Centers for Medicare & Medicaid Services

Medicare Advantage Prescription Drug State User Guide

Version 13.0

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Change Log

The State User Guide Version 13.0 includes comprehensive document updates including formatting overhaul, content revisions, and miscellaneous changes; edits made after version 13.0 will be listed in the change log below.

Please send update requests to MMCO_MMA@cms.hhs.gov.

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1. Introduction

State officials have important roles in ensuring the accurate submission of data that CMS uses to administer several Medicare functions. This Medicare Advantage Prescription Drug State User Guide provides information for Medicaid staff in states, the District of Columbia, and the US territories to understand the content of multiple monthly and daily files, accurately submit state data, and understand file output. CMS uses the data submitted through state MMA files for a variety of functions, including:

- auto-enrolling full-benefit dually eligible beneficiaries into Medicare prescription drug plans;
- deeming certain beneficiaries eligible for the Medicare Part D Low Income Subsidy;
- populating data sources for providers to identify dual status and applicable billing protections;
- calculating state phased-down payment amounts;
- determining eligibility for dual special needs plans, and
- calculating risk adjustment for MA plans serving dually eligible individuals.

This document:

- 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.
- Provides technical instructions on the submission of the MMA file. The MMA file is an exchange between the state and CMS and provides the most up-to-date information on full-benefit dually eligible beneficiaries and partial benefit dually eligible beneficiaries eligibility and enrollment.
- Provides technical guidance on the submission of the TBQ file. The file is a data exchange between CMS and the states. The TBQ file is an ad hoc query process that CMS offers to states and territories to obtain beneficiary entitlement and enrollment information as part of the process for Low-Income Subsidy (LIS) enrollment.
- Provides technical guidance on the submission of the BEQ file. The file is used by plans to conduct initial eligibility checks against the CMS MBD system to verify the beneficiary's Part A / B eligibility.
- Provides technical guidance on the submission of the Puerto Rico Dual Eligible Beneficiaries data exchange between the Medical Assistance Program of Puerto Rico and CMS. The file contains a record for each beneficiary who is eligible for Medicaid during the current month.

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

The Medicare Advantage Prescription Drug (MARx) System User Interface (UI) enables access to enrollment, eligibility, payment, premium withhold, and 4Rx information for beneficiaries. The MARx UI accommodates online and batch processing. Online capabilities enable viewing of beneficiary or contract information. Batch capabilities allow submission of data, such as enrollment and disenrollment transactions. This section provides information necessary to conduct online operations in the MARx UI.

2.1 Getting Started

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

1. Register for a User ID in the Identity Management (IDM) system.
2. Request the State User role for appropriate access to MARx UI.
3. Log into MARx UI as the role of State User.

2.1.1 Registering in IDM

CMS has established the IDM system to provide Medicare Advantage and Prescription Drug (MAPD) stakeholders with a means to apply for, obtain approval, and receive a single User ID they can use to access one 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/data-research/cms-information-technology/cms-identity-management

In the left navigation panel, click the **Information and Overview** 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).

2.1.2 Requesting the MA State/Territory User Role for MARx

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

The MA State/Territory User 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 steps to request a state user role for MARx UI:

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

Figure 2--2-1: Select an Application Drop-down

5. **Step 2: Select a Role** and choose the MA State/Territory User from the drop-down menu. See Figure 2-2.

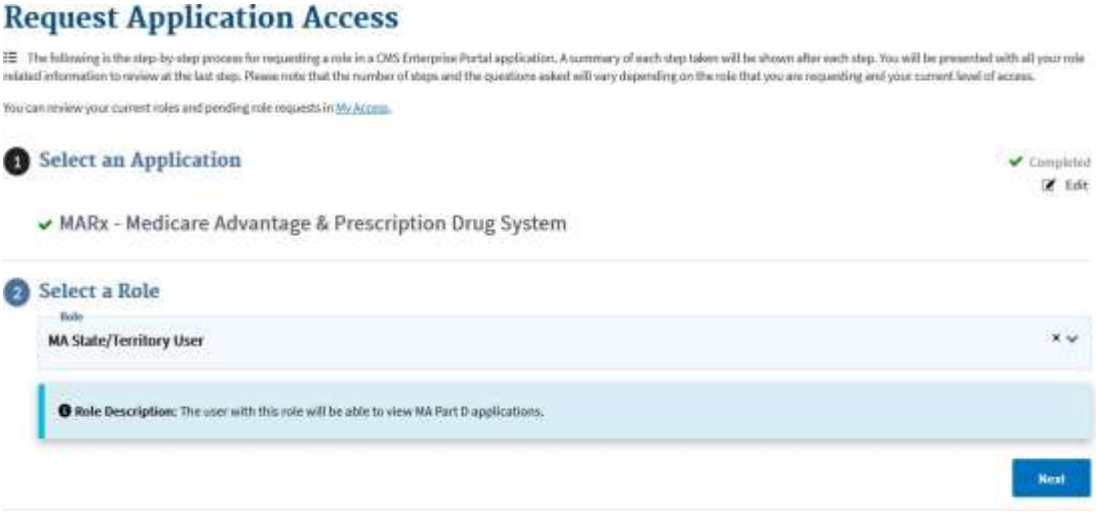


Figure 2--2-2: Select a Role Drop-down

6. **Step 3: Complete Identity Verification.** If you have not completed Identity Verification, you will be prompted to complete Remote Identity Proofing.
7. Complete **Step 4: Enter Business Contact Information, Step 5: Enter Role Details**, and **Step 6: Enter Reason for Request.**
8. Upon approval of your request, you will have access to the MARx UI.

Note: These instructions are outlined in more detail in the Enterprise Portal User Guide located here: https://portal.cms.gov/portal/help/digital/user-guide/?guide=enterprise_portal_user_guide

2.1.3 Logging into MARx

1. Upon receiving the confirmation email of access to MARx UI, navigate to the IDM Enterprise Portal URL: https://portal.cms.gov
2. Enter your **IDM User ID** and **password**.
3. **Accept** the Terms and Conditions
4. Obtain and enter your **MFA code.**
5. Select the **MARx UI** application tile.
6. The **User Security Role Selection (M002)** screen is presented with the State User role preselected. Click Logon with Selected Role.

2.2 Using MARx UI Screens

2.2.1 General Properties of Screens

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

There are two main types of general screen layouts: primary and secondary. The principal differences between a primary window and a secondary window are the header design and content, and how the screens are navigated.

2.2.2 Common Features of 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 this guide.
- User's current role.
- Current date.
- [Print] and [Help] buttons

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

2.2.3 Common Characteristics of Screens

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

- Find specific information.

- Display information.
- Provide links/buttons to additional screens.

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.

Additional rules regarding the combination of acceptable fields are sometimes indicated in the 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. Click on the down arrow next to the field to display the list, and then click on a value to select it.
- **Radio buttons**: To select one of the items in a group, click on the circle next to that item.
- **Check boxes**: You can select any number of items in a group by clicking on the box next to each item.

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

2.2.4 Typographical Conventions

Table 2-1: Typographical Conventions

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 the upper case.

Example	Description
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 on the upper left-hand corner of the screen or the bottom of the screen
The request…	**Status Message**. Status messages are provided 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 blue text.
Note	**Note**. Notes indicate important information. The accompanying text is enclosed in a box with Note as a header.
Tip	**Tip**. Tips alert the user to shortcuts and troubleshooting techniques. Accompanying text is enclosed in a box with Tip as a header.

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

2.2.5 Common Buttons, Links, and Fields

Table 2-2: Common Buttons and Links

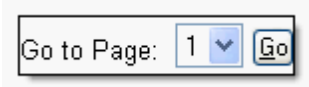
Example	Description
[Print]	**Print**. Every screen contains a [Print] button. The [Print] button supports printing the entire contents of the active webpage. It displays the 'Printer Options' pop-up screen.
[Help]	**Help**. Every screen contains a [Help] button, which invokes a menu of topics.
[Close]	**Close**. Closes the pop-up window without submitting the data. This button does not appear on any screens accessed directly from an item on the MARx UI main menu.
[Cancel]	**Cancel**. Closes the pop-up window without submitting the data.
	**Screen navigation arrows.** When all list items do not fit on the screen, use the navigation arrows to scroll through the list. These arrows are shown at the top and the bottom of the list items on the screen. The arrows function as follows:  – go to the first page of items in the list  – go to the previous page of items in the list  – go to the next page of items in the list  – go to the last page of items in the list
	**Go to Page Number.** In addition to the screen navigation arrows, [Go to Page Number] is displayed at the top of the list items. It allows the user to jump directly to a particular page. Select the page number to display and click on the [Go] button. The page numbers in the drop-down list reflect the actual number of pages in the list.
[Reset]	**Reset**. Resets the entered data to their previous values or clears the screen of the current values.

Table 2-3: 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 • Medicare Beneficiary Identifier (MBI) - The MBI has 11 characters. MBIs are numbers and upper-case letters. MBIs contain numbers 0-9 and all letters from A to Z, except for S, L, O, I, B, and Z. This will help the characters be easier to read. If you use lowercase letters, MARx will convert them to uppercase letters. • 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 digits. An identifier is assigned to each PBP within a contract that a plan sponsor has with CMS.
Segment #	Three digits. A value of 000 indicates that there is no segment.
Date	Month, day, and four-digit year. A zero in front of a single-digit month or day is optional: (M)M/(D)D/YYYY.
Month/Year	Month and four-digit year. A zero in front of a single-digit month is optional: (M)M/YYYY.
Last Name	May contain letters, upper and lower case; apostrophe; hyphen; and blank; with a maximum length of 40 characters.

2.3 Navigating the MARx UI

2.3.1 Main Menu Items

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--2-4: Main Menu Items

Menu Item	Description
|Welcome|	Messages, current payment month, and calendar.

Menu Item	Description
|Beneficiaries|	Search for beneficiaries and view beneficiary information.

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

2.3.2 Screens Available for State Users

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

Table 2--2-5: State User Screen Lookup

Screen Name	Screen Number
User Security Role Selection	M002
Welcome	M101
Beneficiaries: Find	M201
Beneficiaries: Search Results	M202
Beneficiary Detail: Snapshot	M203
Beneficiary Detail: Enrollment	M204
Enrollment Detail	M222
Rx Insurance View	M244
Additional Insurance Information	M251
Low Income Subsidy	M252
Status Activity	M256
Status Detail	M257 *
Personal Information	M259
Beneficiaries: Eligibility	M232
Additional Insurance Information	M251

* The information on this screen will depend on which hyperlink you click on the M256 screen

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

2.3.2.1 Accessibility Standards

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 sub-menu.

2.3.3 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: Find (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 details by clicking on links and/or buttons that lead to additional screens.

2.3.4 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.

The following table shows errors that may occur within the MARx UI screens.

Table 2-6: Error Messages on MARx UI Screens

Message Type	Message Text	Suggested Action
Validation Message	User must enter a contract number	Enter the field specified by the message.
Validation 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.
Validation Message	User must enter a sex	Enter the field specified by the message.
Validation Message	User must select a state	Enter the field specified by the message.
Validation Message	Invalid Contract/PBP combination	Check the combination and re-enter.
Validation Message	Invalid Contract/PBP/segment combination	Check the combination and re-enter.
Validation Message	<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.
Validation Message	User must enter <kind of date>	Enter the field specified by the message.
Validation Message	PBP number must have three alphanumeric characters	Re-enter the field and follow the format indicated in the message.
Validation Message	Please enter at least one of the required fields	Make sure to enter all the required fields.
Validation Message	Please enter user ID or password	Make sure to enter one of the fields specified by the message.
Validation Message	Segment number must have three digits	Re-enter the field and follow the format indicated in the message.
Validation 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.
Validation Message	The last name contains invalid characters	Re-enter the field using only letters, apostrophes, hyphens, or blanks.
Validation Message	The user ID contains invalid characters	Re-enter the field and follow the format indicated in the message.
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 while retrieving information.	Contact the MAPD Help Desk.
Software or Database Error	Invalid input.	Contact the MAPD Help

Message Type	Message Text	Suggested Action
		Desk.
Software or Database Error	Unexpected error code from database.	Contact the MAPD Help Desk.
Software or Database Error	Connection error.	Contact the MAPD Help Desk.

2.3.5 Logging on and Viewing Messages

The first screen that displays after a State User clicks on the MARx Application is the User Security Role Selection (M002) screen. The State User Role is preselected.

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."*

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. The table below describes additional error messages on the M002 screen.

Table 2-7: User Security Role Selection (M002) Error Messages

Message Type	Message Text	Suggested Action
Workstation setup	Click on the message 'Pop-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.

Message Type	Message Text	Suggested Action
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.

Click on the [Logon with Selected Role] button, and the Welcome (M101) screen appears.

Figure 2-4: Welcome (M101) Screen

To log out of MARx, look for the 'log out' link at the top right of a MARx screen. If the screen does not have the 'log out' link, go back to the previous page and click the 'log out' link on that page.

Table 2-8: Welcome (M101) Field Descriptions and Actions

Item	Input/Output	Description
Broadcast Messages	Output	Provides general information about the system's actions, such as whether month-end processing as 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.

Item	Input/Output	Description
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 30 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.
MAPD Help Desk	Link	Provides the user with information about the MAPD Help Desk such as the MAPD Help Desk Website, Phone, Email, Hours of Operation, and links to the Plan Communication User Guide (PCUG) and MARx User Manual (MUM)

2.4 Viewing Medicare Beneficiary Information

2.4.1 Finding a Beneficiary

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

2.4.1.1 Beneficiaries: Find (M201) Screen

From the main menu, click on the |Beneficiaries| menu item. The |Find| sub-menu item has already been selected and displays the Beneficiaries: Find (M201) screen.

Figure 2-5: Beneficiaries: Find (M201)

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

- Search for beneficiaries using the MBI, HICN 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 DOB 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.

Table 2-9: Beneficiaries: Find (M201) Field Descriptions and Actions

Item	Input/Output	Description
Beneficiary ID	Required data entry field	The user finds beneficiaries with this number.
Last Name	Required data entry field if Beneficiary ID is not entered.	The user finds beneficiaries with this Last Name, entered First Name, and Birth Date. (Note: All three fields are required.)
First Name	Required data entry field if Beneficiary ID is not entered.	The user finds beneficiaries with this Firs first name, enters their last name, and enters their birth date (Note: All three fields are required.)
Birth Date	Required data entry field if Beneficiary ID is not entered.	The user finds beneficiaries with this Birth Date, the entered Last Name, and First Name. (Note: All three fields are required.)

Item	Input/Output	Description
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: Beneficiaries: Find (M201) Error Messages

Message Type	Message Text	Suggested Action
Missing entry	Enter a Beneficiary ID.	The user must enter a valid Beneficiary ID or a combination of Last Name, First Name, and Birth Date.
Invalid format	The ID is not a valid SSA, RRB, or CMS internal number.	The user re-enters the ID.
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.

2.4.2 Viewing Summary Information about a Medicare Beneficiary

If the search is successful, a Beneficiary meeting the search criteria is displayed on the Beneficiaries: Search Results (M202) screen as shown in Figure 2-6.

2.4.2.1 Beneficiaries: Search Results (M202) Screen

If the search is successful, the Beneficiaries: Search Results (M202) screen shows.

Figure 2-6: Beneficiaries: Search Results (M202)

Table 2-11: Beneficiaries: Search Results (M202) Field Descriptions and Actions

Item	Input/Output	Description
Beneficiary ID	Link	The user clicks on the Beneficiary's ID 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.
Status	Output	Active allows access to view the beneficiary data or Archived will need to call the MAPD Help Desk for assistance.

For state users, only one beneficiary will be returned.

Any error associated with the search would display on the Beneficiaries: Find (M201) screen. If a user enters an inactive Beneficiary ID for the beneficiary, a message displays to that effect.

2.4.3 Viewing Detailed Information for a Medicare Beneficiary

To see detailed information about any of the beneficiaries listed in the Beneficiaries: Search Results (M202) screen, click on the associated Beneficiary ID.

Note: Instead of seeing a screen in the same area as previously displayed, a new window with a new screen and a new header will 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. The user can switch back and forth among the seven 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.

Table 2-12: 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 and the payment month. 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.
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.
Personal Information	View Personal Information (M259)	Displays a beneficiary's personal information such as Ethnicity, Race, Preferred Language other than English, and Accessible Format.

2.4.4 Viewing a Snapshot of Medicare Beneficiary Information

2.4.4.1 Beneficiary: Snapshot (M203) Screen

The *Beneficiary: Snapshot (M203)* screen provides payment, health status, adjustment, entitlement, eligibility, enrollment, and premium information for the beneficiary as of the date the user specifies. When the beneficiary enrolls in two contracts, one for Part A and/or

Part B a the other for Part D, information is displayed on both contracts. On the initial display, the current date is used. To view the details as of a different date, update the date in the *As Of* data entry area and click on the [Find] button.

If the beneficiary is enrolled with an effective date in the future, no status information is available. Change the *As Of* date to the future date to view the snapshot information.

If the beneficiary is no longer enrolled, a status message states "*the latest available snapshot information is for a payment month in the past, and the last available payments and adjustments are displayed*."

If the user selects an As Of date on which the beneficiary was not enrolled, the page will display a snapshot as of the most recent disenrollment prior to the As Of date; any status changes that occurred after the disenrollment date will not be displayed.

Example: A beneficiary has the following history:

- 12/31/2009 - Disenrolled from a Plan
- 06/01/2017 - Became eligible for Part B coverage
- 01/01/2020 - Enrolled in a Plan.

And

- The As Of date field in the UI is set to 1/1/2018.

Since the beneficiary was not enrolled in a Plan on 1/1/2018 (the *As Of* date), the snapshot will default to 12/2009 (the month-year of the disenrollment previous to the *As Of* date). The Part B Eligibility will not display in the snapshot because the beneficiary was not Part B eligible as of 12/2009. See Table 2-13 for the Beneficiary Snapshot screen descriptions.

Figure 2-8: Beneficiary Snapshot (M203) Screen

Table 2-13: Beneficiary Snapshot (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.
Contract*	Output	Contract number Medicare Advantage (or PACE if it is applicable) for this beneficiary on the As Of date.
MCO Name*	Output	Medicare Advantage 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 the description of the demonstration type the beneficiary is enrolled in. 01 = I-SNP 03 = D-SNP 04 = C-SNP 05 = AIP SNP 06 = HIDE SNP 09 = FIDE SNP
Enrollment Source Code and Description*	Output	The source for this enrollment, along with the associated description. Examples: • B = Beneficiary Election • G= LINET Enrollment
Special Needs Type*	Output	Indicates the special needs population that the contract serves, if applicable.

Item	Input/Output	Description
Bonus Payment Portion Percent*	Output	The percentage is applied to the payment to determine the bonus amount to pay the Medicare Advantage. This does not apply to a PDP.
Residency Status*	Output	The residency status for this beneficiary on the As Of date.
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 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 based on the state user's profile on the As Of date.

*These fields are repeated for each contract, up to two, in which the beneficiary is enrolled.

Table 2-14: Beneficiary Snapshot (M203) Error 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	There is no payment data available for that claim number or beneficiary ID on the As

Message Type	Message Text	Suggested Action
	number <claim number> and coverage date as of <date>.	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 needs to contact 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 or beneficiary ID 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 needs to contact the MAPD Help Desk for assistance.

2.4.5 Viewing Medicare Enrollment Information

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

2.4.5.1 Enrollment View (M204) Screen

To access the Enrollment View (M204) screen, click the |Enrollment| tab. As shown in Figure 2-9, this displays a screen 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.

Figure 2-9: Enrollment View (M204) Screen

Table 2-15: Enrollment View (M204) Field Descriptions and Actions

Item	Input/Output	Description
Contract	Output	Contract in which the beneficiary is enrolled. The values in this column link to 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 Medicare Advantage; 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 • G= LINET Enrollment
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 is displayed in the bottom portion of the screen.

Table 2-16: Enrollment View (M204) Error 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

2.4.5.2 Medicare Enrollment Detail (M222) Screen

The Enrollment Detail (M222) screen is accessible by selecting a Contract # link from the Beneficiary Detail: Enrollment (M204) screen and shows show the enrollment and disenrollment information for a beneficiary.

Figure 2-10: Enrollment Detail (M222) Screen

Table 2-17: Enrollment Detail (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). .If the value is Y, the beneficiary is enrolled in an EGHP.
Enrollment Forced Code	Output	For CMS use for overriding certain enrollment 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.

Item	Input/Output	Description
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.

2.4.5.3 Medicare Rx Insurance View (M244) Screen

Users can view Rx Insurance history, both primary and secondary, if applicable, for beneficiaries enrolled in a Plan on the Rx Insurance View (M244) screen. The screen is accessed by clicking Rx Insurance on the header menu.

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

Table 2-18: Rx Insurance View (M244) Field Descriptions and Actions

Screen Area	Item	Input/Output	Description
Primary Drug Insurance	Contract	Output	The contract for the applicable period.
Primary Drug Insurance	PBP #	Output	The PBP for the applicable period.
Primary Drug Insurance	Primary Drug Insurance Start Date	Output	Start date for Primary 4Rx information on this line.
Primary Drug Insurance	Primary Drug Insurance End Date	Output	End date for the Primary 4Rx information on this line.
Primary Drug Insurance	Primary BIN	Output	Part D insurance Plan's Beneficiary Identification Number (BIN) for the primary contract, PBP, and period specified.
Primary Drug Insurance	Primary PCN	Output	Part D insurance Plan's PCN for the primary contract, PBP, and period specified.
Primary Drug Insurance	Primary GRP	Output	Part D insurance Plan's group (GRP) number for the primary contract, PBP, and period specified.
Primary Drug Insurance	Primary RxID	Output	Identifier assigned to the beneficiary by the primary Part D insurance plan for drug coverage.
Primary Drug Insurance	Source	Output	Source of enrollment into the contract and the PBP for period specified.
Primary Drug Insurance	Record Update Timestamp	Output	Date that Rx insurance information was added or updated.

Screen Area	Item	Input/Output	Description
Secondary Drug Insurance	Insurance Creation Date	Output	Date the secondary insurance period was added.
Secondary Drug Insurance	Secondary BIN	Output	Secondary drug insurance Plan's BIN number.
Secondary Drug Insurance	Secondary PCN	Output	Secondary drug insurance Plan's PCN number.
Secondary Drug Insurance	Secondary GRP	Output	Identifier for a group providing secondary drug insurance.
Secondary Drug Insurance	Secondary RxID	Output	Identifier assigned to a beneficiary by secondary drug insurance.
Secondary Drug Insurance	Record Update Timestamp	Output	Date this row was added or updated.

Table 2-19: Rx Insurance View (M224) Error 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 the MAPD Help Desk for assistance.

2.4.6 Viewing Additional Medicare Insurance Information

2.4.6.1 Additional Insurance Information (M251) Screen

The Additional Insurance Information (M251) screen shows a beneficiary's medical insurance and drug insurance information by start and end dates.

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

Table 2-20: Additional Insurance Information (M251) Field Descriptions and Actions

Screen Area	Item	Input/Output	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).

Screen Area	Item	Input/Output	Description
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.

Screen Area	Item	Input/Output	Description
			• 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. This is 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. This is 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.

21: Additional Insurance Information

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.

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

2.4.7.1 Low Income Subsidy (M252) Screen

The Low-Income Subsidy (M252) screen shows a beneficiary's valid LIS and LIS denied periods. The Low-Income Subsidy (M252) screen is only available to the state user role and can be accessed from the header menu.

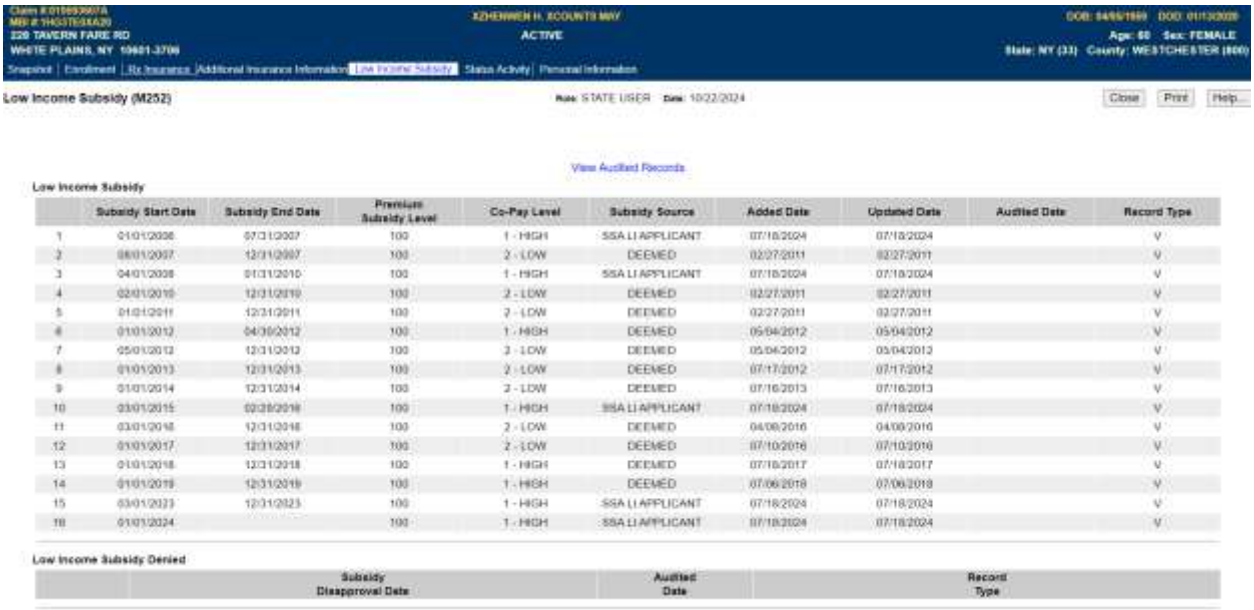


Figure 2-13: Low Income Subsidy (M252) Screen

Table 2-22: Low Income Subsidy (M252) Field Descriptions and Actions

Screen Area	Item	Input/Output	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.

Screen Area	Item	Input/Output	Description
Low-Income Subsidy	Premium Subsidy Level	Output	Identifies the portion of the Part D Premium subsidized. (Effective, 1/1/2024) Values: 100% Prior to 1/1/2024 100 075 050 025
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 certain home and community-based services (HCBS). 4 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 2-23: Low Income Subsidy (M252) Error Messages

Message Type	Message Text	Suggested Action
No data	No Low-Income Subsidy information found for claim number	Search for data in a different way

2.4.8 Viewing Status Activity and Detail Information for Medicare Beneficiaries

2.4.8.1 Status Activity (M256) Screen

The Status Activity (M256) screen 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.

The following special status categories will display on the screen:

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

Figure 2-14: Status Activity (M256) Screen

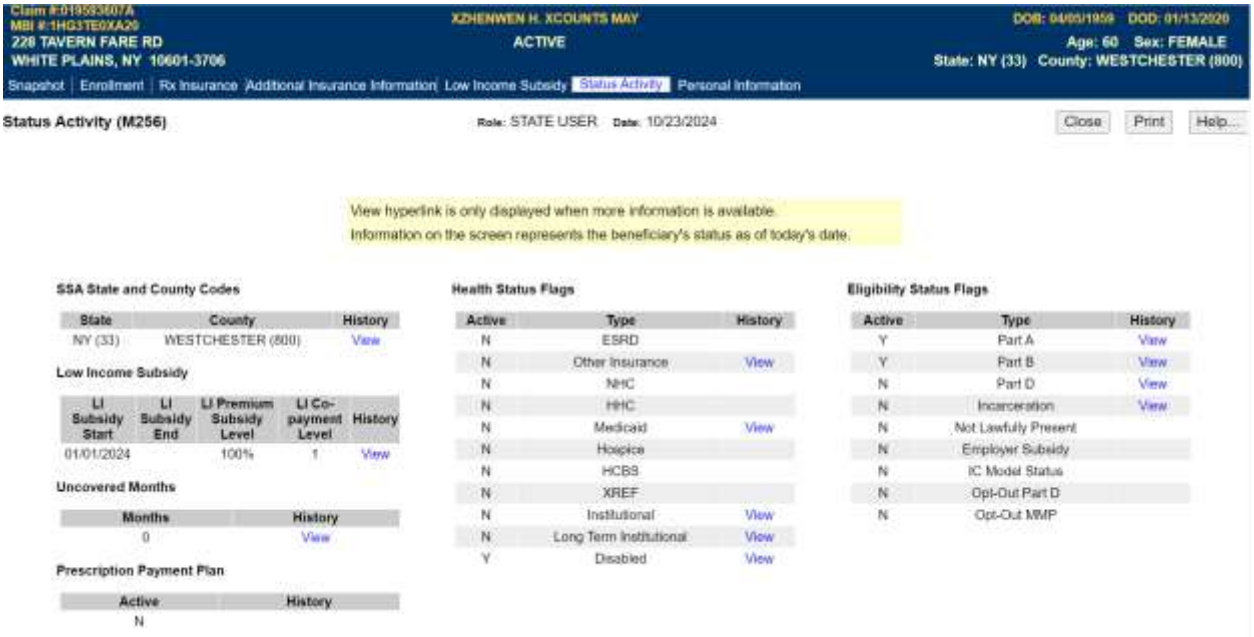


Table 2-24: Status Activity (M256) Field Descriptions and Actions

Screen Area	Item	Input/Output	Description
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)

Screen Area	Item	Input/Output	Description
			• Institutional • Long Term Institutional • Disabled
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 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 a specific beneficiary's status. 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 ###%.
Low-Income Subsidy	LI 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

Screen Area	Item	Input/Output	Description
			income at or below 100% FPL. 3 – No Copay – Assigned to Full Duals who are institutionalized or receiving certain home and community-based services (HCBS). 4 – 15%. 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 a specific beneficiary's status. 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 a specific beneficiary's status. Otherwise, this field is blank.
Prescription Payment Plan Active	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.*
Prescription Payment Plan History	History	Link	*View link appears for user to access the Status Detail: [status category] (M257) screen, when detailed information exists for an eligibility type. Otherwise, this field is blank.*

2.4.8.2 Status Detail: SSA State and County Codes (M257) Screen

The Status Detail: SSA State and County Codes Screen....

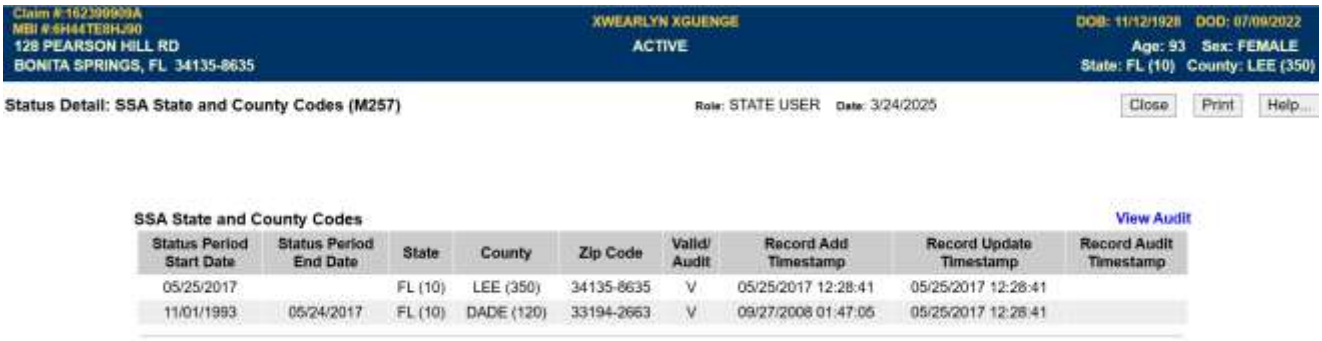


Figure 2-15: Status Detail SSA State and County Codes (M257) Screen

Table 2-25: Status Detail SSA State and County Codes (M257) Field Descriptions and Actions

Item	Input/Output	Description
Status Period Start Date	Output	The first date on which this address applies to the beneficiary.
Status Period End Date	Output	The last date on which this address applies to the beneficiary.
State	Output	State for the period on this line.
County	Output	County for the period on this line.
Zip Code	Output	ZIP for the period on this line.
Valid/Audit	Output	Value is populated based on the SSA State and County Codes record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the “View Audit” link is clicked on the M257 screen.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified
Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.3 Status Detail: Low Income Subsidy (M257) Screen

The Status Detail: Low Income Subsidy Screen.

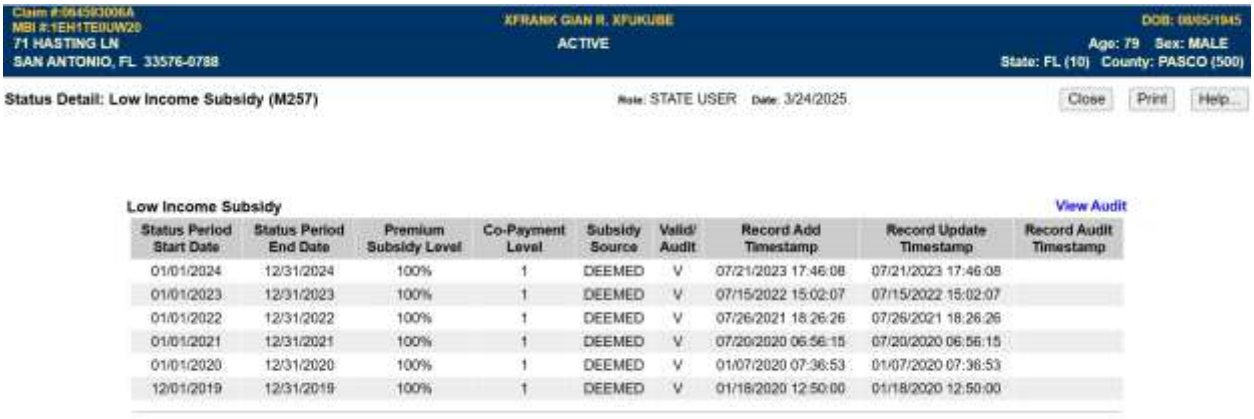


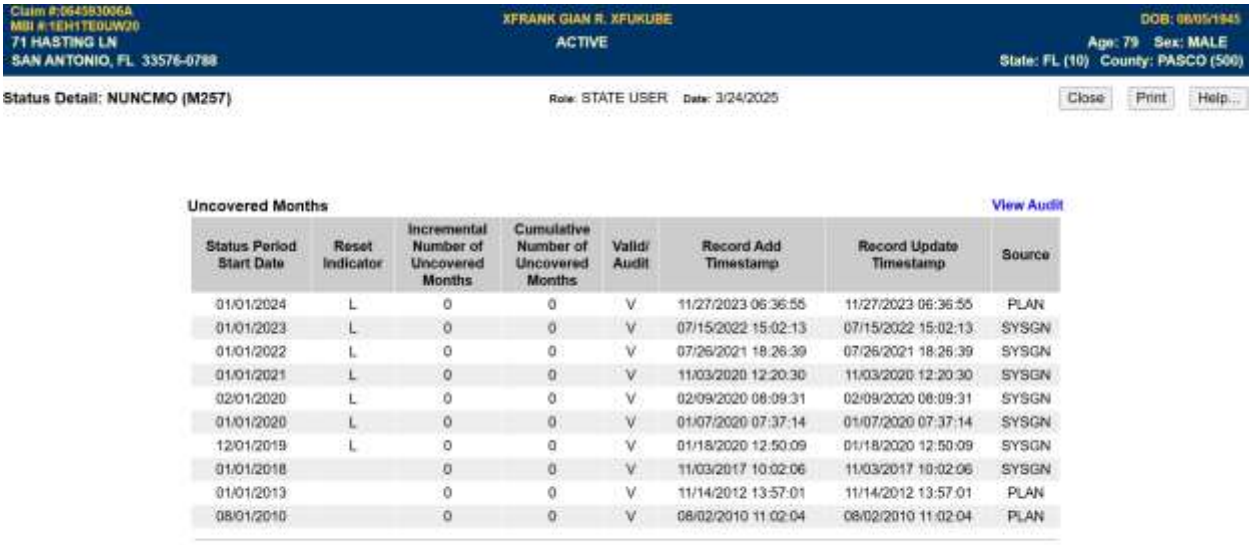
Figure 2-16: Status Detail Low Income Subsidy (M257) Screen

Table 2-26: Status Detail Low Income Subsidy (M257) Field Descriptions and Actions

Item	Input/Output	Description
Status Period Start Date	Output	Date that the low-income subsidy will begin.
Status Period End Date	Output	Date that the low-income subsidy will end.
Premium Subsidy Level	Output	Identifies the portion of the Part D premium subsidized, based on a sliding scale (prior to 2024) linked to the percent of the Federal poverty level (FPL). Beginning 01/01/2024, all beneficiaries who qualify for LIS get a100% Premium Subsidy Level.
Co-Payment Level	Output	The identifier that indicates the level used to compute the co-pay amount.
Subsidy Source	Output	The source of LIS subsidy.
Valid/Audit	Output	Value is populated based on the LIS record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the “View Audit” link is clicked on the M257 screen.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified
Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.4 Status Detail: NUNCMO (M257) Screen

The Status Detail: NUNCMO Screen.



Status Period Start Date	Reset Indicator	Incremental Number of Uncovered Months	Cumulative Number of Uncovered Months	Valid/ Audit	Record Add Timestamp	Record Update Timestamp	Source
01/01/2024	L	0	0	V	11/27/2023 06:36:55	11/27/2023 06:36:55	PLAN
01/01/2023	L	0	0	V	07/15/2022 15:02:13	07/15/2022 15:02:13	SYSGN
01/01/2022	L	0	0	V	07/26/2021 18:26:39	07/26/2021 18:26:39	SYSGN
01/01/2021	L	0	0	V	11/03/2020 12:20:30	11/03/2020 12:20:30	SYSGN
02/01/2020	L	0	0	V	02/09/2020 08:09:31	02/09/2020 08:09:31	SYSGN
01/01/2020	L	0	0	V	01/07/2020 07:37:14	01/07/2020 07:37:14	SYSGN
12/01/2019	L	0	0	V	01/18/2020 12:50:09	01/18/2020 12:50:09	SYSGN
01/01/2018		0	0	V	11/03/2017 10:02:06	11/03/2017 10:02:06	SYSGN
01/01/2013		0	0	V	11/14/2012 13:57:01	11/14/2012 13:57:01	PLAN
08/01/2010		0	0	V	08/02/2010 11:02:04	08/02/2010 11:02:04	PLAN

Figure 2-17: Status Detail NUNCMO (M257) Screen

Table 2-27: Status Detail NUNCMO (M257) Field Descriptions and Actions

Item	Input/Output	Description
Status Period Start Date	Output	Identifies the start date of the incremental uncovered months.
Reset Indicator	Output	Identifies the record as a reset of uncovered month count.
Incremental Number of Uncovered Months	Output	The total Part D uncovered months since the last enrollment.
Cumulative Number of Uncovered Months	Output	Number of months that the beneficiary was not enrolled in Part D and did not have creditable coverage.
Valid/Audit	Output	Value is populated based on the NUNCMO record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the “View Audit” link is clicked on the M257 screen.
Record Add Timestamp	Output	The date and time that the data was added

Item	Input/Output	Description
Record Update Timestamp	Output	The date and time when a record was last modified
Source	Output	The User ID or source of the Period Start Date.

2.4.8.5 Status Detail: Medicare Prescription Payment Plan (M257) Screen

The Status Detail: Medicare Prescription Payment Plan Screen.

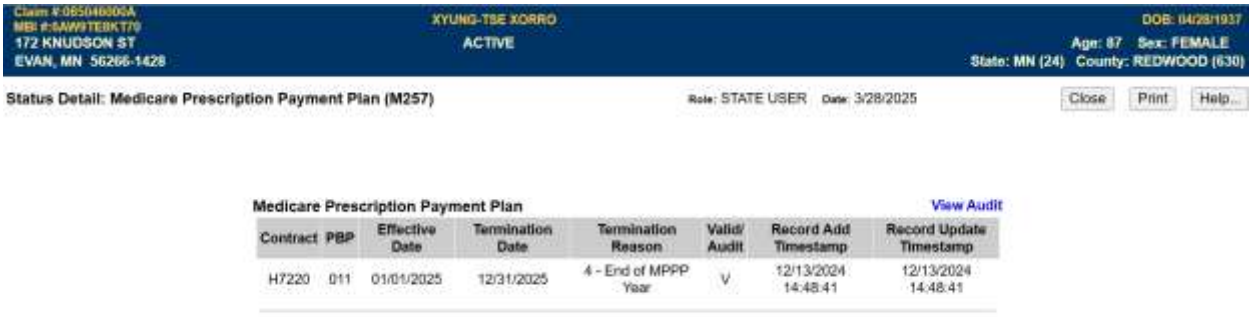


Figure 2-18: Status Detail Medicare Prescription Payment Plan (M257) Screen

Table 2-28: Status Detail Medicare Prescription Payment Plan (M257) Field Descriptions and Actions

Item	Input/Output	Description
Contract	Output	Contract for the Medicare Prescription Payment Plan record
Effective Date	Output	Effective Date of Medicare Prescription Payment Plan
Termination Date	Output	Termination Date of Medicare Prescription Payment Plan
Termination Reason	Output	01 – Voluntary 02 – Involuntary 03 – Deceased04 – End of MPPP Year
Valid/Audit	Output	Value is populated based on the Medicare Prescription Payment Plan record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the “View Audit” link is clicked on the M257 screen.
Record Add Timestamp	Output	The date and time that the data was added

Item	Input/Output	Description
Record Update Timestamp	Output	The date and time when a record was last modified

2.4.8.6 Status Detail: ESRD (M257) Screen

The Status Detail: ESRD Screen.

Figure 2-19: Status Detail ESRD (M257) Screen

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

Screen Area	Item	Input/Output	Description
ESRD – Dialysis	Status Period State Date	Output	Date the beneficiary started dialysis treatments
ESRD – Dialysis	Status Period End Date	Output	Date the beneficiary ended dialysis treatments
ESRD – Dialysis	Record Add Timestamp	Output	The date and time that the record was added
ESRD – Dialysis	Record Update Timestamp	Output	The date and time when a record was last modified
ESRD – Transplant	Status Period State Date	Output	The date on which the beneficiary received a kidney transplant
ESRD – Transplant	Status Period End Date	Output	The date on which the beneficiary functioning kidney transplant status ended.
ESRD – Transplant	Record Add Timestamp	Output	The date and time that the record was added

Screen Area	Item	Input/Output	Description
ESRD – Transplant	Record Update Timestamp	Output	The date and time when a record was last modified

2.4.8.7 Status Detail: Other Insurance (M257) Screen

The Status Detail: Other Insurance Screen.

Figure 2-20: Status Detail Other Insurance (M257) Screen

Table 2-30: Status Detail Other Insurance (M257) Field Descriptions and Actions

Screen Area	Item	Input/Output	Description
Other Insurance – MSP Periods	Valid/Audit	Output	Value is populated based on the Other Insurance record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the "View Audit" link is clicked on the M257 screen.
Other Insurance – MSP Periods	Status Period Start Date	Output	The start date of the other insurance coverage for the beneficiary
Other Insurance – MSP Periods	Status Period End Date	Output	The termination date of the other insurance coverage for the beneficiary
Other Insurance – MSP Periods	Primary Insurance Code	Output	This code identifies the type of primary insurance coverage provided by this enrollment.

Screen Area	Item	Input/Output	Description
			Valid values include Working Aged, Disability, Worker's Comp, No Fault, and Liability, etc. 12 = Working Aged 13 = ESRD 14 = No Fault 15 = Worker Comp 16 = Federal (Public Health) 41 = Black Lung 42 = Veterans 43 = Disabled 47 = Liability
Other Insurance – MSP Periods	Source Code	Output	This code identifies the source that is responsible for updating the beneficiary Medicare Secondary Payer (MSP) information.
Other Insurance – MSP Periods	COB Contractor Code	Output	Identifies the Carrier, Intermediary or COBC Contractor code that Updated the data. NOTE: This column is only used for 'Primary Insurance ("P") rows'. This column value is populated with '~' or Blank for "Secondary Insurance (S)" rows.
Other Insurance – MSP Periods	Other Health Insurance Type Code	Output	The types of other insurance: P- Primary S- Secondary
Other Insurance – MSP Periods	Validity Indicator	Output	When the Part D Plan learns of potential primary coverage and sends information to the BCRC for development and it chooses to wait for validation before considering itself a secondary payer. This option is entirely up to the Plan; it may act as a secondary payer immediately or wait for validation, depending on its confidence of the information's validity.
Other Insurance – MSP Periods	Record Add Timestamp	Output	The date and time that the data was added
Other Insurance – MSP Periods	Record Update Timestamp	Output	The date and time when a record was last modified
Other Insurance – MSP Periods	Record Audit Timestamp	Output	The date and time when an audit entry was created
Other Insurance – All	Valid/Audit	Output	Value is populated based on the Other Insurance record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record

Screen Area	Item	Input/Output	Description
			Note: Audited records will only display when the "View Audit" link is clicked on the M257 screen.
Other Insurance – All	Status Period Start Date	Output	The start date of the other insurance coverage for the beneficiary.
Other Insurance – All	Status Period End Date	Output	The termination date of the other insurance coverage for the beneficiary.
Other Insurance – All	Primary Insurance Code	Output	This code identifies the type of primary insurance coverage provided by this enrollment. Valid values include Working Aged, Disability, Worker's Comp, No Fault, and Liability, etc. 12 = Working Aged 13 = ESRD 14 = No Fault 15 = Worker Comp 16 = Federal (Public Health) 41 = Black Lung 42 = Veterans 43 = Disabled 47 = Liability
Other Insurance – All	Source Code	Output	This code identifies the source that is responsible for updating the beneficiary Medicare Secondary Payer (MSP) information.
Other Insurance – All	COB Contractor Code	Output	Identifies the Carrier, Intermediary or COBC Contractor code that Updated the data. NOTE: This column is only used for 'Primary Insurance ("P") rows'. This column value is populated with '~' or Blank for "Secondary Insurance (S)" rows.
Other Insurance – All	Other Health Insurance Type Code	Output	The types of other insurance: P- Primary S- Secondary
Other Insurance – All	Validity Indicator	Output	When the Part D Plan learns of potential primary coverage and sends information to the BCRC for development and it chooses to wait for validation before considering itself a secondary payer. This option is entirely up to the Plan; it may act as a secondary payer immediately or wait for validation, depending on its confidence of the information's validity.
Other Insurance – All	Record Add Timestamp	Output	The date and time that the data was added
Other Insurance – All	Record Update Timestamp	Output	The date and time when a record was last modified

Screen Area	Item	Input/Output	Description
Other Insurance – All	Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.8 Status Detail: NHC (M257) Screen

The Status Detail: NHC Screen.

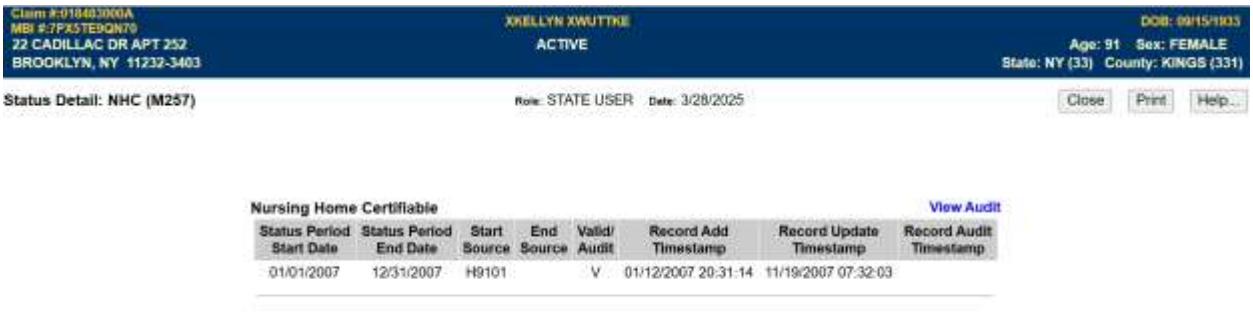


Figure 2-21: Status Detail NHC (M257) Screen

Table 2-31: Status Detail NHC (M257) Field Descriptions and Actions

Item	Input/Output	Description
Status Period Start Date	Output	The date this Medicare Beneficiary became qualified to be admitted to a nursing home.
Status Period End Date	Output	The date on which this Medicare Beneficiary no longer qualifies to attend a nursing home.
Start Source	Output	The User ID or source of the Period Start Date.
End Source	Output	The User ID or source of the period termination date.

2.4.8.9 Status Detail: HHC (M257) Screen

The Status Detail: HHC Screen....

Status Period Start Date	Status Period End Date	Earliest Bill Date	Latest Bill Date	Contractor Number	Status Code	Provider Number	Record Add Timestamp	Record Update Timestamp
07/15/2020	08/13/2020	07/15/2020	08/12/2020	11004	01 - Discharged to home or self care		07/28/2020 04:53:32	08/22/2020 04:33:53
01/12/2019	03/12/2019	01/14/2019	01/23/2019	11004	01 - Discharged to home or self care	197594	02/07/2019 06:52:58	08/22/2020 04:33:53
11/13/2018	01/11/2019	11/15/2018	01/10/2019	11004	30 - Still patient or expected return for outpatient services	197594	12/11/2018 09:10:14	08/22/2020 04:33:53
09/14/2018	11/12/2018	09/18/2018	11/12/2018	11004	30 - Still patient or expected return for outpatient services	197594	10/19/2018 09:03:50	08/22/2020 04:33:53
07/16/2018	09/13/2018	07/16/2018	09/13/2018	11004	30 - Still patient or expected return for outpatient services	197594	08/14/2018 08:00:24	08/22/2020 04:33:53
05/17/2018	07/15/2018	05/17/2018	07/14/2018	11004	30 - Still patient or expected return for outpatient services	197594	06/15/2018 18:08:51	08/22/2020 04:33:53
03/18/2018	05/16/2018	03/18/2018	05/15/2018	11004	30 - Still patient or expected return for outpatient services	197594	04/18/2018 07:44:28	08/22/2020 04:33:53
01/17/2018	03/17/2018	01/17/2018	03/16/2018	11004	30 - Still patient or expected return for outpatient services	197594	01/25/2018 10:12:49	08/22/2020 04:33:53
11/18/2017	01/16/2018	11/18/2017	01/15/2018	11004	30 - Still patient or expected return for outpatient services	197594	12/05/2017 12:04:07	08/22/2020 04:33:53
05/26/2008	07/24/2008	05/27/2008	06/05/2008	00380	01 - Discharged to home or self care	197783	06/06/2008 11:10:39	08/22/2020 04:33:53

Figure 2-22: Status Detail HHC (M257) Screen

Table 2-32: Status Detail HHC (M257) Field Description and Actions

Item	Input/Output	Description
Status Period Start Date	Output	Start of home health care period.
Status Period End Date	Output	End of home health care period.
Earliest Bill Date	Output	When billing began for this home health care period.
Latest Bill Date	Output	When the last bill was sent for this home health care period.
Contractor Number	Output	Identifier of contractor for this home health care period.
Status Code	Output	Status of home health care for this home health care period.
Provider Number	Output	Identifier of home health care provider for this home health care period.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified

2.4.8.10 Status Detail: Medicaid (M257) Screen

The Status Detail: Medicaid Screen.

Figure 2-23: Status Detail Medicaid (M257) Screen

Table 2-33: Status Detail Medicaid (M257) Field Descriptions and Actions

Screen Area	Item	Input/Output	Description
Medicaid Status – Community	Status Period Start Date	Output	A date that indicates the beginning of a beneficiary's Medicaid eligibility period. The date will always be the first of a month.
Medicaid Status – Community	Status Period End Date	Output	A date that indicates the end of a beneficiary's Medicaid eligibility period.
Medicaid Status – Community	Medicaid Source	Output	Value is populated based on the Medicaid record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the "View Audit" link is clicked on the M257 screen.
Medicaid Status – Community	State	Output	State or Territory Abbreviation.
Medicaid Status – Community	Valid/Audit	Output	Value is populated based on the Medicaid record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the "View Audit" link is clicked on the M257 screen.
Medicaid Status – Community	Medicaid Full/Partial/Non-dual	Output	A code describing the dual Medicaid status of beneficiary. Full

Screen Area	Item	Input/Output	Description
			Partial
Medicaid Status – Community	Dual Status Code	Output	A 2-digit code and description to identify the dual status: 01 = Eligible - entitled to Medicare- QMB only (Partial Dual), 02 = Eligible - entitled to Medicare- QMB AND Full-benefit Medicaid coverage (Full Dual), 03 = Eligible - entitled to Medicare- SLMB only (Partial Dual), 04 = Eligible - entitled to Medicare- SLMB AND Full-benefit Medicaid coverage (Full Dual), 05 = Eligible - entitled to Medicare- QDWI (Partial Dual), 06 = Eligible - entitled to Medicare- Qualifying individuals (Partial Dual), 08 = Eligible - entitled to Medicare- Other Full Benefit Dually Eligible (Non QMB, SLMB, QDWI or QI) (Full Dual), 09 = Eligible - entitled to Medicare – Other Dual Eligibles but without Medicaid coverage (Non-Dual), 10 = Other Full Dual, 99 = Unknown, 00 = Non-Dual
Medicaid Status – Community	Record Add Timestamp	Output	The date and time that the data was added
Medicaid Status – Community	Record Update Timestamp	Output	The date and time when a record was last modified
Medicaid Status – Community	Record Audit Timestamp	Output	The date and time when an audit entry was created
Medicaid Status – All	Status Period Start Date	Output	A date that indicates the beginning of a beneficiary's Medicaid eligibility period. The date will always be the first of a month.
Medicaid Status – All	Status Period End Date	Output	A date that indicates the end of a beneficiary's Medicaid eligibility period.
Medicaid Status – All	Medicaid Source	Output	A code identifying the source of a Medicare beneficiary's Medicaid eligibility information. •State •Territory • Point of Sale •Plan
Medicaid Status – All	State	Output	State or Territory Abbreviation.

Screen Area	Item	Input/Output	Description
Medicaid Status – All	Premiums Payer Code	Output	A code indicating the type of third party that paid the Medicare beneficiary's Part A or Part B premiums.
Medicaid Status – All	Medicaid Status	Output	Medicaid Status of Beneficiary. Yes – eligible No – not eligible
Medicaid Status – All	Medicaid Full/Partial/Non-dual	Output	A code describing the dual Medicaid status of beneficiary. Full Partial Non-dual
Medicaid Status – All	Dual Status Code	Output	A 2-digit code and description to identify the dual status: 01 = Eligible - entitled to Medicare- QMB only (Partial Dual), 02 = Eligible - entitled to Medicare- QMB AND Medicaid coverage (Full Dual), 03 = Eligible - entitled to Medicare- SLMB only (Partial Dual), 04 = Eligible - entitled to Medicare- SLMB AND Full-benefit Medicaid coverage (Full Dual), 05 = Eligible - entitled to Medicare- QDWI (Partial Dual), 06 = Eligible - entitled to Medicare- Qualifying individuals (Partial Dual), 08 = Eligible - entitled to Medicare- Other Full Benefit Dually Eligible (Non QMB, SLMB, QDWI or QI) (Full Dual), 09 = Eligible - entitled to Medicare – Other Dual Eligibles but without Medicaid coverage (Non-Dual), 10 = Other Full Dual, 99 = Unknown, 00 = Non-Dual
Medicaid Status – All	Record Add Timestamp	Output	The date and time that the data was added
Medicaid Status – All	Record Update Timestamp	Output	The date and time when a record was last modified

2.4.8.11 Status Detail: Hospice (M257) Screen

The Status Detail: Hospice Screen.

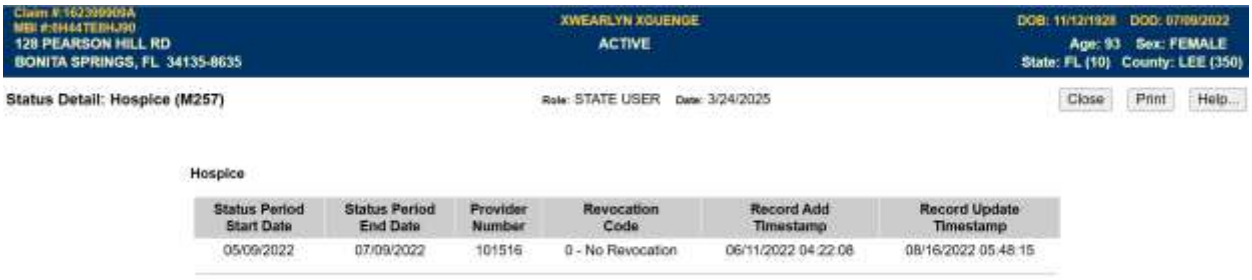


Figure 2-24: Status Detail Hospice (M257) Screen

Table 2-34: Status Detail Hospice (M257) Field Description and Actions

Item	Input/Output	Description
Status Period Start Date	Output	The start date of a beneficiary's Hospice benefit period.
Status Period End Date	Output	The termination date of a beneficiary's Hospice benefit period.
Provider Number	Output	The unique identifier for the hospice provider from which the beneficiary received care.
Revocation Code	Output	This code identifies the election of a beneficiary to terminate the use of hospice.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified

2.4.8.12 Status Detail: HCBS (M257) Screen

The Status Detail: HCBS Screen.

Figure 2-25: Status Detail HCBS (M257) Screen

Table 2-35: Status Detail HCBS (M257) Field Description and Actions

Item	Input/Output	Description
Status Period Start Date	Output	The effective date (MM/DD/CCYY) for this Home and Community Based Services record.
Status Period End Date	Output	The end date (MM/DD/CCYY) for this Home and Community Based Services record.
Medicaid Source	Output	A code identifying the source of a Medicare beneficiary's Medicaid eligibility information. •State •Territory •Point of Sale •Plan
State	Output	Current state of residence abbreviation and number as provided by SSA.
Dual Status Code	Output	A 2-digit code and description to identify the dual status: 01 = Eligible - entitled to Medicare- QMB only (Partial Dual), 02 = Eligible - entitled to Medicare- QMB AND Full-benefit Medicaid coverage (Full Dual), 03 = Eligible - entitled to Medicare- SLMB only (Partial Dual), 04 = Eligible - entitled to Medicare- SLMB AND Full-benefit Medicaid coverage (Full Dual), 05 = Eligible - entitled to Medicare- QDWI (Partial Dual), 06 = Eligible - entitled to Medicare- Qualifying individuals (Partial Dual), 08 = Eligible - entitled to Medicare- Other Full Benefit Dually Eligible(Non QMB, SLMB, QDWI or QI) (Full Dual), 9 = Eligible - entitled to Medicare – Other Dual Eligibles but without Medicaid coverage (Non-Dual), 10 = Other Full Dual, 99 = Unknown, 00 = Non-Dua
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified

2.4.8.13 Status Detail: XREF (M257) Screen

The Status Detail: XREF Screen.

Figure 2-26: Status Detail XREF (M257) Screen

Table 2-36: Status Detail XREF (M257) Field Descriptions and Actions

Item	Input/Output	Description
XREF Date	Output	Date (MM/DD/CCYY) that the cross-reference event occurred.
XREF Beneficiary ID	Output	Beneficiary ID previously used by the beneficiary.
Change/Merge	Output	Identifies the cross-reference event as either a change or a record merge.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified

2.4.8.14 Status Detail: Institutional (M257) Screen

The Status Detail: Institutional Screen.

Figure 2-27: Status Detail Institutional (M257) Screen

Table 2-37: Status Detail Institutional (M257) Field Description and Actions

Item	Input/Output	Description
Status Period Start Date	Output	The date this Medicare Beneficiary's institutional status became effective.
Status Period End Date	Output	The date on which the institutional status for a Medicare Beneficiary expires, is nullified, or becomes useless or ineffective.
Status Switch	Output	Indicates beneficiary is a resident in an inpatient medical treatment facility.

2.4.8.15 Status Detail: Long Term Institutional (M257) Screen

The Status Detail: Long Term Institutional Screen.

Figure 2-28: Status Detail Long Term Institutional (M257) Screen

Table 2-38: Status Detail Long Term Institutional (M257) Field Description and Actions

Item	Input/Output	Description
Coverage Year		Defaults to current year. Optional, select the desired Long Term Institution coverage year.
Status Month	Output	Month for Long Term Institutional status
Status Switch	Output	A 1-character code to identify whether a beneficiary was in a long term care institution for that Status Month Y = Yes

Item	Input/Output	Description
		N = No
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified

2.4.8.16 Status Detail: Disabled (M257) Screen

The Status Detail: Disabled Screen.

Figure 2-29: Status Detail Disabled (M257) Screen

Table 2-39: Status Detail Disabled (M257) Field Descriptions and Actions

Item	Input/Output	Description
Status Start Date	Output	The effective start date (MM/DD/CCYY) of disability.
Status End Date	Output	The end date (MM/DD/CCYY) of disability.
Status Code	Output	A 2-digit code and description to identify the type of disability entitlement.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified

2.4.8.17 Status Detail: Part A (M257) Screen

The Status Detail: Part A Screen.

Figure 2-30: Status Detail Part A (M257) Screen

Table 2-40: Status Detail Part A (M257) Field Descriptions and Actions

Item	Input/Output	Description
Entitlement Start Date	Output	Date (MM/DD/CCYY) entitlement began for this status record.
Entitlement End Date	Output	Date (MM/DD/CCYY) entitlement ended for this status record.
Enrollment Reason	Output	A 1-character code and description to identify the reason for enrollment.
SEP Status	Output	Value displayed when Part A or Part B Medicare entitlement was based on a Special Enrollment Period (SEP). Valid values include: (**Note: The following values P, M, C, E and H from the list below are identified as Part A and Part B Exceptional Condition SEPs.) •S- Special Enrollment Period •P- Formerly Incarcerated Individuals •L- Postal Service Reform Act (PSRA) SEP •M- Medicaid Termination •C- Other Exceptional Conditions •W- Group Health Plan for the Working Disabled •V- International Volunteer •K- TRICARE •E- Individuals Impacted by Emergency or Disaster •H- SEP for Private Group Health Plan or Employer Error
Non-Entitlement Reason	Output	A 1-character code and description to identify the reason a beneficiary was not entitlement to enrollment.
Entitlement Status	Output	The reason for entitlement or termination of a beneficiary's benefits during a period of coverage.

Item	Input/Output	Description
Valid/Audit	Output	Value is populated based on the entitlement record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the "View Audit" link is clicked on the M257 screen.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified
Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.18 Status Detail: Part B (M257) Screen

The Status Detail: Part B Screen.

Figure 2-31: Status Detail Part B (M257) Screen

Table 2-41: Status Detail Part B (M257) Field Descriptions and Actions

Item	Input/Output	Description
Entitlement Start Date	Output	Date (MM/DD/CCYY) entitlement began for this status record.
Entitlement End Date	Output	Date (MM/DD/CCYY) entitlement ended for this status record.
Enrollment Reason	Output	A 1-character code and description to identify the reason for enrollment.
SEP Status	Output	Value displayed when Part A or Part B Medicare entitlement was based on a Special Enrollment Period (SEP). Valid values include:

Item	Input/Output	Description
		(**Note: The following values P, M, C, E and H from the list below are identified as Part A and Part B Exceptional Condition SEPs.) •S- Special Enrollment Period •P- Formerly Incarcerated Individuals •L- Postal Service Reform Act (PSRA) SEP •M- Medicaid Termination •C- Other Exceptional Conditions •W- Group Health Plan for the Working Disabled •V- International Volunteer •K- TRICARE •E- Individuals Impacted by Emergency or Disaster •H- SEP for Private Group Health Plan or Employer Error
Non-Entitlement Reason	Output	A 1-character code and description to identify the reason a beneficiary was not entitlement to enrollment.
Entitlement Status	Output	The reason for entitlement or termination of a beneficiary's benefits during a period of coverage.
Valid/Audit	Output	Value is populated based on the entitlement record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the “View Audit” link is clicked on the M257 screen.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified
Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.19 Status Detail: Part D (M257) Screen

The Status Detail: Part D Screen.

Figure 2-32: Status Detail Part D (M257) Screen

Table 2-42: Status Detail Part D (M257) Field Descriptions and Actions

Item	Input/Output	Description
Eligibility Start Date	Output	Date (MM/DD/CCYY) When the PART D eligibility period began.
Eligibility End Date	Output	Date (MM/DD/CCYY) When the PART D eligibility period ended.
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.
Valid/Audit	Output	Value is populated based on the eligibility record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the “View Audit” link is clicked on the M257 screen.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified
Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.20 Status Detail: Incarceration (M257) Screen

The Status Detail: Incarceration Screen.

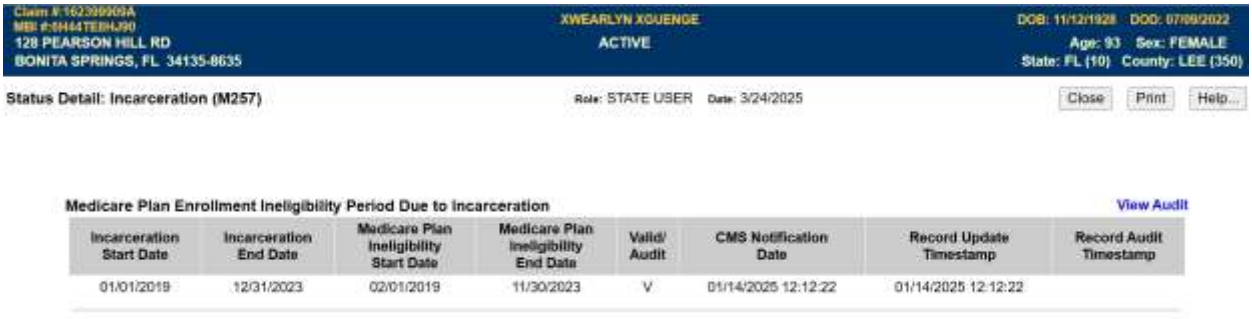


Figure 2-33: Status Detail Incarceration (M257) Screen

Table 2-43: Status Detail Incarceration (M257) Field Descriptions and Actions

Item	Input/Output	Description
Incarceration Start Date	Output	When the incarceration period began.
Incarceration End Date	Output	When the incarceration period ended
Medicare Plan Ineligibility Start Date	Output	Date (MM/DD/CCYY) no longer eligible for enrollment in Medicare plan
Medicare Plan Ineligibility End Date	Output	End date (MM/DD/CCYY) for ineligibility for enrollment in Medicare plan
Valid/Audit	Output	Value is populated based on the incarceration record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the “View Audit” link is clicked on the M257 screen.
CMS Notification Date	Output	Date and time (MM/DD/CCYY HH:MM:SS) the record was added.
Record Update Timestamp	Output	The date and time when a record was last modified
Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.21 Status Detail: Not Lawfully Present (M257) Screen

The Status Detail: Not Lawfully Present Screen.

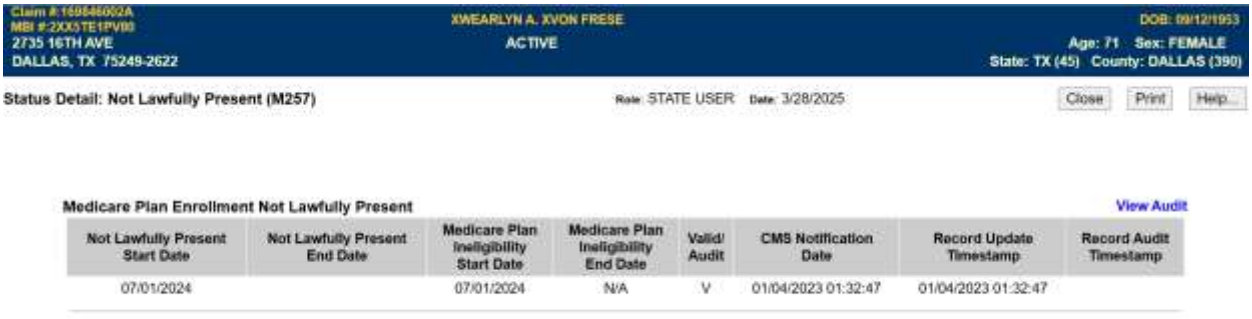


Figure 2-34: Status Detail Not Lawfully Present (M257) Screen

Table 2-44: Status Detail Not Lawfully Present (M257) Field Descriptions and Actions

Item	Input/Output	Description
Not Lawfully Present Start Date	Output	Date (MM/DD/CCYY) SSA has on file as the start date for beneficiary not being lawfully present.
Not Lawfully Present End Date	Output	Date (MM/DD/CCYY) SSA has on file as the end date for beneficiary not being lawfully present.
Medicare Plan Ineligibility Start Date	Output	Start Date (MM/DD/CCYY) of Medicare ineligibility for not lawfully present.
Medicare Plan Ineligibility End Date	Output	End Date (MM/DD/CCYY) of Medicare ineligibility for not lawfully present.
Valid/Audit	Output	Value is populated based on the not lawfully present record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the “View Audit” link is clicked on the M257 screen.
CMS Notification Date	Output	Date and time (MM/DD/CCYY HH:MM:SS) the record was added. SSA notifies CMS
Record Update Timestamp	Output	The date and time when a record was last modified
Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.22 Status Detail: Employer Subsidy (M257) Screen

The Status Detail: Employer Subsidy Screen.

Figure 2-35: Status Detail Employer Subsidy (M257) Screen

Table 2-45: Status Detail Employer Subsidy (M257) Field Descriptions and Actions

Item	Input/Output	Description
Status Period Start Date	Output	The effective start date (MM/DD/CCYY) for employer subsidy.
Status Period End Date	Output	The last date (MM/DD/CCYY) for employer subsidy.
Valid/Audit	Output	Value is populated based on the employer subsidy record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record Note: Audited records will only display when the “View Audit” link is clicked on the M257 screen.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified
Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.23 Status Detail: IC Model Status (M257) Screen

The Status Detail: IC Model Status Screen.

Figure 2-36: Status Detail IC Model Status (M257) Screen

Table 2-46: Status Detail IC Model Status (M257) Field Descriptions and Actions

Item	Input/Output	Description
Contract	Output	IC Model Contract Number
PBP	Output	The Plan Benefit Package number
IC Model Type Indicator	Output	Indicator to determine the type of Innovation Center Model. 01 - VBID (Value Based Insurance Design 02 - Medication Therapy Management
IC Model Benefit Status	Output	Populated if IC Model Type Indicator is '01', Valid values are: 01 – Full Status, 02 – Unearned Status
IC Model Start Date	Output	Start Date (MM/DD/CCYY) of the period that the Contract/PBP is an IC Model participant and within the beneficiary's enrollment period for the contract/PBP.
IC Model End Date	Output	End Date (MM/DD/CCYY) of the period that the Contract/PBP is an IC Model participant and within the beneficiary's enrollment period for the contract/PBP.
IC Model End Date Reason Code	Output	Populated if IC Model End Date is present, Valid values are: 01 – No longer Eligible, 02 – Opted out of program, 03 – Benefit Status Change
Valid/Audit	Output	Value is populated based on the IC Model record being valid (active) or an audited record. Valid values are: • V = Valid record • A = Audited record

Item	Input/Output	Description
		Note: Audited records will only display when the "View Audit" link is clicked on the M257 screen.
Record Add Timestamp	Output	The date and time that the data was added
Record Update Timestamp	Output	The date and time when a record was last modified
Record Audit Timestamp	Output	The date and time when an audit entry was created

2.4.8.24 Status Detail: Opt-Out Part D (M257) Screen

The Status Detail: Opt-Out Part D Screen.

Item	Input/Output	Description

2.4.8.25 Status Detail: Opt-Out MMP (M257) Screen

The Status Detail: Opt-Out MMP Screen.

Item	Input/Output	Description

2.4.9 Viewing Personal Information Screen

2.4.9.1 Personal Information (M259) Screen

This section will be updated with further information at a later date.

2.4.10 Viewing Eligibility Information for Medicare Beneficiaries

Beneficiary eligibility provides information regarding a beneficiary's entitlement for Part A, Part 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.

2.4.10.1 Beneficiary: Eligibility (M232) Screen

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

Figure 2-37: Beneficiary: Eligibility (M232) Screen

Users can either enter a Beneficiary ID OR a combination of First Name, Last Name, Date of Birth, and a SSN/HICN or partial MBI.

Table 2-47: Beneficiary: Eligibility (M232) Field Descriptions for Search Criteria

Item	Input/Output	Description
Beneficiary ID	Required data entry field	This is the beneficiary Medicare Beneficiary Identifier. This is a CMS created number.
Beneficiary ID	Required data entry field	Identifies the beneficiary whose eligibility information displays. Field must be completed if searching by beneficiary identification number.
First Name	Required data entry field	The first name, or initial of the beneficiary. Field must be completed if searching by SSN, HICN, or partial MBI.
Last Name	Required data entry field	The last name of the beneficiary. Field must be completed if searching by SSN, HICN, or partial MBI.
Suffix	Required data entry field	The last name suffix of the beneficiary, if it exists.
Date of Birth	Required data entry field	The birth date of the beneficiary (MM/DD/YYYY). Field must be completed if searching by SSN, HICN, or partial MBI.
SSN or HICN	Required data entry field	The social security number (SSN) or the health insurance claim number (HICN) of the beneficiary. Field must be completed if searching by SSN or HICN.

Item	Input/Output	Description
Partial MBI	Required data entry field	The partial Medicare beneficiary identifier (MBI) of the beneficiary. Field must contain at least 3 characters if searching by partial MBI.
Find	Button	The user clicks this button after entering the search data for the beneficiary. If the beneficiary is found, eligibility information for the beneficiary is displayed.
Reset	Button	The user clicks this button to clear the form to start a new search.

After a user enters the search criteria and clicks Find, the beneficiary's information will display below the Find and Reset buttons.

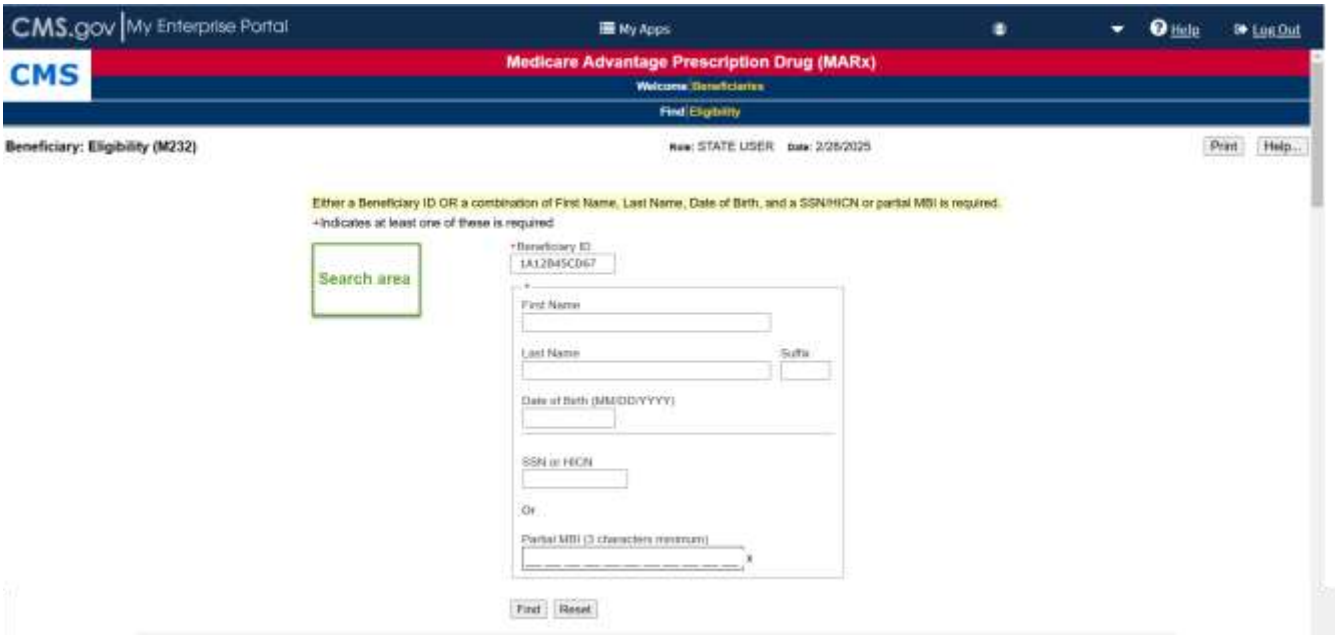


Figure 2-38: Beneficiary: Eligibility (M232) Screen – Search Area

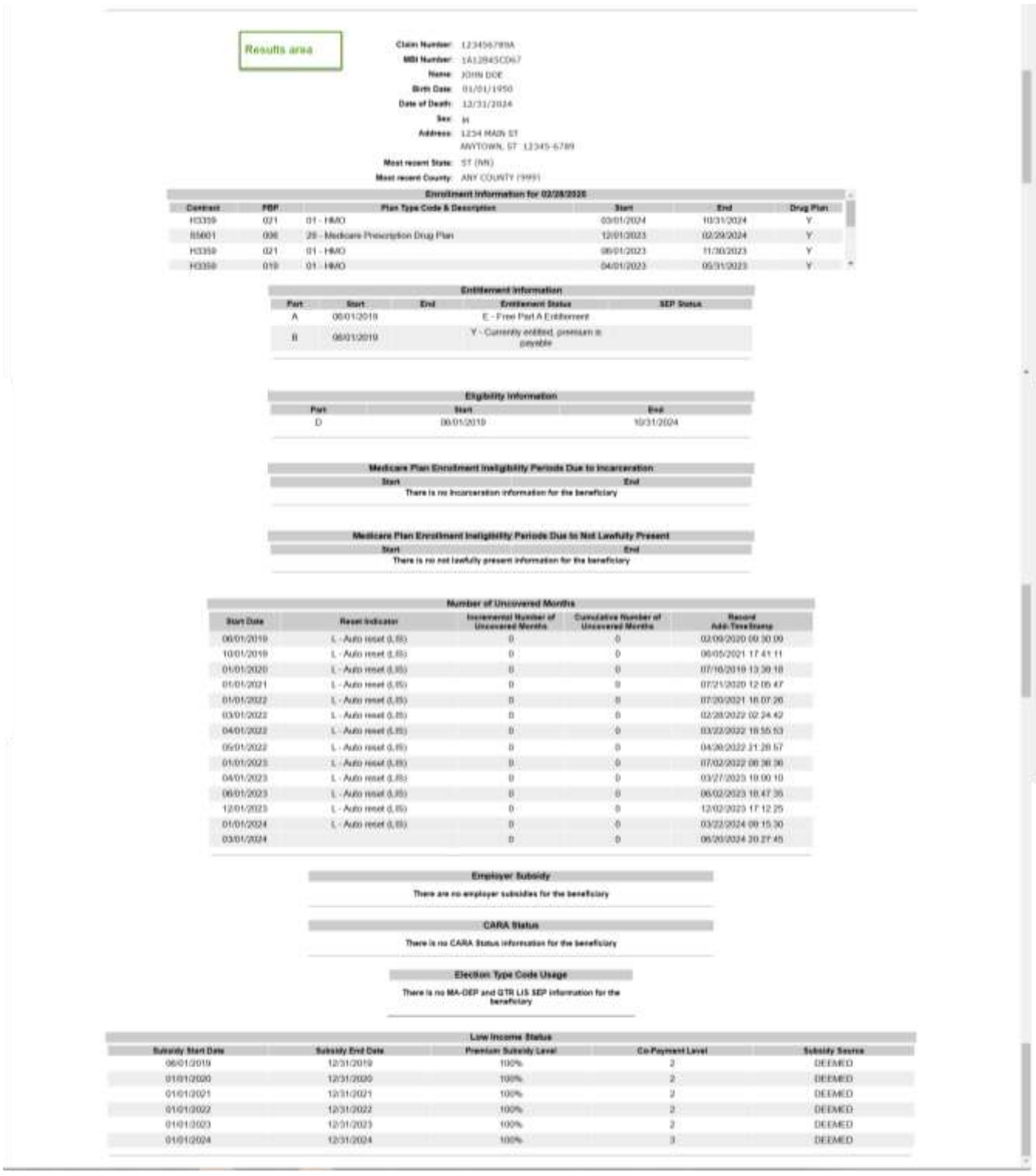


Figure 2-39: Beneficiary: Eligibility (M232) Screen – Results Area

Table 2-48: Beneficiary: Eligibility (M232) Field Descriptions for Beneficiary Information Results

Screen Area	Item	Input/Output	Description
Beneficiary Identification	Claim Number	Output	Claim number of beneficiary.
Beneficiary Identification	MBI Number	Output	Medicare Beneficiary ID of beneficiary.
Beneficiary Identification	Name	Output	Name of beneficiary.
Beneficiary Identification	Birth Date	Output	Date of birth of beneficiary.
Beneficiary Identification	Date of Death	Output	Date of death of beneficiary.
Beneficiary Identification	Sex	Output	Sex of beneficiary.
Beneficiary Identification	Address	Output	Street address, city, state, and zip code of beneficiary.
Beneficiary Identification	Most recent State	Output	The most recent state on record for the beneficiary.
Beneficiary Identification	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).
Enrollment Information	PBP	Output	PBP number for the beneficiary's enrollment(s).
Enrollment Information	Start	Output	Start date of the beneficiary's enrollment(s).
Enrollment Information	End	Output	End date of the beneficiary's enrollment(s).
Enrollment Information	Drug Plan	Output	Drug Plan indicator for the beneficiary's enrollment(s).
Entitlement Information	Part	Output	Entitlement information that applies to Part A and Part B of Medicare.
Entitlement Information	Start	Output	When the entitlement period began.
Entitlement Information	End	Output	When the entitlement period ended, as applicable.
Entitlement Information	Entitlement Status	Output	Option selected for this part. See Section 3 for Entitlement Code values.
Entitlement Information	SEP Status	Output	Value displayed when Part A or Part B entitlement was based on a Special Election Period (SEP). See Section 3 for Entitlement Code values,
Eligibility Information	Part	Output	Eligibility information that applies to this Part D of Medicare.

Screen Area	Item	Input/Output	Description
Eligibility Information	Start	Output	When the eligibility period began.
Eligibility Information	End	Output	When the eligibility period ended, as applicable.
Medicare Plan Enrollment Ineligibility Periods Due to Incarceration	Start	Output	When the incarceration period began.
Medicare Plan Enrollment Ineligibility Periods Due to Incarceration	End	Output	When the eligibility period ended, as applicable.
Medicare Plan Enrollment Ineligibility Periods Due to Not Lawfully Present	Start	Output	When the not lawfully present period began.
Medicare Plan Enrollment Ineligibility Periods Due to Not Lawfully Present	End	Output	When the not lawfully present period ended, as applicable.
Number of Uncovered Months (NUNCMO)	Start Date	Output	Start Date for uncovered months' period.
NUNCMO	Indicator	Output	Indicator showing record type. Values are: R = Reset L = LIS A = Aged 65 IEP
NUNCMO	NUNCMO	Output	Number of Uncovered Months.
NUNCMO	Total NUNCMO	Output	Total NUNCMO based on the Indicator.
NUNCMO	Record Add-Timestamp	Output	Timestamp for when the record was added.
Employer Subsidy	Start	Output	When a Retiree Drug Subsidy (RDS) coverage period began.
Employer Subsidy	End	Output	When an RDS coverage period ended.
CARA Status	Start	Input	A = Add (starts 2019) D = Delete U = Update Space = Not applicable

Screen Area	Item	Input/Output	Description
Election Type Code Usage	End	Output	Chosen based on the plan and the transaction code
Low Income Status	Subsidy Start Date	Output	When the subsidy of Part D premiums began.
Low Income Status	Subsidy End Date	Output	When the subsidy of Part D premiums ends, as applicable.
Low Income Status	Premium Subsidy Level column	Output	Level at which the premiums are subsidized. Values are: (Effective 1/1/2024) 100 Prior to 1/1/2024 100 075 050 025
Low Income Status	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 certain home and community- based services (HCBS). 4 – Unknown. Space – Not applicable.
Low Income Status	Subsidy Source Column	Output	A – Approved SSA or state applicant. D – Deemed eligible by CMS. Space – Not applicable.

Table 2-49: Beneficiary: Eligibility (M232) Error 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

Message Type	Message Text	Suggested Action
		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.

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

- If the beneficiary is not currently enrolled in a Plan, historical, and future information will be 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, 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.

.

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 dually 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.

3. Entitlement Status, Enrollment and Disenrollment Reason Codes

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

The following table shows the Part A Entitlement Status codes that have an entitlement date present, and the termination date is blank.

Table 3-1: Part A Entitlement Status Codes with Entitlement Date Only

Code	Definition
E	Free Part A Entitlement
G	Entitled due to good cause
Y	Currently entitled, premium is payable

The following table shows the Part A Entitlement Status codes that have an entitlement date and termination date present.

Table 3-2: Part A Entitlement Status Codes with Entitlement and Termination Dates

Code	Definition
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

The following table shows the Part A Entitlement Status codes where both the entitlement date and termination date are blank.

Table 3-3: Part A – Non-Entitlement Status Codes with blank Entitlement and Termination Dates

Code	Definition
D	Coverage denied
F	Terminated due to invalid enrollment or enrollment voided
H	Ineligible for free Part A, and/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 3-4: Part A- Enrollment Reason Codes

A	Attainment of age 65.
B	Equitable relief.

D	Disability – Under age 65 entitlement.
G	General Enrollment Period.
H	Entitlement based on Health Hazard
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.

The following table shows the Part B Entitlement Status codes that have an entitlement date present, and the termination date is blank.

Table 3-5: Part B Entitlement Status Codes with Entitlement Date Only

Code	Definition
G	Entitled due to good cause
Y	Currently entitled, premium is payable

The following table shows the Part B Entitlement Status codes that have an entitlement date and termination date present.

Table 3-6: Part B Entitlement Status Codes with Entitlement and Termination Dates

Code	Definition
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

The following table shows the Part B Entitlement Status codes where both the entitlement date and termination date are blank.

Table 3-7: Part B – Non-Entitlement Status Codes with blank Entitlement and Termination Dates

Code	Definition
D	Coverage denied
N	Foreign/Puerto Rican Beneficiary is not entitled to SMI or dually/Technically entitled Beneficiary ID.
R	Refused benefits

Table 3-8: 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 3-9: 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)

Code	Definition
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

Code	Definition
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

*Plan cannot submit 99; it is assigned as a default value by the system only.

**Only valid for MMP Disenrollments, Disenrollment Cancellations or Enrollment Cancellations.

***Plans use only

Table 3-10: Special Enrollment Period (SEP) Status Codes

Code	Definition
S	Special Enrollment Period
P	Formerly Incarcerated Individuals
M	Medicaid Termination
C	Other Exceptional Conditions
W	Group Health Plan for the Working Disabled
V	International Volunteer
K	TRICARE
E	Individuals Impacted by Emergency or Disaster
H	SEP for Private Group Health Plan or Employer Error

Note: If the If the Part A and Part B fields are blank, entitlement was not based on a Special Enrollment Period.

SEP values P, M, C, E and H are considered exceptional condition SEP values.

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

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) File Exchange is the state's data exchange that provides current information on updated full-benefit dually eligible and partial-benefit dually eligible beneficiary status (i.e., those who only receive Medicaid help with Medicare premiums, and often for cost-sharing). The state sends data on the MMA File to the CMS Medicare Beneficiary Database (MBD). For each "request file" received from the state, the CMS MBD generates an MMA Response File to the state.

4.1 State Monthly MMA File Submission Requirements

Since 2005, each of the fifty states and the District of Columbia Medicaid agencies (hereafter referred to as 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 only get Medicaid help with Medicare premiums, and often for cost-sharing). Territories do not participate in this data exchange with CMS.

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 phased-down file." Federal regulations at 42 CFR 423.910(d)(1) requires states, effective April 1, 2022, to submit files daily. Under this requirement, states must submit 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 across the agency:

- Dual Eligible Enrollment
    - Parts A and B: QMB status and related protections
    - Part C: Plan risk adjustment
    - Part D: Auto-enrollment, LIS deeming, and accurate cost-sharing for people in institutions or receiving certain home and community-based services
- State Phased-Down Calculation
- State Low-Income Subsidy (LIS) Applications, and to auto-assign beneficiaries to Medicare Part D plans.

4.2 Dual Eligible Enrollment

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

- Qualified Medicare Beneficiaries (QMB)
- Specified Low-Income Medicare Beneficiaries (SLMB)
- Qualifying Individuals (QI)
- Qualified Disabled and Working Individuals (QDWI)
- Retroactive (Retro) records, Prospective (PRO) records
- State Low-Income Subsidy (LIS) applications for Part D subsidy processed since the last MMA file was created

4.3 State Phased-Down Calculation

CMS uses the state's MMA file submission to calculate the State Phased-Down contribution payment, also known as clawback. 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 (dual status codes 02, 04, and 08).

The clawback process inserts an indicator into the Daily State Phased-Down Calculation Code field, in position 2902 of the MMA Response File and counts the total number of Beneficiary Calculation Code for each state and eligibility month/year.

- Enrollment (E), Disenrollment (D), and Prospective Records (P) are not counted in clawback.

In the case where, in a given month, a state submits multiple records 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.

In the case where, in a given month, multiple records are submitted for the same beneficiary by different states, the clawback is counted for both states. If one state submits a correction, the clawback will be adjusted for that state.

For information on the State Phased-Down contribution payment, click https://www.cms.gov/medicare/medicaid-coordination/about/state-phased-down-billing.

Email DPBCStateBuy-in@cms.hhs.gov if you have questions regarding:

- Medicare Part D bill discrepancies
- A state did not receive the monthly Medicare Part D bill
- To get access to view e-bills in ELMO
- A state needs to update its contact information for authorized fiscal points of contact (maximum of 2) including email address, phone number, and postal mail address to send the SAS bill notice.

- A state wants to make a payment using the Pay.gov application and is requesting access.
- A state's Medicaid Grant Award was offset for non-payment of the SPD contribution and the state can prove that the payment was made timely.
- A state has an overpayment amount and wants to confirm the adjusted/reduced contribution to pay to expend the credit fully.

4.4 State Low-Income Subsidy (LIS) Applications

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

CMS strongly encourages states to use the SSA subsidy application (SSA-1020) for subsidy applicants unless a beneficiary specifically requests the state make the subsidy determination using a state application form.

States should ask applicants if they have already applied for the subsidy with SSA and if so, urge them to wait for a decision from SSA. However, if the applicant insists on filing with the state prior to an SSA decision, the state must comply.

If a beneficiary requests a state determination or refuses to use the SSA application, the state must use its application and process the case using federal LIS income, family size, and resource rules. Refer to 42 CFR § 423.904 (c). The state follows its process for taking applications. The state is then responsible for notices, appeals, and redeterminations for subsidy cases it has determined using a state application form. For more information, please refer to section 10.3.3, The State Application in the CMS Guidance to States on the Low-Income Subsidy.

5. State MMA Request File Timing and Content

The following sections, 5 through 11, provide an overview of how State Medicaid Agencies will send data to CMS, and descriptions of the specific data files that are exchanged between the States and CMS.

5.1 MMA Request File Timing

Each state will send:

At least one comprehensive MMA Request file to CMS between the start and the end of the enrollment month including all known dually eligible beneficiaries, and

Subsequent daily files that include only file accretions, deletions, and changes in dual eligibility status.

Daily means every business day, but if no new transactions are available to transmit, data would not need to be submitted on a given business day.

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

- States submit a full monthly file and subsequent daily (accretions, deletions, and changes) MMA Request files during the month. Subsequent submissions in the same month will be treated as a unique submission and processed like the first file. For each state file accepted and processed successfully, CMS will send an MMA Response file within 24-48 hours.
    - Note: State MMA Request files submitted successfully between 6:00 a.m. – 5:30 p.m. (ET) will be processed the same day. MMA Response files are processed and sent to states between 9:00 a.m. – 10:00 a.m. (ET) the following day.
    - Files received after 5:30 p.m. (ET) will be processed the following day and the response file sent the next day.
    - Example: The state submits an MMA request file to CMS and it is received at 6:00 p.m. 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 processes all files nightly for the LIS deeming and auto-assignment process. CMS sends the resulting enrollment transactions each day (except for Sundays) to the Part D Plans.
- Files that are rejected 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. All enrollment detail (DET) records submitted as 'current' would now be treated as retroactive records, any future DET records would be processed as current records.

The last day of the month cutoff processing times of files are:

- Weekday (including holidays) 5:30 pm Eastern Time
- Saturday or Sunday 1:00 pm Eastern Time

- If no file is successfully submitted for the month, CMS will project enrollment from the prior month's file and apply retroactive updates based on the subsequent months' submittals for the Phased-Down calculation.

5.2 MMA Request File Content

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

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

5.2.1 Current DET Records

States must include a person-month record for each dually eligible beneficiary for the current reporting month.

A person-month record is a full detail record per beneficiary for the current month.

5.2.2 Retro DET Records

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

- Eligibility status (including Medicaid eligibility and dual status)

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

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

1. 1. A state has reported a beneficiary as having eligibility status for the first time in February 2024. The state later determines that the first full month of eligibility was January 2024 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 2024 record.

The picture below of this example shows 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	22024	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	32024	Y	4K88L84HXXX	F	12011950	2	1	Y
DET	12024	Y	4K88L84HXXX	F	12011950	2	1	Y

Figure 55-1: Retroactive DET Record Example 1

2. A state has reported a beneficiary as having a dual-status code of 02 (QMB-plus) in February 2024. 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 2023. The state sends a retroactive detail record showing this update; the file would maintain all fields from December 2023 to February 2024 records and change only the dual status code field.

In the picture below, 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 2023 to February 2024). The state would correct the "Elig M/Y" and "Dual-Status Code" fields, while all other fields would remain the same.

Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	22024	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	32024	Y	4K88L84HXXX	F	12011950	8	1	Y
DET	22024	Y	4K88L84HXXX	F	12011950	8	1	Y
DET	12024	Y	4K88L84HXXX	F	12011950	8	1	Y
DET	122023	Y	4K88L84HXXX	F	12011950	8	1	Y

Figure 5-2: Retroactive DET Record Example 2

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

Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	22024	Y	4K88L84HXXX	F	12011950	2	1	Y
DET	32024	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	22024	Y	4K88L84HXXX	F	12011950	2	1	Y
DET	32024	N	4K88L84HXXX	F	12011950	2	1	Y

Figure 55-3: Retroactive DET Record Example 3

4. If a beneficiary was submitted as a current DET record in a previous submission during the current reporting month as a 'Y', but the state discovered the beneficiary was not Medicaid eligible, the state may correct the eligibility status by resubmitting the beneficiary's record with

an ‘N’ in the Medicaid Eligibility Status field for the current reporting month within the same month.

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

Record ID Code	Elig M/Y	Elig Status	Bene ID	Gender	Date of Birth	Dual Status Code	FPL % Indicator	Institutional Status Indicator
DET	22024	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	22024	N	4K88L84HXXX	F	12011950	2	1	Y

Figure 5-4: Retroactive DET Record Example 4

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 between 36 months and 120 months in the past. All state submissions meeting these criteria will require prior approval by the Medicare-Medicaid Coordination Office (MMCO) via a request to MMCO_MMA@cms.hhs.gov.

5.2.3 Future DET Records

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

5.2.4 LIS Records

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

5.2.5 PRO records

States should include beneficiaries in state Medicaid programs who are not known to be a full-benefit dually eligible beneficiary but are Medicaid eligible and approaching an age (64 and seven months or older in the reporting month) or disability status that is likely to lead to a future determination of full dually eligibility. See **Sections 5.3 – 5.6** for detailed information on PRO Records.

5.3 Prospective Full-Benefit Dually Eligible Individuals

One of the concerns related to the monthly MMA reporting cycle is the effect on Medicaid-only beneficiaries who transition to dually eligible status and the difficulty in ensuring a seamless transition in drug coverage. This section will clarify a few key elements that are part of the submission, as well as processing, of these prospective records.

The state should only submit prospective records for beneficiaries with full Medicaid benefits, i.e., beneficiaries who, if they have Medicare coverage, would be full-benefit dually eligible. Do not include beneficiaries who would only be partial-benefit dually eligible, i.e., QMB-only, SLMB-only, or QI. In the dual status code field in the PRO record, include the full-benefit dually eligible status code(02, 04, 08) which best describes the dual status assuming that the beneficiary is Medicare eligible.

5.4 PRO Enrollment Process

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

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

5.5 Submission of PRO Records

For CMS to successfully process a PRO record the following field requirement must be met in the MMA Request Detail Record:

- Record Identification Code must contain ‘PRO’.
- Eligibility Month/Year 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.
- A record must contain a valid Social Security Number. This field cannot be 9-filled or blank.
- A record must contain a valid Date of Birth. 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 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 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 before the enrollment effective date. For example, the enrollment effective date is December 1, 2025, the earliest CMS can return this information is October 1, 2025.

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. CMS will reject any records where there is both a DET and PRO for the same eligibility month.

5.6 Processing of Returned PRO Records

Once the state has submitted its PRO records to CMS for processing, CMS will respond by returning a PRO record for each PRO record submitted, regardless if found on the CMS Medicare Beneficiary Database (MBD). A state will receive PRO statistics in the MMA Response Summary Record.

Record Return Summary Codes 000009 – 000012 apply to PRO records only. See Record Return Summary Code in the MMA Response File Detail Record (item 55, positions 229-234) 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* section 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 01/01/2024, it is anticipated that a DET record will be submitted for this beneficiary in the January 2024 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 January 2025 State Request File and was found to be Part A and/or B entitled effective 03/01/2025, 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 03/01/2025.

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 2025).

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

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

5.7 Dual Status Code

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 Programs.

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 Medicare Savings Program eligibility groups. Full-benefit dually eligible beneficiaries are dual-status codes: 02, 04, and 08.

Partial-benefit dually eligible beneficiaries are enrolled only in Medicare and a Medicare Savings Program eligibility group. Partial- benefit dually eligible beneficiaries are dual-status codes: 01, 03, 05, and 06.

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

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

5.8 Part B Immunosuppressive Drug (Part B-ID)

Starting January 1, 2023, certain individuals who lose End-Stage Renal Disease (ESRD) Medicare coverage after a successful kidney transplant are eligible for a limited benefit that covers immunosuppressive drug therapy under Medicare Part B (Part B-ID), as required by section 402 of the Consolidated Appropriations Act, 2021. The Part B-ID benefit solely covers immunosuppressive drugs and no other Medicare items, services, or prescription drugs.

Individuals 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. Other health coverage includes:
    - Group Health Plans or Individual Health Plans;
    - Enrolled in the patient enrollment system of the Department of Veterans Affairs (VA) or otherwise eligible to receive immunosuppressive drugs from the VA;
    - TRICARE for Life;
    - Health Insurance Marketplace qualified health plans; and
    - Medicaid or State Children's Health Insurance Program (CHIP) coverage that includes immunosuppressive drugs.

Individuals enrolled in Part B-ID may be considered QMBs, SLMBs, or QIs if they otherwise meet the eligibility requirements of QMB, SLMB, or QI. States would report them with the appropriate dual status codes for QMB-only, SLMB-only, or QI per section 5.7.

Individuals are charged a monthly premium for Part B-ID through direct billing by CMS. Individuals eligible for the 3 primary Medicare Savings Program eligibility groups: QMB, SLMB, or QI Medicaid 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.

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

6. MMA File – Special Key Fields

6.1 Special Key Fields Tips for MMA Request File

6.1.1 Beneficiary Matching Criteria

CMS matches the key beneficiary fields of each record on the states' Request File against the CMS Medicare Beneficiary Database (MBD) to find a match.

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

If the Primary Match does not return a response, the secondary match routine uses the values for the following demographic fields from the beneficiary's MMA Request file record to find a match for the beneficiary in the Medicare database:

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

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

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

6.2 Special Key Fields Tips for MMA Response File

6.2.1 Medicare Part D-Enrollment Indicator

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

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

6.3 Institutional Status Indicator

Under 42 CFR 423.910(d)(1), states must submit an electronic file identifying each full-benefit dually eligible beneficiary enrolled in the state for each month, including information concerning institutional status. Under section 1902(q)(1)(B) of the Social Security Act and 42 CFR 423.772, an institutionalized individual is a full-benefit dually eligible who is an inpatient in a medical institution or nursing facility for which payment is made under Medicaid throughout a month. Thus, for purposes of the required institutional status indicator in 42 CFR 423.910(d)(1), states must include any full-benefit dually eligible beneficiary who received billable inpatient services in a medical institution or nursing facility from the first day of the month throughout the end of the same month.

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

Most non-institutionalized dually eligible beneficiaries pay small co-payments for prescription drugs covered under Medicare Part D. However, section 1860D-14 (a)(1)(D)(i) of the Social Security Act eliminates Medicare Part D co-payments for full-benefit dually 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 that qualify the beneficiary for zero-dollar Part D cost sharing.

To learn more about Home & Community Based Services, visit Medicaid.gov. 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.

7. MMA Request File Layouts

7.1 MMA Request File Dataset Naming Convention

Table 7-1: MMA Request File Dataset Naming Convention

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

7.2 MMA Request File Header Record Layout

Table 7-2: MMA Request File Header Record Layout

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
3	Create Month	2	6-7	NUM	Month (MM) the file is created.
4	Create Year	4	8-11	NUM	Year (CCYY) the file is created.
5	Filler	169	12-180	CHAR	Spaces

Note: The header date must match the file date. If not, the file will be rejected.

7.3 MMA Request File Detail Record Layout

Table 7-3: MMA Request File Detail Record

Item	Field	Size	Position	Format	Valid Values
1	Record Identification Code	3	1-3	CHAR	DET – Beneficiary with Medicare and Medicaid eligibility in the current month. PRO – Beneficiaries with full Medicaid benefits, i.e., beneficiaries who, if they have Medicare coverage, would be full-benefit dually eligible within two months. LIS – Beneficiary has undergone a low-income subsidy determination within the

Item	Field	Size	Position	Format	Valid Values
					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 the prior month's 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.

Item	Field	Size	Position	Format	Valid Values
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 this field.
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 - QMB Only 02 - QMB Plus 03 - SLMB Only 04 - SLMB Plus

Item	Field	Size	Position	Format	Valid Values
					05 - QDWI 06 - Qualifying Beneficiaries 08 – Other full benefit dually eligible For a summary of the eligibility categories for dually eligible individuals, including dual status code and a description of each category and level of assistance, click here.
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. CMS does not use this field.
17	Institutional Status Indicator	1	120	CHAR	Enter one of the following values for DET and PRO records. The 'Y' or 'H' field values trigger a $0 copayment level. Y – 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 (Home and Community Based) – A full-benefit dually eligible beneficiary receives HCBS. 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. 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 has not been approved.

Item	Field	Size	Position	Format	Valid Values
19	LIS Approved/ Disapproved Date	8	122-129	NUM	MMDDCCYY For LIS records, enter the date that the state approved or disapproved the low-income subsidy application.
20	LIS Start Date	8	130-137	NUM	MMDDCCYY 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 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 of the Federal Poverty Level (FPL) as defined by the Federal LIS income determination policy.
23	LIS Level	3	149-151	NUM	For LIS records Enter the following values to describe the portion of Part D premium subsidized. 100 – under 150% FPL (effective 1/1/2024) Prior to 1/1/2024: 100 – under 136% 075 – 136%-140% 050 – 141%-145% 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.

Item	Field	Size	Position	Format	Valid Values
					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

7.4 MMA Request File Trailer Record Layout

Table 7-4: MMA Request File Trailer Record Layout

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

Item	Field	Size	Position	Format	Valid Values
4	Create Month	2	14-15	NUM	Month (MM) the file is created.
5	Create Year	4	16-19	NUM	Year (CCYY) the file is created.
6	Filler	161	20-180	CHAR	Spaces

8. MMA Response File Layouts

8.1 MMA Response File Section Information

8.1.1 Managed Care Organization

There is space for 10 Managed Care Organization Occurrences, items 143-154, on the MMA Response Detail record. It 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 Managed Care Organization 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 Managed Care Organization coverage (i.e. plan enrollment). Presently, this section is populated with Medicare Part C and Medicare Part D organizations enrollments. The organizations can be distinguished by the first position of Beneficiary Managed Care Organization 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)

8.1.2 Plan Benefit Package Enrollment

There is space for 10 occurrences for Plan Benefit Package Enrollment Occurrences, items 155-168. It 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)

09 – FFS (Fee for Service)

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)

14 - – MMP (Medicare/Medicaid Plan).

8.1.3 Part D Plan Benefit Package

There is space for 10 occurrences for Part D Plan Benefit Package Occurrences (items 207-220). It 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.

8.2 MMA Response File Dataset Naming Convention

Table 8-1: MMA Response File Dataset Naming Convention

System	Type	Size	Frequency
MBD	Data File	4000	For each MMA Request File sent an MMA Response File is returned

8.3 MMA Response File Header Record Layout

The MMA Response File Header Record is grouped into the following sections:

Items 1-14: File details

Items 15-19: Original MMA Request File Header Record

Item 20: Filler spaces

Table 8-2: MMA Response File Header Record Layout

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.
3	File Accept Indicator	1	30	CHAR	Y – The state file to CMS is accepted.
4	Filler	1	31	CHAR	Filler spaces.
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

Item	Field	Size	Position	Format	Description
					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	Filler spaces.
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	US Postal Service State Abbreviation
17	Create Month	2	121-122	NUM	Month (MM) the file is created.
18	Create Year	4	123-126	NUM	Year (CCYY) the file is created.
19	Filler	169	127-295	CHAR	Filler spaces.
20	Filler	3705	296- 4000	CHAR	Filler spaces.

8.4 MMA Response File Detail Record Layout

The MMA Response File Detail Record is grouped in the following sections:

Items 1-30: Original MMA Request File Detail Record

Items 31-54: Error Return Codes

Items 55-57: CMS Response Fields Form

Items 58-65: 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.

Items 66-85: Cross Reference Numbers (10 occurrences with the first occurrence being the active/most recent cross-reference Medicare number).

Items 86-90: Social Security Numbers (5 most recent occurrences)

Items 91-100: Mailing Address. This may be the mailing address of the beneficiary or the mailing address of his/her representative payee.

Items 101-109: Residence Address. The beneficiary's most recent residence address.

Items 110-115: Entitlement Reason (5 most recent occurrences)

Items 116-123: Part A Entitlement (5 most recent occurrences)

Items 124-131: Part B Entitlement (5 most recent occurrences)

Items 132-137: Hospice Coverage (5 most recent occurrences)

Items 138-142: Disability Insurance Benefits (3 most recent occurrences)

Items 143-154: Managed Care Organization (10 most recent occurrences)

Items 155-168: Part Benefits Package Election (10 most recent occurrences)

Items 169-171: End-Stage Renal Disease (ESRD) Coverage

Items 172-173: ESRD Clinical Dialysis Dates (See items 267-271 for occurrences 2-6, sorted in descending order by Start Date)

Items 174-175: End-Stage Renal Disease Transplant

Items 176-183: Third-Party Part A History (5 most recent occurrences)

Items 184 -191: Third-Party Part B History (5 most recent occurrences)

Items 192-193: Part D Data Elements

Items 194-206: Beneficiary's Co-Payment History (10 occurrences). The first occurrence is the active/most recent co-payment period.

Items 207 -236: Part D Plan Benefit Package (10 most recent occurrences)

Items 237-240: Medicare Plan Ineligibility Due to Incarceration Periods, 10 occurrences (sorted from latest to earliest based on Medicare Plan Ineligibility Due to Incarceration Start Date). See items 274-291 for occurrences 2-10.

Items 241-242: Special Codes

Items 243-249: Retiree Drug Subsidy (RDS) Coverage Periods (5 most recent occurrences)

Items 250-255: Part D Eligibility (5 most recent occurrences)

Items 256-266: Beneficiary Part D LIS Information (10 most recent occurrences)

Items 267 -271: Beneficiary ESRD Clinical Dialysis Dates Occurrences 2-6, sorted from latest to earliest based on ESRD start date

Items 272: Beneficiary Archive Indicator

Items 273: Medicare-Medicaid Plan (MMP) Opt-Out Indicator

Items 274- 311: Medicare Plan Ineligibility Due to Not Lawful Presence

Items 312-321: MBI data (6 most recent occurrences). Items 322-341: CARA Status

Items 343: Filler

Table 8-3: MMA Response File Detail Record Layout

Item	Field	Size	Position	Format	Description
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	Y: Eligible for Medicaid for that Eligibility Month and Year. N: Not eligible for Medicaid for that Eligibility Month and Year. CMS rejects PRO records with 'N' in this field. Required for DET and PRO record types only.
4	Beneficiary's Identifier	15	11-25	CHAR	Medicare Health Insurance Claim Number (HICN), Railroad Retirement Board (RRB) Number, or Medicare Beneficiary Identifier (MBI) – whichever the state has active and available for the individual.
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	Beneficiary's Social Security Number	9	27-35	NUM	The individual's identification number assigned by the Social Security Administration (SSA). A value should be provided if the Individual Medicare Identifier field is blank. If a value is provided, it should contain nine numerals and should not contain all zeroes or all nines.
7	SMA Identifier	20	36-55	CHAR	Individual's SMA Enrollee Identifier.
8	Beneficiary's First Name	12	56-67	CHAR	The individual's first name.
9	Beneficiary's Last Name	20	68-87	CHAR	The individual's last name.
10	Beneficiary's Middle Name	15	88-102	CHAR	The individual's middle name.

Item	Field	Size	Position	Format	Description
11	Beneficiary's Suffix Name	4	103-106	CHAR	The individual's suffix name.
12	Beneficiary's Gender	1	107	CHAR	A code indicating the individual's sex. The value should be one of the following: 'F' (Female) 'M' (Male) '9' (Unknown)
13	Beneficiary's Date of Birth	8	108-115	NUM	MMDDCCYY
14	Dual Status Code	2	116-117	NUM	Enter one of the following values for DET records: 01 - QMB Only 02 - QMB Plus 03 - SLMB Only 04 - SLMB Plus 05 - QDWI 06 - Qualifying Beneficiaries 08 –Other full benefit dually eligible For a summary of the eligibility categories for dually eligible individuals, including dual status code and a description of each category and level of assistance, click here.
15	FPL Percentage Indicator	1	118	NUM	1- Individual's income at or below 100% FPL. 2- Individual's income above 100% FPL. 9- Unknown. Required for DET and PRO record types only.
16	Drug Coverage Indicator	1	119	NUM	This field is not used by CMS.
17	Institutional Status Indicator	1	120	CHAR	Y- Individual is institutionalized in a nursing facility, intermediate care facility, or inpatient psychiatric hospital for the entire span of eligibility for month. N-Individual is not institutionalized in a nursing facility, intermediate care facility, or inpatient psychiatric hospital for the entire span of eligibility for month.

Item	Field	Size	Position	Format	Description
					H-Individual is receiving home and community-based services at any period during the month. (For Eligibility Month and Year starting January 2012 and later). 9- Unknown Required for DET and PRO record types only.
18	LIS Application Approval Code	1	121	CHAR	Y-The Individual's subsidy application is approved. N- Individual's subsidy application is not approved. Required for LIS record type only.
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	Percentage of income to FPL, as defined by Federal LIS income determination policy. Required for LIS record type only.
23	LIS Level	3	149-151	NUM	For LIS records Enter the following values to describe the portion of Part D premium subsidized. 100 – under 150% FPL (effective 1/1/2024) Prior to 1/1/2024: 100 –under 136% 075 – 136%-140% 050 – 141%-145% 025 – 146%-149%
24	Income used for Determination	1	152	CHAR	1- Income used for determination is based on that of individual.

Item	Field	Size	Position	Format	Description
					2- Income used for determination is based on that of couple Required for LIS record type only.
25	Resource Level	1	153	CHAR	1- Individual's resource limit is over the limit. 2- Individual's resource limit is under the limit. Required for LIS record type only
26	Basis of LIS Denial	1	154	CHAR	1- Not enrolled in Medicare Part A or Part B. 2- Does not reside in the United States. 3- Failure to cooperate. 4- Resources too high 5- Income too high. Reason that state denied the subsidy application. Required for LIS record type only.
27	Result of an Appeal	1	155	CHAR	Y- Decision result of appeal. N- Decision not result of an appeal. Required for LIS record type only.
28	Change to Previous Determination	1	156	CHAR	This is a future element. Required for LIS record type only.
29	Determination Cancelled	1	157	CHAR	Y- Cancellation of previously sent record. N- Y not entered. Required for LIS record type only.
30	Filler	23	158-180	CHAR	Spaces
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.

Item	Field	Size	Position	Format	Description
					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: A 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.

Item	Field	Size	Position	Format	Description
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. 1– 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.

Item	Field	Size	Position	Format	Description
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.

Item	Field	Size	Position	Format	Description
					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

Item	Field	Size	Position	Format	Description
					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.
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.

Item	Field	Size	Position	Format	Description
					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. **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	For DET and PRO records, this field indicates the presence of Medicare Part D eligibility during the Eligibility Month/Year. Values: 0 – Beneficiary is eligible for Medicare Part D. 1 – Beneficiary is not eligible for Medicare Part D.

Item	Field	Size	Position	Format	Description
57	Medicare Part D Enrollment Indicator	1	236	CHAR	For DET and PRO records, this field indicates Medicare Part D enrollment during the Eligibility Month/Year. Values: 0 – Beneficiary is enrolled in a Medicare Part D plan. 1 – Beneficiary is not enrolled in a Medicare Part D plan.
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.
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

Item	Field	Size	Position	Format	Description
					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	CHAR	See item 66
69	Cross-Reference Beneficiary Identification Code (Occurrence 2)	2	356-357	CHAR	See item 67
70	Cross-Reference Beneficiary Claim Account Number (Occurrence 3)	9	358-366	CHAR	See item 66
71	Cross-Reference Beneficiary Identification Code (Occurrence 3)	2	367-368	CHAR	See item 67
72	Cross-Reference Beneficiary Claim Account Number (Occurrence 4)	9	369-377	CHAR	See item 66
73	Cross-Reference Beneficiary Identification Code (Occurrence 4)	2	378-379	CHAR	See item 67
74	Cross-Reference Beneficiary Claim Account Number	9	380-388	CHAR	See item 66

Item	Field	Size	Position	Format	Description
	(Occurrence 5)				
75	Cross-Reference Beneficiary Identification Code (Occurrence 5)	2	389-390	CHAR	See item 67
76	Cross-Reference Beneficiary Claim Account Number (Occurrence 6)	9	391-399	CHAR	See item 66
77	Cross-Reference Beneficiary Identification Code (Occurrence 6)	2	400-401	CHAR	See item 67
78	Cross-Reference Beneficiary Claim Account Number (Occurrence 7)	9	402-410	CHAR	See item 66
79	Cross-Reference Beneficiary Identification Code (Occurrence 7)	2	411-412	CHAR	See item 67
80	Cross-Reference Beneficiary Claim Account Number (Occurrence 8)	9	413-421	CHAR	See item 66
81	Cross-Reference Beneficiary Identification Code (Occurrence 8)	2	422-423	CHAR	See item 67
82	Cross-Reference Beneficiary Claim Account Number (Occurrence 9)	9	424-432	CHAR	See item 66
83	Cross-Reference Beneficiary Identification Code (Occurrence 9)	2	433-434	CHAR	See item 67
84	Cross-Reference Beneficiary Claim	9	435-443	CHAR	See item 66

Item	Field	Size	Position	Format	Description
	Account Number (Occurrence 10)				
85	Cross-Reference Beneficiary Identification Code (Occurrence 10)	2	444-445	CHAR	See item 59
86	Beneficiary Social Security Number (Occurrence 1)	9	446-454	NUM	The beneficiary's identification number is assigned by SSA.
87	Beneficiary Social Security Number (Occurrence 2)	9	455-463	NUM	See item 86
88	Beneficiary Social Security Number (Occurrence 3)	9	464-472	NUM	See item 86
89	Beneficiary Social Security Number (Occurrence 4)	9	473-481	NUM	See item 86
90	Beneficiary Social Security Number (Occurrence 5)	9	482-490	NUM	See item 86
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

Item	Field	Size	Position	Format	Description
					address becomes effective for a Medicare beneficiary.
101	Residence Address Line 1	60	790-849	CHAR	Residence Address
102	Filler	180	850-1029	CHAR	Spaces
103	Residence Address City Name	40	1030-1069	CHAR	Residence City Name
104	Residence Address State Code	2	1070-1071	CHAR	Residence State Code
105	Residence Address Zip code	9	1072-1080	CHAR	Residence Zip Code
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, and/or did not enroll for premium Part A. N – Not valid SSA HIC. (Used by CMS Third-Party system to indicate potential Part A entitlement date) R – Refused benefits. Space – No non-entitlement reason applies.

Item	Field	Size	Position	Format	Description
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.
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	Spaces
112	Beneficiary Entitlement Reason (Occurrence 2)	12	1104-1115	CHAR	See items 110 and 111
113	Beneficiary Entitlement Reason (Occurrence 3)	12	1116-1127	CHAR	See items 110 and 111
114	Beneficiary Entitlement Reason (Occurrence 4)	12	1128-1139	CHAR	See items 110 and 111
115	Beneficiary Entitlement Reason (Occurrence 5)	12	1140-1151	CHAR	See items 110 and 111
116	Beneficiary Part A Entitlement Start Date (Occurrence 1)	8	1152-1159	NUM	MMDDCCYY. The date the 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,

Item	Field	Size	Position	Format	Description
					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

Item	Field	Size	Position	Format	Description
					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	CHAR	Same as Occurrence 1 See items 116 – 119
121	Part A Entitlement (Occurrence 3)	18	1188-1205	CHAR	Same as Occurrence 1 See items 116 – 119
122	Part A Entitlement (Occurrence 4)	18	1206-1223	CHAR	Same as Occurrence 1 See items 116 – 119
123	Part A Entitlement (Occurrence 5)	18	1224-1241	CHAR	Same as Occurrence 1 See items 116 – 119
124	Beneficiary Part B Enrollment Start Date (Occurrence 1)	8	1242-1249	NUM	MMDDCCYY When no Part B enrollment period is found, this field is filled with zeroes.
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

Item	Field	Size	Position	Format	Description
					H – Health hazard I – Initial enrollment period K – Renal disease is or was a reason for enrollment prior to age 65 or 25th month of disability. M –Termination based on renal enrollment, but enrollment based on disability continues. P - Medicare Part B Immunosuppressive Drug (Part B-ID) R – Residency requirements are involved. S – State buy-in. T – Disabled working beneficiary. U –Unknown. If no enrollment is found, this field is filled with a space.
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, a 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 If no enrollment is found, this field is filled with spaces.
128	Part B Enrollment (Occurrence 2)	18	1260-1277	CHAR	Same as Occurrence 1 See items 124 –127

Item	Field	Size	Position	Format	Description
129	Part B Enrollment (Occurrence 3)	18	1278-1295	CHAR	Same as Occurrence 1.
130	Part B Enrollment (Occurrence 4)	18	1296-1313	CHAR	Same as Occurrence 1.
131	Part B Enrollment (Occurrence 5)	18	1314-1331	CHAR	Same as Occurrence 1.
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	NUM	Same as Occurrence 1 See items 132 –133
135	Beneficiary Hospice Coverage (Occurrence 3)	16	1364-1379	NUM	Same as Occurrence 1.
136	Beneficiary Hospice Coverage (Occurrence 4)	16	1380-1395	NUM	Same as Occurrence 1.
137	Beneficiary Hospice Coverage (Occurrence 5)	16	1396-1411	NUM	Same as Occurrence 1.
138	Beneficiary Disability Insurance Benefits (DIB) Entitlement Start Date (Occurrence 1)	8	1412-1419	NUM	MMDDCCYY. The date a beneficiary covered by the SSA disability program becomes entitled to Medicare benefits. This field is filled with zeroes, if no DIB Entitlement Start Date is found.
139	Beneficiary DIB Entitlement End Date (Occurrence 1)	8	1420-1427	NUM	MMDDCCYY The date a beneficiary covered by the SSA disability program is no longer entitled to Medicare benefits.

Item	Field	Size	Position	Format	Description
					If there is a valid DIB Entitlement Start Date and no DIB Entitlement End Date, then this field is filled with 9s. This field is filled with zeroes, if, there is no DIB Entitlement Start Date and no DIB Entitlement End Date.
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	CHAR/ NUM	Same as Occurrence 1 See items 138 – 140
142	Beneficiary DIB Entitlement (Occurrence 3)	17	1446-1462	CHAR/ NUM	Same as Occurrence 1 See items 138 – 140
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. If there is no managed care organization enrollment found, this field is filled with zeroes

Item	Field	Size	Position	Format	Description
					If there is an MCO Contract Enrollment Start Date and no MCO Contract Enrollment End Date, this field is filled with 9s.
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	CHAR/ NUM	Same as Occurrence 1 See items 143 –145
147	Beneficiary MCO (Occurrence 3)	21	1505-1525	CHAR/ NUM	Same as Occurrence 1
148	Beneficiary MCO (Occurrence 4)	21	1526-1546	CHAR/ NUM	Same as Occurrence 1
149	Beneficiary MCO (Occurrence 5)	21	1547-1567	CHAR/ NUM	Same as Occurrence 1
150	Beneficiary MCO (Occurrence 6)	21	1568-1588	CHAR/ NUM	Same as Occurrence 1
151	Beneficiary MCO (Occurrence 7)	21	1589-1609	CHAR/ NUM	Same as Occurrence 1

Item	Field	Size	Position	Format	Description
152	Beneficiary MCO (Occurrence 8)	21	1610-1630	CHAR/ NUM	Same as Occurrence 1
153	Beneficiary MCO (Occurrence 9)	21	1631-1651	CHAR/ NUM	Same as Occurrence 1
154	Beneficiary MCO (Occurrence 10)	21	1652-1672	CHAR/ NUM	Same as Occurrence 1
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. If there is no enrollment found, this field is filled with zeroes.
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. If the beneficiary has no PBP enrollment, this field is filled with zeroes.
157	Plan Benefit Package Enrollment End Date (Occurrence 1)	8	1689-1696	NUM	MMDDCCYY The date the beneficiary's PBP enrollment ends. If there is no PBP Start Date, this field is filled with zeroes. If there is a PBP Start Date and no PBP End Date, this field is filled with 9s.
158	Plan Benefit Package Number (Occurrence 1)	3	1697-1699	CHAR	A unique identifier for the managed care plan benefit package. If the managed care plan has no PBP, this field contains spaces. If a Cost Plan has no PBP, the field contains '999'.
159	Plan Benefit Package Coverage Type Cod	2	1700-1701	CHAR	Identifies the type of managed care plan benefit package in which the beneficiary is enrolled. Values:

Item	Field	Size	Position	Format	Description
	(Occurrence 1)				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). If no PBP enrollment is found, this field is filled with spaces.
160	PBP Enrollment (Occurrence 2)	29	1702-1730	CHAR/ NUM	Same as Occurrence 1 See items 155 –159
161	PBP Enrollment (Occurrence 3)	29	1731-1759	CHAR/ NUM	Same as Occurrence 1 See items 155 – 159
162	PBP Enrollment (Occurrence 4)	29	1760-1788	CHAR/ NUM	Same as Occurrence 1 See items 155 –159
163	PBP Enrollment (Occurrence 5)	29	1789-1817	CHAR/ NUM	Same as Occurrence 1 See items 155 –159
164	PBP Enrollment (Occurrence 6)	29	1818-1846	CHAR/ NUM	Same as Occurrence 1 See items 155 –159
165	PBP Enrollment (Occurrence 7)	29	1847-1875	CHAR/ NUM	Same as Occurrence 1 See items 155 –159

Item	Field	Size	Position	Format	Description
166	PBP Enrollment (Occurrence 8)	29	1876-1904	CHAR/ NUM	Same as Occurrence 1 See items 155 –159
167	PBP Enrollment (Occurrence 9)	29	1905-1933	CHAR/ NUM	Same as Occurrence 1 See items 155 –159
168	PBP Enrollment (Occurrence 10)	29	1934-1962	CHAR/ NUM	Same as Occurrence 1 See items 155 –159
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. If the beneficiary has no ESRD coverage, this field is filled with zeroes.
170	Beneficiary ESRD Coverage End Date	8	1971-1978	NUM	MMDDCCYY The date on which the beneficiary is no longer entitled to Medicare under the ESRD provision. If the beneficiary has no ESRD coverage, this field is filled with zeroes. If there is no ESRD Coverage End Date, this field is filled with 9s.
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. If the beneficiary has no ESRD coverage or if there is no ESRD

Item	Field	Size	Position	Format	Description
					Coverage End Date, this field is filled with spaces.
172	Beneficiary ESRD Clinical Dialysis Start Date (Occurrence 1)	8	1980-1987	NUM	MMDDCCYY. The date when ESRD dialysis starts. If the beneficiary has no ESRD Dialysis Start Date, this field is filled with zeroes.
173	Beneficiary ESRD Clinical Dialysis End Date (Occurrence 1)	8	1988-1995	NUM	MMDDCCYY. The date when ESRD dialysis ends. If the beneficiary has no ESRD Dialysis Start Date, this field is filled with zeroes. If there is no ESRD Dialysis End Date, this field is filled with 9s.
174	Beneficiary ESRD Transplant Start Date	8	1996-2003	NUM	MMDDCCYY The date that a kidney transplant operation occurred. If no ESRD Transplant Start Date is found, this field is filled with zeroes.
175	Beneficiary ESRD Transplant End Date	8	2004-2011	NUM	MMDDCCYY The date that a kidney transplant fails or the transplant benefit ends. When no ESRD Transplant Start Date is found, this field is filled with zeroes. When there is a valid ESRD Transplant Start Date and there is no ESRD Transplant End Date, this field is filled with 9s.

Item	Field	Size	Position	Format	Description
176	Beneficiary Part A Third-Party Start Date (Occurrence 1)	8	2012-2019	NUM	MMDDCCYY The start date of private third-party groups or the State's liability for a beneficiary's Part A premium. If there is no Part A Third-Party Start Date, this field is filled with zeroes.
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 private third-party groups or the State's liability for a beneficiary's Part A premium. If no Part A Third-Party Start Date was found, this field is filled with zeroes. If there is a Third-Party Start Date and no Third-Party End Date, this field is filled with 9s.
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	CHAR/ NUM	Same as Occurrence 1 See items 176 –179
181	Third-Party Part A History (Occurrence 3)	20	2052-2071	CHAR/ NUM	Same as Occurrence 1 See items 176 –179

Item	Field	Size	Position	Format	Description
182	Third-Party Part A History (Occurrence 4)	20	2072-2091	CHAR/ NUM	Same as Occurrence 1 See items 176 –179
183	Third-Party Part A History (Occurrence 5)	20	2092-2111	CHAR/ NUM	Same as Occurrence 1 See items 176 –179
184	Beneficiary Part B Third-Party Start Date (Occurrence 1)	8	2112-2119	NUM	MMDDCCYY. The start date of private third-party groups or the State's liability for a Part B premium. If no Part B Third-Party benefit is found for the beneficiary, this field is filled with zeroes.
185	Beneficiary Part B Third-Party Premium Payer Code (Occurrence 1)	3	2120-2122	CHAR	The identifier for a third-party agency (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 private third-party groups or the State's liability for a beneficiary's Part B premium. If no Part B Third-Party Start Date

Item	Field	Size	Position	Format	Description
					is found, this field is filled with zeroes. If there is a Third-Party Start Date and no Third-Party End Date, this field is filled with 9s.
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.

Item	Field	Size	Position	Format	Description
188	Third-Party Part B History (Occurrence 2)	20	2132-2151	CHAR/ NUM	Same as Occurrence 1 See items 184 –187
189	Third-Party Part B History (Occurrence 3)	20	2152-2171	CHAR/ NUM	Same as Occurrence 1
190	Third-Party Part B History (Occurrence 4)	20	2172-2191	CHAR/ NUM	Same as Occurrence 1
191	Third-Party Part B History (Occurrence 5)	20	2192-2211	CHAR/ NUM	Same as Occurrence 1
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
194	Beneficiary Co-Payment Type (Occurrence 1)	1	2221	CHAR	A code indicating whether the beneficiary was determined eligible for a low-income subsidy (LIS) or deemed eligible. Values: L – Determined eligible D – Deemed.

Item	Field	Size	Position	Format	Description
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. 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 are 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	CHAR/ NUM	Same as Occurrence 1 See items 194 –197
199	Beneficiary Co-Payment History (Occurrence 3)	18	2257-2274	CHAR/ NUM	Same as Occurrence 1
200	Beneficiary Co-Payment History (Occurrence 4)	18	2275-2292	CHAR/ NUM	Same as Occurrence 1
201	Beneficiary's Co-Payment History (Occurrence 5)	18	2293-2310	CHAR/ NUM	Same as Occurrence 1
202	Beneficiary's Co-Payment	18	2311-2328	CHAR/ NUM	Same as Occurrence 1

Item	Field	Size	Position	Format	Description
	History (Occurrence 6)				
203	Beneficiary's Co-Payment History (Occurrence 7)	18	2329-2346	CHAR/ NUM	Same as Occurrence 1
204	Beneficiary's Co-Payment History (Occurrence 8)	18	2347-2364	CHAR/ NUM	Same as Occurrence 1
205	Beneficiary's Co-Payment History (Occurrence 9)	18	2365-2382	CHAR/ NUM	Same as Occurrence 1
206	Beneficiary's Co-Payment History (Occurrence 10)	18	2383-2400	CHAR/ NUM	Same as Occurrence 1
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

Item	Field	Size	Position	Format	Description
					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	CHAR/ NUM	Same as Occurrence 1 See items 207 –211
213	Part D Plan Benefit Package (Occurrence 3)	25	2451-2475	CHAR/ NUM	Same as Occurrence 1
214	Part D Plan Benefit Package (Occurrence 4)	25	2476-2500	CHAR/ NUM	Same as Occurrence 1
215	Part D Plan Benefit Package (Occurrence 5)	25	2501-2525	CHAR/ NUM	Same as Occurrence 1

Item	Field	Size	Position	Format	Description
216	Part D Plan Benefit Package (Occurrence 6)	25	2526-2550	CHAR/ NUM	Same as Occurrence 1
217	Part D Plan Benefit Package (Occurrence 7)	25	2551-2575	CHAR/ NUM	Same as Occurrence 1
218	Part D Plan Benefit Package (Occurrence 8)	25	2576-2600	CHAR/ NUM	Same as Occurrence 1
219	Part D Plan Benefit Package (Occurrence 9)	25	2601-2625	CHAR/ NUM	Same as Occurrence 1.
220	Part D Plan Benefit Package (Occurrence 10)	25	2626-2650	CHAR/ NUM	Same as Occurrence 1
221	Part C Organization Name (contract level)	55	2651-2705	CHAR	This 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	This 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	This 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	This 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.

Item	Field	Size	Position	Format	Description
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 N – Not SNP Corresponds to the first occurrence of the plan benefit package in item 159 (positions 1700-1701).
228	SNP Indicator (Occurrence 2)	1	2864	CHAR	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	CHAR	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	CHAR	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	CHAR	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	CHAR	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	CHAR	Same as Occurrence 1. Corresponds to Occurrence 7 of plan benefit package in item 165 (positions 1847-1875).

Item	Field	Size	Position	Format	Description
234	SNP Indicator (Occurrence 8)	1	2870	CHAR	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	CHAR	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	CHAR	Same as Occurrence 1. Corresponds to Occurrence 10 of plan benefit package in item 168 (positions 1934-1962).
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, 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, 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, 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 the beneficiary was last classified in enrollment and disenrollment counts for the Eligibility

Item	Field	Size	Position	Format	Description
					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 Space – No historical entries found for this Eligibility Month/Year.
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's 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

Item	Field	Size	Position	Format	Description
					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.
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, 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, this

Item	Field	Size	Position	Format	Description
					field is filled with zeroes. If there is an RDS Start Date and no RDS End Date, this field is filled with 9s.
245	RDS Coverage Period (Occurrence 2)	16	2919-2934	NUM	Same as Occurrence 1 See items 243 –244
246	RDS Coverage Period (Occurrence 3)	16	2935-2950	NUM	Same as Occurrence 1
247	RDS Coverage Period (Occurrence 4)	16	2951-2966	NUM	Same as Occurrence 1
248	RDS Coverage Period (Occurrence 5)	16	2967-2982	NUM	Same as Occurrence 1
249	Filler	1	2983	CHAR	Spaces.
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 D Eligibility Start Date is found.
251	Part D Eligibility End Date (Occurrence 1)	8	2992-2999	NUM	Indicates the date 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	NUM	Same as Occurrence 1 See items 250 – 251
253	Part D Eligibility Dates (Occurrence 3)	16	3016-3031	NUM	Same as Occurrence 1
254	Part D Eligibility Dates (Occurrence 4)	16	3032-3047	NUM	Same as Occurrence 1

Item	Field	Size	Position	Format	Description
255	Part D Eligibility Dates (Occurrence 5)	16	3048-3063	NUM	Same as Occurrence 1
256	Subsidy Level (Occurrence 1)	3	3064-3066	CHAR	Identifies the portion of the Part D Premium subsidized. (Effective, 1/1/2024) Values: 100% Prior to 1/1/2024 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 (position 3064). 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	CHAR	Same as Occurrence 1 See items 256 –257
259	Beneficiary LIS Premium Percentage	5	3074-3078	CHAR	Same as Occurrence 1

Item	Field	Size	Position	Format	Description
	and Source (Occurrence 3)				
260	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 4)	5	3079-3083	CHAR	Same as Occurrence 1
261	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 5)	5	3084-3068	CHAR	Same as Occurrence 1
262	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 6)	5	3069-3093	CHAR	Same as Occurrence 1
263	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 7)	5	3094-3098	CHAR	Same as Occurrence 1
264	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 8)	5	3099-3103	CHAR	Same as Occurrence 1
265	Beneficiary Low-Income Subsidy Premium Percentage and Source (Occurrence 9)	5	3104-3108	CHAR	Same as Occurrence 1
266	Beneficiary Low-Income Subsidy Premium Percentage and	5	3109-3113	CHAR	Same as Occurrence 1

Item	Field	Size	Position	Format	Description
	Source (Occurrence 10)				
267	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 2)	16	3114-3129	NUM	Same as Occurrence 1 See items 172 – 173
268	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 3)	16	3130-3145	NUM	Same as Occurrence 1
269	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 4)	16	3146-3161	NUM	Same as Occurrence 1
270	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 5)	16	3162-3177	NUM	Same as Occurrence 1
271	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 6)	16	3178-3193	NUM	Same as Occurrence 1
272	Beneficiary Archive Indicator	1	3194	CHAR	Indicates that beneficiary is in the 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	8	3196-3203	NUM	MMDDCCYY

Item	Field	Size	Position	Format	Description
	2)				
275	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 2)	8	3204-3211	NUM	MMDDCCYY
276	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 3)	8	3212-3219	NUM	MMDDCCYY
277	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 3)	8	3220-3227	NUM	MMDDCCYY
278	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 4)	8	3228-3235	NUM	MMDDCCYY
279	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 4)	8	3236-3243	NUM	MMDDCCYY
280	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 5)	8	3244-3251	NUM	MMDDCCYY
281	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 5)	8	3252-3259	NUM	MMDDCCYY
282	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 6)	8	3260-3267	NUM	MMDDCCYY
283	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 6)	8	3268-3275	NUM	MMDDCCYY

Item	Field	Size	Position	Format	Description
284	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 7)	8	3276-3283	NUM	MMDDCCYY
285	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 7)	8	3284-3291	NUM	MMDDCCYY
286	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 8)	8	3292-3299	NUM	MMDDCCYY
287	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 8)	8	3300-3307	NUM	MMDDCCYY
288	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 9)	8	3308-3315	NUM	MMDDCCYY
289	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 9)	8	3316-3323	NUM	MMDDCCYY
290	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 10)	8	3324-3331	NUM	MMDDCCYY
291	Medicare Plan Ineligibility Due to Incarceration End Date (Occurrence 10)	8	3332-3339	NUM	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

Item	Field	Size	Position	Format	Description
					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	NUM	MMDDCCYY See item 292
295	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 2)	8	3364-3371	NUM	MMDDCCYY See item 293
296	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 3)	8	3372-3379	NUM	MMDDCCYY
297	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 3)	8	3380-3387	NUM	MMDDCCYY

Item	Field	Size	Position	Format	Description
298	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 4)	8	3388-3395	NUM	MMDDCCYY
299	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 4)	8	3396-3403	NUM	MMDDCCYY
300	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 5)	8	3404-3411	NUM	MMDDCCYY
301	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 5)	8	3412-3419	NUM	MMDDCCYY
302	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 6)	8	3420-3427	NUM	MMDDCCYY
303	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 6)	8	3428-3435	NUM	MMDDCCYY
304	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 7)	8	3436-3443	NUM	MMDDCCYY
305	Medicare Plan Ineligibility Due to Not Lawful	8	3444-3451	NUM	MMDDCCYY

Item	Field	Size	Position	Format	Description
	Presence End Date (Occurrence 7)				
306	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 8)	8	3452-3459	NUM	MMDDCCYY
307	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 8)	8	3460-3467	NUM	MMDDCCYY
308	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 9)	8	3468-3475	NUM	MMDDCCYY
309	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 9)	8	3476-3483	NUM	MMDDCCYY
310	Medicare Plan Ineligibility Due to Not Lawful Presence Start Date (Occurrence 10)	8	3484-3491	NUM	MMDDCCYY
311	Medicare Plan Ineligibility Due to Not Lawful Presence End Date (Occurrence 10)	8	3492-3499	NUM	MMDDCCYY
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.

Item	Field	Size	Position	Format	Description
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 – 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

Item	Field	Size	Position	Format	Description
					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	CHAR/ NUM	Same as Occurrence 1 See items 312 –316
318	Beneficiary MBI (Occurrence 3)	37	3574-3610	CHAR/ NUM	Same as Occurrence 1
319	Beneficiary MBI (Occurrence 4)	37	3611-3647	CHAR/ NUM	Same as Occurrence 1
320	Beneficiary MBI (Occurrence 5)	37	3648-3684	CHAR/ NUM	Same as Occurrence 1
321	Beneficiary MBI (Occurrence 6)	37	3685-3721	CHAR/ NUM	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

Item	Field	Size	Position	Format	Description
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	Filler	6	3882-3889	CHAR	Spaces
343	Filler	111	3890-4000	CHAR	Spaces

8.5 MMA Response File Summary Record Layout

Table 8-4: MMA Response File Summary Record Layout

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.

Item	Field	Size	Position	Format	Description
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.
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.

Item	Field	Size	Position	Format	Description
					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	Spaces
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 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.

Item	Field	Size	Position	Format	Description
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

8.6 MMA Response File Monthly Summary Record Layout

Table 8-5: MMA Response File Monthly Summary Record Layout

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.
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.
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

Item	Field	Size	Position	Format	Description
					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

8.7 MMA Response File Trailer Record Layout

Table 8-6: MMA Response File Trailer Record Layout

Item	Field	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.

Item	Field	Size	Position	Format	Description
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	Spaces
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	The value for the same field from the Trailer record of the related Request file
9	State Code	2	55-56	CHAR	US Postal Service State Abbreviation
10	File Create Month	2	57-58	NUM	Month that the MMA Request file is created.
11	File Create Year	4	59-62	NUM	Year that MMA Request file is created.
12	Filler	161	63-223	CHAR	Spaces
13	Filler	3377	224-4000	CHAR	Spaces

9. Territory Beneficiary Query (TBQ) Request File

The Territory Beneficiary Query (TBQ) File is a query process that CMS offers to states and territories. Under this process, the state/territory submits a “finder file” of beneficiaries for the query. CMS then issues a “response file” that includes Medicare Parts A, B, C, and D eligibility and enrollment data on the queried beneficiaries. The Medicare data included in the TBQ Response File pulls from the same database as the CMS MMA Response File but is provided on an ad hoc basis. States and territories may query CMS daily for Medicare beneficiary eligibility and enrollment data on the queried beneficiaries.

9.1 TBQ Request File Dataset Naming Convention

Table 9-1: TBQ Request File Dataset Naming Convention

System	Type	Size	Frequency
MBD	Data File	100	States can send multiple files in a day

9.2 TBQ Request File Header Record Layout

Table 9-2: TBQ Request File Header Record Layout

Item	Field	Size	Position	Format	Description
1	Header Code	8	1 – 8	CHAR	MMATBQH
2	State Code	2	9 – 10	CHAR	US Postal Service State Abbreviation
3	Create Month	2	11 – 12	NUM	MM
4	Create Year	4	13 – 16	NUM	CCYY
5	Filler	84	17 – 100	CHAR	Spaces

9.3 TBQ Request File Detail Record Layout

Table 9-3: TBQ Request File Detail Record Layout

Item	Field	Size	Position	Format	Description
1	Record Type	3	1 – 3	CHAR	DTL
2	Beneficiary’s Social Security Number	9	4 – 12	NUM	Beneficiary’s SSN
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.

Item	Field	Size	Position	Format	Description
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

9.4 TBQ Request file Trailer Record Layout

Table 9-4: TBQ Request File Trailer Record Layout

Item	Field	Size	Position	Format	Description
1	Trailer Code	8	1 – 8	CHAR	MMATBQT
2	Detail Record Count	9	9 – 17	NUM	The count of Detail records in the file.
3	Filler	83	18 – 100	CHAR	Spaces

10. Territory Beneficiary Query (TBQ) Response File

A TBQ Response file is returned 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.

10.1 TBQ Response File Dataset Naming Convention

Table 10-1: TBQ Response File Dataset Naming Convention

System	Type	Size	Frequency
MBD	Data File	100	States can send multiple files in a day

10.2 TBQ Response File Header Record Layout

Table 10-2: TBQ Response File Header Record Layout

Item	Field	Size	Position	Format	Description
1	Header Code	8	1 – 8	CHAR	MMATBQRH
2	File Creation Date	8	9 – 16	NUM	CCYYMMDD
3	Filler	3984	17 – 4000	CHAR	Spaces

10.3 TBQ Response File Detail Record Layout

The TBQ Response File Detail Record is grouped in the following sections:

Items 1-10: Original Detail Record

Items 11-12: Processing Information

Items 13-20: Beneficiary Information

Items 21-31: Cross Reference Numbers (10 occurrences)

Items 32-36: Social Security Numbers (5 occurrences)

Items 37-46: Mailing Address

Items 47-52: Residence Address

Item 53: Representative Payee

Items 54-55: Non-Entitlement Status

Items 56-61: Entitlement Reason (5 occurrences)

Items 62-69: Part A Entitlement (5 occurrences)

Items 70-77: Part B Entitlement (5 occurrences)

Items 78-83: Hospice Coverage (5 occurrences)

Items 84-88: Beneficiary Disability Insurance (3 occurrences)

Items 89-100: Beneficiary's Managed Care Organization (10 occurrences)

Items 101-114: Plan Benefits Package Election (10 occurrences)

Items 115-117: End-Stage Renal Disease Coverage

Items 118-119: End-Stage Renal Disease Clinical Dialysis Dates Occurrence 1 (refer to items 211-215, position 3114-3193 for 5 remaining occurrences)

Items 120-121: End-Stage Renal Disease Transplant

Items 122-129: Third-Party A history (5 occurrences)

Items 130-137: third-Party B History (5 occurrences)

Items 138-139: Part D Data Elements

Items 140-152: Beneficiary's Co-Payment History (10 occurrences)

Items 153-172: Part D Plan Benefit Package (10 occurrences)

Items 173-183: Special Needs Plan (10 occurrences)

Items 184-186: Medicare Plan Ineligibility Due to Incarceration

Items 187-193: RDS Coverage Period (5 occurrences)

Items 194-199: Part D Eligibility Dates (5 occurrences)

Items 200-210: Beneficiary Subsidy Information (10 occurrences)

Items 211-216: Beneficiary ESRD Clinical Dialysis Dates occurrences 2-6 (refer to items 118-119, position 1980-1995 for first occurrence)

Items 217-235: Medicare Plan Ineligibility Due to Incarceration

Items 236-255: Medicare Plan Ineligibility Due to Not Lawful Presence

Items 256-265: Beneficiary MBI- Up to six occurrences listed in descending order by the date the occurrence was added to the beneficiary's record

Items 266-285: CARA Status

Table 10-3: TBQ Response File Detail Record Layout

Item	Field	Size	Position	Format	Description
1	Record Type	3	1 – 3	CHAR	DTL
2	Beneficiary's Social Security Number	9	4 – 12	CHAR	Beneficiary's SSN
3	Beneficiary's First Name	15	13 – 27	CHAR	The beneficiary's first name.
4	Beneficiary's Last Name	20	28 – 47	CHAR	The beneficiary's last name.
5	Beneficiary's Middle Initial	1	48	CHAR	The first character of the beneficiary's middle name.

Item	Field	Size	Position	Format	Description
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	CMS does not use this field
9	Beneficiary Suffix	2	69 – 70	CHAR	CMS does not use this field
10	MPI	13	71 – 83	CHAR	CMS does not use this field
11	Processed Flag	2	84 – 85	CHAR	– Successfully Processed. – Detail Record Identifier not DTL – SSN Missing – First Name Missing 04 – Last Name Missing 05 – Gender Code Missing 06 – Date of Birth Missing – Beneficiary Not Found – Successfully processed, but beneficiary not entitled to Part A and/or Part B – More than One Beneficiary Found
12	Filler	151	86 – 236	CHAR	Spaces.
13	Beneficiary's Claim Account Number	9	237 – 245	CHAR	The number identifying the primary Medicare beneficiary under the SSA program. This number along with the Beneficiary Identification Code is referred to as the Health Insurance Claim Number (HICN), which uniquely identifies a Medicare beneficiary. The field will contain spaces if the beneficiary's associated Request record fails validation (i.e., where the value for the Record Validation Status Code at positions 84 to 85 is not equal to '00' or '08').
14	Beneficiary's Identification Code	2	246 – 247	CHAR	A code that is used in conjunction with the Beneficiary CAN to uniquely identify a

Item	Field	Size	Position	Format	Description
					Medicare beneficiary. The field will contain spaces if the beneficiary's associated Request record fails validation.
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	The beneficiary's current first name. The field will contain spaces if the beneficiary's associated Request record fails validation.
19	Beneficiary's Middle Initial	1	295	CHAR	The beneficiary's current middle initial. The field will contain a space if the beneficiary's associated Request record fails validation or if this data does not exist in the beneficiary's Medicare record.
20	Beneficiary's Last Name	40	296 – 335	CHAR	The beneficiary's current last name. The field will contain spaces if the beneficiary's associated Request record fails validation.
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	CHAR	See items 21 – 22
24	Cross Reference (Occurrence 3)	11	358 – 568	CHAR	The previous HICN that was once used to identify the beneficiary. The field will contain spaces if the beneficiary's associated Request record fails

Item	Field	Size	Position	Format	Description
					validation or if this data does not exist in the beneficiary's Medicare record.
25	Cross Reference (Occurrence 4)	11	369 – 379	CHAR	The previous HICN that was once used to identify the beneficiary. The field will contain spaces if the beneficiary's associated Request record fails validation or if this data does not exist in the beneficiary's Medicare record.
26	Cross Reference (Occurrence 5)	11	380 – 390	CHAR	The previous HICN that was once used to identify the beneficiary. The field will contain spaces if the beneficiary's associated Request record fails validation or if this data does not exist in the beneficiary's Medicare record.
27	Cross Reference (Occurrence 6)	11	391 – 401	CHAR	The previous HICN that was once used to identify the beneficiary. The field will contain spaces if the beneficiary's associated Request record fails validation or if this data does not exist in the beneficiary's Medicare record.
28	Cross Reference (Occurrence 7)	11	402 – 412	CHAR	The previous HICN that was once used to identify the beneficiary. The field will contain spaces if the beneficiary's associated Request record fails validation or if this data does not exist in the beneficiary's Medicare record.
29	Cross Reference (Occurrence 8)	11	413 – 423	CHAR	The previous HICN that was once used to identify the beneficiary. The field will contain spaces if the beneficiary's associated

Item	Field	Size	Position	Format	Description
					Request record fails validation or if this data does not exist in the beneficiary's Medicare record.
30	Cross Reference (Occurrence 9)	11	424 – 434	CHAR	The previous HICN that was once used to identify the beneficiary. The field will contain spaces if the beneficiary's associated Request record fails validation or if this data does not exist in the beneficiary's Medicare record.
31	Cross Reference (Occurrence 10)	11	435 – 445	CHAR	The previous HICN that was once used to identify the beneficiary. The field will contain spaces if the beneficiary's associated Request record fails validation or if this data does not exist in the beneficiary's Medicare record.
32	Social Security Number (Occurrence 1)	9	446 – 454	CHAR	The previous SSN that was once used to identify the beneficiary.
33	Social Security Number (Occurrence 2)	9	455 – 463	CHAR	The previous SSN that was once used to identify the beneficiary.
34	Social Security Number (Occurrence 3)	9	464 – 472	CHAR	The previous SSN that was once used to identify the beneficiary.
35	Social Security Number (Occurrence 4)	9	473 – 481	CHAR	The previous SSN that was once used to identify the beneficiary.
36	Social Security Number (Occurrence 5)	9	482 – 490	CHAR	The previous SSN that was once used to identify the beneficiary.
37	Mailing Address Line 1	40	491 – 530	CHAR	Mailing Address Line
38	Mailing Address Line 2	40	531 – 570	CHAR	Mailing Address Line
39	Mailing Address Line 3	40	571 – 610	CHAR	Mailing Address Line

Item	Field	Size	Position	Format	Description
40	Mailing Address Line 4	40	611 – 650	CHAR	Mailing Address Line
41	Mailing Address Line 5	40	651 – 690	CHAR	Mailing Address Line
42	Mailing Address Line 6	40	691 – 730	CHAR	Mailing Address Line
43	Mailing Address City Name	40	731 – 770	CHAR	Mailing Address City
44	Mailing Address State Code	2	771 – 772	CHAR	Mailing Address State Code
45	Mailing Address Zone Improvement Plan (Zip) Code	9	773 – 781	CHAR	Mailing Address Zipcode
46	Mailing Address Change Date	8	782 – 789	NUM	MMDDCCYY
47	Residence Address Line 1	60	790 – 849	CHAR	Residence Address Line
48	Filler	180	850–1029	CHAR	Spaces
49	Residence Address City Name	40	1030 – 1069	CHAR	Residence Address City
50	Residence Address State Code	2	1070 – 1071	CHAR	Residence Address State
51	Residence Address Zip Code	9	1072 – 1080	CHAR	Residence Address Zip Code
52	Residence Address Change Date	8	1081 – 1088	NUM	MMDDCCYY
53	Beneficiary's Representative Payee Switch	1	1089	CHAR	Y, N, or space
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
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	NUM/ CHAR	N/A
59	Entitlement Reason (Occurrence 3)	12	1116 – 1127	NUM/ CHAR	N/A
60	Entitlement Reason (Occurrence 4)	12	1128 – 1139	NUM/ CHAR	N/A
61	Entitlement Reason (Occurrence 5)	12	1140 – 1151	NUM/ CHAR	N/A

Item	Field	Size	Position	Format	Description
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 before age 65 or before 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

Item	Field	Size	Position	Format	Description
					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	NUM/ CHAR	N/A
67	Part A Entitlement (Occurrence 3)	18	1188 – 1205	NUM/ CHAR	N/A
68	Part A Entitlement (Occurrence 4)	18	1206 – 1223	NUM/ CHAR	N/A
69	Part A Entitlement (Occurrence 5)	18	1224 – 1241	NUM/ CHAR	N/A
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 before age 65 or before 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

Item	Field	Size	Position	Format	Description
					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	NUM/ CHAR	See items 70 – 73
75	Part B Entitlement (Occurrence 3)	18	1278 – 1295	NUM/ CHAR	
76	Part B Entitlement (Occurrence 4)	18	1296 – 1313	NUM/ CHAR	
77	Part B Entitlement (Occurrence 5)	18	1314 – 1331	NUM/ CHAR	
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	NUM	See items 78 – 79
81	Hospice Coverage (Occurrence 3)	16	1364 – 1379	NUM	See items 78 – 79
82	Hospice Coverage (Occurrence 4)	16	1380 – 1395	NUM	See items 78 – 79
83	Hospice Coverage (Occurrence 5)	16	1396 – 1411	NUM	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	NUM/ CHAR	See items 84 – 86

Item	Field	Size	Position	Format	Description
88	Disability Insurance Benefits (Occurrence 3)	17	1446 – 1462	NUM/ CHAR	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	NUM/ CHAR	See items 89 – 91
93	Managed Care Organization (Occurrence 3)	21	1505 – 1525	NUM/ CHAR	See items 89 – 91
94	Managed Care Organization (Occurrence 4)	21	1526 – 1546	NUM/ CHAR	See items 89 – 91
95	Managed Care Organization (Occurrence 5)	21	1547 – 1567	NUM/ CHAR	See items 89 – 91
96	Managed Care Organization (Occurrence 6)	21	1568 – 1588	NUM/ CHAR	See items 89 – 91
97	Managed Care Organization (Occurrence 7)	21	1589 – 1609	NUM/ CHAR	See items 89 – 91
98	Managed Care Organization (Occurrence 8)	21	1610 – 1630	NUM/ CHAR	See items 89 – 91
99	Managed Care Organization (Occurrence 9)	21	1631 – 1651	NUM/ CHAR	See items 89 – 91
100	Managed Care Organization (Occurrence 10)	21	1652 – 1672	NUM/ CHAR	See items 89 – 91
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

Item	Field	Size	Position	Format	Description
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 AllInclusive 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	NUM/ CHAR	See items 101 – 105
107	PBP Election (Occurrence 3)	29	1731 – 1759	NUM/ CHAR	See items 101 – 105
108	PBP Election (Occurrence 4)	29	1760 – 1788	NUM/ CHAR	See items 101 – 105
109	PBP Election (Occurrence 5)	29	1789 – 1817	NUM/ CHAR	See items 101 – 105
110	PBP Election (Occurrence 6)	29	1818 – 1846	NUM/ CHAR	See items 101 – 105
111	PBP Election (Occurrence 7)	29	1847 – 1875	NUM/ CHAR	See items 101 – 105
112	PBP Election (Occurrence 8)	29	1876 – 1904	NUM/ CHAR	See items 101 – 105
113	PBP Election (Occurrence 9)	29	1905 – 1933	NUM/ CHAR	See items 101 – 105

Item	Field	Size	Position	Format	Description
114	PBP Election (Occurrence 10)	29	1934 – 1962	NUM/ CHAR	See items 101 – 105
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
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
120	Beneficiary's ESRD Transplant Start Date	8	1996 – 2003	NUM	MMDDCCYY
121	Beneficiary's ESRD Transplant End Date	8	2004 – 2011	NUM	MMDDCCYY
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

Item	Field	Size	Position	Format	Description
					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	NUM/ CHAR	See items 122 – 125
127	Third-Party Part A History (Occurrence 3)	20	2052 – 2071	NUM/ CHAR	See items 122 – 125
128	Third-Party Part A History (Occurrence 4)	20	2072 – 2091	NUM/ CHAR	See items 122 – 125
129	Third-Party Part A History (Occurrence 5)	20	2092 – 2111	NUM/ CHAR	See items 122 – 125
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

Item	Field	Size	Position	Format	Description
					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	NUM/ CHAR	See items 130 – 133
135	Third-Party Part B History (Occurrence 3)	20	2152 – 2171	NUM/ CHAR	See items 130 – 133
136	Third-Party Part B History (Occurrence 4)	20	2172 – 2191	NUM/ CHAR	See items 130 – 133
137	Third-Party Part B History (Occurrence 5)	20	2192 – 2211	NUM/ CHAR	See items 130 – 133
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
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
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	NUM/ CHAR	See items 140 – 143
145	Co-Payment History (Occurrence 3)	18	2257 – 2274	NUM/ CHAR	See items 140 – 143
146	Co-Payment History (Occurrence 4)	18	2275 – 2292	NUM/ CHAR	See items 140 – 143
147	Co-Payment History (Occurrence 5)	18	2293 – 2310	NUM/ CHAR	See items 140 – 143
148	Co-Payment History (Occurrence 6)	18	2311 – 2328	NUM/ CHAR	See items 140 – 143
149	Co-Payment History (Occurrence 7)	18	2329 – 2346	NUM/ CHAR	See items 140 – 143
150	Co-Payment History (Occurrence 8)	18	2347 – 2364	NUM/ CHAR	See items 140 – 143
151	Co-Payment History (Occurrence 9)	18	2365 – 2382	NUM/ CHAR	See items 140 – 143

Item	Field	Size	Position	Format	Description
152	Co-Payment History (Occurrence 10)	18	2383 – 2400	NUM/ CHAR	See items 140 – 143
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	NUM/ CHAR	See items 153 – 157
159	Part D Plan Benefit Package (Occurrence 3)	25	2451 – 2475	NUM/ CHAR	See items 153 – 157
160	Part D Plan Benefit Package (Occurrence 4)	25	2476 – 2500	NUM/ CHAR	See items 153 – 157
161	Part D Plan Benefit Package (Occurrence 5)	25	2501 – 2525	NUM/ CHAR	See items 153 – 157
162	Part D Plan Benefit Package (Occurrence 6)	25	2526 – 2550	NUM/ CHAR	See items 153 – 157
163	Part D Plan Benefit Package (Occurrence 7)	25	2551 – 2575	NUM/ CHAR	See items 153 – 157
164	Part D Plan Benefit Package (Occurrence 8)	25	2576 – 2600	NUM/ CHAR	See items 153 – 157
165	Part D Plan Benefit Package (Occurrence 9)	25	2601 – 2625	NUM/ CHAR	See items 153 – 157
166	Part D Plan Benefit Package (Occurrence 10)	25	2626 – 2650	NUM/ CHAR	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	

Item	Field	Size	Position	Format	Description
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)
179	Special Needs Plan Indicator (Occurrence 7)	1	2869	CHAR	Y or N or Space (not applicable)
180	Special Needs Plan Indicator (Occurrence 8)	1	2870	CHAR	Y or N or Space (not applicable)
181	Special Needs Plan Indicator (Occurrence 9)	1	2871	CHAR	Y or N or Space (not applicable)
182	Special Needs Plan Indicator (Occurrence 10)	1	2872	CHAR	Y or N or Space (not applicable)
183	Special Needs Plan Indicator (Occurrence 11)	1	2873	CHAR	Y or N or Space (not applicable)
184	Medicare Plan Ineligibility Due to Incarceration Start Date (Occurrence 1)	8	2874 – 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
187	RDS Start Date (Occurrence 1)	8	2903 – 2910	NUM	MMDDCCYY
188	RDS Termination Date (Occurrence 1)	8	2911 – 2918	NUM	MMDDCCYY

Item	Field	Size	Position	Format	Description
189	RDS Coverage Period (Occurrence 2)	16	2919 –2934	NUM	MMDDCCYY
190	RDS Coverage Period (Occurrence 3)	16	2935 – 2950	NUM	MMDDCCYY
191	RDS Coverage Period (Occurrence 4)	16	2951 – 2966	NUM	MMDDCCYY
192	RDS Coverage Period (Occurrence 5)	16	2967 – 2982	NUM	MMDDCCYY
193	Filler	1	2983	CHAR	Spaces
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	NUM	MMDDCCYY
197	Part D Eligibility Dates (Occurrence 3)	16	3016 – 3031	NUM	MMDDCCYY
198	Part D Eligibility Dates (Occurrence 4)	16	3032 – 3047	NUM	MMDDCC MMDDCCYY YY
199	Part D Eligibility Dates (Occurrence 5)	16	3048 – 3063	NUM	MMDDCCYY
200	Subsidy Level (Occurrence 1)	3	3064 – 3066	NUM	(Effective 1/1/2024) 100 Prior to 1/1/2024 • 100 • 075 • 050 • 025
201	LIS DEEM Source Code (Occurrence 1)	2	3067 – 3068	CHAR	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.
202	Beneficiary Subsidy Information (Occurrence 2)	5	3069 – 3073	NUM/ CHAR	See items 200 – 201
203	Beneficiary Subsidy Information (Occurrence 3)	5	3074 – 3078	NUM/ CHAR	See items 200 – 201
204	Beneficiary Subsidy Information (Occurrence 4)	5	3079 – 3083	NUM/ CHAR	See items 200 – 201
205	Beneficiary Subsidy Information (Occurrence 5)	5	3084 – 3088	NUM/ CHAR	See items 200 – 201

Item	Field	Size	Position	Format	Description
206	Beneficiary Subsidy Information (Occurrence 6)	5	3089 – 3093	NUM/ CHAR	See items 200 – 201
207	Beneficiary Subsidy Information (Occurrence 7)	5	3094 – 3098	NUM/ CHAR	See items 200 – 201
208	Beneficiary Subsidy Information (Occurrence 8)	5	3099 – 3103	NUM/ CHAR	See items 200 – 201
209	Beneficiary Subsidy Information (Occurrence 9)	5	3104 – 3108	NUM/ CHAR	See items 200 – 201
210	Beneficiary Subsidy Information (Occurrence 10)	5	3109 – 3113	NUM/ CHAR	See items 200 – 201
211	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 2)	16	3114 – 3129	NUM	See items 118 – 119
212	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 3)	16	3130 – 3145	NUM	See items 118 – 119
213	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 4)	16	3146 –3161	NUM	See items 118 – 119
214	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 5)	16	3162-3177	NUM	See items 118 – 119
215	Beneficiary ESRD Clinical Dialysis Dates (Occurrence 6)	16	3178-3193	NUM	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	8	3228-3235	NUM	MMDDCCYY

Item	Field	Size	Position	Format	Description
	Date (Occurrence 4)				
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	8	3332-3339	NUM	MMDDCCYY

Item	Field	Size	Position	Format	Description
	Date (Occurrence 10)				
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

Item	Field	Size	Position	Format	Description
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
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	MMDDCCYY The Effective Date of the beneficiary's most recent Beneficiary MBI period.

Item	Field	Size	Position	Format	Description
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	MMDDCCYY The End Date of the beneficiary's most recent Beneficiary MBI period. 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

Item	Field	Size	Position	Format	Description
					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	NUM/ CHAR	See items 256 – 260
262	Beneficiary MBI (Occurrence 3)	37	3574-3610	NUM/ CHAR	See items 256 – 260
263	Beneficiary MBI (Occurrence 4)	37	3611-3647	NUM/ CHAR	See items 256 – 260
264	Beneficiary MBI (Occurrence 5)	37	3648-3684	NUM/ CHAR	See items 256 – 260
265	Beneficiary MBI (Occurrence 6)	37	3685-3721	NUM/ CHAR	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
269	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

Item	Field	Size	Position	Format	Description
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	Filler	6	3882-3889	CHAR	Spaces
287	Filler	111	3890-4000	CHAR	Spaces

10.4 TBQ Response File Trailer Record Layout

Table 10-4: TBQ Response File Trailer Record Layout

Item	Field	Size	Position	Format	Description
1	Trailer Code	8	1 – 8	CHAR	MMATBQRT
2	Detail Record Count	9	9 – 17	NUM	The count of Detail records in the file.
3	Filler	3983	18 – 4000	CHAR	Spaces.

11. Batch Eligibility Query (BEQ)

State users can request eligibility information for multiple beneficiaries within one file, the Batch Eligibility Query file. The file is used to conduct initial eligibility checks against the CMS MBD system to verify the beneficiary is Part A / B eligible.

After a BEQ file is sent, an e-mail acknowledgment of receipt and status is sent 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.

CMS generates one BEQ Response File for every BEQ Request File. The BEQ Response File includes the transaction records contained in the request. If multiple BEQ Request Files are submitted during a regular business day, the state user receives multiple BEQ Response files, corresponding to each BEQ Request File, during that same business day. In order to ensure acceptable performance and processing time, the number of transaction records in a BEQ file should not exceed 100,000.

Note: BEQ Response Files are not time-stamped, so the user must process these files immediately upon receipt.

Additional details regarding BEQs such as, BEQ Request file layouts, acknowledgements emails, and BEQ Response file layouts can be found in the Plan Communications User Guide at https://www.cms.gov/data-research/cms-information-technology/access-cms-data-application/mapd-plan-communication-user-guide

12. Puerto Rico Dual Eligibles File Process

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

The Medicare Enrollment & Premium Billing Systems (MEPBS)) 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.

MEPBS 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.

12.1 Puerto Rico Dual Eligibles Request File Dataset Naming Convention

Table 12-1: Puerto Rico Dual Eligibles Request File Dataset Naming Convention

System	Type	Size	Frequency
MBD	Data File	129	Monthly

12.2 Puerto Rico Dual Eligibles Request File Header Record Layout

Table 12-2: Puerto Rico Dual Eligibles Request File Dataset Naming Convention

Item	Field	Size	Position	Format	Description
1	File ID Name	8	1-8	CHAR	MMATMA1H
2	State Code	2	9-10	CHAR	PR
3	File Creation Month	2	11-12	NUM	MM
4	File Creation Year	4	13-16	NUM	CCYY
5	Filler	113	17-129	CHAR	Spaces

12.3 Puerto Rico Dual Eligibles Request File Detail Record

Layout

Table 12-3: Puerto Rico Dual Eligibles Request File Detail Record Layout

Item	Field	Size	Position	Format	Description
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	Beneficiary's SSN
7	Medicaid Identifier	24	32-55	CHAR	CMS does not use this field.
8	Beneficiary's First Name	15	56-70	CHAR	The beneficiary's current first name
9	Beneficiary's Last Name	20	71-90	CHAR	The beneficiary's current last name.
10	Beneficiary's Middle Name	15	91-105	CHAR	The beneficiary's current middle initial.
11	Beneficiary's Gender Code	1	106-106	CHAR	F – Female M – Male U - Unknown
12	Beneficiary's Date of Birth	8	107-114	CHAR	CCYYMMDD
13	Filler	15	115-129	CHAR	Spaces

12.4 Puerto Rico Dual Eligibles Request File Trailer Record

Layout

Table 12-4: Puerto Rico Dual Eligibles Request File Trailer Record Layout

Item	Field	Size	Position	Format	Description
1	Trailer Code	8	1-8	CHAR	MMATMA1T
2	Detail Record Count	9	9-17	NUM	The count of Detail records in the file.
3	Filler	112	18-129	CHAR	Spaces

12.5 Puerto Rico Dual Eligibles Response File Dataset Naming Convention

Table 12-5: Puerto Rico Dual Eligibles Response File Dataset Naming Convention

System	Type	Size	Frequency
MBD	Data File	129	Monthly

12.6 Puerto Rico Dual Eligibles Response File Header Record Layout

Table 12-6: Puerto Rico Dual Eligibles Response File Header Record Layout

Item	Field	Size	Position	Format	Description
1	File ID Name	8	1-8	CHAR	MMATMA1H
2	File Creation Date	8	9-16	NUM	CCYYMMDD
3	Filler	113	17-129	CHAR	Spaces

12.7 Puerto Rico Dual Eligibles Response File Detail Record

Layout

Table 12-7: Puerto Rico Dual Eligibles Response File Detail Record Layout

Item	Field	Size	Position	Format	Description
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	Beneficiary's Social Security Number
7	Medicaid Identifier	24	32-55	CHAR	Beneficiary's ID
8	Beneficiary's First Name	15	56-70	CHAR	Beneficiary's First Name
9	Beneficiary's Last Name	20	71-90	CHAR	Beneficiary's Last Name
10	Beneficiary's Middle Name	15	91-105	CHAR	Beneficiary's Middle Name
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	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.

Item	Field	Size	Position	Format	Description
15	Beneficiary's MBI	11	118-128	CHAR	The MBI from the beneficiary's most recent Beneficiary MBI period. The value is a system-generated identifier used internally and externally to uniquely identify the beneficiary in the Medicare database.
16	Filler	1	129-129	CHAR	Space

12.8 Puerto Rico Dual Eligibles Response File Trailer Record Layout

Table 12-8: Puerto Rico Dual Eligibles Response File Trailer Record Layout

Item	Field	Size	Position	Format	Description
1	Trailer Code	8	1-8	CHAR	MMATMA1T
2	Detail Record Count	9	9-17	NUM	The count of Detail records in the file.
3	Filler	112	18-129	CHAR	Spaces

12.9 Puerto Rico Dual Eligibles File Email Acknowledgement

Below is an example of the email text for a file that passed all validation tests.

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

Figure 12-1: Example of Puerto Rico Dual Eligible File Passing Validation Email Acknowledgment

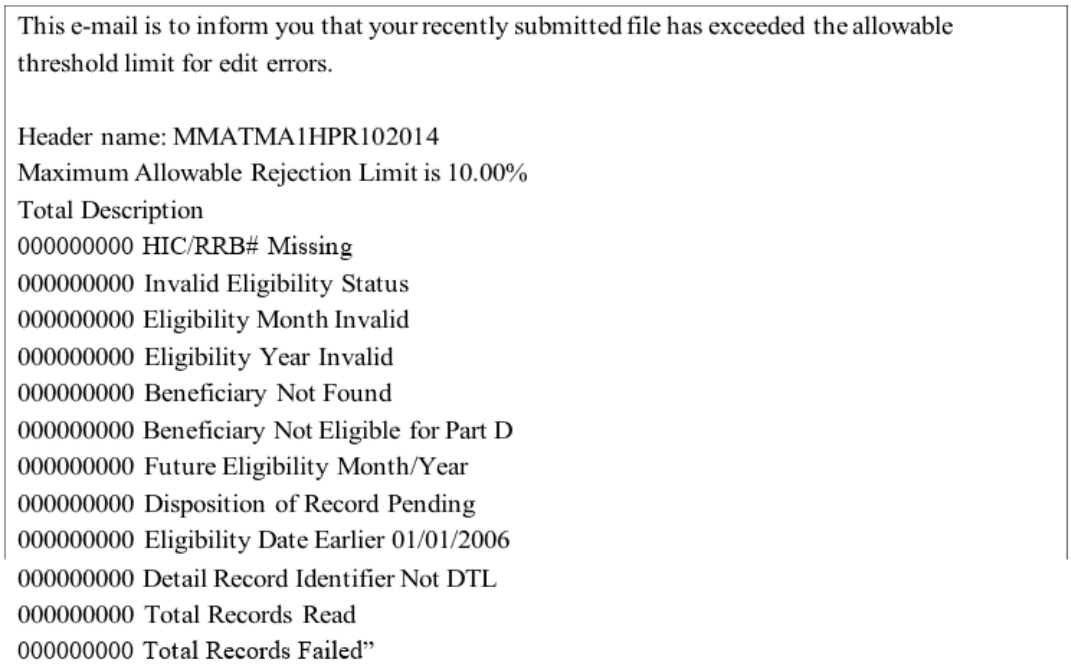
If the incoming file is rejected for file format errors, a file rejection will be sent to Puerto Rico. A template of the e-mail text is as follows:

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

This file must be corrected and resubmitted.

Figure 12-2: Example of Puerto Rico Dual Eligible File Rejected for Format Errors Email Acknowledgment

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"

Figure 12-3: Example of Puerto Rico Dual Eligible File Exceeding Allowable Threshold Limit Error Email Acknowledgment

13. 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.
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.
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 enrollment in the Plan.
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.
Home and Community Based Services (HCBS)	Eliminates Medicare Part D co-payments for full-benefit dually 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. Not all HCBS programs deem individuals eligible for the $0 copayment for Part D.

Term	Definition
Home Health Care	A mandatory benefit and include intermittent nursing services, home health aide services and medical equipment, supplies and appliances. At the states option, it may include physical therapy, occupational therapy and speech therapy/audiology. It is on the CMS-64 Line 12. Medicaid Home Health services are defined at 42 CFR 440.70.
Hospice	A comprehensive, holistic program of care and support for terminally ill patients and their families. Patients with Medicare Part A can get hospice care benefits if they meet the following criteria: • They get care from a Medicare-certified hospice • Their attending physician (if they have one) and the hospice physician certifies them as terminally ill, with a medical prognosis of 6 months or less to live if the illness runs its normal course • They sign an election statement to elect the hospice benefit and waive all rights to Medicare payments for the terminal illness and related conditions
Long Term Institutional	A person who is receiving long-term care services in a medical or nursing facility, or has been screened and approved to receive Medicaid-covered Long-Term Care (LTC) services in the person's home or community setting.
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 organization 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.
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. CMS no longer uses this code.
Program for All-Inclusive Care for the Elderly (PACE)	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.
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

Term	Definition
	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)	SNPs are types of MA Plans that serve limited populations of beneficiaries in CMS special needs categories, as defined at 42 CFR 422.2.
User ID	Valid IDM user identification code used for accessing MARx.

14. Acronyms

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
HHC	Home Health Care
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

Acronym	Definition
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
Part B-ID	Part B Immunosuppressive Drug
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	QualifyingIndividual Medicaid eligibility group
QDWI	Qualified Disabled and Working Individual eligibility group
QMB	Qualified Medicare Beneficiary Medicaid eligibility group
RACF	Resource Access Control Facility
RDS	Retiree Drug Subsidy
RRB	Railroad Retirement Board
SCC	State and County Code
SLMB	Specified Low-Income Medicare Beneficiary Medicaid eligibility group
SNP	Special Needs Plan
SPAP	State Pharmaceutical Assistance Program
SSA	Social Security Administration

Acronym	Definition
SSN	Social Security Number
TBQ	Territory Beneficiary Query
UI	User Interface
XREF	Cross Reference