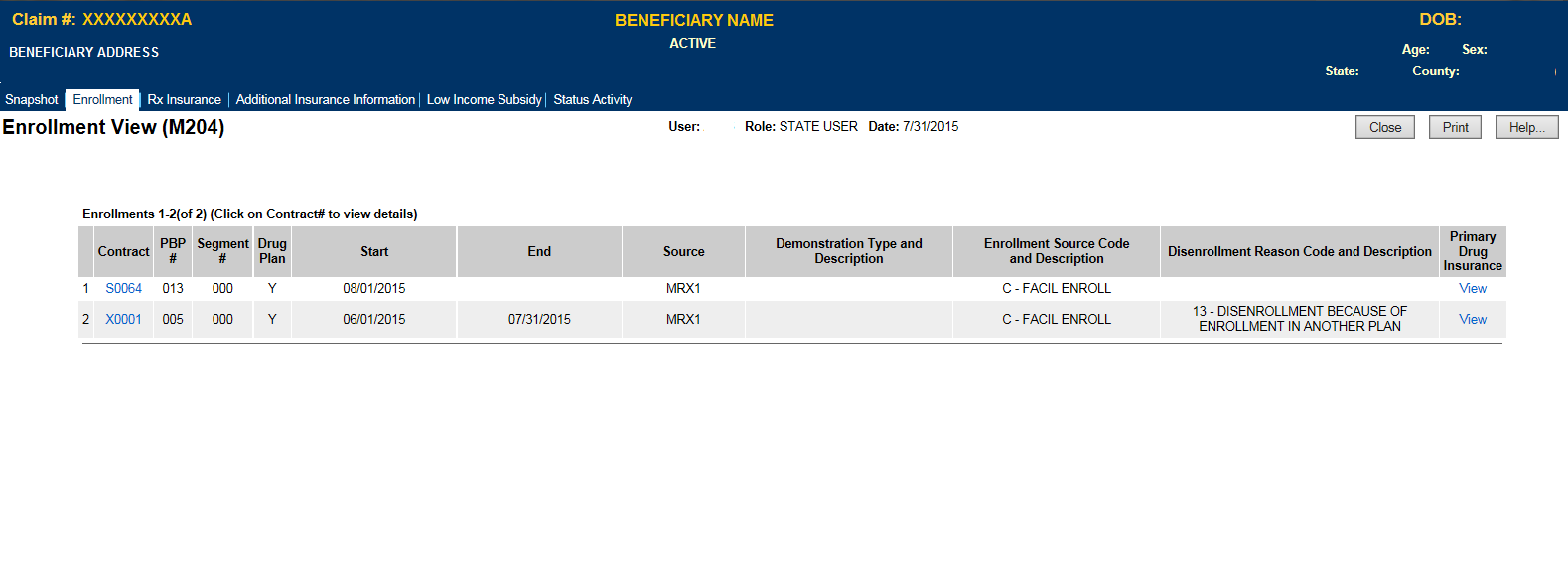
Figure 2‑9: State User Beneficiary Detail: Enrollment (M204) Screen

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). |
| 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. |
| 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**.

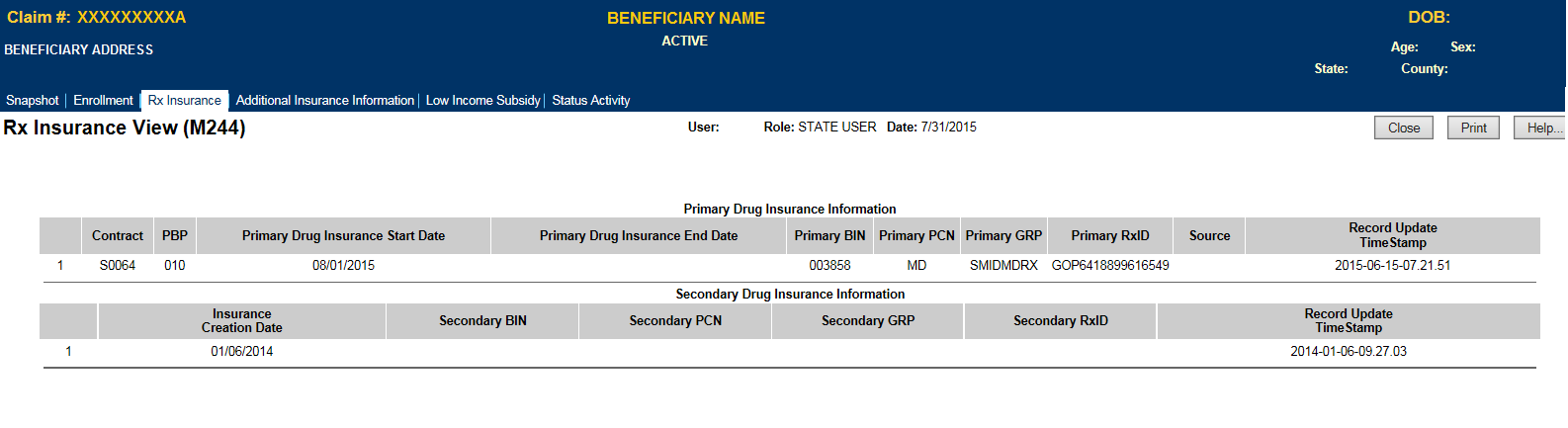
Figure 2‑11: Rx Insurance View (M244) Screen

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. |
| **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. |

### 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**.

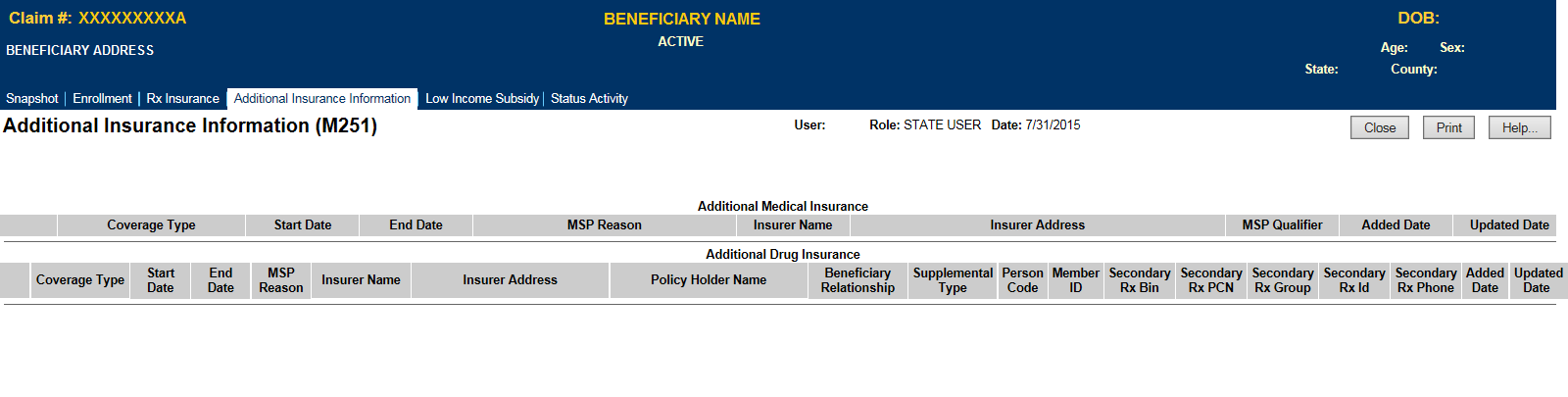
**Figure 2‑12: Additional Insurance Information (M251) Screen**

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 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 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 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. |

### 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 | 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. |
| 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. |

### 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**.

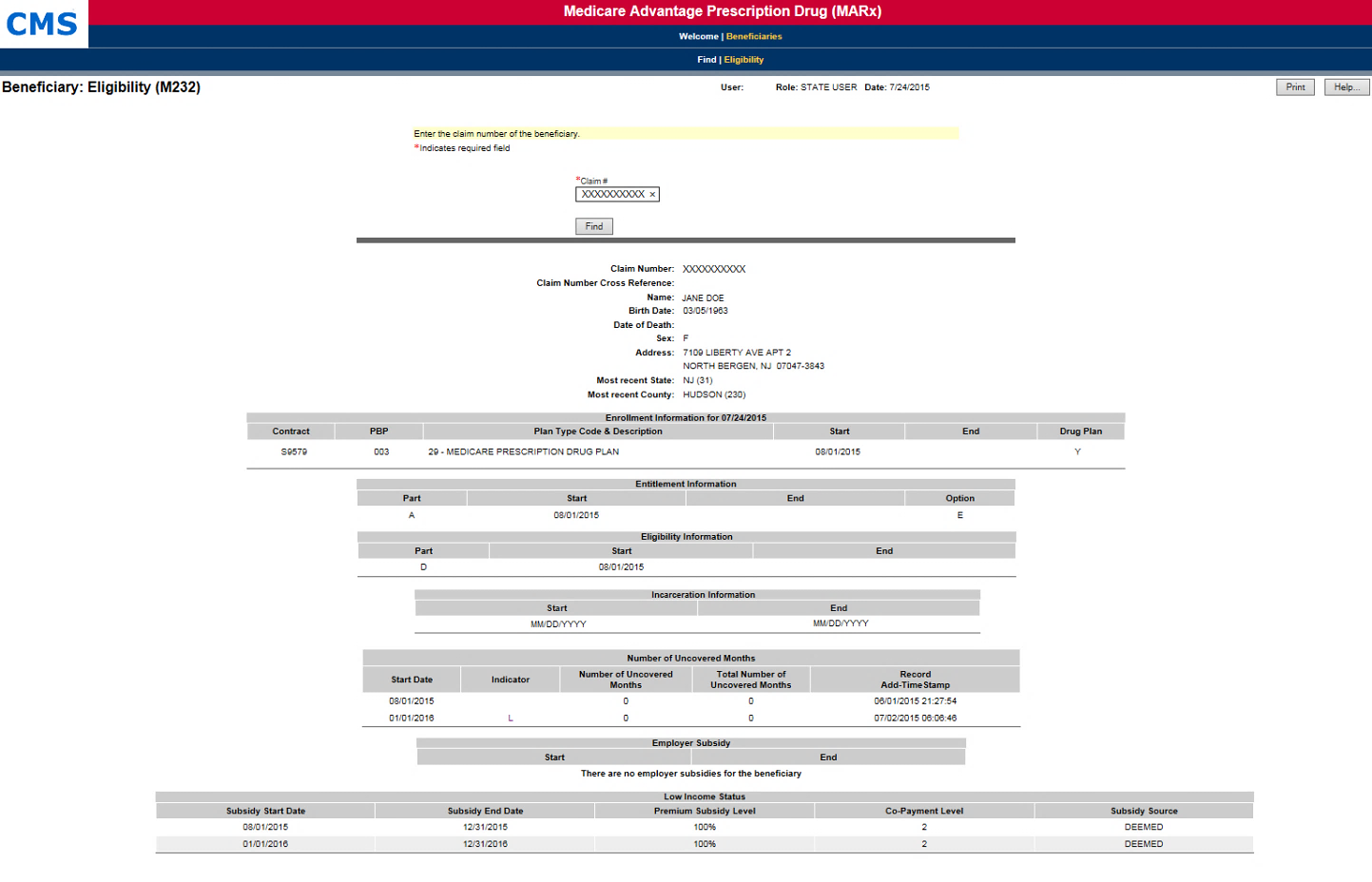
Figure 2‑14: State User Beneficiary: Eligibility (M232) Screen

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. |
| 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](#_Entitlement_Status,_Enrollment,) 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. |
| 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.

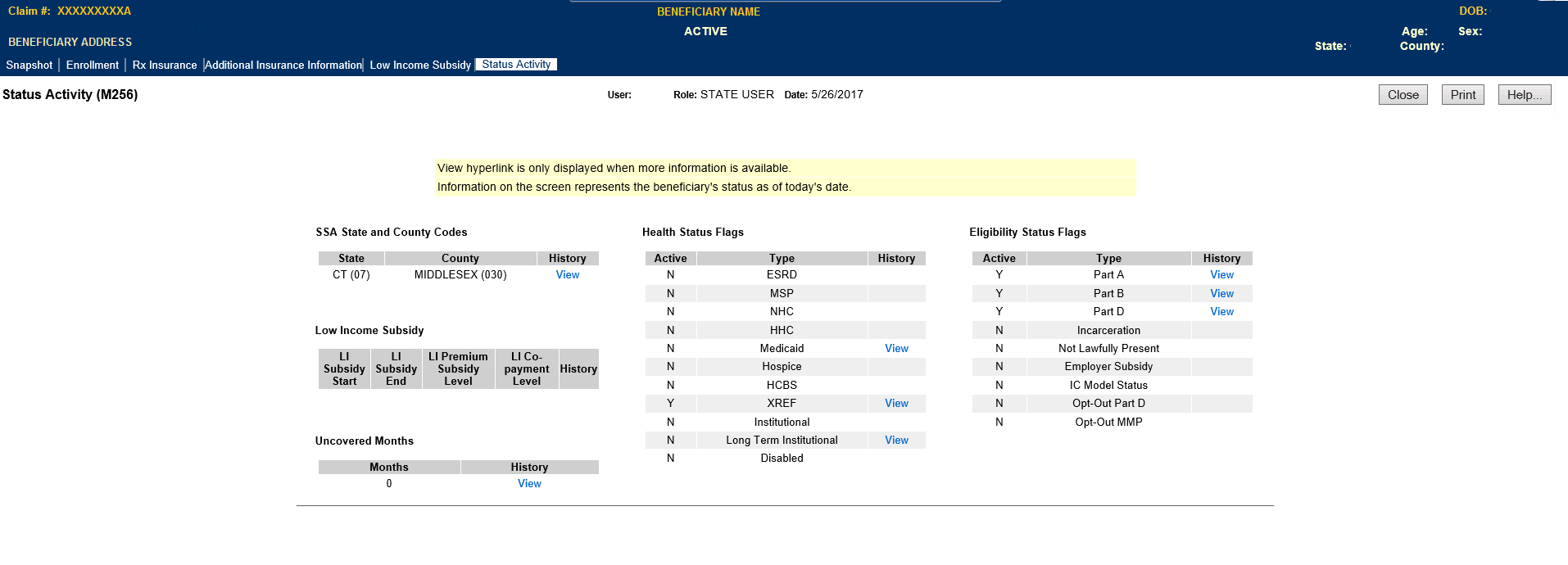
### Viewing Status Activity and Detail Information for Beneficiaries

#### 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.

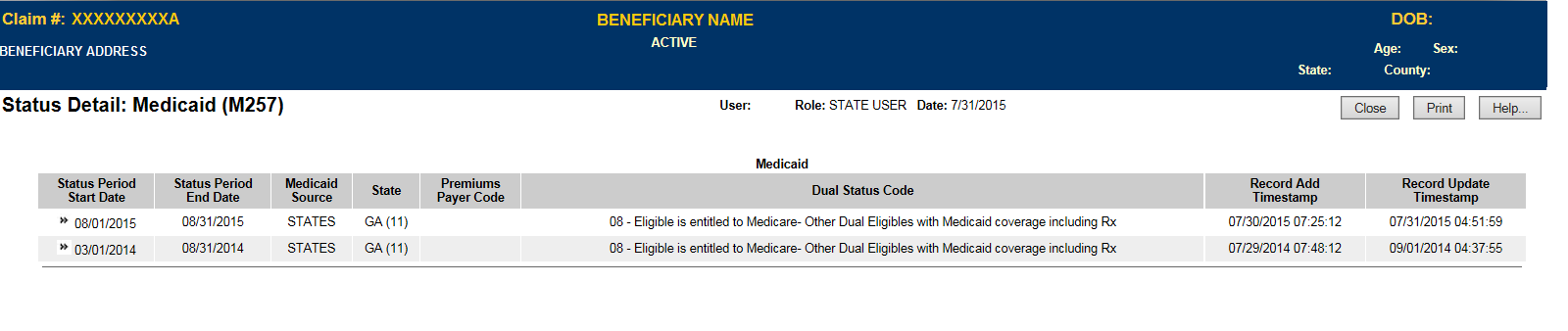
Table 2‑28: Status Activity (M256) Field Descriptions and Actions

| **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. |
| 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. |
| 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. |

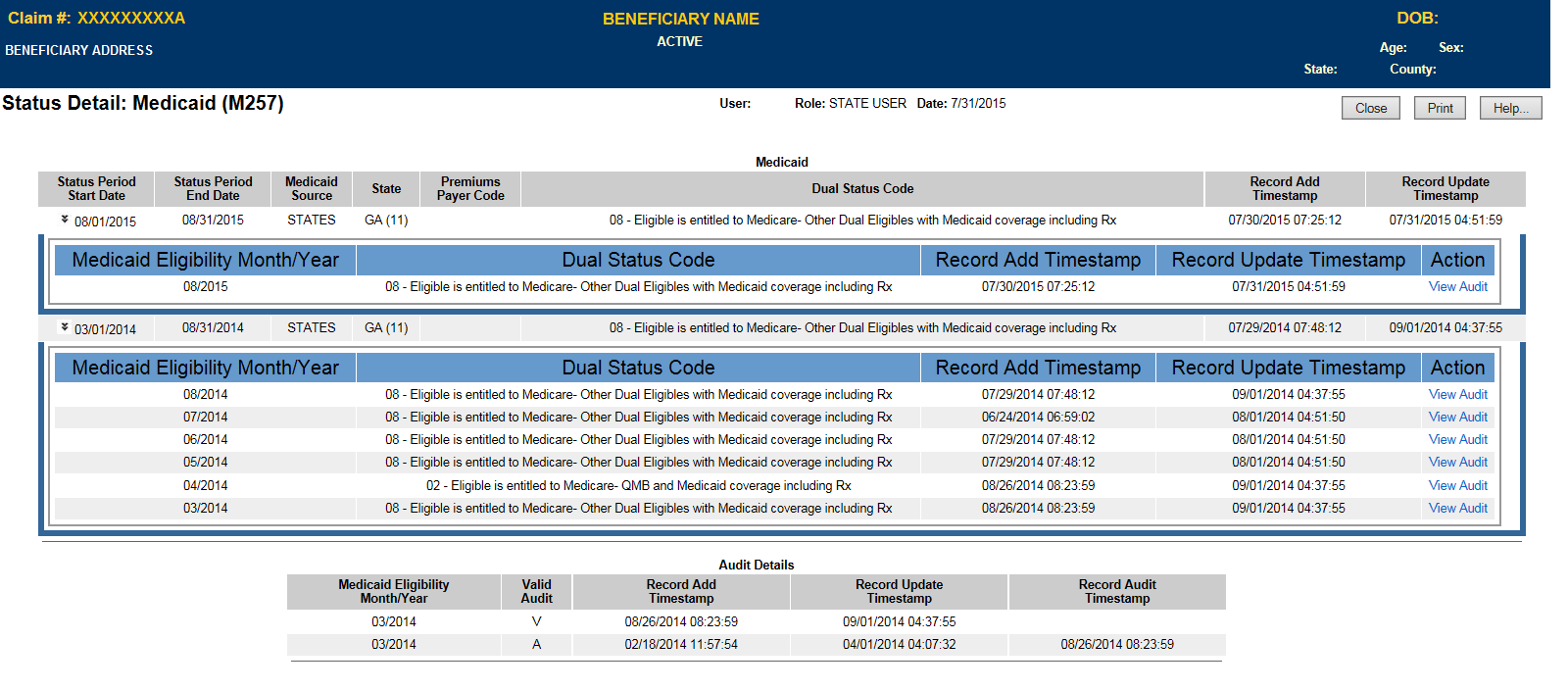
#### Step 9a: Viewing Status Detail

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**.

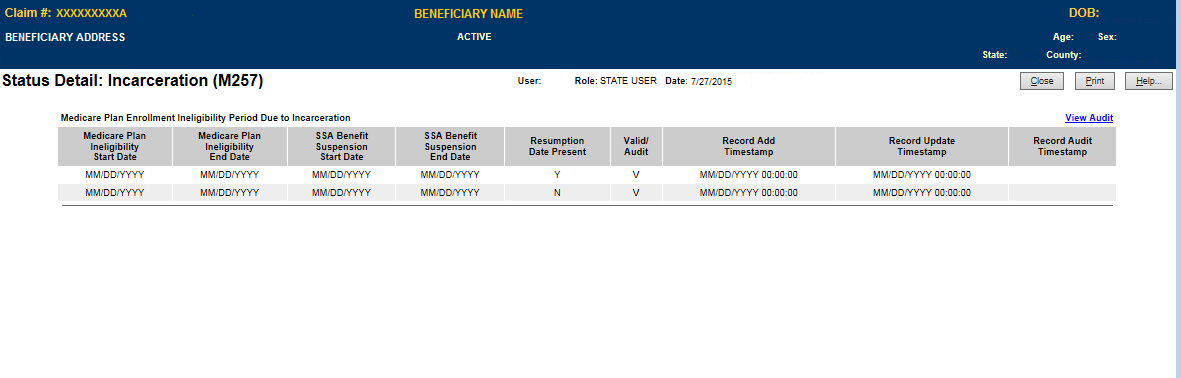
Figure 2‑18: State User Status Detail: Incarceration (M257) Screen

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. |
| [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 |
| 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. |
| 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. |
| 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. |

### 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.

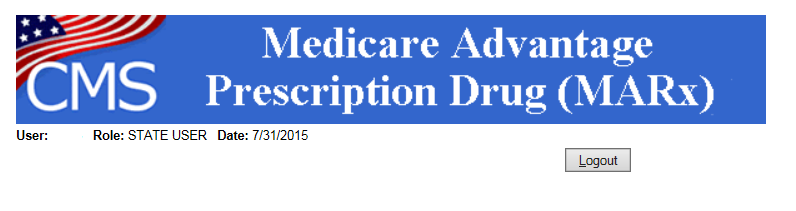
Figure 2‑19: State User Logout Screen

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. |

### 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. |
| 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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# 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 3‑1: 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 3‑2: 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 3‑3: 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. |
| 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 3‑4: 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 3‑5: 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 3‑6: 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 3‑7: 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 |
| 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 |
| 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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# 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**.

## 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

## 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.

## 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](https://www.cms.gov/medicare-medicaid-coordination/medicare-medicaid-coordination-office/state-phased-down-billing).

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.

## 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](https://www.ssa.gov/forms/ssa-1020b-ocr-sm-inst.pdf)) 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](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Downloads/StateLISGuidance021009.pdf).

# 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](#_Glossary,_List_of) provides information specific to the process for Puerto Rico to exchange data with CMS.

## 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.

## 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

### 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.

### 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.* | | | | | | | | |

1. 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 |

1. 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.



1. 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.



**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](mailto:MMCO_MMA@cms.hhs.gov).

### Future DET Records

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

### LIS Records

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

### 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.

## 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.

## 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.

## 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**](#_MMA_Request_File)):

* 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.

## 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**](#_MMA_Response_File_2). 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**](#_MMA_Response_File_1) 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.

## 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).

## 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](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c02.pdf)).

# MMA Request File

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

### 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.

### 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)](https://www.ssa.gov/OP_Home/ssact/title18/1860D-14.htm) 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.

## 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_2)
* [**MMA Request File Detail Record**](#_MMA_Request_File)
* [**MMA Request File Trailer Record**](#_MMA_Request_File_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 |

## 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. |
| 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. |
| 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.   1. – Eligible is entitled to Medicare – QDWI. 2. – Eligible is entitled to Medicare – Qualifying beneficiaries. 3. – 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. |
| 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. |
| 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). |
| 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 |

## 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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# MMA Response File

## 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](https://statedataresourcecenter.com/mma-announcements/).

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

1. [**7.4 – MMA Response File Header Record**](#_MMA_Response_File) 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:**](#_MMA_Response_File_1)
   1. Copy of the incoming MMA Request file detail record, position 1-180.
   2. Series of edit error return codes, position 181-228.
   3. Data from the MBD, position 229-4000.
3. [**7.6 – MMA Response File Summary Record**](#_MMA_Response_File_2) including record validation and matching outcomes, position 1-4000.
4. [**7.7 – MMA Response File Monthly Summary Record**](#_MMA_Response_File_3) 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**](#_MMA_Response_File_4) with identifying information and a copy of the incoming MMA Request file trailer record, position 1-4000.

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

### 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.

### 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)

### 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)

### 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.

## 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_6)
* [**MMA Response File Detail Record**](#_MMA_Response_File_1)
* [**MMA Response File Summary Record**](#_MMA_Response_File_2)
* [**MMA Response File Monthly Summary Record**](#_MMA_Response_File_3)
* [**MMA Response File Trailer Record**](#_MMA_Response_File_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 |
| 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** | | | | | |
| 20 | Filler | 3705 | 296-4000 | CHAR |  |

## 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 |  |
| 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. |
| 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. |
| 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. |
| 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. |
| 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 |
| 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** | | | | | |
| 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. |
| 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 |
| 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. |  |
| 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. |  |
| 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. |
| 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 |  |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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)** | | | | | |
| 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. |
| 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. |
| 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’. |
| 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. |
| 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. |
| 170 | Beneficiary ESRD Coverage End Date | 8 | 1971-1978 | MMDDCCYY | 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** | | | | | |
| 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 |
| 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. |
| 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. |
| 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. |
| 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.** | | | | | |
| 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. |
| 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 |
| 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. |
| 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). |
| 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). |
| 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. |
| 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** | | | | | |
| 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’. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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. |
| 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 |
| 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 |
| 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. |
| 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. |
| 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 |
| 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 |

## 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. |
| 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. |
| 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. |

## 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’. |
| 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. |

## 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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# 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.

## 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)
* [**BEQ Request File Detail Record**](#_BEQ_Request_File_1)
* [**BEQ Request File Trailer Record**](#_BEQ_Request_File_2)

See [**Section 8.5**](#_Sample_BEQ_Request) for a sample of the BEQ Request File Pass and Fail Acknowledgements.

## 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. |
| 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 |  |

## 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 |  |

## 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 |  |

## 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](mailto:Jim.Doe@xxs).net

TO: [Chris.Doe@dxxx](mailto:Chris.Doe@dxxx).org

TO: [Falcon.Doe@xxxx](mailto:Falcon.Doe@xxxx).org

FROM: [MBD#BQ94.HCFJES@cms](mailto: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](mailto:Jim.Doe@xxs).net

TO: [Chris.Doe@dxxx](mailto:Chris.Doe@dxxx).org

TO: [Falcon.Doe@xxxx](mailto:Falcon.Doe@xxxx).org

FROM: [MBD#BQ30.HCFJES@cms](mailto: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

# 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.

## 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_3)
* [**BEQ Response File Detail Record**](#_BEQ_Response_File_1)
* [**BEQ Response File Trailer Record**](#_BEQ_Response_File_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 |

## 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 |
| 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 |
| 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 |
| 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 |  |
| 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 |  |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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. |
| 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). |
| 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 |
| **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 |

## 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 |

# 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.

## 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)
* [**TBQ Request File Detail Record**](#_TBQ_Request_File_1)
* [**TBQ Request File Trailer Record**](#_TBQ_Request_File_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. |

## 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. |

## 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. |

# 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.

## 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_1)
* [**TBQ Response File Detail Record**](#_TBQ_Response_File_2)
* [**TBQ Response File Trailer Record**](#_TBQ_Response_File_3)

## 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. |

## 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 |  |
| 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 |  |
| 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 |  |
| **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. |
| 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. |
| 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. |
| 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 |  |
| 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 |  |
| 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 |  |
| 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 |  |
| 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. |
| 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. |
| 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 |  |
| 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 |  |
| 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. |
| 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). |
| 179180 | 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. |
| **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 |  |
| 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. |
| 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. |
| 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. |
| **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. |
| 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 |
| 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 |
| 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 |

## 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. |

# 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.

## 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_1)
* [Puerto Rico Dual Eligible Request File Detail Record](#_Puerto_Rico_Dual_2)
* [Puerto Rico Dual Eligible Request File Trailer Record](#_Puerto_Rico_Dual_3)

## 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 |

## 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 |

## 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 |

## 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_4)
* [Puerto Rico Dual Eligible Response File Detail Record](#_Puerto_Rico_Dual_5)
* [Puerto Rico Dual Eligible Response File Trailer Record](#_Puerto_Rico_Dual_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 |

## 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 |
| 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. |
| 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 |

## 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 |

## 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”

# Glossary, List of Acronyms, and State Codes

Table 13‑1: 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. |
| 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. |
| User Interface | The screens, forms, and menus that display to a user logged on to an automated system. |

Table 13‑2: 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 |
| 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 13‑3: 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 |