The State Medicare Modernizations Act (MMA) File to CMS for Dually Eligible Individuals

Frequently Asked Questions

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MMA File Submissions	June 2021
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1. MMA File Submissions

1.1. What is the state MMA file of dually eligible beneficiaries?

Since 2005, states have been submitting files at least monthly to the Centers for Medicare & Medicaid Services (CMS) to identify all dually eligible beneficiaries. This includes full-benefit dually eligible beneficiaries and partial-benefit dually eligible beneficiaries (i.e., those who get Medicaid help with Medicare premiums, and often for cost-sharing). The file is called the "MMA file" (after the Medicare Prescription Drug, Improvement and Modernization Act of 2003) but is occasionally referred to as the "state phasedown file."

However, federal regulations at 42 CFR 423.910 now require states, effective April 1, 2022, to submit files daily.

1.2. Should states that submit multiple MMA files per month include only changes?

These states should submit one complete monthly file, and subsequent files that month should include only file accretions and deletions.

1.3. Should states that submit daily MMA files continue to submit one full monthly file?

Yes. These states should submit one complete monthly file at the beginning of the month, and daily files that follow should include only file accretions, deletions, and changes.

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

1.4. Should the daily file submissions be on "business days" only?

States may submit on any calendar day. However, please note the following state file cutoff processing times for the last calendar day in a month:

- If the last day of the month is a weekday (including holidays that fall on a weekday), the cutoff processing time is 6 p.m. ET.
- If the last day of the month is on Saturday or Sunday, the cutoff processing time is 1 p.m. ET.

1.5. What should states do if they use multiple upstream systems to produce the daily MMA file?

We encourage states to automate their upstream systems to send changes daily to the system that generates the MMA file, which can then check if it needs to generate a daily update to CMS on the MMA file. This would support automating a process by which the system only generates an MMA file upon identifying such a change. We will work with states that have already implemented these changes to identify and share best practices in identifying data changes to trigger daily submissions.

1.6. What happens if the state submits a file on the last day of the month after the cutoff day/time?

We encourage states and their contractors to make every effort to submit files before the cutoff. However, we have contingency processes in place if a state submits a file on the last day of the month and it is received on or after the cutoff processing time. In those cases, CMS will process the file the first day of the subsequent month. Detail (DET) records submitted as "current" would now be treated as retroactive records, and any DET records with month/year populated as one month into the future would be processed as current records. These adjustments ensure CMS processes the data for the originally intended effective date, and that there is no negative beneficiary, provider, or plan impact.

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

1.7. What is the production turnaround time for testing files to move to a daily submission from weekly or monthly?

Test file response timeframes will be communicated to the state when it is in testing with CMS' Medicare Beneficiary Database (MBD) contractor. It is a process that is manually set, and the contractor determines when testing occurs, as CMS must coordinate with the integration testing contractor to determine the availability of the test environment. Once the MBD contractor determines the availability of the test environment, turnaround time for a test file is 48–72 hours. The state should contact the Medicare Advantage Prescription Drug (MAPD) Help Desk at (800) 927-8069 or MAPDHelp@cms.hhs.gov to inform the MBD Support Team of their interest in testing for more frequent file submission, testing submission when making changes to the MMA file, or testing when a new vendor assumes responsibility for generating the file.

1.8. How does CMS validate individual records on a state MMA file? What records are accepted/rejected on the MMA file?

The MAPD State User Guide (SUG), Sections 4–7, outlines technical instructions for submission of the MMA file to CMS and state request and CMS response file layouts.

- Section 6, Special Key Fields/User Tips for the MMA Request File, lists the key beneficiary fields used to perform a match between the state's incoming beneficiary records to the CMS MBD. CMS can only process records for individuals who are in CMS systems.
- Section 7.5, MMA Response File Detail Record Layout, item # 31–54, provides Error Return Codes (ERC), e.g., Eligibility Month/Year, Eligibility Status, and Beneficiary SSN.

1.9. When CMS rejects the whole MMA file (i.e., rather than just a specific record), how can a state know what caused CMS to reject the whole file?

While infrequent, there are times when CMS rejects the whole file (e.g., when a state submits a file with the incorrect naming convention). If a state has questions about a rejected MMA file, please reach out to the MAPD Help Desk at (800) 927-8069 or MAPDHelp@cms.hhs.gov and request that the ticket is assigned to the MBD Production Control team.

1.10. How many months are states required to look back for retroactive eligibility changes that could change data previously reported on the MMA file?

CMS is only able to process records up to 36 months retroactive from the current reporting month. Any records older than 36 months will be rejected. We encourage states to use a similar window for looking back for changes.

Note: The CMS database will allow states to correct information submitted on the MMA file with eligibility months prior to 36 months and not exceeding 120 months. All state submissions meeting these criteria will require prior approval by emailing the Medicare-Medicaid Coordination Office (MMCO) at MMCO_MMA@cms.hhs.gov.

1.11. Is Medicare Beneficiary Identifier (MBI)/Health Insurance Claim Number (HICN) a mandatory field for CMS to accept the record?

The MBI/HICN field is not mandatory, but if MBI/HICN is not present, the Social Security number (SSN) must be present so that CMS can identify the individual.

1.12. Now that the Social Security Number Removal Initiative (SSNRI) project is complete, will states only send the MBI on the MMA file?

Now that the SSNRI is complete, most external CMS partners will be limited to MBI in data exchanges, but states are an exception. States will continue to be able to use the same range of identifiers they do now for specified data exchanges. As noted in the response to 1.11, states may send the MBI, HICN, and even SSN on their MMA file to CMS, and these same identifiers may be in the CMS response file to states.

1.13. How do you validate the SSN in the MMA file?

As noted above, either the SSN or the MBI/HICN must be present. If the state only submits the SSN, the values must be numeric and not all 0s or 9s. CMS validates it against the SSN on file, which we get from the Social Security Administration.

1.14. Is there a resource that contains technical guidance regarding the submission of the MMA file?

Yes, the MAPD SUG provides technical instructions for submission of the MMA file to CMS and request and response file layouts.

The MAPD SUG can be found here.

1.15. How does a state report contact changes to receive automated file notifications out of MBD applications (e.g., MMA or Territory & States Beneficiary Query (TBQ) file)?

Contact the MAPD Help Desk at 800-927-8069 or MAPDHelp@cms.hhs.gov and provide the updated information and request the Help Desk assign the ticket to the MBD Application Support team.

2. Dual Status Code

2.1. Who qualifies as a full-benefit dually eligible beneficiary?

A full-benefit dually eligible beneficiary is enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits. These beneficiaries are also often receiving assistance with Medicare premiums or cost sharing through the Medicare Savings Program (MSP). For the regulatory definition, please see 42 CFR 423.902.

2.2. Who does not qualify as a full-benefit dually eligible beneficiary?

Individuals for whom Medicaid only covers a narrow benefit or set of benefits under the state plan or demonstration or waiver authority (e.g., family planning services, tuberculosis-related services, or treatment of emergency medical conditions) do not meet the definition of a full-benefit dually eligible beneficiary. For the regulatory definition of a full-benefit dually eligible beneficiary, please see 42 CFR 423.902. They should only be included on the MMA file if they are eligible as a Qualified Medicare Beneficiary (QMB)-only, Specified Low-Income Medicare Beneficiary (SLMB) -only, or Qualifying Individual (QI) .

2.3. How does a state derive the dual status code? If the recipient is eligible for both Medicaid and Medicare, does that determine that they are dually eligible?

Dually eligible individuals are enrolled in both Medicare and Medicaid. This includes beneficiaries enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of these MSP categories:

- **QMB Program:** Helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs.
- **SLMB Program:** Helps pay Part B premiums.
- **QI Program:** Helps pay Part B premiums.
- **Qualified Disabled Working Individual (QDWI) Program:** Pays the Part A premium for certain disabled and working beneficiaries.

We encourage Medicaid Management Information System (MMIS) maintainers who create the MMA file to connect with the eligibility staff in the given state's Medicaid agency.

To learn more about categories of eligibility for dually eligible beneficiaries, click here.

2.4. What should the dual status code be for an individual who has Supplemental Security Income (SSI)?

Individuals who receive SSI may have different dual status codes depending on a given state's eligibility criteria for full Medicaid. MMIS maintainers who create the MMA file should consult with the eligibility experts in the state Medicaid agency.

2.5. Could you please elaborate with examples on how CMS uses data submitted in the dual status code and federal poverty level (FPL) percent code fields?

As noted elsewhere, CMS uses MMA file data in all four parts of Medicare. Below is a description of how CMS uses the data in each part of Medicare.

Parts A and B

CMS uses the dual status code provided in the MMA file to alert providers and beneficiaries of QMB status. For providers, the data populate Medicare's HIPAA Eligibility Transaction System (HETS), which provides real-time 270/271 responses on Medicare Parts A and B eligibility data to providers, suppliers, or their authorized billing agents. Specifically, the 271 response returns a 2110C loop for applicable beneficiaries to indicate periods where the beneficiary is enrolled in the QMB program. For more information on HETS, see https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/.

CMS also uses the dual status code to indicate the QMB status and protection from Medicare cost-sharing liability in the Medicare Remittance Advice to providers and the Medicare Summary Notice to beneficiaries.

Part C

CMS uses Medicaid dual status code to determine which risk adjustment factor is used to calculate payment to Medicare Advantage plans for most beneficiary payments by determining risk scores under the CMS Hierarchical Condition Category (HCC) model. Specifically, Medicaid status is used for community beneficiaries to determine which of the following risk adjustment segments is used:

1. Full benefit dual aged.
2. Full benefit dual disabled.
3. Partial benefit dual aged.
4. Partial benefit dual disabled.
5. Non-dual aged.
6. Non-dual disabled.

Medicaid status is also used to determine risk scores under the HCC model used for new enrollees (individuals with less than 12 months of Part B enrollment in the data collection period).

Part D

CMS uses dual status codes as well as FPL Indicator and Institutional Status fields in its process to deem dually eligible individuals automatically eligible for the Medicare Low-Income Subsidy (LIS). All dually eligible individuals get full LIS,[1] but the MMA file data prompt establishment of copayment levels as zero, low, or high, as well as start and end dates.

- Copayment levels:
    - For full-benefit dually eligible individuals (i.e., those with dual status code of 02, 04, and 08), CMS sets the Medicare Part D LIS copayment levels based on the following data:

[1] "Dually eligible beneficiaries" generally describes beneficiaries enrolled in Medicare and Medicaid. The term includes beneficiaries enrolled in Medicare Part A and/or Part B and getting full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through the MSP.

        - Individual's applicable income is equal to or less than 100 percent FPL; copayment level is low
        - Individual's applicable income is greater than 100 percent FPL; copayment level is high
        - If the individual has institutional/home and community-based services (HCBS) status (institutional status = Y or HCBS = H), CMS sets LIS copayment levels at $0, regardless of FPL percent code level.
    - For partial-benefit dually eligible individuals (i.e., those with dual status code 01, 03, or 06), CMS sets the Medicare Part D LIS copayment level to high (regardless of income or institutional status).
- Effective dates of and changes to deemed LIS status.
    - For eligibility months of January to June, CMS sets the end date of deemed status as December of current year.
    - For eligibility months of July to December, CMS sets the end data of deemed status as December of the following year.
    - CMS only changes copayment levels within an existing span of deemed LIS if it is to advantageous to the beneficiary.

Examples:

- Beneficiary 1:
    - State submits a person with eligibility month/year April 2020, with dual status code 02 (QMB plus - full dual) and income under 100 percent FPL.
        - CMS sets the copayment level to low for April to December 2020.
    - State submits the same person with eligibility month/year June 2020, with status code 08 (other full dual) and income greater than 100 percent FPL.
        - No change to the copayment level/dates.
    - State submits the same person with eligibility month/year October 2020, dual status code 02 (QMB plus – full dual) and income less than 100 percent FPL
        - No change to the copayment level; CMS extend end date to December 2021.
- Beneficiary 2:
    - State submits a person with eligibility month/year April 2020, with dual status code 02 (QMB plus – full dual), with income less than 100 percent FPL and HCBS status (H).
        - CMS sets the copayment level to zero for April to December 2020.
    - State submits the same person with eligibility month/year September 2020, with dual status QMB-plus and no "H" code to indicate HCBS status.

- No change to the copayment level for 2020; sets new copayment level of high for January to December 2020

To learn more about the categories of dual eligibility and the federal income criteria, click here.

3. Institutional Status Indicator/HCBS

3.1. What is the institutional status indicator?

The institutional status indicator denotes whether a full-benefit dually eligible individual receives services at a Medicaid-covered nursing facility, immediate care facility, inpatient psychiatric hospital, or HCBS.

CMS uses this field to establish the correct beneficiary copayment levels. In addition, to ensure that CMS provides the zero-copayment level for the correct effective date, it is essential that states submit accurate current-month institutional status and retroactive records reflecting institutional status changes in prior months. 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.

3.2. What are the institutional status indicator field values?

The institutional status indicator is an indicator a beneficiary resides in a medical institution or a nursing facility or receives HCBS. Information about the valid values for the indicator are:

- **Y:** Indicates that a full-benefit dually eligible beneficiary is enrolled in a Medicaid paid institution for the full reporting month or is projected by the state to remain in the institution for the remainder of the month.
- **H:** Indicates that a full-benefit dually eligible beneficiary receives HCBS in any period during the month. This includes HCBS delivered under a Section 1115 demonstration, under a 1915(c) or (d) waiver, under a state plan amendment under 1915(i), or through a Medicaid managed care organization (MCO) with a contract under section 1903(m) or under Section 1932 of the Social Security Act.
- **N:** Indicates the beneficiary does not meet the criteria for Y or H.
- **9:** Unknown.

3.3. Does the HCBS indicator include all HCBS programs?

The HCBS indicator includes many but not all types of HCBS programs. A state should populate the field with the H indicator for full-benefit dually eligible individuals receiving HCBS delivered under a Section 1115 demonstration, under a 1915(c) or (d) waiver, under a state plan amendment under 1915(i), or through a Medicaid MCO with a contract under Section 1903(m) or under section 1932 of the Social Security Act. It does not include HCBS or personal care programs authorized under 1905(a), 1915(j) (self-directed personal care under a state plan), or 1915(k) (community first choice services).

4. Low-Income Subsidy

4.1. How often does CMS provide the LIS level updates to the Part D plans?

CMS uses the dual status code to automatically deem dually eligible individuals for the full LIS premium subsidy level. We use the beneficiary's dual status code, FPL percentage indicator, and institutional/HCBS status indicator to set or update the specific LIS copayment level. We send new LIS status and changes in the LIS copayment levels to Part D plans daily.

4.2. What fields are specific for LIS record types?

Please refer to the MAPD SUG section 6.4, MMA Request File Detail Record, Items 18–29. At present, Items 24, 27 and 29 are "informational." Item 28 is for future use.

5. MMA, TBQ and EDB Files

5.1. What are the differences between the MMA, TBQ, and Enrollment Database (EDB) files?

The chart below summarizes three CMS data files and the similarities and differences between each. A detailed comparison of these files can be found here.

Information about File	MMA	EDB	TBQ
Data Exchange vs. Data Query?	Exchange	Query	Query
Operational vs. Elective?	Operational	Elective	Elective
States and/or Territories Eligible?	States	States & Territories	States & Territories
CMS Source Database?	CMS MBD	CMS EDB	CMS MBD
Medicare Parts Included?	A, B, C, D	A, B	A, B, C, D

Note: CMS is planning to retire the EDB file exchange June 30, 2022.

6. Part D Eligibility

6.1. Can you explain when the Medicare Part D eligibility start date is determined, in relation to Part A and Part B? How is the Part D enrollment determined?

The Part D start date is the earlier of the Part A or B start dates, but if either A or B has a retroactive effective date, the Part D effective date is not retroactive (e.g., for a person who received notice of Part A/B entitlement in the month of March 2019, they have Part A back to October 1, 2018, and the Part D effective date is March 1, 2019).

6.2. Do individuals need both Part A and Part B to be eligible for Part D? Are they still eligible for Part D if they lose either Part A or Part B?

Individuals need either Part A or Part B to be Part D eligible. They do not need both.

7. Medicare Dual-Eligible Special Needs Plan (D-SNP)

7.1. What is the state's responsibility in assisting a Medicare D-SNP?

Medicare D-SNPs must be able to confirm dual eligible status of enrollees. To operate in a given state, each D-SNP must have a contract with the state Medicaid agency. If a state declines to

contract with the D-SNP, or if the contract with a D-SNPs does not include all the required elements, including the state's agreement to provide D-SNPs with information to confirm dual eligible status for their enrollees, the D-SNP may not be permitted to operate. For more information, click here.

8. Medicare Part C (Group Health Plans (GHP))

8.1. For Medicare Part C plans, is there a crosswalk of the Group Health Contract number (specifically, the field called "Beneficiary MCO Number") to the Group Health Name (i.e., the name of the plan)?

To crosswalk contract number to the plan's name, click here for the 2020 MA Landscape Source File containing Part C plan information as well the 2020 PDP Landscape Source File immediately below it for Part D plans. (Please note: the MMA file still has older terminology referencing "Group Health Plans" for what are now called Medicare Part C or Medicare Advantage plans).

8.2. Can you explain the relationship between Group Health Plan (GHP) Enrollment Start Date field, Plan Benefit Package (PBP) Enrollment Start Date, and Plan Benefit Package Enrollment End Dates fields? Is it valid for one GHP enrollment occurrences to overlap with another GHP enrollment occurrences?

Normally a beneficiary would only have one Medicare plan (contract and plan benefit package) for a given month. However, there can be valid overlapping enrollment occurrences of two plans, specifically if one plan is Medicare Advantage only (i.e., does not offer the Part D benefit) and the other is a stand-alone Prescription Drug Plan (PDP). In that case, the MCO/GHP contract numbers will be different.

For a detailed discussion of these fields and when they can overlap, please see section 7.2 of the MAPD SUG, which can be found here.

9. Medicare Disenrollment Codes

9.1. How can a state receive clarification on Medicare disenrollment codes for state buy-in transactions?

For a list of disenrollment codes, refer to section 3.2.5 in the Plan Communication User Guide, Table 3-6, for plan submitted disenrollment codes.

Please direct all questions regarding Medicare buy-in disenrollment codes to SPBCStateBuy-In@cms.hhs.gov.

10. Comprehensive Addiction and Recovery Act (CARA)

10.1. Is the CARA section of the MMA file new?

The CARA start and end date fields were added to the MMA Response file layout in 2018.

11. Contacts for the MMA file

11.1. Who do I contact with general questions about the MMA file?

Contact the CMS MMCO at MMCO_MMA@cms.hhs.gov to learn about MMA file submissions.

11.2. Who do I contact with technical issues/concerns about the MMA file submission?

The MAPD Help Desk provides technical system support to states for file exchanges. Contact the MAPD Help Desk at MAPDHelp@cms.hhs.gov or (800) 927-8069. Visit the MAPD Help Desk website at http://go.cms.gov/mapdhelpdesk.

11.3. Is there a webinar available?

Yes, the slides and recording from a previous webinar are available on the SDRC public website: www.StateDataResourceCenter.com.

Please submit additional questions about the MMA file to MMCO_MMA@cms.hhs.gov.