Medicare Modernization Act (MMA)

State File Specifications and Data Dictionary

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

1.1 State Monthly MMA File Submission Requirements

CMS data collection needs from the States for MMA implementation will be met by monthly file submittal(s). Effective June, 2008, States have the option to submit dual eligibles in a single file or multiple files which reflect updated dual eligible enrollment during the month.

States may submit a single monthly file including all known dual eligibles, or multiple files throughout the month (up to one per day). Multiple files are intended to give the States the opportunity to provide current information on updated dual eligibility status. We expect that many States will opt to submit a large initial file including the bulk of enrollments for the reporting month, and smaller incremental files providing updates for changes in dual eligibility status (additions, deletions, or changes). We cannot process multiple full replacement files from States, and multiple submittals should represent only those individual person-months with changes in status.

The monthly files will address the following program needs:

1.2 Dual Eligible Enrollment

The monthly file submittals will include all Medicare/Medicaid dual eligibles in the State (full benefit as well as QMB, SLMB, and QI), and will allow CMS to establish the low-income-subsidy (LIS) status of dual eligibles, and to perform auto-assignment of individuals to Medicare Part D plans. Effective August 2006, the files were modified to allow reporting of individuals in state medicaid programs who are not known to be full dual eligibles, but are medicaid eligibles approaching an age or disability status that is likely to lead to a future determination of full dual eligibility (aka a PROspective record).

Effective June 2008, a number of changes to the file submittal process will support timelier reporting, enrollment, and deeming. The file submittal timing will be modified to allow state file submittal anytime during a month. This removes the restriction in place through June 2008, that files may only be submitted between the 15th and the end of the month. In addition, effective June 2008, states may include individuals on a file submittal who have been determined eligible effective in the following month. (aka as a future DETail record).

A significant change in processing is also being implemented in CMS effective June 2008 to further improve the timeliness of Part D enrollment processing. In the past, records submitted by the State in a month were held until early the following month for Low-Income-Subsidy deeming and auto-enrollment into Part D plans. Information resulting from these processes was not available to States until the following month. Effective June, 2008, records submitted by the State will be processed for deeming and auto-enrollment in a single cycle, and the results from that activity will be reflected in the response file for that submittal.

1.3 Phased Down State Calculation

The file is used to count the number of enrollees for the phased-down State contribution payment.

1.4 State LIS Applications

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

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

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

The State Enrollment File(s) will be transferred using Connect:Direct electronic file transfer. The Enrollment Return File from CMS will be transferred to the State using the same Connect:Direct medium.

Refer technical support questions regarding file specifications or the submittal process to our technical assistance mailbox at:

StateMMAdatafeed@cms.hhs.gov

File transmission issues should also be sent to **MBDUser@cms.hhs.gov**.

2 State Enrollment File(s)

This monthly file submittal must include a person-month record for each Medicare/Medicaid dual eligible actively enrolled in the State Medicaid program for the reporting month. This includes those eligible for Medicare and comprehensive Medicaid benefits (whether eligible through the State plan or a section 1115 demonstration), as well as those for whom the State pays Medicare cost sharing (QMB, SLMB, and QI). The file(s) will also include a record for each individual for whom the State has made an eligibility determination for Medicare Part D low income subsidy. The file(s) may also include records for individuals not yet known to be full dual eligibles, but who are approaching an age or disability status that is likely to lead to a future determination of full dual eligibility (see section on Prospective Dual Eligibles, or PRO records). Effective June 2008, the file(s) may also include Medicare beneficiaries who will be identified as Medicaid beneficiaries one month into the future.

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

Note that the data fields populated for this file will differ for records representing dual eligible enrollment and low income subsidy application determinations.

The information on Medicare status (for Medicare Parts A, B, C and D) will be returned to the State in the normal response file format (see Section 2. Enrollment Return File Specifications for details). For records which do not match Medicare records, the Medicare enrollment information will be blank. For records having current Medicare enrollment, all available enrollment information will be returned on the response file, including any prospective enrollment dates derived from the SSA prospective enrollment information. NOTE: Medicare enrollment systems can only return auto-enrollment information for prospective periods two months prior to the enrollment effective date.

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

2.1 Enrollment File Timing and Content

Each month's enrollment file(s) is sent to CMS between the 1st and the end (i.e. 30th or 31st) of the enrollment month (eff July 2008; until June 2008 between the 15th and the end of the month).

The monthly file submittal(s) will include all enrollment accretions and updates to State enrollment through the file creation date. The monthly file submittal will also include all State LIS applications for Part D subsidy processed through the file creation date. Any accretions or updates after the creation date for the last accepted State file will be included in the subsequent month's file submittal (until May 2008). However, as of June 2008, potential additional accretions and deletions could be submitted as a subsequent file submission until the end of the month.

With the onset of a State being able to submit multiple enrollment files per any given month (eff. June 2008), once a file has been accepted, any subsequent submissions in the same month will be treated as a unique submission and processed like the first file. CMS is envisioning that a State could potentially submit an initial “complete “ file, and may submit further “smaller update” files thereafter, as is seen necessary by a State. For each State enrollment file submitted, CMS will send a response file within 24 to 48 hours. CMS will process all files nightly for the deeming and auto-assignment process. Resulting enrollment transactions shall be sent weekly (on Saturdays) to the Part D Plans, effective June 2008.

CMS is requesting that a State not submit multiple “complete” files, due to the extra processing time needed to continually process a State’s complete enrollment file, vs adhering to a model of a “master (complete)” submission followed by “transaction” files. Replacement submittals of files that are rejected based on data quality validation must be received in CMS by the last day of the month if this is to be the sole submission of the month. In the case that a State submits an additional file, and it is received after 6 p.m. Eastern time the last day of the month (processing times cutoff the file will be processed for the subsequent month and the eligibility dates submitted will be assessed in regard to that month and not the prior one). Thus if a file of end of month updates is submitted to CMS on June 30th, 2008, at 11pm EST, it would not be processed until July 1 and all DETail records submitted as “current” for June 2008 would now be treated as retroactive records, any (one month into the future) DETail records would be processed as current records. If no file is successfully submitted for the month, CMS will project enrollment from the prior month’s file and apply retroactive updates based on the subsequent months’ submittals for the purpose of the phasedown calculation.

The file(s) should include one record for each actively enrolled (or potential prospective) dual eligible for the current reporting month or the subsequent month (DETail records only). As of the June 2008 submission month, if a State is only submitting one file, then this submittal must be a complete monthly dual eligible enrollment file as in prior months and years. If a State chooses to submit more than one monthly file, then a State may either submit one complete enrollment file and submit subsequent files including only file accretions and deletions, or a State may conceivably also submit multiple files throughout the month each consisting only of partial enrollments, as long as the accrual of all those file submission would deliver, by month’s end, a complete representation of all eligible enrollment for that State for that month. Additionally, all files will include a full person-month record to report information on changes in the circumstances for individuals that were effective in a prior month. These records are referred to as “retroactive” records and will be identified in the monthly file by the effective month and year to which the retroactive record data are to be applied. Illustrative examples of possible situations that would lead to retroactive changes include:

1. an individual not previously reported who was determined by the State to be retroactively eligible three months prior to the reporting month,
2. an individual having a change in dual status code two months prior to the reporting month, but for whom the State was not aware of the change until the reporting month.
3. an individual who was previously reported eligible but is deceased or ineligible for another reason.

In each of these cases, the state file will include a complete person-month record for that individual for the current month, and a second (or more, as needed) record providing a replacement record for the effective month and year of the change. For example, in the April 2008 reporting month file due by April 30, a dual eligible that became retroactively eligible in January 2008 would have to have a full, complete record for each month of eligibility through the reporting month i.e., 4 records (January-April 2008). Since this is a replacement record, the record will include data in all required fields; not just those fields that have changed. A person

who was reported eligible for March but was discovered in April to be deceased during the full month of March would have a change record for March showing an eligibility status of ineligible (coded value of “N”) for the March enrollment month.

NOTE: CMS is only able to process records spanning a 36 month retroactive period.

3 Selection Criteria for the Reporting Necessary for the State Phasedown Contribution Calculation

The Enrollment File(s) will include all dual eligibles including full-benefit dual eligibles for comprehensive benefits under the State plan or section 1115 demonstration, and those dual eligibles for which the State is providing only Medicare premium or limited coinsurance or deductible payments. One of the purposes for which the State's monthly MMA file submission will be used is to calculate the State's phasedown contribution payment. The phasedown process requires a monthly count of all full benefit dual eligibles with active Part D plan enrollment in the month. CMS will make this selection of records using dual eligibility status codes contained in the person-month record to identify all full-benefit dual eligibles (codes 02, 04 and 08 as described in the data dictionary). In the case where in a given month (eff. June 2008), multiple records were submitted for the same client in multiple file submittals, the last record submitted for that client shall be used to determine the final effect on the Phasedown count.

3.1 Prospective Full Dual Eligibles

One of the concerns related to the monthly MMA reporting cycle is the effect on Medicaid-only individuals who transition to dual eligible status and the difficulty in ensuring a seamless transition in drug coverage. Effective August, 2006 States were to include individuals on the monthly file who may not have been known full dual eligibles, but met at least one of the following conditions :

- Medicaid eligibles age 64 and 7 months or older in the reporting month
- Medicaid eligibles having a disability-related condition who are not known by the State to have Medicare entitlement

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

These records are reported on the file with a Record Identifier code of "PRO" (for prospective dual eligible) and are REPORTED ONLY BASED ON CURRENT MONTH ELIGIBILITY (i.e.; Do not include retroactive or prospective eligibility months). Based on this coding, these records will be subjected to special processing. This processing will bypass counting for the phased-down State contribution but will allow us to prospectively auto-enroll these individuals and to establish an appropriate Part D low-income subsidy level. These records will also be excluded from the file acceptance threshold for a 90-percent Medicare match rate.

3.2 PRO Enrollment Process

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

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

As part of implementation over the last months, we would like to clarify some key elements that are part of the submission, as well as processing, of these Prospective records.

3.3 Submission of PRO Records

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

- State Record must contain ‘PRO’ in the first positions of the record

- Eligibility month/ year of submission must be the current processing month/year. CMS will reject past or future dates.
- Record must contain a valid, two byte dual status code (position 116-118) of a ‘02’, ‘04’ or ‘08’. CMS will reject any other codes.
- Record must contain a valid SSN (may not be 9-filled or blank).
- Record must contain a “Y” in the ELIGIBILITY STATUS field (position 10)
- Record must contain a valid date of birth. If date of birth is unknown, enter best available data. This policy applies to DET records as well. Records containing no date of birth will be ignored.

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

3.4 Processing of Returned PRO Records

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

According to match result, VALID MATCHED records are marked as a ‘000000’ or ‘000001’ in the RECORD RETURN CODE FIELD, VALID records for which no match was found are marked with a ‘000003’ in positions 229-234. INVALID DUPLICATE RECORDS shall contain a ‘000010’ in that same position. INVALID, and thus NON-MATCHED, records shall contain a ‘000009’ in this return code field. PRO INVALID and DUPLICATES OF DET RECORDS shall contain a ‘000011’ in the record return code field.

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

For matched PRO records, a State should submit a DET record once the period of current dual eligibility has been reached and the beneficiary is assigned to a PDP. This information is contained in the Eligibility Information for Parts A/B and D in the MMA Response File. If, for example, a PRO record is returned in the December Response File as matched (return code = ‘000001 or ‘000000’) and the Part A/ B/D Entitlement Start Date is 01/01/2008, it is anticipated that a DETail record will be submitted for this beneficiary in the January 2008 File.

Valid PRO records which were matched and are found to be PART A/B entitled within two months of submission, will be auto-assigned to a PDP. Auto-assignment may only occur up to

two months into the future. For example, in a December 2008 State submission, any PRO record with entitlement no later than March 2008 would be submitted to the nightly (eff June 2008) available auto-assignment process. The enrollment information would be available in the generated response file within 24 – 48 hours. 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 2008). Deeming, however, will occur at the same time for the appropriate time span, regardless if onset is more than two months into the future

For example, if a beneficiary PRO record was submitted in a December 2008 State File and was found to be PART A/B /D entitled 03/01/2009, the member would be submitted to the deeming process the evening of file submission, and be returned in the RESPONSE FILE within 24 – 48 hours with a deeming onset date of 03/01/2009. The beneficiary would not, however, be submitted to the auto-assignment process by CMS until January 2009 , with an enrollment date of 03/01/2009. The enrollment information would be available in any January created response file, given the beneficiary is submitted by the State at some point in January. This auto-assignment would occur even if the member is not resubmitted after December's submission.

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

SPECIAL USER TIPS

We have received feedback indicating confusion regarding the definition or interpretation of a number of fields, and hope to clarify just a few of the following:

3.5 Fields submitted by the State on monthly MMA File

3.5.1 Bene Birth Dt (beneficiary date of birth)

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

EITHER

- (SSN--5.0 points

OR

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

AND

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

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

SECONDARY MATCHING Criteria is based on :

- 1st 6 positions of the last name
- 1st position of the first name
- HICN or SSN
- Exact Gender

3.5.2 Institutional Status Indicator

(Indicator of nursing facility, ICFMR or inpatient psychiatric hospital)

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

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

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

3.6.1 Medicare Part D Finder Code

(Part D Payment Switch or MARx Payment Switch)

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

3.6.2 Group Health Organization: GHO (10 Occurences)

<u>(Prior to the onset of Part D benefits, this part of the record only contained Part C MA Organizations</u>

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

- The first occurrence is the active (current or future) or most recent Medicare Group Health Organization coverage (i.e. plan enrollment). Presently, this section is populated with Medicare Part C and Medicare Part D Organizations enrollments. The organizations can be distinguished by the first position of 'BENE GHO CNTRCT NUM':

- H# is for local MA and MA-PDs; PACE, Cost Plans, and Demos
- S# is for STAND ALONE PDP'S
- R# is for Regional MA and MA-PDs
- [9 in the first position may denote a Demo Plan; or a Chronic Care Improvement Pilot]
- E# -- an employer sponsored prescription drug plan (began with contract year 2007).

3.6.3 Plan Benefit Package Election (10 Occurences)

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

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

MBD PBP CVRG TYPE CD:

NF=pay bill option was not found for the contract
3 =CCP - COORDINATED CARE PLAN
5 = PFFS - PRIVATE FEE FOR SERVICE
6 = PACE - PACE PGM OF ALL INCLSVE CARE FOR THE ELDERLY
8 =DEMO - DEMONSTRATION
9 = FFS - FEE FOR SERVICE
10 = Cost/
HCPP - COST/HEALTH CARE PREPAYMENT PLAN
11=PDP - Part D Drug Plan ELECTION

3.6.4 Part D Plan Benefit Package (10 Occurrences)

(This portion of the record will list the Part D Plans which also trigger the MEDICARE PART D FINDER CODE to reflect a ‘0’, denoting “Part D Enrollment found”

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

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

-Values for Enrollment Type Code:

A - Beneficiary was auto-enrolled thru CMS (full duals)
B - Beneficiary elected plan (overrides auto enrolled plan)
C - Facilitated enrollment: CMS facilitates enrollment of partial duals into a PDP

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

3.7 Enrollment File and Record Specifications

3.7.1 Data Types:

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

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

3.7.2 File Format:

File naming standard – **P#DDP.#DDP3.CMS.IN.ELIGIBLE.ss**

Where "ss" represents the FIPS State abbreviation, see table below:

Mainframe EBCDIC file format, FB
Record Lengths:
HEADER LRECL= 180, (40 + 140 space filled),
DETAIL LRECL=180,
TRAILER LRECL=180, (40 + 140 space filled).

Where "FB" = Fixed Block, and "LRECL" = Record Length

3.8 *State Code Abbreviations Table*

State Code - Valid Code

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

3.9 *Enrollment File to CMS*

3.9.1 Header Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
RECORD IDENT CODE	X(03)	001	003
STATE CODE	X(02)	004	005
CREATE MONTH	9(02)	006	007
CREATE YEAR	9(04)	008	011
FILLER	X(169)	012	180

3.9.2 Header Record Data Element Specifications

Data Element Name	Specifications			
RECORD IDENT CODE	Always contains value of “MMA”			
STATE CODE	**State Code - Valid Code**			
	Alabama	AL	Missouri	MO
	Alaska	AK	Montana	MT
	Arizona	AZ	Nebraska	NE
	Arkansas	AR	Nevada	NV
	California	CA	New Hampshire	NH
	Colorado	CO	New Jersey	NJ
	Connecticut	CT	New Mexico	NM
	Delaware	DE	New York	NY
	District of Columbia	DC	North Carolina	NC
			North Dakota	ND
	Florida	FL	Ohio	OH
	Georgia	GA	Oklahoma	OK
	Hawaii	HI	Oregon	OR
	Idaho	ID	Pennsylvania	PA
	Illinois	IL	Rhode Island	RI
	Indiana	IN	South Carolina	SC
	Iowa	IA	South Dakota	SD
	Kansas	KS	Tennessee	TN
	Kentucky	KY	Texas	TX
	Louisiana	LA	Utah	UT
	Maine	ME	Vermont	VT
	Maryland	MD	Virginia	VA
	Massachusetts	MA	Washington	WA
	Michigan	MI	West Virginia	WV
	Minnesota	MN	Wisconsin	WI
	Mississippi	MS	Wyoming	WY
CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12)			
CREATE YEAR	Year Code for Current Year – i.e. 2008 Current Year equals Calendar Year the file is created			

3.9.3 State Enrollment File Record Layout

FIELD NAME	FORMAT	<------POSITION------>	
		START	END
RECORD IDENT CODE	X(03)	001	003
ELIGIBILITY MONTH/YEAR	9(06)	004	009
ELIGIBILITY STATUS	X(01)	010	010
HICN/RRB	X(15)	011	025
HICN-RRB IND	X(01)	026	026
SOCIAL SECURITY NUM	9(09)	027	035
SMA IDENTIFIER	X(20)	036	055
FIRST NAME	X(12)	056	067
LAST NAME	X(20)	068	087
MIDDLE NAME	X(15)	088	102
SUFFIX NAME	X(04)	103	106
GENDER	X(01)	107	107
DATE OF BIRTH	9(08)	108	115
DUAL STATUS CODE	9(02)	116	117
FPL % IND	9(01)	118	118
DRUG COVERAGE IND	9(01)	119	119
INSTITUTIONAL STATUS IND	X(01)	120	120

NOTE: The following fields are based on LOW INCOME SUBSIDY applications processed by the State

FIELD NAME	FORMAT	START	END
LOW INCOME SUBSIDY APPRVD	X(01)	121	121
LOW INCOME SUBSIDY APPRVD DATE	9(08)	122	129
LOW INCOME SUBSIDY START DATE	9(08)	130	137
LOW INCOME SUBSIDY END DATE	9(08)	138	145
INCOME AS % OF FPL	9(03)	146	148
LOW INCOME SUBSIDY LEVEL	9(03)	149	151
INCOME USED FOR DETERMINATION	X(01)	152	152
RESOURCE LEVEL	X(01)	153	153
BASIS OF LOW INCOME SUBSIDY DENIAL	X(01)	154	154
RESULT OF AN APPEAL	X(01)	155	155
CHANGE TO PREVIOUS DETERMINATION	X(01)	156	156
DETERMINATION CANCLD	X(01)	157	157
FILLER	X(23)	158	180

3.9.4 State Enrollment Record Data Element Specifications

Data Element Name	Specifications	Required
RECORD IDENT CODE	Identifies record transaction type. Code as "DET" for an enrollment detail record or future Medicaid detail record, "PRO" for prospective Dual Eligible records, and "LIS" is for a low-income subsidy determination.	Required
ELIGIBILITY MONTH/YEAR	RECORD TYPE – DET, PRO Format :MMCCYY Calendar Month/Year Code for applicable Medicaid eligibility (e.g.012008). Valid Month Values: 01 – 12 (e.g. January=01, December=12.) OR 999999 for a LIS record For retroactive enrollment records use effective month of the changes for each record. Retroactive changes must be submitted to reflect prior-month changes in one or more of the following fields: - ELIGIBILITY STATUS - HIC/RRB - SOCIAL SECURITY NUM - SEX - DATE OF BIRTH - DUAL STATUS CODE - FPL % IND - INSTITUTIONAL STATUS IND Retro active records must include replacement values for ALL fields for that record; NOT just the field(s) that have changed. **DET can reflect one month future of current month/year combination for future Medicaid beneficiaries only.**	Required
ELIGIBILITY STATUS	RECORD TYPE – DET, PRO Indicator of beneficiary's Medicaid eligibility for that person-month – Valid values "Y" (yes) or "N" (no) or "9" for a LIS record This field requires the value 'Y' for a PRO detail record, or the detail record will be rejected.	Required
HICN/RRB	RECORD TYPE – DET, LIS, PRO Either the Health Insurance Claim Number (HICN) or the Railroad	Required (if not reporting SSN)

Data Element Name	Specifications	Required
	Retirement Board Number (RRB), whichever the State has active and available for the beneficiary. (NOTE: Alphanumeric Field – LEFT JUSTIFIED)	
HICN-RRB IND	RECORD TYPE – DET, LIS, PRO Indicator for HICN or RRB – Valid Values: "R" for RRB and "H" for HIC This field is not used by CMS.	
SOCIAL SECURITY NUM	RECORD TYPE – DET, LIS, PRO Beneficiary's own Social Security Number	Required (if not reporting HICN)
SMA IDENTIFIER	RECORD TYPE – Optional for any record type State Medicaid Agency Enrollee Identifier for the beneficiary – For use by State in associating records on Enrollment Return File.	
FIRST NAME	RECORD TYPE – DET, LIS, PRO Beneficiary First Name (First 12 letters)-Used for beneficiary secondary match	
LAST NAME	RECORD TYPE – DET, LIS, PRO Beneficiary Last Name (First 20 letters)-Used for beneficiary secondary match	
MIDDLE NAME	RECORD TYPE – DET, LIS, PRO Beneficiary Middle Name (First 15 letters)	
SUFFIX NAME	RECORD TYPE – DET, LIS, PRO Beneficiary Suffix Name (First 4 letters)e.g., JR, III	
GENDER	RECORD TYPE – DET, LIS, PRO Beneficiary Gender – Sex code values F=Female, M=Male, 9=Unknown Used for beneficiary secondary match	Required
DATE OF BIRTH	RECORD TYPE – DET, LIS, PRO	Required

Data Element Name	Specifications	Required
	MMDDCCYY: Month,day,century and year of Beneficiary Birth, (e.g. 05051935). If unknown = '99999999' NOTE: if unknown is submitted the record will be unmatched	
DUAL STATUS CODE	RECORD TYPE – DET, PRO 01 = Eligible is entitled to Medicare- QMB only 02 = Eligible is entitled to Medicare- QMB AND Full Medicaid coverage 03 = Eligible is entitled to Medicare- SLMB only 04 = Eligible is entitled to Medicare- SLMB AND Full Medicaid coverage 05 = Eligible is entitled to Medicare- QDWI 06 = Eligible is entitled to Medicare- Qualifying individuals 08 = Eligible is entitled to Medicare- Other Full Dual Eligibles (Non QMB, SLMB,QWDI or QI)with Full Medicaid coverage 09 = Eligible is entitled to Medicare – Other Dual Eligibles but without Medicaid coverage, includes Pharmacy Plus and 1115 drug-only demonstration. NOTE: For prospective enrollment (PRO) records, include a dual eligible code for full dual eligible status which best describes the dual status assuming that individual is Medicare eligible; i.e., codes 02-QMB plus, 04-SLMB plus, or 08-Other.	Required
FPL % IND	RECORD TYPE – DET, PRO, LIS Federal Poverty Level Indicator. Values: 1=at or below 100% FPL, 2=above 100% FPL. FPL is determined using the individual State's income rules. Include income based on the eligibility intake system, but do not derive this field from the Dual Status Code. If it is necessary to replace unknown FPL % IND values, CMS will derive the value using consistent rules.	Required
DRUG COVERAGE IND	RECORD TYPE – DET, PRO This field is not used by CMS.	

Data Element Name	Specifications	Required
	Effective January 2006, code this field as 9. For months prior to January 2006 the values submitted were: 0=no drug coverage by Medicaid; 1= Medicaid drug coverage.	
INSTITUTIONAL STATUS IND	RECORD TYPE – DET, PRO Indicator of NURSING FACILITY, INTERMEDIATE CARE FACILITY/MENTALLY RETARDED or INPATIENT PSYCHIATRIC HOSPITAL: Values “Y” or “N”. Code this field as “Y” (yes) only when the individual is institutionalized for the entire span of eligibility for the month.	Required
LOW-INCOME SUBSIDY DETERMINATION HISTORY SECTION	THE FOLLOWING FIELDS RELATE TO THE LOW INCOME SUBSIDY DETERMINATIONS. FOR RECORDS THAT ARE DUAL ENROLLMENT RECORDS (DET),ALL THE FOLLOWING FIELDS SHOULD BE DEFAULTED TO 9-FILLED VALUES	
LOW INCOME SUBSIDY APPLICATION APPROVAL CODE	RECORD TYPE – LIS Identifies whether application was approved or not. Approved code values Y=yes, N=no.	Required
LOW INCOME SUBSIDY APPROVED/DISAPPROVED DATE	RECORD TYPE – LIS Subsidy Determination Process or System Date. MMDDCCYY.	Required
LOW INCOME SUBSIDY EFFECTIVE DATE	RECORD TYPE – LIS Subsidy Effective Date MMDDCCYY. May not be earlier than 01/01/2006. Must be first day of the month in which application received by State.	Required
LOW INCOME SUBSIDY END DATE	RECORD TYPE – LIS Subsidy Termination Date MMDDCCYY. This field is not required and should be left blank or filled with all 9’s, unless the state has a definite knowledge of what the Termination date should be for the Low Income Subsidy determination.	

Data Element Name	Specifications	Required
INCOME AS % OF FPL	RECORD TYPE – LIS For those individuals who apply for the low income subsidy, identify the specific percent of Federal Poverty Level, as defined by Federal LIS income determination policy. Do not fill this out for those individuals who receive any Medicaid benefits, including payment of Medicare cost-sharing obligations. N/A='999'.	
LOW INCOME SUBSIDY LEVEL	RECORD TYPE – LIS Identifies portion of Part D premium subsidized, based on sliding scale linked to %FPL. If person is under 135% FPL, enter 100. If person is 136-140% FPL, enter 075. If person is 141-145% FPL, enter 050. If person is 146-149% FPL, enter 025. If person has 150% FPL, enter 000.	Required
INCOME USED FOR DETERMINATION	RECORD TYPE – LIS Income Used Indicator 1=Individual, 2=Couple N/A='9'	
RESOURCE LEVEL	RECORD TYPE – LIS Resource Level 1=over limit, 2=under limit N/A='9'.	
BASIS OF LOW INCOME SUBSIDY DENIAL	RECORD TYPE – LIS Denial codes 1=NAB (Not enrolled in Medicare Part A or B), 2=NUS (Does not reside in the USA), 3=FTC (Failure to Cooperate), 4=RES (Resources too High), 5=INC (Income too High).	
RESULT OF AN APPEAL	RECORD TYPE – LIS Appeal Result Y=yes, N=no (Only populated if appeal is filed).	
CHANGE TO PREVIOUS DETERMINATION	RECORD TYPE – LIS Change to Previous Determination Indicator Y=yes, N=no. Enter Y if this	

Data Element Name	Specifications	Required
	record changes a determination sent in a previous transmission. Default is N. (Future Element).	
DETERMINATION CANCELLED	RECORD TYPE – LIS Cancelled Indicator Y=yes, N=no. Default is N. Enter Y if this record cancels previous record sent. N/A='9'.	

3.9.5 State Trailer Physical Record Layout

FIELD NAME	FORMAT	<------POSITION------> START	 END
RECORD IDENT CODE	X(03)	001	003
BENE RECORD COUNT	9(08)	004	011
STATE CODE	X(02)	012	013
CREATE MONTH	9(02)	014	015
CREATE YEAR	9(04)	016	019
FILLER	X(161)	020	180

3.9.6 Trailer Record Data Element Specifications

Data Element Name	Specifications
RECORD IDENT CODE	Identifies Record as Trailer always = 'TRL"
BENE RECORD COUNT	Total number of records on the file
STATE CODE	**State Code - Valid Code** Alabama AL Alaska AK Arizona AZ Arkansas AR California CA Colorado CO Connecticut CT Delaware DE District of Columbia DC Florida FL Georgia GA Hawaii HI Idaho ID Illinois IL Indiana IN Iowa IA Kansas KS Kentucky KY Louisiana LA Maine ME Maryland MD Massachusetts MA Michigan MI Minnesota MN Mississippi MS Missouri MO Montana MT Nebraska NE Nevada NV New Hampshire NH New Jersey NJ New Mexico NM New York NY North Carolina NC North Dakota ND Ohio OH Oklahoma OK Oregon OR Pennsylvania PA Rhode Island RI South Carolina SC South Dakota SD Tennessee TN Texas TX Utah UT Vermont VT Virginia VA Washington WA West Virginia WV Wisconsin WI Wyoming WY
CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12
CREATE YEAR	Year Code for Current Year – i.e. 2008 Current Year equals Calendar Year the file is created

4 Enrollment Return File Specifications

This file will be automatically returned to the State through the Connect:Direct file transfer process upon the successful processing of a State Enrollment File. There may be a delay in sending the response file based upon other scheduling issues.

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

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

Each Section is identified by a Record-Identifier code in the first three positions of the record. The physical record layouts and field descriptions for these sections are provided below.

4.1 Header Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
RECORD IDENT CODE	X(03)	0001	0003
FILE PROCESS TIMESTAMP	X(26)	0004	0029
FILE ACCEPT IND	X(01)	0030	0030
FILLER	X(01)	0031	0031
RECORDS TOTAL	9(08)	0032	0039
RECORDS DUPLICATE	9(08)	0040	0047
RECORDS NONDUP	9(08)	0048	0055
RECORDS VALID	9(08)	0056	0063
RECORDS INVALID	9(08)	0064	0071
RECORDS MATCHED	9(08)	0072	0079
RECORDS NOT MATCHED	9(08)	0080	0087
FILE CREATE MONTH	9(02)	0088	0089
FILE CREATE YEAR	9(04)	0090	0093
FILLER	X(22)	0094	0115
*********ORIG STATE HEADER REC 180 characters ****************************			
RECORD IDENT CODE	X(03)	0116	0118
STATE CODE	X(02)	0119	0120
CREATE MONTH	9(02)	0121	0122
CREATE YEAR	9(04)	0123	0126
FILLER	X(169)	0127	0295
*********REMAINDER OF RECORD***			
FILLER	X(3105)	0296	3400

4.2 Person-Level Detail Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
******ORIGINAL RECORD SUBMITTED BY STATE****************************			
RECORD IDENT CODE	X(03)	0001	0003
ELIGIBILITY MONTH/YEAR	9(06)	0004	0009
ELIGIBILITY STATUS	X(01)	0010	0010
HICN/RRB	X(15)	0011	0025
HICN-RRB IND	X(01)	0026	0026
SOCIAL SECURITY NUM	9(09)	0027	0035
SMA IDENTIFIER	X(20)	0036	0055
FIRST NAME	X(12)	0056	0067
LAST NAME	X(20)	0068	0087
MIDDLE NAME	X(15)	0088	0102
SUFFIX NAME	X(04)	0103	0106
GENDER	X(01)	0107	0107
DATE OF BIRTH	9(08)	0108	0115
DUAL STATUS CODE	9(02)	0116	0117
FPL % IND	9(01)	0118	0118
DRUG COVERAGE IND	9(01)	0119	0119
INSTITUTIONAL STATUS IND	X(01)	0120	0120
LOW INCOME SUBSIDY APPLICATION APPROVAL CODE	X(01)	0121	0121
LOW INCOME SUBSIDY APPRVD/DISAPPRVD DATE	9(08)	0122	0129
LOW INCOME SUBSIDY EFFECTIVE DATE	9(08)	0130	0137
LOW INCOME SUBSIDY END DATE	9(08)	0138	0145
INCOME AS % OF FPL	9(03)	0146	0148
LOW INCOME SUBSIDY LEVEL	9(03)	0149	0151
INCOME USED FOR DETERMINATION	X(01)	0152	0152
RESOURCE LEVEL	X(01)	0153	0153
BASIS OF LOW INCOME SUBSIDY DENIAL	X(01)	0154	0154
RESULT OF AN APPEAL	X(01)	0155	0155
CHANGE TO PREVIOUS DETERMINATION	X(01)	0156	0156
DETERMINATION CANCLD	X(01)	0157	0157
FILLER	X(23)	0158	0180
*********** ERROR RETURN CODES (ERC) **************************************			
RECORD IDENT CODE ERC	X(02)	0181	0182
ELIGIBILITY MONTH/YEAR ERC	X(02)	0183	0184
ELIGIBILITY STATUS ERC	X(02)	0185	0186
HIC/RRB ERC	X(02)	0187	0188
HIC-RRB IND ERC	X(02)	0189	0190
SOCIAL SECURITY NUM ERC	X(02)	0191	0192
GENDER ERC	X(02)	0193	0194
DATE OF BIRTH ERC	X(02)	0195	0196
DUAL STATUS CODE ERC	X(02)	0197	0198
FPL % IND ERC	X(02)	0199	0200

DRUG COVERAGE IND ERC	X(02)	0201	0202
INSTITUTIONAL STATUS IND ERC	X(02)	0203	0204
LOW INCOME SUBSIDY APPLICATION APPROVAL CODE ERC	X(02)	0205	0206
LOW INCOME SUBSIDY APPRVD/ DISAPPRVD DATE ERC	X(02)	0207	0208
LOW INCOME SUBSIDY EFFECTIVE DATE ERC	X(02)	0209	0210
LOW INCOME SUBSIDY END DATE ERC	X(02)	0211	0212
INCOME AS % OF FPL ERC	X(02)	0213	0214
LOW INCOME SUBSIDY LEVEL ERC	X(02)	0215	0216
INCOME USED FOR DETERMINATION ERC	X(02)	0217	0218
RESOURCE LEVEL ERC	X(02)	0219	0220
BASIS OF LOW INCOME SUBSIDY DENIAL ERC	X(02)	0221	0222
RESULT OF AN APPEAL ERC	X(02)	0223	0224
CHANGE TO PREVIOUS DETERMINATION ERC	X(02)	0225	0226
DETERMINATION CANCLD ERC	X(02)	0227	0228
*************************** **CMS MBD FILE** **************************************			
RECORD RETURN CODE	X(06)	0229	0234
MEDICARE PART A/B FINDER CODE	X(01)	0235	0235
MEDICARE PART D FINDER CODE	X(01)	0236	0236
*** BENEFICIARY IDENTIFICATION ***			
BENE CLM ACNT NUM	X(09)	0237	0245
BENE IDENT CD	X(02)	0246	0247
BENE BIRTH DT	9(08)	0248	0255
BENE DEATH DT	9(08)	0256	0263
BENE GENDER IDENT	X(01)	0264	0264
BENE GIVN NAME	X(30)	0265	0294
BENE MDL NAME	X(01)	0295	0295
BENE SURN NAME	X(40)	0296	0335
*** CROSS REFERENCE NUMBERS (10 TIMES) ***		0336	0445
XREF BENE CLM ACCT NUM	X(09)		
XREF BENE IDENT CODE	X(02)		
*** SOCIAL SECURITY NUMBERS (5 TIMES) ***		0446	0490
BENE SSN NUM	9(09)		
*** MAILING ADDRESS ***			
MLNG ADDR LINE1	X(40)	0491	0530
MLNG ADDR LINE2	X(40)	0531	0570
MLNG ADDR LINE3	X(40)	0571	0610
MLNG ADDR LINE4	X(40)	0611	0650
MLNG ADDR LINE5	X(40)	0651	0690
MLNG ADDR LINE6	X(40)	0691	0730
MLNG ADDR CITY NAME	X(40)	0731	0770
MLNG ADDR STATE CODE	X(02)	0771	0772

MLNG ADDR ZIP CD	X(09)	0773	0781
MLNG ADDR CHG DT	9(08)	0782	0789
*** RESIDENCE ADDRESS (not available) ***			
FILLER	X(299)	0790	1088
*** REPRESENTATIVE PAYEE ***			
BENE REP PAYEE SW	X(01)	1089	1089
*** NON-ENTITLEMENT STATUS ***			
PRT A NENTLMT STUS CODE	X(01)	1090	1090
PRT B NENTLMT STUS CODE	X(01)	1091	1091
*** ENTITLEMENT REASON (5 TIMES) ***		1092	1151
(not available)			
FILLER	X(60)		
*** PART A ENTITLEMENT (5 TIMES) ***		1152	1241
BENE PTA ENTLMT STRT DT	9(08)		
BENE PTA ENTLMT END DT	9(08)		
BENE PTA ENRLMT RSN CD	X(01)		
BENE PTA ENTLMT STUS CD	X(01)		
*** PART B ENTITLEMENT (5 TIMES) ***		1242	1331
BENE PTB ENTLMT STRT DT	9(08)		
BENE PTB ENTLMT END DT	9(08)		
BENE PTB ENRLMT RSN CD	X(01)		
BENE PTB ENTLMT STUS CD	X(01)		
*** HOSPICE COVERAGE (5 TIMES) ***		1332	1411
BENE HSPC CVRG STRT DT	9(08)		
BENE HSPC CVRG END DT	9(08)		
*** DISABILITY INSURANCE (3 TIMES) ***		1412	1462
BENE DIB ENTLMT STRT DT	9(08)		
BENE DIB ENTLMT END DT	9(08)		
BENE DIB ENTLMT DT JSTFCTN CD	X(01)		
*** GROUP HEALTH ORGANIZATION (10 TIMES) ***		1463	1672
BENE GHO ENRLMT STRT DT	9(08)		
BENE GHO ENRLMT END DT	9(08)		
BENE GHO CNTRCT NUM	X(05)		
*** MBD PLAN BENEFITS PACKAGE ELECTION (10 TIMES) ***		1673	1962
MBD GHP ENRL EFCTV DT	9(08)		
MBD PBP STRT DT	9(08)		
MBD PBP END DT	9(08)		
MBD PBP NUM	X(03)		
MBD PBP CVRG TYPE CD	X(02)		
*** END STAGE RENAL DISEASE COVERAGE ***			
BENE ESRD CVRG STRT DT	9(08)	1963	1970
BENE ESRD CVRG END DT	9(08)	1971	1978

BENE ESRD TRMNTN RSN CD	X(01)	1979	1979
*** END STAGE RENAL DISEASE DIALYSIS ***			
BENE ESRD DLYS STRT DT	9(08)	1980	1987
BENE ESRD DLYS END DT	9(08)	1988	1995
*** END STAGE RENAL DISEASE TRANSPLANT ***			
BENE ESRD TRNSPLNT STRT DT	9(08)	1996	2003
BENE ESRD TRNSPLNT END DT	9(08)	2004	2011
*** THIRD PARTY PART A HISTORY (5 TIMES) ***		2012	2111
BENE PTA TP STRT DT	9(08)		
BENE PTA TP PRM PYR CD	X(03)		
BENE PTA TP END DT	9(08)		
BENE PTA TP BUYIN ELGBLTY CD	X(01)		
*** THIRD PARTY PART B HISTORY (5 TIMES) ***		2112	2211
BENE PTB TP STRT DT	9(08)		
BENE PTB TP PRM PYR CD	X(03)		
BENE PTB TP TRMNTN DT	9(08)		
BENE PTB TP BUYIN ELGBLTY CD	X(01)		
*** PART D DATA ELEMENTS ***			
BENE FIRST ELIGIBLE PART D DATE	9(08)	2212	2219
BENE AFF DECL IND (BENE PTD OPT OUT IND)	X(01)	2220	2220
****BENE COPAY HISTORY(10 TIMES)****		2221	2400
BENE COPAY TYPE	X(01)		
BENE COPAY LEVEL	X(01)		
BENE COPAY START DATE	9(08)		
BENE COPAY END DATE	9(08)		
****PART D PLAN BENEFIT PACKAGE(10 TIMES)		2401	2650
BENE CONTRACT NUM	X(05)		
BENE PTD PBP ENRLMNT STRT DT	9(08)		
BENE PTD PBP ENRLMNT END DT	9(08)		
BENE PTD PBP PLAN ID	X(03)		
BENE ENROLL TYPE IND	X(01)		
PART C ORGANIZATION NAME	X(55)	2651	2705
PART C PLAN NAME	X(50)	2706	2755
PART D ORGANIZATION NAME	X(55)	2756	2810
PART D ORGANIZATION PLAN NAME	X(50)	2811	2860
PART D ORGANIZATION PLAN BENEFIT	X(01)	2861	2861
BENEFICIARY LANGUAGE IND	X(01)	2862	2862
SNP IND (10 TIMES)	X(01)	2863	2872
INCARCERATION START DATE	9(08)	2873	2880

INCARCERATION TERM DATE	9(08)	2881	2888
FILLER	X(11)	2889	2899
PRIOR SPD CALCULATION IND	X(01)	2900	2900
SECONDARY MATCH IND	X(01)	2901	2901
DAILY SPD CALCULATION IND	X(01)	2902	2902
***RDS COVERAGE PERIODS(5 TIMES)		2903	2982
RDS Start Date	9(08)		
RDS Term Date	9(08)		
Filler	X(01)	2983	2983
***PART D ELIGIBILITY DATES(5 TIMES)		2984	3063
Part D Eligibility Start Date	9(08)		
Part D Eligibility Term Date	9(08)		
***BENEFICIARY SUBSIDY INFORMATION(10 TIMES)		3064	3113
Subsidy Level	9(03)		
LIS DEEM Source Code	X(02)		
*** REMAINDER OF RECORD ***			
FILLER	X(287)	3114	3400

4.3 File Summary Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
REC IDENT CODE	X(03)	0001	0003
STATE CODE	X(02)	0004	0005
FILE PROCESS TIMESTAMP	X(26)	0006	0031
FILE CREATE MONTH	9(02)	0032	0033
FILE CREATE YEAR	9(04)	0034	0037
RECORDS TOTAL	9(08)	0038	0045
RECORDS DUPLICATE	9(08)	0046	0053
RECORDS NONDUP	9(08)	0054	0061
RECORDS VALID	9(08)	0062	0069
RECORDS INVALID	9(08)	0070	0077
RECORDS MATCH	9(08)	0078	0085
RECORDS NOT MATCHED	9(08)	0086	0093
FILLER	X(01)	0094	0094
FILLER	X(20)	0095	0114
FILLER	X(26)	0115	0140
VALID DUAL RECORDS	9(08)	0141	0148
VALID DUAL MATCHES	9(08)	0149	0156
VALID DUAL NONMATCHES	9(08)	0157	0164
VALID LIS RECORDS	9(08)	0165	0172
VALID CURRENT DUALS	9(08)	0173	0180
VALID RETRO DUALS	9(08)	0181	0188
TOTAL ELIG MONTHS	9(02)	0189	0190
TOTAL VALID PRO RECORDS	9(08)	0191	0198
TOTAL INVALID PRO RECORDS	9(08)	0199	0206
TOTAL MATCHED PRO RECORDS	9(08)	0207	0214

FILLER	X(3186)	0215	3400

4.4 Month Summary Record Physical Layout

(One generated for each Eligibility month found in the file.)

FIELD NAME	FORMAT	<------POSITION------> START	END
REC IDENT CODE	X(03)	0001	0003
STATE CODE	X(02)	0004	0005
FILE PROCESS TIMESTAMP	X(26)	0006	0031
FILE CREATE MONTH	9(02)	0032	0033
FILE CREATE YEAR	9(04)	0034	0037
ELIGIBILITY MONTH	9(02)	0038	0039
ELIGIBILITY YEAR	9(04)	0040	0043
CALCULATION SWITCH	X(01)	0044	0044
TOTAL VALID RECORDS	9(08)	0045	0052
TOTAL VALID FULL DUAL RECORDS	9(08)	0053	0060
TOTAL VALID NON-FULL DUAL RECORDS	9(08)	0061	0068
NET TOTAL VALID FULL DUAL ENROLLMENTS	9(08)	0069	0076
NET TOTAL VALID FULL DUAL DISENROLLMENTS	9(08)	0077	0084
FILLER	X(3316)	0085	3400

4.5 Trailer Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
RECORD IDENT CODE	X(03)	0001	0003
FILE PROCESS TIMESTAMP	9(26)	0004	0029
FILE CREATE MONTH	9(02)	0030	0031
FILE CREATE YEAR	9(04)	0032	0035
FILE ACCEPT IND	X(01)	0036	0036
FILLER	X(07)	0037	0043
***********ORIG STATE TRAILER REC 180 characters ******************************			
RECORD IDENT CODE	X(03)	0044	0046
BENE RECORD COUNT	9(08)	0047	0054
STATE CODE	X(02)	0055	0056
CREATE MONTH	9(02)	0057	0058
CREATE YEAR	9(04)	0059	0062
FILLER	X(161)	0063	0223
***********REMAINDER OF RECORD***			
FILLER	X(3177)	0224	3400

4.6 Header Record Data Element Specifications

RECORD IDENT CODE	"SRF"
FILE PROCESS TIMESTAMP	Format: YYYY.MM.DD.hh.mm.ss.nnnn YYYY = Year; MM = Month; DD = Day; hh = hour; mm = minute; ss = second; nnnnnn = microsecond The exact time that the State file had been processed.
FILE ACCEPT IND	Y = The State file had been accepted; N = the State file had not been accepted.
FILLER	Filler.
RECORDS TOTAL	The total number of detail records in the State file. RECORDS VALID + RECORDS INVALID = RECORDS TOTAL. RECORDS MATCHED + RECORDS NOT MATCHED = RECORDS TOTAL. This total does not include PRO records.
RECORDS DUPLICATE	The total number of duplicate detail records found in the State file. This count does not include PRO records.
RECORDS NONDUP	The total number of non-duplicate valid detail records found in the State file. This count does not include PRO records.
RECORDS VALID	The total number of valid detail records found in the file. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes (ERC) Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth - HICN or RRB, Date of Birth - Social Security Number, Date of Birth This count does not include PRO records.
RECORDS INVALID	The total number of invalid detail records found in the file See also Person-Level Record Data Element Specifications: Error Return Codes (ERC) This count does not include PRO records.
RECORDS MATCHED	The total number of detail records that could be matched successfully to an individual on the Medicare Beneficiary

RECORD IDENT CODE	"SRF"
	Database. This count does not include PRO records.
RECORDS NOT MATCHED	The total number of detail records that could not be matched successfully to an individual on the Medicare Beneficiary Database. This count includes Invalid detail records because no match is attempted on an invalid detail record. This count does not include PRO records.
FILE CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12) Create Month of the MMA State File
FILE CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created Create Year of the MMA State File
FILLER	
***********************	**ORIGINAL STATE HEADER RECORD 180 BYTES**
FILLER	
***********************	**REMAINDER OF RECORD**
FILLER	

4.7 Person-Level Detail Record Data Element Specifications

***********************	ORIGINAL RECORD SUBMITTED BY STATE
***********************	**ERROR RETURN CODES (ERC)**
RECORD IDENT CODE ERC	**If this field is invalid, the detail record is invalid.** 00: Value is Valid 01: Invalid - Value is not in Valid Value Set
ELIGIBILITY MONTH/YEAR ERC	**If this field is invalid, the DET detail record is invalid.** **If this field is invalid, the PRO detail record is invalid.** 00: Value is Valid 02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 10: Invalid - Value is Future 11: Invalid - Month value is not between 01 and 12 inclusive 20: Invalid - Year value is before 2004 05: Invalid – PRO record Eligibility month/Year not Current Month/Year 37: Month/Year combo is > 36 months old from current processing date 99: Not Scanned - LIS Record
ELIGIBILITY STATUS ERC	**If this field is invalid, the DET detail record is invalid.** **If this field is invalid, the PRO detail record is invalid.** 00: Value is Valid 01: Invalid - Value is not in Valid Value Set 06 – Invalid – PRO record Eligibility Status not = Y 99: Not Scanned - LIS Record
HIC/RRB ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 03: Invalid - Field is Empty **Critical Identification field**: Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth - HICN or RRB, Date of Birth - Social Security Number, Date of Birth
HIC-RRB-IND ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set
SOCIAL SECURITY NUM ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 02: Invalid - Value is not Numeric 03: Invalid - Field is Empty **Critical Identification field**:

	Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth - HICN or RRB, Date of Birth - Social Security Number, Date of Birth
GENDER ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set
DATE OF BIRTH ERC	00: Value is Valid 02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 10: Invalid - Value is Future 11: Invalid - Month value is not between 01 and 12 inclusive 12: Invalid - Day value is out of range 21: Warning - Year is before 1899 **Critical Identification field**: Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth - HICN or RRB, Date of Birth - Social Security Number, Date of Birth
DUAL STATUS CODE ERC	**If this field is invalid, the PRO detail record is invalid.** 00: Value is Valid 01: Invalid - Value is not in Valid Value Set 40: Warning - Value is 99 for Dual Eligible record 07: Invalid – PRO record with Dual Status not Full Dual 99: Not Scanned - LIS record
FPL % IND ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 99: Not Scanned - LIS record
DRUG COVERAGE IND ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 99: Not Scanned - LIS record
INSTITUTIONAL STATUS IND ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 99: Not Scanned - LIS record
LOW INCOME SUBSIDY APPLICATION APPROVAL CODE ERC	**If this field is invalid, the LIS detail record is invalid.** 00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
LOW INCOME SUBSIDY APPRVD/DISAPPRVD DATE ERC	**If this field is invalid, the LIS detail record is invalid.** 00: Value is Valid

	02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 10: Invalid - Value is Future 11: Invalid - Month value is not between 01 and 12 inclusive 12: Invalid - Day value is out of range 31: Invalid - Value is later than LOW INCOME SUBSIDY End Date 98: Not Scanned – DET or PRO record
LOW INCOME SUBSIDY EFFECTIVE DATE ERC	**If this field is invalid, the LIS detail record is invalid.** 00: Value is Valid 02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 10: Invalid - Value is Future 11: Invalid - Month value is not between 01 and 12 inclusive 12: Invalid - Day value is out of range 31: Invalid - Value is later than LOW INCOME SUBSIDY End Date 36: Invalid – Value is earlier than January 1, 2006 37: Warning - Day value is not first day of the month 98: Not Scanned – DET or PRO record
LOW INCOME SUBSIDY END DATE ERC	00: Value is Valid 02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 10: Invalid - Value is Future 11: Invalid - Month value is not between 01 and 12 inclusive 12: Invalid - Day value is out of range 33: Invalid - Value is earlier than LOW INCOME SUBSIDY Approved/Disapproved Date 34: Invalid - Value is earlier than LOW INCOME SUBSIDY EFFECTIVE DATE 35: Invalid - Value is earlier than LOW INCOME SUBSIDY Approved/Disapproved Date and LOW INCOME SUBSIDY EFFECTIVE DATE 98: Not Scanned – DET or PRO record
INCOME AS % OF FPL ERC	00: Value is Valid 01: Invalid - Value is not Numeric. 98: Not Scanned – DET or PRO record
LOW INCOME SUBSIDY LEVEL ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
INCOME USED FOR DETERMINATION ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
RESOURCE LEVEL ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record

BASIS OF LOW INCOME SUBSIDY DENIAL ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
RESULT OF AN APPEAL ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
CHANGE TO PREVIOUS DETERMINATION ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 98: Not Scanned – DET or PRO record
DETERMINATION CANCLD ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 98: Not Scanned DET or PRO record
***********************	**CMS MBD FILE**
RECORD RETURN CODE	This field is an assessment of the detail record. 000000: Record is Valid no errors. 000001: Record is Valid with errors. 000002: Record is Invalid: Invalid Record Identification Code. 000003: Record is Invalid: Insufficient Valid Identifying Information [May potentially indicate a mismatch on the submitted date of birth.] 000004: Record is Invalid: DET Record - Invalid Required Fields 000005: Record is Invalid: LIS Record - Invalid Required Fields 000006: Record is Invalid: DET Record - Duplicate 000007: Record is Invalid: LIS Record - Duplicate 000009: Record is Invalid: PRO Record – Invalid Key Fields 000010: Record is Invalid: PRO Record – Invalid is PRO Duplicate 000011: Record is Invalid: PRO Record – Invalid is DET Duplicate
MEDICARE PART A/B FINDER CODE	For Dual Eligible (DET) records and Prospective Full Dual (PRO) records, this field indicates the presence of Medicare Part D Eligibility during the Eligibility Month/Year. For Low-Income Subsidy (LIS) records, this field indicates the presence of Medicare Part D Eligibility during the first month of the Subsidy period as given by the LOW INCOME SUBSIDY Apprvd/Disapprvd Date. Values: 0 = The person had Medicare Part D Eligibility 1 = The person was not eligible for Medicare Part D NOTE: For Eligibility Month/Eligibility Year values January 2006 and later, this field equates to Medicare Part D Eligibility. E.g., if the Eligibility Month/Year is 112005, this field would not indicate Medicare Part D Eligibility.
MEDICARE PART D FINDER CODE	For Dual Eligible (DET) records and Prospective Full Dual (PRO) records, this field indicates the presence of Medicare

	Part D enrollment during the Eligibility Month/Year. For Low-Income Subsidy (LIS) records, this field indicates the presence of Medicare Part D enrollment during the first month of the Subsidy period as given by the LOW INCOME SUBSIDY Apprvd/Disapprvd Date. Values: 0 = The person had Medicare Part D coverage 1 = The person did not have Medicare Part D coverage.
***********************	**BENEFICIARY IDENTIFICATION** **This remainder of the record is populated if the person was found in the CMS Medicare information systems. A person will be found in the CMS Medicare information systems if they have Medicare.** **If the person is not found successfully in the CMS Medicare information systems, then the remainder of the record will be populated with SPACES (alphanumeric fields) and ZEROS (numeric fields).**
BENE CLM ACNT NUM	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.
BENE IDENT CD	A code that is used in conjunction with the Beneficiary Claim Account Number to uniquely identify a Medicare Beneficiary. The BIC Code establishes the beneficiary's relationship to a primary Social Security Administration (SSA) or Railroad Retirement Board (RRB) wage earner and is used to justify entitlement to Medicare benefits.
BENE BIRTH DT	The date of birth of the Medicare Beneficiary. MMDDCCYY: Month, day, century and year
BENE DEATH DT	The date of death of the Medicare Beneficiary. MMDDCCYY: Month, day, century and year
BENE SEX IDENT CD	Represents the sex of the Medicare Beneficiary. Examples include: Male and Female Valid values: 0 = Unknown 1 = Male 2 = Female
BENE GIVN NAME	The first name of the Medicare beneficiary.
BENE MDL NAME	The middle initial of the Medicare Beneficiary middle name.
BENE SURN NAME	The last name (surname) of the Medicare Beneficiary including any following titles.
***********************	**CROSS REFERENCE MEDICARE NUMBERS (10 OCCURRENCES)** **First occurrence is the active/most recent cross-reference**

	Medicare number.
XREF BENE CLM ACCT NUM	An additional beneficiary claim account number associated with the Medicare Beneficiary. The beneficiary's entitlement has been cross-referenced from this number to the beneficiary's active claim account number. (Audited records are invalidated)
XREF BENE IDENT CODE	The beneficiary's identification code associated with the Medicare Beneficiary's cross-referred claim account number.
***********************	**SOCIAL SECURITY NUMBERS (5 OCCURRENCES)** **First occurrence is the active/most recent Social Security Number.**
BENE SSN NUM	The beneficiary's identification number that was assigned by the Social Security Administration.
***********************	**MAILING ADDRESS** **This may be the address of a rep-payee where that represents the official mailing address.**
MLNG ADDR LINE 1	The first line of the address.
MLNG ADDR LINE 2	The second line of the street address.
MLNG ADDR LINE 3	The third line of the street address.
MLNG ADDR LINE 4	The fourth line of the mailing address.
MLNG ADDR LINE 5	The fifth line of the mailing address.
MLNG ADDR LINE 6	The sixth line of the mailing address.
MLNG ADDR CITY NAME	The name of the city for the Medicare Beneficiary's residence, or temporary residence and/or mailing address.
MLNG ADDR STATE CODE	The beneficiaries' postal State code.
MLNG ADDR ZIP CODE	The zip code associated with the address
MLNG ADDR CHG DT	The date a new or corrected address becomes effective for a Medicare Beneficiary. MMDDCCYY: Month, day, century and year
***********************	RESIDENCE ADDRESS The Residence address is NOT currently being used nor is it being populated
***********************	**REPRESENTATIVE PAYEE**
BENE REP PAYEE SW	A switch that indicates whether the beneficiary has a Representative Payee for social security cash benefit purposes. Values: Space or N = Field is not applicable, no rep payee indicated Y = Beneficiary has designated a representative payee
***********************	**MEDICARE NON-ENTITLEMENT STATUS**

PRT A NENTLMT STUS CODE	The reason for a beneficiary's current non-entitlement to Part A Medicare Benefits. Values: D = Coverage was denied F = Terminated due to invalid enrollment or enrollment voided H = Not eligible for free Part A, or did not enroll for premium Part A R = Refused benefits N = Not a valid SSA HIC, but used by CMS' Third Party system to indicate a potential PTA entitlement date This field may have the value SPACE if no non-entitlement reason applies to the beneficiary.
PRT B NENTLMT STUS CODE	The reason for a beneficiary's current non-entitlement to Part B Medicare Benefits. Values: D = Coverage was denied N = No (Foreign/Puerto Rican beneficiary not entitled to SMI) Also, dually/technically, beneficiary is not entitled to SMI. R = Refused benefits This field may have the value SPACE if no non-entitlement reason applies to the beneficiary.
***********************	**MEDICARE ENTITLEMENT REASON (5 OCCURRENCES) This section is not presently populated.**
***********************	**MEDICARE PART A ENTITLEMENT (5 OCCURRENCES) First occurrence is the active/most recent Medicare Part A entitlement.**
BENE PTA ENTLMT STRT DT	The date a beneficiary became entitled to Medicare Benefits. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no entitlement period is found.
BENE PTA ENTLMT END DT	The Medicare program entitlement termination date for a beneficiary. The last day that a beneficiary is entitled to benefits. After this day the benefits are terminated. MMDDCCYY: Month, day, century and year If this field and the Entitlement Start Date are both populated with zeros, then no entitlement period was found. If this field is populated with zeros and the entitlement start date is a valid date, then the entitlement period is not ended.
BENE PTA ENRLMT RSN CD	This code is used by SSA to reflect information about a specific Part A enrollment is based upon equitable relief (and Medicare's usual business rules for Part B start Date may not be appropriate) Values: A = Attainment of age 65 B = Equitable relief D = Disability G = General Enrollment Period I = Initial Enrollment Period

	J = MQGE Entitlement K = Renal disease is or was a reason for entitlement prior to age 65 or 25th month of disability L = Late filing M = Termination based on renal entitlement but entitlement based on disability continues N = Age 65 and uninsured P = Potentially insured beneficiary is enrolled for Medicare coverage only Q = Quarters of coverage requirements are involved R = Residency requirements are involved S = State Buy-In T = Disabled working individual U = Unknown Blank = Not applicable This field will be populate with SPACE if no entitlement period is found
BENE PTA ENTLMT STUS CD	Represent the Medicare Part A entitlement status for a beneficiary. Values are: E = Free Part A Entitlement G = Entitled due to good cause Y = Currently entitled, premium is payable Valid values when Part A Entitlement Effective date and Termination Date are present: C = No longer entitled due to disability cessation S = Terminated, no longer entitled under ESRD provision T = Terminated for non-payment of premiums W = Voluntary withdrawal from premium coverage X = Free Part A terminated or refused HI This field will be populated with SPACE if no entitlement period is found.
***********************	**MEDICARE PART B ENTITLEMENT (5 OCCURRENCES) First occurrence is the active/most recent Medicare Part B entitlement.**
BENE PTB ENTLMT STRT DT	The date a beneficiary became entitled to Medicare Benefits. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no entitlement period is found.
BENE PTB ENTLMT END DT	The Medicare program entitlement termination date for a beneficiary. The last day that a beneficiary is entitled to benefits. After this day the benefits are terminated. MMDDCCYY: Month, day, century and year If this field and the Entitlement Start Date are both populated with zeros, then no entitlement period was found. If this field is populated with zeros and the entitlement start date is a valid date, then the entitlement period is not ended.

BENE PTB ENRLMT RSN CD	This code is used by SSA to reflect information about a specific Part B enrollment is based upon equitable relief (and Medicare's usual business rules for Part B start Date may not be appropriate) Valid values: B = Equitable relief C = Good Cause D = Deemed date of birth F = Working Aged G = General enrollment period I = Initial enrollment period K = Renal disease is or was a reason for entitlement prior to age 65 or 25th month of disability M = Termination based on renal entitlement but entitlement based on disability continues 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 This field will be populate with SPACE if no entitlement period is found
BENE PTB ENTLMT STUS CD	This code represents the Part B Medicare entitlement status for a beneficiary. Valid values when Part B Entitlement Effective date is present and Termination Date is blank: G Entitled due to good cause Y Currently entitled, premium is payable Valid values when Part B Entitlement Effective date and Termination Date are present: C No longer entitled due to disability cessation F Terminated due to invalid enrollment or enrollment voided S Terminated, no longer entitled under ESRD provision T Terminated for non-payment of premiums W Voluntary withdrawal from premium coverage This field will be populated with SPACE if no entitlement period is found.
***********************	**HOSPICE COVERAGE (5 OCCURRENCES)** **First occurrence is the active/most recent Hospice coverage.**
BENE HSPC CVRG STRT DT	The elected start date of a beneficiary's period of Hospice Coverage. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no Medicare Hospice coverage period is found.
BENE HSPC CVRG END DT	The termination date of a beneficiary's period of Hospice Coverage. MMDDCCYY: Month, day, century and year If the Hospice Start Date is populate with zeros, then this date

	will be populated with zeros. This field will be populated with zeros if the hospice period is open (not ended).
***********************	**DISABILITY INSURANCE (3 OCCURRENCES)** **First occurrence is the active/most recent Disability Insurance.**
BENE DIB ENTLMT STRT DT	The date that a beneficiary covered by the SSA disability program becomes entitled to Medicare benefits. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no disability coverage period is found.
BENE DIB ENTLMT END DT	The date that Medicare benefits due to disability end for a beneficiary who was covered by the SSA disability program. MMDDCCYY: Month, day, century and year This field will be populated with zeros if the Disability Entitlement Start Date is zeros. This field will be zeros if the Disability Entitlement Period is open (not ended).
BENE DIB ENTLMT DT JSTFCTN CD	The justification for a beneficiary's Part A and/or Part B Medicare entitlement dates based upon his/her disability insurance benefits (DIB) status. 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 BLANK = N/A This field will be populated with SPACE if no Disability Entitlement Period is found.
***********************	**GROUP HEALTH ORGANIZATION (10 OCCURRENCES)** **The first occurrence is the active or most recent Medicare Group Health Organization coverage (ie plan enrollment). Presently, this section is populated with Medicare Part C and Medicare Part D plan enrollments.**
BENE GHO ENRLMT STRT DT	The date that the beneficiary enrolled in the Service Elections. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no service election (plan enrollment) has been found.
BENE GHO ENRLMT END DT	The date that the beneficiary disenrolled in the Service Elections. MMDDCCYY: Month, day, century and year This field will be populated with zeros if the GHO Enrollment Start Date is populated with zeros. This field will be populated with zeros if the Service Election (plan enrollment) is open (not ended).
BENE GHO CNTRCT NUM	Unique identification for an agreement between CMS and a Managed Care Organization (MCO) enabling the MCO to provide Medicare + choice coverage to eligible beneficiaries.

	This field will be populated with spaces only if neither Medicare Part C nor Medicare Part D enrollment has been found. Generally the following applies, but there could be some exceptions especially with 9. A contract number beginning with the letter H indicates local MA (Medicare Advantage) plans, MA-PD (Medicare Advantage with Prescription Drug) plans, PACE organizations, cost plans, and some demonstrations. A contract number beginning with the letter R indicates regional MA and MA-PD plans. A contract number beginning with the number 9 indicates a Medicare Demonstration plan. A contract number beginning with the letter S indicates Stand-Alone PDP (Prescription Drug Plan). Starting with contract year 2007, a contract number starting with E indicates an employer sponsored prescription drug plan.
***********************	**MBD PLAN BENEFIT PACKAGE ELECTION (10 OCCURRENCES) The first occurrence is the active or most recent Medicare Plan Benefit Package coverage. Presently, this section is populated with Medicare Part C and Medicare Part D plan benefit package selections.**
MBD GHP ENRLMT EFCTV DT	The date that the beneficiary enrolled in the Service Elections. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no service election (plan enrollment) has been found.
MBD PBP STRT DT	Date the PBP election started. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no plan benefit package selection has been found.
MBD PBP END DT	Date the PBP election ended. MMDDCCYY: Month, day, century and year This field will be populated with zeros if the PBP Start Date is populated with zeros. This field will be populated with zeros if the PBP election is open (not ended).
MBD PBP NUM	A unique identifier for the managed care benefit package. This field will be populated with spaces if no PBP election has been found for the beneficiary.
MBD PBP CVRG TYPE CD	Identifies the type of managed care enrollment or FFS period. 3 =CCP COORDINATED CARE PLAN 6 = PACE PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) 8 =DEMO DEMONSTRATION 5 = PFFS PRIVATE FEE FOR SERVICE 10 = Cost/HCPPCOST/HEALTH CARE PREPAYMENT PLAN

	9 = FFS (FEE FOR SERVICE) 11 = PDP Election This field will be populated with spaces if no PBP election has been found for the beneficiary.
***********************	**END STAGE RENAL DISEASE COVERAGE (1 OCCURRENCE)**
BENE ESRD CVRG STRT DT	The date on which the beneficiary is entitled to Medicare in some part because of a diagnosis of End Stage Renal Disease. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no ESRD coverage is found for the beneficiary.
BENE ESRD CVRG END DT	The date on which the beneficiary is no longer entitled to Medicare under ESRD Provisions. MMDDCCYY: Month, day, century and year This field will be populated with zeros if the ESRD Coverage Start Date is populated with zeros. This field will be populated with zeros if the ESRD Coverage period is open (not ended).
BENE ESRD TRMNTN RSN CD	The reason Medicare-Based ESRD coverage was terminated. DATA VALIDATION: A = Month of transplant plus 36 months; B = Last month of chronic dialysis; C = Part A termination; D = Death; E = ESRD ended This field will be populated with spaces if either no ESRD Coverage has been found for the beneficiary or the ESRD Coverage Period has not been ended (s open/active).
***********************	**END STAGE RENAL DISEASE DIALYSIS (1 OCCURRENCE)**
BENE ESRD DLYS STRT DT	A date that indicates when the ESRD Dialysis started. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no ESRD Dialysis is found for the beneficiary.
BENE ESRD DLYS END DT	A date that indicates when ESRD Dialysis ended. MMDDCCYY: Month, day, century and year The field will be populated with zeros if the Dialysis Start Date is populated with zeros. This field will be populated with zeros if the beneficiary is presently receiving Dialysis care through Medicare.
***********************	**END STAGE RENAL DISEASE TRANSPLANT (1 OCCURRENCE)**
BENE ESRD TRNSPLNT STRT DT	A date that indicates when a Kidney Transplant Operation Occurred. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no ESRD Kidney Transplant is found for the beneficiary.

BENE ESRD TRNSPLNT END DT	A date that indicates when a Kidney Transplant failed. MMDDCCYY: Month, day, century and year The field will be populated with zeros if the Transplant Start Date is populated with zeros. This field will be populated with zeros if the beneficiary is presently benefiting from Kidney Transplant (ie the Transplant Start Date is populated with a date value).
**********************	**THIRD PARTY PART A HISTORY** **(5 OCCURRENCES)** **First occurrence is the active/most recent Third Party Part A period.**
BENE PTA TP STRT DT	The start date of a private third party group's or State's liability for a beneficiary's Part A premium. MMDDCCYY: Month, day, century and year
BENE PTA TP PRM PYR CD	Part A – The identifier for a third party agency (either a private group's, State buy-in agency) responsible for paying a beneficiary's Medicare Part A premium. Part A: S01- S99 State billing T01-Z98 Private Third Party Billing Z99 Conditional State Group Payer Enrollment.
BENE PTA TP END DT	The termination date of a private third party group's or State's liability for a beneficiary's Part A premium. MMDDCCYY: Month, day, century and year
BENE PTA TP BUYIN ELGBLTY CD	A code that indicates the reason for Part A State buy-in eligibility. A = AGED RECIPIENT OF SSI PAYMENTS (CMS TO STATE) B = BLIND RECIPIENT OF SSI PAYMENTS (CMS TO STATE) C = ENTITLED TO PART A OF TITLE IV (AFDC) (STATE TO CMS) D = DISABLE RECIPIENT OF SSI PAYMENTS (CMS TO STATE) E = AGED RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) F = BLIND RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) G = DISABLED RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) H = AGED, BLIND, OR DISABLED RECIPIENT OF A ONE-TIME PAYMENT (OTP) (CMS TO STATE) M = ENTITLED TO MEDICAL ASSISTANCE ONLY (MAO), NON-CASH RECIPIENT (STATE TO CMS) Z = DEEMED CATEGORICALLY NEEDY (STATE TO CMS)
**********************	**THIRD PARTY PART B HISTORY** **(5 OCCURRENCES)** **First occurrence is the active/most recent Third Party Part B period.**

BENE PTB TP STRT DT	The start date of a private third party group's or State's liability for a Part B premium. MMDDCCYY: Month, day, century and year
BENE PTB TP PRM PYR CD	Part B - The identifier for a third party agency (either a private group, State buy-in agency or the Office of Personnel Management (OPM) responsible for paying a beneficiary's Medicare Part B premium. Part B: Blank No Bill Determined 000 Beneficiary is having Part B premium deducted from Title II check 001 Uninsured beneficiary 005 Insured beneficiary 006 Program Service Center control, no bill 007 Special age 72 enrollee 008 PSC annual billing 010- 650 State billing 700 Office of Personnel Management (OPM) A01-R99 Group Payers for Part B premiums.
BENE PTB TP TRMNTN DT	The termination date of a private third party group's or State's liability for a beneficiary's Part B premium. MMDDCCYY: Month, day, century and year
BENE PTB TP BUYIN ELGBLTY CD	A code that indicates the reason for Part B State buy-in eligibility. A = AGED RECIPIENT OF SSI PAYMENTS (CMS TO STATE) B = BLIND RECIPIENT OF SSI PAYMENTS (CMS TO STATE) C = ENTITLED TO PART A OF TITLE IV (AFDC) (STATE TO CMS) D = DISABLE RECIPIENT OF SSI PAYMENTS (CMS TO STATE) E = AGED RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) F = BLIND RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) G = DISABLED RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) H = AGED, BLIND, OR DISABLED RECIPIENT OF A ONE-TIME PAYMENT (OTP) (CMS TO STATE) M = ENTITLED TO MEDICAL ASSISTANCE ONLY (MAO), NON-CASH RECIPIENT (STATE TO CMS) P = QUALIFIED MEDICARE BENEFICIARY (QMB) Z = DEEMED CATEGORICALLY NEEDY (STATE TO CMS)
***********************	**PART D DATA ELEMENTS**
BENE FIRST ELIGIBLE PART D DATE	The first date on which a beneficiary had become eligible for Medicare Part D, whether or not enrolled on a Medicare Part D plan. Note: If multiple Part D periods exist for the beneficiary, this will contain the earliest Part D Eligibility Start Date.
BENE AFF (AFFIRMATIVELY) DEC (DECLINE) INDICATOR	An indicator providing whether or not a beneficiary had chosen not to be auto-enrolled by CMS in a Medicare Part D plan.

also known as, Bene Part D Opt-Out Indicator	Values: Y = YES Space (default value) or N = NO
***********************	**BENE COPAY HISTORY (10 TIMES)**
BENE COPAY TYPE	A code indicating whether the beneficiary was determined eligible for Low-Income Subsidy or Deemed eligible. Values: L = Low-Income Subsidy (LIS) D = Deemed
BENE COPAY LEVEL	An indicator providing the level of copay granted to the beneficiary. Values: If BENE LIS TYPE = L 1 = HIGH 4 = 15% If BENE LIS TYPE = D 1 = HIGH 2 = LOW 3 = 0 (ZERO)
BENE COPAY START DATE	The effective date of the copay period. Format: **MMDDCCYY**
BENE COPAY END DATE	The end date of the copay period. Format: **MMDDCCYY**
***********************	**PART D PLAN BENEFIT PACKAGE (10 TIMES)** **The first occurrence is the active or most recent Medicare Part D Plan coverage. Presently, this section is populated with Medicare Part C offering drug coverage and Medicare Part D plan benefit package selections.** **For Medicare Part C plans that offer Part D (e.g. (Medicare Advantage MA-PD) the beginning date of enrollment in the Part C plan may be earlier than January 1, 2006 (the start of the Medicare Part D program).**
BENE CONTRACT NUM (NUMBER)	Unique identifications for an agreement between CMS and a managed care organization o PDP sponsor enabling the plan to provide Medicare Part D prescription drug coverage.
BENE PTD PBP ENRLMNT STRT DT	The effective date that the beneficiary was enrolled in the Service Elections (PBP). Format: **MMDDCCYY** **For Medicare Part C plans that offer Part D (e.g. (Medicare Advantage MA-PD) the beginning date of enrollment in the Part C plan may be earlier than January 1, 2006 (the start of the Medicare Part D program)**
BENE PTD PBP ENRLMNT END DT	The end date of the beneficiary's enrollment in the Service Elections (PBP). Format: **MMDDCCYY**
BENE PTD PBP PLAN ID	A unique identifier for the managed care benefit package. For Medicare Part D, this number is a unique identification for an agreement between CMS and a Medicare Part D provider, enabling the Medicare Part D provider to provide prescription

	drug coverage to eligible beneficiaries.
BENE ENROLL TYPE IND (INDICATOR)	An indicator providing the type of enrollment performed. Values: A = Auto-Enrolled B = Beneficiary Election C = Facilitated Enrollment D = System-Generated Enrollment (Rollover) E=Plan submitted auto-enrollments F=Plan submitted facilitated enrollments G=Point of Sale (POS) submitted enrollments H=CMS- or Plan submitted re-assignment enrollments I=Assigned to Plan-submitted transactions with enrollment source other than any of the following: B,E,F,G,H and blank
Part C Organization Name	Relates to the first occurrence of the Beneficiary's Group Health Organization Contract Number, i.e. name of Part C organization with contract number in positions 1479-1483.
Part C Plan Name	Same as above, i.e. name of plan with Part C plan benefit package number in positions 1697-1699.
Part D Organization Name	Relates to the first occurrence of the Beneficiary's Contract Number in Part D Plan Benefit Package, i.e. name of Part D organization with contract number in positions 2401-2405.
Part D Organization Plan Name	Same as above, i.e. name of Part D plan benefit package number in positions 2422-2424.
Part D Organization Plan Benefit	*Note: this field cannot be populated at this time, but is being reserved for future use for this purpose*. Four types of benefit package values exist. Valid Values: 1=Defined Standard 2=Actuarial Equivalent 3=Basic Alternative 4=Enhanced Alternative Space = not applicable. This corresponds to the Part D plan benefit package in positions 2422-2424.
Beneficiary Language Indicator	A code that identifies the language that the beneficiary requested SSA to use for beneficiary notices. Valid values: **Blank/Null**=English assumed E=English requested C=Chinese D=German F=French G=Greek I=Italian J=Japanese N=Norwegian P=Polish R=Russian S=Spanish V=Swedish W=Serb-Croatian
SNP Indicator occurs 10 times.	Relates to the Beneficiary's Group Health Organization Contract Number (Special Needs Plan) , e.g. first occurrence corresponds to first GHO (Part C) occurrence in positions 1697-

	1699. Valid Values: Y = SNP N = Not a SNP Space = not applicable
INCARCERATION Start Date	The start date that a beneficiary became incarcerated. Provided solely to inform why a dual eligible is not auto-enrolled. If there is no incarceration start date, this field will be populated with all zeroes.
INCARCERATION Term Date	The date that this beneficiary's incarceration period terminated. Provided solely to inform why a dual eligible is not auto-enrolled. If there is no incarceration term date, this field will be populated with all zeroes. If the Incarceration Start Date has a value, and the Term date has not been populated in CMS' systems, the Term Date will be populated will 9's.
Filler	**space**
Prev Month SPD Calculation Code	Code to indicate how the individual beneficiary was used for calculations for State enrollment and disenrollment in a prior month's entry. Valid 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 recs) P=Prospective DUALS, not considered in CLAWBACK counts Null or Space=Historical entries before code was added.
SECONDARY MATCH IND	This field indicates if a matched detail record was matched under the Secondary Match algorithm of (HICN or SSN) and first 6 letters of last name and first letter of first name and exact gender . ** A matched detail record is indicated by the presence of alphanumeric values in the fields: BENE CLM ACNT NUM, BENE IDENT CD and a Record Return Code of '000000' or '000001'. **Valid Values:** SPACE : Default for either primary match located beneficiary (if RRC = 000000 or 000001) or neither primary nor secondary match was successful (if RRC = 000003). 'S': Match accomplished by Secondary Match Algorithm
SPD CALCULATION IND	Code to indicate if the individual beneficiary was used for calculations for State enrollment and disenrollment in a current file's entry. (This entry will relate to the latest beneficiary information provided by the State) Valid 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 recs) P=Prospective DUALS, not considered in CLAWBACK counts

	Null or Space=Historical entries before code was added.
RDS Start Date	The start date of the employer plan period for the beneficiary.
RDS Term Date	The end date of the employer plan period for the beneficiary.
Part D Eligibility Start Date	Indicates the start date for the most recent Part D eligibility span.
Part D Eligibility Term Date	Indicates the end date for the most recent Part D eligibility span.
Subsidy Level	The LIS premium subsidy amount. Relates to the numbered occurrence of the Beneficiary's Co-payment History, e.g. first occurrence here relates to first occurrence of Copayment in position 2222. If the information in the Co-payment History is DEEMed info, the default for subsidy is 100%. VALID VALUES: 100 075 050 025.
LIS DEEM Source Code	Code indicating the source of the LIS/Deeming action found in position 2221 (copayment occurrence) and 3064 (premium subsidy occurrence). **Valid values for D(Deemed)**: 01=MBD Third Party 02=EEVS(State data in baseline) 03=SSA 04=State 05=Deemed source is Contingency Contractor 06=CMS User. **VALID values for L(LIS)**: SS = SSA <st> = State Code abbr.
***********************	**REMAINDER OF RECORD**
FILLER	

4.8 File Summary Record Data Element Specifications

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

FILE PROCESS TIMESTAMP	Format: YYYY.MM.DD.hh.mm.ss.nnnn
	YYYY = Year;
	MM = Month;
	DD = Day;
	hh = hour;
	mm = minute;
	ss = second;
	nnnnnn = microsecond
	
	The exact time that the State file had been processed.

FILE CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12) The month in which the MMA State file was created.
FILE CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created The year in which the MMA State file was created.
RECORDS TOTAL	The total number of detail records in the State file. RECORDS VALID + RECORDS INVALID = RECORDS TOTAL.

	RECORDS MATCHED + RECORDS NOT MATCHED = RECORDS TOTAL. This total does not include PRO detail records.
RECORDS DUPLICATE	The total number of duplicate detail records found in the State file. This count does not include PRO detail records.
RECORDS NONDUP	The total number of non-duplicate valid detail records found in the State file. This count does not include PRO detail records.
RECORDS VALID	The total number of valid detail records found in the file. Valid records are non-duplicate and provide valid essential information. Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth - HICN or RRB, Date of Birth - Social Security Number, Date of Birth This count does not include PRO detail records. See also Person-Level Record Data Element Specifications: Error Return Codes.
RECORDS INVALID	The total number of invalid detail records found in the file. See also Person-Level Record Data Element Specifications: Error Return Codes. This count does not include PRO detail records.
RECORDS MATCHED	The total number of detail records that could be matched successfully to an individual on the Medicare Beneficiary Database. This count does not include PRO detail records.
RECORDS NOT MATCHED	The total number of detail records that could not be matched successfully to an individual on the Medicare Beneficiary Database. This count includes Invalid detail records because no match is attempted on an invalid detail record. This count does not include PRO detail records.
FILLER	
VALID DUAL RECORDS	The total number of valid Dual Eligible detail records found in the file. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes.

	This count does not include PRO detail records.
VALID DUAL MATCHES	The total number of valid Dual Eligible detail records that could be matched successfully to an individual on the Medicare Beneficiary Database. This count does not include PRO detail records.
VALID DUAL NONMATCHES	The total number of valid Dual Eligible detail records that could not be matched successfully to an individual on the Medicare Beneficiary Database. This count does not include detail records that were not tried in the match process i.e. invalid records. This count does not include PRO detail records.
VALID LIS RECORDS	The total number of valid Low-Income Subsidy detail records found in the file. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes. This count does not include PRO detail records.
VALID CURRENT DUALS	The total number of valid Dual Eligible detail records with Eligibility Month/Year = File Create Month/Year. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes. This count does not include PRO detail records.
VALID RETRO DUALS	The total number of valid Dual Eligible detail records with Eligibility Month/Year < File Create Month/Year. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes. This count does not include PRO detail records.
TOTAL ELIG MONTHS	The total number of Eligibility months found in the file. This count does not include PRO detail records.
TOTAL VALID PRO RECORDS	The total number of valid Prospective Full Dual (PRO) detail records found in the file. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes.
TOTAL INVALID PRO RECORDS	The total number of invalid Prospective Full Dual (PRO) detail records found in the file See also Person-Level Record Data Element Specifications: Error Return Codes (ERC)
TOTAL MATCHED PRO	The total number of valid Prospective Full Dual (PRO) detail

RECORDS	records that could be matched successfully to an individual on the Medicare Beneficiary Database.
FILLER	

4.9 Month Summary Record Data Element Specifications

***********************	**ONE OF THESE RECORDS WILL BE GENERATED FOR EACH ELIGIBILITY MONTH FOUND IN THE FILE.**
REC IDENT CODE	**"MSM"**
STATE CODE	**State Code - Valid Code** Alabama AL Alaska AK Arizona AZ Arkansas AR California CA Colorado CO Connecticut CT Delaware DE District of Columbia DC Florida FL Georgia GA Hawaii HI Idaho ID Illinois IL Indiana IN Iowa IA Kansas KS Kentucky KY Louisiana LA Maine ME Maryland MD Massachusetts MA Michigan MI Minnesota MN Mississippi MS Missouri MO Montana MT Nebraska NE Nevada NV New Hampshire NH New Jersey NJ New Mexico NM New York NY North Carolina NC North Dakota ND Ohio OH Oklahoma OK Oregon OR Pennsylvania PA Rhode Island RI South Carolina SC South Dakota SD Tennessee TN Texas TX Utah UT Vermont VT Virginia VA Washington WA West Virginia WV Wisconsin WI Wyoming WY
FILE PROCESS TIMESTAMP	Format: The exact time that the State file had been processed.
FILE CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12) Create Month of the MMA State File
FILE CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created Create Year of the MMA State File
ELIGIBILITY MONTH	Calendar Month Code for applicable Medicaid eligibility (e.g.012006) found in the MMA State file. Valid Month Values:

	01 – 12 (e.g. January=01, December=12.)
ELIGIBILITY YEAR	Calendar Year Code for applicable Medicaid eligibility (e.g.012006) found in the MMA State file. Valid Month Values: 01 – 12 (e.g. January=01, December=12.)
CALCULATION SWITCH	Y = This Eligibility Month/Year was used in the State phase-down calculation. N = This Eligibility Month/Year was not used in the State phase-down calculation. Please note: Months previous to 012006 are not used in State Phase-Down Calculation.
TOTAL VALID RECORDS	The total number of valid Dual Eligible detail records found in the MMA State file for this Eligibility Month/Year. TOTAL VALID FULL DUAL RECORDS + TOTAL VALID NON-FULL DUAL RECORDS = TOTAL VALID RECORDS This count does not include PRO detail records.
TOTAL VALID FULL DUAL RECORDS	The total number of valid full dual beneficiary records. This count does not include PRO detail records.
TOTAL VALID NON-FULL DUAL RECORDS	The total number of valid non-full dual beneficiary records. This count does not include PRO detail records.
NET TOTAL VALID FULL DUAL ENROLLMENTS	The net total number of valid Full Dual Eligible enrollments counted for this Eligibility Month/Year. This count does not include PRO detail records.
NET TOTAL VALID FULL DUAL DISENROLLMENTS	The net total number of valid Full Dual Eligible disenrollments counted for this Eligibility Month/Year. This count does not include PRO detail records.
FILLER	

4.10 Trailer Record Data Element Specifications

RECORD IDENT CODE	**"TRL"**

FILE PROCESS TIMESTAMP	Format: YYYY.MM.DD.hh.mm.ss.nnnn
	YYYY = Year;
	MM = Month;
	DD = Day;
	hh = hour;
	mm = minute;
	ss = second;
	nnnnnn = microsecond
	
	The exact time that the State file had been processed.

FILE CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12) The month in which the MMA State file was created.
FILE CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created The year in which the MMA State file was created.
FILE ACCEPT IND	Y = The State file had been accepted; N = the State file had not been accepted.
FILLER	
***********************	**ORIGINAL STATE TRAILER RECORD (180 BYTES)**
FILLER	
***********************	REMAINDER OF RECORD
FILLER	